From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-19 6:47 PM
To: Rendall, Jennifer (PHAC/ASPC)
Subject: FW: [MARKETING] Public Health Weekly

We could send the ASTHO CEO a link to the CPHO report

From: ASTHO
Sent: 2019-12-19 6:10 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Subject: [MARKETING] Public Health Weekly

View this email in your browser.

astho™

PUBLIC HEALTH WEEKLY

Dec. 19, 2019

This Week's Highlights

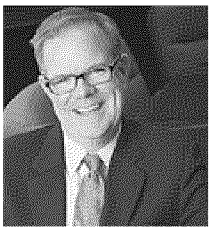
Congress reached a bipartisan agreement to fund the federal government for the remainder of FY20. The agreement includes a two-year extension of Medicaid funding for the U.S. territories and raises the federal tobacco purchasing age from 18 to 21 years old. Read more in our legislative alert.

What can state health leaders expect from Congress in the new year? Carolyn Mullen, ASTHO chief of public relations and government affairs, reflects on the biggest federal health news of 2019 and previews what's to come in 2020.

ASTHO finalized its federal legislative agenda for FY20. Priorities include funding for CDC, investment in programs that increase access to healthcare, and increased support for the nation's preparedness efforts.

Note: In light of the holiday break, the next edition of Public Health Weekly will run on Jan. 9, 2020.

Leading State Health



2019 was a year of great progress and great challenges in public health. But in those challenges was a chance for state leaders to once again demonstrate their value to the nation. ASTHO CEO Mike Fraser writes on his top nine public health moments of 2019 in this week's column.

Read here.

From the Field

ASTHO staff gathered at our annual holiday luncheon last week to unwind and celebrate another terrific year of public health accomplishments.

Read more about our 2019 highlights as we wrap up the year and set our sights on 2020.

Health Policy Update

Cannabidiol—better known as CBD—is everywhere, and proponents of the hemp-based compound claim it treats health ailments ranging from anxiety to joint pain. But what exactly is CBD, and how are states regulating it? Get the rundown in our latest blog.

PRESS ROOM | PODCAST

BLOG | NEWSLETTERS

Visit ASTHO's website for more information on public health jobs, funding opportunities, and events.

WITHHELD / RETENUE

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CANADA

PRIVY COUNCIL • CONSEIL PRIVÉ

P.C. 2019-376
April 15, 2019
EXTRACT

Her Excellency the Governor General in Council, on the recommendation of the Prime Minister, fixes the remuneration, in the amount and on the date indicated in the annexed schedule, of:

Tam,Theresa, former interim Chief Public Health Officer, Public Health Agency of Canada, within the range ($234,700 - $275,100), effective December 17, 2016, within the range ($237,700 - $278,600), commencing on April 1, 2017 and ending on June 20, 2017; and

Tam, Theresa, Chief Public Health Officer, Public Health Agency of Canada, within the range ($237,700 - $278,600), effective June 21, 2017, within the range ($237,700 - $278,600), effective April 1, 2018, within the range ($237,700 - $278,600), effective December 21, 2018.

CERTIFIED TO BE A TRUE COPY–COPIE CERTIFIÉE CONFORME

Michael Vernon

CLERK OF THE PRIVY COUNCIL–GREFFIER DU CONSEIL PRIVÉ

P.C. 2019-376

SCHEDULE

Public Health Agency of Canada
Theresa Tam
Former interim Chief Public Health Officer

New Salary [redacted]
Effective 17/Dec/2016
Revised 2016-17 Performance Pay [redacted]
For the period 17/Dec/2016 to 31/Mar/2017
The previous performance pay award amount of [redacted] has been adjusted to [redacted] which is an additional [redacted] to be awarded.

New Salary [redacted]
Effective 01/Apr/2017 to 20/Jun/2017

Public Health Agency of Canada
Theresa Tam
Chief Public Health Officer

New Salary [redacted]
Effective 21/Jun/2017
Revised 2017-18 Performance Pay [redacted]
For the period 01/Apr/2017 to 31/Mar/2018
The previous performance pay award amount of [redacted] has been adjusted to [redacted] which is an additional [redacted] to be awarded.

New Salary [redacted]
Effective 01/Apr/2018
New Salary [redacted]
Effective 21/Dec/2018

CANADA

PRIVY COUNCIL • CONSEIL PRIVÉ

C.P. 2019-376
15 avril 2019
EXTRAIT

Sur recommandation du premier ministre, Son Excellence la Gouverneure générale en conseil fixe la rémunération, conformément au montant et à la date indiqués dans l'annexe ci-jointe, de :

Tam, Theresa, ancienne administratrice en chef de la santé publique par intérim, Agence de la santé publique du Canada, dans l'échelle (234 700 $ – 275 100 $), à compter du 17 décembre 2016, dans l'échelle (237 700 $ – 278 600 $), commençant le 1er avril 2017 et se terminant le 20 juin 2017;

Tam, Theresa, administratrice en chef de la santé publique, Agence de la santé publique du Canada, dans l'échelle (237 700 $ – 278 600 $), à compter du 21 juin 2017, dans l'échelle (237 700 $ – 278 600 $), à compter du 1er avril 2018, dans l'échelle (237 700 $ – 278 600 $), à compter du 21 décembre 2018.

CERTIFIED TO BE A TRUE COPY–COPIE CERTIFIÉE CONFORME

Michael Wernick

CLERK OF THE PRIVY COUNCIL–GREFFIER DU CONSEIL PRIVÉ

ANNEXE

Agence de la santé publique du Canada
Theresa Tam
Ancienne administratrice en chef de la santé publique par intérim

Nouveau salaire [redacted]
Date d'entrée en vigueur 17/déc/2016
Rémunération au rendement 2016-2017 révisée [redacted]
Date d'entrée en vigueur 17/déc/2016 au 31/mar/2017
Le montant antérieur de [redacted] comme rémunération au rendement a été ajusté à [redacted] ce qui représente un montant de [redacted] supplémentaire.

Nouveau salaire [redacted]
Date d'entrée en vigueur 01/avr/2017 au 20/juin/2017

Agence de la santé publique du Canada
Theresa Tam
Administratrice en chef de la santé publique

Nouveau salaire [redacted]
Date d'entrée en vigueur 21/juin/2017
Rémunération au rendement 2017-2018 révisée [redacted]
Date d'entrée en vigueur 01/avr/2017 au 31/mar/2018
Le montant antérieur de [redacted] comme rémunération au rendement a été ajusté à [redacted] ce qui représente un montant de [redacted] supplémentaire.

Nouveau salaire [redacted]
Date d'entrée en vigueur 01/avr/2018
Nouveau salaire [redacted]
Date d'entrée en vigueur 21/déc/2018

From: [redacted]
Sent: 2019-12-19 11:21 AM
To: Patty.Hajdu@parl.gc.ca
Cc: Tam, Dr Theresa (PHAC/ASPC); [redacted]
Subject: 7 Year Study on Vaping
Attachments: Vaping Journey.docx

Dear Madam,

Re. the recent article in the Globe and mail on long term effects of vaping I attach my findings. Which may allay your fears.

[redacted]

I am an 87 years old retired R & D scientist who smoked strong, unfiltered cigarettes for 69 years before changing to vaping in 2012, some 7 years ago. At that time I was diagnosed with Chronic Obstructive Pulmonary Disease (COPD), the same disease which caused the death of my only son at the age of 47.

On being given a Lung Function Test it showed a breathing rate of only 50% of normal. On searching the internet, I could find no evidence of the possible effects of vaping on my lungs, so I became a guinea pig by arranging with my surgery to have annual lung function tests in order to find out.

My breathing rate improved to 80% after 18 months, 82% at 3 years, 88% at 4 years, and 88% at year 5 and 6, showing it had stabilised, resulting in my health and quality of life improving dramatically, whilst still satisfying my nicotine dependency. Chest infections have been reduced. This demonstrates the body's remarkable recuperative properties in only 4 years, despite abuse over 69 years! It will never reach 100% because of the irrevocable damage caused to my alveoli by smoking.

I have just had my 7th annual test which showed my breathing to be now 90% of normal.

Although these improvements are entirely due to stopping using tobacco, I find it significant that:

(a) Breathing rate improved from 50% of normal, stabilising at 88% after 4 years.
(b) Chest infections reduced by 37%.
(c) Quality of life improved significantly.
(d) Changing from smoking tobacco to vaping nicotine, did not appear to interfere with the bodies natural recuperative powers.
(e) It is **NEVER** too late to stop smoking.

For many, the electronic cigarette has proved to be the most effective nicotine delivery system ever developed, allowing hardened smokers to change from smoking tobacco, to vaping nicotine, both quickly and effectively. As an ex- smoker I find it easy to see why. It addresses most of the elements which give pleasure to smokers, and one does not feel they have irrevocably stopped smoking but merely changed one cigarette for a much safer type.

[redacted]

From: Patrice, France (PHAC/ASPC) on behalf of Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-06 12:40 PM
To: Lucas, Stephen (HC/SC)
Subject: Accepted: Department Heads Food Safety Committee

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-05 7:04 PM
To: Hostrawser, Bonnie (PHAC/ASPC)
Cc: Bell, Tammy (PHAC/ASPC); Rendall, Jennifer (PHAC/ASPC)
Subject: Re: Adaptation 2020: Attendance and Leadership

Could you just send me a bit more info re Adaptation meeting. I can't quite recall what you told me before.

Sent from my iPhone

> On Dec 5, 2019, at 16:01, Hostrawser, Bonnie (PHAC/ASPC) <bonnie.hostrawser@canada.ca> wrote:
>
> Hello Theresa, as Tammy indicated today, we do plan to come to you with a proposed way forward on Dec 19th for the climate change portion of the next report.
>
> In the meantime we are wondering if you support the idea of you attending Adaptation 2020 in Vancouver around Feb 19th?
>
> We would like to organize a consultation with you and some key leaders in health adaptation. As well, if you go, Program is interested in having you moderate their session focused on infectious disease and delivering opening remarks on the importance of broader adaptation. Program would like to confirm for conference program development.
>
> Thanks so much for considering,
> Bonnie
>
> Sent from my iPhone

From: Bulmer, Jackie (PHAC/ASPC)
Sent: 2019-12-13 3:03 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Subject: address for House of Commons badge

Security Screening and Access Card

Address:
Confederation Building
229 Wellington Street
Room G-70

Phone: 613-992-7218

Email: HoCAccreditationCdC@parl.gc.ca

Hours of operation:
Monday to Friday
8:00 a.m. to 4:00 p.m.
Closed on statutory holidays.

From: [redacted]

Sent: 2019-12-10 9:14 AM

To: Tam, Dr Theresa (PHAC/ASPC)

Subject: Addressing Vaccine Hesitancy in Ontario

Attachments: Addressing Vaccine Hesitancy in Ontario.pdf

Follow Up Flag: Follow up

Flag Status: Flagged

Categories: Follow-Up

[redacted] has attached the following document:

Addressing Vaccine Hesitancy in Ontario

Hi Theresa,

Thank you again for your time and consideration. I'm available to you and your team for any questions on this proposal and would love to talk about it more. As a parent of young kids in the Ontario school system I believe this meets a need for improved communications and good information put directly in the hands of people making health decisions for families. There's no shortage of convincing misinformation, and it's flooding social media. We can create something that adds fact to this conversation in a way that talks to parents.

I'd be grateful for your thoughts on this.

All the best,

[redacted]

Addressing Vaccine Hesitancy in Ontario

[redacted]

Proposal:

A communications plan regarding illness prevention to be used in Ontario schools.

Problem:

In Ontario and throughout Canada we're seeing a growing rate of vaccine hesitancy. As vaccination rates dip below the required threshold to maintain herd immunity, or community immunity, we're seeing a resurgence of vaccine-preventable diseases in our population. In 2018 Canada had 29 measles cases. In 2019 we've seen that number rise to 113 as of week 46. The numbers aren't linear, but show our vulnerability as a population that can be easily exposed due to travel. This year the US nearly lost its measles elimination status and Canada isn't far behind.

In 12 years we've seen non-medical exemptions in Toronto for the MMR vaccine rise from 0.8 to 1.72%. It is estimated that ~20% of Toronto parents are vaccine hesitant. This is a growing problem throughout the province and across Canada.

The issue:

There's a great deal of misinformation about vaccination and vaccine-preventable diseases on the internet, and communications addressing the necessity and benefit of vaccination is often less accessible, less clear, and less discussed. As a result, when decision makers (parents) have questions about vaccination for their children, they're more likely to find misinformation than facts, and misinformation is more likely to be shared in a way that's compelling and easy to understand.

Young parents today have the benefit of not growing up with the consequences of the diseases vaccines prevent, the same way previous generations did. They haven't seen the full strength of measles, mumps, pertussis, or diphtheria in a population, making it more difficult to understand how these diseases would affect their children.

Response:

Create a multi-pronged approach to communicate with parents regarding vaccination and illness prevention for their children, providing them directly with facts and useful information.

Framework:

The communication plan would involve several components, making this information more accessible and visible to parents. Communications would address:

- Vaccination - reminders to check with family doctor to make sure kids are up-to-date on and a recommendation to speak with their family doctor if they have any questions regarding vaccination, and a reminder when the flu shot is available
- School sick day policies - when kids can and can't come to school if they're unwell, school protocol when children show specific symptoms while in class; include an explanation why these policies are in place
- Hand hygiene - how often to wash and for how long, and how to get kids in the habit
- Covering coughs and sneezes, cleaning frequently touched surfaces

Components would include:

- Direct messaging to parents through school communications messaging including newsletters, email, social media, and school websites
- Printables for schools - messaging regarding sick day policies and vaccination would be recommended in offices, and hand hygiene and covering coughs/sneezes in classrooms
- Web resources - a comprehensive website that's easy to navigate and provides information in a clear, accessible way. Information about illness prevention needs to be written with the audience in mind. The website should include:
    - A general overview of illness prevention
    - Vaccination schedule for Ontario
    - Explanation of each infectious disease (how it's spread, what the symptoms are, how it could affect their children, whether a vaccination is available, when we vaccinate for it)
    - Sick day policies and the importance of staying home
    - Other methods of illness prevention, including handwashing, covering coughs and sneezes, cleaning frequently touched surfaces
    - Community immunity concept - it takes a village
    - FAQs
    - Contact information for public health (questions and reporting vaccination status)
    - Flu shot locator
    - Tips for talking to kids about illness prevention and making shots easier
    - Reminder to speak with a family doctor regarding any questions

Future goals:

- Pursue a single vaccination schedule across Canada
- Pursue a digital vaccination record system
- Include vaccination early in H&PE curriculum

WITHHELD / RETENUE

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From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-17 11:07 PM
To: Lucas, Stephen (HC/SC)
Subject: Fwd: alPHa Letter - Ministerial Mandate
Attachments: image001.jpg; ATT00001.htm; alPHa_Letter_Hajdu_Mandate_231219.pdf; ATT00002.htm

---

Hi Steve,

FYI

Sent from my iPhone

Begin forwarded message:

From [redacted]
Date: December 17, 2019 at 15:02:51 EST
To: "Patty.Hajdu@parl.gc.ca" <Patty.Hajdu@parl.gc.ca>
Cc [redacted] 'Tam, Dr Theresa (PHAC/ASPC)"
Subject: alPHa Letter - Ministerial Mandate

Dear Minister Hajdu,
Please find attached a letter from the President of the Association of Local Public Health Agencies regarding our work and its alignments with your mandate.

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-17 3:27 PM
To: Namiesniowski, Tina (PHAC/ASPC); Johnstone, Marnie (PHAC/ASPC); Bent, Stephen (PHAC/ASPC)
Subject: FW: alPHa Letter - Ministerial Mandate
Attachments: alPHa_Letter_Hajdu_Mandate_231219.pdf

Not sure this requires a response but for your awareness. I could send to Steve Lucas as well.

From: [redacted]
Sent: 2019-12-17 3:03 PM
To: Patty.Hajdu@parl.gc.ca
Cc: [redacted] Tam, Dr Theresa (PHAC/ASPC)
Subject: alPHa Letter - Ministerial Mandate

Dear Minister Hajdu,

Please find attached a letter from the President of the Association of Local Public Health Agencies regarding our work and its alignments with your mandate.

[redacted]

alPHa
Association of Local PUBLIC HEALTH Agencies

480 University Ave., Suite 300
Toronto, Ontario M5G 1V2
Tel: (416) 595-0006
E-mail: info@alphaweb.org

alPHa's members are the public health units in Ontario.

alPHa Sections:

- Boards of Health Section
- Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

- Association of Ontario Public Health Business Administrators
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Association of Public Health Nursing Leaders
- Ontario Dietitians in Public Health

Hon. Patty Hajdu
Minister of Health
House of Commons
Ottawa, Ontario, K1A 0A6

December 17, 2019

Re: Ministerial Mandate Letter

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing today to congratulate you on your appointment as Canada's Minister of Health and to inform you of some of our related work.

Our members are very pleased that the Prime Minister has chosen an individual with a keen understanding of the social determinants of health and with direct experience working in Ontario's public health system with the Thunder Bay District Health Unit. We have no doubt that this experience has given you a sense of the importance of local public health and the considerable return on investment of health promotion and disease prevention.

We have examined your ministerial mandate letter, and we would like to take this opportunity to share some of our related positions, as I think you will agree that alPHa will be an important ally in Ontario to assist you in meeting the expectations outlined therein.

Attached to this letter are several alPHa Resolutions that have been passed during recent annual meetings of our membership, the operative clauses of which are directly related to the priorities that the Prime Minister has identified for your ministry. We invite you to examine them and welcome any opportunity to discuss them with you further, as some call for specific action by your office.

We look forward to contributing to your success in serving the health needs of people throughout Canada, particularly where prevention is the focus. We would be pleased engage in further dialogue on these and other health topics. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Yours sincerely,

[redacted]

alPHa President

COPY: Hon. Christine Elliott, Minister of Health (Ontario)
Dr. Theresa Tam, Chief Public Health Officer of Canada
[redacted]

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. alPHa advises and lends expertise to members on the governance, administration and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

CONSULT-WITHHELD / CONSULTER-RETENUE

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14

The head of a government institution may refuse to disclose any record requested under this Act that contains information the disclosure of which could reasonably be expected to be injurious to the conduct by the Government of Canada of federal-p

Le responsable d’une institution fédérale peut refuser la communication de documents contenant des renseignements dont la divulgation risquerait vraisemblablement de porter préjudice à la conduite par le gouvernement du Canada des affaires fédéro

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Le responsable d’une institution fédérale peut refuser la communication de documents contenant des renseignements dont la divulgation risquerait vraisemblablement de porter préjudice à la conduite par le gouvernement du Canada des affaires fédéro

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-14 4:24 PM
To: Noad, Lindsay (NRCAN/RNCAN)
Subject: Re: AMR

Yes I'm very happy about the mandate letter, as is Kim and the team.

I think the CCA report helped and I like to think that the CPHO Spotlight and other efforts contributed to the public and political awareness in the last months :-)

ADMs and then DMs will meet soon to discuss path forward.

Sent from my iPhone

> On Dec 14, 2019, at 16:09, Noad, Lindsay (NRCAN/RNCAN) <lindsay.noad@canada.ca> wrote:
>
> Hi Theresa,
>
> I saw AMR finally made it into the mandate letter!! Congratulations! I miss the file so am keeping an eye on it- I cannot wait to see what you can accomplish on it now!
>
> I hope that you are well and have a wonderful holiday season!
>
> Lindsay

From: [redacted]
Sent: 2019-12-14 5:46 PM
To: Tam, Dr Theresa (PHAC/ASPC); Dumulon, Louis (SAC/ISC)
Cc: Wong, Tom (SAC/ISC); Njoo, Howard (PHAC/ASPC); [redacted]
Subject: [redacted] to present new analysis on RSV in [redacted] on the Monday call
Attachments: Literature Review Write up RSV.pdf; Synagis Program 2019-2020.docx

---

Hello all

As discussed I am sending you the background information the Department of Health uses internally.

One document is an internal literature review completed several years ago. It is a very good summary of the concerns that our Department has with [redacted] work.

The second document is the current acceptance criteria for our palivizumab program. These criteria are reviewed on an annual basis.

I have cc'd [redacted] as the team that does this work (annual review etc) reports to her.

I would ask that neither of these documents be publicly shared at this time.

[redacted]

WITHHELD / RETENUE

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From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-08 1:14 PM
To: [redacted]
Subject: Re: Any materials for Vaping items that will be discussed at the Dec 10th PT PHNC meeting?

Thanks [redacted] I'll get my office to find some time.

Sent from my iPhone

On Dec 8, 2019, at 11:51, [redacted] wrote:

> Attached to this email chain is the draft of the CCMOH position statement #4 on vaping. It will be discussed on out PT call this Tuesday. It has been reviewed and okayed by [redacted] plus I the first draft was reviewed by [redacted]
>
> It would be good for you and I to discus this before our FPT call.
>
> [redacted]
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** [redacted]
> **Date:** December 6, 2019 at 3:45:59 PM AST
> **To:** [redacted]
> **Subject: RE: Any materials for Vaping items that will be discussed at the Dec 10th PT PHNC meeting?**
>
> I have heard from [redacted] on this and they are fine with this version so it can be circulated to the rest of PT CMOHs for discussion on Tuesday.
>
> [redacted]
>
> **From:** [redacted]
> **Sent:** December 5, 2019 3:21 PM
> **To:** [redacted]
> **Subject:** RE: Any materials for Vaping items that will be discussed at the Dec 10th PT PHNC meeting?
> H[redacted]
> Thank you for getting back to me so quickly. Yes. Tomorrow or Monday would be fine.
> I will be uploading other materials to the meeting invite today. As soon as I receive yours, I will distribute it to PT members through the meeting invite as well as via an email.
> Thanks,
>
> [redacted]
>
> **From:** [redacted]
> **Sent:** Thursday, December 5, 2019 11:49 AM
> **To:** [redacted]

Subject: RE: Any materials for Vaping items that will be discussed at the Dec 10th PT PHNC meeting?
I am still waiting to hear back from [redacted]
Can I send this to you tomorrow or at the latest Monday am for distribution?

[redacted]

From: [redacted]
Sent: December 5, 2019 1:22 PM
To: [redacted]
Cc [redacted]

Subject: Any materials for Vaping items that will be discussed at the Dec 10th PT PHNC meeting?

** EXTERNAL EMAIL / COURRIEL EXTERNE **
Exercise caution when opening attachments or clicking on links / Faites preuve de prudence si vous ouvrez une pièce jointe ou cliquez sur un lien

Hello [redacted]
Attached please find the finalized agenda for the December 10th PT PHNC meeting. Given you will be leading the Vaping item (item #3), just wondering if there is any material that you would like to share with PT PHNC members prior to the meeting.
I am hoping to send out the agenda and other meeting materials indicated in the agenda to PT PHNC members sometime today or early tomorrow. If there is any material (s) related to vaping, please send it to me. I can circulate it along with other materials.
Thank you!

[redacted]
Provincial/Territorial Public Health Network Council Secretariat
[redacted]
Bus: [redacted]

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-13 12:25 PM
To: [redacted]
Subject: Fwd: AP: Tramadol is an odd, unpredictable opioid, scientists say

---

Sent from my iPhone

Begin forwarded message:

> **From:** "Media Monitoring / Suivi des Medias (HC/SC)" <hc.media.monitoring-suivi.des.medias.sc@canada.ca>
> **Date:** December 13, 2019 at 11:42:25 EST
> **Subject: AP: Tramadol is an odd, unpredictable opioid, scientists say**
>
> Dist: HC.F PEIA Opioids / Opioides AREP F.SC
> December 13, 2019
> **Tramadol is an odd, unpredictable opioid, scientists say**
> Source: Associated Press
> Scientists who've studied the curious chemistry of the opioid tramadol use an array of adjectives to describe it: "unpredictable," "messy," "crazy."
> Tramadol is unlike most other opioids in that it must pass through the liver to be metabolized into its most potent form. At the same time, it releases another type of drug that acts as an antidepressant because it increases levels of serotonin in the brain, which elevates mood.
> But how much opioid and how much antidepressant is released is heavily dependent on users' genetics, said Bertha Madras, professor of psychobiology at Harvard Medical School. One person might get a potent dose of opioid, while the next gets nearly none.
> Research has shown that some ethnic groups are prone to process tramadol as a far more potent opioid, upping the risk of addiction, Madras said. In a cruel twist, those groups are largely clustered in the areas that lack access to other opioid medications, so are dependent on tramadol for pain relief: Africa, the Middle East and parts of Asia. Studies suggest nearly 30% of North Africans metabolize tramadol to the most active opioid potency, she said, compared with about 1 per cent of northern Europeans.
> Grunenthal, the German pharmaceutical company that originally synthesized tramadol, also points to its strange chemistry to defend its claim that the drug is less prone to be abused. As people begin to abuse most opioids, they move to higher doses, then to snorting or shooting up as they build up tolerance and no longer feel the same high from the same dose. But tramadol, one recent survey suggests, might naturally deter that trajectory because as doses increase, nasty side effects become more pronounced. And since it must pass through the liver to reach full effect, users do not transition to snorting or injecting.
> Tramadol taken at high doses — particularly when combined with other drugs — can cause the respiratory depression that leads to overdose deaths. The United Kingdom, for example, decided to regulate the drug in 2014, after researchers found that as the number of tramadol prescriptions increased, so did the number of times it was mentioned on death certificates. But it has not as routinely caused overdose as more traditional opioids. Users who take too much often first have a side effect different than other opioids: an overload of serotonin that causes seizures.

“Tramadol is most likely not as problematic as some of the big gun opioids like oxycodone and fentanyl and heroin,” Madras said. “But it certainly can be in certain populations and it certainly can be if it’s abused by a wider and wider swath of the population.”

When people who’ve become dependent try to stop taking tramadol, they have withdrawal symptoms like those of traditional opioids, including pain, sweating, diarrhea and insomnia, according to the World Health Organization. But the serotonin crash adds other problems: hallucinations, panic, paranoia and confusion.

https://toronto.citynews.ca/2019/12/13/tramadol-is-an-odd-unpredictable-opioid-scientists-say/

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-24 1:37 PM

To: Namiesniowski, Tina (PHAC/ASPC)

Cc: Romano, Anna (PHAC/ASPC); Bent, Stephen (PHAC/ASPC); Johnstone, Marnie (PHAC/ASPC)

Subject: Re: B2020

Agreed. The only way may be to reach Steve if ADMs are not on the same page.

Do you want me to do this?

Sent from my iPhone

On Dec 24, 2019, at 13:33, Namiesniowski, Tina (PHAC/ASPC) <tina.namiesniowski@canada.ca> wrote:

> I think we need to have one integrated strategy that makes clear what we think should go now (b2020) and what might follow in (b2021). We haven't had that discussion yet to the best of my knowledge.
>
> Sent from my iPhone
>
> On Dec 24, 2019, at 12:36 PM, Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca> wrote:
>
> > Tina, Theresa
> >
> > Apologies for reaching out today but thought you should be aware of my exchange below with Eric.
> >
> > I can let it go, but if the B2020 PSU proposal moves forward, I don't get how the PHAC ask would be separated out. It's one letter that goes from Min of Health.
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** "Costen, Eric (HC/SC)" <eric.costen@canada.ca>
> > **Date:** December 24, 2019 at 12:25:12 PM EST

To: "Romano, Anna (PHAC/ASPC)" <anna.romano@canada.ca>
Cc: "Elmahdy, Kareem (HC/SC)" <kareem.elmahdy@canada.ca>, "Morissette, Guy (HC/SC)" <guy.morissette@canada.ca>, "Baljak, Merima (HC/SC)" <merima.baljak@canada.ca>, "Boudreau, Michelle (HC/SC)" <michelle.boudreau@canada.ca>
Subject: Re: B2020

That is not my understanding. I don't know where this direction is coming from. Unless the dms agreed to something when they met last week I think we proceed as the original template set out.

Copying my group who are at the office.

Associate Assistant Deputy Minister
Controlled Substances and Cannabis Branch
Health Canada

Sous-ministre Adjoint Délégué
Direction générale des substances contrôlées et du cannabis
Santé Canada

> On Dec 24, 2019, at 12:02 PM, Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca> wrote:
>
> Hi Eric
>
> Apologies for the intrusion today...but just wanted to quickly check in on PSU B2020 proposal as I have staff back at the office trying to navigate the various deadlines and processes (both at PHAC and HC).
>
> I received the following de-brief today: "Yesterday staff were on a call hosted by HC during which HC made it clear that only the surveillance portion of PSU would be incorporated into their template and that the youth prevention portion (G&C) was to be submitted separately."

Is this your understanding? After you left bi-lat with Theresa last week, Tina arrived to review all of the B2020 material (in prep for the DM meeting that was happening the next morning). During that chat, we were perplexed by the line in the PSU template that said something like “PHAC g+c ask will follow a separate ask”.

So....practically speaking, there may be a decision to move all of the PSU asks to 2021 but in the meantime, can we agree that there would be one consolidated ask? If the whole thing gets pushed off to 2021 and/or parts of the 2020 ask get cut, that is one thing. But in the meantime staff need some clarity.

Let me know what you think.

Thanks

A

Sent from my iPhone

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-03 4:29 PM

To: Namiesniowski, Tina (PHAC/ASPC)

Subject: Back pocket in Guidelines at PHAC

Backpocket for Min briefing.

The Public Health Agency of Canada (PHAC) develops guidelines that provide advice to healthcare providers and Canadians through the support of standing guideline panels, and by providing funding or collaborating with external organizations on ad hoc topics.

* Across PHAC, current and planned guidance spans over 15 topic areas including travel medicine, immunizations, influenza prevention, problematic substance use, family violence, dementia, suicide prevention, traumatic head injury/concussions, physical activity, cancer prevention, sexual health, healthcare-acquired infections, and tobacco cessation.

* The standing guideline panels supported by PHAC regularly develop guidelines in areas such as newborn and maternal health, preventive medicine, and infection prevention/control. The panels that PHAC supports are:
  - The Canadian Task Force on Preventive Healthcare
  - The National Advisory Committee on Immunization
  - The Canadian Guidelines for Sexually Transmitted Infections Expert Advisory Body
  - The Healthcare Acquired Infections - Infection Prevention and Control Expert Advisory Body
  - The Committee to Advise on Tropical Medicine and Travel
  - The Family-Centred Maternity and Newborn Care: National Guidelines oversight committee

* In 2018, the Canadian Task Force on Preventive Healthcare released guidelines on screening for breast cancer, visual acuity, and asymptomatic bacteriuria in pregnancy. The former garnered significant attention from media and other stakeholders.

Sent from my iPhone

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-18 7:48 AM
To: Romano, Anna (PHAC/ASPC)
Cc: Namiesniowski, Tina (PHAC/ASPC); Johnstone, Marnie (PHAC/ASPC); McLeod, Robyn (PHAC/ASPC); Patrice, France (PHAC/ASPC); Hrynuik, Lisa (PHAC/ASPC)
Subject: Re: Background Information for meeting with INFC for Dec 17 prep and mtg with President

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Thanks Anna

Sent from my iPhone

On Dec 18, 2019, at 07:43, Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca> wrote:

> Hello Tina.
>
> Attached is a backgrounder on opportunities for engagement with INFC for today's meeting with Kelly Gillis. It touches on the key aspects you raised in your email to Kelly last month with respect to the Smart Cities Challenge and PHAC's possible engagement on the 2nd Challenge.
>
> In addition we signal an opportunity for collaboration on PHAC's Healthy Build Environment Prize/Challenge – an idea that emerged at a federal dialogue hosted in 2018 by PHAC and INFC. It also describes opportunities related to CIHR's Healthy Research Initiative and other areas for funding alignment.

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 12, 2019 VOL. 381 NO. 24

A Randomized, Controlled Trial of Ebola Virus Disease Therapeutics

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ABSTRACT

BACKGROUND

Although several experimental therapeutics for Ebola virus disease (EVD) have been developed, the safety and efficacy of the most promising therapies need to be assessed in the context of a randomized, controlled trial.

METHODS

We conducted a trial of four investigational therapies for EVD in the Democratic Republic of Congo, where an outbreak began in August 2018. Patients of any age who had a positive result for Ebola virus RNA on reverse-transcriptase–polymerase-chain-reaction assay were enrolled. All patients received standard care and were randomly assigned in a 1:1:1:1 ratio to intravenous administration of the triple monoclonal antibody ZMapp (the control group), the antiviral agent remdesivir, the single monoclonal antibody MAb114, or the triple monoclonal antibody REGN-EB3. The REGN-EB3 group was added in a later version of the protocol, so data from these patients were compared with those of patients in the ZMapp group who were enrolled at or after the time the REGN-EB3 group was added (the ZMapp subgroup). The primary end point was death at 28 days.

RESULTS

A total of 681 patients were enrolled from November 20, 2018, to August 9, 2019, at which time the data and safety monitoring board recommended that patients be assigned only to the MAb114 and REGN-EB3 groups for the remainder of the trial; the recommendation was based on the results of an interim analysis that showed superiority of these groups to ZMapp and remdesivir with respect to mortality. At 28 days, death had occurred in 61 of 174 patients (35.1%) in the MAb114 group, as compared with 84 of 169 (49.7%) in the ZMapp group (P=0.007), and in 52 of 155 (33.5%) in the REGN-EB3 group, as compared with 79 of 154 (51.3%) in the ZMapp subgroup (P=0.002). A shorter duration of symptoms before admission and lower baseline values for viral load and for serum creatinine and aminotransferase levels each correlated with improved survival. Four serious adverse events were judged to be potentially related to the trial drugs.

CONCLUSIONS

Both MAb114 and REGN-EB3 were superior to ZMapp in reducing mortality from EVD. Scientifically and ethically sound clinical research can be conducted during disease outbreaks and can help inform the outbreak response. (Funded by the National Institute of Allergy and Infectious Diseases and others; PALM ClinicalTrials.gov number, NCT03719586.)

From Institut National de Recherche Biomédicale, Democratic Republic of Congo (S.M., O.T.M., D.M., M.L.M., D.N., A.T.O., A.I., R.A., J.-J.M.-T.); the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, MD (L.E.D., R.T.D., M.P., H.C.L.); the Alliance for International Medical Action, Dakar, Senegal (S.C.); International Medical Corps, Los Angeles (A.C.L.); Epicentre, Médecins sans Frontières, Paris (R.G.); and the World Health Organization, Geneva (J.D.). The full names, academic degrees, and affiliations of the members of the PALM Writing Group are listed in the Appendix. Address reprint requests to Dr. Lane at the National Institute of Allergy and Infectious Diseases, National Institutes of Health, 10 Center Dr., Rm. 4-1479, MSC 1460, Bethesda, MD 20892-1504, or at clane@niaid.nih.gov.

*A complete list of members of the PALM Consortium Study Team is provided in the Supplementary Appendix, available at NEJM.org.

Drs. Mulangu, Dodd, and Davey and Drs. Lane and Muyembe-Tamfum contributed equally to this article.

This article was published on November 27, 2019, at NEJM.org.

N Engl J Med 2019;381:2293-303.
DOI: 10.1056/NEJMoa1910993

A Quick Take is available at NEJM.org

In August 2018, an outbreak of Ebola virus disease (EVD) began in the provinces of North Kivu and Ituri in the Democratic Republic of Congo (DRC); it was the tenth known outbreak of EVD in that country.[1,2] The outbreak became the second largest that has been recorded since the first description of *Zaire ebolavirus* infection in 1976, and it is surpassed only by the 2013–2016 outbreak in West Africa that resulted in more than 11,000 deaths.

After the end of the outbreak in West Africa, the World Health Organization (WHO) initiated a series of discussions to develop an R&D Blueprint for EVD research that included a working group focused on how experimental therapeutics should be assessed in the context of the next EVD outbreak.[3] These and other discussions led to a consensus that when a new outbreak occurred, the most promising experimental therapeutics should be studied in the context of a randomized, controlled trial, if possible.[4] This groundwork facilitated the uniting of the international community and DRC leadership to develop and implement the trial described in this report.

METHODS

TRIAL DESIGN

The Pamoja Tulinde Maisha (PALM ["Together Save Lives" in the Kiswahili language]) trial compared ZMapp with three newer investigational agents.[5] Patients were assigned in a 1:1:1:1 ratio to receive ZMapp (a triple monoclonal antibody agent), remdesivir (a nucleotide analogue RNA polymerase inhibitor[6]), MAb114 (a single human monoclonal antibody derived from an Ebola survivor[7,8]), or REGN-EB3 (a coformulated mixture of three human IgG1 monoclonal antibodies[9,10]). ZMapp was chosen as the control on the basis of data from the Partnership for Research on Ebola Virus in Liberia II (PREVAIL II) trial.[11] The current trial was originally designed in November 2018 as a three-group trial, and the protocol was updated in January 2019 to add REGN-EB3 as a fourth group; data from this group were compared with those of patients in the ZMapp group who were enrolled on or after the time the REGN-EB3 group was added (the ZMapp subgroup). The primary end point was death at 28 days.

TRIAL OVERSIGHT

The trial was jointly approved by the ethics board at the University of Kinshasa and the institutional review board at the National Institute of Allergy and Infectious Diseases (NIAID) and was overseen by an independent data and safety monitoring board. Trial staff at participating Ebola treatment centers included staff from the Alliance for International Medical Action (ALIMA), International Medical Corps (IMC), Médecins sans Frontières (MSF), and the DRC Ministry of Health. Written informed consent was obtained from all patients or their legal guardians, and assent forms were obtained for children according to local standards and requirements. Full details about the trial design, conduct, oversight, and analyses are provided in the protocol and the Supplementary Appendix, both available with the full text of this article at NEJM.org. The PALM Writing Group performed the primary data analyses, wrote the manuscript, and, on behalf of the PALM Study Group, vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol. The Office of Clinical Research Policy and Regulatory Operations of the Division of Clinical Research of the NIAID is the holder of the Investigational New Drug application (125530) from the Food and Drug Administration. The Biomedical and Advanced Research and Development Authority of the U.S. Department of Health and Human Services provided financial support for the production of ZMapp and REGN-EB3. NIAID and the Defense Advanced Research Projects Agency of the U.S. Department of Defense provided financial support for the production and provision of MAb114.

SCREENING AND RANDOMIZATION

Patients were assessed for eligibility on the basis of a reverse-transcriptase–polymerase-chain-reaction (RT-PCR) assay to detect the RNA of the nucleoprotein of Ebola virus (EBOV). Patients of any age, including pregnant women, were eligible if they had a positive result on RT-PCR within 3 days before screening and if they had not received other investigational agents (except experimental vaccines) within the previous 30 days. Neonates who were 7 days of age or younger were eligible if the mother had documented EVD. Randomization was stratified according to baseline nucleoprotein cycle-threshold (Ct) value (≤22.0 or >22.0, corresponding to higher and lower viral loads, respectively, as determined by quantitative RT-PCR) and Ebola treatment center. Trial-group assignments were placed in sequentially numbered envelopes, which were distributed to trial sites

to be opened at the time of enrollment. Data were recorded on bar-coded paper case-report forms that were transmitted from the site to a server, where they were digitally sorted into electronic patient folders with the use of software developed by the University of Minnesota and were then entered by trial staff at the Institut National de Recherche Biomédicale (INRB) Coordinating Center (Kinshasa, DRC) and NIAID (Bethesda, MD) into the Web-based REDCap database.

TRIAL PROCEDURES

All patients received standard care, which consisted of administration of intravenous fluids, daily clinical laboratory testing, correction of hypoglycemia and electrolyte imbalances, and administration of broad-spectrum antibiotic agents and antimalarial agents as indicated. All four trial agents were administered intravenously. Patients in the ZMapp group received a dose of 50 mg per kilogram of body weight every third day beginning on day 1 (for a total of three doses). Patients in the remdesivir group received a loading dose on day 1 (200 mg in adults, and adjusted for body weight in pediatric patients), followed by a daily maintenance dose (100 mg in adults) starting on day 2 and continuing for 9 to 13 days, depending on viral load. Patients in the MAb114 group received a dose of 50 mg per kilogram, administered as a single infusion on day 1. Patients in the REGN-EB3 group received a dose of 150 mg per kilogram, administered as a single infusion on day 1.

The Xpert Ebola Assay (Cepheid) was used for detection of the EBOV RNAs encoding surface glycoprotein and nucleoprotein.[12-14] Clinical chemical analyses of plasma samples that had been separated from whole blood were performed with the use of the Piccolo Xpress Chemistry Analyzer (Abbott).

STATISTICAL ANALYSIS

The primary end point (death at 28 days) was assessed with the use of a modified Boschloo's test for hypothesis testing.[15] We estimated that 145 patients would need to be enrolled in each group to give the trial approximately 80% power, at a type I error rate of 5%, to show that mortality would be 50% lower in each of the groups than in the ZMapp group (15% vs. 30%). Each of the primary comparisons of remdesivir, MAb114, and REGN-EB3 with ZMapp was tested at a two-sided type I error rate of 5%, without adjustment for multiplicity (as prespecified in the statistical analysis plan). After an assessment that was conducted in a blinded manner, the protocol was amended in July 2019 to increase the sample size to 725 to improve the power of the trial while taking into account the availability of ZMapp. The sample size was revised to 185 patients each in the ZMapp, remdesivir, and MAb114 groups and 170 in the REGN-EB3 group. Comparisons were restricted to patients who were enrolled in the trial concurrently.[15,16] Interim data and safety monitoring included four analyses of efficacy that were performed on the basis of prespecified enrollment targets (Table S1 in the Supplementary Appendix). Additional details are provided in the statistical analysis plan, which is included with the protocol.

RESULTS

PATIENTS

From November 20, 2018, to August 9, 2019, a total of 681 patients were enrolled and underwent randomization at Ebola treatment centers in Beni (335 patients), Butembo (243 patients), Katwa (46 patients), and Mangina (57 patients). Eight patients were excluded from the final analysis: 1 patient was later found to have been ineligible because of a false positive EVD result on RT-PCR assay, and 7 patients underwent randomization during a 2-week period when ZMapp was unavailable because of compromised cold-chain conditions. Of the remaining 673 participants, 169 were assigned to receive ZMapp, 175 to receive remdesivir, 174 to receive MAb114, and 155 to receive REGN-EB3. A total of 154 patients were assigned to the ZMapp group after the REGN-EB3 group had been added (the ZMapp subgroup), and data from these patients were used in the comparison of REGN-EB3 with ZMapp (Fig. S1).

Most patients (74.4%) were 18 years of age or older, 12.8% were 6 to 17 years of age, and 12.8% were 5 years of age or younger, of whom 0.7% were neonates (≤7 days old). A total of 55.6% patients were female, of whom 6.1% were pregnant at the time of EVD diagnosis (Table 1).

The mean (±SD) baseline nucleoprotein Ct value was 24.0±5.6, and 42.1% of patients had a baseline value of 22.0 or lower. Patients were enrolled within an average of 5.5 days after the onset of symptoms. The most commonly reported baseline symptoms were diarrhea (in 53.8% of

Table 1. Baseline Demographic and Clinical Characteristics of the Trial Population.*

Characteristic	All Patients (N=673)	ZMapp (N=169)	Remdesivir (N=175)	MAb114 (N=174)	REGN-EB3 (N=155)	ZMapp Subgroup† (N=154)
Age — yr	28.8±17.6	29.7±16.8	29.6±17.2	27.4±18.5	28.2±18.2	30.2±16.7
Age group — no. (%)						
≤5 yr	86 (12.8)	20 (11.8)	16 (9.1)	26 (14.9)	24 (15.5)	17 (11.0)
≤7 days	5 (0.7)	2 (1.2)	2 (1.1)	1 (0.6)	0	2 (1.3)
>5 yr to <18 yr	86 (12.8)	14 (8.3)	25 (14.3)	29 (16.7)	18 (11.6)	13 (8.4)
≥18 yr	501 (74.4)	135 (79.9)	134 (76.6)	119 (68.4)	113 (72.9)	124 (80.5)
Female sex — no. (%)	374 (55.6)	87 (51.5)	98 (56.0)	98 (56.3)	91 (58.7)	80 (51.9)
Positive result on pregnancy test — no./total no. (%)	17/277 (6.1)	4/63 (6.3)	6/77 (7.8)	5/69 (7.2)	2/68 (2.9)	4/61 (6.6)
Weight — kg (% with missing data)	47.0±19.3 (0.1)	49.2±19.2 (0)	47.8±17.7 (0.6)	44.8±19.8 (0)	46.1±20.4 (0)	49.6±18.8 (0)
Patient-reported vaccination with rVSVΔG-ZEBOV-GP — no./total no. (%)‡	155/620 (25.0)	41/154 (26.6)	43/156 (27.6)	36/157 (22.9)	35/153 (22.9)	41/154 (26.6)
<10 days before admission to the Ebola treatment center	80/155 (51.6)	21/41 (51.2)	18/43 (41.9)	21/36 (58.3)	20/35 (57.1)	21/41 (51.2)
≥10 days before admission to the Ebola treatment center	60/155 (38.7)	18/41 (43.9)	21/43 (48.8)	10/36 (27.8)	11/35 (31.4)	18/41 (43.9)
Timing not reported	15/155 (9.7)	2/41 (4.9)	4/43 (9.3)	5/36 (13.9)	4/35 (11.4)	2/41 (4.9)
Current illness§						
Nucleoprotein Ct value ≤22 — no./total no. (%)	282/670 (42.1)	70/168 (41.7)	73/173 (42.2)	73/174 (42.0)	66/155 (42.6)	64/153 (41.8)
Nucleoprotein Ct value (% with missing data)¶	24.0±5.6 (0.4)	23.4±5.2 (0.6)	23.8±5.3 (1.1)	24.6±6.4 (0)	24.1±5.3 (0)	23.3±5.1 (0.7)
Glycoprotein Ct value (% with missing data)	28.5±4.9 (2.4)	28.3±4.7 (1.2)	28.4±4.8 (2.3)	28.5±5.1 (5.2)	28.7±4.9 (0.6)	28.0±4.6 (1.3)
Days since onset of symptoms (% with missing data)	5.5±3.5 (1.2)	5.6±3.6 (1.2)	5.4±3.4 (2.3)	5.5±3.6 (0.6)	5.4±3.2 (0.6)	5.5±3.6 (1.3)
Positive result for malaria — no./total no. (%)	57/557 (10.2)	12/140 (8.6)	15/139 (10.8)	13/140 (9.3)	17/138 (12.3)	12/140 (8.6)
Serum chemical values (% with missing data)						
Creatinine — mg/dl¶	2.5±2.9 (18.6)	2.9±3.3 (22.5)	2.7±3.0 (17.7)	2.1±2.6 (17.2)	2.5±2.8 (16.8)	2.7±3.0 (22.7)
Potassium — mmol/liter	4.4±1.1 (30.5)	4.3±1.1 (34.9)	4.3±1.1 (26.9)	4.4±1.3 (28.7)	4.4±1.0 (31.6)	4.3±1.1 (33.8)
AST — U/liter¶	668±700 (40.6)	767±745 (43.2)	713±702 (47.2)	546±617 (42.0)	648±726 (38.1)	775±749 (42.9)
ALT — U/liter	379±464 (18.1)	404±475 (21.3)	385±471 (18.3)	358±433 (17.8)	368±483 (14.8)	390±445 (21.4)
Vital signs (% with missing data)						
Blood pressure — mm Hg						
Systolic	106.9±17.5 (13.7)	106.1±14.9 (8.9)	107.2±18.5 (13.1)	106.7±17.6 (17.2)	107.6±19.0 (15.5)	105.9±14.8 (9.1)
Diastolic	70.3±15.0 (13.7)	71.0±14.1 (8.9)	70.7±14.4 (13.1)	69.7±14.7 (17.2)	70.0±17.1 (15.5)	70.2±14.0 (9.1)

Pulse — beats/min	98.2±20.8 (2.2)	97.2±21.1 (2.4)	97.2±20.0 (1.7)	98.5±21.5 (1.7)	100.0±20.6 (3.2)	97.4±21.4 (2.6)
Body temperature — °C	37.4±1.2 (1.0)	37.5±1.2 (0.6)	37.3±1.3 (1.1)	37.4±1.2 (1.1)	37.4±1.2 (1.3)	37.5±1.2 (0.6)
Respiratory rate — breaths/min	25.1±7.5 (4.6)	24.8±7.0 (5.9)	24.6±6.9 (2.3)	25.1±7.8 (4.6)	25.8±8.2 (5.8)	24.8±7.3 (5.8)
Oxygen saturation — %	95.8±4.2 (5.2)	95.7±3.1 (5.3)	96.4±3.9 (2.9)	95.5±5.4 (6.9)	95.8±4.1 (5.2)	95.6±3.2 (5.8)

* Plus–minus values are means ±SD. The term "% with missing data" refers to the percentage of patients with missing data. All participants received standard care in addition to the assigned treatment. To convert the values for creatinine to micromoles per liter, multiply by 88.4. To convert the values for potassium to milligrams per deciliter, divide by 0.2558. Percentages may not total 100 because of rounding. ALT denotes alanine aminotransferase, AST aspartate aminotransferase, and RT-PCR reverse-transcriptase–polymerase-chain-reaction.
† The ZMapp subgroup consisted of patients who were enrolled in the ZMapp group on or after the time the REGN-EB3 group was added.
‡ Information on vaccination status during screening was not collected until January 26, 2019, with a revision to the protocol. The total number of patients reflects this.
§ The nucleoprotein and glycoprotein of Ebola virus RNA were detected with the use of quantitative reverse-transcriptase–polymerase-chain-reaction assay, and the levels are expressed as cycle-threshold (Ct) values.
¶ Figure S2 provides the distributions according to group of nucleoprotein Ct values, creatinine levels, AST levels, and the median values for each group.

the patients), fever (in 51.4%), abdominal pain (in 46.4%), headache (in 44.4%), and vomiting (in 39.4%) (Table S2). Malaria coinfection was identified in 57 of 557 patients (10.2%). Patient-reported information regarding vaccination status (i.e., whether the patient had received the rVSVΔG-ZEBOV-GP vaccine) was available for 620 patients; of these, 155 (25.0%) reported that they received the vaccine. Among patients who reported that they had been vaccinated, 38.7% reported that they had received the vaccination at least 10 days before enrollment.

The mean baseline serum creatinine level was 2.5±2.9 mg per deciliter (221±256 μmol per liter), the mean aspartate aminotransferase level was 668±700 U per liter, and the mean alanine aminotransferase level was 379±464 U per liter. The mean baseline creatinine and aspartate aminotransferase values were higher in the ZMapp and remdesivir groups than in the other two groups. However, the baseline creatinine level was not recorded in 18.6% of patients, aspartate aminotransferase level was not recorded in 40.6%, and alanine aminotransferase level was not recorded in 18.1%. In addition, 70.1% of the available baseline samples indicated some degree of hemolysis.

MORTALITY

On August 9, 2019, when 681 patients had been enrolled, the data and safety monitoring board conducted an interim analysis on data from 499 patients and, on the basis of two observations, recommended terminating random assignment to ZMapp and remdesivir. First, results in the REGN-EB3 group crossed an interim boundary for efficacy with respect to a surrogate end point for death at 28 days that took into account outcomes in all patients with at least 10 days of follow-up (Fig. S3). Second, an analysis of mortality showed that there was a clear separation between the MAb114 and REGN-EB3 groups and the ZMapp and remdesivir groups (Fig. S4).

A total of 673 patients were included in the primary analyses. At 28 days, death had occurred in 290 patients (43.1%) overall, in 18.8% of patients with a low viral load (Ct value >22.0), and in 76.1% with a high viral load (Ct value ≤22.0) (Table 2).

The percentage of patients who died was lower in the MAb114 group and in the REGN-EB3 group than in the ZMapp group (Fig. 1 and Table 2). The difference between the MAb114 and

Table 2. Comparison of Death at 28 Days According to Treatment Group.

Population	ZMapp	Remdesivir	Difference, Remdesivir vs. ZMapp	MAb114	Difference, MAb114 vs. ZMapp	REGN-EB3	ZMapp Subgroup	Difference, REGN-EB3 vs. ZMapp Subgroup
	no. of deaths/ total no. (%)	*no. of deaths/ total no. (%)*	*percentage points (95% CI)*	*no. of deaths/ total no. (%)*	*percentage points (95% CI)*	*no. of deaths/ total no. (%)*	*no. of deaths/ total no. (%)*	*percentage points (95% CI)*
Overall	84/169 (49.7)	93/175 (53.1)	3.4 (−7.2 to 14.0)	61/174 (35.1)	−14.6 (−25.2 to −1.7)*	52/155 (33.5)	79/154 (51.3)	−17.8 (−28.9 to −2.9)*
Patients with high viral load†	60/71 (84.5)	64/75 (85.3)	0.8 (−15.3 to 17.2)	51/73 (69.9)	−14.6 (−33.0 to −0.5)	42/66 (63.6)	56/65 (86.2)	−22.5 (−41.8 to −5.1)
Patients with low viral load†	24/98 (24.5)	29/100 (29.0)	4.5 (−9.1 to 19.1)	10/101 (9.9)	−14.6 (−32.4 to −2.6)	10/89 (11.2)	23/89 (25.8)	−14.6 (−32.6 to −2.3)

* The result is significant according to the interim stopping boundary of P<0.035 for the MAb114 group and P<0.028 for the REGN-EB3 group.
† Patients with a high viral load had an EBOV nucleoprotein Ct value of 22.0 or less. Patients with a low viral load had an EBOV nucleoprotein Ct value of more than 22.0. The total number is the total number of patients in this category for each group.

the ZMapp groups was −14.6 percentage points (95% confidence interval [CI], −25.2 to −1.7; P=0.007); the difference between the REGN-EB3 group and the ZMapp subgroup was −17.8 percentage points (95% CI, −28.9 to −2.9; P=0.002); and the difference between the remdesivir and ZMapp groups was 3.4 percentage points (95% CI, −7.2 to 14.0). (Fig. S5 shows the differences in mortality in the remdesivir, MAb114, and REGN-EB3 groups relative to the ZMapp group according to Ct value, age, sex, and site.) The survival benefits seen in the MAb114 and REGN-EB3 groups were also seen in sensitivity analyses adjusted for potential baseline imbalances (Tables 3 and 4 and Table S3).

SECONDARY EFFICACY END POINTS

In an analysis of the time to the first negative result on RT-PCR assay for EBOV nucleoprotein, in which patients who had died were considered as not having had viral clearance, the time to the first negative result was shorter in the MAb114 and REGN-EB3 groups than in the ZMapp group (median in the MAb114 group, 16 days; median in the REGN-EB3 group, 15 days; median in the ZMapp group, 27 days) (Fig. 2). Among patients in the remdesivir group, the estimated median time was more than 28 days because mortality exceeded 50%.

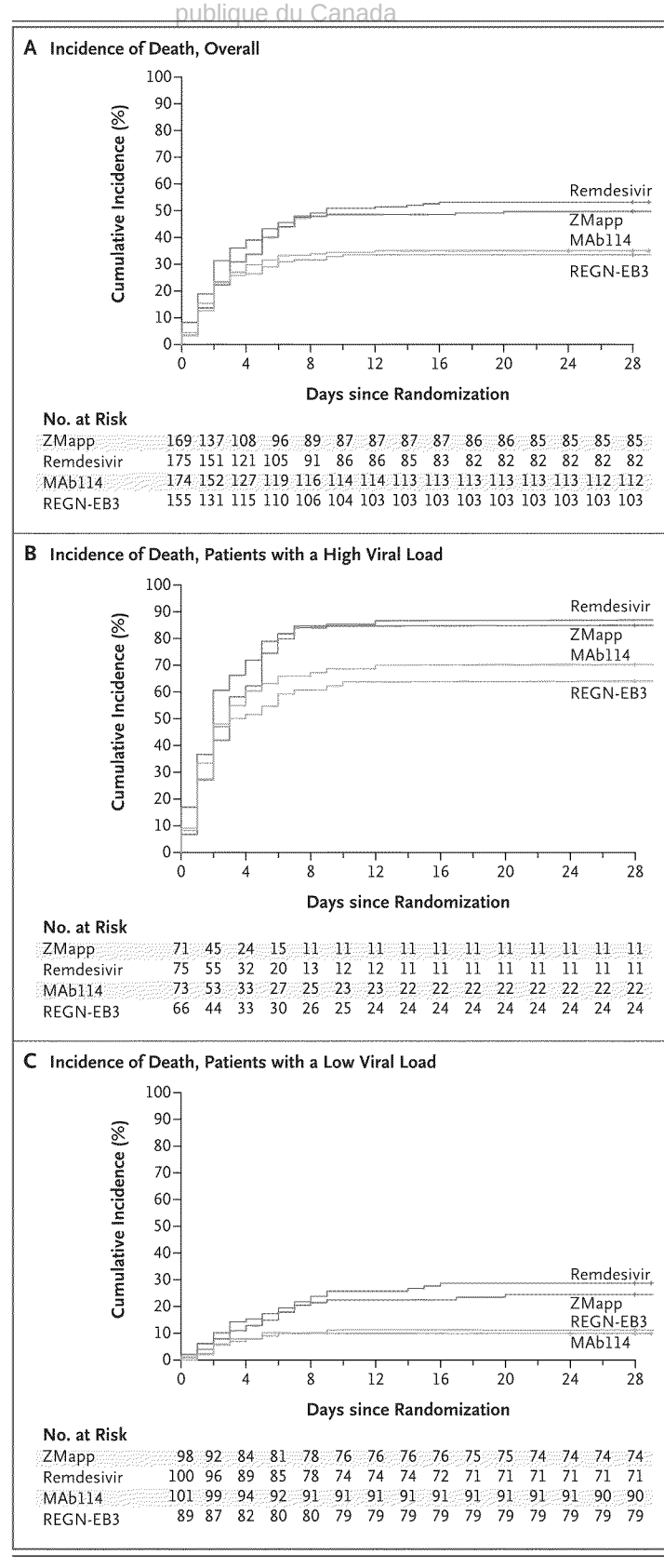
PROGNOSTIC VARIABLES

A longer duration of symptoms before treatment was associated with significantly worse outcomes. Of note, 19% of patients who arrived at the treatment center within 1 day after the reported onset of symptoms died, as compared with 47% of patients who arrived after they had had symptoms for 5 days (Table S4). The odds of death increased by 11% (95% CI, 5 to 16) for each day after the onset of symptoms that the patient did not present to the treatment center (Table 3).

The odds of death were lower among patients with lower viral loads (odds ratio per unit increase in Ct value, 0.66; 95% CI, 0.62 to 0.71) and higher among patients with higher levels of creatinine (odds ratio per 1 mg per deciliter increase, 1.43; 95% CI, 1.31 to 1.56), aspartate aminotransferase (odds ratio per 100 U per liter increase, 1.15; 95% CI, 1.11 to 1.20), and alanine aminotransferase (odds ratio per 100 U per liter increase, 1.43; 95% CI, 1.33 to 1.54). A multivariate logistic-regression analysis showed that

Figure 1. Cumulative Incidence of Death.

Shown are Kaplan–Meier estimates of the cumulative incidence of death. Panel A shows the estimates in the overall population, Panel B the estimates in patients who had a nucleoprotein cycle-threshold (Ct) value of 22 or less at baseline (corresponding to a high viral load), and Panel C the estimates in patients who had a Ct value of more than 22 at baseline (corresponding to a low viral load).



the duration of symptoms at enrollment, baseline nucleoprotein Ct value, and serum creatinine level all remained significant prognostic indicators of death (Table 4). Across all models, the effect estimates of treatment with MAb114 and REGN-EB3 remained significant (Table 3 and 4).

The percentage of patients who died was lower among those who reported that they had received the rVSVΔG-ZEBOV-GP vaccine than among those who reported no vaccination (27.1% [42 of 155 patients] vs. 48.4% [225 of 465]). However, patients who reported vaccination were also more likely to have had fewer days of illness before enrollment, higher baseline nucleoprotein Ct values, and lower levels of alanine aminotransferase (Table S5).

SAFETY

At least 98% of the patients received the infusions according to protocol (Table S6). A total of 29 serious adverse events were determined by trial investigators to be potentially related to the trial drugs (Table S7). However, after adjudication by an independent pharmacovigilance committee, four events in three patients, all of which resulted in death, were determined to be possibly related to a trial drug: one patient in the ZMapp group had worsening of gastrointestinal symptoms; one patient in the ZMapp group had periinfusional hypotension and hypoxia that responded to resuscitation after treatment interruption but that resulted in death within 24 hours; and one patient in the remdesivir group had hypotension that resulted in cessation of a loading dose of remdesivir and that was followed rapidly by cardiac arrest. However, even in these cases, the deaths could not readily be distinguished from underlying fulminant EVD itself.

DELAYS IN TREATMENT ADMINISTRATION

The mean time from randomization to administration of the first infusion was somewhat lon-

Table 3. Logistic-Regression Analyses for Death at 28 Days.

Variable	No. of Patients in Analysis*	Odds Ratio (95% confidence interval)†			
		For Each Variable	Remdesivir vs. ZMapp	MAb114 vs. ZMapp	REGN-EB3 vs. ZMapp
Duration of symptoms	615	1.11 (1.05–1.16) per day of symptoms‡	1.04 (0.66–1.64)	0.49 (0.31–0.78)	0.45 (0.28–0.73)
Nucleoprotein Ct value	620	0.66 (0.62–0.71) per 1 unit increase	1.29 (0.71–2.34)	0.39 (0.21–0.73)	0.37 (0.20–0.68)
Years of age	623	1.00 (1.00–1.01) per 1 yr increase	1.07 (0.68–1.66)	0.52 (0.33–0.82)	0.48 (0.31–0.77)
Creatinine level§	507	1.43 (1.31–1.56) per 1 mg/dl increase	0.93 (0.54–1.59)	0.48 (0.27–0.84)	0.38 (0.21–0.67)
AST level§	380	1.15 (1.11–1.20) per 100 U/liter increase	1.06 (0.54–2.05)	0.31 (0.14–0.67)	0.29 (0.14–0.63)
ALT level§	511	1.43 (1.33–1.54) per 100 U/liter increase	0.95 (0.54–1.68)	0.37 (0.20–0.69)	0.36 (0.20–0.66)
Patient-reported vaccination§	620	0.37 (0.24–0.55) yes vs. no	1.06 (0.67–1.68)	0.48 (0.30–0.77)	0.44 (0.28–0.71)

* Model estimates include data from patients who were enrolled after the REGN-EB3 group was added. The number of patients in the analysis reflects the number enrolled after the REGN-EB3 group was added for whom data were available for each variable.

† Each row shows the odds ratios derived from a multivariate logistic-regression model that included the variable listed plus the four treatment groups.

‡ The variable reflects each additional day of symptoms before admission to the treatment center.

§ Because of its clinical significance, the variable was added after the statistical analysis plan was finalized but before analysis of the data.

ger in the ZMapp and remdesivir groups than in the MAb114 and REGN-EB3 groups. (Table S8 and Fig. S6 provide a summary of the time from randomization to the first infusion according to trial group and site, and Table S9 provides the results of a sensitivity analysis of outcomes that excluded data from patients with delays of more than 6 hours.) Twelve patients were enrolled but died before receiving the first infusion: one in the ZMapp group, three in the remdesivir group, three in the MAb114 group, and five in the REGN-EB3 group.

DISCUSSION

In this trial of four promising experimental treatments against *Z. ebolavirus*, the combination of standard care plus either MAb114 or REGN-EB3 was superior to standard care plus ZMapp against the Ituri EBOV variant currently circulating in the DRC. Survival benefits were seen both in patients with high viral loads and in those with low viral loads at presentation. The reason that mortality among patients who received ZMapp was 22% in the PREVAIL II trial (conducted during the outbreak in West Africa) and 50% in our trial (conducted during the current outbreak in the DRC) is unclear. Potential differences in virulence, the relevant viral epitopes,[14] patient populations, duration of symptoms, and standard-of-care practices are being explored.

In addition to differential effects of the four trial agents with respect to mortality, the results showed the importance of early diagnosis and treatment. We observed an 11% increase in the odds of death for each day that symptoms persisted before enrollment. These data highlight the need for community awareness that earlier diagnosis and treatment are associated with increased survival. Similarly, there was an effect of baseline viral load with respect to death at 28 days with each trial drug: mortality among patients who had a nucleoprotein Ct value of 22 or less at screening (i.e., high viral load) was 4 times as high as mortality among patients with a nucleoprotein Ct value of greater than 22 (i.e., low viral load). As described previously, the degree of baseline renal dysfunction was also a strong adverse prognostic indicator of survival, despite the use of medical countermeasures,[17,18] with higher creatinine levels at presentation correlating with a higher risk of death.

Given that 97% of deaths in this trial occurred within 10 days after enrollment, the efficacy of MAb114 and REGN-EB3 as compared with that of ZMapp and remdesivir might be partly attributable to the fact that the full treatment courses of MAb114 and REGN-EB3 were administered in a single dose, whereas ZMapp

and remdesivir were administered in multiple infusions. Differences in the time to appearance of the first negative nucleoprotein Ct result among trial groups support this observation; patients in the MAb114 and REGN-EB3 groups had faster rates of viral clearance than patients in the ZMapp and remdesivir groups. With ZMapp, the longer preparation time and the recommendation to allot up to 4 hours for the infusion of the first dose led to some delays in initiating therapy until the following day for patients who arrived later in the day to their respective treatment centers. However, in a sensitivity analysis, mortality was only slightly lower when ZMapp recipients with delayed therapy were excluded.

Although most characteristics at baseline were balanced across the four groups, values for serum creatinine and aminotransferases were higher in the ZMapp and remdesivir groups than in the MAb114 and REGN-EB3 groups; patients in the latter groups had better outcomes, despite similar durations of illness before enrollment. This suggests that enrolled patients might, on average, have been somewhat sicker in the ZMapp and the remdesivir groups, which could potentially account for some of the differences in outcomes. A high percentage of missing baseline data complicates this analysis. Nevertheless, sensitivity analyses confirm the persistence of benefits of treatment with MAb114 and REGN-EB3 despite these potential imbalances.

Of the 620 patients for whom information on vaccination with rVSVΔG-ZEBOV-GP was available, 155 patients (25.0%) reported that they had received the vaccine; of these, 38.7% reported that they had received the vaccine at least 10 days before the onset of clinical symptoms. Patients who reported vaccination were more likely to enroll sooner after the onset of symptoms and generally had more favorable prognostic profiles at baseline, suggesting a possible relationship between vaccination and health-seeking behaviors associated with improved outcomes. Alternatively, the less severe clinical status of these persons at presentation could be the result of a direct effect of the vaccine on outcomes. A limitation of these results is that vaccination status was reported by the patient; efforts to confirm vaccination status are under way. Given that vaccination status was not a randomization factor in this trial, it is not possible to draw firm conclusions about its effect on mortality.

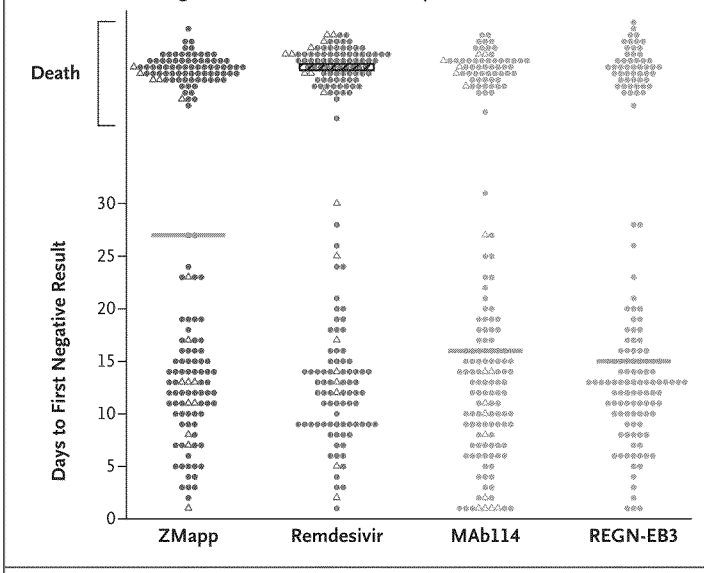
Table 4. Multivariate Logistic-Regression Analyses for Death at 28 Days in the 371 Patients Who Had Data Available for All Variables.

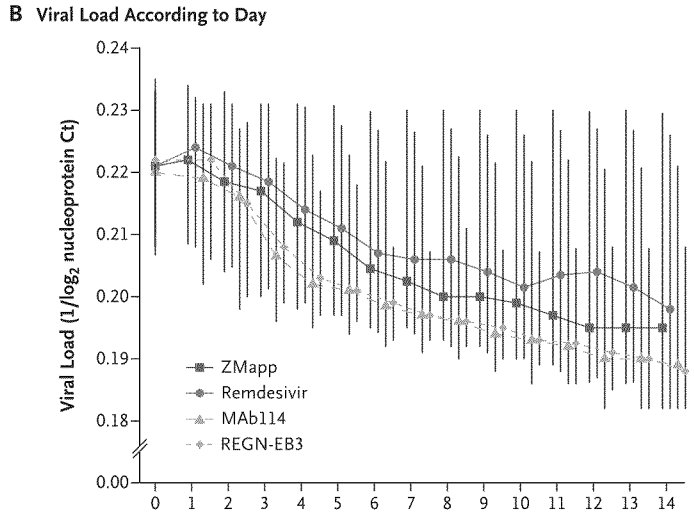
Variable	Odds Ratio (95% CI)
Assignment to remdesivir vs. ZMapp	0.99 (0.46–2.14)
Assignment to MAb114 vs. ZMapp	0.24 (0.10–0.61)
Assignment to REGN-EB3 vs. ZMapp	0.21 (0.08–0.53)
Duration of symptoms before admission to treatment center, per each additional day	1.12 (1.00–1.24)
Baseline nucleoprotein Ct value per 1-unit increase	0.67 (0.59–0.76)
Years of age per 1 yr increase	1.02 (1.00–1.04)
Creatinine level per 1 mg/dl increase	1.36 (1.18–1.58)
AST level per 100 U/liter increase	1.00 (0.92–1.07)
ALT level per 100 U/liter increase	0.96 (0.79–1.17)
Patient-reported vaccination, yes vs. no	0.47 (0.21–1.01)

With few exceptions, the safety profiles of all four trial drugs were generally consistent with either their limited previous investigational use in EBOV-infected humans, published phase 1 data in healthy volunteers, or both. Twenty-nine serious adverse events were reported by the investigators as possibly related to the experimental treatments — not all of which occurred during the treatment period. On review, four were thought to be possibly related to the trial-drug infusions. It is difficult to distinguish adverse events associated with the trial drug from those related to underlying EVD, so the assessment of relatedness is challenging. These favorable safety profiles support the notion that relative efficacy rather than safety considerations will most likely provide the major rationale for the future use of these drugs.

Although the observed treatment benefits of MAb114 and REGN-EB3 were striking, 34% of all patients and 67% of patients who presented with higher viral loads died despite receiving one of these agents. Exploration of more efficacious interventions — such as further improvements in aggressive supportive-care measures and combination strategies that use agents with potentially complementary mechanisms of action — is needed. It is worth noting, however, that all the treatments chosen for this trial had shown comparatively high survival rates in nonhuman primate EBOV challenge models with the use of a non-Ituri EBOV variant (Kikwit), which illustrates a potential limitation of these models in evaluating single-drug and (future) combination-drug strategies.

We encountered numerous challenges in the performance of this trial. It was conducted in a





No. at Risk

ZMapp	168	147	159	162	161	159	167	165	165	164	164	163	167	166	168
Remdesivir	173	159	160	162	163	164	170	171	168	173	174	170	169	170	174
MAb114	174	154	161	161	163	163	167	170	164	168	167	166	172	171	170
REGN-EB3	155	139	144	139	143	137	150	152	146	151	152	150	149	150	149

No. of Deaths, Last Observation Carried Forward

ZMapp	0	24	43	58	62	69	74	79	80	82	82	82	82	82	82
Remdesivir	0	17	27	49	55	64	73	83	85	87	89	89	89	90	91
MAb114	0	12	33	45	52	53	58	58	59	60	60	60	60	61	61
REGN-EB3	0	17	29	39	40	43	47	48	49	51	52	52	52	52	52

No. Discharged, Last Observation Carried Forward

ZMapp	0	0	0	0	1	1	2	4	6	10	12	13	15	16	21
Remdesivir	0	0	0	0	0	0	0	0	0	2	7	7	9	13	22
MAb114	0	0	0	2	4	6	9	11	13	17	19	24	30	35	40
REGN-EB3	0	0	0	0	2	4	5	7	7	11	13	16	19	25	31

Figure 2. Time to Viral Clearance.

Panel A shows the time to the first negative result for Ebola virus (EBOV) nucleoprotein on reverse-transcriptase–polymerase-chain-reaction (RT-PCR) assay in all groups, with deaths imputed as the worst time. The dots indicate individual patients, the triangles indicate patients who were enrolled before January 2019 when the protocol was revised to add the REGN-EB3 group, and the horizontal bars indicate the group means. The black hashed bar in the remdesivir group indicates that the median time was not observed because more than 50% of patients in this group died before the first negative result. Data are not shown for one patient in the ZMapp group and one patient in the REGN-EB3 group who did not have a first negative result before day 28 but who had a negative result at days 48 and 41, respectively. Panel B shows the values for EBOV nucleoprotein as determined on RT-PCR, according to day of the trial. The symbols indicate the median, and the vertical bars indicate the interquartile range.

region of the DRC in which there is regional violence, mistrust of government, mistrust of the Ebola response, an unstable electrical power grid, transportation difficulties, and a history of high morbidity from other infectious diseases. Missing results from laboratory tests make the logistic-regression analyses difficult to interpret. Continual oversight of staffing and supply-chain issues by the DRC Ministry of Health, the INRB, the WHO, ALIMA, IMC, and MSF was essential to maintaining an appropriate standard of supportive care in the trial centers. The trial was interrupted temporarily in two participating centers that had to be evacuated because of violence directed against those units by local community or paramilitary groups who were reportedly suspicious of the activities under way in those facilities.

Reaching a successful conclusion to this challenging trial required careful planning as well as the cooperation, support, and coordination of national and international health agencies, government leaders, pharmaceutical companies, dedicated oversight boards, scientists, and nongovernmental organizations. This trial showed that it is possible to conduct scientifically rigorous and ethically sound research during an outbreak, even in a conflict zone. Although it is important to recognize the collective strength of this partnership in ensuring the completion of the trial, the single greatest factor that ensured its success was the commitment of the staff in the field and at the sites (the physicians, nurses, pharmacists, hygienists, the *gardes-malades* [guardians of the sick], and the numerous other support staff) who worked under highly challenging circumstances at the front lines of this effort in the Ebola treatment centers, as well as that of the patients themselves.

The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. government.

A data sharing statement provided by the authors is available with the full text of this article at NEJM.org.

Supported primarily by the National Institute of Allergy and Infectious Diseases (NIAID), National Institutes of Health (NIH). In-kind support and cosponsorship were provided by the national government of the Democratic Republic of Congo (DRC) and the African Coalition for Epidemic Research, Response, and Training. Logistic support was provided by the World Health Organization (WHO). Some funding for NIAID was provided by the National Cancer Institute through a contract (HHSN261200800001E) with Leidos Biomedical Research and subcontracts to the Mitchell Group. The Biomedical and Advanced Research and Development Authority of the U.S. Department of Health and Human Services provided financial support for the production of ZMapp (contract number, HHSO100201400009C) and REGN-EB3 (contract number, HHSO100201700016C). NIAID and the Defense Advanced Research Projects Agency of the U.S. Department of Defense provided financial support for the production and provision of MAb114. Mapp Biopharmaceutical provided ZMapp, Gilead Sciences provided remdesivir, and NIAID provided MAb114 to the project. Regeneron Pharmaceuticals provided financial support for the provision of REGN-EB3 to the project.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

We thank the members of the PALM Consortium Study Team (see the Supplementary Appendix) for their many contributions in conducting the trial under very challenging field conditions, the members of the data and safety monitoring board (Lisa A. Cooper, M.D., M.P.H. [chair], Scott Hammer, M.D., Dave DeMets, Ph.D., M.Sc., Ann Sarah Walker, Ph.D., M.Sc., Mesia Kahunu, Pharm.D., Ph.D., Amadou Traore, M.D., M.Sc., Albert Faye, Ph.D., Salim Abdulla, Ph.D., M.Sc., and Rebecca DerSimonian, Sc.D., and Sally Hunsberger, Ph.D. [coexecutive secretaries]) for their oversight, the WHO and their coordinating committees (see Table S11), Anthony Fauci (NIAID), Robert Redfield (Centers for Disease Control and Prevention [CDC]), and Peter Salama and Michael Ryan (WHO) for leadership guidance, CDC staff (including Raimi Ewetola, Alstead Forbes, and Laetitia Vahaviraki) and the WHO staff (including the incident manager and field coordinators, supply and logistic teams, and Global Outbreak Alert and Response Network clinician experts) for in-country support, Raoul Kamanda and colleagues from the DRC Ministry of Health for invaluable support, and, most important, the patients themselves for their extraordinary bravery and altruism in participating in a trial of these experimental countermeasures.

APPENDIX

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PHAC/INFC/CIHR: Opportunities for Engagement
Background for Meeting on December 18, 2019

Federal Dialogue on Designing Communities for Healthy Living

- In June 2018, PHAC and Infrastructure Canada (INFC) co-hosted a federal dialogue in Ottawa. The objectives were to increase awareness of federal roles and responsibilities in the area of healthy built environment and identify possible areas for collaboration. Cross-cutting themes included: the need for data integration and partnerships, capacity building and knowledge sharing across government, the importance of inclusion and diversity across federal departments, and the need for more flexible governance structures and mechanisms to support collaboration.
- A Healthy Built Environment (HBE) Prize/Challenge was one of the ideas that emerged from the Federal Dialogue. It could be an opportunity for horizontal collaboration to support green/natural infrastructure that reduces the impact of extreme weather events caused by climate change while simultaneously creating accessible green space and urban forests that improve mental health and increase physical activity. Other federal departments, (Health Canada's Climate Change Bureau) and Natural Resources Canada (Canadian Forest Services) as well as national organizations (Canadian Institute of Planners) signalled an interest in supporting this type of HBE Challenge.

INFC Smart Cities Challenge

- PHAC reviewed nine health-related submissions as part of INFC's first Smart Cities Challenge in the spring of 2019. Of note, is that three of the four winning projects include a health component e.g., Guelph – food environments; Montreal – active transportation; Nunavut – social cohesion.
- INFC is currently working on establishing outcomes-based contribution agreements for the winners of the Smart Cities Challenge. PHAC has agreed to provide an overview of experiences with establishing outcomes for the *Healthy Living and Chronic Disease Prevention – Multisectoral (MSP)* program and the process of negotiating outcomes with recipients for the Treasury Board Generics Base Plus Premium Payment projects. A meeting is being planned with analysts from INFC and PHAC's MSP program.
- It may be worth discussing opportunities to engage with INFC more proactively in the development of the second Smart Cities Challenge. We understand that options for the design and focus of the second Challenge are currently being considered based on lessons learned from the first Challenge. PHAC expertise in identifying and measuring health-related outcomes is one area for partnership.

CIHR Engagement

- PHAC is partnering with CIHR on its Implementation Science Team Grants, a funding opportunity available through CIHR's Healthy Cities Research Initiative. This co-funding opportunity will allow PHAC to leverage the research capacity of CIHR and support the testing of interventions that provide long-term, scalable and impactful solutions in addressing chronic disease prevention and health equity. The six-year Implementation Science Team Grants will be launched in March 2020 with the goal of better understanding how to design and promote the uptake of evidence-based interventions in multiple urban environments to improve health and well-being.

Opportunities for Funding Alignment

- It may be worth exploring other opportunities to leverage the expertise and resources of INFC and PHAC for bigger impact. By doing so, the benefits of federal investments in social, green and public transit infrastructure could be further amplified by enabling the health and well-being gains of these investment to be measured and articulated to Canadians.
- It may be worth noting PHAC's two built environment initiatives funded through the MSP program that have successfully leveraged partnerships with infrastructure developers:
    - *Housing for Health* project led by University of Alberta, aims to integrate evidence-based active design features into two new housing infrastructure developments in the municipalities of Edmonton and Whitecourt, Alberta, in partnership with a local developer and twelve other local partners.
    - *Community Connections:* the City of St. Thomas Ontario is working with public health, two developers and a range of NGOs to create active transportation infrastructure to facilitate increased walkability and walking.
- Also of note, is that INFC's Mandate letter of December 13, 2019 includes as a priority "the launch of a new call for proposals under the Disaster Mitigation and Adaptation Fund to address the impacts of climate change…including those (projects) related to natural infrastructure" and this may be an entry point for some type of collaboration.

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Subject: Fwd: Baycrest and CABHI Renewal

Attachments: [redacted] CABHI Federal 2020 Pre-Budget Submission FINAL.PDF; ATT00002.htm; [redacted]

Hii everyone. Wanted to flag that Isabelle had questions yesterday from Min's Chief of Staff re CABHI. Have included the email attachments they received below from Baycrest CEO [redacted]

[redacted]

CENTRE FOR AGING + BRAIN HEALTH INNOVATION

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Written Submission for the Pre-Budget Consultations in Advance of the 2020 Budget

CABHI 2025: Amplifying Our Impact

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List of Recommendations:

- Recommendation 1: The Federal government renew its contribution to CABHI with $66 million in funding over 5 years to grow and amplify our impact.

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CABHI 2025: Amplifying Our Impact

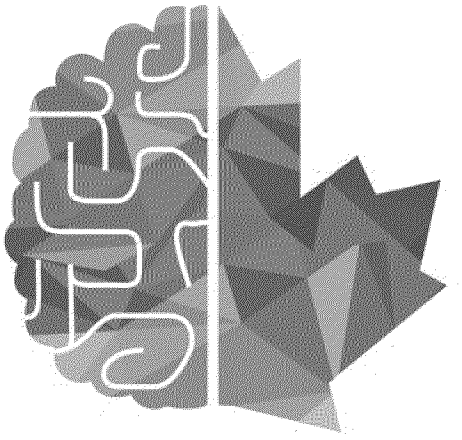
As Canada's aged population increases, so too does the prevalence of age-related brain disorders, such as Alzheimer's disease, the principal cause of dementia in older adults. As a recent Senate report notes, over 700,000 Canadians currently suffer from dementia, and that number is expected to climb to 1.4 million by 2031. Costs for the direct care of Canadian dementia patients has been estimated at $10 billion; the combined direct and indirect costs already exceed $30 billion; and, of course, the costs to individuals and their caregivers living with dementia are immeasurable.

Canada has committed to improving the lives of its growing number of older adults by proactively addressing the challenges of dementia, an aging-associated condition that adversely impacts older individuals, their family caregivers, friends, and communities, and our healthcare system. The Federal government's commitment to this cause has been demonstrated though the creation of the first ever National Dementia Strategy, through unprecedented investments toward fundamental research, including support of the Canadian Institutes of Health Research Institute of Aging, which leads a Dementia Research Strategy as one of its key initiatives.

However, traditionally-funded discovery and translational research take us only so far in advancing our Strategy. Innovations stemming from research at Canada's colleges, universities, and hospitals, or developed by industry or seniors' care providers, must be developed sufficiently to establish value, scalability, and the potential for widespread procurement and adoption. This can occur only through rigorous testing, disciplined evaluation, and compelling validation by engaging end-users in real-world seniors' clinical care and residential settings. Once value is established, procurement and adoption must be deliberately facilitated to establish meaningful market entry. Historically, these conditions, which are essential to introduce impactful innovations into the seniors' care sector, have been largely unmet.

Canada Specifically Needs:

- Innovative solutions to diagnose at-risk patients for dementia as early as possible
- New approaches to maintaining and enhancing brain health in older adults
- Innovative, replicable, scalable technologies and related solutions to enhance the safety, health, and well-being of individuals suffering from dementia and their caregivers
- Increased support for innovators to develop and bring to market the next generation of aging, brain health, and dementia care solutions



The programs and services provided by the Centre for Aging + Brain Health Innovation (CABHI) are critical for Canada to meet these needs.

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CABHI is Improving the Aging Experience in Canada

In just its first four years, CABHI has become Canada's premier innovation accelerator in the aging and brain health sector with a focus on dementia and elevated Canada's reputation as a true champion of innovation. Overall, CABHI has directed and committed more than $85 million to its programs and projects, of which more than $52 million has been levered from other sources external to Federal government contributions.

Since receiving our initial funding support, CABHI continues to add significant value to existing government investment. To date, for every $1 of federal funding invested into a CABHI program or project, an additional $1.66 is levered from other sources (even though most of our programs were not initially designed with matching fund requirements). The fact that private and public sector organizations have chosen to invest their own funding to support our programs speaks to the value CABHI provides.

CABHI has created a network of more than 100 trial sites through numerous public and private partnerships and supported the development of hundreds of new products, practices, and services that have enhanced the lives of more than 45,000 Canadian older adults and their families.

CABHI has supported the development of more than 350 promising innovations, of which 245 completed evaluation, and 157 have been introduced into the market or adopted into practice.

CABHI has successfully engaged more than 82,000 members of the public in our activities focused on creating a collaborative community of innovators and stakeholders. An additional 35,000 individuals have participated in our information sharing and knowledge translation activities.

CABHI projects are stimulating significant economic activity across Canada: more than $40 million has been directed towards creating new and sustained highly skilled jobs. CABHI projects have engaged more than 2,000 highly qualified personnel across 934 partners and collaborators, including technology and software developers, front-line care workers, and entrepreneurs. We have also built innovation capacity by including students and scientists in validation projects.

CABHI's innovators and companies are beginning to generate significant interest and secure outside investments to scale, spread, and de-risk their innovations beyond the pilot project phase. CABHI innovators and companies have received more than $42 million in secured investments from private and public sources since engaging with CABHI.

CABHI funds projects coast to coast, and its projects have engaged with has established formal partnerships in British Columbia, Northwest Territories, Alberta, Saskatchewan, Manitoba, Ontario, Québec, New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador. As a result, each province has earmarked additional funding for regional priorities in aging and brain health innovation, including advancing innovative solutions for Indigenous and rural populations.

Even at this early stage in its development, CABHI's strong results demonstrate its significant impact.

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CABHI'S Unique Value Proposition

CABHI was spearheaded in 2015 by Baycrest, a global leader in aging and brain health care and home to the Rotman Research Institute, one of the world's most acclaimed research centres in aging and human brain science. CABHI was built on Baycrest's much sought-after expertise through a 5-year funding commitment from the Public Health Agency of Canada (PHAC, $42M), which enabled additional matching support from the Ontario Government ($23.5M), along with commitments from private donors to the Baycrest Foundation ($25M) and an ever-growing consortium of private and public partners, including IBM Canada, Rogers, National Bank, the Alzheimer Society of Canada, MaRS Innovation, the Seniors Quality Leap Initiative, the Ontario Long Term Care Association, additional Canadian provinces, and the State of Israel.

Such strong and multi-sector support of CABHI reflects the potential and achieved impact that our programs offer: identification and advancement of the most promising innovations to optimize brain health in aging adults, and to improve the lives of individuals living with dementia and their caregivers.

Despite large investments, most innovations developed for seniors' health are not widely adopted because innovators fail to address end-users' priorities. CABHI developed a partnership model that optimizes the innovation process through co-development – ensuring that end-users' (e.g., patients, caregivers, healthcare providers) perspectives are integrated into decision-making, priority-setting, user testing, and dissemination. For example, CABHI's Seniors Advisory Panel works closely with selected innovators to refine and optimize their solutions before entering validation testing.

CABHI's programs span the innovation pipeline addressing the unique needs of different groups to meet our primary objectives. To inspire a culture of innovation in seniors' care, CABHI supports the design, development, and testing of new ideas brought forth by front-line care workers. For innovators with a developed product or process in hand, we open doors to real-world seniors' care sites for larger-scale validation testing. We support all of our innovators through a variety of tailored foundational support services: from scientific advising, to training in innovation and health systems, to developing procurement options and marketing plans.

To ensure successfully validated solutions reach maximum users for adoption, CABHI connects companies to external advisors and mentors, provides enhanced access to partner accelerators and incubators, and procures third-party consultation services where needed. It also delivers refined business and market launch plans associated with requests for investment. CABHI's services are not intended to duplicate services companies could access through other means, for example through Regional Innovation Centres. Instead, CABHI provides specialized advising and support targeted specifically at the Canadian seniors' care sector, building on its unique and deep expertise in aging and brain health innovation.

We are substantially raising Canada's profile in the longevity sector by collaborating with international innovation consortia and innovators from around the world, including an increasing number from the Silicon Valley and other innovation hotspots in the United States and beyond. For example, our partnership with the Israel Innovation Authority (IIA) attracted $1 million in international funding (with a promise of an additional $5 million should CABHI's funding be renewed), and provided Canadian seniors with access to cutting-edge technologies from one of the world's innovation leaders. These partnerships have led to dozens of innovation projects launching in Canada, have sparked interest for more collaborations with new global partners, have led to foreign investments in Canada, such as the creation of the Canadian headquarters for Norway-based companies, Motitech and Ably Medical, and provide a pathway for export of Canadian innovations.

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The Vision for CABHI 2025

CABHI initially was funded as a proof-of-concept. Just four years later, CABHI's value is proven. Our approach makes a meaningful difference for older adults and their caregivers, for seniors' care organizations, for innovators, and for the health system. CABHI helps Canada meet its commitment to older adults.

To date, CABHI has engaged over 45,000 Canadian older adults and caregivers in the testing and validation of innovations critical to addressing the growing challenges and costs associated with dementia. As outlined in *A Dementia Strategy for Canada: Together We Aspir*e, "For research on dementia therapies to be effective and culturally appropriate, people living with dementia as well as their families and caregivers must be meaningfully involved as active participants and partners. Their voluntary participation is a vital contribution to our understanding of which therapies are effective, as well as a core tenet of ethical research practice."

CABHI amplifies the federal government's impact through its dual approach in accelerating dementia-relevant research and innovations, and has been identified as a key contributor to the *National Strategy for Alzheimer's Disease and Other Dementias Act*.

With our original funding term ending in 2020, CABHI must secure additional funding to accelerate and amplify our impact. Maintaining the status quo will not keep pace with the health needs of Canada's rapidly aging population, with market-driven demand, or with the accelerating rate of innovation around the globe.

CABHI's plans for the next five years are targeted on achieving the largest societal impact possible. We will:

1. Maintain our focus on the effects of an aging population on brain health and the challenges of dementia
2. Strategically increase the number of Canadian innovators and partners in the aging and brain health space
3. Engage Canada's diverse population more directly in our innovation activities
4. Grow Canada's culture of innovation and support our innovation economy
5. Attract more foreign investment and promote Canadian innovations globally
6. Facilitate implementation, dissemination, and adoption of critically important solutions for aging and brain health
7. Increase the sustainability, efficiency, and effectiveness of Canada's health care systems for our aging population
8. Enhance the health and well-being of older individuals at risk for or living with dementia, and their caregivers

REQUEST: The Federal government to commit to a renewal of funding for CABHI of **$66 million over 5 years** to grow and amplify our impact to date.

This contribution will be matched by an additional commitment of $25 million from the Baycrest Foundation and at least $40 million from other sources (provincial, international, private, and public sector partners), for a total budget of $131 million. This investment will enable CABHI to amplify our impact: increasing innovation in seniors' care; enhancing the health and quality of life among older Canadians; cementing Canada's reputation as the leading centre for innovation in aging and brain health; and helping grow Canadian companies, while reducing health system costs.

WITHHELD / RETENUE

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From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-05 8:42 PM

To: Hostrawser, Bonnie (PHAC/ASPC)

Cc: Rendall, Jennifer (PHAC/ASPC); Bell, Tammy (PHAC/ASPC); McLeod, Robyn (PHAC/ASPC)

Subject: Re: BBE health inequalities for sexual and gender minorities

---

Cara is great.

Will await your info as the bits of paper in front of me suggest I will be speaking on Jan 16th

Sent from my iPhone

> On Dec 5, 2019, at 20:17, Hostrawser, Bonnie (PHAC/ASPC) <bonnie.hostrawser@canada.ca> wrote:
>
> The event is at CIHR on Elgin. There is an evening reception but not mandatory. Cara Tannenbuam is one of the opening speakers. I have the list of participants on my desk. I will bring down list and agenda tomorrow. I remember that there was good representation from Black researchers network, two spirit researchers and LGBT community.
>
> Sent from my iPhone
>
>> On Dec 5, 2019, at 7:57 PM, Tam, Dr Theresa (PHAC/ASPC) [redacted] wrote:
>>
>>
>> Is this in Ottawa?
>>
>> If I am invited to the event on Jan 16th does that mean the evening?
>>
>> Any idea on invitees?
>>
>> TT
>>
>> Sent from my iPhone

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-05 7:36 PM
To: Charos, Gina (PHAC/ASPC)
Cc: Elmslie, Kim (PHAC/ASPC); Henry, Erin E (PHAC/ASPC); Thom, Alan (PHAC/ASPC); Paddle, Lisa (PHAC/ASPC); Smith, Sharon E (PHAC/ASPC); Hartigan, Maureen (HC/SC)
Subject: Re: [redacted] Antiviral stockpile

Hi Gina,

Thank you for the follow up with HC and [redacted] to bring clarity to the issue.

The survey would be useful but this looks like something that PTs will have to resolve amongst themselves. It is probably quite expensive to store these drugs so this is another pressure that CDMH needs to be aware of.

Sent from my iPhone

On Dec 5, 2019, at 10:55, Charos, Gina (PHAC/ASPC) <gina.charos@canada.ca> wrote:

> Theresa, Kim,
> Quick note to close the loop on [redacted]
>
> Yesterday, we had a call with [redacted]

[redacted]

Note that [redacted] has asked that this item be included on next week's CCMOH agenda as an emergent issue. As such, a more fulsome note will follow in the CCMOH meeting package.
Let me know if you have questions.
Gina

GINA CHAROS
Director General
Centre for Immunization and Respiratory Infectious Diseases (CIRID)
Infectious Disease Prevention and Control Branch
Directrice générale
Centre de l'immunisation et des maladies respiratoires infectieuses (CIMRI)
Direction générale de la prévention et du contrôle des maladies infectieuses

PUBLIC HEALTH AGENCY OF CANADA | AGENCE DE LA SANTÉ PUBLIQUE DU CANADA
130 Colonnade Road, room/pièce 106A, Ottawa, ON K1A 0K9
Phone | Téléphone: **613 960-2893**
gina.charos@canada.ca

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-19 7:01 PM
To: Namiesniowski, Tina (PHAC/ASPC); Thornton, Sally (PHAC/ASPC)
Cc: Gomes, Lisa (PHAC/ASPC); Johnstone, Marnie (PHAC/ASPC); Mead, Jobina (PHAC/ASPC)
Subject: RE: Bilat Friday & Odds & Ends

Yes , I always appreciates these odds and ends emails.

Thanks Sally

From: Namiesniowski, Tina (PHAC/ASPC)
Sent: 2019-12-19 4:40 PM
To: Thornton, Sally (PHAC/ASPC)
Cc: Tam, Dr Theresa (PHAC/ASPC) ; Gomes, Lisa (PHAC/ASPC) ; Johnstone, Marnie (PHAC/ASPC) ; Mead, Jobina (PHAC/ASPC)
Subject: Re: Bilat Friday & Odds & Ends

Sally. Thanks for this. Most helpful.

Sent from my iPhone

On Dec 19, 2019, at 3:28 PM, Thornton, Sally (PHAC/ASPC) <sally.thornton@canada.ca> wrote:

Hi Tina/Theresa – for our bilat tomorrow:

- Would like to discuss/provide heads up re: potential LR issue
- Discuss any outstanding items re: coverage over holiday season.

A few other things, FYI

Management Variance Report P8

- Working closely with OCFO, and HSIB on track re: MVR P8.

Ebola situation in the DRC

- The WHO reported 24 new confirmed Ebola cases from December 9 to 15, 2019. While EVD is now contained to 4 health districts (down from a high of 29 at the outbreak's peak), the current case count represents an increase that can be directly attributed to regional violence. The violence is centered around Beni, where 43 people died over the weekend of December 13, as a result of two separate attacks. Violent attacks are making critical response functions such as contact tracing, vaccinations, and safe burials increasingly difficult (again). To ensure continued care, the WHO has recently mounted a limited daily helicopter "air bridge" operation to the communities still at risk.

- The WHO is planning to reduce its overall footprint in DRC by 28% in January 2020, commensurate with the outbreak's geographic containment to a few key rural areas. However, an end to this outbreak is difficult to predict, especially given that some of the violence is directly linked to the exploitation of the Ebola outbreak and response efforts in the region for political and economic gain.

- We will not be proceeding with a December deployment, but will continue to monitor and will revisit in 2020.

Regulatory Agenda

The last portfolio meeting was December 18th.

- DM Lucas reported on briefing with Minister Hajdu on Regulatory Modernization. The Minister will consider requests and feedback and from stakeholders/regulated parties
    - Anticipate that there will be opportunities for verbal Ministerial briefings on key regulatory initiatives in the New Year.
    - Priorities in Ministers' Mandate Letters will influence the delivery of the Health Portfolio's regulatory agenda – so there will be another prioritization exercise – reflecting mandate priorities and recognizing that the current Health Portfolio regulatory agenda is too optimistic given the limited number of TB meeting dates.

- A forecast of Portfolio regulatory submissions by TB meeting dates until June 2020 has been prepared to facilitate planning.
    - Currently, 27 submissions are identified, 16 for Canada Gazette, Part I and 11 for Canada Gazette, Part II.
    - No PHAC submissions are planned for the January-June 2020 Parliamentary session.
    - PHAC plans amendments (Quarantine Regulations & HPTA Toxins Schedule) for the September – December 2021 session.

- HC prepared a Regulatory Modernization Dashboard to track implementation of Round 1 commitments.
    - Joint PHAC-CFIA item on pathogen oversight is on track for December 2020 completion.

- For Round 2, TBS is seeking to narrow the number of proposals from 70 Acts to 10-15.
    - TBS exploring both inclusion in a BIA, and a stand alone. (PHAC has no items)

Next steps, in the new year, include discussion on the Portfolio's capacity for Cost-Benefit Analysis.

Mobilizations

Issue	Name	Location	Dates
EVD support to WHO AFRO Regional Office	Lise Gauthier	Brazzaville, Congo	8 November – 20 December 2019
Vaping support to HPDCP	Peter Uhthoff	130 Colonnade Road	15 October 2019 – 31 March 2020
Vaping support to HPCDP	Yuhui Xu	130 Colonnade Road	2 December 2019 – 2 March 2020

Sally

Subject: Bilat w/ Eric Costen
Location: Room 146B, 130 Colonnade Road

Start: Thu 2019-12-19 4:00 PM
End: Thu 2019-12-19 5:00 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Costen, Eric (HC/SC); Broadway-Bennett, Lynn (HC/SC); Tosh, Casey (PHAC/ASPC); Macey, Jeannette (PHAC/ASPC); Killen, Marita (PHAC/ASPC); Romano, Anna (PHAC/ASPC); Hould, Laura (PHAC/ASPC)

Subject: Bilat w/ Tammy Bell
Location: Theresa's office

Start: Thu 2019-12-05 10:30 AM
End: Thu 2019-12-05 11:15 AM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Bell, Tammy (PHAC/ASPC)

Subject: Calendar review
Location: TT's office

Start: Fri 2019-12-20 9:30 AM
End: Fri 2019-12-20 10:00 AM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Bell, Tammy (PHAC/ASPC); Macey, Jeannette (PHAC/ASPC)

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-12 3:57 PM

To: Lucas, Stephen (HC/SC)

Subject: Re: Call

Thank you Steve.

That was great. I think members really appreciated the opportunity and the support for more holistic approaches including prevention would have resonated.

The line went very noisy at the end so I had to end the call.

Of interest, CCMOH is now discussing another statement on Vaping cannabis products, in addition to the one on youth vaping and nicotine.

Will keep you appraised.

TT
Sent from my iPhone

> On Dec 12, 2019, at 15:33, Lucas, Stephen (HC/SC) <stephen.lucas@canada.ca> wrote:
>
> Hi Theresa - I tried to call you. Hope that was ok and helpful for you and Tina.
>
> Steve
>
> Stephen Lucas, PhD
> Deputy Minister
> Health Canada

Subject: Call w/ Deputy Secretary Janine Sherman
Location: Theresa to call 613-957-5465

Start: Fri 2019-12-20 1:00 PM
End: Fri 2019-12-20 1:05 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: janine.sherman@pco-bcp.gc.ca; josette.guindon@pco-bcp.gc.ca

Subject: Call w/ Drs. Sharma and Wong
Location: Dial-in [redacted] / Conference ID [redacted]

Start: Thu 2019-12-19 9:30 AM
End: Thu 2019-12-19 9:45 AM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Sharma, Supriya (HC/SC); Alvarez, Annette (HC/SC); Wong, Tom (SAC/ISC); James, Michelle (SAC/ISC)

WITHHELD / RETENUE

Is(Are) exempted and/or excluded pursuant to section(s)
est(sont) exemptée(s) et/ou exclus en vertu de(s)(l')article(s)

19(1)
Subject to subsection (2), the head of a government institution shall refuse to disclose any record requested under this Act that contains personal information as defined in section 3 of the Privacy Act
Sous réserve du paragraphe (2), le responsable d’une institution fédérale est tenu de refuser la communication de documents contenant les renseignements personnels visés à l’article 3 de la Loi sur la protection des renseignements personnels

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From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-16 10:19 AM

To: Hostrawser, Bonnie (PHAC/ASPC); Rendall, Jennifer (PHAC/ASPC); Bell, Tammy (PHAC/ASPC)

Subject: Fwd: Canadian scientist undergoes novel brain stimulation treatment for alcoholism | CTV News

---

Sent from my iPhone

Begin forwarded message:

> **From:** "Johnstone, Marnie (PHAC/ASPC)" <marnie.johnstone@canada.ca>
> **Date:** December 16, 2019 at 07:54:41 EST
> **To:** "Namiesniowski, Tina (PHAC/ASPC)" <tina.namiesniowski@canada.ca>, "Tam, Dr Theresa (PHAC/ASPC)" [redacted] "Elmslie, Kim (PHAC/ASPC)" <kim.elmslie@canada.ca>
> **Subject: Fwd: Canadian scientist undergoes novel brain stimulation treatment for alcoholism | CTV News**
>
> Good morning. Marita passed this interesting. article .Dr. Plummer (longtime and former Scientific Dg at the NML) is undergoing experimental therapy (deep brain stimulation) to help deal with alcoholism.
>
> https://www.ctvnews.ca/health/canadian-scientist-undergoes-novel-brain-stimulation-treatment-for-alcoholism-1.4729940

Subject: PREP RE: Cannabis Forum
Location: Room 146B

Start: Tue 2020-01-28 1:00 PM
End: Tue 2020-01-28 1:45 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Bell, Tammy (PHAC/ASPC); Rendall, Jennifer (PHAC/ASPC)

RE: cannabis forum

From: Rendall, Jennifer (PHAC/ASPC) []
To: McLeod, Robyn (PHAC/ASPC) [robyn.mcleod@canada.ca]
Subject: RE: cannabis forum
Date: Thursday, November 14, 2019 11:21:40

How about just me and tammy for now and I'll ask phac briefing to confirm.

Does that work?

Jennifer Rendall

Director, CPHO Outreach / Directrice de sensibilisation de l'ACSP

Office of the Chief Public Health Officer/Bureau de l'Administratrice en chef de la santé publique

Public Health Agency of Canada / Agence de la santé publique du Canada
Ottawa, Canada K1A 0K9
Tel: 613-853-3428

jennifer.rendall@canada.ca

From: McLeod, Robyn (PHAC/ASPC) <robyn.mcleod@canada.ca>
Sent: 2019-11-14 10:05 AM
To: Rendall, Jennifer (PHAC/ASPC) <jennifer.rendall@canada.ca>
Subject: RE: cannabis forum

Sure, I can schedule it on Tuesday, December 17th @ 1:30 pm. Who should be invited?

From: Rendall, Jennifer (PHAC/ASPC)
Sent: 2019-11-14 10:01 AM
To: McLeod, Robyn (PHAC/ASPC)
Subject: FW: cannabis forum

Do you want to book a prep and then I can action to phac briefing the materials? If we could do an early check in mid December that would be great.

Jennifer Rendall

Director, CPHO Outreach / Directrice de sensibilisation de l'ACSP

Office of the Chief Public Health Officer/Bureau de l'Administratrice en chef de la santé publique

Public Health Agency of Canada / Agence de la santé publique du Canada
Ottawa, Canada K1A 0K9
Tel: 613-853-3428

jennifer.rendall@canada.ca

From: Pacha, Meagan (PHAC/ASPC) <meagan.pacha@canada.ca>
Sent: 2019-11-14 8:29 AM
To: Rendall, Jennifer (PHAC/ASPC) <jennifer.rendall@canada.ca>
Cc: Priest, Stephanie (PHAC/ASPC) <stephanie.priest@canada.ca>
Subject: RE: cannabis forum

Hi Jen,

I understand that Dr. Tam had confirmed her availability to provide remarks on Jan 16. It will be the morning of day two of the event, and she currently has 10 minutes on the agenda. If you can create the tasking and set up a prep, that would be great. I assume that our team would be tasked with the scenario note and speaking points.

Of note, the symposium is no longer focussed on cannabis pub ed. Jacquie Bogden requested that the symposium be expanded beyond cannabis to all substances. We are plugged into the planning, which now includes a fairly broad group given the expanded scope. Our team is leading the planning of a panel on upstream prevention and will also support a panel on stigma.

Meagan Pacha

A/Manager / Gestionnaire p.i.

Prevention of Problematic Substance Use / Prévention de la consommation problématique de substances

Centre for Health Promotion / Centre pour la promotion de la santé

Public Health Agency of Canada / Agence de la santé publique du Canada

meagan.pacha@canada.ca / (343) 542-3895

From: Rendall, Jennifer (PHAC/ASPC) <jennifer.rendall@canada.ca>
Sent: 2019-11-13 3:42 PM
To: Pacha, Meagan (PHAC/ASPC) <meagan.pacha@canada.ca>
Subject: cannabis forum

Hi

I saw a note about TT going to the cannabis forum and doing opening remarks maybe?

Just wondering if I need to action anything and set up any preps or anything to get things moving at all? I don't think anything has been actioned form our end (scenario note, speaking points, any other background etc.)

Thank you

Jennifer Rendall

Director, CPHO Outreach / Directrice de sensibilisation de l'ACSP

Office of the Chief Public Health Officer/Bureau de l'Administratrice en chef de la santé publique

Public Health Agency of Canada / Agence de la santé publique du Canada
Ottawa, Canada K1A 0K9
Tel: 613-853-3428

jennifer.rendall@canada.ca

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-02 10:20 AM
To: McLeod, Robyn (PHAC/ASPC)
Subject: Fwd: CBC News: The road to vaping

Please print

Sent from my iPhone

Begin forwarded message:

> **From:** "Media Monitoring / Suivi des Medias (HC/SC)" <hc.media.monitoring-suivi.des.medias.sc@canada.ca>
> **Date:** December 2, 2019 at 10:06:05 EST
> **Subject: CBC News: The road to vaping**
>
> Distribution group/Groupe de distribution: HC.F PEIA Vaping / Vapotage AREP F.SC
> December 2, 2019
> **The road to vaping**
> *Less than two years ago, the federal government officially welcomed the vaping industry to Canada. The belief among policy-makers and public health experts was that e-cigarettes were safer than combustible cigarettes and would help smokers kick their habit. That's not what happened.*
> CBC News, Kelly Crowe
> ***This story is part of Vape Fail, a CBC News series examining some of the policy failures that led to the adoption of vaping as a smoking alternative and the resulting consequences.***
> Most Canadians don't smoke.
> Yet Canada has chosen to implement a nationwide smoking-cessation strategy to make nicotine vaping devices as accessible as possible.
> It was an unusual public health decision for regulators to deliberately craft a law to encourage the sale of an addictive product.
> The federal government's goal was "to strike a balance between protecting youth from inducement to nicotine and tobacco use, while allowing adult smokers to legally access vaping products," Health Minister Jane Philpott told a Senate committee on April 12, 2017, as the legislation was being debated before final approval.
> The resulting law, which came into effect in May 2018, means vaping devices have fewer restrictions than tobacco and cannabis under Canada's Tobacco and Vaping Products Act.
> Unlike cannabis, vaping devices can be sold anywhere, and unlike tobacco, there are no warning signs on packages and the sale of fruit flavours is allowed.
> Canada's vaping approach was based on a hypothesis — that the minority of Canadians who still smoked might switch to vaping.
> Federal health officials knew when they drafted the law that they did not have definitive evidence that e-cigarettes were effective at helping people quit smoking.
> And today it's becoming clear that the utopian post-tobacco vision is not materializing the way it was imagined.
> "The majority of smokers do not switch," said Dr. Charlotta Pisinger, a leading researcher on tobacco prevention at the University of Copenhagen in Denmark. "It was wishful thinking. The smokers didn't do as we wanted them to do."
> Instead of abandoning cigarettes, many smokers have added vaping to their nicotine habits, becoming dual-users.
> And even though the law tried to protect teens, through advertising and age restrictions, it hasn't worked. The latest statistics show that about a quarter of high school students across Canada are vaping.
> Add to that a mysterious and deadly vaping illness, along with new research showing vaping poses unique risks for organ damage and chronic disease, and some of the same health advocates who promoted vaping are now calling for a course correction in Health Canada's policy.
> "We opened it up too wide," said David Hammond, a professor of public health at the University of Waterloo who researches tobacco-control policies. "We still have very few regulations on e-cigarettes."
> As they drafted the new vaping laws, health officials also appeared unconcerned about the looming spectre of Big Tobacco — with its devastating history of death and disease — moving prominently into the vaping sphere.

"It was kind of like the standard public health precautionary principles got thrown out the window," said Andrew Pipe, a heart specialist and smoking cessation physician in Ottawa.

"It's perplexing because otherwise sentient, thoughtful people allowed this to happen."

Everything is safer than a cigarette

The evolution of Canada's vaping policies was based on a theory of relativity.

The battery-operated heating devices were novel consumer products that deliver nicotine and other unknown compounds into the lungs.

But instead of being judged in isolation, e-cigarettes have always been measured in relative terms — how safe they are compared to combustible cigarettes.

And because almost every other consumer product is safer than a cigarette, vaping devices came on the market already bearing a healthy halo.

"It is the wrong way to look at it," said Pisinger, who realized early on the risks of comparing vaping to cigarette smoking.

"We have been so focused on smokers and how to make it easy for smokers to quit, or reduce their harm, that we have forgotten to take care of the rest of the population."

The emergence of e-cigarettes should not have caught tobacco-control experts by surprise. The tobacco industry has been working on a novel way to offer nicotine to their cigarette customers for decades.

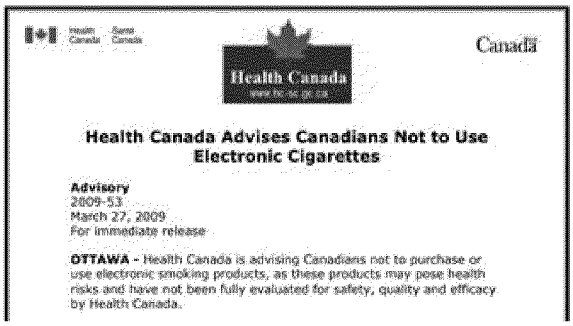
Industry documents released through the courts show tobacco executives imagining an invention that would "act as an acceptable alternative to both cigarettes and quitting."

"Perhaps we could develop cigarettes that would not have to be lighted with a flame … that would burn without smoke … and that would not leave butts. Ridiculous? Perhaps," an industry executive wrote in 1976.

All of the early industry prototypes failed in the market. But by 2006, a new version of Chinese-made "nicotine inhalers" began to be imported and sold in the U.S. They simulated the look and feel of a cigarette, but used a battery to create a nicotine vapour.

When those first e-cigarettes appeared in Canada in 2009, Health Canada's instinct was to slam the door shut.

The agency issued a public warning to Canadians "not to purchase or use electronic smoking products, as these products may pose health risks and have not been fully evaluated for safety, quality and efficacy by Health Canada."



Canada

Health Canada

Health Canada Advises Canadians Not to Use Electronic Cigarettes

Advisory
2009-53
March 27, 2009
For immediate release

OTTAWA - Health Canada is advising Canadians not to purchase or use electronic smoking products, as these products may pose health risks and have not been fully evaluated for safety, quality and efficacy by Health Canada.

In the beginning, the U.S. Food and Drug Administration (FDA) also tried to crack down by blocking imports of e-cigarettes, calling them "unapproved drug/device combinations" that would need special health approval and licensing.

But when two U.S. companies sued the government, a district court in D.C. ruled the FDA did not have jurisdiction to regulate e-cigarettes because they were not being marketed as a treatment for nicotine addiction. Instead, the judge determined the marketing was aimed at "encouraging nicotine use."

The FDA decided not to appeal, and instead drafted legislation to regulate e-cigarettes as tobacco products that need FDA approval. That regulation process is still unfolding.

Although nicotine e-cigarettes remained technically illegal in Canada, small vape shops selling flavoured vaping juices began popping up across the country. Canadians were also able to buy e-cigarettes online.

The first e-cigarettes were advertised in magazines and online as a way for smokers to keep smoking with greater freedom — on airplanes, in bars and other places where cigarettes were banned.

An e-cigarette advertisement published in 2011 asks, "Why Quit?" and urges smokers to use the e-cigarette to "take back your freedom to smoke when and where you want without ash or smell."

When tobacco prevention researcher Charlotta Pisinger saw that ad she had a flashback to the tobacco industry's campaign several decades earlier promoting the benefits of switching to "light" cigarettes.

"Suddenly I could see it in the historical perspective," the researcher said. "And we knew from light cigarettes that it was a public health disaster because they undermined smokers' wish to quit completely."

Andrew Pipe, the heart specialist in Ottawa, used the "Why quit?" ad in seminars at medical conferences five years ago to warn about the ways tobacco companies could use e-cigarettes to promote smoking.

He told his audiences it would be an opportunity for the tobacco industry to push back against the social forces that had made smoking increasingly unacceptable in public.

"There was a disinclination to thoughtfully regulate these products," he said.

The Blu brand, featured in the ad, is now owned by Imperial Brands, which acquired it in 2014, as part of a merger. A spokesperson for Fontem Ventures, a subsidiary of Imperial, said the company can't speak to the motivations of ads created before the acquisition.

"In regards to this specific advertisement and messaging, this is not the type of language that we would use."

No proof, but plenty of faith

From the start, vaping companies were given a free pass on the health effects of their products. The industry was never pressured to prove that e-cigarettes were anything more than recreational devices. And, in an odd reversal of marketing roles, public health officials began promoting the health benefits of vaping.

In 2015, Public Health England famously announced that e-cigarettes were "95 per cent safer than cigarettes" based on a review of the evidence. That endorsement was reported in headlines around the world.

But the "95 per cent safer" claim was immediately criticized in an editorial in The Lancet as having an "extraordinarily flimsy foundation," which was largely based on "the opinions of a small group of individuals with no prespecified expertise in tobacco control."

The editorial also points out that some authors had potential conflicts of interest with the e-cigarette industry.

"It's as if this was scientifically established. It's not," said Richard Stanwick, the chief medical health officer for Island Health in Victoria. "It's just opinion."

Still, the U.K. pronouncement became one of the main pieces of evidence cited by public health officials to support a pro-vaping stance.

"It went all over the world, and it confused many public health people," said Pisinger, who was doing her own research on the health effects of vaping.

A year earlier, Pisinger published the first systematic review of the studies into the health effects of e-cigarettes and concluded the evidence was so weak and marred by severe conflicts of interest that no firm conclusions could be made about safety.

She updated that review for the World Health Organization in 2015, stepping up the warning by concluding: "Even though no firm conclusions can be drawn on the safety of e-cigarettes, there is an increasing body of evidence indicating harm."

"I felt a great responsibility on drawing these conclusions," she said. "But I felt I had to focus on the public health and not only on smokers."

But she was a lonely voice amid the rising chorus of experts trumpeting the end of cigarette smoking through e-cigarettes.

"I felt very much isolated."

Early signs of youth vaping

As the pro-vaping forces gathered steam, there was evidence from all over the world that young people were experimenting with e-cigarettes.

In 2013, the CDC reported "e-cigarette experimentation and recent use doubled" among middle and high school students during 2011-2012.

Two years later, the CDC reported a 900 per cent increase in teen e-cigarette use, prompting the U.S. surgeon general to announce that it had become "a major public health concern."

The same pattern was emerging in France, Poland and Canada, where a 2014 survey showed 16 per cent of young people reported trying e-cigarettes. And the majority of them were "never smokers."

By 2015, Dr. Richard Stanwick in Victoria was so concerned about youth vaping that he wrote an urgent position paper for the Canadian Paediatric Society urging Ottawa and the provinces to create regulations that would restrict the sale and marketing of e-cigarettes.

He said he felt dismissed as a "nervous Nellie."

At the time, e-cigarettes with nicotine were still illegal in Canada. But enforcement was weak.

"We know that youth are using these products," Hillary Geller, an assistant deputy minister at Health Canada, told the Commons health committee in October 2014.

"In some cases, marketing appears to be targeted at youth and young adults through the use of flavours and certain promotional techniques that glamorize their use."

Health Canada's Dr. John Patrick Stewart testified that the addictive potential of e-cigarettes was unknown, and that they "may be as addictive as, if not more addictive than cigarettes."

Another Health Canada official, Suzy McDonald, told the committee: "The bottom line is that we do not have the evidence yet to demonstrate that these products definitively help folks quit smoking."

Despite that uncertainty, Health Canada did not require the vaping industry to provide any evidence e-cigarettes are safe and effective at helping smokers quit.

As a heart specialist who works with patients on smoking cessation, Pipe was growing increasingly concerned about the lack of evidence supporting e-cigarettes.

"The degree to which people became enthralled with the harm-reduction approach, I think, led to a suspension of critical thinking."

Big Tobacco is also Big Vape

As they designed a policy to bring electronic cigarettes into the marketplace, the policy-makers ignored the signs that Big Tobacco had become Big Vape.

Beginning in 2010, the major international tobacco companies entered the e-cigarette industry by acquiring smaller companies and developing their own devices.

It's almost evangelical in this movement that the vape industry is the one that's going to solve the cigarette problem.

By 2018, they dominated the market, a development tracked by Annalise Mathers at the University of Toronto.

"I think they were just kind of lying in wait in terms of when to start to acquire these products, kind of slowly and silently," she said.

"The TTCs [transnational tobacco companies] really wanted another opportunity to establish their legitimacy, to establish their place at the table in terms of policy and regulation moving forward. So I think this has to be viewed in terms of a very long-term business strategy."

Vape FAIL

- The hope of vaping as a safer alternative to smoking is fading. We explore why
- The science behind why vaping is becoming so popular in Canada

The World Health Organization warned countries that the increasing involvement of the global tobacco giants in the marketing of e-cigarettes "is a major threat to tobacco control."

In Victoria, Richard Stanwick watched the involvement of Big Tobacco with growing concern, even though other smoking-cessation experts still believed that vaping could end tobacco smoking.

"It's almost evangelical in this movement that the vape industry is the one that's going to solve the cigarette problem," Stanwick said. "The rest of us really see the big engagement of Big Tobacco."

Canada's Tobacco and Vaping Products Act came into effect in May 2018, just three months before the arrival of JUUL, a radical innovation in e-cigarettes.

Representatives from the vaping giant made a courtesy call to Health Canada in August to introduce the new devices the company was about to launch in Canada.

The sleek JUUL device could be easily hidden from parents and teachers. And the tiny cartridge filled with flavoured nicotine salts gave users a hit of nicotine that rivalled a traditional cigarette.

In September 2018, the JUUL juggernaut landed with force.

Teenage vaping surged to the point where some schools took the doors off bathrooms, and teachers were seizing devices from students.

"I think this is what is most frustrating," said Stanwick. "We had a chance to get ahead of this product."

Health Canada helps market e-cigarettes

Meanwhile, Health Canada officials were working on ways to promote vaping to smokers by developing a series of health claims the industry could use to market the products.

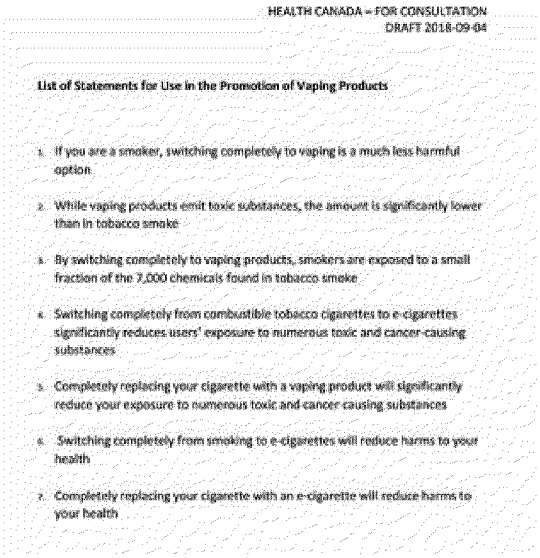
In early September 2018, Health Canada sent a letter inviting industry officials and tobacco-control advocates to comment on six statements, all variations on the claim that vaping is safer than smoking.

The consultations were not made public. But the federal government did make an announcement at a World Trade Organization committee meeting last year that it is developing regulations "to allow for certain statements to be used in the promotion of vaping products that compare the health effects of vaping to smoking."

(Health Canada told CBC News in an email this week that the proposal for comparative health statements is still under consideration.)

"It floored me, and got me busy writing comments," Neil Collishaw, research director with Physicians for a Smoke-Free Canada, said of his reaction to learning about the consultations.

He wrote a detailed response to Health Canada, concluding: "Rather than seeking to create a series of ill-advised comparative risk statements, Health Canada is encouraged to take effective action to mitigate serious public health problems associated with e-cigarette use."



HEALTH CANADA – FOR CONSULTATION
DRAFT 2018-09-04

List of Statements for Use in the Promotion of Vaping Products

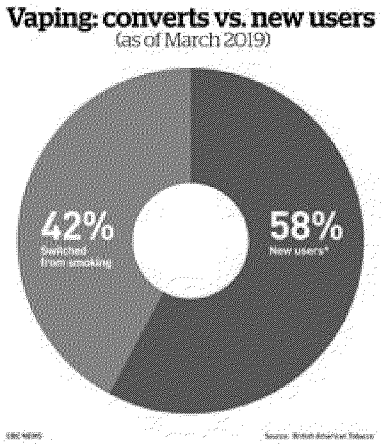
1. If you are a smoker, switching completely to vaping is a much less harmful option
2. While vaping products emit toxic substances, the amount is significantly lower than in tobacco smoke
3. By switching completely to vaping products, smokers are exposed to a small fraction of the 7,000 chemicals found in tobacco smoke
4. Switching completely from combustible tobacco cigarettes to e-cigarettes significantly reduces users' exposure to numerous toxic and cancer-causing substances
5. Completely replacing your cigarette with a vaping product will significantly reduce your exposure to numerous toxic and cancer causing substances
6. Switching completely from smoking to e-cigarettes will reduce harms to your health
7. Completely replacing your cigarette with an e-cigarette will reduce harms to your health

Tobacco-control advocate Stanton Glantz, a professor of medicine at the University of California, San Francisco, warned Health Canada that the proposed health claims "could be misread by consumers and potential consumers as indicating that e-cigarettes are safe."

Fontem Ventures, which markets the Blu vaping device, said in a submission that it "applauds" Health Canada for the initiative.

The company suggested eight revised statements and also advised Health Canada to replace the term "e-cigarette" with "vaping products."

"Although we suggested minor revisions to the wording of these statements, we strongly support the concept of public authorities making scientifically substantiated statements that allow adult smokers to make an informed choice about how they consume nicotine," Fontem Ventures spokesperson Ross Parker told CBC News in an email.



Big Tobacco at the policy table

So, in a stunning resurrection from the ashes of a public health disaster, Big Tobacco is back at the health policy table.

After decades of fierce legal and legislative battles, the tobacco industry and health policy-makers are now on the same side, promoting a nicotine product aimed at harm reduction.

Timothy Dewhirst, a marketing professor at the University of Guelph, said it's not harm reduction if vaping ends up drawing in new users to nicotine or if smokers add vaping to their cigarette habit and ultimately fail to quit.

"I think there's overall a net harm," he said, pointing out that the goal of complete smoking cessation is not a good business strategy for the tobacco industry.

"Their objectives are different than the public health community's objectives," he said. "It's not in their interest to have people successfully quit altogether."

'Bad news on all fronts'

At this point, tobacco industry projections still emphasize traditional cigarette sales as the core of their business.

"Cigarette sales around the world have been quite stable and I don't think that those will be going down anytime soon," said Annalise Mathers, of the Ontario Tobacco Research Unit at the University of Toronto.

Industry documents reveal that rather than switching completely to vaping, many smokers are using both e-cigarettes and combustible cigarettes.

It's also becoming clear that many vapers are new to the nicotine habit.
"E-cigarettes and reduced-risk products are kind of seen as a nice complement to maintain that core business, which is nicotine," Mathers said. "Keeping people addicted to nicotine."
At the same time, an entirely new generation of teenage nicotine addiction is taking hold.
University of Waterloo professor David Hammond tracks youth vaping trends through a survey of thousands of teenagers in Canada, the U.S. and U.K.
Last year, his research picked up the first signs of a vaping surge in Canada following JUUL's arrival.
This year, the numbers have gone up again.
"Vaping has almost doubled again among youth," he said. "What we're seeing is more frequent vaping. We're seeing more and more ... that they feel they're addicted to vaping.
"So, essentially, it's bad news on all fronts in terms of youth."
Add to that the continued lack of evidence that vaping helps smokers quit.
"There are three or four good review studies that show that these things are 85 to 95 per cent ineffective," said Andrew Pipe, the heart specialist in Ottawa. "And that's generally not appreciated."
CBC News asked Health Canada for a chance to interview the minister or a department official about the agency's vaping policy, but no interview was granted.
On Nov. 21, shortly after she was sworn in as Canada's new health minister, Patty Hajdu was asked by reporters what she planned to do about youth vaping.
"I will say, as the mother of two now grown boys, I can imagine the stress this is giving to parents all across Canada," she said.
"So, we have to do more. I'll be speaking with stakeholders. I'll be speaking with my colleagues about what stronger actions we can take to protect young people from the effects of vaping but also the effects of advertising that tries to convince them that this is a healthier choice."
For Charlotta Pisinger, the Danish researcher, all of the commotion about vaping has obscured the fact that smokers already had the tools to help shed their nicotine dependency. Smoking rates have fallen dramatically over the past several decades.
In 1965, about half of the population smoked. Fifty years later, the smoking rate in Canada was down to about 15 per cent.
She is concerned that encouraging smokers to vape assumes that they can never be fully free of nicotine.
"Is risk reduction the aim? Isn't our aim to get smokers to breathe clean air?"
Pipe has some even darker fears.
"My biggest fear is that we are going to go back to a time where we see a significant, if not a majority of the population dependent on nicotine as was the case with cigarettes in the '50s and '60s," he said.
"Are we going to see history repeat itself?"
https://newsinteractives.cbc.ca/longform/the-road-to-vaping

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-17 2:42 PM
To: Romano, Anna (PHAC/ASPC)
Subject: Fwd: CBC: UPEI supporting students and staff with weekly concussion clinic

---

Nice

Sent from my iPhone

Begin forwarded message:

> **From:** "Media Monitoring / Suivi des Medias (HC/SC)" <hc.media.monitoring-suivi.des.medias.sc@canada.ca>
> **Date:** December 17, 2019 at 11:50:46 EST
> **Subject: CBC: UPEI supporting students and staff with weekly concussion clinic**
>
> Distribution group/Groupe de distribution: HC.F PEIA Health Promotion / Promotion de la sante AREP F.SC
> December 17, 2019
> **UPEI supporting students and staff with weekly concussion clinic**
> CBC News
> *'To be able to have this on campus is just another great support'*
> A new clinic is now open at UPEI Heath and Wellness Centre in Charlottetown to better support students who have had a concussion.
> The clinic will assist students with rehabilitation after a concussion, ensure patients are recovering properly and reduce the risk of further harm.
> "We want to make sure that people who have had concussions return to their normal activities as seamlessly as possible," said said Gail Macartney, assistant professor in UPEI's Faculty of Nursing and member of the UPEI Concussion Awareness Program Research Team.
> "We really want to reduce the risk of second impact syndrome or getting people back to high-risk activities too soon."
> Macartney said that they also want to ensure that people don't remain sedentary after injury, but take a measured approach to their rehabilitation.
> "We see this kind of downward spiral sometimes, of concussion, where kids are not getting back to their activities or individuals are not getting back to work in a timely fashion and then they start spending to much time at home and they get depressed,"
> Free clinic and checkups
> The free clinic will be offered once a week for students and staff. Officials hope the new clinic will help prevent longer term physical and emotional damage in patients.
> Students, faculty and staff with a head injury can come in for an assessment and advice on safely returning to their normal routine.
> They are invited for a follow-up appointment six to eight weeks later.
> Macartney said that feedback has already been positive.
> "The student that I saw, I saw a bit of relief in his eyes because I gave him the green light to exercise," Macartney said.
> "He was thinking he needed to rest. You tell a 22-year-old to go home and rest, they really don't like that too much."
> UPEI already has a concussion research program on campus and officials said the clinic will take that work one step further.

"We're constantly looking at how we can prevent, better detect and then better treat any of our students and student athletes who have had a concussion or signs of concussion symptoms," said Chris Huggan, UPEI's director of athletics and recreation.

"So to be able to have this on campus is just another great support."

UPEI plans to expand the program in the new year to allow referrals from community care providers, physicians and nurse practitioners.

The university hopes the new clinic will also assist with UPEI's own concussion research into best practices for concussion treatment.

https://www.cbc.ca/news/canada/prince-edward-island/pei-upei-free-concussion-clinic-opening-1.5398357 HC.F PEIA Health Promotion / Promotion de la sante AREP F.SC

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-19 7:43 PM
To: CCMOH SECRETARIAT / CMHC (PHAC/ASPC); Sharma, Supriya (HC/SC); MacKenzie, Sara (HC/SC); Auger, Julie (PHAC/ASPC)
Subject: CCMOH Cannabis EET statement
Attachments: Clean 19Dec19_TTcomments CCMOH Cannabis EET [redacted]DraftStmt.docx; TrackChange19Dec19_TTcomments CCMOH Cannabis EET [redacted]DraftStmt.docx

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Dear All

I sent this draft that includes comments from me (with advice from Jen H, Sara M, Anna Romano and Jacquie) to the PT CCMOH leads on the statement.

[redacted] are happy to sign off on it and they are fine with the Secretariat facilitating the completion of the process with Comms. Would the secretariat please send this draft to the rest of the CCMOH members for final comments tomorrow.

I am also including Supriya so she can do the usual fact checking.

The aim is to have this Statement posted at the beginning of January but it would be good to get comments by Monday at the latest so that Comms colleagues can get the ball rolling.

TT

Dr. Theresa Tam, BMBS (UK), FRCPC
Chief Public Health Officer of Canada
Public Health Agency of Canada
[redacted]
Follow me on Twitter

Administratrice en chef de la santé publique du Canada
Agence de la santé publique du Canada
[redacted]
Suivez-moi sur Twitter

Council of Chief Medical Officers of Health (CCMOH) Statement on Cannabis Extracts, Edibles and Topical Products

Draft December 19, 2019

In follow up to our October, 2018 statement on cannabis and health, we want to advise Canadians on ways to reduce the health risks associated with using cannabis, particularly in relation to the new cannabis products becoming legally available across the country.

As with other regulated substances, such as alcohol and tobacco, **cannabis is not harmless**. While there is some evidence of potential therapeutic uses for cannabis, evidence continues to emerge on the longer-term health effects of cannabis, highlighting the importance of ongoing research. The only way to avoid the risks associated with cannabis use is to not use it.

People who use cannabis should know the different risks associated with the various ways of consuming it, including for edible cannabis and cannabis extracts. How much you consume and how quickly you consume can influence whether or not you experience adverse effects. Start low and go slow. Choose products with a low amount of tetrahydrocannabinol (THC) and an equal or higher amount of cannabidiol (CBD) to minimize health risks and reduce the potential for overconsumption.

Given the recent and ongoing concerns about vaping-associated lung illness (VALI)–and the limited overall understanding of the short- and long-term risks of vaping–the safest approach for people who use cannabis is to avoid smoking or vaping cannabis products. Those who use cannabis-containing vaping products can consider the following advice to help reduce risks to their health:

- Limit the amount and frequency of consumption. Initial effects can be felt within seconds to minutes, but full effect can take up to 30 minutes. Begin with one or two puffs of a vape or joint with 10 percent (100mg/g) or less of THC.
- Always read the label to understand the strength of the product. The concentration (% or mg/g) of THC can be found on the label.
- Avoid deep inhalation and breath-holding.
- Use vaping products that have been obtained from legal, regulated sources only. Illegal or unregulated sources are not subject to any control or oversight and may pose additional risks to health and safety.
- Avoid using any modified vaping products and do not add substances to products that are not intended by the manufacturer.
- Avoid consuming other substances, such as alcohol, when using cannabis.

Cannabis products that do not involve inhalation such as oils, edibles, topicals or sprays, can be an option to avoid potential impacts on lung health. However when eaten, edible cannabis products carry a risk of overconsumption and poisoning due to the delayed onset of psychoactive effects. Edible cannabis products also carry a higher risk of accidental poisoning of children and pets because they are difficult to distinguish from regular food and drink.

To minimize the risks associated with using edible cannabis products, consumers of these products can:

- Always read the label to understand the strength of the product. The total amount of THC in a single package of edible cannabis can be up to 10 mg, which would be a large amount for someone consuming cannabis for the first time or infrequently.
- Label and store all cannabis securely. Edible cannabis may look like regular food such as baked goods or candy. Store them securely in clearly labelled containers away from food products and out of the reach of children and pets.
- Start with small amounts - 2.5 mg of THC or less for products that you eat or drink.
- Wait until you feel the effects before taking more. It may take up to 2 hours to feel the effects of edible cannabis, and up to 4 hours to feel the full effects.
- Don't drive or operate heavy equipment after using cannabis. Cannabis can cause drowsiness and impair your ability to concentrate and make quick decisions. The effects from edible cannabis last 4 to 12 hours, with some effects lasting up to 24 hours

If you experience any adverse effects from cannabis—including edible cannabis, cannabis extracts or topicals--seek appropriate health care and report side effects from cannabis products to Health Canada.

Finally, when using any type of cannabis product, it is important to remember that cannabis can be addictive, and frequent use can cause harm to your physical and mental health. In fact, close to 10% of adults who have ever used cannabis will develop cannabis use disorder. The younger you are when you start using cannabis, and the more often and the longer you use it, the more likely that it will have a adverse impact on your health. People who experience problems related to their use of cannabis can speak to a healthcare provider about evidence-based behavioral treatment and recovery options.

As Canada's Chief Medical Officers of Health, we encourage all those who use or are considering using cannabis to be aware of the ways they can minimize the potential negative impacts of cannabis use.

Get informed. Protect your health and the health of your family.

Helpful Links:

- What You Need to Know if You Choose to Consume Cannabis
- Cannabis: Lower Your Risks
- Vaping-Associated Lung Illness in Canada
- Consider the Consequences of Vaping

Council of Chief Medical Officers of Health (CCMOH) Statement on Cannabis Extracts, Edibles and Topical Products

Draft December ~~11~~19, 2019

In follow up to our ~~statement on cannabis and health from~~ October, 2018 statement on cannabis and health[1], we want to advise Canadians on ways to reduce the health risks associated with using cannabis, particularly in relation to the new cannabis products becoming~~and with~~ legally available across the country ~~cannabis edibles, extracts and topical products soon to be available, we wish to advise Canadians on ways of reducing the risk of using cannabis products~~.

Commented [DT1]: Footnote deleted hyperlinked to statement on cannabis and health

As with other regulated substances, such as alcohol and tobacco, **cannabis is not harmless**. While there is some evidence of potential therapeutic uses for cannabis, ~~the long-term effects remain unknown, and more research needs to be done~~evidence continues to emerge on the longer-term health effects of cannabis, highlighting the importance of ongoing research. The only way to ~~completely~~ avoid the risks associated with ~~from~~ cannabis use is ~~by choosing~~ to not ~~to~~ use it.

~~For those~~People who ~~choose to~~ use cannabis~~,~~ should know ~~there are some specific~~ the different risks associated with the various ways of consuming it, including for edible cannabis and cannabis extracts ~~the newly legal classes of product coming into the Canadian market~~. How much you consume and how quickly you consume can influence whether or not you experience adverse effects. Start low and go slow. Choose products with a low amount of tetrahydrocannabinol (THC) and an equal or higher amount of cannabidiol (CBD) to minimize health risks and reduce the potential for overconsumption.

Given the recent and ongoing concerns about vaping-associated lung illness (VALI) ~~and severe pulmonary illness~~ and the limited overall understanding of the short- and long-term risks of vaping~~,~~ the safest approach for people who ~~choose to~~ use cannabis is to avoid smoking or vaping cannabis products.

~~Those~~ Those who ~~choose to~~ use cannabis-containing vaping products ~~should~~can consider the following advice to help reduce risks to their health:

- Limit the amount and frequency of consumption. Initial effects can be felt within seconds to minutes, but full effect can take up to 30 minutes. Begin with one or two puffs of a vape or joint with 10 percent (100mg/g) or less of THC.
- Always read the label to understand the strength of the product. The concentration (% or mg/g) of THC can be found on the label.
- Avoid deep inhalation and breath-holding.

[1] ~~https://www.newswire.ca/news-releases/council-of-chief-medical-officers-of-health-remind-canadians-of-the-harms-and-risks-associated-with-cannabis-use-698541831.html~~

- Use~~only use~~ vaping products that have been obtained from legal, regulated sources only. Illegal or unregulated sources are not subject to any control or oversight and may pose additional risks to health and safety.
- ~~avoid~~ Avoid using any modifi~~ying~~ed vaping products and do not ~~or~~ add~~ing~~ substances to products that are not intended by the manufacturer.
- Avoid consuming other substances, such as alcohol, when using cannabis.

~~For Canadians who choose to use cannabis~~Cannabis products that do not involve inhalation ~~we recommend that they use other legal cannabis products~~ such as oils, edibles, topicals or sprays, ~~over vaping products~~can be an option to avoid potential impacts on lung health. However~~,~~ when eaten, edible cannabis products carry a ~~unique~~ risk of overconsumption and poisoning~~,~~ due to the delayed onset of psychoactive effects~~, when cannabis is eaten. These~~ Edible cannabis products also ~~have~~ carry a higher risk of accidental poisoning ~~in~~ of children and pets because they are difficult to distinguish from regular food and drink.

To minimize ~~these~~ the risks associated with using edible cannabis products, ~~users should~~consumers of these products can:

- Always read the label to understand the strength of the product. The total amount of THC in a single package of edible cannabis can be up to 10 mg, which would be a large amount for someone consuming cannabis for the first time or infrequently.
- Label and store all cannabis securely. Edible cannabis may look like regular food such as baked goods or candy. Store them securely in clearly labelled containers away from food products and out of the reach of children and pets.
-
- ~~Use caution when taking edible cannabis products, waiting to feel effects before taking more~~Start with small amounts: 2.5 mg of Tetrahydrocannabinol (THC) or less for products that you eat or drink

~~Don't take more right away – effects from an edible cannabis product may not be felt for 2 hours, and it may take 4 hours for effects to peak~~

~~Clear your schedule – the effects from edible cannabis last 4 to 12 hours with some effects lasting up to 24 hours~~

~~Using low-dose products containing no more than 2.5mg THC may assist you in determining your individual response to and comfort level with the effects of edible cannabis. This careful small-dose approach will help you avoid overconsumption that can result in unpleasant effects including extreme sedation/inability to move, anxiety, paranoia, hallucinations, delusions, rapid heartbeat or respiratory depression.~~

- Start with small amounts - 2.5 mg of THC or less for products that you eat or drink.
- Wait until you feel the effects before taking more. It may take up to 2 hours to feel the effects of edible cannabis, and up to 4 hours to feel the full effects.
- Don't drive or operate heavy equipment after using cannabis. Cannabis can cause drowsiness and impair your ability to concentrate and make quick decisions. The effects from edible cannabis last 4 to 12 hours, with some effects lasting up to 24 hours

If you experience any adverse effects from ~~the newly distributed~~ cannabis~~—e~~including ~~xtract,~~ edible cannabis, cannabis extract~~s~~s or topicals~~--, in addition to seeking~~seek appropriate health care and~~,~~ ~~report~~ report side effects from cannabis products ~~the event~~ to Health Canada.

Commented [DT2]: hyperlinked to the Health Canada adverse effect reporting report side effects from cannabis products and therefore deleted the next paragraph

~~Details on how to report adverse effect from cannabis to Health Canada are at https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/recalls-adverse-reactions-reporting/report-side-effects-cannabis-products.html~~

Finally, when using any type of cannabis product, it is important to remember that cannabis can be addictive, and frequent use can cause harm to your physical and mental health. In fact, close to 10% of adults who have ever used cannabis will develop cannabis use disorder. The younger you are when you start using cannabis, and the more often and the longer you use it, the more likely that it will have a ~~negative~~ adverse impact on your health. People who experience problems related to their use of cannabis ~~should~~ can ~~seek~~ speak to a healthcare provider about evidence-based behavioral treatment and recovery ~~services for assistance~~options.

As Canada's Chief Medical Officers of Health, we encourage all those who use or are considering using cannabis to be aware of the ways they can minimize the potential negative impacts of cannabis use.

Get informed. Protect your health and the health of your family.

Helpful Links:

- What You Need to Know if You Choose to Consume Cannabis
- Cannabis: Lower Your Risks
- Vaping-Associated Lung Illness in Canada
- Consider the Consequences of Vaping

~~*Is there a Health Canada weblink we want to use as a reference for "Get informed"?*~~

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-19 7:23 PM
To: [redacted]
Wong, Tom (SAC/ISC)
Cc: [redacted]
Subject: RE: CCMOH Cannabis statement

Jan 2 is possible, but from a communications perspective it may be better to aim for January 6 after all the new year stories.

Let me know which date and I will have the team line things up.

From [redacted]
Sent: 2019-12-19 6:54 PM
To: Tam, Dr Theresa (PHAC/ASPC) [redacted]; Wong, Tom (SAC/ISC)
Cc [redacted]
Subject: RE: CCMOH Cannabis statement

Thanks, Theresa. I am comfortable with these changes, and i[redacted]are ok, and the CCMOH secretariat is willing to coordinate a last round of feedback, I'm more than happy to have them take that on tomorrow if they can! I'm also good with getting this out early in January – the earlier the better though.

A[redacted]were part of the team that worked on the first draft, I have copied them in here to see if they have any further suggestions.

Thanks for these suggestions,

[redacted]

[redacted] University of Calgary
24th Floor, ATB Place North Tower
10025 Jasper Avenue | Edmonton, Alberta T5J 1S6
Office [redacted] Cell Phone [redacted]

From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: Thursday, December 19, 2019 4:44 PM
To [redacted]
[redacted]@novascotia.ca>; Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Subject: CCMOH Cannabis statement

Hi[redacted]

[redacted]

[redacted]

TT

P.S. I will loop back on the vaping statement tomorrow.

From: [redacted]
Sent: 2019-12-12 1:53 PM
To: [redacted]

Tam, Dr Theresa (PHAC/ASPC) [redacted] Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Cc: [redacted]
Subject: RE: special CCMOH call re position statements on vaping

Thank [redacted]

I am attaching here the draft of the cannabis statement for discussion at our meeting next week.

[redacted]

[redacted]

From: [redacted]
Sent: Thursday, December 12, 2019 11:45 AM
To: [redacted] Theresa Tam' [redacted] Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Cc: [redacted]
Subject: special CCMOH call re position statements on vaping

Dear Colleagues,

My office has identified that most of us are available for a 1 hour teleconference on Dec. 18th 1-2 pm (Atlantic) as a follow-up discussion on the draft CCMOH position papers on nicotine vaping and cannabis vaping. Therefore you will soon be receiving an appointment for that time. I hope that those who my office has not heard from can make themselves available. Thank you and materials to inform our discussions will be forth coming.

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-19 7:16 PM
To: MacKenzie, Sara (HC/SC)
Subject: FW: CCMOH Cannabis statement
Attachments: TrackChange19Dec19 TTcomments CCMOH Cannabis EET [redacted] DraftStmt.docx; Clean 19Dec19 TTcomments CCMOH Cannabis EET [redacted] DraftStmt.docx

---

What will be the best date to aim for at the start of Jan?

From: [redacted]
Sent: 2019-12-19 6:54 PM
To: Tam, Dr Theresa (PHAC/ASPC) ; [redacted] Wong, Tom (SAC/ISC)
Cc: [redacted]
Subject: RE: CCMOH Cannabis statement

Thanks, Theresa. I am comfortable with these changes, and if [redacted] are ok, and the CCMOH secretariat is willing to coordinate a last round of feedback, I'm more than happy to have them take that on tomorrow if they can! I'm also good with getting this out early in January – the earlier the better though.

As [redacted] were part of the team that worked on the first draft, I have copied them in here to see if they have any further suggestions.

Thanks for these suggestions,

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: Thursday, December 19, 2019 4:44 PM
To: [redacted] Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Subject: CCMOH Cannabis statement

Hi [redacted]

[redacted]

[redacted]

TT
P.S. I will loop back on the vaping statement tomorrow.

From: [redacted]
Sent: 2019-12-12 1:53 PM
To: [redacted]

Tam, Dr Theresa (PHAC/ASPC) [redacted] Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Cc: [redacted]
Subject: RE: special CCMOH call re position statements on vaping

Thanks [redacted]

I am attaching here the draft of the cannabis statement for discussion at our meeting next week.

[redacted]

From [redacted]
Sent: Thursday, December 12, 2019 11:45 AM
To: [redacted] 'Theresa Tam' [redacted] Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Cc: [redacted]
Subject: special CCMOH call re position statements on vaping

Dear Colleagues,

My office has identified that most of us are available for a 1 hour teleconference on Dec. 18th 1-2 pm (Atlantic) as a follow-up discussion on the draft CCMOH position papers on nicotine vaping and cannabis vaping. Therefore you will soon be receiving an appointment for that time. I hope that those who my office has not heard from can make themselves available. Thank you and materials to inform our discussions will be forth coming.

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-20 7:45 AM
To: Macey, Jeannette (PHAC/ASPC); Mackenzie, Sara (HC/SC)
Subject: Fwd: CCMOH Cannabis statement

Note, Website link comment.

Supriya may be the best person to answer this question.

Sara, Who normally incorporates comments received when we go with the normal process? Is it the secretariat or Comms?

TT

Sent from my iPhone

Begin forwarded message:

From: [redacted]
Date: December 19, 2019 at 19:55:31 EST
To: "Wong, Tom (SAC/ISC)" <tom.wong@canada.ca> [redacted]
Cc: "Tam, Dr Theresa (PHAC/ASPC)" [redacted]
Subject: RE: CCMOH Cannabis statement

[redacted]

From: Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Sent: December 19, 2019 4:42 PM
To: [redacted]
Cc: [redacted]
Subject: Re: CCMOH Cannabis statement
This looks great! Just 2 minor comments:

[redacted]

Tom
Sent from my BlackBerry 10 smartphone on the Bell network.

From: [redacted]
Sent: Thursday, December 19, 2019 7:16 PM
To: [redacted]

Cc: Tam, Dr Theresa (PHAC/ASPC); Wong, Tom (SAC/ISC); [redacted]
Subject: Re: CCMOH Cannabis statement
Also good from my end and happy to hand this over now to PHAC Comms and secretariat. Thanks everyone.

[redacted]

Sent from my iPhone

On Dec 19, 2019, at 7:53 PM [redacted] wrote:

** EXTERNAL EMAIL / COURRIEL EXTERNE **
Exercise caution when opening attachments or clicking on links / Faites preuve de prudence si vous ouvrez une pièce jointe ou cliquez sur un lien

Thanks, Theresa. I am comfortable with these changes, and if [redacted] are ok, and the CCMOH secretariat is willing to coordinate a last round of feedback, I'm more than happy to have them take that on tomorrow if they can! I'm also good with getting this out early in January – the earlier the better though.
As [redacted] were part of the team that worked on the first draft, I have copied them in here to see if they have any further suggestions.
Thanks for these suggestions,

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: Thursday, December 19, 2019 4:44 PM
To: [redacted] Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Subject: CCMOH Cannabis statement
Hi [redacted]

[redacted]

TT

P.S. I will loop back on the vaping statement tomorrow.

From: [redacted]
Sent: 2019-12-12 1:53 PM
To: [redacted]
[redacted]Tam, Dr Theresa (PHAC/ASPC)
[redacted] Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Cc: [redacted]
Subject: RE: special CCMOH call re position statements on vaping

Thanks, [redacted]

I am attaching here the draft of the cannabis statement for discussion at our meeting next week.

[redacted]

From: [redacted]
Sent: Thursday, December 12, 2019 11:45 AM
To: [redacted]
[redacted]'Theresa Tam'
[redacted]Wong, Tom (SAC/ISC) <tom.wong@canada.ca>
Cc: [redacted]
Subject: special CCMOH call re position statements on vaping

Dear Colleagues,

My office has identified that most of us are available for a 1 hour teleconference on Dec. 18th 1-2 pm (Atlantic) as a follow-up discussion on the draft CCMOH position papers on nicotine vaping and cannabis vaping. Therefore you will soon be receiving an appointment for that time. I hope that those who my office has not heard from can make themselves available. Thank you and materials to inform our discussions will be forth coming.

[redacted]

From: Auger, Julie (PHAC/ASPC)
Sent: 2019-12-23 5:20 PM
To: Tam, Dr Theresa (PHAC/ASPC); MacKenzie, Sara (HC/SC)
Cc: CCMOH SECRETARIAT / CMHC (PHAC/ASPC); Robinson, Kerry (PHAC/ASPC); Macey, Jeannette (PHAC/ASPC)
Subject: Re: CCMOH Cannabis Statement - PT and HC comments

Thank you Dr.Tam. The Secretariat can attempt to combine the comments tomorrow AM if that's helpful based on your direction. Sara, just let me know if you prefer to proceed differently.

Julie

Sent from my iPhone

On Dec 23, 2019, at 4:20 PM, Tam, Dr Theresa (PHAC/ASPC) wrote:

Overall the HC changes look good in terms of providing clarification and do not alter the recommendations. I think we have to go back to [redacted] and perhaps [redacted] rather than the whole group.
The PT changes are also minor. In terms of changes in the order of the recommendations in the edibles section either the HC or the [redacted] reordering is fine.
Simplest is to go with the HC draft, add the PT changes as appropriate and then get the changes to [redacted] I can give them a heads up.
If you have difficulties combining the changes I can do it.
TT

From: McDonald, Alexa (HC/SC) **On Behalf Of** CCMOH SECRETARIAT / CMHC (PHAC/ASPC)
Sent: 2019-12-23 3:51 PM
To: Tam, Dr Theresa (PHAC/ASPC) ; MacKenzie, Sara (HC/SC)
Cc: Auger, Julie (PHAC/ASPC) ; Robinson, Kerry (PHAC/ASPC) ; Macey, Jeannette (PHAC/ASPC)
Subject: CCMOH Cannabis Statement - PT and HC comments
Hello Dr. Tam and Sara,
The Secretariat has compiled comments received on the draft CCMOH Statement on Cannabis edibles, extracts and topical products. I have separated PT and HC comments into 2 separate documents for your review, as HC's feedback is somewhat substantial. Please note as well, HC is inquiring if the next draft of the statement will be sent back to members for approval, as they would like to provide their ADMs with the opportunity to see a revised statement before it is finalized.
Additional information on PT/Ex-officio input can be found below:
No reply: [redacted] FNHA, CSC
Approved with no comments: [redacted] DND, ISC (previous comments were incorporated)
Thank you,
CCMOH Secretariat

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-12 7:08 PM
To: Bogden, Jacqueline (HC/SC); Hollington, Jennifer (HC/SC) (jennifer.hollington@canada.ca); Bent, Stephen (PHAC/ASPC); Romano, Anna (PHAC/ASPC)
Subject: CCMOH statement on Cannabis EET
Attachments: CCMOH Cannabis EET Statement Draft for discussion.docx

---

A call has been scheduled for next Wednesday to discuss the CCMOH statement on youth vaping but there will also be discussion on another statement re Cannabis EET.

This one look good to me but welcome any comments.

TT

Dr. Theresa Tam, BMBS (UK), FRCPC
Chief Public Health Officer of Canada
Public Health Agency of Canada
[redacted]
Follow me on Twitter

Administratrice en chef de la santé publique du Canada
Agence de la santé publique du Canada
[redacted]
Suivez-moi sur Twitter

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-13 7:31 AM
To: Hollington, Jennifer (HC/SC)
Cc: Bogden, Jacqueline (HC/SC); Bent, Stephen (PHAC/ASPC); Romano, Anna (PHAC/ASPC)
Subject: Re: CCMOH statement on Cannabis EET

Thanks for this initial feedback.

Sent from my iPhone

On Dec 13, 2019, at 07:08, Hollington, Jennifer (HC/SC) <jennifer.hollington@canada.ca> wrote:

> I agree, Theresa. This is a helpful statement and is very consistent with our messaging. I would be happy to suggest a webpage to add as a link for more information, as indicated in the draft.
>
> Also, at the appropriate time, I could make a few small editorial suggestions (e.g., we say "edible cannabis" as opposed to "cannabis edibles").
>
> Let me know if you need anything further from me and my team.
>
> Jen
>
> Jennifer Hollington
> jennifer.hollington@canada.ca | Tel: 613-960-2176 | Cel: 613-816-6073
>
> -------- Original message --------
> From: "Tam, Dr Theresa (PHAC/ASPC)" [redacted]
> Date: 2019-12-12 7:08 PM (GMT-05:00)
> To: "Bogden, Jacqueline (HC/SC)" <jacqueline.bogden@canada.ca>, "Hollington, Jennifer (HC/SC)" <jennifer.hollington@canada.ca>, "Bent, Stephen (PHAC/ASPC)" <stephen.bent@canada.ca>, "Romano, Anna (PHAC/ASPC)" <anna.romano@canada.ca>
> Subject: CCMOH statement on Cannabis EET
>
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> TT
> Dr. Theresa Tam, BMBS (UK), FRCPC
> Chief Public Health Officer of Canada
> Public Health Agency of Canada
> [redacted]
> Follow me on Twitter
> Administratrice en chef de la santé publique du Canada
> Agence de la santé publique du Canada
> [redacted]

Suivez-moi sur Twitter

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-17 1:58 PM
To: McLeod, Robyn (PHAC/ASPC)
Subject: Fwd: CCMOH statement on Cannabis EET

Please include in CCMOH call folder.

Sent from my iPhone

Begin forwarded message:

> **From:** "Hollington, Jennifer (HC/SC)" <jennifer.hollington@canada.ca>
> **Date:** December 13, 2019 at 07:08:20 EST
> **To:** "Tam, Dr Theresa (PHAC/ASPC)" [redacted] "Bogden, Jacqueline (HC/SC)" <jacqueline.bogden@canada.ca>, "Bent, Stephen (PHAC/ASPC)" <stephen.bent@canada.ca>, "Romano, Anna (PHAC/ASPC)" <anna.romano@canada.ca>
> **Subject: RE: CCMOH statement on Cannabis EET**
>
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>
> Also, at the appropriate time, I could make a few small editorial suggestions (e.g., we say "edible cannabis" as opposed to "cannabis edibles").
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> Jen
>
> Jennifer Hollington
> jennifer.hollington@canada.ca | Tel: 613-960-2176 | Cel: 613-816-6073
>
> -------- Original message --------
> From: "Tam, Dr Theresa (PHAC/ASPC)" [redacted]
> Date: 2019-12-12 7:08 PM (GMT-05:00)
> To: "Bogden, Jacqueline (HC/SC)" <jacqueline.bogden@canada.ca>, "Hollington, Jennifer (HC/SC)" <jennifer.hollington@canada.ca>, "Bent, Stephen (PHAC/ASPC)" <stephen.bent@canada.ca>, "Romano, Anna (PHAC/ASPC)" <anna.romano@canada.ca>
> Subject: CCMOH statement on Cannabis EET
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> Dr. Theresa Tam, BMBS (UK), FRCPC
> Chief Public Health Officer of Canada

Public Health Agency of Canada
[redacted]
Follow me on Twitter
Administratrice en chef de la santé publique du Canada
Agence de la santé publique du Canada
[redacted]
Suivez-moi sur Twitter

From: Auger, Julie (PHAC/ASPC)

Sent: 2019-12-05 2:38 PM

To: Tam, Dr Theresa (PHAC/ASPC)

Cc: Bent, Stephen (PHAC/ASPC); Denis, Joel (PHAC/ASPC)

Subject: CCMOH Statement on Vaping - December 12

Hello Dr. Tam,

I am writing to see if you had the opportunity to discuss with [redacted] regarding a new draft statement on vaping, as mentioned a few days ago?

Given sensitivities around the regulatory aspects of youth vaping - which we expect will be discussed at the Dec.17 CDMH meeting - there may be value in getting a sense from [redacted] of the direction of the draft, timing, focus (PT CMOHs vs. CCMOH) and expectations for Dec.12 knowing that DM Lucas may be on the line for this particular item.

Please let us know - I am happy to reach out to [redacted] as well and to continue investigating with the PT PHNC Secretariat and Health Canada colleagues.

Regards,
Julie

Julie Auger
Manager / gestionnaire
Intergovernmental & Stakeholder Policy Division / Division des politiques intergouvernementales et liées aux intervenants
Office of Strategic Policy and Planning / Bureau des poliques et de la planification stratégiques
Public Health Agency of Canada / Agence de santé publique du Canada
Email : julie.auger @canada.ca
Phone : 613-668-0040

-----Original Message-----
From: McDonald, Alexa (HC/SC) On Behalf Of CCMOH SECRETARIAT / CMHC (PHAC/ASPC)
Sent: 2019-12-03 3:13 PM
To: Tam, Dr Theresa (PHAC/ASPC); CCMOH SECRETARIAT / CMHC (PHAC/ASPC)
Cc: Bent, Stephen (PHAC/ASPC); Robinson, Kerry (PHAC/ASPC); Auger, Julie (PHAC/ASPC); Denis, Joel (PHAC/ASPC); PHN Secretariat / RSP (PHAC/ASPC)
Subject: RE: Dec 12 call

Hi Dr. Tam,

We have heard from [redacted] the small group plans to discuss the draft statement at the December 10th PT CMOH call, after which he hopes to send the draft to the CCMOH Secretariat for distribution to members.

We will ensure to distribute material as soon as it is received.

Thank you

CCMOH Secretariat

-----Original Message-----
From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: 2019-12-02 9:17 AM
To: CCMOH SECRETARIAT / CMHC (PHAC/ASPC) <phac.ccmoh.secretariat-cmhc.aspc@canada.ca>
Cc: Bent, Stephen (PHAC/ASPC) <stephen.bent@canada.ca>; Robinson, Kerry (PHAC/ASPC) <kerry.robinson@canada.ca>; Auger, Julie (PHAC/ASPC) <juliea.auger@canada.ca>; Denis, Joel (PHAC/ASPC) <joel.denis@canada.ca>; PHN Secretariat / RSP (PHAC/ASPC) <phac.phn.secretariat-rsp.aspc@canada.ca>
Subject: Re: Dec 12 call

I am OK with this approach.

Sent from my iPhone

> On Dec 2, 2019, at 09:03, CCMOH SECRETARIAT / CMHC (PHAC/ASPC) <phac.ccmoh.secretariat-cmhc.aspc@canada.ca> wrote:
>
> Good morning Dr. Tam,
>
> We have framed the agenda so that you will open the call and chair the discussion with DM Lucas, and then alternate chairing the remainder of the PHNC items with Dr. Shahab. Dr. Henry will chair the 2 CCMOH items, vaping and lead, (Dr. Hanley will not be able to attend the meeting). Are you comfortable with this approach?
>
> Early last week [redacted] indicated that the small group was working on a draft statement to bring forward on December 12th. The Secretariat will reach out again to inquire if there are plans to share a draft beforehand.
>
> Thank you,
>
> CCMOH Secretariat
>
>
>
>
> -----Original Message-----
> From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
> Sent: 2019-11-29 6:48 PM
> To: CCMOH SECRETARIAT / CMHC (PHAC/ASPC) <phac.ccmoh.secretariat-cmhc.aspc@canada.ca>; Bent, Stephen (PHAC/ASPC) <stephen.bent@canada.ca>; Robinson, Kerry (PHAC/ASPC) <kerry.robinson@canada.ca>
> Cc: Auger, Julie (PHAC/ASPC) <juliea.auger@canada.ca>; Denis, Joel (PHAC/ASPC) <joel.denis@canada.ca>
> Subject: RE: Dec 12 call
>
> Thanks for the reminder and clarification. I think the agenda looks OK. I would prefer not to chair the vaping agenda item.
>
> Will we get a draft of the CCMOH vaping statement beforehand?
>
>
> TT
>
> -----Original Message-----
> From: McDonald, Alexa (HC/SC) <alexa.mcdonald@canada.ca> On Behalf Of CCMOH SECRETARIAT / CMHC (PHAC/ASPC)
> Sent: 2019-11-29 12:16 PM

> To: Tam, Dr Theresa (PHAC/ASPC) [redacted] Bent, Stephen (PHAC/ASPC) <stephen.bent@canada.ca>; Robinson, Kerry (PHAC/ASPC) <kerry.robinson@canada.ca>
> Cc: Auger, Julie (PHAC/ASPC) <juliea.auger@canada.ca>; Denis, Joel (PHAC/ASPC) <joel.denis@canada.ca>
> Subject: RE: Dec 12 call
>
> Hello Dr. Tam,
>
> The December 12th call was originally scheduled as a back to back PHNC-CCMOH call, with PHNC scheduled from 1 - 2 pm EST, and CCMOH scheduled from 2 - 3:30 pm EST. Should DM Lucas attend, we are now proposing a joint PHNC-CCMOH meeting. A revised draft agenda is attached for your consideration.
>
> Thank you
>
> CCMOH Secretariat
>
>
>
> -----Original Message-----
> From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
> Sent: 2019-11-29 11:46 AM
> To: CCMOH SECRETARIAT / CMHC (PHAC/ASPC) <phac.ccmoh.secretariat-cmhc.aspc@canada.ca>; Bent, Stephen (PHAC/ASPC) <stephen.bent@canada.ca>; Robinson, Kerry (PHAC/ASPC) <kerry.robinson@canada.ca>
> Subject: Dec 12 call
>
> Can someone confirm that this is a CCMOH call and not PHNC.
>
>
> Sent from my iPhone

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-18 1:32 PM
To: Macey, Jeannette (PHAC/ASPC)
Subject: FW: CCMOH statements

From: Hollington, Jennifer (HC/SC)
Sent: 2019-12-18 1:25 PM
To: Tam, Dr Theresa (PHAC/ASPC) ; Bogden, Jacqueline (HC/SC) ; Romano, Anna (PHAC/ASPC) ; Bent, Stephen (PHAC/ASPC)
Subject: RE: CCMOH statements

Thanks Theresa. Does "sooner rather than later" mean before Christmas? If so, we'll have to move quickly.

Also, here are the weblinks that could be used in the statements, though if my team picks up the finessing of the documents, we could add them in.

Cannabis:
Infographic: What You Need to Know:
https://www.canada.ca/content/dam/themes/health/campaigns/cannabis/media-kit/34-18-2205-Cannabis%20Edibles%20Infographic%20Trifold-EN%20-%20Copy.pdf
Infographic: Cannabis: Lower Your Risks:
https://www.canada.ca/content/dam/themes/health/campaigns/cannabis/media-kit/34-19-2307-Cannabis%20Start%20low%20go%20slow-EN%20-%20Copy.pdf

Vaping:
Vaping-Associated Lung Illness in Canada: https://www.canada.ca/en/public-health/services/diseases/vaping-pulmonary-illness.html
Consider the Consequences of Vaping:
https://www.canada.ca/en/services/health/campaigns/vaping.html

Jen

Jennifer Hollington
jennifer.hollington@canada.ca | TEL: 613-960-2176 | CEL: 613-816-6073

-----Original Message-----
From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: 2019-12-18 13:10
To: Hollington, Jennifer (HC/SC) <jennifer.hollington@canada.ca>; Bogden, Jacqueline (HC/SC) <jacqueline.bogden@canada.ca>; Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca>; Bent, Stephen (PHAC/ASPC) <stephen.bent@canada.ca>
Subject: CCMOH statements

Just had the call with PTs.

They are hoping the Cannabis statement to be asap and the vaping reg focused statement in January, 3rd week linked to national mob smoking week.

I signaled that I would like to sign on to both pending internal discussions and will forward the edits.

I also indicated that I have to bring Comms and the Secrétariat into the picture ASAP as I am not able to tell them what is in the realm of the possible esp the Cannabis statement getting out sooner rather than later.

Sent from my iPhone

From: Tam, Dr Theresa (PHAC/ASPC)
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Subject: RE: CCMOH statements

They would like that but I did not over promise.

I am going to link in with Sara M /Laura to give them an update and perhaps they can tell me what is possible.

From: Hollington, Jennifer (HC/SC)
Sent: 2019-12-18 1:25 PM
To: Tam, Dr Theresa (PHAC/ASPC) ; Bogden, Jacqueline (HC/SC) ; Romano, Anna (PHAC/ASPC) ; Bent, Stephen (PHAC/ASPC)
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https://www.canada.ca/content/dam/themes/health/campaigns/cannabis/media-kit/34-19-2307-Cannabis%20Start%20low%20go%20slow-EN%20-%20Copy.pdf

Vaping:
Vaping-Associated Lung Illness in Canada: https://www.canada.ca/en/public-health/services/diseases/vaping-pulmonary-illness.html
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Jen

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From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: 2019-12-18 13:10
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Sent from my iPhone

Subject: Chat w/ Tammy Bell RE: Release of Report
Location: Theresa's office

Start: Tue 2019-12-17 12:15 PM
End: Tue 2019-12-17 12:30 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Bell, Tammy (PHAC/ASPC)

Subject: Check in on the BBE (Jan 16)
Location: Room 146B

Start: Tue 2020-01-07 1:00 PM
End: Tue 2020-01-07 1:30 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Rendall, Jennifer (PHAC/ASPC)

Subject: Check in on the BBE (Jan 16)
Location: Room 146B

Start: Wed 2020-01-08 2:00 PM
End: Wed 2020-01-08 2:30 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: Rendall, Jennifer (PHAC/ASPC)

From: [redacted]

Sent: 2019-12-19 7:39 AM

To: Tam, Dr Theresa (PHAC/ASPC)

Subject: Re: Chief Public Health Officer's Annual Report on Stigma Launches Tomorrow// Le Rapport annuel de l'administratrice en chef de la santé publique sur la stigmatisation sera publié demain

Attachments: A LFLEAI - RAPPORT - 12 mars 2019.pdf; A LFLEAI - Rapport - 12 avril 2019_FINAL.pdf; A EVENT 3 - RAPPORT FINAL (16-10-19) ver (06-11-19_.pdf

---

Dr. Tam:
On behalf of my organization let me take this moment to congratulate you and your team for your excellent work as exemplified by this report. We will surely use your recommendations as a template for future activities. I also attach 3 reports on our consultations this year focusing on the problematic of seniors of immigrant origins (e.g., social isolation, family caregivers and housing issues) wherein the question of stigma surfaced during all discussions.
I also wish you and your staff a very Happy Holiday Season.
I am at your beck and call for any future collaboration and
remain yours sincerely,
[redacted]

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: Tuesday, December 17, 2019 4:35 PM
To: CPHO Report / Rapport ACSP (PHAC/ASPC) ; Rendall, Jennifer (PHAC/ASPC) ; Hostrawser, Bonnie (PHAC/ASPC)
Subject: Chief Public Health Officer's Annual Report on Stigma Launches Tomorrow// Le Rapport annuel de l'administratrice en chef de la santé publique sur la stigmatisation sera publié demain

(Le français suit)

Greetings,

I am pleased to let you know that tomorrow, my annual report on the state of public health in Canada will be tabled in Parliament. This year's annual report provides a snapshot of key public health trends in Canada and shines a light on stigma and its impacts on health.

As part of the development of the report, it was important to me to hear from experts, including those with lived and living experience, on the topic of stigma and health. I am grateful for the input and insights you shared this spring through discussion groups and key informant interviews and applaud your leadership in this area to improve health and address stigma. Hearing from and collaborating with Canadians on this issue grounds the report in the realities of day-to-day experiences and is essential for accelerating progress toward a more inclusive health system.

Tomorrow, my office will send you a link to the report and additional available materials including the What We Heard report which summarizes the findings from the discussion groups and key informant interviews.

Also, as part of continuous learning and improvement, we will be sending out a feedback survey at a later date on the report and would be grateful for your input.

Thank you again for your contributions.

Dr. Theresa Tam, BMBS (UK), FRCPC
Chief Public Health Officer of Canada
Public Health Agency of Canada

Bonjour,

Je suis heureuse de vous informer que mon rapport annuel sur l'état de la santé publique au Canada sera déposé demain devant le Parlement. Le rapport annuel de cette année présente un aperçu des principales tendances en matière de santé publique au Canada et fait la lumière sur la stigmatisation et ses effets sur la santé.

Dans le cadre de l'élaboration du rapport, il était important pour moi d'avoir l'avis des experts, y compris ceux ayant une expérience vécue, au sujet de la stigmatisation et de la santé. Je suis reconnaissante de la contribution et des perspectives que vous avez partagées ce printemps lors des groupes de discussion et des entrevues menées auprès d'informateurs clés et j'applaudis votre leadership dans ce domaine afin d'améliorer la santé et de lutter contre la stigmatisation. Obtenir l'avis des Canadiens et collaborer avec eux sur cet enjeu fonde le rapport sur la réalité des expériences quotidiennes et est indispensable pour accélérer les progrès en vue d'un système de santé plus inclusif.

Demain, mon bureau vous enverront un lien au rapport et à d'autres documents disponibles, y compris le Rapport sur ce que nous avons entendu, qui résume les conclusions des groupes de discussion et des entrevues menées auprès d'informateurs clés.

Dans le cadre de nos efforts de formation et d'amélioration continues, nous vous enverrons un sondage sollicitant votre rétroaction concernant le rapport à une date ultérieure. Nous vous serions reconnaissants de nous faire part de vos commentaires.

Nous vous remercions encore une fois de votre contribution.

D^re^ Theresa Tam, BMBS (R.-U.), FRCPC
Administratrice en chef de la santé publique
Agence de la santé publique du Canada

Rapport
Montréal – 16 octobre 2019

Tirer des leçons des expériences des personnes âgées immigrantes

Table-ronde des organismes montréalais desservant les personnes âgées immigrantes

Thème : Le logement

16 octobre 2019

Document produit le 29 octobre 2019 par Julien Simard et Shari Brotman.

Table des matières

Remerciements et partenaires

Merci d'abord à toutes les participant.e.s à cette table-ronde pour votre implication et votre intérêt pour ces enjeux importants.

- *L'équipe de recherche*

Shari Brotman (McGill School of Social Work) – chercheuse principale
Pam Orzeck (McGill School of Social Work) - animation
Julien Simard (INRS-UCS) – coordination et animation
Pascual Delgado (ACCÉSSS) – collaborateur et animation
Marie-Ève Samson (Université de Montréal) – animation
Raphaël Massé (TCAIM) – animation
Valérie Lemieux (DRSP) – animation
Shu Luo (Université de Montréal) – prise de notes
Imane El Mahi (TCAIM) – prise de notes
Adina Ungureanu (ACCESSS) – prise de notes
Gabrielle Jacobs (McGill School of Social Work) – prise de notes
Tamar Wolofsky (McGill School of Social Work) – prise de notes
Yanina Chukhovich (McGill School of Social Work) – prise de notes

- *Les partenaires*

Nous aimerions remercier chaleureusement Pascual Delgado (ACCÉSSS) pour ses précieux conseils et pour ses incalculables contributions à l'organisation de cet évènement, ainsi que Raphaël Massé de la Table de concertation des aînés de l'île de Montréal (TCAIM), co-organisateur de cette table-ronde.

ACCÉSSS
Alliance des Communautés Culturelles pour l'Égalité dans la Santé et les Services Sociaux

Table de concertation des aînés de l'île de Montréal

Centre de recherche et d'expertise en gérontologie sociale
Center for Research and Expertise in Social Gerontology

- *Bailleurs de fonds*

McGill | School of Social Work

Social Sciences and Humanities Research Council of Canada
Conseil de recherches en sciences humaines du Canada
Canada

Introduction

- Présentation du projet

Le projet *Tirer des leçons des expériences de personnes âgées immigrantes* porte sur les stratégies requises pour faire face à l'exclusion sociale des personnes âgées immigrantes. Il a pour objectif de réunir des intervenant.e.s du réseau public et communautaire qui desservent les personnes âgées immigrantes pour discuter de leurs réalités et de pistes de solutions face aux enjeux touchant cette clientèle.

Ce projet est la deuxième phase d'une étude sur les parcours de vie des personnes âgées immigrantes qui s'est déroulée entre 2014 et 2017 : *Les expériences de personnes âgées immigrantes. Une étude narrative - « photovoix »*. Cette étude incorpore l'approche narrative et la technique *photovoix* dans le but d'explorer comment le processus de l'immigration influence la vie des personnes âgées. Les résultats de cette étude sont présentés sous forme d'une exposition de photos, résumant les parcours de vie et les expériences de 19 personnes âgées immigrantes. Un des principaux buts du projet est de contribuer aux efforts permettant d'améliorer notre capacité - en tant que chercheur.e.s, praticien.n.e.s et militant.e.s - de travailler ensemble pour contrer les stéréotypes affectant personnes âgées immigrantes, qui sont malheureusement trop communs dans notre société. Il s'agit également d'adapter nos services pour mieux répondre aux besoins et aux réalités des diverses communautés.

- Équipe de travail

Notre équipe de recherche représente un partenariat entre l'université et la communauté, avec des comités consultatifs composé d'organismes communautaires ethnoculturels et d'immigrants, de prestataires de services et de décideurs politiques du Québec, Alberta et de la Colombie-Britannique. Nous avons travaillé au sein d'une diversité d'immigrants et de groupes ethnoculturels, et ce dans 7 langues différentes pour atteindre les personnes âgées immigrantes qui sont sous-représentées dans la prestation de services, dans les politiques et dans la recherche.

- Description du présent rapport

Ce rapport préliminaire présente un résumé des discussions de la table ronde qui a eu lieu le **16 octobre 2019, au 7000 avenue du Parc, à Montréal.** Cette table ronde avait comme thématique principale *le logement* et a réuni plus de 62 participant.e.s. À chaque table, entre 8 et 12 participant.e.s appartenant à diverses organisations communautaires et institutionnelles ainsi qu'une personne chargée de l'animation ont échangé ensemble pendant près d'une heure. Les grandes lignes de leurs propos, notés minutieusement par des membres de notre équipe, furent par la suite rapportés en plénière. Veuillez noter que les opinions présentées dans ce rapport ne reflètent pas nécessairement celles de l'équipe de recherche ou de tous les participant.e.s présents, mais documentent plutôt la diversité des positions et des commentaires formulés lors de ces discussions.

- Prochaines étapes

Un rapport final sera produit à la fin des consultations pancanadiennes. Ce rapport résumera les thématiques et les discussions émanant de toutes les tables rondes qui auront lieu au cours des 18 prochains mois dans 5 différentes villes (Laval, Montréal, Québec, Calgary et Vancouver). Au total, à l'échelle du Canada, se tiendront 10 évènements sur divers thèmes. Parmi ceux-ci : l'isolement et l'inclusion sociale, la proche-aidance, le logement et les transports ainsi que la maltraitance.

Présentation de la TCAIM et de la Direction régionale de la santé publique (DRSP) – Raphaël Massé et Valérie Lemieux

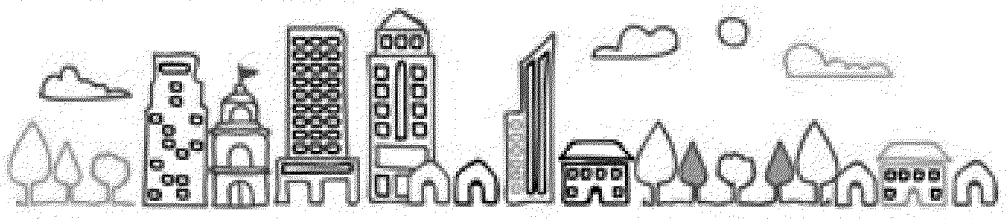
TIRER DES LEÇONS DES EXPÉRIENCES DES PERSONNES ÂGÉES IMMIGRANTES

-

Un portrait de données statistiques sur la thématique de l'habitation

Table de concertation des aînés de l'île de Montréal

Québec



PLAN DE PRÉSENTATION

OBJECTIF DE LA PRÉSENTATION:

Proposer un portrait statistique mettant en lumière différentes composantes de la réalité de la population aînée immigrante, principalement en ce qui a trait aux enjeux d'habitation.

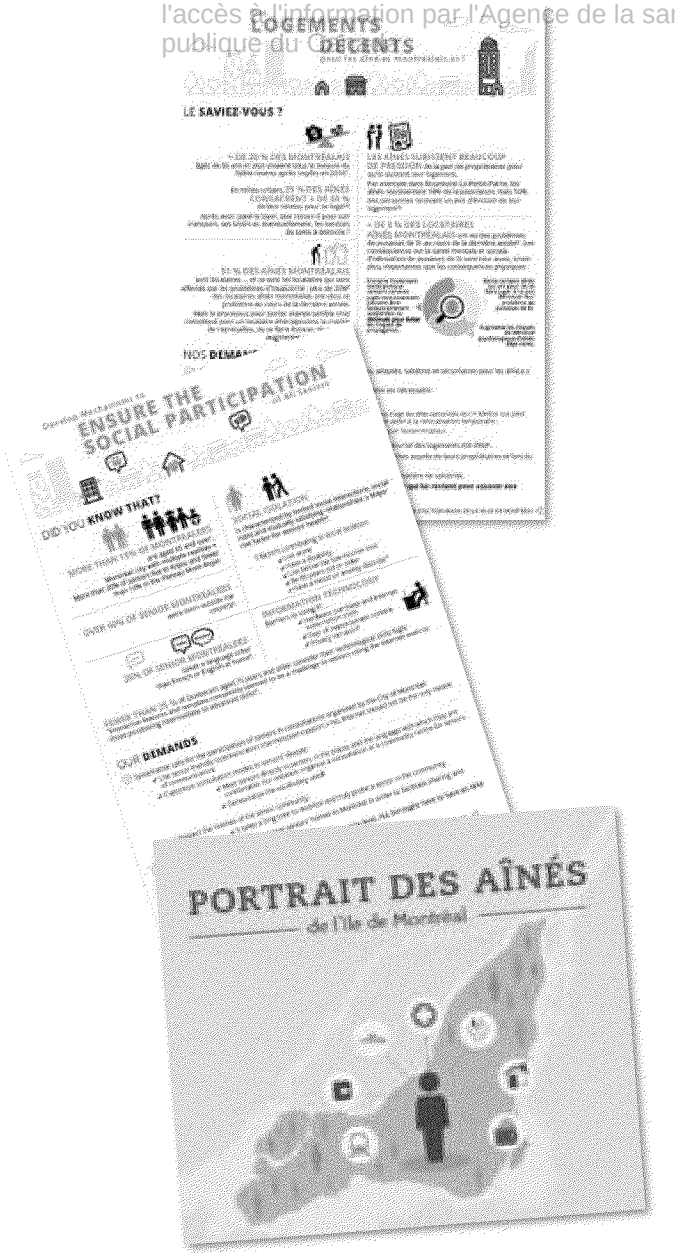
DÉROULEMENT DE LA PRÉSENTATION

1) Origine du projet
2) Objectifs du projet
3) Présentation de données générales sur la population aînée immigrante montréalaise
4) Présentation de données liées à l'habitation
5) Synthèse
6) Pistes de réflexion

ORIGINE DU PROJET

FICHES STATISTIQUES

- ✓ Désir d'étendre le champ d'action de la TCAÎM
  - Dispersion des savoirs
- ✓ Suite logique aux Fiches thématiques MADA (2018) de la TCAÎM et du Portrait des aînés de l'île de Montréal de la DRSP (2017)
- ✓ Besoin d'approfondir les données statistiques pour mieux documenter certains enjeux spécifiques
- ✓ Faire le pont entre le milieu institutionnel et communautaire/citoyen.



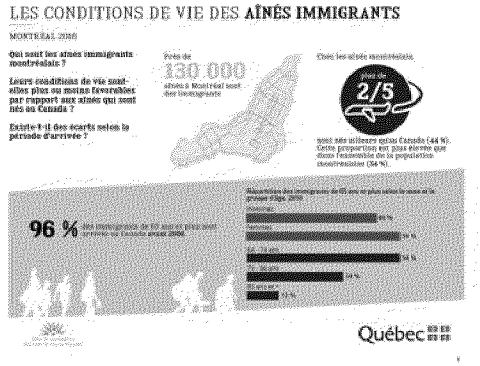
OBJECTIFS DU PROJET

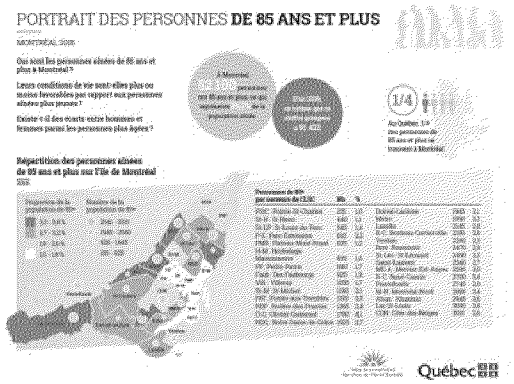
FICHES STATISTIQUES

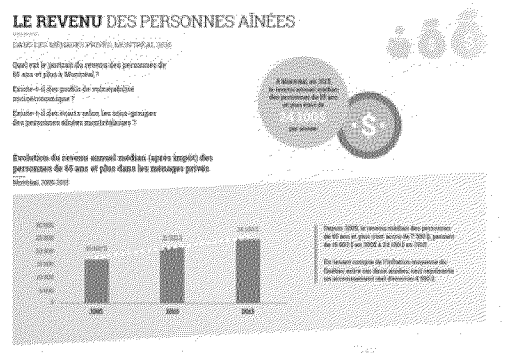
- ✓ Développer les connaissances sur des enjeux spécifiques liés aux aînés montréalais
  - Immigrants
  - 85 ans +
  - Pauvreté
  - Logement
  - Aînés vivant seuls

... plus concrètement

- ✓ Outiller les organismes pour mieux appuyer leurs demandes de financement (ex.: PNHA, SHV, QADA)
- ✓ Outiller les organismes/citoyens dans leurs représentations/planifications/etc
- ✓ Ultimement, influencer les politiques publiques





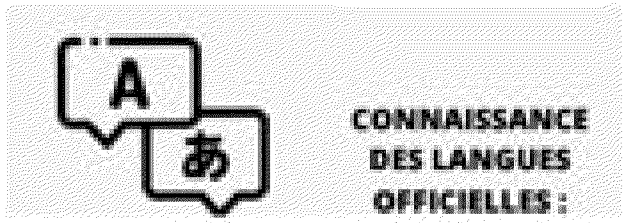


LA POPULATION AÎNÉE IMMIGRANTE À MONTRÉAL, ÇA REPRÉSENTE QUOI?

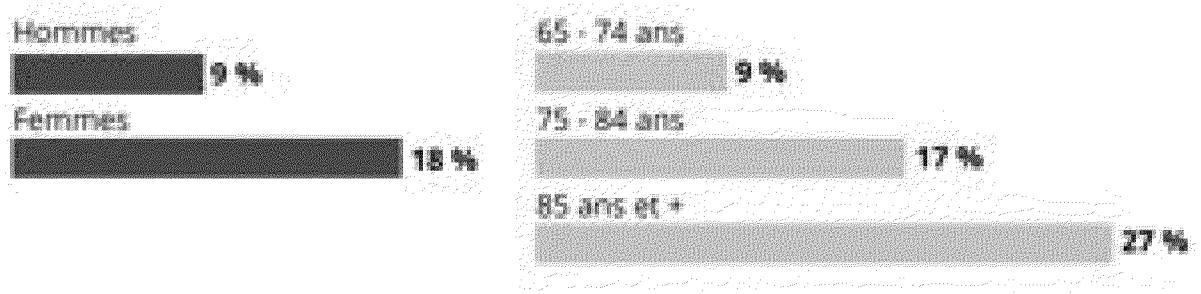
96 % des immigrants de 65 ans et plus sont arrivés au Canada **avant 2006**.

QUI CONNAIT LES LANGUES OFFICIELLES?

14 %
des aînés immigrants ne connaissent ni l'anglais, ni le français

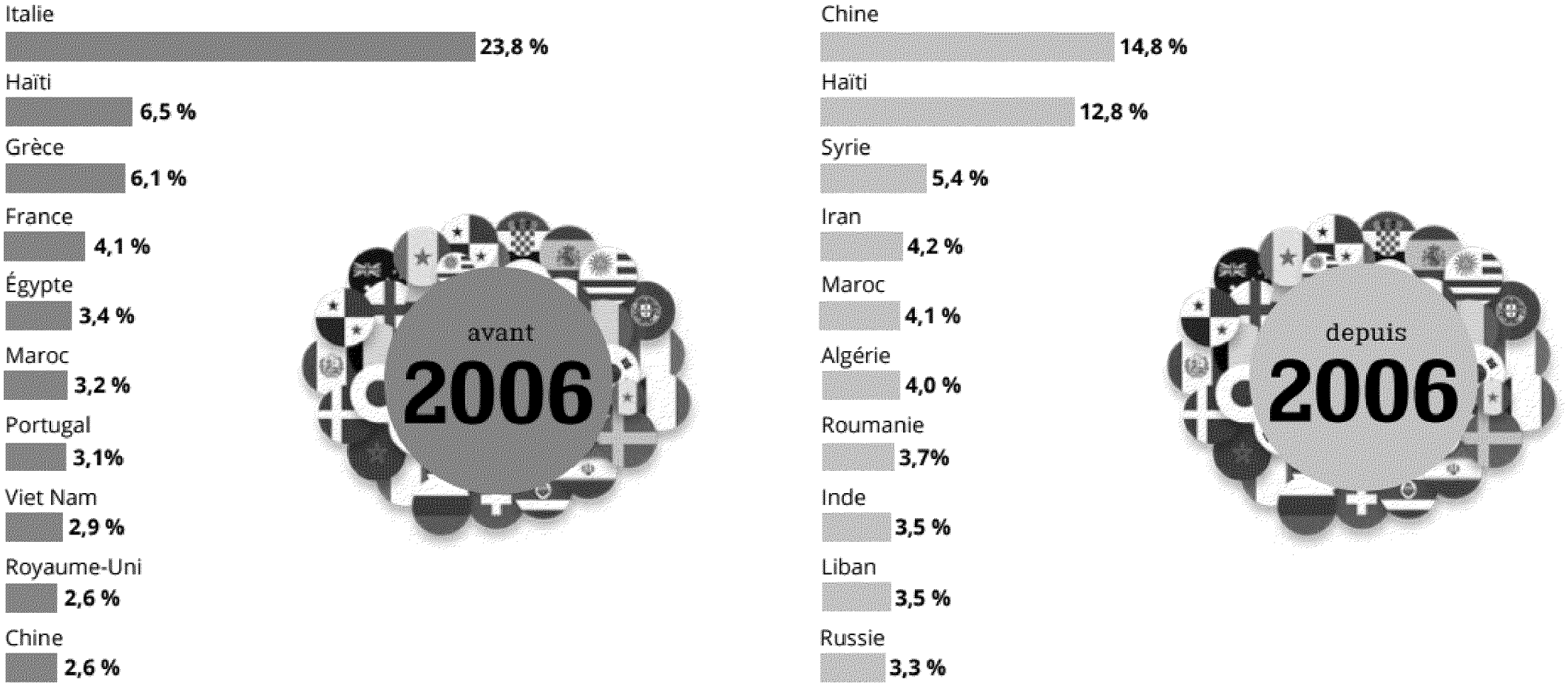


Proportion des immigrants de 65 ans et plus qui ne connaissent aucune des langues officielles selon le sexe et le groupe d'âge, 2016

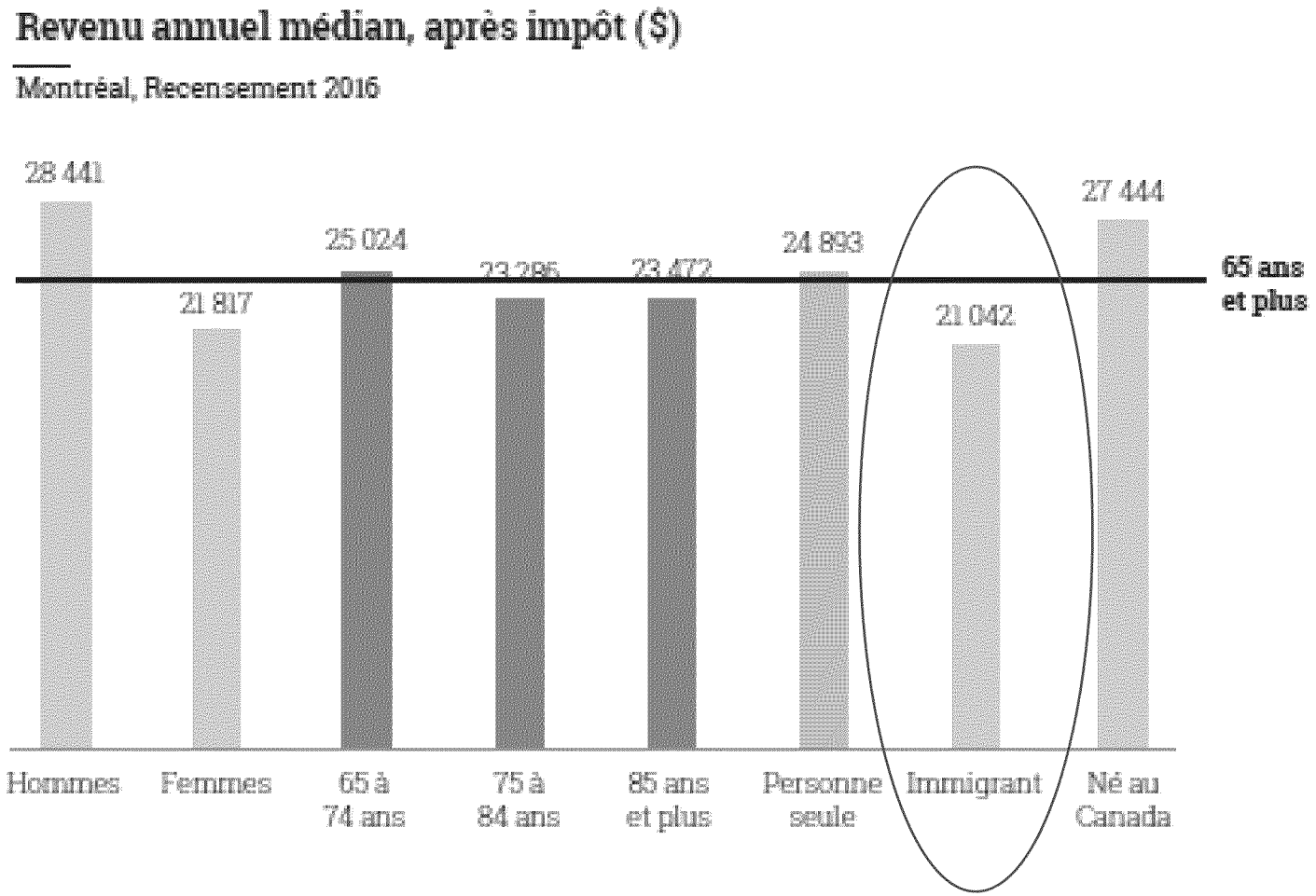


D'OÙ PROVIENNENT LES AÎNÉS IMMIGRANTS MONTRÉALAIS?

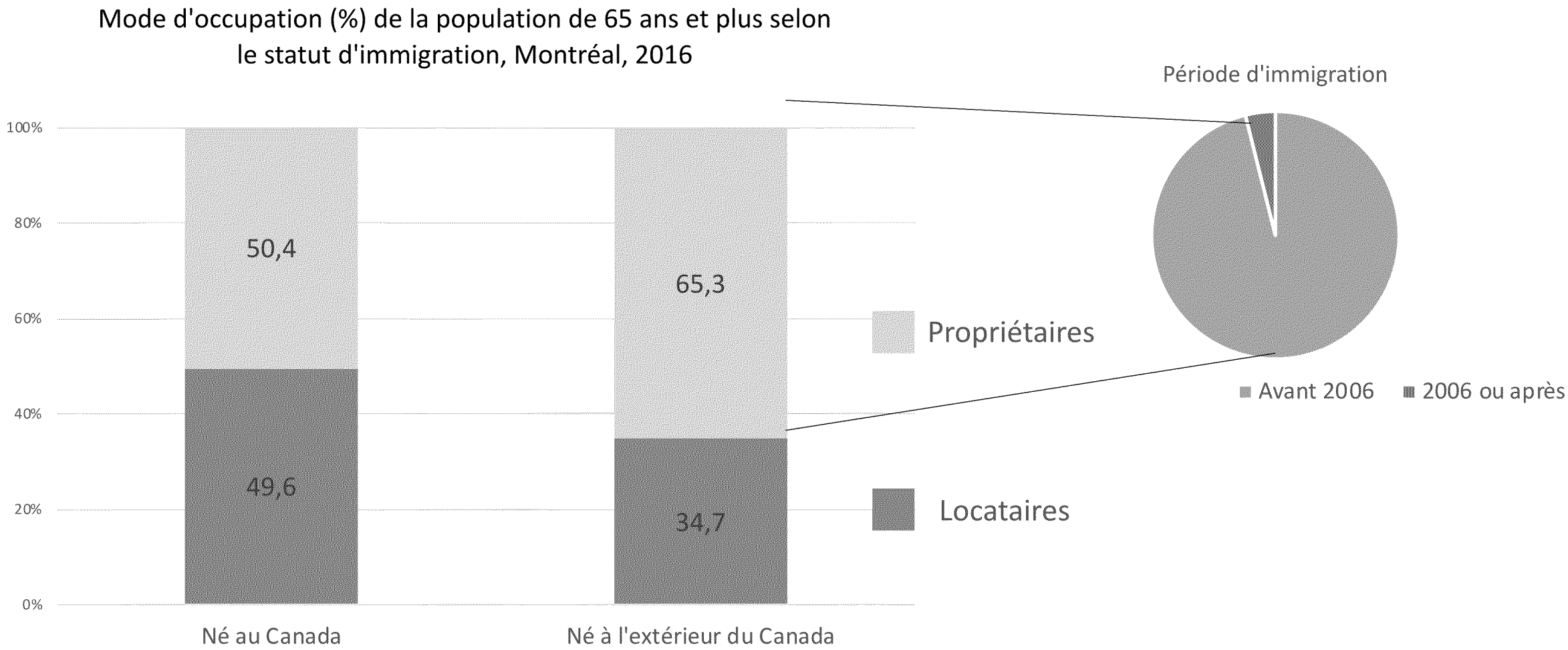
Principaux pays de provenance selon la période d'immigration : population immigrante de 65 ans et plus, Montréal, 2016



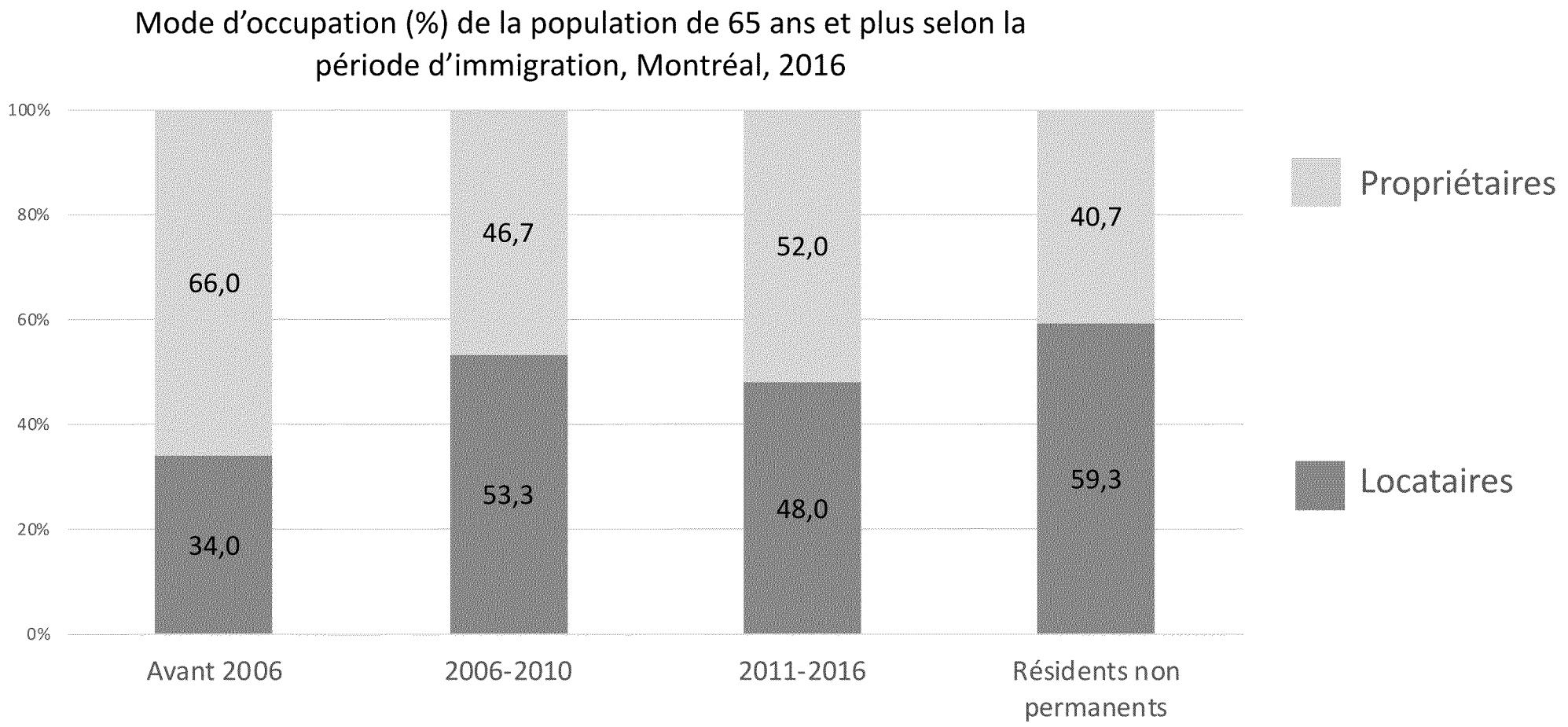
OÙ SE SITUE LE REVENU DES AÎNÉS IMMIGRANTS MONTRÉALAIS?



IMMIGRANTS: PROPRIÉTAIRES OU LOCATAIRES?

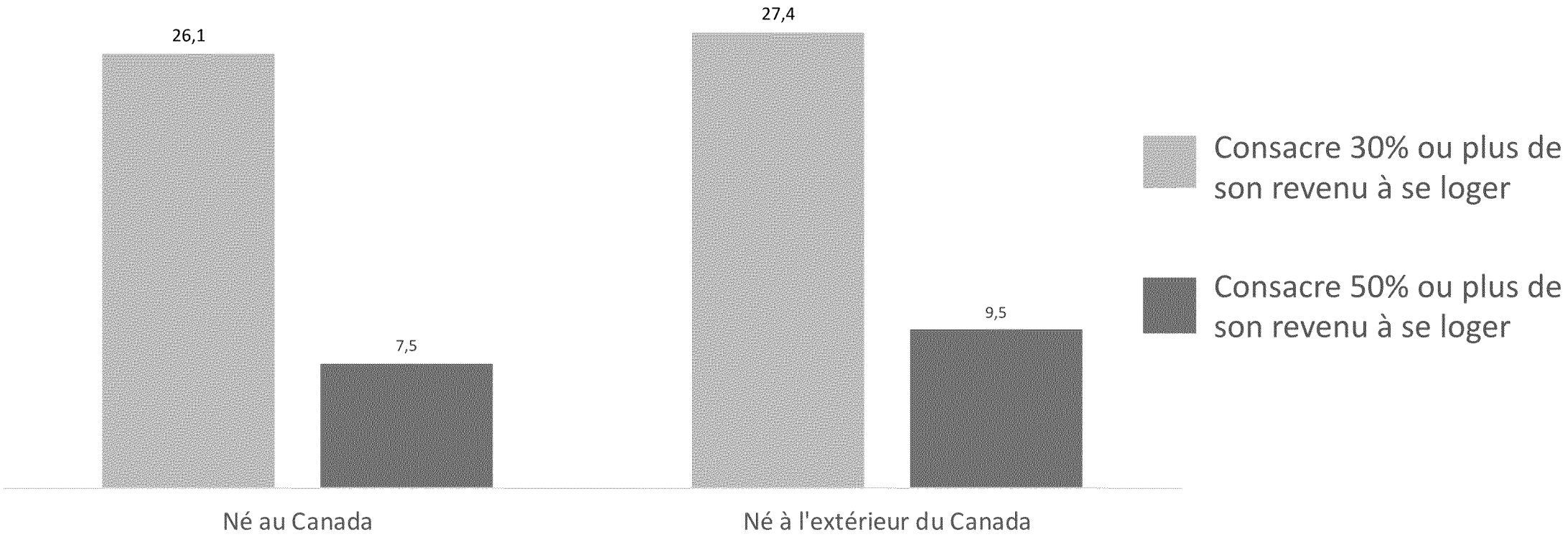


IMMIGRANTS: PROPRIÉTAIRES OU LOCATAIRES?

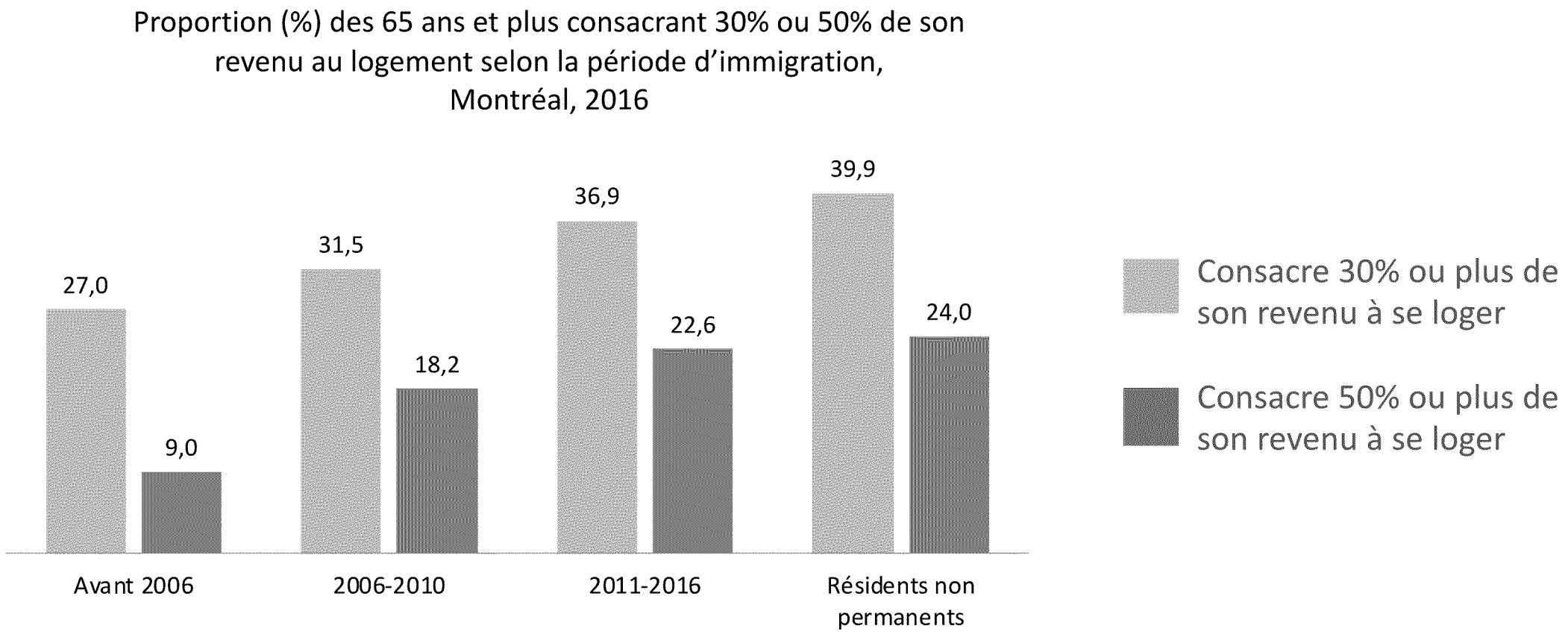


TAUX D'EFFORT SELON LE STATUT D'IMMIGRATION

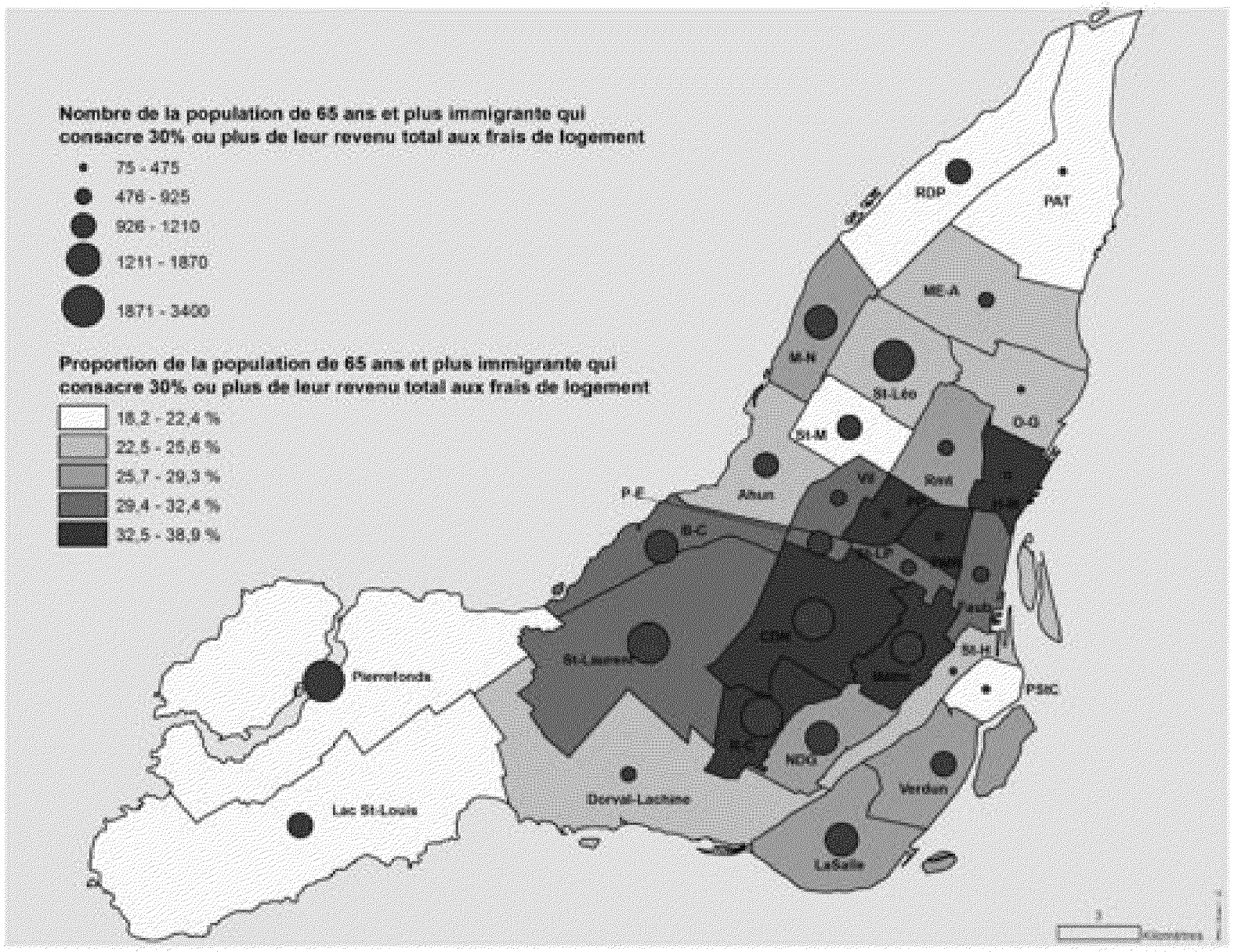
Proportion (%) des 65 ans et plus consacrant 30% ou 50% de son revenu au logement selon le statut d'immigration, Montréal, 2016



TAUX D'EFFORT SELON LA PÉRIODE D'IMMIGRATION



RÉPARTITION TERRITORIALE DES AÎNÉS IMMIGRANTS SELON LE TAUX D'EFFORT



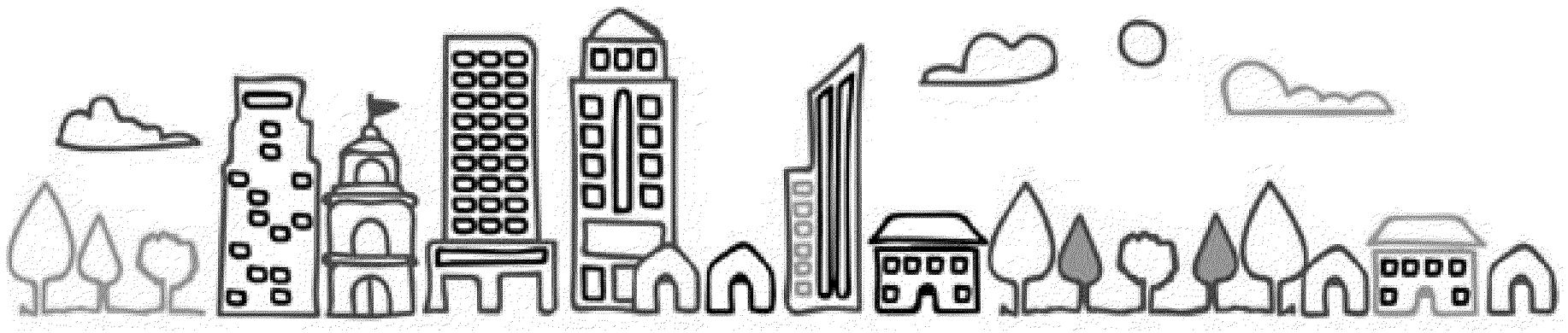
SYNTHÈSE

- Population aînée immigrante ≠ bloc monolithique;
- Néanmoins, des caractéristiques peuvent accroitre leur vulnérabilité:
  - Le fait d'avoir immigré au Canada après 2006 ;
  - Le fait d'être une femme ;
  - Le fait de ne pas connaître l'une des deux langues officielles.
- Tout comme les femmes et les personnes seules, les personnes nées à l'étranger sont les groupes aux revenus les plus faibles et affichant un profil de plus grande précarité économique;
- Taux d'effort: un enjeu à surveiller dans les quartiers centraux de Montréal;
- Être un.e immigrant.e propriétaire: situation courante…pour certain.ne.s.

PISTES DE RÉFLEXION

- Quels accompagnements/programmes institutionnels pour les aînés nouveaux arrivants en matière d'habitation?
- Taux d'effort: Est-ce que le fait d'être propriétaire est un facteur de protection à toute épreuve?
- Taux d'effort: Nécessité d'un rôle accru des administrations locales pour protéger les populations aînées immigrantes des différents quartiers montréalais?
- Au-delà de l'aspect financier, les enjeux de salubrité et de sécurité du logement pour les aînés immigrants.

C'est à vous ce matin de nourrir la réflexion…et de proposer des pistes de solutions!



Présentation de Mazen Houdeib, Directeur général, Regroupement des organismes du Montréal ethnique pour le logement (ROMEL)

ROMEL

Toit Dignité Intégration

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LE ROMEL ET SA MISSION

Le ROMEL a été fondé en 1984 par sept organismes communautaires et publics pour venir en aide aux personnes vulnérables, plus particulièrement les communautés ethniques, en matière de logement et de lutte contre la discrimination et l'exclusion sociale.

Les sept membres fondateurs sont: Le YMCA, l'Hirondelle, le CLSC CDN, La Maisonnée, L'OEIL de CDN, la Maison Internationale de la Rive-Sud et la Communauté Laotienne de Montréal

PROBLÉMATIQUE DE LOGEMENT

La population, en général, fait face aux problèmes suivants en matière de logement:

- L'insalubrité
- Le surpeuplement
- La sécurité
- La proximité des services
- Le prix de location
- La discrimination
- La baisse du taux d'inoccupation

PROBLÉMATIQUE SPÉCIFIQUE AUX P/AGÉES

- La sécurité
- La disponibilité de services
- L'isolement
- La vulnérabilité face à la maltraitance
- Le revenu
- La condition de santé physique
- La condition de santé psychologique

DEUX GROUPES DE PERSONNES AGEES ISSUES DE L'IMMGRATION

1) Celles qui sont nées ici ou arrivées très jeunes au Québec

Ce groupe vit les mêmes difficultés (pour se loger adéquatement) que l'ensemble des personnes âgées. On parle ici de la sécurité, la maltraitance, l'isolement et sur un autre plan le taux d'effort et le coût du logement. Même celles qui ont travaillé toute leur vie au Québec, elles peuvent se trouver privées de moyens financiers à leur retraite et/ ou isolées de leurs proches. Cette réalité les exposent à différents problèmes mentionnés ultérieurement. Toutefois, leur vécu et leur capacité de communiquer dans les langues officielles représentent un facteur aidant pour réduire leur vulnérabilité. Je dis bien réduire et non pas éliminer.

2) Celles qui font partie de l'unification de familles immigrantes, ou qui n'ont pas travaillé de longues années au Québec

Ce groupe vit des difficultés additionnelles, et sur certains aspects, plus prononcées, du fait des différences culturelles et de la méconnaissance des langues officielles. Cette réalité les rend plus vulnérables et pose un problème sérieux à leur bien-être social et leur cause beaucoup d'angoisse et de sentiment d'insécurité. Par contre, ce qui contribue parfois à atténuer ces sentiments, sont les liens familiaux et les coutumes s'y rattachées et partagées par l'ensemble des différentes composantes de la société d'accueil.

DÉFIT FINANCIERS ET SOCIAUX (1)

Trois secteurs “officiaux” dessèrent les personnes âgées:

1) Le secteur privé (maisons de retraite et de ressources intermédiaires)
2) Le secteur public (CHSLD, OMHM, CIUSS)
3) Le secteur communautaire (OBNL d’habitation et différents organismes communautaires de services)

Un quatrième secteur à ne pas négliger ou sous-estimer: le domicile et les proches aidants

DÉFIS FINANCIERS ET SOCIAUX (2)

- Le secteur privé représente un défit financier pour les personnes âgées à revenu moyen et modeste et particulièrement celles appartenant au groupe 2. On parle, entre autres, de maltraitance financière (78% des cas répertoriés), en plus de la maltraitance psychologique et physique. 44% des victimes demeurent dans un domicile privé ou en ressources intermédiaires. (***selon les rapports 2018-2019 des commissaires aux plaintes et à la qualité des services)***
- Le secteur public représente un moindre défit au niveau financier mais pas au niveau des autres formes de maltraitance selon le même rapport (27% des victimes demeurent dans un CHSLD)
- Le secteur communautaire représente, selon nous, une piste intéressante pour faire face aux défits, mais il manque de ressources et de moyens financiers. L'avantage de ce secteur, sur le plan théorique et pratique, serait sa capacité de bénéficier des pogrammes de subvention pour rejoindre les personnes âgées vulnérables sur le plan financier, et pour bénéficier du réseau communautaire sur le plan soutien psychologique et en services. À chaque fois que l'engagement et la solidarité sociales sont mis en pratique, les défits sont moins difficiles à relever.

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DÉFIS FINANCIERS ET SOCIAUX (3)

La diversité culturelle représente un défit dans la gestion des services dans une maison de personnes âgées.

Le bien-être social et physique est conditionnel à l'absence de l'isolement et de la maltraitance sous toutes ses formes et aussi à une nutrition adéquate.

Les conséquences d'un échec sur ce chapitre sont néfastes sur la santé mentale et physique des personnes qui vivent souvent, pratiquement de facto, un deuil permanent et un sentiment d'insécurité.

Pistes de réflexion:

1. ***Investir davantage dans la mise sur pied de projets de résidences de personnes âgées style intergénérationnelles !?***
2. ***A part les mesures légales et règlementaires, investir davantage dans la création de ressources expérimentées multilingues !?***
3. ***Soutenir les organismes communautaires agissant sur le terrain et surtout ceux qui forment et encadrent les proches aidant !?***

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Notes des discussions

Table A

Question no 1 – Réactions face à l'exposition

- Manque de personnes d'origine chinoise dans l'exposition; pourtant, il y a beaucoup d'histoires heureuses et malheureuses en lien avec cette communauté au Québec/Canada.

- De manière plus générale, il a une exclusion des immigrants de l'histoire québécoise telle qu'elle nous est transmise. Par exemple, les immigrants chinois ont construit les chemins de fer au Canada; certains sont arrivés au Canada à l'époque de la Nouvelle-France. Plusieurs autres communautés immigrantes se sont installées ici depuis l'Independence des États-Unis.

- Les immigrants étaient totalement exclus des discours du Gouvernement Couillard qui n'a jamais mentionné leurs contributions en lien avec les mouvements féministes et des ouvriers (des mouvements qui sont attribuables à des personnes immigrantes). Il faut se questionner sur la place des immigrants au Québec, que ce soit dans le domaine du logement ou ailleurs.

- Peu d'espoir pour une personne aînée qui est retraitée au Canada et qui reçoit seulement un montant de base (aide sociale). Les personnes âgées immigrantes ont moins de revenu de retraites privées. L'aide sociale n'est pas suffisante pour loger quelqu'un dans le secteur privé. Une personne qui est jeune peut au moins espérer trouver un emploi et améliorer sa situation.

- L'injustice est présente partout. Ça doit être très démoralisant de travailler pendant des années, et tout à coup, de se faire mettre à la porte sans explication et sans ressources.

- La thématique de la résilience revient beaucoup à travers l'exposition. Plusieurs immigrants attribuent leur résilience au bénévolat qu'ils entreprennent eux-mêmes. C'est formidable de constater qu'ils gardent espoir.

- La question de la religion : les gens avaient souvent besoin d'un endroit où ils avaient besoin de prier, de se recueillir (un endroit harmonieux, comme un banc, par exemple). Beaucoup de parcs et de verdure figurent dans les photos; cela signifie que ce sont des lieux importants pour eux. Certains objets d'appartenance ont également une connotation spirituelle ou une signification intergénérationnelle.

Question no 2 – Constats

- On n'aborde pas suffisamment la régionalisation du logement au Québec. En ce moment, les aînés ont de la difficulté à se trouver un logement à l'extérieur de Montréal car ils obtiennent très peu d'information sur les régions.

- La langue peut également représenter une barrière pour un immigrant qui souhaite se loger à l'extérieur de Montréal car la plupart des réseaux et services dans les régions sont francophones.

- La gentrification des quartiers centraux à Montréal force les personnes aînées à faible revenu de se déplacer à Laval, Dorval, Vaudreuil et d'autres régions qui sont mal desservies par un système de transport en commun, les services communautaires, les comptoirs alimentaires et les épiceries, etc..

- La gentrification a un effet d'entraînement sur les autres quartiers à Montréal (Hochelaga, Petite Bourgogne, etc.). Les nouveaux commerçants sur Notre-Dame dans le quartier St-Henri se voient forcés de quitter les lieux. La ville doit adopter des politiques pour contrôler les effets de la gentrification. Les petits financements n'ont pas de pérennité.

- La situation de logement dans les villes, c'est comme mettre son doigt entre l'arbre et l'écorce. Une amélioration des résidences dans un quartier entraîne une augmentation des revenus. Dans Parc-Extension, il y a déjà une transformation qui se produit; tout se rénove et on voit paraître des condos et des épiceries dispendieuses (ex : Provigo). Les gens qui sont sur l'aide sociale ne peuvent pas y magasiner; ils vont aux dépanneurs. Les immigrants à faible revenu vont être exclus de ces quartiers bientôt.

- CLSC Parc-Ex.: dernière rue à se faire nettoyer pendant l'hiver. Au lieu de l'arrondissement de la mairesse, la première route à se faire nettoyer devrait être celle menant au CLSC depuis le métro.

- Les personnes aînées qui sont propriétaires doivent s'occuper de la maison et des rénovations, et cela devient plus difficile avec l'âge. Il y a même des promoteurs qui en profitent pour faire du porte-à-porte dans le but d'offrir un prix en argent liquide pour la maison.

- Ailleurs, il y a des lois pour contrôler le marché. Les investisseurs étrangers se dirigent maintenant vers Montréal. Les personnes aînées se retrouvent donc avec un nouveau propriétaire, qui fait plein de nouvelles rénovations (ce qui augmente le loyer).

- Malgré le fait que les personnes aînées soient protégées par l'article 1959.1 (personnes de 70 et plus sont protégés contre l'éviction si elles résident dans leur logement depuis plus de 10 ans, ont un revenu faible) les gens ne font pas appel à cette loi sur le terrain car ce processus est long, et les locateurs harcèlent leurs locataires pendant ce temps-là.

- Les aînés ont encore moins accès aux services judiciaires. S'il n'y a pas d'accompagnement sur le terrain, ils passeront à travers les mailles et ne pourront pas rester chez eux (surtout ceux qui habitent seuls et qui n'ont pas de témoins). Il n'y a aucune protection contre le harcèlement par les propriétaires. Ce n'est pas comme la maltraitance dans les institutions qui est beaucoup plus visible et publique. C'est comme la loi de la jungle.

- Un autre obstacle : la langue. Est-ce qu'ils savent qu'ils ont ce droit? Les immigrants aînés ignorent parfois qu'ils ont des recours. Même s'ils connaissent leurs droits, c'est fatiguant et ils ne veulent pas se battre. Ils ne savent pas qui peut les aider ou bien le comité de logement ne parle pas leur langue. C'est décourageant de devoir se battre quand il y a tellement d'obstacles.

- Quand on demande aux aînés immigrants de contester une expulsion ou des conditions insalubres avec leur propriétaire, il faut aussi prendre en compte leur parcours d'immigration. Il se peut que s'opposer au gouvernement soit impossible pour quelqu'un qui vient d'un pays où il y a une guerre ou un conflit politique.

- Statistique : la plupart des aînées immigrants arrivent au Canada par voie de parrainage. Sur papier, les enfants ont une bonne relation avec leurs parents, mais cette relation peut changer beaucoup quand les parents arrivent ici. Ils veulent éventuellement leur propre logement et ce n'est pas faisable

financièrement. Il faut attendre 10 ans pour obtenir une pension de la sécurité de vieillesse. Peut-être qu'ils ont apporté quelque chose de leur pays d'origine, mais il y a tout de même une difficulté financière.

- Culturellement, il existe entre les parents immigrants et leurs enfants des différences importantes (ils sont la tête de la famille en Chine, mais quand ils arrivent ici, leur statut social baisse nettement). Ils ne comprennent pas la langue, ils ne peuvent pas sortir de chez eux ou même acheter leurs propres épiceries. Les parents se sentent très isolés.

- Les parents chinois sans enfants ressentent parfois que le futur est fini; ils souffrent physiquement et psychologiquement. Pour les gens dans le quatrième âge (80 ans+) ils ont du mal à gérer leurs AVQs à la maison. Ils font parfois des chutes, et se retrouvent à l'hôpital, mais il n'y a pas de psychologues qui parle leur langue et ils se font renvoyer chez eux sans services de réadaptation.

- Programme HLM : le temps d'attente et souvent de 5-6 ans. Les gens oublient parfois qu'ils ont fait une demande, ou bien il manque l'appel de l'organisme et doivent postuler à nouveau (il y a des listes d'attente avec 11 000 noms).

- En dessous de l'échangeur Turcot, ou il y a un HLM, il n'y a pas de banc (malgré une grande population aînée qui habite là). Ça fait longtemps qu'on le demande : on veut dix bancs!

- Dans le réseau de la sante, le maintien à domicile ne sera plus durable dans 10-20 ans. Les personnes qui habitent en CHLSD, c'est les situations les plus avancées. Ce qui s'en vient, c'est qu'on va maintenir les gens à domicile. Plus de gens chez eux, isolées, peut-être ne parlent pas le français ou l'anglais. On est très en retard pour leur donner une vie décente.

- Projet D'Or Des Îles (Cartierville) : résidence pour personnes aînées. C'est un défi pour les immigrants de vivre dans un lieu comme ça parce que ce dernier ne représente par leur culture (repas, etc.). Par contre, les gens sont satisfaits du logement en tant que tel.

- Plusieurs aînés immigrants ne veulent pas manger la nourriture qu'ils reçoivent dans les résidences/centres d'hébergement. La religion peut également jouer un rôle par rapport à cette question. Le résultat c'est que les gens restent chez eux jusqu'au dernier moment.

- Le développement des projets est difficile en raison des embûches administratives (c'est long). Pourquoi la ville ne facilite pas le travail de développement s'ils connaissent le problème?

- Au Sud-Ouest (Petite Bourgogne): le Foyer Hongrois (endroit OBNL) est un projet innovateur (mobilisation/foyer subventionné). Les résidents viennent d'une communauté hongroise qui a immigré il y a longtemps; ils se retrouvent dans le quatrième âge maintenant et on doit leur trouver un logement. Mais on apprend également à les connaître, on aborde la question de maltraitance avec eux, on gère les enjeux tels que la retraite des médecins qui laissent plein de patients sans ressources. Ces gens ne parlent pas la langue, et se méfient du réseau de la santé.

- À St-Henri, il y a des coops mais le bassin HLM est moins grand. En raison de la gentrification, les services de proximité ne sont plus pareils. Les gens ne se reconnaissent plus; c'est moins accessible.

- Il y a bien des organismes porteurs qui travailleront auprès des aînés qui veulent créer un projet de développement. Mais la longueur des projets est prohibitive (12 ans, c'est une éternité pour une personne aînée… certaines personnes sont décédées alors qu'on leur cherche un logement).

- Le problème n'est pas unique à la Ville de Montréal. La fonction publique (municipale et provinciale) se caractérise par un mode de culture qui gère les dossiers par silo/cloisonnement. Dans le réseau communautaire, la gestion de dossier mise sur le partage des responsabilités et une approche intersectorielle. Quand ils s'alignent, ça ne fonctionne pas. C'est un discours où on n'est pas capable de se comprendre. Les projets ne fonctionnent pas parce que le mode de fonctionnement doit changer.

Question no 3 – Solutions

- Il n'y a pas un seul type d'immigrant; il faut assurer des services différents pour répondre à des besoins particuliers. Certains immigrants peuvent être méfiants des réseaux publics en raison de leur parcours migratoire.

- Ce n'est pas juste une question de manque information. S'il y a des coquerelles ou une situation d'insalubrité, ce sont des tendances qui doivent changer.

- Il faut trouver des mécanismes de soutien psychologique/social pour les immigrants aînées. La ville doit adopter une approche intersectorielle (services alimentation, transport en commun pour créer une vie de quartier/une vie sociale) pour offrir une vie décente aux aînées immigrants.

- Une approche globale plutôt qu'une approche de projet (12-18 mois) : il faut collaborer avec les services de proximité pour augmenter l'accessibilité du transport, de pharmacie, alimentaire. Un partenariat à long terme nécessite une transformation de la fonction municipale et du secteur communautaire.

- La Banque d'interprètes : pas parfait, mais c'est des personnes qui peuvent faciliter l'accès dans les réseaux de la santé. Le problème, c'est que ça coute de l'argent, mais plusieurs langues y figurent et les gens qui travaillent à la BII ont une compréhension des parcours migratoires. Il faut pousser pour que ce réseau soit plus accessible (ainsi que d'autres services comme les comités de logement).

- La ville doit créer plus de disponibilité dans les logements HLM. Le gouvernement ne construit plus de résidences HLM depuis 1994. La France a beaucoup évolué sur ce point; il y a des lois qui obligent les propriétaires à rendre accessible les logements abordables (20% du nombre de logements total). Il y plus de résidences fermées également (plus sécuritaire, plus beau).

- La ville doit acheter les terrains pour bâtir et garder des espaces où il y a des services de proximité/services communautaires qui sont accessibles aux immigrants aînés

- Réflexion doit être faite au niveau de la ville: est-ce que les villes sont faites pour les citoyens ou pour aller chercher des revenus pour la ville?

Table B

Question no 1 – Réactions face à l'exposition

- Le témoignage le plus marquant est celui de la femme qui a été parrainée par sa fille. Les ainés qui sont parrainés deviennent très dépendants des membres de la famille qui les ont parrainés.

- Avec cette exposition, je retiens que le fait d'être aîné est étroitement lié à la précarité. Pour cette raison les aînés tendent vers des métiers d'artistes. Il devrait y avoir des formations qui accompagnent nos aînés afin de mieux les aider à cheminer leur parcours de vieillesse.

- Le cas de la famille qui résidait à Montréal et qui était contrainte d'aller vivre en banlieue car n'avait plus les finances pour payer le logement à Montréal. Cela remet en cause la question du rêve canadien qui n'est pas toujours concrétisé pour les immigrants qui viennent. En effet, les immigrants aînés ou jeunes au moment où ils immigrent aspirent à réaliser des rêves qu'ils n'ont pas pu réaliser dans le pays d'origine.

- Dans le cas de la francisation des aînés immigrants, il est préférable que le formateur soit multilingue afin qu'il s'adapte à la langue des usagers.

- Les témoignages des parcours de vie dégagent beaucoup de talent et de résilience.

- Le problème rencontré dans la société d'accueil (dans notre cas le Québec) peut toujours être de victimiser les immigrants aînés par des contraintes de langues.

- Les aînés auraient beaucoup de talents à apporter au secteur communautaire mais on les approche peu.

Question no 2 – Constats

Précarité :

- Les loyers sont plus élevés pour les aînés alors que les revenus sont de moins en moins importants. Les aides gouvernementales ne suffisent pas et certains aînés se trouvent obligés de faire usage des banques alimentaires.

- Les aînés ne sont pas au courant de leurs droits en tant que locataires. Des fois on oblige les habitants à quitter l'appartement pour des raisons spécifiques, Ex : Une dame de Parc-Extension s'est faite renvoyée de chez elle car le propriétaire voulait augmenter le loyer.

- Les propriétaires qui décident de se faire plus d'argent vont toujours trouver une façon de contourner les faits : Réaménagement, travaux dans l'appartement.

- Les plaintes sur les problèmes de salubrité peuvent être faite par un tiers (membre de sa famille, proche…). Disponible au 311.

- Les immigrants aînés ont moins tendance à déposer plainte, par hésitation ou par manque d'informations sur leurs droits fondamentaux.

- Le processus de plainte est long pour les aînés immigrants. Aller vers les ressources nécessite un accompagnement. Il faut que l'aîné soit accompagné par une personne qui peut s'assurer de faire le suivi.

- Quand vous voyez des maisons pour personnes aînés, exemple : Côte-St-Luc, ses habitants sont privilégiés. Ils ont des services d'accompagnements sur place. Alors que dans un quartier comme parc extension, c'est une autre réalité. D'ailleurs, récemment, un aîné est décédé devant la porte de la résidence car il n'a pas reçu d'aide au moment il en faisait appel.

- Il y'a un grand besoin d'accompagnement au sein des HLM, car ces aînés habitants souffrent d'un grand isolement. Nos aînés ont besoin d'un contact humain au sein de ces habitations : « lors d'une récente interventions auprès d'aînées d'une résidence privée, les femmes aînées disaient se sentir isolées alors qu'il y'avait des animateurs d'activités sur place ».

- Les aînés au début sont souvent des personnes qui ont une situation financière stable, mais qu'avec la force des choses ils se retrouvent sans logement.

Isolement :

- Les activités au sein des résidences privés ne sont pas toujours efficaces pour combattre l'isolement des aînés. Les activités sont payantes.

- Dans notre quartier, on a reçu beaucoup de réfugiés syriens. Il y'a un problème intergénérationnel. Les personnes venant d'ailleurs sont encore attachées aux valeurs du pays d'origine. Les parents parrainés ne comprennent pas souvent la vie active des enfants. Les aînés parrainés par leurs enfants sont contraints de souffrir d'isolement alors qu'ils vivent avec ceux-ci. Un exemple : Lorsqu'une une belle-mère est parrainée, il peut arriver qu'elles ne puissent pas vouloir être un problème dans le couple avec la belle fille. Donc elle va se retirer petit à petit de la famille.

Question no 3 – Solutions

- Le CACI offre des logements ou les prix sont abordables mais il faut s'inscrire. Mais ces logements ne suffisent pas car ils sont limités. Le problème c'est que la procédure avec l'office municipal est lente. Il faut tenir compte des statistiques ou les aînés s'expriment sur leurs besoins.

- Les aînés au début sont souvent des personnes qui ont une situation financière stable, mais qu'avec la force des choses ils se retrouvent sans logement.

- Dans tous les logements (HLM) pour aînés, il faut mettre des services de base, accessibles à tous les résidents. Il peut s'agir d'activités pour briser l'isolement, de service d'alimentation (popote-roulante), de permettre aux habitants de socialiser au moins 2h par jour.

- Il faut faire connaitre les besoins en matière de logement à l'office municipal d'habitation. « Il y'a des aînés en plein hiver qui viennent nous voir pour un service alimentaire, en « babouche » ».

- Meilleure communication entre les institutions municipales et le communautaires.

- Favoriser les activités/ ateliers dans les HLM.

- Les logements sociaux ne sont pas des services universels comme la santé et l'éducation.

- Mettre en place des compensations financières pour remboursement mensuel pour que les aînés arrivent à joindre les deux bouts.

- L'accompagnement (long-terme) est important pour inciter les citoyens aînés à aller chercher leurs droits.

- Le modèle de gouvernance participative : aller entendre tous les besoins des aînés pour assurer une représentation effective dans les instances décisionnelles.

- Habiter la Mixité : Le développement de logements sociaux. Les problèmes qui peuvent exister dans les HLM, ça prend des moyens et des ressources.

- Les CLSC et l'office municipale de l'habitation doivent unir leurs forces pour améliorer la qualité de vie des citoyens aînés dans les HLM.

- Il faut plus de programme d'aide aux déplacements. Comme dans le cas des aînés qui suivent des cours de francisation ou des formations quelconques. Il est important de les encourager davantage dans leurs engagements et ne pas briser cela en ne les aidant pas à se déplacer plus facilement.

- Le gouvernement doit tenir compte que les aînés ont les compétences nécessaires pour occuper des emplois.

Table C

Question no 1 – Réactions face à l'exposition

La résilience et l'importance de la famille sont les deux éléments qui ont le plus ressorti quant aux éléments qui ont impressionné les membres de notre table. Il y a eu une réflexion par rapport aux services offerts qui sont surtout centrés sur l'individu, sans prendre en compte, ou presque, sa réalité familiale. L'une des participantes a surtout été impressionnée par le récit de la dame coréenne qui luttait contre la discrimination à laquelle elle faisait face dans son HLM. Des cas de discrimination dans les HLM sont, de l'avis des personnes qui en connaissent la réalité, une monnaie assez courante dans ce type d'installation.

Question no 2 – Constats

- La perte du rôle social fragilise et isole la personne aînée.

- Les personnes aînées qui ne parlent pas la langue deviennent vulnérables et dépendantes de leurs enfants.

- Les expériences intergénérationnelles ont donné de beaux résultats, ici comme ailleurs. On parle surtout d'activités impliquant les jeunes qui peuvent recevoir l'aide des aînés par rapport à leurs devoirs, ce qui confère un rôle à la personne aînée et la valorise. Il s'agit là de projets de jumelage qui ne demandent presque pas de ressources, mais une animation efficace, par contre.

- On a également parlé des résidences intergénérationnelles, une idée qui permet une meilleure fluidité entre les générations et brise l'isolement.

- Le fait qu'il existe des résidences uniquement pour aînés, ne laissant pas de place aux autres générations, contribue à l'isolement des aînés et ne permet pas toujours la création d'un sentiment d'appartenance.

- Les coopératives d'habitation constituent une bonne formule d'habitat, mais une prise en charge est requise. On revient, donc, à l'important rôle d'une personne-ressource qui anime le tout et favorise la cohésion et le sentiment d'appartenance.

- Il existe des situations d'abus assez fréquentes sur le marché locatif privé, de par le fait que certains aînés ne reçoivent pas les services auxquels ils auraient droit (par exemple des réparations essentielles) étant donné que leur loyer est bas (dans le cas où ils occupent le logement depuis longtemps).

- Des situations d'abus sont observées, par exemple des aînés qui versent un montant disproportionné à leur église d'appartenance.

- Les HLM se confrontent à des problèmes récurrents de salubrité et souvent les aînés immigrants ignorent les modalités leur permettant de défendre leurs droits.

- Il est difficile de rentrer en HLM, les listes d'attente sont longues et le critère du revenu est injuste, dans le sens qu'on demande à une personne seule d'avoir un revenu de 29 000 $ et moins et à un couple d'avoir le même revenu (de 29 000$ et moins à deux !).

- Il y a un manque criant d'information par rapport aux services offerts aux ainés — en général.

- Les travailleurs sociaux et étudiants dans le domaine ne suivent aucun cours sur la gérontologie et la réalité des personnes aînées, dont la démence. Il manque de formation dans ce domaine des personnes censées les aider.

- Il y a peu de moyens concrets permettant aux aînés de rester à la maison (ressources, soutien, aide, etc.).

Question no 3 – Solutions

- Formation obligatoire des inspecteurs incendie à la sécurité des aînés.

- Mettre en place des programmes tel qu'il en existe (sous la forme d'initiatives ponctuelles) comme l'Appel Bon Matin et la formation de sentinelles (ex. employés des banques, de pharmacies, de popotes roulantes, etc.) permettant de redoubler de vigilance et de déceler des situations de maltraitance et de détresse rapidement.

- Mettre en place des programmes de réinsertion sociale visant les personnes ayant fait des délits mineurs afin de leur permettre de s'impliquer auprès des aînés en effectuant des tâches aidantes et créer ainsi des liens doublement profitables.

- Mettre en place des programmes ados-aînés, un peu comme celui qui a cours en Suisse et qui a été ci-haut énoncé (l'aide aux devoirs).

- Prévoir l'attribution d'un travailleur social automatiquement à toute personne ayant atteint l'âge de 70 ans afin qu'elle puisse s'y référer en cas de besoin, dans une optique de *outreach* des personnes (car certaines tarderont de demander de l'aide et ne sauront pas toujours ou se référer).

- Avoir une optique plus large permettant le développement de programmes qui tiennent compte des différentes réalités des aînés.

Table D

Question no 1 – Réactions face à l'exposition

Une participante a donné des commentaires : l'exposition est intéressante. Ça lui touche beaucoup et la fait penser à sa propre situation et les parcours d'autrui qu'elle a rencontrés dans le travail. En plus, les articles sont bien synthétisés, donc ils ne sont pas trop longs à lire. Cependant, les affiches sont petites.

Question no 2 – Constats

- Précarité jamais disparue : parcours comparé à une autoroute pleine de nids de poule.

- Certains programmes n'ont pas suivi le changement. La situation change toujours, mais les bailleurs de fonds préfèrent voir les statistiques au lieu de conclusion sur terrain.

- La continuité des programmes et des services pose un problème : « lâcher l'innovation ». Les bailleurs de fonds coupent le financement. Les bailleurs de fonds à tous les niveaux devraient s'habituer à faire confiance sur les professionnels sur terrain.

- Les organismes communautaires travaillent dans la première ligne, mais il manque de moyen et outil pertinent pour eux.

- L'effort sur le toit et les services ne sont pas équilibrés. Les services comprennent l'analyse des besoins régulière, l'aide familial/domicile, la gestion du logement, etc.

- « Vieillir chez soi » devient un thème de plus en plus important. Les personnes âgées aiment chez soi, mais il n'y a pas de services suffisants.

Question no 3 – Solutions

- Maintenir la balance entre le toit et les services.

- Réaliser le rôle important des organismes communautaires et leur fournir des outils pertinents.

- Améliorer la gestion des projets : la continuité ou le changement.

- Bagage à partager. Ex : habitation intergénérationnelle.

Table E - English

Question no 1 – Réactions face à l'exposition

- People are struck by the complexity of interactions within this population. So many of them have experiences of trauma, family separation, war (especially World War II), over many years - these things seem to be universal and take a toll on people across cultures.

- The exposition was captivating - all the stories were so different and they captured my attention. It made me think of an Afghan woman I met through my organization. She has been in Canada for 17 years and she doesn't speak English or French, always needs an interpreter. It took her 10 years to find her place. She is a beautiful artist, and now she teaches art. She still doesn't speak English or French, but she shows the art and people understand. But one day in our Music program, someone played a song in her language for her. She cried so much, and we couldn't understand but we comforted her. During the exhibition, I saw her in front of me.

- Older immigrants find common ground only after many years of persistence. They have to find their niche to feel security.

- The exhibition can be helpful for future immigrants, for them to know that it takes time to find their way.

- Finding religion and people from their community comes first, and then the community expands from there.

- The Jewish community founded the community sector here. They didn't close the door to other immigrant groups, they shared what they had and allowed other groups to learn from them. In the Ethiopian community, many came as youth, and we learned from the experience of older immigrants who shared their experiences of making community spaces. Much of the community sector today exists because of the work done by the Jewish community. It is important to seek out mutual aid.

- Many of our clients are of very old ages, 97, 93 years old. They struggle to work or provide for themselves. Housing becomes an issue when they go back to their country for the winter or to visit - often they have problems finding a subletter, or there is a problem with the subletter. They can't just move around every year. One of my clients doesn't have a lease, she lives with a friend in the living room. She gets services from CLSC home care, but she lives in a living room. I went to visit her and I wondered, how is it possible for her to establish a daily routine when she lives like this? This is the reality of housing for older immigrants.

- For sponsored immigrants, the stipend is only 30$ a week. Normally it's more than 100$ a week.

Question no 2 – Constats et solutions

- The government should allow access to low-income housing more rapidly. When immigrants come, no one tells them the full story of what it's like here, they think that everything is great. And then reality hits them. Sometimes a couple will sponsor their parents and then the couple divorces, the parents feel responsible.

- It's hard that these things are not within our control - the new government promises more affordable housing, but that won't happen.

- Sponsors take on the liability, but there should be an interim period -- sponsorship shouldn't cause suffering, the government should respect human dignity.

- Housing is the way to make people feel secure and able to move forward with dignity! We need to get out of the vicious cycle where we always repeat the same problems - every government does this. We could be spending money better, more wisely. Community organizations do the work but are not recognized. There is no perfect answer, as the problems change over the years. At one time, housing programs were welcomed and financed, and they were working - but as soon as they start to work, the services get cut, the government has new priorities.

- This is the problem in community organizations - they are underfinanced, so they can't be creative. They spend their time applying for money and less than half their time is spent providing services.

- The CLSC is one of our main partners. But how does it help with diversity? We just do referrals, back and forth. In our organization we see issues with people self-segregating, as well as issues related to cultural diversity. How can we move forward with a housing project - it's still not totally clear. Aging in dignity is not as easy when people self-segregate.

- A roof gives dignity and independence, leads to integration and minimizes isolation. We have to connect with the CLSC, it gives us power and voice.

- We have to elevate our partnership with the CLSC. When we meet with them, everybody is satisfied with where they are and what they're doing, they're afraid to change. The CLSC is a public body, there are more restrictions on workers and more rules than in the community sector. Community organizations are supposed to be more creative, but they are always fighting for funding and that doesn't allow them to be creative. The problems and needs are diverse, there is no one single solution. We tried to start an intergenerational housing project in Saint Laurent, but we had trouble convincing the municipality on the concept. Seniors need a feeling of safety in their homes - they are vulnerable. In nonprofit housing, they feel supported and the risk is minimized.

- A budget from the government comes with a mandate and deliverables. We can't do anything but fulfill the mandate, otherwise there is a risk of losing funding. So then we are able to serve less clients, and then the budget gets cut.

- We need a collective of community organizations. There is a lack of social engagement amongst community organizations. We are always competing for funding, and this makes us weak - we have no solidarity. Why do we turn in circles around the same problems for 25 years? Why can't we find solutions? The competition for funding makes us weak: we play the same game that serves the system. We are cheap and expendable labour. There will always be someone who doesn't contest the policies, who will take the funding that is offered to them. Our level of social commitment and solidarity is lacking.

Table F

Question no 1 – Réactions face à l'exposition

- C'était une excellente exposition qui nous fait connaître les réalités de certains immigrants ainés. Le récit de Julio du Nicaragua qui se dévoue au bénévolat m'a marqué – mais il y a plusieurs autres récits [que nous n'avons pas eu le temps de lire]. Il serait bien de recevoir tous ces récits afin de pouvoir les lire tranquillement chez nous.

- Parmi les quelques histoires que j'ai eu le temps de lire, j'ai reconnu plusieurs difficultés et réalités par rapport à l'immigrant. Par exemple, un des récits de Vancouver, où la notion de subvention est reliée au handicap, c'est marquant. Mais sinon, la notion de résilience, on voit ça beaucoup à notre organisme. On veut monter un projet comme ça de *storytelling* pour mettre en valeur ces histoires que nous voyons aussi.

Question no 2 – Constats

- Quand les gens font une application pour avoir accès à un logement HLM, il y a un règlement d'attribution [décidé par] le gouvernement du Québec. Les personnes sur la liste d'attente sont anonymes et on ne fonctionne que par pointage. Les logements sont attribués selon la position sur la liste d'attente, et [cette position monte ou descend selon] ces pointages. Ça peut prendre jusqu'à 5 ans d'attente... présentement il y a 20 000 personnes ou familles sur la liste d'attente. Il n'y a pas de différence par rapport au statut migratoire [et ce n'est pas de l'information demandée par l'OMHM].

- Sur le terrain, les questions de handicap et de vieillesse, ça se rejoint. On n'est vraiment pas assez avancé à Montréal dans cette question. Que tu sois ainé [et en perte de mobilité] ou handicapé, ton problème est non seulement de trouver un logement, mais d'en trouver un qui correspond à tes besoins.

- On sait que normalement le revenu moyen est bon, mais dans le secteur locatif on sait aussi qu'il y a beaucoup d'immigrants. Parfois ils vivent dans des appartements surpeuplés. J'ai visité des sous-sols insalubres [où plusieurs gens vivaient ensemble]. Il y a beaucoup à faire dans ce domaine. Pour toute personne qui vient ici le logement et l'accès au logement c'est le problème numéro un. J'étais membre

d'un comité [époque non précisée] et nous avons fait pression à la Ville pour construire un édifice pour immigrants. La plupart [des nouveaux logements ou des logements abordables] sont de petits appartements qui ne conviennent pas aux besoins de familles immigrantes qui ont plusieurs enfants ou sont des foyers intergénérationnels.

- L'OMHM offre différentes grandeurs de logement. Les normes sont là pour accommoder les différentes compositions de ménages. Comme il y a une carence de 20000 unités, on n'a pas le luxe de donner de gros logements à qui en veut. On est conscients du déficit de logements adaptés – ça reste un problème de financement. Nos habitations les plus récente dates des années 1980. Aucun nouveau HLM n'a été construit en plus de 40 ans. Les montants qui nous viennent annuellement ne suffisent même pas à entretenir le parc. Par exemple, on aurait besoin de 150 million par année seulement à Montréal, mais on a eu environ 85 million cette année. À cause de restrictions budgétaires, on n'arrête pas de repousser ou changer nos priorités.

- [Tout le processus d'attribution de logement à prix modique] est anonyme, donc on ne détient pas de données sur la situation immigrante des gens. Je sais que la thématique de cette rencontre c'est le logement, mais le logement ne règle pas tout. J'ai remarqué que lors de la présentation de ce matin on a mis les logements sociaux et les CHSLDs dans la même catégorie de type de logement. Or, les HLMs ce ne sont pas des logements comme les CHSLDs. Nos appartements sont pareils à ceux du marché privé, soit qu'ils sont pour autonomes, et n'offrent aucun service. Notre préoccupation présente c'est la perte d'autonomie [qui est quasi impossible de déceler avec le système utilisé présentement]. Comme les gens sont tellement anonymes [dans le système], [et souvent] isolés, cela présente [de plus en plus de] difficultés liées à la gestion du logement. Par exemple, on a un problème de salubrité dû aux punaises de lit. [Régler une infestation de punaises ou de coquerelles est un processus à long terme qui requiert beaucoup de coopération et d'efforts de la part des locataires affectés, incluant bouger des meubles lourds, mettre tous les vêtements dans des sacs, etc]. Les gens isolés et en perte d'autonomie ne sont pas aptes à ces efforts de gestion nécessaires lorsqu'il y a une crise de salubrité – [nous avons des situations où] des gens sont incapable de préparer leur logement avant la venue des exterminateurs. L'Office essaie de s'en occuper et demande aussi l'aide d'organismes qui font l'entretien communautaire, par exemple. Aucun organisme ne veut ne veut s'impliquer, [particulièrement lorsqu'il s'agit de punaises de lit].

Question no 3 – Solutions

- Un des enjeux [dans le secteur locatif public] – pas nécessairement seulement le lot des personnes immigrantes – c'est le vivre ensemble. Même entre québécois dits 'de souche' c'est dur vivre entre voisins. Les gens auront été autonomes des années, et se retrouvent dans un bâtiment à vivre une certaine promiscuité, à devoir partager des espaces communs, et ça crée des frictions. Pendant plusieurs années on avait une subvention pour un programme qui faisait de l'intervention en lien avec le multiculturalisme à l'intérieur des habitations, le Programme Habiter la Mixité. Ça aidait beaucoup, mais nous avons dû ferme le programme faute de financement.

- Dans ma communauté il y a aussi un problème au niveau de la langue, car avec l'âge la connaissance du français se détériore. On pense sérieusement ouvrir une résidence hispanophone pour que les ainés se sentent plus à l'aise. Il n'y pas beaucoup de personnes d'affaires, d'individus dans la communauté, qui peuvent financer un projet semblable aux projets de résidences chinoises ou italiennes ou portugaises etc. C'est malheureux car je crois qu'il devrait y avoir de la mixité, mais c'est difficile.

Plénière – Discussion en grand groupe

- Besoin d'adapter le milieu d'éducation au vieillissement. Les établissements de santé ne tiennent pas compte de ces facteurs dans leurs formations. La formation des préposés qui servent cette population n'est pas faite de manière réfléchie. Recommandations : améliorer la formation des travailleurs sociaux et autres facultés en gérontologie, intégrer également une formation interculturelle qui reflète la diversité culturelle du pays.

- Il faut une personne pivot (travailleur social ou autre) dans les établissements pour les populations aînées qui peut faire un suivi des besoins d'une personne (faire des demandes de services auprès des CLSCs au besoin). Les familles souvent ne connaissent pas ces services.

- AQDR : nous menons des initiatives pour les aînés immigrants (développer un réseau de transport en commun à Montréal pour les 65 ans et plus, assurance-médicaments publique non-restreinte).

- Besoin d'améliorer le GIS pour les gens les plus pauvres (qui sont souvent des immigrants).

- Centre d'appui conseil immigrant : Projet Québec à Nous les Aînés (bénévoles non-rémunérés offrent des formations en français). Nous encourageons une société d'accueil afin de créer des liens d'amitié durable (organisation d'activités, soirée d'amitié interculturelle).

- Nécessite d'arrêter de sillonner les projets car les besoins sont les mêmes.

- Le manque de financement et la non-reconnaissance a mené à la démission des personnes pivots dans les établissements d'habitation.

- Le réseau communautaire est faible face au « système » en raison du manque de solidarité entre les organismes communautaires (même un manque d'engagement parmi les intervenants qui jouent le rôle de fonctionnaires). Le réseau communautaire doit savoir s'imposer.

- Besoin d'organismes/de personnes chercheurs car les besoins évoluent avec le temps. Le financement a été coupé sans raison valable.

Contact

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MERCI DE LA PART DE TOUTE L'ÉQUIPE !

Rapport
Montréal – 12 avril 2019

Tirer des leçons des expériences des personnes âgées immigrantes

Table-ronde des organismes montréalais desservant les personnes âgées immigrantes

Thème : La proche aidance

12 avril 2019

Document produit le 29 avril 2019 par Julien Simard et Shari Brotman.

Table des matières

Remerciements et partenaires

Merci d'abord à toutes les participant.e.s à cette table-ronde pour votre implication et votre intérêt pour ces enjeux importants.

- *L'équipe de recherche*

Shari Brotman (McGill School of Social Work) – chercheuse principale

Zelda Freitas (CRÉGÈS) - animation

Julien Simard (INRS-UCS) – coordination et animation

Pascual Delgado (ACCÉSSS) – collaborateur et animation

Denis Dubé (McGill School of Social Work) - animation

Chidinma Ihejirika (Ingram School of Nursing, McGill University) – prise de notes

Nina Meango (Université de Montréal, ACCÉSSS) – prise de notes

Kharoll-Ann Souffrant (McGill School of Social Work) - prise de notes

Ash Lowenthal (McGill School of Social Work) – prise de notes

- *Les partenaires*

Nous aimerions remercier chaleureusement Pascual Delgado (ACCÉSSS) pour ses précieux conseils et pour ses incalculables contributions à l'organisation de cet évènement.

ACCÉSSS
Alliance des Communautés Culturelles pour l'Égalité dans la Santé et les Services Sociaux

Centre de recherche et d'expertise en gérontologie sociale
Center for Research and Expertise in Social Gerontology

- *Bailleurs de fonds*

McGill | School of Social Work

Social Sciences and Humanities Research Council of Canada
Conseil de recherches en sciences humaines du Canada
Canada

Introduction

- Présentation du projet

Le projet *Tirer des leçons des expériences de personnes âgées immigrantes* porte sur les stratégies requises pour faire face à l'exclusion sociale des personnes âgées immigrantes. Il a pour objectif de réunir des intervenant.e.s du réseau public et communautaire qui desservent les personnes âgées immigrantes pour discuter de leurs réalités et de pistes de solutions face aux enjeux touchant cette clientèle.

Ce projet est la deuxième phase d'une étude sur les parcours de vie des personnes âgées immigrantes qui s'est déroulée entre 2014 et 2017 : *Les expériences de personnes âgées immigrantes. Une étude narrative - « photovoix »*. Cette étude incorpore l'approche narrative et la technique *photovoix* dans le but d'explorer comment le processus de l'immigration influence la vie des personnes âgées. Les résultats de cette étude sont présentés sous forme d'une exposition de photos, résumant les parcours de vie et les expériences de 19 personnes âgées immigrantes. Un des principaux buts du projet est de contribuer aux efforts permettant d'améliorer notre capacité - en tant que chercheur.e.s, praticien.n.e.s et militant.e.s - de travailler ensemble pour contrer les stéréotypes affectant personnes âgées immigrantes, qui sont malheureusement trop communs dans notre société. Il s'agit également d'adapter nos services pour mieux répondre aux besoins et aux réalités des diverses communautés.

- Équipe de travail

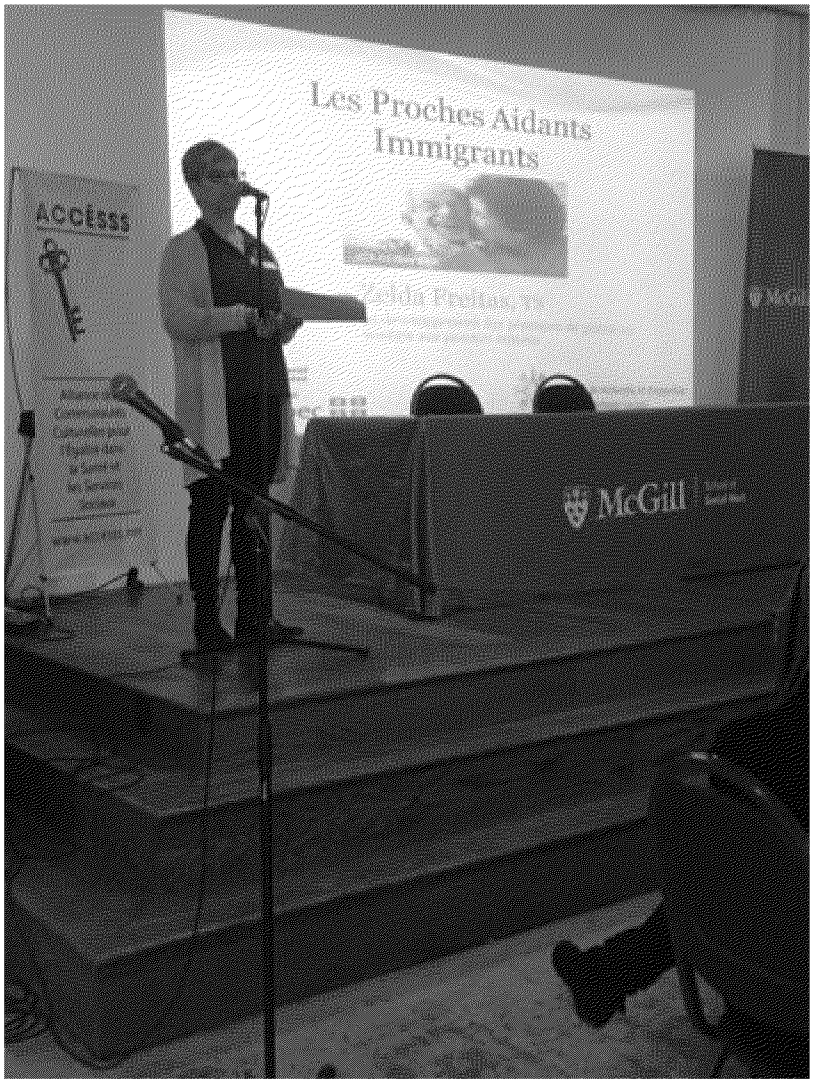
Notre équipe de recherche représente un partenariat entre l'université et la communauté, avec des comités consultatifs composé d'organismes communautaires ethnoculturels et d'immigrants, de prestataires de services et de décideurs politiques du Québec, Alberta et de la Colombie-Britannique. Nous avons travaillé au sein d'une diversité d'immigrants et de groupes ethnoculturels, et ce dans 7 langues différentes pour atteindre les personnes âgées immigrantes qui sont sous-représentées dans la prestation de services, dans les politiques et dans la recherche.

- Description du présent rapport

Ce rapport préliminaire présente un résumé des discussions de la première table ronde qui a eu lieu le **12 avril 2019, au 7000 avenue du Parc, à Montréal.** Cette table ronde avait comme thématique principale *la proche aidance* et a réuni plus de 62 participant.e.s. À chaque table, 10-12 participant.e.s appartenant à diverses organisations communautaires et institutionnelles ainsi qu'une personne chargée de l'animation ont échangé ensemble pendant près d'une heure. Les grandes lignes de leurs propos, notés minutieusement par des membres de notre équipe, furent par la suite rapportés en plénière. Veuillez noter que les opinions présentées dans ce rapport ne reflètent pas nécessairement celles de l'équipe de recherche ou de tous les participant.e.s présents, mais documentent plutôt la diversité des positions et des commentaires formulés lors de ces discussions.

- Prochaines étapes

Un rapport final sera produit à la fin des consultations pancanadiennes. Ce rapport résumera les thématiques et les discussions émanant de toutes les tables rondes qui auront lieu au cours des 18 prochains mois dans 5 différentes villes (Laval, Montréal, Québec, Calgary et Vancouver). Au total, à l'échelle du Canada, se tiendront 10 évènements sur divers thèmes. Parmi ceux-ci : l'isolement et l'inclusion sociale, la proche-aidance, le logement et les transports ainsi que la maltraitance.



Présentation de Laura Tellalian

Présentation Hay Doun

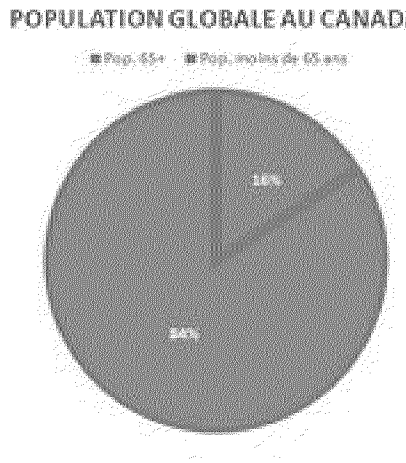
Présentée par Laura Tellalian,
Intervenante psychosociale

Hay Doun
Հայ Տուն

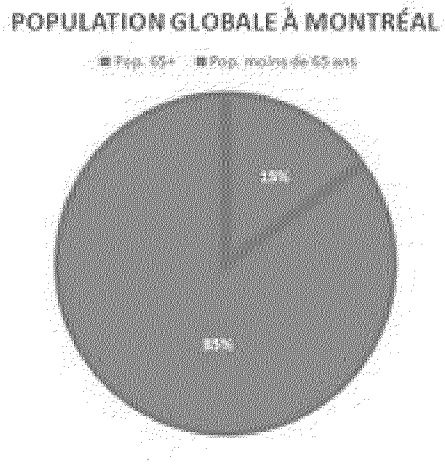
Présentation Hay Doun

Présentée par Laura Tellalian,
Intervenante psychosociale

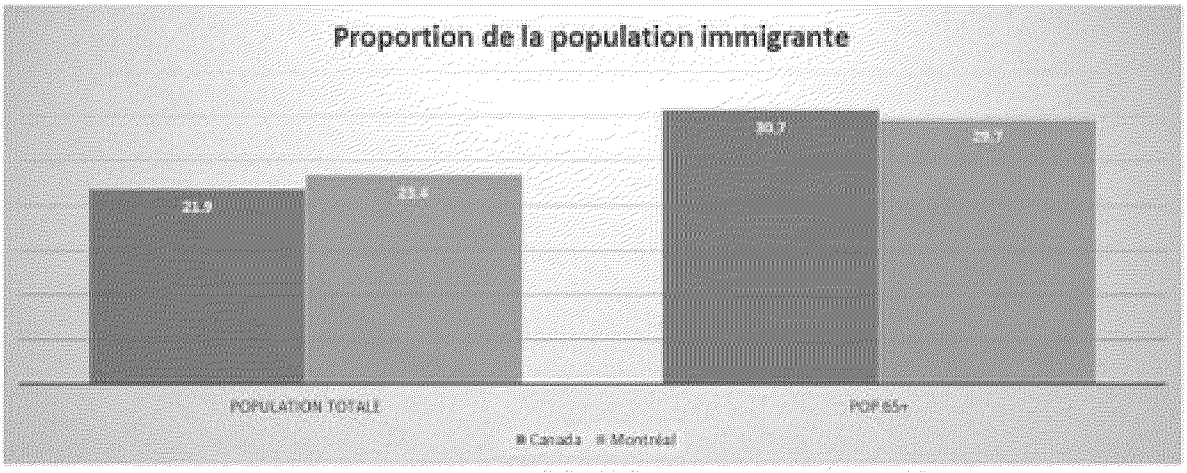
PDV Canada vs Montréal



Population canadienne : 34,460,065

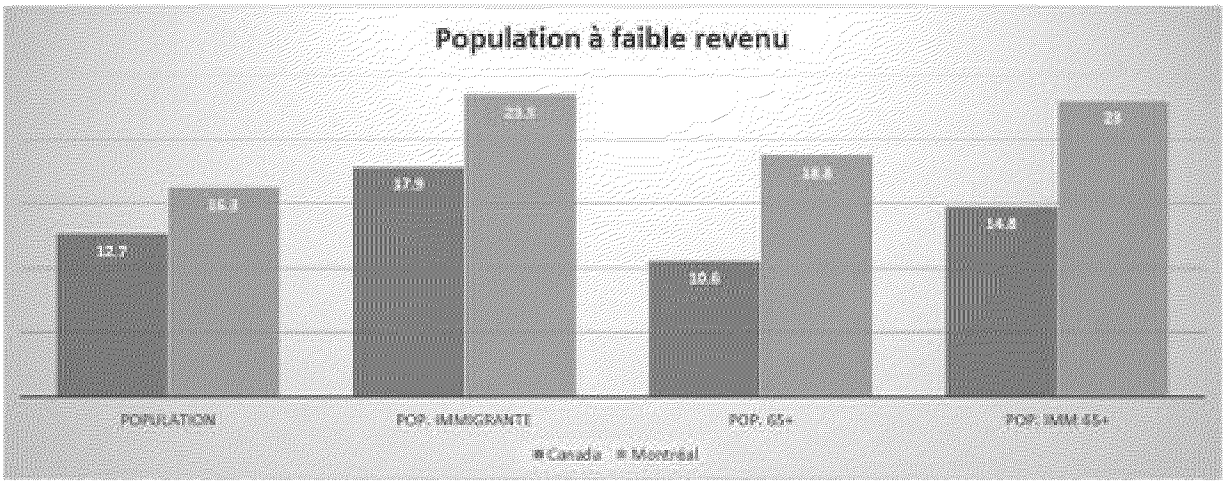


Population montréalaise : 4,009,790



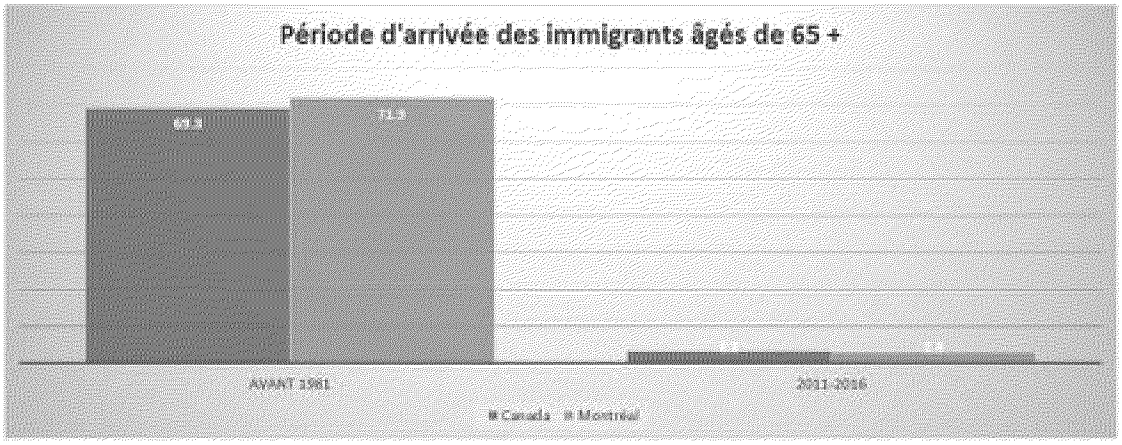
PDV Population immigrante

Les immigrants représentent une plus grande proportion dans la population des aînés que dans la population en général - Montréal équivaut au Canada à près d'un tiers.



PDV Population à faible revenue:

La proportion d'aînés immigrants vivant avec un faible revenu est plus élevée que celle des aînés en général, mais pas autant que celle des immigrants en général. À noter que Montréal compte une proportion plus élevée de personnes âgées à faible revenu que la population totale.



Periode d'arrivée des immigrants âgés de 65 ans +:

La majorité des aînés immigrants ont vieilli sur place - ils sont arrivés avant 1981. Très peu sont arrivés récemment (au cours des cinq dernières années). Peut indiquer des obstacles à la réunification familiale et à la permanence.

- Organisme communautaire à but non-lucratif charitable
- Mis sur pied le 1er avril 2007
- Offre des outils efficaces d'intégration et de soutien à une population montréalaise vulnérable issue de diverses communautés culturelles
- Projet parrainage (10 ans) — Entente avec le MIDI pour faire du parrainage privé (depuis 2009, 1500 réfugiés)
- Gestionnaire d'une résidence pour personnes agées à Laval
- Projet PIF : proches aidants (depuis 2013) — Soutien psychosocial, groupes de soutien mensuels, conférences, cuisines interculturelles, répit accessoire
- Nouveau projets : Aînés et intimidation, PROGAM (ressouces d'accompagnements pour nouveaux arrivants – stress et anxiété qui peut amener à la violence conjugale)

Service de soutien à la famille

Les défis que peuvent rencontrer les proches aidants d'aînés des communautés culturelles ?

- Barrière de la langue
- Difficulté d'accepter l'aide extérieure (méfiance, lien de confiance)
- S'identifier avec le rôle
- Isolement (reseau social qui s'effrite)
- Vieillissement à domicile souvent comme seule option (craintes face à l'hébergement)
- Multipes deuils – transitions et proches aidants (parcours migratoire, leur culture, leurs valeurs, leurs croyances ainsi que leurs pratiques)
- D'avoir des services dans leur langue d'origine (ex. service de répit aux aînés dans leur langue)
- Rôle supplémentaire pour le proche aidant qui agit à titre d'interprète entre les professionnels et son proche
- Plusieurs intervenants qui répondent à différents besoin : 1 personne-ressource
- Méconnaissance du système de santé et des ressources associés à la maladie
- Mesures d'aide financières insuffisantes pour les proches aidants

Les défis de l'organisme

- Attentes des proches aidants envers l'organisme
- Durée de l'intervention : rencontre multi (interprétariat, intervention)
- Rôle de l'intervenante si nécessaire : démarches pour ouvrir un dossier au CLSC, les accompagner à différents niveaux
- Complexité des besoins au niveau de l'adaptation (surtout des familles arrivées dans les dernières années)
- Haute demande de soins à domicile assuré par une personne qui parle la langue de l'aîné (ex : préposé qui parle leur langue)

Enjeux structurels

- Financement
- Augmentation des demandes vs ressources humaines
- Autres besoins de la communauté non comblés (bénévoles, acc. aînés, centre de jour adapté dans leur langue)
- Méconnaissance de la proche aidance et des services associés
- Impact de mesures d'austérité au niveau de l'aide à domicile

Nos stratégies gagnantes

- ✓ Formations continu des intervenantes; Intervention centré sur la personne; Deuils.

Autres recommendations?
(à suivre…)

Présentation de Zelda Freitas

Les Proches Aidants Immigrants

Zelda Freitas, TS

Coordonnatrice du développement des pratiques de pointe en soutien aux proches aidants

Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'île-de-Montréal
Québec

Centre de recherche et d'expertise en gérontologie sociale

Contexte sociopolitique

- L'accent est mis sur le maintien des personnes en perte d'autonomie dans la « communauté » plutôt qu'en établissement.
- Les décisions politiques se concentrent sur la famille et amis comme agent primaire dans la nouvelle ère de soins communautaires (les proches aidants fournissent 80% des soins dispensés à la maison).
- Le domicile est idéalisé comme « lieu » normal et naturel des soins.
- Cela met beaucoup de pression sur les épaules des aidants.

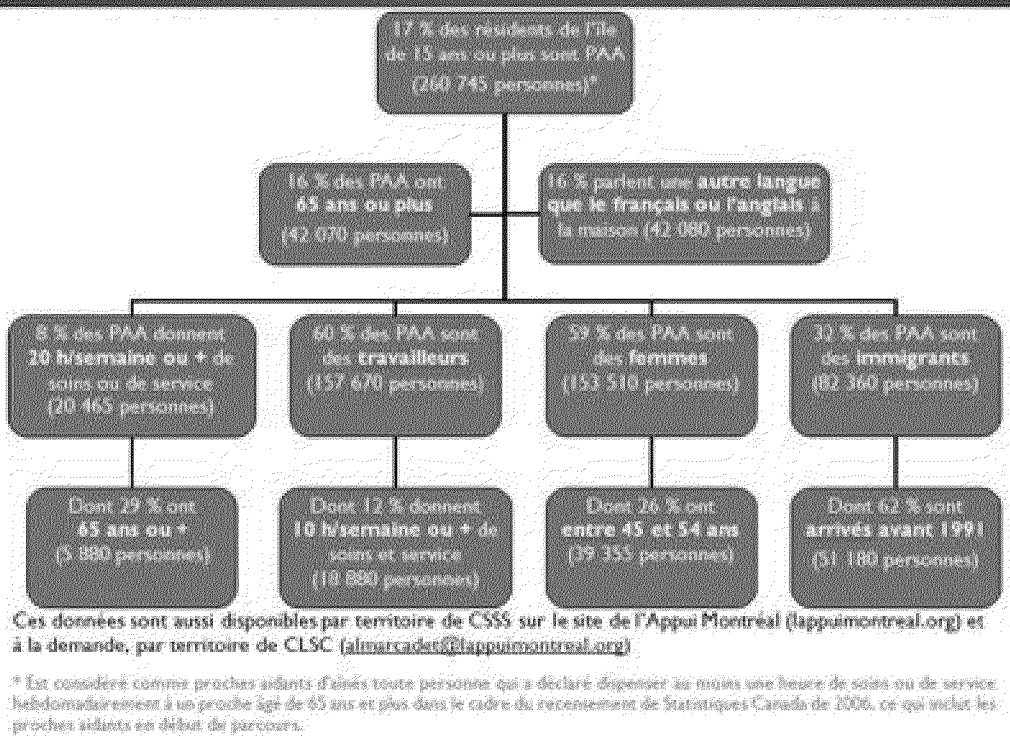
DONC…

- Toutes les personnes âgées n'ont pas besoin d'aide…

… mais une proportion importante d'entre elles vont en avoir besoin

- Et… les familles et les amis sont la première source d'aide aux personnes âgées

Faits saillants à propos des proches aidants d'aînés de l'île de Montréal



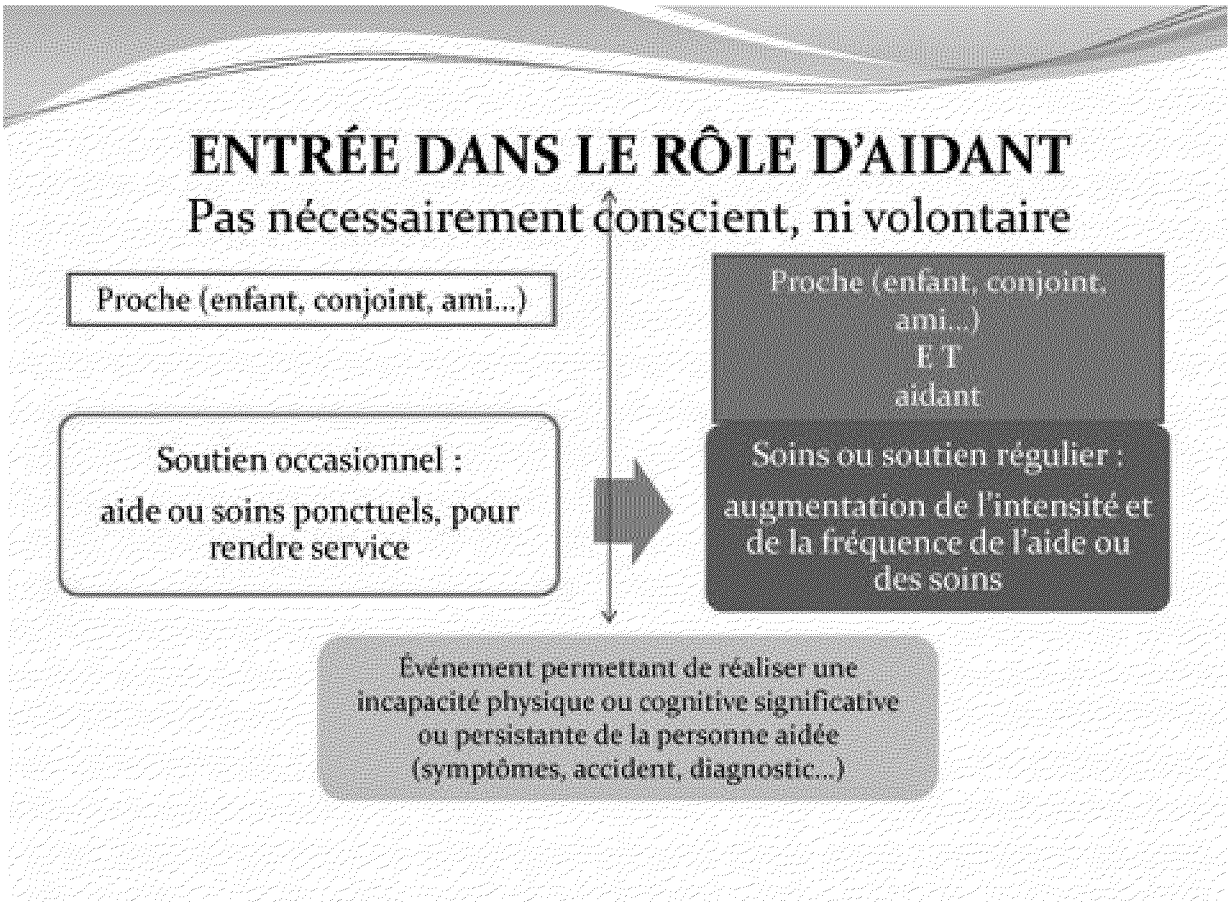
Ces données sont aussi disponibles par territoire de CSSS sur le site de l'Appui Montréal (lappuimontreal.org) et à la demande, par territoire de CLSC (almarcadet@lappuimontreal.org)

* Est considéré comme proches aidants d'aînés toute personne qui a déclaré dispenser au moins une heure de soins ou de service hebdomadairement à un proche âgé de 65 ans et plus dans le cadre du recensement de Statistiques Canada de 2006, ce qui inclut les proches aidants en début de parcours.

- **Immigrants :** les personnes nées à l'extérieur du pays.
- **2 aînés sur 5 sont nés à l'extérieur du pays**
- La part d'immigrants aînés sur les territoires de CLSC de l'île varie considérablement

La principale langue immigrante parlée, Montréal, 2016

Arabe	191 960
Espagnol	145 650
Italien	88 915
Créole	78 905
Mandarin	44 095



Les aidants et les services

- Souvent les aidants ne se reconnaissent pas dans le terme "proche aidant"
- Souvent les aidants sont hésitants à accepter des services

Que font les aidants?

- Aide pratique (médicaments, injections, bains)
- Mobilisation et coordination des services et autres ressources
- Soutien émotionnel (appels, visites)
- Tâches ménagères (repas, lessive, courses)
- Accompagnement aux rendez-vous
- Défense des droits dans le système de santé
- Soins palliatifs

Enjeux = inégalités

- Les **barrières culturelles et linguistiques** sont parmi les obstacles les plus importants auxquels font face les aînés et les proches aidants immigrants lorsqu'ils tentent d'accéder aux services de santé et aux services sociaux et d'y avoir recours.
- C'est pourquoi de nombreuses personnes âgées dépendent entièrement des membres de leur famille et de bénévoles pour les aider à naviguer dans le système de santé afin de répondre à leurs besoins de base en matière de santé.
- Par conséquent, les personnes âgées d'origines ethnoculturelles diverses et les personnes âgées issues de l'immigration ou de groupes racialisés courent un plus **grand risque de souffrir de problèmes de santé** et d'obstacles à l'accès aux soins de santé.

(traduction libre)

Plus grande réticence à recourir aux services publics ou privés

Les personnes âgées de cultures diverses ont déclaré des taux beaucoup plus faibles d'utilisation des services publics de soins à domicile que les immigrants plus établis et ceux des pays européens, respectivement.

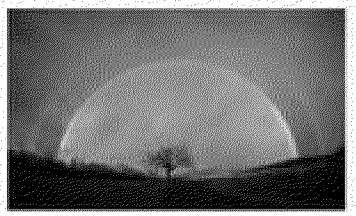
La moitié des personnes ayant une incapacité déclarent avoir besoin d'aide pour effectuer leurs activités de la vie quotidienne ou domestique. Environ la moitié de celles-ci ne reçoivent pas l'aide souhaitée.

Risque d'isolement social pour les nouveaux immigrants et les réfugiés âgés

Différences culturelles Difficultés de langage Degré élevé d'attachement à la culture/langue d'origine Activités religieuses et culturelles limitées Racisme Discrimination Les relations de parrainage et leurs attentes le manque de services d'établissement	Diminution du revenu ou de la statut socioéconomique Perte du statut social Petite taille des communautés de la même ethnie Manque de connaissance de la culture et des normes du nouveau pays Manque de connaissances chez les intervenants, les organismes communautaires, les amis et la famille au sujet de l'impact des parcours d'immigration et de l'admissibilité des aînés aux services.

EN CONCLUSION

- Les proches aidants forment la structure portante du réseau de la système de santé en assumant 80% de soins.
- Il n'y a pas de reconnaissance officielle du statut d'aidant.
- Les proches aidants aimeraient être considerés comme des vraies partenaires, pas seulement comme les dispenseurs des soins.
- Les enjeux des PA immigrants a besoin de plus d'attention et d'advocacy et de partenariat.



Points de discussion

- Pourquoi pensez-vous qu'e les aidants immigrants peuvent être hésitants à accepter des services?
- Quelles mesures peut-on prendre pour briser l'isolement social des aidants naturels immigrants?
- Quels sont les défis et les solutions que vous envisagez pour offrir des services aux aînés ?
- Quelles pistes d'action mettre en place pour remédier à ces défis et/ou améliorer les services à ces populations ?

References

Diversity, Aging, and Intersectionality in Ontario Home Care | Think Piece © Wellesley Institute 2017

https://www.quebec.ca/sante/systeme-et-services-de-sante/organisation-des-services/systeme-quebecois-de-sante-et-de-services-sociaux/

COUP D'OEIL SUR LES STATISTIQUES | FÉVRIER 2017
www.institutvanier.ca

Je vous remercie de votre attention.

Notes des discussions

Table A

Question no 1 – Réactions à l'exposition

- Impact négatif de la discrimination à l'embauche et de la non-reconnaissance des diplômes obtenus à l'étranger.
- Barrières linguistiques apparaissent comme un problème majeur dans la prestation des services, méconnaissance du système de santé québécois, rend difficile les interventions des intervenants de la santé et des services sociaux, ça amène à agir sur des cas dans l'urgence (par ex. : placer quelqu'un d'urgence, car la personne aurait attendu trop longtemps avant de demander de l'aide). Crainte du placement comme une barrière à demander de l'aide dite « formelle » de la part du réseau de la santé et des services sociaux, peur de ce qui va arriver si on parle et qu'on ose demander de l'aide.
- Le système prend du temps à s'adapter à d'autres réalités : il faut de la communication, de la patience pour briser la méfiance. Y aller étapes par étapes.
- Proches aidants souvent exclus des interventions en matière de santé et des services sociaux (oubliés des services).
- Éviter l'assimilation, importance d'avoir de la nourriture adaptée à diverses réalités culturelles.

- Les statistiques qui démontrent que la majorité des immigrants ne sont pas des immigrants récents. La majorité sont installés depuis longtemps. Les enjeux seraient donc + pour l'immigration récente ?
- Difficulté pour les personnes issues des communautés culturelles de se définir comme proches aidants, ce rôle étant vu comme naturel et allant de soi (aider les proches). Le terme proche aidant n'est pas reconnu par ces personnes, ne comprennent pas ce que ce terme veut dire, ne fait pas sens pour eux.
- Méconnaissance par les intervenants du parcours migratoire des individus.
- Appréhension + forte chez les communautés culturelles car la santé et les soins de santé sont compris et perçus différents dans le pays d'origine. Par ex. : prévention absente des soins de santé dans certains pays d'Afrique et les gens vont chez le médecin seulement quand ils n'arrivent pas à fonctionner. Cette idée de faire des « check-up » de routine chez le médecin par prévention, c'est très québécois.

- Le système de santé change beaucoup (réforme à toutes les x années), on s'intéresse au système de santé uniquement lorsqu'on doit entrer en contact avec lui en raison de problèmes de santé.
- Crainte du jugement des intervenants : par ex. nutrionniste qui peut juger de la qualité nutritive de certains aliments typiques de certaines communautés culturelles.
- Avoir un réseau dans le pays d'accueil et être impliqué socialement permet de mieux comprendre les rouages du système de santé et de services sociaux.
- Le manque de temps qui fait en sorte que les professionnels ne peuvent « traduire culturellement » comment le système fonctionne, expliquer les nuances, le rôle de chacun, etc. Cela mène à de l'isolement, le fait de ne pas savoir à quelle porte cogner pour de l'aide (besoin d'accompagnement).
- Avoir des infirmières et autres professionnels de la santé qui parlent la langue du patient pour éviter les malentendus et les incompréhensions de part et d'autre.

Question no 2 – Solutions

- Dialogue de part et d'autre.
- Formation interculturelle des infirmières, actuellement c'est très localisé, n'est pas appliqué partout de manière universelle, systématique et automatique dans tous les CIUSSS à travers le Québec.
- S'inspirer des pratiques innovantes de d'autres pays (par ex. : Angleterre).
- Avoir une approche + sensible, intégrer l'aspect interculturel de manière transversale.
- Utiliser des visuels (pictogrammes) afin d'établir un profil du patient, qui détaille ses goûts, ce qu'il aime, ses passions (avoir une histoire de vie du patient, ce qui rend le dialogue et les interventions + faciles et adaptées, moins de risques de malentendus).
- Prendre exemple sur la clinique Hay Doun, créée et enracinée dans la communauté. Avoir d'autres organismes qui ont une approche similaire en matière de proche aidance.

- Avoir une approche flexible (aller à domicile) et avoir aussi un horaire flexible pour accommoder les proches aidants.
- Créer des liens/ponts entre le milieu communautaire et le réseau de la santé et des services sociaux.
- Il faudrait investir + dans les soins à domicile (gouvernement) mais cela représente une somme considérable, est-ce que collectivement nous sommes prêts à payer + d'impôt pour financer cela ?
- Pallier le manque de ressources humaines.
- Collaborer avec l'offre de services déjà en place.
- Crédit d'impôt pour proche aidants sont méconnus, les faire connaître davantage, notamment avec l'aide des intervenants des CLSC.
- Prendre en compte l'enjeu de la maltraitance du proche aidant envers l'ainé, mais aussi de l'ainé en perte d'autonomie envers son aidant.
- Organiser des conférences/discussion pour être au courant des services communautaires. Aller directement vers les gens, ne pas attendre qu'ils viennent à nous (par ex. : être présent dans la salle communautaire dans un milieu de vie) pour être capable de les rejoindre.

Table B

Question no 1 – Réactions à l'exposition

- Préoccupation : les barrières linguistiques auxquelles font face les personnes ainées sont-elles présentes parce qu'elles ont oublié la deuxième langue qu'elles ont apprise ou parce qu'elles sont arrivées sur la terre d'accueil étant déjà âgées et qu'elles n'ont pas pu apprendre les langues officielles du Québec ?
- Les ainés rencontrent beaucoup de difficultés, car lorsque leur âge est avancé, ils ont de la difficulté à apprendre une nouvelle langue.
- Parfois ces personnes ont été parrainées par d'autres membres de la famille dans le cadre d'un regroupement familial et ne peuvent pas apprendre de nouvelles langues.
- Il n'existe pas programmes pour eux pour leur faire apprendre une langue.
- Beaucoup de croyances fortes : la femme doit rester à la maison, les personnes âgées doivent s'occuper des petits enfants.

- Les proches aidants ou les personnes aînées n'ont peu ou pas de revenus et manquent d'activités.
- Notion de rester fidèle aux personnes qui nous ont parrainé qui nous ont offert la chance d'immigrer au Canada => impossibilité de dénoncer la maltraitance, sentiment de gêne et d'ingratitude face à la personne qui t'a parrainée. Exemple : Difficile de dire pour un aîné '' ma fille ne me donne pas d'argent''.
- Certains proches aidants ont arrêté de travailler par obligation car ils doivent prendre soin des aînés.
- Phénomène culturel courant dans plusieurs cultures : notion ''d'enfant sacrifié'', celui qui va tout arrêter pour s'occuper de ses parents, il y en a toujours un qui arrête et prend soin des parents, les autres enfants passent de temps en temps mais tout repose sur cette personne. Ceci est en rapport aussi avec la structure familiale, parfois l'aîné ou le plus jeune qui se sacrifie.

- Barrières culturelles et linguistiques ont un impact sur l'isolement.
- Expérience personnelle d'une participante qui a immigré suite à la guerre et au contexte politique dans son pays d'origine qui s'est retrouvé être proche-aidante et a vécu beaucoup de difficultés.
- Barrières linguistiques : dans les établissements c'était difficile de trouver quelqu'un qui parlait la même langue.
- Difficulté pour les personnes des établissements d'accepter la religion des personnes immigrantes, parfois mise de côté pourtant cela fait parte de leurs croyances.
- Choc culturel, post-traumatique qui s'ajoute à la prise en charge de toutes les personnes dont on est responsable.

Constats :

- Pas de subventions de la part du gouvernement pour les proches aidants depuis plus de 10 ans.
- Décalage entre les normes provinciales et fédérales : Les personnes parrainées ne perçoivent souvent pas d'aide financière.
- Notion de génération ''sandwich'' : des personnes qui doivent s'occuper en même temps de leurs parents et de leurs enfants : tenir compte de ce type de personnes.

- Certains services sont coupés pour les proches aidants / surcharge de travail / ils sont souvent délaissés.
- Beaucoup de proches aidants sont eux-mêmes des aînés : Parfois les aînés sont justes là pour aider à s'occuper du petit enfant et ce sont des proches aidants au quotidien mais il ne parle pas la langue donc isolement est plus marqué à leur niveau.

- Épuisement à tous les niveaux : psychologique, mental, physique.
- Les proches aidants ne se reconnaissent pas eux-mêmes proches-aidants pour certains c'est vraiment normal de le faire et ne se considère pas comme proche-aidant. En effet cette personne s'identifie plus comme : père, mère, fils ou fille, etc. Il faut quelqu'un qui vient souvent de l'extérieur pour lui faire comprendre son rôle. Pourtant il s'agit d'une personne ayant des besoins bien spécifiques auxquels il faudrait répondre.
- Sentiment de méfiance, difficulté de créer des liens de confiance : ce n'est parfois pas la même personne qui nous avait aidé la dernière fois qui sera encore présente la fois d'après.
- Double discrimination pour les personnes immigrantes.
- Manque de ressources financières.
- Les ressources disponibles sont non seulement minimes mais très peu utilisées.
- Manque de ressources humaines ''formées'' sur la question de la diversité ethnoculturelle et des besoins des proches –aidants et des personnes ainées : la difficulté se trouve au niveau du roulement constant du personnel et du changement dans les différents établissements même au niveau gouvernemental chaque 4 ans il y a un nouveau gouvernement : c'est un éternel recommencement. Cela prend du temps pour se réadapter et connaitre qui fait qui ? Qui est responsable de quoi ? Difficulté de naviguer dans le système.

- Manque de connaissances des ressources existantes pour les proches-aidants et les services dont ils doivent bénéficier.
- Désengagement de l'état quant aux besoins des proches aidants et des personnes aînés, et souvent les ressources ne sont attribuées qu'à une minorité.
- Manque de connaissance du système complexe québécois par les communautés/ les ainés/ les proches aidants en plus des différentes barrières linguistiques, culturelles, les préjugés, etc.
- Peu de connaissances de la part des professionnels établissements de santé et un manque d'ouverture de leur part : leur rôle devrait être de faire comprendre aux proches aidants qu'ils sont des partenaires de soins.
- Les professionnels dans les établissements de santé n'assument souvent pas leur rôle : les professionnels renvoient souvent les personnes issues des communautés ethnoculturelles vers les organismes communautaires.
- Méconnaissance des droits des personnes ainées/ des proches-aidants même par les organismes communautaires qui sont en première ligne de services.
- Immigrants quasi absents dans les services publics québécois (très peu représentés).
- Organismes communautaires essaient de répondre aux besoins mais font face à beaucoup d'obstacles.
- Manque de reconnaissances des proches-aidants comme des partenaires de soins.
- Difficultés d'uniformité dans les réformes d'un établissement de santé à un autre : problème de cohérence du système.

- Cloisonnement des proches aidants dans des catégories / manque d'uniformité alors que leurs besoins sont pratiquement semblables : besoin de répit, etc. Exemple : Proches-aidants de personnes âgées ou Proches-aidants des personnes handicapées.

Question no 2 – Solutions

- Informer et diffuser
- Quoi ? Trouver de l'information claire juste et adéquate sur les ressources disponibles pour répondre aux besoins des proches aidants mais également leurs droits.
- Comment ? Outils multilingues : Favoriser la création et la diffusion des informations multilingues nécessaires pour une bonne prise en charge des personnes aînés, des proches-aidantes issues de l'immigration.
- Qui? Les intervenants, la communauté, les organismes communautaires, les décideurs politiques, les proches-aidants, la société québécoise.

- Droits des personnes
- Faire valoir les droits des personnes immigrantes, des proches-aidants, des personnes ainées issues de l'immigration qui vivent un double fardeau.
- Professionnels de la santé doivent assumer leur rôle et faire valoir les droits des personnes proches-aidantes.
- Foncer en tant qu'organisme communautaire et accompagner la personne au sein des établissements pour faire comprendre qu'ils ont des droits et que les professionnels se doivent d'assurer leur rôle.
- Représentation des immigrants dans les différents services publics québécois.
- Ouverture d'esprit de la part de la société québécoise.

- Formation.
- Outiller les organismes sur les différentes ressources et programmes que doivent bénéficier les proches-aidants et les personnes ainées.
- Faire une mise à jour constante de toutes les informations disponibles et des besoins.
- Donner des cours de langue officielle du Québec à ''moindre coût'', voire gratuitement.
- Personnes ainées et proches – aidantes comme partenaires de soins et experts de leur situation.
- Garder les ainés actifs pour retarder les besoins des proches aidants.
- Mettre des services accessibles à proximité pour briser l'isolement des personnes ainées et des proches aidants (pour éviter les longs déplacements/ de dépenser de l'argent).
- Trouver du soutien financier pour mettre en place les outils nécessaires.
- Services adaptés aux besoins des proches aidants.
- Évaluation des pratiques : faire une évaluation de nos approches : voir les impacts et les effets.

Table C

Question no 1 – Réactions à l'exposition

- Les participants ont aimé que c'est là une forme de recherche qui donne la voix de manière accessible aux ainés, et les impliquent dans la recherche.
- Ils ont été touchés par le deuil de laisser leur culture et leur pays d'origine.
- Ils ont remarqué que les ainés de l'exposition sont des gens qui veulent faire du bien, qui veulent aider leur communauté.

- Différences de la culture québécoise ou montréalaise aux cultures des pays d'origine :
    - Rythme de vie très différent ici.
    - La culture nord-américaine est plus individualiste, il y a moins d'entraide ici, ce qui surcharge les proches-aidants.
    - Ici, les ainés ne sont pas aussi valorisés, subissent une perte de leur statut dans la famille, ont une position inférieure, en dépendance sur leurs enfants résultant dans une perte de dignité.
    - Dans plusieurs pays d'origine des immigrants ainés et de leurs proches-aidants, il y a tout un village qui s'occupe de toi, aider ses proches est valorisé, le concept de la famille est très large, et il y a un sens de devoir « naturel ».
    - Il y a une grande différence entre l'expérience d'être soigné par nos proches que par un service public formel.

- Stress sur la relation entre parent ainé et leur enfants proche-aidants
    - Les enfants travaillent beaucoup, ont leurs propres enfants à soigner.
    - Les enfants souvent ont des sentiments de culpabilité de ne pas pouvoir aider plus.
    - Les parents se sentent coupables de déranger leurs enfants chaque fois qu'ils ont un rendez-vous.
    - Les enfants veulent protéger les parents, ont peur que les intervenant ne vont pas comprendre leur culture, les enfants vont cacher la personne âgée parce qu'ils ont peur qu'elle soit placée.
- Résistance au départ en institution
    - Certains ainés (de l'Afrique de l'ouest) préfèrent retourner à leur pays d'origine que de rester ici dans une institution.
    - Pour d'autres ainés, cette porte est fermée parce qu'elles n'ont plus rien dans leurs pays d'origine.
- Les proche-aidants doivent coordonner tous les soins et services, et naviguer le système, ce qui est très difficile, spécialement quand on maîtrise moins la langue.
    - Conciliation de toutes leurs responsabilités : enfants, parents, travail.
- Racisme, ethnocentrisme et manque de compétences culturelles dans le système public formel.
    - On ne devrait pas se poser la question du pourquoi les ainés ne viennent pas rechercher les services. Qu'est-ce qu'on fait plutôt pour les rejoindre?
    - Quand on offre des services qui ne respectent pas leurs croyances culturelles et religieuses, on leur demande de se défaire de leur identité.

Question no 2 – Solutions

- Offrir des soins qui respectent leurs conceptions ethnoculturelles des maladies; adapter nos pratiques d'intervention; écouter quelles sont les croyances culturelles, de travailler avec ce qu'elle dit qui est important.
- Inviter d'autres membres de leurs familles dans les rencontres s'ils le demandent.
- Implique l'ainé et ne pas imposer notre façon de voir les choses.
- Financement pour des interprètes dans les organismes.
- Manifester contre le racisme – comme le projet de loi 21.

Table D (English)

- Discussion centered on three main themes:

- "Brewing pot" of intersecting burdens and disadvantage for immigrant family caregivers accruing from:
- Linguistic limitations and differences in culture ("values") lead to family caregivers serving both as translators/interpreters and cultural go-betweens
- Ageism.
- Prejudice and discrimination.
- Simultaneous balancing of employment demands.
- Gender.
- Filial obligations in various cultural groups that may be a burden.

- Loss of social supports and community ("village") after immigration.
- Overworked, burdened health and social systems.
- Astronomical financial cost of family caregiving.
- Definition of family caregiver (proche aidant) inconsistent with how family caregivers may see themselves ("stigma", "It is the family that is caring, not just one caregiver").
- This "brewing pot" shaped by history of immigration in two waves (pre- and post-1981), and associated changes in immigration policy, as well as restructuring of care predominantly into the home = political underpinnings.

- Multiple solutions brought forward, in view of complexity of burden:
- General solutions to address this "brewing pot" included: Need to better link immigrants to system supports and resources; rejection of "bandaid solutions" that fail to address "systemic changes"; dual focus on both "prevention and response"; and better preparing immigrants across the waves of immigration to know what to expect when they come to this life stage of aging and increased needs for family caregiving in the context of immigration (life-course approach).
- Specific solutions raised by the group were based in political action:

- Formation of specialized body for advocacy ("lawyers, psychologists, etc").
- Use of propaganda and news outlets.
- Changes to professional education curricula.

- Intergenerational life-course education beyond professional training.
- "Buddy system" during settlement.

- Dissemination of research results to government as part of advocacy.
- Representation from different sectors at roundtable discussions. E.g. politicians, journalists, newspaper outlets.
- Advocates to stand in for family caregivers who might be too busy.
- Acknowledgment and documentation of costs saved by family caregiving to the healthcare system concurrent with deficits resulting from lost hours of employment accruing from family caregiving = need for better "remuneration" in view of high financial cost of family caregiving.
- Collaboration with private sectors, mainly employers, in terms of better support for immigrant family caregivers.

Plénière – Discussion en grand groupe

- Différences culturelles du Québec versus Mtl.
- Rythme de vie ici qui est différent que dans d'autres cultures : individualisme.
- Dévalorisation des aînés ici, perte de statut, perte de dignité.
- Importance de créer un village autour des proches aidants.
- Responsabilité des services formels d'offrir un service adapté aux besoins des proches aidants et de leurs familles. Actuellement, il y a un désengagement de l'État.
- Représentativité des immigrants dans les services publics est important.

- Organisations communautaires sont la 1ière ligne des services, importance d'outiller et de former.
- Faire la promotion des droits des personnes proches aidantes.
- Activités à proximité pour briser l'isolement.
- Sensibiliser dès l'école primaire à la réalité des proches aidants, cependant faire attention au fait que les jeunes sont des jeunes et doivent vivre leur vie d'enfant et non uniquement prendre soin de leurs aînés. (risques de décrochage scolaire, perte d'opportunité). Actuellement aucun service pour les jeunes proches aidants excepté quelques services à Montréal en santé mentale.
- Adresser la déconnection entre les valeurs dites canadiennes et les valeurs dites du pays d'origine.
- Importance de ne pas oublier les « familles aidantes » et non uniquement les proches aidants.

- Idée d'avoir du parrainage entre un nouvel arrivant et une personne établie au Québec depuis un certain temps pour échanger des trucs et favoriser l'entraide.
- Partenariat en le réseau de la santé et des services sociaux et le système informel.
- Abus à l'intérieur du système qu'il faut nommer (violence systémique).
- Prendre en compte l'état de stress post-traumatique chez les populations qui proviennent de pays en guerre et qui sont immigrantes, réfugiées et vieillissantes.
- Maltraitance envers les proches aidants à prendre en compte (auto-maltraitance, de la personne aidée, de l'entourage qui force à se confiner dans un rôle de proche aidant, et du réseau de la santé et des services sociaux).

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MERCI DE LA PART DE TOUTE L'ÉQUIPE !

Rapport
Laval – 12 mars 2019

Tirer des leçons des expériences des personnes âgées immigrantes

Table-ronde des organismes lavallois desservant les personnes âgées immigrantes

12 mars 2019

Centre communautaire St-Joseph, Chomedey, Laval.

Document produit le 25 mars 2019 par Julien Simard et Shari Brotman.

Table des matières