- consider making age 21 the minimum sales age for both tobacco and vaping products, knowing that establishing the legal minimum sales age requires balancing policy objectives to minimize an illegal market while delaying the onset of youth use through limiting access through social sources~~, consider making age 21 the minimum sales age for both tobacco and vaping products~~
- create requirements for age-verification of internet purchases of vaping products that are the same as those required for cannabis
- enhance surveillance and reporting of vaping product use

Areas in Federal Jurisdiction

- restrict the advertising/marketing/promotion/sponsorship of vaping devices and products in a manner consistent with maximizing youth protection, including online advertising/promotion and social influencers, while allowing adult-oriented marketing as a product that supports adult smokers solely to end or reduce their use of all nicotine-containing products
- require vaping product manufacturers to disclose all ingredients to Health Canada as a condition of being marketed, including establishing consistency in reporting nicotine levels in both open and closed vaping systems
- require plain and standardized packaging along with health risk warnings for all vaping products
- include vaping in smoke-free restrictions for locations under federal jurisdiction
- enhance surveillance and reporting of vaping industry business practices

Commented [JH2]: Not sure what this means.

Areas in Provincial Jurisdiction

- ~~B~~ban all point~~-~~of~~-~~sale advertising of vaping devices and products with an exception for specialized vaping product stores accessible only to those of minimum age
- require a vendor's licen~~c~~se for those selling vaping devices and products
- include vaping in provincial smoke-free restrictions
- routinely use youth test purchaser programs for all tobacco and vaping product retail locations

Areas in Municipal Jurisdiction

- include vaping in municipal smoke-free restrictions
- restrict the density of tobacco and vaping product~~s~~ retail sites and ban the sale of vaping products and devices within at least 250 m of a school

Along with these policy and regulatory actions, we ~~also~~ recommend that federal, provincial and territorial governments continue to work collaboratively to ~~enhance~~:

- enhance public awareness and educational initiatives on the risks of vaping products ~~for~~ targeted at youth, parents, teachers and health care providers

- put in place comprehensive cessation initiatives for people with nicotine addiction, especially for youth
- research ~~on~~ the short- and long-term health effects of vaping products
- research ~~on~~ the effectiveness of vaping products in supporting smokers to end or reduce their use of all nicotine-containing products~~.~~

A number of other products for the delivery of nicotine have or are being developed (e.g., heated tobacco devices, oral nicotine products). We encourage federal and provincial governments to work together to develop a broad regulatory approach to all alternative ~~(i.e. other than tobacco products)~~ methods of nicotine delivery (i.e., other than tobacco products) that has strong youth protection while allowing appropriate access for adult smokers to products proven to decrease or stop the use of all nicotine-containing products. A key component of any such regulatory approach should be the requirement for the manufacturer to provide enough evidence to satisfy the regulator that allowing any new product on the market is in the public interest before that product can be legally sold.

Dr. Theresa Tam
Chief Public Health Officer of Canada

Dr. Bonnie Henry
Provincial Health Officer, British Columbia
Chair, Council of Chief Medical Officers of Health

Dr. Brendan E. Hanley
Chief Medical Officer of Health, Yukon
Vice-Chair, Council of Chief Medical Officers of Health

Dr. Janice Fitzgerald
I/Chief Medical Officer of Health, Newfoundland and Labrador

Dr. Heather Morrison
Chief Public Health Officer, Prince Edward Island

Dr. Robert Strang
Chief Medical Officer of Health, Nova Scotia

Dr. Jennifer Russell
Chief Medical Officer of Health, New Brunswick

Dr. Horacio Arruda
Director of Public Health and Assistant Deputy Minister
Ministry of Health and Social Services, Québec

Dr. David Williams
Chief Medical Officer of Health, Ontario

Dr. Brent Roussin
Chief Provincial Public Health Officer, Manitoba

Dr. Saqib Shahab
Chief Medical Health Officer, Saskatchewan

Dr. Deena Hinshaw
Chief Medical Officer of Health, Alberta

Dr. Michael Patterson
Chief Medical Officer of Health, Nunavut

Dr. Kami Kandola
Chief Public Health Officer, Northwest Territories

Dr. Evan Adams
Chief Medical Officer, First Nations Health Authority, British Columbia

Dr. Tom Wong
Chief Medical Officer, Public Health, Indigenous Services Canada

Important Links

About Vaping

From:	Tam, Dr Theresa (PHAC/ASPC)
Sent:	2019-12-05 8:54 PM
To:	Lucas, Stephen (HC/SC); Namiesniowski, Tina (PHAC/ASPC)
Subject:	Fwd: Special Media Intel: Speech from the Throne - December 5, 2019
Attachments:	Special Intel_Throne Speech_December 5 2019.docx; ATT00001.htm

---

A bit disappointing to see “substance abuse” term in SFT.

Hoping mandate letter will use more appropriate language.

TT

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 5, 2019 at 18:20:31 EST
> **Subject: Special Media Intel: Speech from the Throne - December 5, 2019**
>
> **Health Canada and Public Health Agency of Canada**
> **Santé Canada et l'Agence de la santé publique du Canada**
> Distribution group/Groupe de distribution: HC.F PEIA Executive Media Summary / Sommaire executif des medias AREP F.SC >; HC.F PEIA PHAC Executive Summary / Sommaire Executif
> Please find our Special Intel attached. / S'il vous plaît trouver notre rapport ci-joint.
>
> ---
>
>

iNTEL on health Snapshot

Subject: Speech from the Throne

Search Time Frame: December 5, 2019

Overview

The Speech from the Throne, read by Gov. Gen. Julie Payette, dominated news headlines on December 5, 2019 and was covered live by multiple sources, including CBC News and CTV News. Sources indicated that the speech offered few details of the Liberal minority government's agenda for its second mandate, beyond reiterating Liberal campaign promises: stronger action to fight climate change, lower taxes for middle-class Canadians, beefed-up gun control, steps towards national pharmacare and investments in infrastructure, public transit, affordable housing and health care. But it also made pointed references to issues that are dear to the NDP and Bloc Quebecois. The Liberals will need the support of at least one of those two parties to pass legislation and survive confidence votes. Universal dental care, one of NDP Leader Jagmeet Singh's priorities, was cited as an idea "worth exploring" and one that Parliament was encouraged to look into.

Key Issues

Climate

- iPolitics and the Hill Times indicated that the Liberals committed in the speech, as the party had in the fall campaign, to make energy efficient homes more affordable, incentivize the purchase of zero-emission vehicles, support the development of clean technology businesses and make "clean, affordable power available in every Canadian community."

Dental care

- Multiple sources, including iPolitics, the Hill Times, the Toronto Star and widely published CP article reported that the Liberals said they are open to new ideas like "universal dental care," and "encourage Parliament to look into this."

Economy

- According to CBC News, the first order of business for this 43rd Parliament will be enacting a new middle-class tax cut and making the Canada Child Benefit — payments to parents to help offset the costs of raising a child — more generous.

Foreign affairs

- CBC News noted that the Liberal government said it would continue its efforts to secure Canada a seat on the United Nations Security Council.

Gender-based violence

- According to iPolitics, the speech promised to develop a national action plan to address gender-based violence in Canada.

Gun control

- iPolitics and the Hill Times reported that there is also a call in the speech to ban military-style assault rifles and take steps to introduce a buy-back program; give municipalities the power to ban handguns; and provide funding to "help cities fight gang-related violence."

Healthcare/primary care

- The CP and iPolitics indicated that the speech said the government would "work with provinces, territories, health professionals and experts in industry and academia to make sure that all Canadians can access a primary care family doctor."

Indigenous issues

- CBC News and the Hill Times indicated that the speech vowed to co-develop new legislation with Indigenous peoples to improve access to "culturally relevant" health care and mental health services, compensate First Nations kids who were subjected to the discriminatory child welfare system, and continue to implement the calls for justice of the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG).

Mental health & addiction

- According to iPolitics, the speech said the federal government would partner with the provinces, territories and health professionals to develop mental health standards in the workplace and ensure Canadians have access to mental health care; and "make it easier for people to get the help they need when it comes to opioids and substance abuse."

- According to iPolitics, the speech mentioned improvement for mental health supports for veterans.

National unity

- According to the Hill Times, in a nod to the mounting frustrations from Saskatchewan and Alberta, where the Liberals were shut out in the federal election on Oct. 21, the speech referenced the economic anxieties facing Western Canada.

Pharmacare

- Multiple sources, including iPolitics, the Hill Times, the Toronto Star and widely published CP article reported that the Liberals in the speech again reiterated that they would "take steps to introduce and implement national pharmacare so that Canadians have the drug coverage they need." Beyond noting that it is the "key missing piece of universal healthcare in this country," it did little to clarify the timeline around its implementation or the government's preferred model.

Quotes

"We are very disappointed in this throne speech. [Trudeau] has pitted region against region and that is not the way to keep this Confederation together."
-Conservative leader Andrew Scheer

Social Media and Stakeholder Trends

Canadian Nurses Association (@canadanurses)	• CNA welcomes Canada's 43rd Parliament - we look forward to working with all parties to create effective #healthcare policies! #cdnpoli #CNA2019 #ThroneSpeech https://t.co/0khCdNCutW • QT @CanadianPM: CNA welcomes today's #ThroneSpeech – we are optimistic with the priorities put forward & will work with this Parliament to accomplish common goals such as #pharmacare, increased access to #Health services & #ClimateChange! #cdnpoli #CNA2019 #Nurses ; The Speech from the Throne introduces the Government of Canada's direction and goals, and how it will work to achieve them. ...	**Positive**
Canadian Pharmacists Association (@CPhAAPhC)	• There have now been 200+ #drugshortages reported since election day. Addressing this growing crisis and securing our drug supply needs to be a priority in the government's mandate. #thronespeech #cdnpoli #cdnhealth https://t.co/g9EgdEtWiE • CPhA Chair @ChristineHrudka on today's #ThroneSpeech and the need to address the growing issue of #drugshortages in Canada. #cdnhealth #cdnpoli https://t.co/DsPL4uLpyE	**Negative**

Canadian Doctors for Medicare (@CdnDrs4Medicare)	• Canadians have demanded, and deserve, real action on universal public pharmacare. Visit our newsroom to read our statement on today's #ThroneSpeech. #cdnpoli #cdnhealth https://t.co/AQiaqCrqAA	**Neutral**
Canadian Agency for Drugs and Technologies in Health Canada (@CADTH_ACMTS)	• "Ensuring a better quality of life for Canadians also involves putting the right support in place so that when people are #sick, they can get the help they need." Here's what you missed from the #ThroneSpeech ☞ https://canada.ca/en/privy-council/campaigns/speech-throne/moving-forward-together.html #CdnHealth	**Neutral**
CARP (@CARPAdvocacy)	• #pension protection, better #healthcare and #pharmacare were all represented in the #thronespeech . We'll be watching for real action. #seniors	**Neutral**
Canadian Centre for Policy Alternatives (@ccpa)	• RT @ArmineYalnizyan: Opportunity costs, y'all. What else could we buy with $6B in the 43rd Parliament? #cdnecon #canpoli #ThroneSpeech https://twitter.com/ccpa/status/1192874666748186625/photo/1	**Negative**
Health Canada/PHAC (@GovCanHealth) (@GouvCanSante)	• RT @CanadianPM #ThroneSpeech | All Canadians want to make Canada a better place for themselves, their children, and their communities. Learn about the Government of Canada's commitment to keep Canadians safe and healthy: http://ow.ly/VSyW50xsNJj • RT @PMcanadien: #DiscoursDuTrône | Tous les Canadiens veulent faire de leur pays un meilleur endroit où vivre pour eux-mêmes, pour leurs enfants et pour leurs communautés. Voir l'engagement du gouvernement du Canada d'assurer la santé et la sécurité des Canadiens: http://ow.ly/XCvc50xsPHc	**Neutral**
NDP Health critic Don Davies (@DonDavies)	• Canadians need their medicine and pharmacare now. The Liberals' promise to "take steps" toward it with no commitment to universal, comprehensive and public coverage is not good enough. The #NDP will continue to work for the results Canadians deserve. #ThroneSpeech • RT @gsdenton: Promising to "take steps" to implement pharmacare: A part of our heritage. 👟 Get those steps in, Liberals #Fitbit #ThroneSpeech	**Neutral / Negative**
Kristy Kirkup (CP) @kkirkup	• RT @RobertFife: Liberals pledge to fight climate change, cut taxes in Throne Speech #cdnpoli #thronespeech	**Neutral**
Andre Picard (G&M) (@picardonhealth)	• Pressure mounts on Trudeau to increase health care funding to provinces, by @aballinga @yowflier https://thestar.com/politics/federal/2019/12/04/pressure-mounts-on-trudeau-to-increase-health-care-funding.html via @torontostar #cdnhealth #cdnpoli	**Neutral**
Kelly Grant (G&M) (@kellygrant1)	• RT @picardonhealth: Pressure mounts on Trudeau to increase health care funding to provinces, by @aballinga @yowflier https://thestar.com/politics/federal/2019/12/04/pressure-	**Neutral**

	mounts-on-trudeau-to-increase-health-care-funding.html via @torontostar #cdnhealth #cdnpoli	
Chantal Hebert (Toronto Star) (@ChantalHbert)	• RT @CBCAlerts: Bloc Québécois Leader Yves-François Blanchet says his party will vote in favour of the Throne Speech. This gives the Liberal government the support it needs to continue its mandate. • RT @KarlBelanger: Singh n'est prêt pas à voter pour le Discours du Trône à ce moment-ci. • RT @theJagmeetSingh: Canadians need help now. If this #ThroneSpeech, full of empty promises and little action, is all the Liberals have to offer people, it's not good enough. If they show they're willing to take real actions, we're ready to work with them to deliver the help Canadians need. • @ChantalHbert: BQ will support Throne speech says @yfblanchet explicitly.	**Neutral**
Conservatives (@CPC_HQ)	• RT @AndrewScheer: I am extremely disappointed by Trudeau's Throne Speech. He has learned nothing from the last month and has taken no steps to unite our country. Conservatives will be here fighting every day for Canadians with everything we have. Speaking to media LIVE: https://facebook.com/AndrewScheerMP/videos/756236054876213/	**Negative**
Green Party (@CanadianGreens)	• Canadians voted for climate action.They deserve to know whether this government is guided by science or politics. Be wary of politicians who brand themselves "climate leaders" without showing their work.	**Neutral / Negative**
Andrew Scheer (@AndrewScheer)	• I am extremely disappointed by Trudeau's Throne Speech. He has learned nothing from the last month and has taken no steps to unite our country. Conservatives will be here fighting every day for Canadians with everything we have. Speaking to media LIVE: https://facebook.com/AndrewScheerMP/videos/756236054876213/ • Je suis extrêmement déçu du discours du Trône de Justin Trudeau. Il n'a rien appris du dernier mois et il ne prend aucune mesure pour unir notre pays. Les conservateurs vont se battre tous les jours pour les Canadiens. Je parle aux médias EN DIRECT: https://facebook.com/AndrewScheerMP/videos/756236054876213/	**Negative**
Justin Trudeau (@JustinTrudeau)	• Canadians are counting on us to work together on the issues that matter most to them, and overcome the challenges of today to build a brighter tomorrow. The plan we've put forward in the Speech from the Throne is a path forward for everyone. https://pm.gc.ca/en/news/statements/2019/12/05/statement-prime-minister-speech-throne …	**Neutral**

Jagmeet Singh (@theJagmeetSingh)	• Canadians need help now. If this #ThroneSpeech, full of empty promises and little action, is all the Liberals have to offer people, it's not good enough.If they show they're willing to take real actions, we're ready to work with them to deliver the help Canadians need. • Les Canadiens.nes ont besoin d'aide maintenant. Si ce discours est tout ce que les libéraux ont à offrir, ce n'est pas assez.S'ils montrent qu'ils sont prêts à prendre des mesures concrètes, nous sommes prêts à travailler avec eux pour fournir l'aide dont les gens ont besoin.	**Negative**
Elizabeth May (@ElizabethMay)	• "A clear majority of Canadians voted for ambitious climate action now." True- so where is the revised target for 2030 - consistent with Liberals' promise of net zero carbon by 2050? #climate #SFT2019 #cdnpoli #GPC	**Negative**

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-20 12:23 PM
To: McLeod, Robyn (PHAC/ASPC)
Subject: RE: Summary of MTF study

Please print

From: MacKenzie, Sara (HC/SC)
Sent: 2019-12-20 11:55 AM
To: Macey, Jeannette (PHAC/ASPC) ; Tam, Dr Theresa (PHAC/ASPC)
Subject: FW: Summary of MTF study

This may be of interest ☺

Sara MacKenzie
Director General, Strategic Communications
Directrice générale, Communications stratégiques

613-853-4524 | BBME: EF03B2C2

From: Johnson, Sonia (HC/SC) <sonia.johnson@canada.ca>
Sent: 2019-12-20 11:20 AM
To: Clare, John (HC/SC) <john.clare@canada.ca>; Budgell, Andrea (HC/SC) <andrea.budgell@canada.ca>; Cain, Todd (HC/SC) <todd.cain@canada.ca>; Pellmann, David (HC/SC) <david.pellmann@canada.ca>; Apse, Krista (HC/SC) <krista.apse@canada.ca>; Laroche, Julie (HC/SC) <juliea.laroche@canada.ca>; MacKenzie, Sara (HC/SC) <sara.mackenzie@canada.ca>; Butara, Frank (HC/SC) <frank.butara@canada.ca>; Van Loon, James (HC/SC) <james.vanloon@canada.ca>
Cc: Abramovici, Hanan (HC/SC) <hanan.abramovici@canada.ca>; Niddery, Breton (HC/SC) <breton.niddery@canada.ca>
Subject: FW: Summary of MTF study

Hello colleagues,

On Wednesday, the Monitoring the Future (MTF) survey results were released. This is a US survey of high school students, similar to our CSTADS, and there were some interesting findings on cannabis in particular. Hanan's team prepared a summary of the results, which I shared with Jacquie this morning.

The MTF also looks at tobacco, nicotine vaping, alcohol and drug use, and we'll make sure there is a summary of the broader findings, and a comparison to our CSTADS results where possible. In the meantime, I wanted to share with you the cannabis summary for your awareness.

Sonia

From: Abramovici, Hanan (HC/SC) <hanan.abramovici@canada.ca>
Sent: 2019-12-19 4:12 PM

To: Johnson, Sonia (HC/SC) <sonia.johnson@canada.ca>
Subject: Summary of MTF study

Sonia,

Please see attached for summary of MTF study released today that includes data on cannabis and cannabis vaping. You may wish to brief JB on this.

Thanks,
hanan

ATIA - 19(1)
ATIA - 17

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-30 11:28 AM

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

Subject: Fwd: Summer Student Job Opportunities

Attachments: FSWEP resume global health .pdf; ATT00001.htm

For your consideration

Sent from my iPhone

Begin forwarded message:

From: [redacted]
Date: December 28, 2019 at 15:24:55 EST
To: [redacted]
Subject: Summer Student Job Opportunities

Dear Dr. Tam,

[redacted]

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

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-01 9:09 AM

To: Tremblay, Genevieve (PHAC/ASPC)

Cc: Namiesniowski, Tina (PHAC/ASPC); Tafaghod, Marzieh (HC/SC)

Subject: Re: Sunday wad event

I'll be there with gloves on.

Sent from my iPhone

On Dec 1, 2019, at 08:21, Tremblay, Genevieve (PHAC/ASPC) <genevieve.tremblay@canada.ca> wrote:

> Hi Tina,
>
> [redacted]We can definitely let organizers know and they will understand[redacted]
>
> Gen
>
> Sent from my iPhone
>
> On Nov 30, 2019, at 9:34 PM, Namiesniowski, Tina (PHAC/ASPC) <tina.namiesniowski@canada.ca> wrote:
>
> [redacted]
>
> Sent from my iPhone
>
> On Nov 30, 2019, at 2:47 PM, Namiesniowski, Tina (PHAC/ASPC) <tina.namiesniowski@canada.ca> wrote:

[redacted]

Sent from my iPhone

On Nov 30, 2019, at 9:17 AM, Tafaghod, Marzieh (HC/SC) <marzieh.tafaghod@canada.ca> wrote:

> Sent from my Bell Samsung device over Canada's largest network.
>
> Genevieve has confirmed that ACO is aware that [redacted] is offering on behalf of the Minister.
>
> If there are any issues, please Genevieve can be reached e at 613-617-2654 (with the exception of this evening as she has [redacted]
>
> Thanks
>
> Marzieh

From: Namiesniowski, Tina (PHAC/ASPC)
Sent: 2019-12-11 3:11 PM
To: Hollington, Jennifer (HC/SC); Romano, Anna (PHAC/ASPC); Tam, Dr Theresa (PHAC/ASPC)
Cc: Patrice, France (PHAC/ASPC)
Subject: Fwd: Support public service mental health June 13 2020
Attachments: 2020 RFW BILPoster.pdf; ATT00001.htm; RFW2020_TeamCaptainsRecruitment_Ottawa.pdf; ATT00002.htm

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Views?

Sent from my iPhone

Begin forwarded message:

From [redacted]
To: "Namiesniowski, Tina (PHAC/ASPC)" <tina.namiesniowski@canada.ca>
Cc: [redacted]
Subject: Support public service mental health June 13 2020

Ms. Tina Namieniowski
President, Public Health Agency
Dear Tina:
We are reaching out to you directly about an exciting national mental health initiative - the SHOPPERS LOVE.YOU. Run/Walk for Women on Saturday, June 13, 2020! We would love to see employees from your team be part of this amazing experience!
As you may know, the recent **Clerks of the Privy Council have made mental health in the workplace one of their top priorities** and we know you are actively engaged in supporting mental health initiatives with your teams.
Supporting The Royal's Run (walk) For Women (RFW) initiative will not take much of your time, or of those in your department. However, the impact on the mental health of the women in the public service and our broader community can be life changing.
Did you know:

- One in three people will be affected by mental illness in their lifetime.
- Women are twice as likely as men to experience major depression.
- Over 25,000 people participated in the 2019 SHOPPERS LOVE.YOU. Run (walk) For Women (RFW) in 17 cities across Canada!
- Since 2013, over 100,000 people have participated, raising over $8.3 million for women's mental health in Canada? Moreover, in Ottawa, over 10,000 people have participated in past seven years raising over $1.2 million for Women's Mental Health at The Royal

Money raised from The Royal's Run (or walk) for Women on **Saturday, June 13, 2020**, supports the **Women's Mental Health program at The Royal.**
The Royal is one of Canada's foremost mental health care, teaching and research hospitals. Its mandate is simple: to help more people living with mental illness and addiction into recovery faster. The Royal combines specialized mental health care, advocacy, research, and education to transform the lives of people living with complex and treatment-resistant mental illness. The Royal's Institute of Mental Health Research, affiliated with the University of Ottawa, brings together leading mental health professionals, scientists, and technology to gain a deeper understanding of the brain, and investigate innovative approaches to preventing and treating mental illness
Meet an amazing person, Peggy, who has been helped by The Royal.

There are three things you can do to help save lives and change mental health outcomes by supporting this fun and inspiring initiative:

1. Indicate your leadership support for women's mental health by endorsing The Royal's annual SHOPPERS LOVE.YOU. Run (or walk) for Women on **Saturday, June 13, 2020**, an event that transforms women's lives not only through The Royal's women's mental health program, but for all participants*.
2. Identify an individual (or 2-3) who would be interested in being a team Captain (a team by definition is a minimum of 5 individuals). There are Champions for Mental Health/Team Captains at other departments who would be happy to provide information on what has worked in their organizations and how they have grown their teams to support their fellow colleagues and this important cause. **Captain job description is attached.**
3. Identify who in your Communication Branch could help support the dissemination of social media and other messaging to encourage participation in the event and to raise awareness about mental wellness.

Public servants in Health Canada, EDC, RCMP, ISED, CMHC, CATSA, and Canada Post have already registered their 2020 teams. We are approaching a number of other departments and agencies to join these teams and get involved with the mission to promote public servants' mental health and wellness* (running and walking) while supporting programs and research for women living with mental illnesses in 17 communities across Canada.

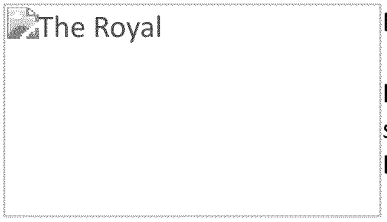
Want a glimpse about the fun in store for June 13? **Check this video out! Poster also attached.**
We have an enthusiastic group of people who could speak to your teams about women's mental health or work at The Royal. We would be grateful to talk with you or someone on your team for 30 minutes about getting involved with the SHOPPERS LOVE.YOU. Run (or walk) for Women on Saturday, June 13, 2020. **Click here to organize this conversation** (email: **foundation@theroyal.ca**).
Looking forward to hearing from you before January 10, 2020!
With gratitude for your consideration.

[redacted]

NB: The main goal is not running, but moving for mental health and raising awareness and support for mental health and mental illnesses.
*In the 2019 Post-event survey, **61%** responded, "Participating in the Run for Women has encouraged me to take action to improve my own mental health and/or access mental health resources".

[redacted]

Royal Ottawa Foundation for



Mental Health

Fondation de santé mentale Royal Ottawa

ATIA - 17

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-12 7:11 PM
To: McLeod, Robyn (PHAC/ASPC)
Subject: Sync issues with cell phone

Will we be able to get someone to look at the calendar sync issues tomorrow?

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

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

From: Josee.Beaudoin@cie.parl.gc.ca
Sent: 2019-12-19 12:58 PM
To: info@cie.parl.gc.ca
Subject: Teleconference on post-employment rules / Téléconférence sur les règles d'après-mandat

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Le français suit l'anglais

Thank you to those who attended the teleconference on post-employment hosted by myself and my colleague the Commissioner of Lobbying Nancy Bélanger last month.

Because several of you asked for an alternate date and some who joined the teleconference had technical difficulties, we have decided to organize a second teleconference on post-employment **on January 21, 2020**. Like the last informational teleconference, we will focus on post-employment obligations under the *Conflict of Interest Act* and the five-year prohibition on lobbying activities in accordance with the *Lobbying Act.*

The English and the French teleconferences will be held separately; one after the other.

During each of these 30-minute calls, which will include a question and answer portion and we will discuss the provisions that will apply to you upon leaving office. This is an informational session for all reporting public office holders, regardless of their status.

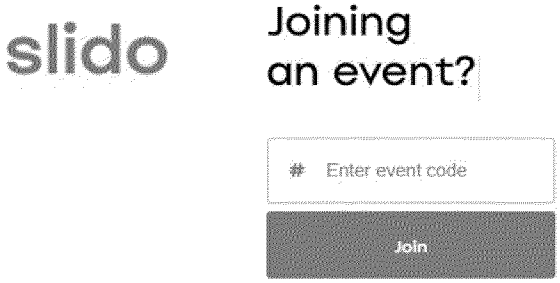
Click here to find the presentation slides we will be referring to during the teleconference.

English teleconference information:

Date and time: Tuesday, January 21, 2020, **from 12 p.m. to 12:30 p.m. EST**

[redacted]

Access Code: [redacted]



You are encouraged to anonymously ask questions and view other participants' questions by using Slido:
https://www.sli.do/
Event code: [redacted]

-

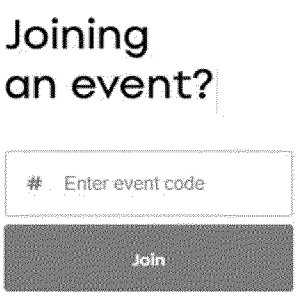
-

French teleconference information:

Date and time: Tuesday, January 21, 2020, **from 12:45 p.m. to 1:15 p.m. EST**

[redacted]

Access Code [redacted]



You are encouraged to anonymously ask questions and view other participants' questions by using Slido: https://www.sli.do/
Event code: [redacted]

Please contact our Office by email at ciec-ccie@parl.gc.ca or by telephone at 613-995-0721 to confirm participation.

Josée Beaudoin on behalf of
Mario Dion
Conflict of Interest and Ethics Commissioner

Merci à celles et ceux qui ont assisté à la téléconférence sur l'après-mandat animée par ma collègue, la commissaire au Lobbying Nancy Bélanger, et moi-même le mois dernier.

Étant donné que plusieurs personnes ne pouvaient y participer et que d'autres ont éprouvé des problèmes techniques, nous avons décidé d'offrir une deuxième téléconférence sur l'après-mandat **le 21 janvier 2020**. À l'instar de la dernière téléconférence, celle-ci portera surtout sur les obligations d'après-mandat aux termes de la *Loi sur les conflits d'intérêts* et sur l'interdiction quinquennale d'exercer des activités de lobbying qui est prévue dans la *Loi sur le lobbying.*

Des téléconférences distinctes se tiendront en anglais et en français, une après l'autre.

Au cours de chacune de ces téléconférences d'une demi-heure, il y aura une période de questions et de réponses et une discussion sur les dispositions qui s'appliquent à vous lorsque vous quittez votre charge. La séance d'information s'adresse à toutes les titulaires de charge publique principales et à tous les titulaires de charge publique principaux, sans égard à leur statut.

Il suffit de cliquer ici pour voir les diapositives qui serviront à la téléconférence.

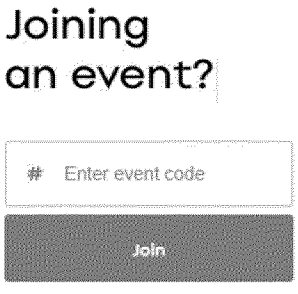
Téléconférence en français

Mardi 21 janvier 2020, de **12 h 45 à 13 h 15, heure de l'Est**

[redacted]

Code d'accès : [redacted]

slido



Les participantes et participants sont invités à poser leurs questions de façon anonyme et à voir les questions des autres au moyen de Slido : https://www.sli.do/
Code de l'événement : [redacted]

-

-

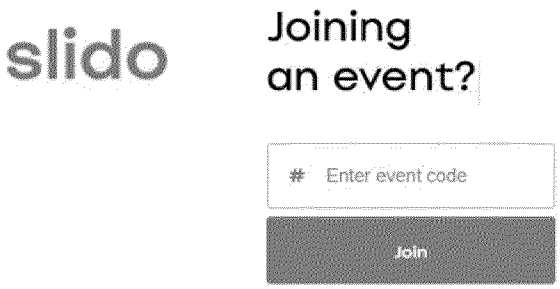
-

Téléconférence en anglais

Mardi 21 janvier 2020, de **12 h à 12 h 30, heure de l'Est**

[redacted]

Code d'accès : [redacted]



Les participantes et participants sont invités à poser leurs questions de façon anonyme et à voir les questions des autres au moyen de Slido : https://www.sli.do/
Code de l'événement : [redacted]

Si vous désirez vous inscrire, veuillez communiquer avec le Commissariat à ciec-ccie@parl.gc.ca ou au 613-995-0721.

Josée Beaudoin au nom de
Mario Dion
Commissaire aux conflits d'intérêts et à l'éthique

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-04 9:30 AM
To: Gaudreau, Marc-Andre (PHAC/ASPC); Shore, Jessica (PHAC/ASPC); Clark, Ray (PHAC/ASPC); Scott, Sally (PHAC/ASPC); Dubuc, Martine (PHAC/ASPC); Koo, Henry (PHAC/ASPC); Toews, Jennette (PHAC/ASPC); McRae, Louise (PHAC/ASPC); Currie, Andrea (PHAC/ASPC); Tosh, Casey (PHAC/ASPC); Burkholder, Elfreda J (PHAC/ASPC); Duhaime, Marc (PHAC/ASPC)
Cc: Njoo, Howard (PHAC/ASPC); Robinson, Kerry (PHAC/ASPC); Henry, Erin E (PHAC/ASPC); Shankar, Craig (PHAC/ASPC); Ugnat, Anne-Marie (PHAC/ASPC); 'Russo, Laura (HC/SC'
Subject: Thank you

Dear all,

Thank you everyone for all of the hard work and planning for the trip to Toronto to meet with WE, visit Access Alliance, meet with regional office staff, meet with Canadian chiropractors and learn about [redacted]s immunization partnership fund project. It was a whirlwind day filled with very engaged stakeholders! It is always great to hear and learn from people who are working at different levels, and what is always interesting is how aligned our goals are when we start talking about the health of Canadians. I also appreciated the interesting lunch discussions with regional staff and insight into the work everyone is doing.

Thanks to everyone who worked behind the scenes to make everything run smoothly and allow for such a productive day. I am very grateful for all of the support.

TT

PS If I have forgotten anyone, please send along on my behalf.

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-19 7:10 PM

To: Lucas, Stephen (HC/SC); Namiesniowski, Tina (PHAC/ASPC)

Subject: RE: Thank you for participating in our 100 Years of Health event

---

It was a pleasure. I will not be around for the next 100 years so this was a great opportunity. TT

From: Lucas, Stephen (HC/SC)
Sent: 2019-12-19 12:03 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Subject: Thank you for participating in our 100 Years of Health event

Thank you for taking the time to prepare for, and participate in, our 100 Years of Health event on November 29. Your perspective, as the Chief Public Health Officer, on how we are working to better respond to complex and emerging public health challenges was a valuable contribution to the discussion.

We have received only positive feedback about the content and flow of the dialogue and the exchange between you, the moderator and the other members of the panel. You may be interested to know that close to 300 employees attended the event in person, and several hundred others from our regional offices and across the National Capital Region tuned into the webcast.

We hope that you enjoyed the discussion. Here is a link to photos from the event to remind you of the experience. Thank you for taking the time to help us celebrate and reflect on the past 100 years of our health history.

Sincerely,

Stephen Lucas, Ph.D. Tina Namiesniowski
Deputy Minister President
Health Canada Public Health Agency of Canada

ATIA - 19(1) ATIA - 17

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-17 7:52 PM
To: [redacted]
Subject: Thank you for telling your story

Hi [redacted]

It was great to see you looking so well on TV. I am just happy that the procedure was a success for you and that you have a new lease on life, connecting with family and your passions.

Thank you for telling your story publicly to help destigmatize alcohol use disorder. I was just at a CCSA meeting talking about the power of stories to reduce stigma associated with substance use and here you are doing your part!

I have learned so much about the impact of stigma on health in the last years. As I listened to hundreds of Canadians during my engagements, stigma comes up repeatedly as a common barrier that people living with a range of stigmatised health conditions (eg related to substance use, mental health, HIV, obesity) encounter. The stigma for health conditions also intersects with stigma related to social identities eg racism, homophobia.

My CPHO report this year is on stigma and its impact on health and I expect it to be released tomorrow. In return for the book you gave me on Canadian Failures, I will send you a link to the report when it is out.

Say hi to [redacted]

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: [redacted]
Sent: 2019-12-18 2:49 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Subject: RE: The Chief Public Health Officer of Canada's Annual Report Available Now: Addressing Stigma Towards a More Inclusive Health System

---

Many thanks Theresa.
I look forward to reading this, and also working with you personally again in the near future.

Best wishes

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: Wednesday, December 18, 2019 11:52 AM
To: [redacted]
Cc: Pearson, Michael (PHAC/ASPC) ; Jones, Luke (PHAC/ASPC) ; Rendall, Jennifer (PHAC/ASPC)
Subject: The Chief Public Health Officer of Canada's Annual Report Available Now: Addressing Stigma Towards a More Inclusive Health System

Dear [redacted]

Today, I released my annual report on the State of Public Health in Canada 2019, *Addressing Stigma: Towards a More Inclusive Health System*. This report provides a snapshot of key public health trends in Canada and focuses on the impact of stigma and actions to address it across health systems.

This report positions stigma as a public health issue and builds on recent efforts to understand the full impact and significance of stigma on the health of populations; often health inequities that prevent people from achieving their full potential can only be explained by how people are treated.

The report highlights how stigma associated with health issues such as mental illness, HIV status, obesity or substance use cannot be addressed without also tackling threats to equity such as racism, homophobia, transphobia, ageism and sexism. Stigma increases the likelihood of worsening health due to conditions such as anxiety, depression, cardiovascular disease and injury. It also keeps people away from the resources they need to live a healthy life, such as having housing, an income and accessible health services.

The report offers an action framework outlining how we – as individuals, institutions and as a population – can take steps to address stigma to build an inclusive health system.

The report and accompanying materials are available at the link below. Thank you in advance for your support amplifying the key messages and catalyzing action.

- **Annual report:** Read more on the state of health of Canadians and how stigma can lead to health inequities.
- **What We Heard Report:** Learn more about the drivers and experiences of stigma as well as actions to address it from community-based organizations, service providers, policymakers, researchers, individuals with those lived and living experience who participated in discussion groups and key informant interviews.
- **Action framework poster:** Use and share this poster to stimulate discussion and guide your actions to address stigma.

I am enclosing a link to the **stakeholder kit**, which provides customizable messages should you wish to share across your networks on Facebook, LinkedIn and Twitter. Access the kit here.

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.

Sincerely,

Theresa

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

ATIA - 19(1) ATIA - 17

From: [redacted]
Sent: 2019-12-18 3:49 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Cc: [redacted]
Subject: RE: The Chief Public Health Officer of Canada's Annual Report Available Now: Addressing Stigma: Towards a More Inclusive Health System [SEC=No Protective Marking] [SEC=OFFICIAL]

Thanks
I look forward to reading it.
Best wishes for Christmas and the New Year

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Date: Thursday, 19 Dec 2019, 3:58 am
To: [redacted]
Cc: Pearson, Michael (PHAC/ASPC) <michael.pearson@canada.ca>, Jones, Luke (PHAC/ASPC) <luke.jones@canada.ca>, Rendall, Jennifer (PHAC/ASPC) <jennifer.rendall@canada.ca>
Subject: The Chief Public Health Officer of Canada's Annual Report Available Now: Addressing Stigma: Towards a More Inclusive Health System [SEC=No Protective Marking]

Dear [redacted]

Today, I released my annual report on the State of Public Health in Canada 2019, *Addressing Stigma: Towards a More Inclusive Health System*.

This report provides a snapshot of key public health trends in Canada and focuses on the impact of stigma and actions to address it across health systems.
This report positions stigma as a public health issue and builds on recent efforts to understand the full impact and significance of stigma on the health of populations; often health inequities that prevent people from achieving their full potential can only be explained by how people are treated.
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The report offers an action framework outlining how we – as individuals and as a collective – can take steps to address stigma to build an inclusive health system.
The report and accompanying materials are available at the links below.

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policymakers, researchers, individuals with those lived and living experience who participated in discussion groups and key informant interviews.

- Action framework poster**:** Use and share this poster to stimulate discussion and guide your actions to address stigma.

I am enclosing a link to the **stakeholder kit**, which provides customizable messages should you wish to share across your networks on Facebook, LinkedIn and Twitter. Access the kit here.
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.
Sincerely,
Theresa
Dr. Theresa Tam, BMBS (UK), FRCPC
Chief Public Health Officer
Public Health Agency of Canada

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-13 2:59 PM
To [redacted]
Subject: RE: The Chief Public Health Officer's 2017 Report – Designing Healthy Living

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Dear [redacted]

Thank you for your correspondence of November 25, 2019, indicating your interest in learning more about the impact of my 2017 Report on the State of Public Health in Canada – Designing Healthy Living (Report).

The Report considers the influence that the built environment has on healthy living in terms of encouraging increased physical activity, improving access to healthy food and food literacy skills, and facilitating opportunities for social connectedness and improved mental wellbeing. The Report also issues six calls to action to domestic and international partners, all levels of government, political decision makers, community organizations, and private sector entrepreneurs for designing and re-designing communities and community features that foster healthy living.

Although the Public Health Agency of Canada (PHAC) does not formally track the impact of my reports, the reports provide a framework for guiding PHAC's work. I am happy to relate that, since the release of my 2017 Report, there have been many positive developments with respect to healthy built environments. There is evidence that the report has raised awareness of how built environments promote healthy living and has catalyzed new multi-sectoral collaborations both within and outside of government.

The public release of the Report created opportunities for my colleagues and I to provide keynote addresses and to participate in forums and symposiums at academic and professional conferences. These opportunities included summits on active transportation and cycling, a forum on the health benefits of parks and green space, conferences of the Urban Land Institute and Canadian Institute of Planners, and a speaking engagement with transportation engineers. These occasions have fostered discussion about the themes and calls for action in the Report.

In June 2018, I hosted a Federal Dialogue on Designing Communities for Healthy Living. This dialogue brought together 13 federal departments, including Infrastructure Canada, Statistics Canada, and the Canadian Mortgage and Housing Corporation to explore opportunities for joint federal action on the themes in the Report. As a result, we have seen greater inter-departmental collaboration: discussions have taken place on how health metrics can be included in new federal housing investments, PHAC officials have provided health expertise when reviewing Infrastructure Canada's proposals for its Smart Cities Challenge, and we are better able to measure transportation infrastructure data from communities across Canada.

The Report has also strengthened relationships with key stakeholders outside of government and in different sectors, including with the Canadian Institute of Planners. We have had the opportunity to provide input on the Institute's Policy for Healthy Community Planning, co-present on panels, and continue to meet regularly with them to identify mutually beneficial ways of advancing urban planning and health goals.

A key theme in my Report is the need to address data gaps through targeted and hypothesis-driven research and systematic evaluations of the health impact of community design features. To this end, we are currently exploring opportunities with different organizations, such as the

Canadian Institutes of Health Research, Canada's major federal agency for funding health and medical research.

In addition, through PHAC's *Healthy Living and Chronic Disease Prevention - Multi-sectoral Partnerships* program, we continue to invest in interventions that evaluate the health impacts of community design features. For example, the Housing for Health Project, led by the University of Alberta, in collaboration with a developer and local multi-sectoral partners, integrates and evaluates evidence-based, active-design features in and around two new housing developments for aging populations in Alberta, Canada.

Lastly, my colleague Steven Hoffman, Scientific Director of the Institute of Population & Public Health at the Canadian Institutes of Health Research, has engaged me in the development of their recently released five-year strategic plan with Healthy Cities as a key priority for five years. He would be happy to provide you with information on the research they are funding and the areas of focus linking back to the theme of my report. He can be reached at steven.hoffman@globalstrategylab.org.

While there is no formal quantification of other impacts of my report, I have received many verbal comments on the integration of this report as part of university curriculum, and it has be used by municipalities and local public health departments in their work on healthy communities.

I hope this information has been helpful and thank you for your interest.

Sincerely,

Theresa

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

From: [redacted]
Sent: November 25, 2019 1:06 PM
To: ph-sp-info@phac-aspc.gc.ca
Subject: The Chief Public Health Officer's 2017 Report – Designing Healthy Living

Dear Sir or Madam,

I work at Manchester Metropolitan University (MMU) in the United Kingdom and I am looking to gather information on any impact that has arisen from The Chief Public Health Officer's Report on the State of Public Health in Canada 2017 – Designing Healthy Living.

The reason behind this request is because MMU is one of several UK universities preparing for the national research assessment that also takes into account the wider (non-academic) 'impact' of research. As such, we are keen to report on the successful impact of The Chief Public Health Officer's Report on the State of Public Health in Canada 2017 – Designing Healthy Living, because of research from this institution that was included within the report. Therefore, I wondered if you could help me in providing any information to support any impact that has arisen from it, as we hope for it to feature in one of our impact case studies for the assessment.

The specific information we hope to gather may be changes to government policy, increased funding for projects or the designing of new/existing housing that can be attributed to the report.

ATIA - 19(1)

Therefore, any information/metrics you could provide regarding this would be gratefully received.

In keen anticipation of your reply

[redacted]

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-18 11:40 AM

To: [redacted]

Cc: Rendall, Jennifer (PHAC/ASPC)

Bcc: Maika, Christine (PHAC/ASPC); Bland-Lasso, Laura (PHAC/ASPC)

Subject: The Chief Public Health Officer's Annual Report Available Now: Addressing Stigma Towards a More Inclusive Health System

---

Dear [redacted]

Today, I released my annual report on the State of Public Health in Canada 2019, *Addressing Stigma: Towards a More Inclusive Health System*.

This report provides a snapshot of key public health trends in Canada and focuses on the impact of stigma and actions to address it across health systems.

Canadians continue to be among the healthiest people in the world. However, persistent health inequities prevent many people from being able to achieve their full potential. Often these differences can only be explained by how people are treated.

As part of the development of the report, it was important to me to hear from Indigenous peoples on the topic of stigma and racism in health. I am grateful to the Indigenous peoples and those representing the Assembly of First Nations who participated in discussion group conversations I held to learn from those with lived and living experience.

The report offers an action framework outlining how we – as individuals, institutions and as a population – can take steps to address stigma to build an inclusive health system.

Stigma affects us all. Please help to raise awareness and catalyze action by sharing the report and accompanying materials:

- **Annual report:** Read more on the state of health of Canadians and how stigma can lead to health inequities.
- **What We Heard Report:** Learn more about the drivers and experiences of stigma as well as actions to address it from community-based organizations, service providers, policymakers, researchers, individuals with those lived and living experience who participated in discussion groups and key informant interviews.
- **Action framework poster:** Use and share this poster to stimulate discussion and guide your actions to address stigma.

I am enclosing a link to the **stakeholder kit**, which provides customizable messages should you wish to share across your networks on Facebook, LinkedIn and Twitter. Access the kit here.

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.

Sincerely,

Theresa

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

ATIA - 19(1)

From: Costen, Eric (HC/SC)
Sent: 2019-12-15 10:27 AM
To: Lucas, Stephen (HC/SC); Tam, Dr Theresa (PHAC/ASPC); Hoffman, Abby (HC/SC); Romano, Anna (PHAC/ASPC); Priest, Stephanie (PHAC/ASPC); Gagne, Marie-Anik (HC/SC); Namiesniowski, Tina (PHAC/ASPC); Moriarty, Cindy (HC/SC); Saulnier, Marcel (HC/SC)
Cc: Charlebois, Eric (HC/SC); Bogden, Jacqueline (HC/SC); Hollington, Jennifer (HC/SC); White, Belinda (HC/SC)
Subject: The Sunday Edition with Michael Enright - Dec. 13, 2019: The mental health crisis among young Canadians

---

Morning everyone,

While I know it is hard to find a whole hour to spare these days but [redacted] or otherwise need some intelligent distraction I highly recommend listening the first segment of today's Sunday Edition which is about youth mental. Seems a very good and timely primer as the Task Team gets underway...

Eric

https://www.cbc.ca/listen/live-radio/1-57-the-sunday-edition/clip/15751569-the-mental-health-crisis-among-young-canadians

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

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-13 6:48 PM
To: Hostrawser, Bonnie (PHAC/ASPC); Macey, Jeannette (PHAC/ASPC)
Subject: Fwd: The UK Guardian: Canada: nearly 14,000 people die from opioid overdoses in four years

---

Nice ending

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 15:13:20 EST
> **Subject: The UK Guardian: Canada: nearly 14,000 people die from opioid overdoses in four years**
>
> Dist: HC.F PEIA Opioids / Opioides AREP F.SC
> December 13, 2019
> **Canada: nearly 14,000 people die from opioid overdoses in four years**
> *More than 17,000 have been hospitalized in what officials say is mounting crisis*
> Source: THeGuardian.com, by Leyland Cecco
> Nearly 14,000 people in Canada have died from opioid overdoses in the last four years and more than 17,000 have been hospitalized in what officials say is a mounting crisis that shows few signs of relief.
> In a report titled Opioid-related harms in Canada released this week, Canada's public health agency outlined the scope of the crisis.
> "The opioid overdose crisis continues to devastate many Canadians, their families and their communities from coast to coast to coast," Dr Theresa Tam, Canada's chief public health officer, and Dr Saqib Shahab, Saskatchewan's chief medical health officer, said in a joint statement issued alongside the report.
> "It's very disturbing to see these kind of numbers," said Dr Anita Srivastava, a physician professor of medicine at the University of Toronto
> The largest driver of the the crisis is fentanyl, a powerful synthetic drug that is often mixed into heroin to amplify its effects.
> Because almost all of the deaths recorded were determined to be accidental, health officials fear the extent to which street drugs are tainted with potent and toxic substances is poorly understood by the public.
> At the same time, a proliferation of opioid prescriptions over the last decade has exacerbated the problem: Canada remains one of the largest per capita consumers of prescription opioids in the world.
> Srivastava points to a "fragmented" healthcare system ill-equipped to blunt the growing crisis: opioid treatment is often limited to specialized clinics, meaning not all health centres are properly equipped to identify and deal with patients displaying symptoms of addiction.
> "If somebody shows up in the emergency room with an infection related to injecting opiates, more likely than not, they won't get offered treatment for opiate addiction," she said.
> While few places in the country have been spared by the crisis, western Canada continues to be the site of the most troubling statistics. British Columbia's rate of 22 deaths for every 100,000 residents is double the national average. Neighbouring Alberta has the second-highest rate in the country, at 16.2 deaths.

According to the report, men make up three-quarters of all opioid-related deaths, with those in their 30s at greatest risk of a fatal overdose.

Over the summer, Canada's governing Liberal party promised to increase funding to to combat the crisis, raising the total amount committed to $100m. Part of the effort includes greater resources for rural communities – among the worst hit – as well as the deployment of lifesaving naloxone kits and more resources for hospitals.

Canada has also passed legislation to increase the number of safe injection sites, a move welcomed by addiction advocates amid criticism from conservative politicians.

While the report's authors acknowledge the complexity of the the crisis, they stress the importance of overcoming many of the stigmas associated with addiction – something Srivastava often sees firsthand.

"Addiction is a great equalizer. It doesn't spare anybody and it goes across all spectrums of people," said Srivastava. "But there's very much this feeling [among the public] that it's not us that's being affected; it's somebody else."

https://www.theguardian.com/world/2019/dec/13/canada-opioids-crisis-overdoses-report

From: [redacted]

Sent: 2019-12-04 6:24 PM

To: Jenny.Kwan@parl.gc.ca

Cc: Justin.Trudeau@parl.gc.ca; Chrystia.Freeland@parl.gc.ca; Patty.Hajdu@parl.gc.ca; Diane.Lebouthillier@parl.gc.ca; Carla.Qualtrough@parl.gc.ca; Lawrence.Macaulay@parl.gc.ca; Navdeep.Bains@parl.gc.ca; Bill.Morneau@parl.gc.ca; Ahmed.Hussen@parl.gc.ca; Maryam.Monsef@parl.gc.ca; Bardish.Chagger@parl.gc.ca; Catherine.McKenna@parl.gc.ca; Deb.Schulte@parl.gc.ca; Tam, Dr Theresa (PHAC/ASPC); Michael.Strong@cihr-irsc.gc.ca; Coordinator@alliesforme.ca; [redacted]

Subject: Three Actions to Increase Awareness of Myalgic Encephalomyelitis

Attachments: Letter to MP Kwan re ME - December 4, 2019.pdf

Dear Ms. Kwan,

I am writing as one of your constituents, to express my concerns as someone affected by the debilitating chronic illness Myalgic Encephalomyelitis (ME, formerly known by the stigmatizing name Chronic Fatigue Syndrome or ME/CFS) to ask for your assistance in helping Canadians like me raise awareness about this debilitating disease.

Please see the attached letter.

Sincerely,

[redacted]

December 2, 2019

Jenny Kwan
MP for Vancouver East
House of Commons, Ottawa
K1A 0A6

Re: Three Actions to Increase Awareness of Myalgic Encephalomyelitis

Dear Ms. Kwan,

I am writing as one of your constituents, to express my concerns as someone affected by the debilitating chronic illness Myalgic Encephalomyelitis (ME, formerly known by the stigmatizing name Chronic Fatigue Syndrome or ME/CFS) to ask for your assistance in helping Canadians like me raise awareness about this debilitating disease.

What is ME?

ME is a complex, multi-system disease classified by the World Health Organization (WHO) as a neuro-immune illness occurring in sporadic and epidemic forms, and it can affect anyone at any given time, including children.

"*The onset of ME is often sudden, typically following a viral or other type of infection but may occur following other types of physical trauma. In other cases, the disease may develop gradually, over a period of weeks or months. Patients describe feeling severe 'flu-like' symptoms chronically. In addition to the characteristic post-exertional malaise (PEM), patients may also experience cognitive impairment, unrefreshing sleep, autonomic manifestations, such as heart rate variability, and also experience muscle and joint pain and sound, light, and chemical sensitivity. Elevated antibody titers to viruses may be present, in addition to low levels of autoimmune serology. ME/CFS can present with a wide range of severity*"[1].

First, The Bad News...The Canadian Context of ME

First, a bit of background on an illness that is still very much in the shadows in Canada. Based on the Statistics Canada 2016 Canadian Community Health Survey, this illness directly and severely impacts **over half a million Canadians**, as well as hundreds of thousands of their family members and loved ones. About 75% of individuals with ME are no longer able to work; 25% are house or bed bound[2]. The severely ill require complete darkness, complete silence, complete isolation, a feeding tube and catheter.

This has a significant impact on our Canadian economy. In the US, where an estimated 1 - 2.5 million individuals live with ME, the impact on the economy translates into approximately $17-24 billion annually in lost productivity and direct medical costs[3]. In Canada, a comparable and conservative estimate would be between $11-15 billion lost annually. It just doesn't make economic sense to continue ignoring this illness and those suffering from it.

History of the Illness

ME was first recognized during the 1934 Los Angeles outbreak and thought to be an atypical form of polio, although descriptions of ME symptoms can be dated back hundreds of years prior. Over the ensuing decades, ME outbreaks occurred in Iceland, Switzerland, Australia and elsewhere. From 1984 to 1992, ME outbreaks were endemic in North America. And then in 2015, Canadian ME rates surged by 37% over the previous year.

However, for close to 35 years, a psychological narrative (represented in the misleading and dismissive term 'chronic fatigue syndrome') has overtaken the medical discussion and research on this biological illness and patients have suffered and died because of this institutional harm and neglect.

Unfortunately, the medical establishment has a long history of psychologizing physical illnesses that predominantly affect women (e.g., MS, Endometriosis, Lupus, Ehlers Danlos, Fibromyalgia) and has irrevocably done the same with ME. However, it was subsequently confirmed that these illnesses do in fact have a biological basis, but only after decades of stigma that has resulted in lives lost.

This harmful practice is still happening today to all Canadians with ME, despite the numerous internationally-based scientific discoveries of metabolic dysfunction, epigenetic changes, and 'something in the serum' of ME patients. Unfortunately, ME is not taught in medical schools and even the colleges of physicians and surgeons is woefully behind in their understanding of this illness.

Chronic Illness, Compounded by Medical Harm, Significantly Increases Suicide Risk

It is important to note that, while our illness is <u>not</u> caused by depression or anxiety, it is common for patients to contemplate suicide due to the unrelenting pain and suffering. It is easy to empathize with these individuals who have spent decades of their lives suffering with an untreatable, incurable illness that is still today widely stigmatized by the healthcare system - a healthcare system that has yet to catch up with the science and is causing daily harm to patients and their families.

Several studies, including a recent Spanish one, have shown that patients with ME have a suicide rate approximately 5 times higher than the national average due to ongoing and untreated physical pain, loss of income and career, loss of independence and the lowest quality of life[4] of any chronic illness. And yet, we are dismissed in our physicians' offices because they, and their Physician Colleges, have not kept up to date on current ME research.

The impact is not just medical and social harm to ME patients, but this false narrative of ME has almost completely impeded research funding. Up until very recently, there were zero CIHR dollars committed for biomedical ME research.

The Good News Is…

CIHR is committed to moving biomedical ME research forward.

In December 2018, in collaboration with CIHR, ME stakeholders met in Montreal to establish the Interdisciplinary Canadian Collaborative ME Research Network (ICanCME) in anticipation of a CIHR funding opportunity for biomedical ME research. The funding opportunity was released in April and was for $280 000 each year, for 5 years.

On August 22nd, our community attended a funding announcement with the Minister of Health, Ginette Petitpas Taylor, where CIHR committed to funding the ICanCME Research Network.

Our community sees this as building an important foundation for further biomedical research. While we are certainly thankful to CIHR for their acknowledgement and understanding that this illness is biologically based and requires research and collaboration to turn the tide and stop the harm, this funding will only cover the basics of building a network.

Much more is needed to help us attract the best researchers and to really dig in to the science of ME. Regardless, our community is committed to making the most of this opportunity and will expand our research capacity to receive larger grants in the near future.

ME patients require a great deal more comprehensive investment to address our needs effectively and our government needs to provide what is equitable and meaningful to attract the best and the brightest researchers to this field.

All this begins with ME awareness. This is where we require your assistance. We need our elected representatives to step up and stand *with* us.

Three Actions You Can Take Today

I am writing to you as my elected representative because I want to invite you to take three actions which will support patients and increase momentum towards equitable funding, accessible treatments and a cure:

1 - Please write to the new Federal Minister of Health, the Honourable Patty Hajdu, to express your support and ask her to request that relevant Ministers and their teams **host a meeting with patients and researchers** to learn more about our illness and our challenges accessing adequate care and supports within their departments. These Ministers include those listed below in the CC section.

2 - Please share a resolution (SO31) in the House of Commons, drawing awareness to this illness and the need to have equitable biomedical research funding, on behalf of your constituents.

3 - Please join our non-partisan Allies for ME group and help us to raise public and physician awareness of this stigmatized, debilitating and chronic illness by including ME in your town halls, newsletters, consultations and other constituency activities. You can learn more by visiting AlliesForME.ca or by emailing us at Coordinator@AlliesForME.ca.

Some examples of this could include ...

a) Discussing ME issues as part of a health-themed town hall or roundtable discussion.
b) Connecting and meeting with your constituents who live with ME (and co-existing illnesses)
c) Supporting International ME Awareness Day on May 12th and International Severe ME Awareness Day on August 8th, on your social media. The previous Minister of Health, Ginette Petitpas Taylor, used her online platform recently to draw attention to our illness, challenges and needs and it was incredibly impactful.
d) Join our monthly news bulletin by emailing us at **Coordinator@AlliesForME.ca**

Your willingness to take action now will demonstrate your support for **over half a million Canadian ME patients** and will be a vital next step towards equitable research funding, increased physician awareness and the reduction of medical, social and financial harm.

This can also be a very important piece of the legacy you will leave behind, as an elected representative.

Thank you for your commitment. I look forward to receiving a response from you.

Sincerely,

[redacted]

cc.
Right Hon. Justin Trudeau, Prime Minister
Hon. Chrystia Freeland, Deputy Prime Minister and Minister of Intergovernmental Affairs
Hon. Patty Hajdu, Minister of Health
Hon. Diane Lebouthillier, Minister of National Revenue
Hon. Carla Qualtrough, Minister of Employment, Workforce Development and Disability Inclusion
Hon. Lawrence MacAulay, Minister of Veteran Affairs
Hon. Navdeep Bains, Minister of Innovation, Science and Industry
Hon. William Morneau, Minister of Finance
Hon. Ahmed Hussen, Minister of Families, Children and Social Development
Hon. Maryam Monsef, Minister for Women and Gender Equality and Rural Economic Development
Hon. Bardish Chagger, Minister of Diversity and Inclusion and Youth
Hon. Catherine McKenna, Minister of Infrastructure and Communities
Hon. Deb Schulte, Minister of Seniors
Dr. Theresa Tam, Chief Public Health Officer
Dr. Michael Strong, President of CIHR

Allies for ME (Coordinator@AlliesForME.ca)

[1] Dimmock, M., Levine, S., Wilder, T. (2018). Myalgic Encephalomyelitis / Chronic Fatigue Syndrome: What every family physician needs to know. Family Doctor, 6 (Winter 2018), 23-25. http://www.nysafp.org/NYSAFP/media/PDFs/Family%20Doctor/Family-Physician-Winter-2018WEB.pdf#page=23

[2] Institute of Medicine. *Beyond Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Redefining an Illness*. Washington, DC: The National Academies Press (2015). Available online at: http://www.nationalacademies.org/hmd/Reports/2015/ME-CFS.aspx

[3] Dimmock, M., Levine, S., Wilder, T. (2018). Myalgic Encephalomyelitis / Chronic Fatigue Syndrome: What every family physician needs to know. Family Doctor, 6 (Winter 2018), 23-25. http://www.nysafp.org/NYSAFP/media/PDFs/Family%20Doctor/Family-Physician-Winter-2018WEB.pdf#page=23

[4] Nacul, L. C., Lacerda, E. M., Campion, P., Pheby, D., Drachler, M. D., Leite, J. C., . . . Molokhia, M. (2011). The functional status and well being of people with myalgic encephalomyelitis/chronic fatigue syndrome and their carers. BMC Public Health, 11(1). doi:10.1186/1471-2458-11-402

From: Drugs Urgent Need / Besoins Urgent Drogues (HC/SC)
Sent: 2019-12-23 4:03 PM
To: Drugs Urgent Need / Besoins Urgent Drogues (HC/SC)
Subject: To notify of the removal of Priftin from the List/Aviser du retrait de Priftin à la Liste

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(le français suit)

This notification is to inform you of the removal of Priftin (rifapentine) 150 mg Tablet from the List of Drugs for an Urgent Public Health Need (Urgent Public Health Need List) for Ontario.

Health Canada announced the proposed publication of Regulations Amending the *Food and Drug Regulations* (Importation of Drugs for an Urgent Public Health Need) in Canada Gazette Part I on April 22, 2017. These Regulations were accepted into Canada Gazette Part II on June 20, 2017.

These Regulations allow for the importation and sale of certain foreign approved drugs that are not approved in Canada, as a means to address urgent public health needs in Canada, such as the current opioid crisis. Drugs eligible for this regulatory pathway will be placed on a list that will be maintained by the Minister of Health and published on the Government of Canada website. Only drugs that have been authorised for sale in the United States, the European Union, or Switzerland are eligible for importation under these Regulations.

****

(English is above)

La présente vise à vous informer du retrait de Priftin (rifapentine) comprimé 150 mg de la Liste des drogues utilisées pour des besoins urgents en matière de santé publique (Liste des drogues utilisées pour des besoins urgents en matière de santé publique) en Ontario.

Santé Canada a annoncé la publication proposée du règlement modifiant le *Règlement sur les aliments et drogues* (importation de drogues pour des besoins urgents en matière de santé publique) dans la Partie I de la *Gazette du Canada* le 22 avril 2017. Ce règlement a été publié dans la Partie II de la *Gazette du Canada* le 20 juin 2017.

Il permet l'importation et la vente de médicaments approuvés par un pays étranger et non approuvés par le Canada, afin de combler les besoins urgents du Canada en matière de santé publique, comme la crise des opioïdes qui sévit à l'heure actuelle. Les médicaments admissibles dans le cadre de la voie réglementaire actuelle figureront sur une liste qui sera tenue à jour par la ministre de la Santé et publiée sur le site Web du gouvernement du Canada. Seuls les médicaments dont la vente est autorisée aux États-Unis, dans les pays de l'Union européenne ou en Suisse sont admissibles à l'importation dans le cadre de ce règlement.

Therapeutic Products Directorate, Health Products and Food Branch
Health Canada/Government of Canada
drugs_urgent_need_besoin_urgent_medicaments@hc-sc.gc.ca

Direction des produits thérapeutiques, Direction générale des produits de santé et des aliments
Santé Canada/Gouvernement du Canada
drugs_urgent_need_besoin_urgent_medicaments@hc-sc.gc.ca

From: Tam, Dr Theresa (PHAC/ASPC)

Sent: 2019-12-05 1:49 PM

To: Bell, Tammy (PHAC/ASPC)

Subject: Touch base tomorrow

If for some reason Sara or Laura cannot meet tomorrow, I am fine with meeting you and Jeannette.

TT

Sent from my iPhone

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-23 5:29 PM
To: Bell, Tammy (PHAC/ASPC); Rendall, Jennifer (PHAC/ASPC); Hostrawser, Bonnie (PHAC/ASPC); Macey, Jeannette (PHAC/ASPC); Killen, Marita (PHAC/ASPC); Johnstone, Marnie (PHAC/ASPC)
Subject: FW: TRANSCRIPT: BNN - CPHO Dr. Tam discusses the opioid crisis - Dec 23 2019

This is the second half of the interview with Bloomberg. Looks OK – [redacted]

From: Frate, Nicolas (HC/SC) **On Behalf Of** Media Monitoring / Suivi des Medias (HC/SC)
Sent: 2019-12-23 4:30 PM
Subject: TRANSCRIPT: BNN - CPHO Dr. Tam discusses the opioid crisis - Dec 23 2019

Dist : HC.F PEIA Opioids / Opioides AREP F.SC

BNN
Mon Dec 23 2019
1:10 PM ET
CPHO Dr. Tam discusses the opioid crisis

JON ERLICHMAN (BNN-TV): A recent report revealed that stigma in Canada's healthcare system is diminishing the quality of health services available for those who might need it the most. Amanda Lang spoke earlier with Theresa Tam, Canada's Chief Public Health Officer, on just how urgent this problem is when it comes to addressing the country's opioid crisis.

THERESA TAM (Chief Public Health Officer of Canada): Particularly opioid related deaths is a massive issue, and I think you're right, many Canadians I talk to have no idea of the huge impact this has had in Canada. You know, 13,913 people since 2016 have died as a result of opioid-related deaths. Massive. And I think a huge segment of the population, particularly males, 75% of them are males, but also it cuts across all sectors of society, and that is having a massive impact. It is one of the biggest public health crises that we've seen in recent times.

AMANDA LANG (BNN-TV): In terms of the government response to that, part of the real, I guess the tragedy of this, are the people that are accessing street drugs with illegal components that then kill them, like fentanyl, because of the stigma around it. What do we need to do to reduce the stigma of addiction so that people who need the drugs for their addiction in a safe way can get them, and the people who need the help can get that help?

THERESA TAM: Well, you point to a very critical aspect of why this epidemic, this crisis, continues, is that people who use substances are afraid to present themselves to healthcare, and sometimes they have difficulty accessing care, and overall society stigmatises the individual people who use drugs. That is the truth of the matter in Canada.

I think a number of the actions have been used at multiple levels of government and in communities. One is providing naloxone so that people can use them to counteract an overdose of the toxic street supply. In some ways that's actually a way of reaching out the Good Samaritan law, which essentially says if you help people who are experiencing overdose you're not going to be penalized in any way, moves towards de-stigmatisation. Destigmatising language I think is very important. I always say use people first language, people who use substances, don't call people addicts and use derogatory discriminatory terminology.

I think one of the more visible ways to destigmatise substance use disorders is safe consumption sites and overdose prevention sites as well, because what these sites are trying to do, not just to help people, prevent them from dying from an overdose, they're at a point at which people can build the trust back into the linkages with the healthcare system. So, I think that's a fundamental aspect of these sites, is people who use drugs do not trust the health system, and this is a bridge to meet people where they're at, bridge them into care when they're ready.

So, a number of things, public awareness campaigns, telling people that it's not them or us, it can happen to any of us, your family members. It' so pervasive that no one is actually safe. The supply is extremely toxic.

AMANDA LANG: You also addressed, and I was interested, you know, in the report looking at kind of the state of affairs in Canada, this notion of discrimination for some people. Why is this such an important subject in terms of accessing the system and equity that we look at just groups that are discriminated against?

THERESA TAM: I think my report is pointing out that stigma is a fundamental barrier to accessing care. It is a main underlying factor leading to inequities. And so stigma, and its resulting discriminatory actions, does many things negatively impacting people's health. It's not just presenting barriers to access to care and other treatment services, social services, but housing, and society at large in terms of access.

But, also, stigma results in a chronic stress response in your body that can lead to physical harms such as high blood pressure, cardiovascular disease, mental health impacts like anxiety and depression. So, stigma, in a multitude of forms, is happening right now in society, but it's actually happening in the health system, and we can do better.

JON ERLICHMAN: That was Theresa Tam, Canada's Chief Public Health Officer, speaking with Amanda Lang.

-30-

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-04 8:53 AM
To: McLeod, Robyn (PHAC/ASPC)
Subject: Try a call with Comms and Anna at 9:30?

I won't be in for 9

Sent from my iPhone

ATIA - 19(1)

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-02 8:53 PM
To: Bell, Tammy (PHAC/ASPC)
Cc: McLeod, Robyn (PHAC/ASPC); Rendall, Jennifer (PHAC/ASPC); Hostrawser, Bonnie (PHAC/ASPC)
Subject: Re: Tuesday's meeting with comms on CPHO mandate and activities

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Thanks for these points.

Given the limited time i think setting the expectation on close collaboration to deliver outputs and results is a good start.

Sent from my iPhone

On Dec 2, 2019, at 16:32, Bell, Tammy (PHAC/ASPC) <tammy.bell@canada.ca> wrote:

> Hi Theresa,
> Tomorrow morning is the long-anticipated meeting between you and leads on the "three-legged stool". Jen, Bonnie and I have come up with some key messages you may wish to convey during that meeting. They are attached. Given this is only a 30 minute meeting, we expect this will be an opportunity for you to talk about your vision for collaboration amongst the three areas, to reinforce the small wins that have already been put in place and to acknowledge that both teams are still going through a transition and there is more work to do. I spoke about this approach with comms and they felt that it was a good way to proceed. They are anxious to hear from you.
> Just a heads up tha[redacted]
>
> Thanks,
> Tammy

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-04 1:14 PM
To: Bell, Tammy (PHAC/ASPC) [redacted] Rendall, Jennifer (PHAC/ASPC); Duhaime, Marc (PHAC/ASPC)
Subject: FW: University of Toronto: U of T researchers identify four types of opioid stigma contributing to the current crisis

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Some good alignment with the CPHO report and the messaging on the opioid/substance use crisis.

From: Cammock, Adelaide (HC/SC) **On Behalf Of** Media Monitoring / Suivi des Medias (HC/SC)
Sent: 2019-12-04 11:49 AM
Subject: University of Toronto: U of T researchers identify four types of opioid stigma contributing to the current crisis

Distribution group/Groupe de distribution: HC.F PEIA Opioids / Opioides AREP F.SC

December 2, 2019
U of T researchers identify four types of opioid stigma contributing to the current crisis
University of Toronto

Researchers from the University of Toronto have identified four types of opioid-related stigma that depend on a variety of factors, including the context of opioid use, the social identity and networks of the person who is consuming the opioid, and what type of opioid is being consumed, including prescribed opioids.

Each type requires targeted strategies to address the unique stigmas and reduce health inequities, the researchers say. The study was published in the December 2019 edition of the International Journal of Drug Policy.

“We know that stigma is both a driver and consequence of the current overdose crisis, but opioid-related stigma is poorly understood,” said Daniel Buchman, an assistant professor at the Dalla Lana School of Public Health and a senior author of the paper.

North America is in the grips of an opioid-related overdose crisis and stigma, discrimination and prejudice are major contributors. Substance use in general is highly stigmatized, but stigma is a complex concept. Researchers say that there’s a lack of good evidence on the specific sources of opioid stigma, how it manifests in various contexts and its impact on affected groups.

Buchman worked with a research team to conduct a review of publications on opioid-related stigma. The team identified more than 8,500 papers of which 51 were analyzed. Four main themes emerged: interpersonal and structural stigma toward people accessing opioid agonist therapy, which involves taking long-acting opioid medications like methadone and buprenorphine to prevent withdrawal symptoms; stigma related to opioids for the treatment of chronic pain; stigma in health-care settings; and self-stigma.

“Labels like ‘addict,’ ‘drug-seeker’ and ‘junkie’ are barriers to accessing treatment and many people who use opioids internalize these labels and report feelings of self-blame, loathing, despair, shame and moral weakness,” said Melissa McCradden, first-author on the paper and a master of health science student at the U of T Joint Centre for Bioethics.

Opioid agonist therapy is the gold standard of treatment for opioid use disorders, but researchers found that individuals receiving this treatment face stigma from multiple angles.

For example, methadone’s association with heroin use stigmatizes the medication and the people who use it. The literature suggests that some physicians refuse to prescribe opioid agonist therapy out of fear of being stigmatized by their colleagues. Some patients who are prescribed opioids for cancer pain feel compelled to disclose their identity as a ‘cancer patient’ at the pharmacy in order to differentiate themselves from people on methadone and avoid barriers in accessing their medications.

Stigma in health-care settings was another theme identified by the research team, both in the perception of physicians, nurses and pharmacists toward people who use opioids, as well as within health care's bureaucratic systems. For example, excessive regulation, paperwork and requirements specific to prescribing opioids may intensify the stigma experienced by people who use opioids.

"The literature suggests that some health-care professionals will make a distinction between patients with legitimate pain who have 'legitimate' reasons for accessing opioids, and patients with 'illegitimate' pain who do not have legitimate reasons for accessing opioids," said McCradden.

"This makes a harsh moral distinction between so-called 'deserving' and 'undeserving' patients. It entrenches stigma."

Ultimately, researchers say that a paradigm shift is needed to address the structural forms of stigma – including social and economic determinants, laws and public attitudes – in order to have an impact at the individual level.

"Stigma is considered a fundamental cause of population health inequalities and an independent social determinant of health," said Buchman, who is also a bioethicist at the University Health Network.

The social determinants of health are the conditions in which people live that are shaped by the distribution of money, power and resources. Social disadvantages – such as poverty, housing instability and discrimination – often occur simultaneously and can intensify stigma toward those who use opioids. This further marginalizes individuals, exacerbates health inequities and perpetuates stigma.

Buchman and McCradden say that evidence-based strategies to address stigma and its long-term impact on population health are critical to curb the overdose crisis.

"The more familiar you are with a person, the less likely you are to stigmatize them, so there's tremendous value in including and amplifying the voices of people who use opioids in health policy-making," said Buchman.

"Humanizing people who use drugs and moving towards decriminalization of all drugs are key to a cultural shift in re-thinking substance use and redressing opioid-related stigma."

https://www.utoronto.ca/news/u-t-researchers-identify-four-types-opioid-stigma-contributing-current-crisis

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From: Dickson, Samantha M (HC/SC)
Sent: 2019-12-04 8:47 AM
To: Namiesniowski, Tina (PHAC/ASPC); Tam, Dr Theresa (PHAC/ASPC)
Subject: Update and PHAC Retreat

Hello,

I hope all is well.

A quick update on the staffing of the LSU Director and General Counsel position for PHAC. We are in the final steps of the HR process and are expecting Sara Guild to join the team on 16 December 2019.

I also wanted to let you know that because I had planned on [redacted] I will unfortunately not be able to attend part I of the PHAC Priority-Setting retreat. Kathy Lipic will attend for LSU (Sabrina [redacted] I will be attending the second part of the retreat next Tuesday.

Should you have any questions or wish to discuss, please let me know.

Regards,
Samantha

Samantha Maislin Dickson
Executive Director and Senior General Counsel
Department of Justice
Health Legal Services / Government of Canada
samantham.dickson@canada.ca / Tel: 613-957-3766

Directrice exécutive et Avocate générale principale
Ministère de la Justice
Services juridiques de Santé / Gouvernement du Canada
samantham.dickson@canada.ca / Tél: 613-957-3766

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-30 11:31 AM
To: Costen, Eric (HC/SC)
Subject: Re: Update on Canada- U.S. Joint Action Plan on Opioids

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Thanks for the update

Sent from my iPhone

On Dec 27, 2019, at 14:29, Costen, Eric (HC/SC) <eric.costen@canada.ca> wrote:

> Dear Colleagues,
> As you are well aware, we have been working with the U.S. to finalize the Canada-U.S. Joint Action Plan on Opioids. You may recall, our U.S colleagues confirmed their availability for an in-person meeting in Washington on January 31. The purpose of this email is to provide you with a status update on this work and a summary of next steps.
> Following our engagement at the North American Dialogue on Drug Policy meeting on December 5-6, both countries have increased their efforts at the working level to finalize the Action Plan and outline parameters for the January 31 meeting. In preparation for this meeting, on December 18, Canadian and U.S lead departments met at the working level and agreed on the following:
>
> - Both countries should identify a maximum of 3 key activities under each strategic area;
> - The January 31 meeting should be a half-day meeting, focusing on 3 key activities currently outlined under the three strategic areas in the Action Plan (working draft attached); and
> - Develop a terms of reference document to outline the roles, responsibilities, timelines, and how the activities under the Action Plan will be completed.
>
> Both countries are currently consulting with their respective departments/agencies to select 3 key activities. In addition, Health Canada is currently developing a terms of reference document. We will request that our Government of Canada working-level partners provide their input to identify the 3 key activities and regarding the draft terms of reference document by January 8, 2020. An additional follow-up meeting at the working level will take place during the week of January 13 to discuss the revised draft Action Plan and to finalize details for the January 31 meeting.
> Given the timelines, a common briefing note will be prepared for departments to use in briefing up on the Action Plan. I would like to have a short **ADM-level preparatory call the week of January 6** to get your thoughts on our approach to finalize the Action Plan and next steps. An invite will be sent to your offices shortly.
> Thanks very much,
> Michelle on behalf of Eric Costen
> 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

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-12 5:52 PM
To: Bell, Tammy (PHAC/ASPC)
Cc: Rendall, Jennifer (PHAC/ASPC); Hostrawser, Bonnie (PHAC/ASPC); McLeod, Robyn (PHAC/ASPC); Killen, Marita (PHAC/ASPC); Macey, Jeannette (PHAC/ASPC)
Subject: RE: update on plan for release of your report

Sounds like a very sensible plan.

From: Bell, Tammy (PHAC/ASPC)
Sent: 2019-12-12 4:32 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Cc: Rendall, Jennifer (PHAC/ASPC) ; Hostrawser, Bonnie (PHAC/ASPC) ; McLeod, Robyn (PHAC/ASPC) ; Killen, Marita (PHAC/ASPC) ; Macey, Jeannette (PHAC/ASPC)
Subject: update on plan for release of your report

Hi there,

I just wanted to give you an update on the latest planning for the release of your report, in light of the vaping announcement next Wednesday.

We will proceed with tabling the report on the 18th and sending out advance copies to key stakeholders.

The report will go live the morning the 19th and comms will send out the NR that morning, along with a media offer. There will be no proactive media ahead of this.

Proposed media availability is the afternoon of the 19th.

We'll continue with social media until Dec. 22 and then continue with additional promotion in January. Comms is developing a separate plan for that.

There is a very small possibility that someone will pick up on the fact that the report is tabled on the 18th but no official comms will start until the 19th. If that's the case, we can always provide a copy of the report and respond reactively if needed. Comms thinks its more likely that media outlets will hold on the story until between Christmas and the NY when there are less "news" stories to include.

Let me know if you have any questions.

Tammy

ATIA - 19(1) ATIA - 17

From: McLeod, Robyn (PHAC/ASPC) on behalf of Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-13 9:39 AM
To: Romano, Anna (PHAC/ASPC); Tam, Dr Theresa (PHAC/ASPC)
Cc: Bell, Tammy (PHAC/ASPC); Halliday, Barrett (PHAC/ASPC); Hrynuik, Lisa (PHAC/ASPC)
Subject: RE: Update on UPHN proposal for Training platform on Healthy Cities

---

Hi Anna, Theresa's ok with your recommendation.

From: Romano, Anna (PHAC/ASPC)
Sent: 2019-12-13 9:13 AM
To: Tam, Dr Theresa (PHAC/ASPC)
Cc: Bell, Tammy (PHAC/ASPC) ; McLeod, Robyn (PHAC/ASPC) ; Halliday, Barrett (PHAC/ASPC) ; Hrynuik, Lisa (PHAC/ASPC)
Subject: RE: Update on UPHN proposal for Training platform on Healthy Cities

Hello Theresa,

Just closing the loop on this email trail. As you may recall, in October you received a message from [redacted] regarding the Urban Public Health Network's proposed Training for Healthy Interdisciplinary Knowledge in Cities project. [redacted] was requesting a letter of support to include with his letter of intent seeking funding from the Canadian Institutes of Health Research.

Earlier this week, Barrett provided [redacted] with the attached letter of support. After connecting with [redacted] directly, it was determined that this would be sufficient at this stage of the application process.

We recommend preparing a letter of support from you if the project is selected to go to the full proposal stage. It is anticipated that [redacted] will be informed whether he can submit a full proposal on January 31, 2020. The full proposal will then be due August 27, 2020.

Anna

From: Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca>
Sent: 2019-10-30 9:10 AM
To: Tam, Dr Theresa (PHAC/ASPC [redacted]
Cc: McLeod, Robyn (PHAC/ASPC) <robyn.mcleod@canada.ca>; Halliday, Barrett (PHAC/ASPC) <barrett.halliday@canada.ca>; Hrynuik, Lisa (PHAC/ASPC) <lisa.hrynuik@canada.ca>
Subject: RE: UPHN proposal for Training platform on Healthy Cities

Yes – have him send it to Barrett.

Thanks

From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: 2019-10-29 7:55 PM
To: Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca>

Cc: McLeod, Robyn (PHAC/ASPC) <robyn.mcleod@canada.ca>; Halliday, Barrett (PHAC/ASPC) <barrett.halliday@canada.ca>; Hrynuik, Lisa (PHAC/ASPC) <lisa.hrynuik@canada.ca>
Subject: Re: UPHN proposal for Training platform on Healthy Cities

Thanks.

Should I get Corey to send the proposal to Barrett?

Sent from my iPhone

On Oct 29, 2019, at 18:45, Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca> wrote:

> Yes of course. We will have a look.
>
> Sent from my iPhone
>
> On Oct 29, 2019, at 6:32 PM, Tam, Dr Theresa (PHAC/ASPC) [redacted] wrote:
>
> > At a very superficial glance, this like a good initiative for capacity building. Would there be someone on your team who would be able to provide comments?
> >
> > If the proposal looks good I could provide a letter of support.
> >
> > TT
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From** [redacted]
> > **Date:** October 29, 2019 at 18:16:04 EDT
> > **To** [redacted]
> > **Subject: UPHN proposal for Training platform on Healthy Cities**
> >
> > Theresa,
> > The Urban Public Health Network is the Nominated Principle Applicant for a CIHR/SSHRC/NSERC Training Platform grant on Healthy Cities
> > http://www.sshrc-crsh.gc.ca/news_room-salle_de_presse/latest_news-nouvelles_recentes/2019/healthy_cities-villes_en_sante-eng.aspx
> > We are working with a core group of about 8 core researchers on the initial LOI (and three co-PIs from U of T, UBC, and University of Montreal representing CIHR, SSHRC and NSERC scholars)to identify 50+ researchers across Canada to flesh out a proposal to train the next generation of researchers on methods to create healthy cities in areas of housing, built environment, food systems, transportation, and city planning, etc.

We will put in an application at the Letter of Intent stage by early December 2019 and if selected to go to full proposal, we will work on more details over the winter. I am writing to find out who within PHAC we could send a draft proposal for comment and possibly get a letter of support from you for this initiative. The intent will be to work with the UPHN and partners such as FCM, the Canadian Institute of Planners and PHAC to determine research priorities and to embed research trainees within the local context to carry our practical research and evaluation. See below for a brief description of our LOI at this stage, and I welcome your thoughts and reaction. Thanks!

Training for Healthy INterdisciplinary Knowledge in Cities (THINK-Cities)

The THINK-Cities Research Training Platform is a national initiative to develop a new generation of leaders with interdisciplinary expertise in implementation of research-based approaches to improve health and reduce health inequalities in cities across Canada and globally. We will recruit trainees with disciplinary expertise from health, social science and humanities and natural sciences and engineering and to implement a team-focused, problem-based training initiative. Training will focus on core challenges faced by cities such as housing, transportation, delivery of municipal services and neighbourhoods (including natural spaces and food environments), with inequity, sustainability and sociopolitical context as overarching domains. We will create fruitful long term collaborations with municipalities and between trainees and established researchers from CIHR-NSERC-SSHRC research disciplines, and will build a network reflecting the national and international scope of the project.

Through the Urban Public Health Network (UPHN) we leverage the 15 years of successful collaboration linking together Medical Health Officers from across Canada to address public health issues common to urban populations. Our team leads represent diversity in disciplinary expertise, gender, career stage and who are based at major educational institutions within Canada's three largest cities. In addition we include both a "smaller cities" node. Our proposal is also informed by our collective experience in delivering CIHR-NSERC training programs. Internationally we link with the multiple Healthy Cities research consortia working in low, middle and high income countries.

We focus not only on absolute health, but health disparities within cities and identifying and the drivers of such inequality and the development and application of interventions to reduce inequality. As such, our training program will emphasize the sociopolitical context of specific cities or

neighborhoods, geospatial approaches and cross-cultural factors. Our proposed training model will be multi-level and institutionally-based, complemented by pan-Canadian multidisciplinary problem-based teams embedded within municipal organizations. Functionally, we also propose regional training centers that will house regional healthy cities work to ensure we adapt to the generalizable and context specific aspects of healthy cities research. Our specific vision for the structure of THINK-Cities consists of integrated training activities connecting and building capacity across graduate student and decision-maker partners.

From: Beresford-Green, Debbie (HC/SC)

Sent: 2019-12-11 3:48 PM

To: Namiesniowski, Tina (PHAC/ASPC); Tam, Dr Theresa (PHAC/ASPC)

Cc: Beaudoin, Carlo (PHAC/ASPC); Thornton, Sally (PHAC/ASPC); Elmslie, Kim (PHAC/ASPC); Bent, Stephen (PHAC/ASPC); Romano, Anna (PHAC/ASPC); Borys, Shelley (PHAC/ASPC); Pearson, Michael (PHAC/ASPC); McKenna, Scott (HC/SC); O'Reilly, Joanna (HC/SC)

Subject: Update on Windows 10 deployments at PHAC

Attachments: Windows 10 is here! - Windows 10 est arrivé!.docx

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Tina, Theresa

I want to advise you that we are starting the official roll-out of Windows 10 to Public Health Agency of Canada (PHAC) employees over the coming weeks. While we have already upgraded 44% of PHAC employees to Windows 10 proactively, through “break fix” replacements, delivery of systems for new employees and upgrades to regional workstations, we are now targeting the roughly 650 workstations remaining within 100, 120, and 130 Colonnade and 785 Carling in December.

The attached notification will be sent out shortly to Colonnade and 785 Carling employees to advise that technicians will be onsite upgrading workstations that have been identified as ready.

As you know, we are committed to completing all of PHAC’s Windows 10 upgrades, in the regions and the NCR, by January 2021. I appreciate your continued support as we roll-out Windows 10. If you have any questions or concerns, please don’t hesitate to contact me or Scott.

Thank you,

Debbie

FROM / De:	**Please specify / Veuillez préciser :** CIO email account / compte de courriel de DPI For mass emails / pour les courriels au masses
To / À	Occupants of 100, 120, 130 Colonnade Road and 785 Carling Avenue
Cc	
BCC	Gerry Moysey Catherine Mahoney Jason McAndrew Jennifer Holloway Don Dodds Joanne Martel Mark Rogers John Koenders Satnam Girn
Date to be sent	December 11, 2019 (once confirmed that our ADM has sent a related message to PHAC President)
Subject / Sujet	Windows 10 is here! / Windows 10 est arrivé!
Hyperlinks / Hyperliens	
Attachments	

(Le français suit)

Starting in December, as part of workplace modernization, we will be replacing remaining Windows 7 devices with a comparable computer pre-loaded with the Windows 10 operating system. This upgrade will also include all required software.

Technicians will be at 100, 120 and 130 Colonnade Road and 785 Carling Avenue starting next week to verify workstations to ensure they are ready for the upgrade. When your workstation is ready, you will receive an email from the Windows 10 Project team providing you with further details.

What you need to do:

- Update your Directory information so that it is current. **You will not be upgraded if you haven't identified yourself as an employee working at 100, 120 or 130 Colonnade or 785 Carling Avenue**. Please ensure that your office location (i.e., room number) is also listed in the Directory.
- Move all files of corporate business value to the corporate shared drive or repository (e.g. RDIMS, Y:Drive, L:Drive).

- Delete transitory files.
- Store personal files on your K:Drive.
- Remove all personal effects and clutter from your desk area so the technician can readily access your system and cabling.
- Visit the Windows 10 section on mySOURCE to answer any common questions you may have prior to the upgrade.

PLEASE NOTE: All data stored on your C: drive (i.e. desktop, downloads, my documents, my pictures, my music, my videos etc.) will be permanently deleted.

If you have any questions or concerns please visit mySOURCE for contact information.

Scott McKenna

Acting Chief Information Officer, Corporate Services Branch
Health Canada and Public Health Agency of Canada / Government of Canada

****

À compter de décembre, dans le cadre de la modernisation des lieux de travail, nous remplacerons les appareils Windows 7 restants par un ordinateur comparable préinstallé avec le système d'exploitation Windows 10. Cette mise à niveau comprendra également tous les logiciels requis.

Les techniciens seront aux 100, 120 et 130, chemin Colonnade et 785, avenue Carling à compter de la semaine prochaine pour vérifier les postes de travail afin de s'assurer qu'ils sont prêts pour la mise à niveau. Lorsque votre poste de travail est prêt, vous recevrez un courriel de l'équipe du projet Windows 10 vous fournissant de plus amples détails.

Ce que vous devez faire :

- Mettez à jour les informations dans l'Annuaire. **Vous n'aurez pas la mise à niveau si vous n'avez pas indiqué que vous travaillez au 100, 120, et 130, chemin Colonnade ou 785, avenue Carling.** Veuillez-vous assurer que l'emplacement de votre bureau (c. à d. numéro de la pièce) figure également dans l'Annuaire.
- Déplacer tous les fichiers ayant une valeur opérationnelle dans un répertoire partagé (p. ex. SGDDI, répertoire partagé Y; répertoire partagé L).
- Supprimez les documents éphémères.
- Sauvegarder vos fichiers personnels sur votre lecteur K :
- Enlever tous vos effets personnels et autres objets de votre poste de travail, afin que le technicien puisse facilement accéder à votre système et aux câbles.
- Consulter la section au sujet de Windows 10 sur maSOURCE afin de trouver les réponses aux questions courantes sur la mise à niveau.

VEUILLEZ NOTER : Toutes les données sauvegardées sur votre répertoire C : (i.e. bureau de votre ordinateur, téléchargement, mes documents, mes photos, ma musique, mes vidéos etc.) seront définitivement supprimées.

Si vous avez des questions ou des préoccupations, veuillez visiter maSOURCE pour obtenir les coordonnées de la personne-ressource.

Scott McKenna

Dirigeant principal de l'information par intérim, Direction générale des services de gestion
Santé Canada et Agence de la santé publique du Canada / Gouvernement du Canada

From: Hrynuik, Lisa (PHAC/ASPC)
Sent: 2019-12-03 4:47 PM
To: Namiesniowski, Tina (PHAC/ASPC); Tam, Dr Theresa (PHAC/ASPC)
Cc: Romano, Anna (PHAC/ASPC); Tafaghod, Marzieh (HC/SC)
Subject: UPDATE: MIN briefing tomorrow on opioids, cannabis and vaping
Attachments: Min Briefing P2 on Vaping - PHAC prep Dec 3 2019.docx; Prelim PHAC activities youth vaping-Nov 27.docx; Points to Register - Opioids and Cannabis.docx

---

Anna asked that I send the attached to you both in advance of the MIN briefing Dec. 4th. PW to follow for all.

VAPING – re-purposed points to register and backpocket information on PT regulations based on what was provided last week, since there is no new vaping deck in the e-binder (notes just a verbal briefing on vaping). This includes re-sending the preliminary B2020 ask.

OPIOID – This is a continuation of the MinDM on problematic substance use from last week where only Part A was presented(the diagnostique). Part B tomorrow will include Community Youth prevention and scaling up Pathways.

CANNABIS – New deck and item; speaking points for this are embedded in the Opioids and Cannabis document.

Vaping Ministerial Briefing: Part 2
December 4, 2019
PHAC Points to register and Back Pocket Information

Vaping is the third item for this briefing, following opioids and cannabis. No deck has been provided; the E-binder notes that it will be a verbal briefing on vaping; we anticipate the focus will be on regulatory options.

If asked about status of pulmonary illnesses related to vaping – Canada

- As of November 29, 2019, there are 11 confirmed or probable cases of vaping-associated lung illness reported in Canada. Four provinces have reported cases: British Columbia (3), Ontario (3), Quebec (3), and New Brunswick (2).

- PHAC is currently working with Council of Chief Medical Officers of Health (CCMOH) to identify cases, and is exploring strategies for potentially expanding case finding strategies and and an approach to clinical guidance.

- Will be discussed during next CCMOH call planned for December 12, 2019. We have been advised that DM Lucas will be attending this meeting.

Youth Vaping: Options for the Way Forward

- PHAC is supportive of the proposed regulatory actions and can play a complimentary role on non-regulatory activities.

- You may want to signal the need to be mindful of potential increase of youth vaping of cannabis as new products enter Canadian market.

Potential PHAC Non-Regulatory Options Moving Forward

Immediate Proposed Additional Actions to Address Youth Vaping:

- In addition to CCMOH collaboration, CPHO can leverage role to engage additional networks (e.g. Health Professionals Forum; School Stakeholders Forum; and Joint Consortium of School Health).

- PHAC can help to amplify impact of federal actions, sharing information, and fostering collaboration across existing public health networks and partnerships.

Additional Proposed Future Actions:

- PHAC can help build evidence base, particularly related to equity, and support targeted interventions for priority youth populations and health professionals. PHAC has proposed potential work in a preliminary template as requested by Health Canada (attached):
  - Developing equity-oriented evidence to identify sub-populations of youth who are disproportionately affected by vaping;

- Knowledge mobilization and guidance products for health professionals and targeted public education for priority youth populations;

- Expand and leverage innovative G&C program for healthy living and chronic disease prevention, including youth cessation for priority populations; and

- Develop new G&C program to prevent problematic substance use among youth across substances, including vaping through data-driven, tailored interventions for communities **(NOTE: same proposal is included under potential actions forward under opioids and alcohol, as it helps to address common risk and protective factors across substances).**

Back pocket information on PT Regulatory Action

- As of November 2019, **nine of thirteen provinces and territories (PTs) have regulatory measures to address vaping***. Four PTs do not currently have or are in the process of changing their regulations on vaping.

- Most recently:
  - **British Columbia** introduced a 10-point plan that will reduce nicotine content in vaping products, restrict flavours, increase sales tax, and support a youth-led social media campaign against vaping.
  - **Quebec** announced a new Task Force against vaping and smoking, which will consult with stakeholders, look at nicotine levels in vaping products, the accessibility of vaping products, and propose new measures against vaping and smoking. A final recommendation report is expected in April 2020.
  - **Prince Edward Island** will consult the public and industry stakeholders on new vaping regulations, which include raising the minimum age of purchase from 19 to 21 and a ban on certain flavours.

- PTs with existing regulations to addressing vaping are: British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador.

- Of those jurisdictions with regulatory action on vaping, regulations are varied and focus on:
  - Bringing vaping/vaping products in line with existing tobacco legislation
  - Restricting age** of purchase
  - Restricting place of use
  - Restricting promotion and/or advertising
  - Restrictions on point of sale (vape shops, online market place, etc.)
  - Increases to sales tax rates

- Yukon, Northwest Territories and Nunavut are currently in the process of introducing regulations on vaping.
  - Yukon has introduced a bill that would set minimum age of purchase to 19 and prohibit the display or advertisement of vaping products;
  - Northwest Territories passed the *Smoking Control and Reduction Act* in August 2019, but it is not yet in effect.

- Nunavut has indicated amendments to the *Tobacco Control Act* to more strictly regulate vaping in line with tobacco will come in 2020.
- Alberta does not currently have regulations on vaping, and has indicated they are reviewing smoking and tobacco legislation to regulate vaping.

* Some jurisdictions have introduced new regulations that have not yet come into effect and are expected in 2020.

**Minimum age of purchase (where regulated) varies across the country from age 18-21.

Back pocket information on PT non-regulatory action

- All jurisdictions provide some level of public education and awareness around vaping, including within existing programming on smoking cessation and school-based initiatives. Messaging and programs target the following audiences:
  - Youth
  - Students
  - Parents
  - Health professionals
  - Teachers/Schools

- Some PTs, such as British Columbia and Manitoba are undertaking vaping-related initiatives in communities or with specific populations. For example:
  - British Columbia announced plans for a new social media campaign led by youth to "de-normalize" vaping
  - Manitoba is expanding its school-based Review and Rate anti-tobacco program to include vaping, which promotes critical thinking from a variety of perspectives including cessation, marketing and health impacts

Back pocket information on PT Cannabis Vaping Regulations

- British Columbia and Quebec have announced specific actions to address cannabis vaping:
  - British Columbia will apply all new regulations to both nicotine and cannabis vaping products, including a sales tax increase to 20%.
  - Quebec will restrict THC concentration to a maximum of 30% THC, effectively preventing cannabis vaping products from being sold in Quebec's legal market. The SQDC has announced it will not sell any cannabis vaping products.

Ministerial Briefing on Opioids, Cannabis and Vaping
Points below related to Opioids and Cannabis
(December 3, 2019)

At the last ministerial briefing on November 28, 2019, the Minister was presented with *Opioids Deck A* covering the diagnostique for the opioids crisis.

During today's briefing, the Minister will be presented with *Opioids Deck B* covering forward looking proposals, including PHAC's two proposals:

- *Support communities and school stakeholders to promote positive youth development and prevent problematic substance use.*

- *Promote non-stigmatizing and compassionate care from health and social service providers.*

Below are proposed points to register for these two proposals, as well as points to register with respect to the data and evidence proposal.

Youth Prevention Proposal: Support communities and school stakeholders to promote positive youth development and prevent problematic substance use

- The CPHO's 2018 report on the state of public health focussed on youth substance use and provided a strong evidence-based case and call to action to make prevention a priority to help reverse trends for future generations.

- We know that the opioid crisis is a symptom of a larger public health problem fueled by many interconnected issues, including trauma, social isolation, and social inequities – often referred to as "root causes".

- Prevention efforts represent the greatest potential for population health gains and cost savings over the long term compared to late and costly harm reduction and treatment; return on investment has been estimated at $15-18 for every dollar spent.

- Prevention will help reduce demand for potentially contaminated substances, helping to prevent deaths and harms in the short-term, while also helping to reverse trends for generations to come.

- PHAC is well-placed to leverage existing relationships and prevention work with youth and school stakeholders.

- Our proposal is based on an internationally-proven approach ('Iceland Model'), which supports communities to implement tailored, data-driven interventions to prevention problematic substance use among youth.

If pressed on examples of prevention interventions that could be implemented within schools or communities:

- *Interactive programs that help build social, emotional and executive function skills, such as planning, decision-making, communication and peer-resistance. These can support positive development and effective coping.*

Timelines, Costs and Scalability – Youth Prevention

- Implementation of this proposal could begin as early as Budget 2020.
- Breakdown of proposed costs include:
    - $10M per year and ongoing in G&Cs to support communities to implement interventions.
    - $3M per year and ongoing of contribution funding to support a research organization to operate a data and knowledge translation platform to provide communities with analyzed data and recommendations for community-based interventions.
    - $500K O&M plus 5 FTEs per year to support program delivery.
- Appropriate phasing of activities would involve funding to support collecting and synthesizing data in years 1-2, followed by supporting the implementation of data-driven community-based interventions in years 3-5.

- This proposal is completely scalable. Proposed costs could be reduced based on supporting fewer communities. Current proposal is based on supporting 50 communities.
- The costs associated with G&C funding to support communities is approximately $200K per community per year.
- The cost to support a research organization to operate the data platform is approximately $1M per year, plus approximately $40K per community per year.
- For example, this program could be scaled down by 30% to support 35 communities instead of 50 communities for ~$34.5M over 5 years, and $9.7M ongoing (plus costs associated with 3 FTEs).

Compassionate Care Proposal: Promote non-stigmatizing and compassionate care from health and social service providers

- Stakeholders—including people with lived and living experience and health professionals—have made it clear that people who use substances experience many barriers to care, including stigma within health systems.

- If efforts are to be made to divert people away from criminal justice systems towards health and social systems, it is crucial that barriers are addressed, and that these systems are safe and accessible.

- To help address these barriers, PHAC issued an anticipatory call for proposals for projects that enhance pathways to care for people who use drugs through system-level changes by scaling up evidence-informed interventions. We anticipate that 5-7 large-call projects could be supported through a time-limited investment ($3.5M over two years).

- Response to the call for proposals was high; 119 LOIs were received, totalling $68M in funding requests from across the country.

- Scaling up this investment in terms of time, funding and scope would allow PHAC to support more projects nationally across a broader range of health and social systems that interact with people who use substances.

If pressed on examples of interventions:

- *Evidence-based interventions such as trauma-informed practice, cultural safety, peer support and contact-based programming.*

Timelines, Costs and Scalability – Compassionate Care

- Implementation of this proposal could begin as early as Budget 2020.
- Breakdown of proposed costs include:
    - $5M per year and ongoing in G&Cs to support interventions.
    - $1M per year and ongoing of contribution funding to support an external organization to operate a knowledge hub.
    - $500K O&M plus 4 FTEs per year to support program delivery.
- This proposal is completely scalable. Proposed costs could be reduced based on supporting fewer interventions.
- The knowledge hub could be removed from a scaled down version.
- For example, this program could be scaled back by 50% without the knowledge hub for ~$13.75M over 5 years, and $2.75M ongoing (plus costs associated with 2 FTEs to support program delivery).

Support for Data and Evidence

Support for P/T capacity

- Funding received from Budget 2018, and proposed through the current off-cycle funding, has enabled the establishment and enhancement of substance-related harms surveillance. That said, there is a need for continued funding to support to provinces and territories to ensure they have the requisite capacity to contribute to these efforts.

- This could be accomplished by extending the placement of Public Health Officers in provinces and territories, which is currently set to expire in March 2021.

Canadian Drugs Observatory

- Strong governance and clear roles and responsibilities will be key as this initiative is developed.
- PHAC sees itself as feeding into the CDO by continuing to leverage its relationships and infrastructure with federal, provincial and territorial partners, in line with its mandate for substance-related harms surveillance.

On Cannabis

- The deck on cannabis primarily focusses on Health Canada's new control framework, but also includes a slide highlighting the need to promote informed decisions related to cannabis use.

- In 2017, PHAC received $2.8M over 5 years to support the role of the CPHO, and work with partners and stakeholders to effectively reach priority populations with tailored public education messaging related to cannabis (e.g. health professionals, pregnant and breastfeeding individuals, and seniors).

Prepared by Prevention of Problematic Substance Use
December 3, 2019

Preliminary PHAC proposals for non-regulatory activities to address youth vaping

	Small	Medium	Large
	Includes immediate actions to be taken within existing resources/reallocations and limited new resources	**Includes all items from small plus additional actions within a reasonable budget of new funding**	**Includes all items from small and medium asks plus additional actions. Reach for the stars model.**
1.	**Strengthening the Evidence Base on Equity-Oriented Dimensions of Youth Vaping**		
	Expand existing resources for FPT surveillance, coordination and information sharing on vaping-related lung illness in support of federal activities on youth and adult vaping to better understand the health effects.	Leverage existing PHAC evidence tools, including the Health Inequalities Reporting Initiative and the Health Behaviours in School-Aged Children survey to conduct equity-oriented analyses on vaping in priority sub-populations including risk and protective factors.	Collaborate with CIHR to co-fund a new applied public health chair to conduct research on equity dimensions of youth vaping and related harms.
		Work with provinces, territories and other stakeholders to identify the PHAC contributions to a Portfolio approach to 'natural experiments'; PHAC could provide expertise on equity analyses and non-regulatory levers within the context of broader policy frameworks; scalable across medium and large proposals.	Develop new/complementary data collection methods (e.g. oversampling specific areas/sub-groups) to better understand the equity dimensions of youth vaping and related harms, including in key sub-populations and diverse regions and communities.
2.	**Supporting Guidance Development and Knowledge Mobilization for Health and Related Allied Professionals**		
	Continue to leverage role of CPHO as leading voice of public health and engage CPHO networks (e.g. CCMOH, HP Forum; School Stakeholders Network) to support collaboration across jurisdictions and with key stakeholders to amplify impact of federal activities on public education and awareness. Work with existing health and allied professional networks to build youth vaping prevention messaging into existing and planned public education efforts (e.g. knowledge mobilization resources and guidance).	Support work with existing health professional and allied professional networks to develop new, youth vaping-specific knowledge mobilization and guidance products for professionals including information on nicotine, cannabis, prevention, cessation, and harm reduction.	Lead the development of a comprehensive suite of knowledge mobilization materials and clinical and community guidance products for professionals on youth vaping cessation and prevention, including information on nicotine, cannabis, prevention, cessation, and harm reduction.

3.	**Investing in Prevention and Cessation Interventions for Youth Priority Populations**		
	Expand current investment in Multi-sectoral Partnerships (MSP) program to support healthy living interventions that address multiple risk factors for chronic diseases (including tobacco/nicotine) to add vaping content, including vaping cessation, into pre-existing projects for priority youth populations (e.g. young LGBTQ2+ and low-income Canadians).	Provide new funding to the MSP program to launch solicitations focused on healthy living interventions that directly address vaping, including vaping cessation, for priority youth populations. **Note:** This option is scalable.	Establish a new dedicated funding stream within the MSP program that prioritizes innovative healthy living interventions that directly address vaping, including vaping cessation, for priority youth populations. Unique aspects would include the development of partnership platforms (e.g. peer network, liaison, youth engagement) to maximize uptake and impact. (scalable) **Note**: This option is scalable.
		Establish a new G&Cs program for youth prevention that supports the implementation of data-informed, community-based interventions that address risk and protective factors (e.g. mental health, bullying, stigma/discrimination, adult attachment community engagement) that related to youth vaping and other substance use. **Note:** This option is scalable and currently also being considered under the opioids and alcohol proposals as it cuts across substances.	Establish a new G&Cs program for youth prevention that supports the implementation of data-informed, community-based interventions that address the risk and protective factors (e.g. mental health, bullying, stigma/discrimination, adult attachment, community engagement) related to youth vaping and other substance use. Scaled-up to reach more communities across Canada. **Note:** This option is scalable and currently also being considered under the opioids and alcohol proposals as it cuts across substances.

Prepared by PHAC
November 27, 2019

ATIA-16(2)(c)

From: Hrynuik, Lisa (PHAC/ASPC)
Sent: 2019-12-03 4:48 PM
To: Namiesniowski, Tina (PHAC/ASPC); Tam, Dr Theresa (PHAC/ASPC)
Cc: Romano, Anna (PHAC/ASPC); Tafaghod, Marzieh (HC/SC)
Subject: RE: UPDATE: MIN briefing tomorrow on opioids, cannabis and vaping

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PW [redacted]

From: Hrynuik, Lisa (PHAC/ASPC)
Sent: 2019-12-03 4:47 PM
To: Namiesniowski, Tina (PHAC/ASPC) ; Tam, Dr Theresa (PHAC/ASPC)
Cc: Romano, Anna (PHAC/ASPC) ; Tafaghod, Marzieh (HC/SC)
Subject: UPDATE: MIN briefing tomorrow on opioids, cannabis and vaping

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CANNABIS – New deck and item; speaking points for this are embedded in the Opioids and Cannabis document.

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-05 5:05 PM
To: Romano, Anna (PHAC/ASPC)
Cc: Namiesniowski, Tina (PHAC/ASPC); Hollington, Jennifer (HC/SC); Gallagher, Gerry (PHAC/ASPC)
Subject: Re: UPDATE: New VALI case reported by Ontario

Sensitivity: Confidential

Yes I recommend waiting till next Thursday for web, unless there is any other extra ordinary reason on why we can't wait.

TT

Sent from my iPhone

On Dec 5, 2019, at 16:41, Romano, Anna (PHAC/ASPC) wrote:

> Hi Theresa,
> Ontario has now formally reported a new probable case of VALI. Therefore, as of today, a total of 14 confirmed (5) and probable (9) cases of vaping-associated lung illness have been reported to PHAC from British Columbia (3), New Brunswick (2), Ontario (4) and Quebec (5). Details are included in the attached Epi summary.
> Note: This case is not captured in the web update that went live yesterday at 5pm. The Ontario Ministry of Health does not plan on doing proactive communications to media, however we should be prepared that this may end up in the media anyway (as we've seen for other cases).
>
> Based on your direction yesterday, I wanted to double check that you would recommend waiting until the regular Thursday schedule for updating the website.
> Anna
> ***Anna Romano***
> Vice-President | vice présidente
> Health Promotion and Chronic Disease Prevention Branch | Direction générale de la promotion de la santé et de la prévention des maladies chroniques
> Public Health Agency of Canada | Agence de la santé publique du Canada
> Tel: 613-960-2863

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-03 6:36 PM
To: Romano, Anna (PHAC/ASPC); Namiesniowski, Tina (PHAC/ASPC)
Cc: Tafaghod, Marzieh (HC/SC); Mead, Jobina (PHAC/ASPC); Killen, Marita (PHAC/ASPC); Gallagher, Gerry (PHAC/ASPC); Hrynuik, Lisa (PHAC/ASPC)
Subject: RE: Update: New VALI cases reported by Quebec

Sensitivity: Confidential

Thanks Anna.

Do we know if QC is going public with the new cases before Thurs or are they only going to react to media once we have posted the national update?

TT

From: Romano, Anna (PHAC/ASPC)
Sent: 2019-12-03 6:29 PM
To: Namiesniowski, Tina (PHAC/ASPC) ; Tam, Dr Theresa (PHAC/ASPC)
Cc: Tafaghod, Marzieh (HC/SC) ; Mead, Jobina (PHAC/ASPC) ; Killen, Marita (PHAC/ASPC) ; Gallagher, Gerry (PHAC/ASPC) ; Hrynuik, Lisa (PHAC/ASPC)
Subject: Fwd: Update: New VALI cases reported by Quebec
Sensitivity: Confidential

FYI

Sent from my iPhone

Begin forwarded message:

> **From:** "Romano, Anna (PHAC/ASPC)" <anna.romano@canada.ca>
> **Date:** December 3, 2019 at 6:28:03 PM EST
> **To:** "Bogden, Jacqueline (HC/SC)" <jacqueline.bogden@canada.ca>, "Hollington, Jennifer (HC/SC)" <jennifer.hollington@canada.ca>, "Ianiro, Robert (HC/SC)" <robert.ianiro@canada.ca>, "Costen, Eric (HC/SC)" <eric.costen@canada.ca>
> **Cc:** "Ponic, Pamela (PHAC/ASPC)" <pamela.ponic@canada.ca>, "Gallagher, Gerry (PHAC/ASPC)" <gerry.gallagher@canada.ca>, "Hrynuik, Lisa (PHAC/ASPC)" <lisa.hrynuik@canada.ca>, "Vaping illness-maladie vapotage (PHAC/ASPC)" <phac.vapingillness-maladievapotage.aspc@canada.ca>, "Ugnat, Anne-Marie (PHAC/ASPC)" <anne-marie.ugnat@canada.ca>, "Ogunnaike-Cooke, Susanna (PHAC/ASPC)" <susanna.ogunnaike-cooke@canada.ca>, "MacKenzie, Sara (HC/SC)" <sara.mackenzie@canada.ca>
> **Subject: Update: New VALI cases reported by Quebec**
>
> Colleagues,
>
> This is to inform you that PHAC received official confirmation from Quebec that they have identified 2 new confirmed cases. Epi summary

and case tracker to follow. The updated statement for Min-DM briefing is outlined below:

- As of December 3, 2019, a total of 13 cases of vaping-associated lung illness have been reported to PHAC from British Columbia (3), New Brunswick (2), Ontario (3) and Quebec (5).

Pending DM and MinO receipt, we propose that the VALI website content be updated on Thursday, December 5 to reflect this information.

Jacquie: Appreciate you copying Tina and Theresa on the email to Stephen.

Regards,

Anna

ATIA-16(2)(c)

Subject: URGENT Discussion RE: Statements
Location: Dial-in [redacted] / Conference ID [redacted]

Start: Wed 2019-12-18 1:40 PM
End: Wed 2019-12-18 2:00 PM
Show Time As: Tentative

Recurrence: (none)

Meeting Status: Not yet responded

Organizer: Tam, Dr Theresa (PHAC/ASPC)
Required Attendees: MacKenzie, Sara (HC/SC; Russo, Laura (HC/SC); Auger, Julie (PHAC/ASPC)

ATIA - 13(1)(b) ATIA - 19(1)

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-13 10:38 AM
To: [redacted]
Cc:
Subject: Re: Urgent guidance please - EB report

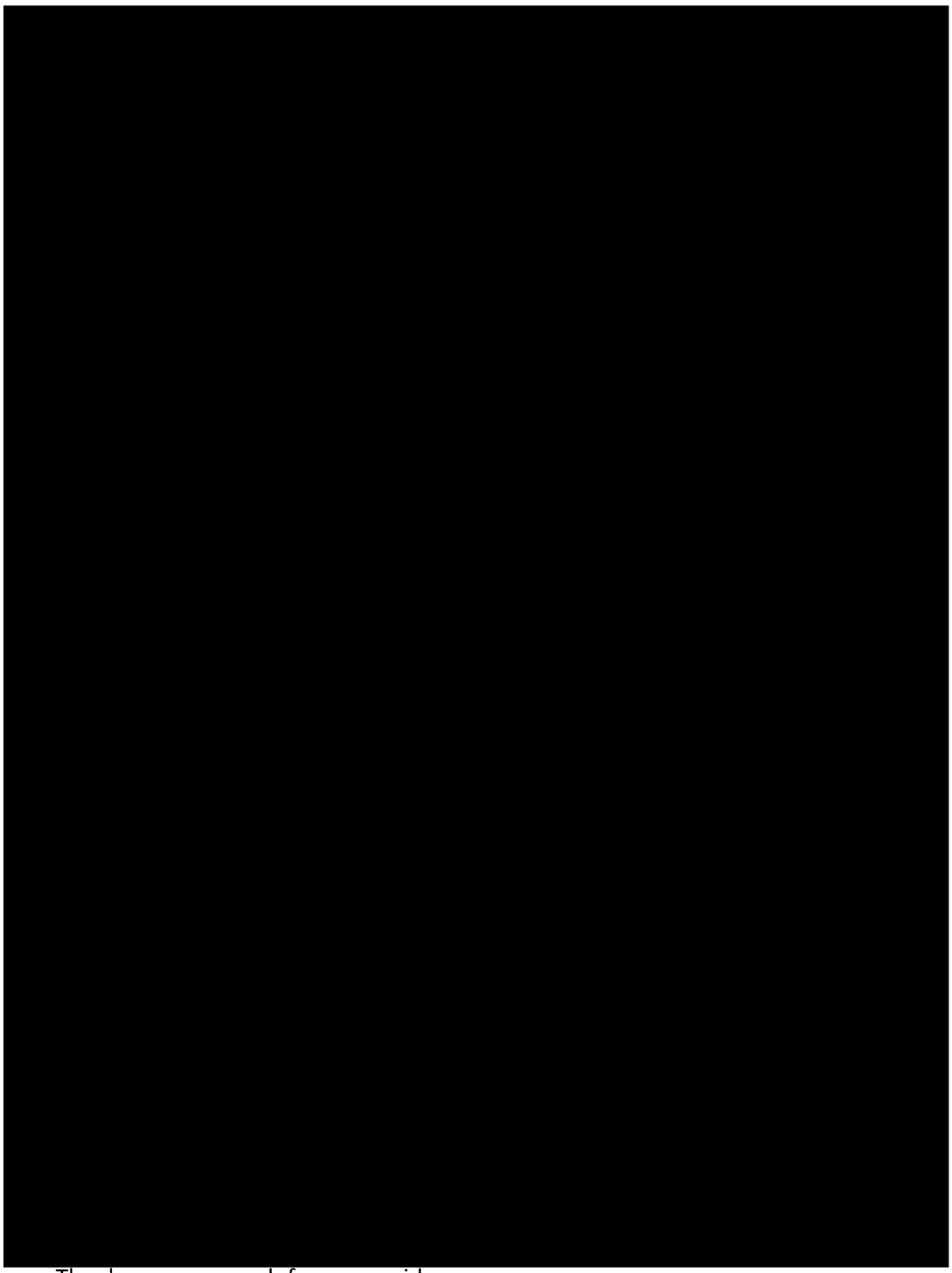
I am also fine with revisions and prefer 2nd version of para 12 but either is fine

Sent from my iPhone

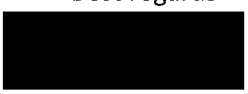
On Dec 13, 2019, at 09:55, [redacted] wrote:

> Hi all - the suggested revisions look fine to me.
>
> [redacted]
>
> Sent from my iPhone
>
> On Dec 13, 2019, at 09:26, [redacted] wrote:
>
> > Dear all
> > We are at the final stage of producing the EB report and would like to seek your urgent guidance on two paragraphs. Please note that we aim to finalize the document by COB today.
> >
> > [redacted]

ATIA - 13(1)(b) ATIA - 19(1)



Thank you very much for your guidance
Best regards



From: [redacted]

Sent: 2019-12-04 10:35 AM

To: Scott.Duvall@parl.gc.ca

Cc: Justin.Trudeau@parl.gc.ca; Chrystia.Freeland@parl.gc.ca; Patty.Hadju@parl.gc.ca; Diane.Lebouthillier@parl.gc.ca; Carla.Qualtrough@parl.gc.ca; Lawrence.Macaulay@parl.gc.ca; Navdeep.Bains@parl.gc.ca; Bill.Morneau@parl.gc.ca; Ahmed.Hussen@parl.gc.ca; Maryam.Monsef@parl.gc.ca; Bardish.Chagger@parl.gc.cc; Catherine.McKenna@parl.gc.ca; Deb.Schulte@parl.gc.ca; Tam, Dr Theresa (PHAC/ASPC); Michael.Strong@cihr-irsc.gc.ca

Subject: Urgent: Three Actions to Increase Awareness of Myalgic Encephalomyelitis

---

December 2nd, 2019

Scott Duvall
MP for Hamilton Mountain
House of Commons, Ottawa
K1A 0A6

Re: Three Actions to Increase Awareness of Myalgic Encephalomyelitis

Dear Mr. Scott Duvall

I am writing as one of your constituents, to express my concerns as someone affected by the debilitating chronic illness Myalgic Encephalomyelitis (ME, formerly known by the stigmatizing name Chronic Fatigue Syndrome or ME/CFS) to ask for your assistance in helping Canadians like me raise awareness about this debilitating disease.

What is ME?

ME is a complex, multi-system disease classified by the World Health Organization (WHO) as a neuro-immune illness occurring in sporadic and epidemic forms, and it can affect anyone at any given time, including children.

"*The onset of ME is often sudden, typically following a viral or other type of infection but may occur following other types of physical trauma. In other cases, the disease may develop gradually, over a period of weeks or months. Patients describe feeling severe 'flu-like' symptoms chronically. In addition to the characteristic post-exertional malaise (PEM), patients may also experience cognitive impairment,*

unrefreshing sleep, autonomic manifestations, such as heart rate variability, and also experience muscle and joint pain and sound, light, and chemical sensitivity. Elevated antibody titers to viruses may be present, in addition to low levels of autoimmune serology. ME/CFS can present with a wide range of severity"[i].

First, The Bad News...The Canadian Context of ME

First, a bit of background on an illness that is still very much in the shadows in Canada. Based on the Statistics Canada 2016 Canadian Community Health Survey, this illness directly and severely impacts **over half a million Canadians**, as well as hundreds of thousands of their family members and loved ones. About 75% of individuals with ME are no longer able to work; 25% are house or bed bound[ii]. The severely ill require complete darkness, complete silence, complete isolation, a feeding tube and catheter.

This has a significant impact on our Canadian economy. In the US, where an estimated 1 - 2.5 million individuals live with ME, the impact on the economy translates into approximately $17-24 billion annually in lost productivity and direct medical costs[iii]. In Canada, a comparable and conservative estimate would be between $11-15 billion lost annually. It just doesn't make economic sense to continue ignoring this illness and those suffering from it.

History of the Illness

ME was first recognized during the 1934 Los Angeles outbreak and thought to be an atypical form of polio, although descriptions of ME symptoms can be dated back hundreds of years prior. Over the ensuing decades, ME outbreaks occurred in Iceland, Switzerland, Australia and elsewhere. From 1984 to 1992, ME outbreaks were endemic in North America. And then in 2015, Canadian ME rates surged by 37% over the previous year.

However, for close to 35 years, a psychological narrative (represented in the misleading and dismissive term 'chronic fatigue syndrome') has overtaken the medical discussion and research on this biological illness and patients have suffered and died because of this institutional harm and neglect.

Unfortunately, the medical establishment has a long history of psychologizing physical illnesses that predominantly affect women (e.g., MS, Endometriosis, Lupus, Ehlers Danlos, Fibromyalgia) and has irrevocably done the same with ME. However, it was subsequently confirmed that these illnesses do in fact have a biological basis, but only after decades of stigma that has resulted in lives lost.

This harmful practice is still happening today to all Canadians with ME, despite the numerous internationally-based scientific discoveries of metabolic dysfunction, epigenetic changes, and 'something in the serum' of ME patients. Unfortunately, ME is not taught in medical schools and even the colleges of physicians and surgeons is woefully behind in their understanding of this illness.

Chronic Illness, Compounded by Medical Harm, Significantly Increases Suicide Risk

It is important to note that, while our illness is not caused by depression or anxiety, it is common for patients to contemplate suicide due to the unrelenting pain and suffering. It is easy to empathize with these individuals who have spent decades of

their lives suffering with an untreatable, incurable illness that is still today widely stigmatized by the healthcare system - a healthcare system that has yet to catch up with the science and is causing daily harm to patients and their families.

Several studies, including a recent Spanish one, have shown that patients with ME have a suicide rate approximately 5 times higher than the national average due to ongoing and untreated physical pain, loss of income and career, loss of independence and the lowest quality of life[iv] of any chronic illness. And yet, we are dismissed in our physicians' offices because they, and their Physician Colleges, have not kept up to date on current ME research.

The impact is not just medical and social harm to ME patients, but this false narrative of ME has almost completely impeded research funding. Up until very recently, there were zero CIHR dollars committed for biomedical ME research.

The Good News Is...

CIHR is committed to moving biomedical ME research forward.

In December 2018, in collaboration with CIHR, ME stakeholders met in Montreal to establish the Interdisciplinary Canadian Collaborative ME Research Network (ICanCME) in anticipation of a CIHR funding opportunity for biomedical ME research. The funding opportunity was released in April and was for $280 000 each year, for 5 years.

On August 22nd, our community attended a funding announcement with the Minister of Health, Ginette Petitpas Taylor, where CIHR committed to funding the ICanCME Research Network.

Our community sees this as building an important foundation for further biomedical research. While we are certainly thankful to CIHR for their acknowledgement and understanding that this illness is biologically based and requires research and collaboration to turn the tide and stop the harm, this funding will only cover the basics of building a network.

Much more is needed to help us attract the best researchers and to really dig in to the science of ME. Regardless, our community is committed to making the most of this opportunity and will expand our research capacity to receive larger grants in the near future.

ME patients require a great deal more comprehensive investment to address our needs effectively and our government needs to provide what is equitable and meaningful to attract the best and the brightest researchers to this field.

All this begins with ME awareness. This is where we require your assistance. We need our elected representatives to step up and stand *with* us.

Three Actions You Can Take Today

I am writing to you as my elected representative because I want to invite you to take three actions which will support patients and increase momentum towards equitable funding, accessible treatments and a cure:

1 - Please write to the new Federal Minister of Health, the Honourable Patty Hajdu, to express your support and ask her to request that relevant Ministers and

their teams **host a meeting with patients and researchers**to learn more about our illness and our challenges accessing adequate care and supports within their departments. These Ministers include those listed below in the CC section.

2 - Please share a resolution (SO31) in the House of Commons, drawing awareness to this illness and the need to have equitable biomedical research funding, on behalf of your constituents.

3 - Please join our non-partisan Allies for ME group and help us to raise public and physicianawareness of this stigmatized, debilitating and chronic illness by including ME in your town halls, newsletters, consultations and other constituency activities. You can learn more by visiting AlliesForME.ca or by emailing us at Coordinator@AlliesForME.ca.

Some examples of this could include ...

a) Discussing ME issues as part of a health-themed town hall or roundtable discussion.
b) Connecting and meeting with your constituents who live with ME (and co-existing illnesses)
c) Supporting International ME Awareness Day on May 12th and International Severe ME Awareness Day on August 8th, on your social media. The previous Minister of Health, Ginette Petitpas Taylor, used her online platform recently to draw attention to our illness, challenges and needs and it was incredibly impactful.
d) Join our monthly news bulletin by emailing us at Coordinator@AlliesForME.ca

Your willingness to take action now will demonstrate your support for **over half a million Canadian ME patients** and will be a vital next step towards equitable research funding, increased physician awareness and the reduction of medical, social and financial harm.

This can also be a very important piece of the legacy you will leave behind, as an elected representative.

Thank you for your commitment. I look forward to receiving a response from you.

Sincerely,

[redacted]

cc.
Right Hon. Justin Trudeau, Prime Minister

Hon. Chrystia Freeland, Deputy Prime Minister and Minister of Intergovernmental Affairs

Hon. Patty Hajdu, Minister of Health
Hon. Diane Lebouthillier, Minister of National Revenue

Hon. Carla Qualtrough, Minister of Employment, Workforce Development and Disability Inclusion

Hon. Lawrence MacAulay, Minister of Veteran Affairs

Hon. Navdeep Bains, Minister of Innovation, Science and Industry

Hon. William Morneau, Minister of Finance

Hon. Ahmed Hussen, Minister of Families, Children and Social Development

Hon. Maryam Monsef, Minister for Women and Gender Equality and Rural Economic Development

Hon. Bardish Chagger, Minister of Diversity and Inclusion and Youth

Hon. Catherine McKenna, Minister of Infrastructure and Communities

Hon. Deb Schulte, Minister of Seniors

Dr. Theresa Tam, Chief Public Health Officer

Dr. Michael Strong, President of CIHR

Allies for ME (Coordinator@AlliesForME.ca)

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[i] Dimmock, M., Levine, S., Wilder, T. (2018). Myalgic Encephalomyelitis / Chronic Fatigue Syndrome: What every family physician needs to know. Family Doctor, 6 (Winter 2018), 23-25. http://www.nysafp.org/NYSAFP/media/PDFs/Family%20Doctor/Family-Physician-Winter-2018WEB.pdf#page=23

[ii] Institute of Medicine. *Beyond Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Redefining an Illness*. Washington, DC: The National Academies Press (2015). Available online at: http://www.nationalacademies.org/hmd/Reports/2015/ME-CFS.aspx

[iii] Dimmock, M., Levine, S., Wilder, T. (2018). Myalgic Encephalomyelitis / Chronic Fatigue Syndrome: What every family physician needs to know. Family Doctor, 6 (Winter 2018), 23-25. http://www.nysafp.org/NYSAFP/media/PDFs/Family%20Doctor/Family-Physician-Winter-2018WEB.pdf#page=23

[iv] Nacul, L. C., Lacerda, E. M., Campion, P., Pheby, D., Drachler, M. D., Leite, J. C., . . . Molokhia, M. (2011). The functional status and well being of people with myalgic encephalomyelitis/chronic fatigue syndrome and their carers. BMC Public Health, 11(1). doi:10.1186/1471-2458-11-402

ATIA - 17 ATIA - 19(1)

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-20 5:22 PM
To: Romano, Anna (PHAC/ASPC)
Cc: Johnstone, Marnie (PHAC/ASPC)
Subject: RE: VALI case reporting over the holidays

[redacted]

From: Romano, Anna (PHAC/ASPC)
Sent: 2019-12-20 4:56 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Cc: Johnstone, Marnie (PHAC/ASPC)
Subject: RE: VALI case reporting over the holidays

Yes! Was just about to send you a Vaping update. Will do that shortly.

But short answer is yes – we finalized process with HC this morning.

Just to confirm – you are away for 2 weeks?

From: Tam, Dr Theresa (PHAC/ASPC) [redacted]
Sent: 2019-12-20 4:53 PM
To: Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca>
Cc: Johnstone, Marnie (PHAC/ASPC) <marnie.johnstone@canada.ca>
Subject: VALI case reporting over the holidays

Hi Anna

Hopefully you now have the process in place for flagging and reporting up VALI cases.

Is your team well set up for reporting over the holidays? Do you need any support?

Any intel from your team on cases in the "pipeline" that may get reported in the next couple of weeks?

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: 2019-12-20 5:49 PM
To: Romano, Anna (PHAC/ASPC); Namiesniowski, Tina (PHAC/ASPC)
Cc: Hollington, Jennifer (HC/SC); Hrynuik, Lisa (PHAC/ASPC); Gallagher, Gerry (PHAC/ASPC); McKinnon, Karen (PHAC/ASPC)
Subject: RE: Resending: VALI website updates over the holidays

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Thanks Anna

From: Romano, Anna (PHAC/ASPC)
Sent: 2019-12-20 5:29 PM
To: Tam, Dr Theresa (PHAC/ASPC) ; Namiesniowski, Tina (PHAC/ASPC)
Cc: Hollington, Jennifer (HC/SC) ; Hrynuik, Lisa (PHAC/ASPC) ; Gallagher, Gerry (PHAC/ASPC) ; McKinnon, Karen (PHAC/ASPC)
Subject: FW: Resending: VALI website updates over the holidays

Here is the plan over the holiday period.

From: Vaping illness-maladie vapotage (PHAC/ASPC) <phac.vapingillness-maladievapotage.aspc@canada.ca>
Sent: 2019-12-20 4:01 PM
To: MacKenzie, Sara (HC/SC) <sara.mackenzie@canada.ca>
Cc: Hollington, Jennifer (HC/SC) <jennifer.hollington@canada.ca>; Mcleod, Kathleen (HC/SC) <kathleen.mcleod@canada.ca>; Ugnat, Anne-Marie (PHAC/ASPC) <anne-marie.ugnat@canada.ca>; Gallagher, Gerry (PHAC/ASPC) <gerry.gallagher@canada.ca>; Romano, Anna (PHAC/ASPC) <anna.romano@canada.ca>
Subject: Resending: VALI website updates over the holidays

On behalf of Anna Romano, please find below, as discussed on the Vaping Coordination call this morning, the summary of the P/T reporting and website update plan:

- For the week of Dec 23 to 27, we expect to have minimal reports coming in that week, given that Dec 25th and 26th are holidays. P/Ts will report on any deaths or first case of VALI in jurisdictions that have not yet reported any cases. A website update can happen on Dec 27, as directed by the President; if there are no cases reported on December 24, the website update will simply be to change the date (i.e. "As of **December 27, 2019**, there were 14 cases …").

  Please note: we recommend that the update happen late on Friday Dec 27, in order to give the VALI staff the day to collate P/T reports if there is case information to pull together.

- P/Ts will report as usual on Tuesday, Dec 31. We recommend that the web update happen on January 3rd, given that January 1 is a holiday and no staff will be asked to work on that day to tally the P/T reports.

- The Vaping generic account will be monitored on work days over the holiday period. For Dec 25, 26 and Jan 1, and on weekends, an automatic out-of-office message will be in place which will provide a phone number for a staff member in case of urgent need. Therefore, if a jurisdiction has a first case or a death that must be reported asap (due to plans to go to the media), the jurisdiction rep will be able to notify the Agency by calling the phone number.

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-24 12:17 PM
To: Thornton, Sally (PHAC/ASPC)
Subject: FW: Various
Attachments: Healthcare Mgmt Forum Article 18Dec2019 FINAL.docx

---

Hi Sally,

I wanted to ask a couple of PTs as to what their hospitals do in terms of emergency exercises. Could you send me the contact for the BC and ON health emergency director?

Here is a copy of the article I am working on . the Journal is for Health Leaders and they are putting together a special edition that will have David (Butler) Jones as guest editor. I cannot recall all the other topics that will be covered but I know that there will be someone covering international perspective. Please provide comments if you are interested and if you have time!

Please find a request below. Could I send the PhD candidate your way? Anyone else I should send them to? I am thinking Gina Charos and the pandemic team because I know ethics is considered in the Canadian Pandemic Influenza Planning ….

TT

From: [redacted]
Sent: 2019-12-20 12:06 PM
To: Tam, Dr Theresa (PHAC/ASPC)
Subject: Various

Dear Theresa,

The below paragraph is from [redacted]

In the meantime, a very merry Christmas to you and your family, and all the best for the new year 2020.

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

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-24 5:51 PM
To: [redacted]
Cc: Thornton, Sally (PHAC/ASPC)
Subject: Re: Various

Dear [redacted]

Lovely to hear from you.

Sally Thornton, our VP in charge of Health Security would be happy to assist [redacted] Sally is copied on this email.

I have been busy focusing on substance use challenges including the opioid crisis but also working on AMR.

Did you finish editing the next edition of the Control of Communicable Diseases? I recall doing something for the IHR chapter but have not really followed up on new developments since then.

Have a Merry Christmas and a Healthy 2020.

Theresa

Sent from my iPhone

On Dec 20, 2019, at 12:06, David Heymann [redacted] wrote:

> Dear Theresa,
> The below paragraph is from [redacted]
> In the meantime, a very merry Christmas to you and your family, and all the best for the new year 2020.
> [redacted]

Manuscript Submission: ***Healthcare Management Forum***

Title: Preparing for uncertainty in public health emergencies: What Canadian health leaders can do now to optimize future emergency responses

Author names and affiliations: Theresa WS Tam, BMBS (UK), FRCPC[1]

[1]Chief Public Health Officer of Canada, Public Health Agency of Canada

130 Colonnade Road, Ottawa, Ontario, Canada, K1A 0K9

Telephone 1-613-954-8524, Fax 1-613-954-8529, email: drtheresa.tam@canada.ca

Corresponding author: Theresa Tam

130 Colonnade Road, Ottawa, Ontario, Canada, K1A 0K9

[redacted]

Key words: health leaders, public health, hospital, uncertainty, emergencies, preparedness, planning, health security

Word count: 2,617

Abstract

Planning for uncertainty, such as the emergence of an unknown pathogen, is a critical component of preparedness for public health emergencies and strengthening health security. This article highlights principles and best practices to assist healthcare leaders in preparing for uncertainty, including: using planning assumptions as a starting point; integrating scalability to ensure response activities can be more easily adapted to suit evolving needs; assessing risk and capabilities to inform planning for appropriate response measures; and considering overall flexibility and adaptability of plans, systems, and resources. Health leaders are encouraged to prepare for the next emergency by developing, enhancing, and exercising resources, building in flexible and scalable measures to manage uncertainty that integrates lessons learned from past experiences and utilizes evidence-based best practices. Importantly, preparedness means investing now to be better prepared for future response.

Introduction

Over 15 years have passed since the emergence and containment of Severe Acute Respiratory Syndrome (SARS), our first "Disease X" of the 21st Century. The term "Disease X" is a relatively recent term coined by the World Health Organization (WHO) to represent uncertainty, as a critical planning element in preparedness for a serious international epidemic, and specifically to encourage preparedness activities that account for uncertainty.[1] There are many sources of uncertainty that can be thought of as variations/deviations from the normal or expected "who, what, when, where, why, and how" characteristics of an outbreak. The disease could be causing severe illness in a new or atypical population group as was observed in persons with obesity during the 2009 H1N1 influenza pandemic.[2] There could be unexpected outcomes of infection like microcephaly in infants born to mothers infected with the Zika virus during pregnancy.[3] The initial outbreak could occur at an unpredicted time or in an unexpected location as was the case with the H1N1 influenza pandemic[4] that started at the end of a typical influenza season and in North America rather than, as anticipated, in Asia. Moreover, if a disease emerges due to factors (like globalization, climate change, or changes in travel patterns) that are outside of the health sector's control, this can introduce uncertainty in terms

of how to effectively prepare and respond. Also, in the event of an unknown pathogen, like SARS-coronavirus emergence in 2003, the outbreak response will need to run parallel with a rapid gathering of evidence (clinical, laboratory, epidemiological, etc.) from partners across many countries.

The purpose of this article is to identify some basic principles and best practices for dealing with uncertainty in the context of a public health emergency; to provide some examples of how these principles in combination with past experience have advanced planning and preparedness within the health sector in Canada; and to stimulate thinking regarding what health leaders can do to further improve preparedness across the health sector.

The Role of Assumptions

In terms of preparedness planning, assumptions help establish a "starting point" – a direction to proceed until a need to adjust the course is identified. For that reason, they are included as the basis for many preparedness and response plans and could be considered a "basic principle" or "best practice" when it comes to incorporating flexibility. Assumptions can quickly refer the user of a guidance document or response plan to established/routine practices that they are already familiar with, which builds confidence when dealing with unknowns. They also give outbreak responders an indication of what real-time data to collect or what to watch for to either validate the planning assumptions or signal that a change in approach is needed. For example, an assumption used in influenza pandemic planning posits that the novel influenza virus will be transmitted from person to person in the same way seasonal influenza is transmitted. Healthcare providers will thus know what infection prevention and control (IPC) precautions to utilize and how these measures can be scaled up or down if reality proves to be different from the planning assumption. This example also illustrates another key principle, i.e. scalability.

Scalability as a Key Principle

In the emergency preparedness and response context, scalability is used to convey the need for response activities to be dynamic. To manage demands and risks by scaling up (e.g. adding more resources, increasing the level of personal protective equipment, extending "business hours") or scaling down when there is evidence to indicate that specific response actions are no longer needed to achieve the objectives of the response. A lesson learned from past responses is that uncertainty and/or risk aversion can lead to overcompensation during a response, leading to: inappropriate use of limited resources, responder burnout, and/or angst when trying to de-escalate the response. However, overcompensation can be avoided by ensuring there is sufficient content in guidance, plans, and emergency exercises to demonstrate how and when the response will be scaled up or down based on risk assessments and specific data analyses that build confidence and reduce risk aversion.

Risk and Capability Assessment

Another key principle involves taking a risk management approach to preparedness and response. Specifically, using risk and capability assessments (i.e. assessment of current resources available to mitigate and respond to the risk) to not only inform planning and response measures, but also to identify gaps or enhancements that need to be addressed as a priority.

Again, using assumptions is a good starting point. Assumptions can be used to create scenarios against which risks can be identified and assessed along with the current capability to mitigate or manage the risk. Suppose the scenario is that a person presents to the emergency department of a suburban hospital in Canada complaining of nausea, weakness, and fever. To prepare for uncertainty, one must consider variables in the scenario. For example, if this person had recently returned from a country with an ongoing Ebola outbreak, would the existing triage system be sufficient to identify, assess, and rapidly contain a possible Ebola case? This type of assessment helps identify specific risks, such as not including Ebola in the intake

differential diagnosis for ill travellers returning from an outbreak affected area. Furthermore, it facilitates discussion regarding what capabilities are currently in place to mitigate this risk.

It is important, however, to identify what might change the risk profile in the scenario. For example, the Toronto SARS case that triggered the first hospital-based outbreak was initially missed because the person had no travel history and it was not immediately apparent that they had been infected through close contact with the actual index case who had the significant travel history.[5,6] This flagged a gap in our risk mitigation – that the capability to rapidly identify, and therefore contain, a SARS case that had no travel history was lacking. To close this gap, triage questions needed to include questions about close contact with an ill traveller, not just a history of personal travel.

Unfortunately, not all risks can be accounted for in emergency response planning, so it is important to consider what unknowns might significantly impact a risk and what planning can be done to account for them. Emergency planners with expertise in risk and capability assessment need to work with healthcare leaders to determine how changes to risk levels will be addressed in real time, when to change course, and whether the capabilities are in place to deal with the requirements of the "new course."

Flexibility and Adaptation

To date, public health preparedness efforts have been largely based on previous infectious disease outbreaks, models, and scenarios. It is important to consider the flexibility and adaptability of current plans, systems, and resources when preparing for any health emergency; this is a key principle in "all-hazard" emergency preparedness. The preparedness efforts and response resources that have been developed and used for infectious disease outbreaks are now being utilized for other public health threats.[7] Borne out of the SARS and H1N1 experience, new Federal/Provincial/Territorial (FPT) governance structures were established to oversee the overall public health response.[8] These governance structures, which include the

creation of the Chief Public Health Officer of Canada as the national voice for public health, have in turn been leveraged to respond to non-infectious disease national response, most recently the national epidemic of opioid-related deaths in Canada, demonstrating the vital importance of flexibility.

Adaptable response systems can quickly establish new inter-sectoral connections to meet immediate specific response needs while increasing general response capabilities. The use of infectious disease response foundations and adaptation to the different resources and stakeholders needed for monitoring and data collection of opioid-related mortality has had benefits across the system. In particular, a lack of real-time mortality surveillance has been a long recognized gap in infectious disease emergency response. The urgency and new and pooled resources mobilised for the opioid response enabled us to address this persistent challenge through the establishment of a timely surveillance and reporting network with coroners and medical examiners. Therefore, the stakeholder engagement and resources implemented for the opioid response has resulted in an overall increase in flexible response capacity. Utilising sustainable, flexible governance structures and resources ensures the response system is well exercised and able to adapt to uncertainties, while supporting readiness for other threats and emergencies, both infectious in nature and not.

Learning from Past Experience

The idea of identifying “lessons learned” after the conclusion of an emergency response is also a basic principle/best practice. But how do health leaders ensure that the lessons identified are truly “learned” and that these learnings are not forgotten in the interval and inevitable staff turnover that occurs between large public health emergencies? The importance of risk communication, building and maintaining public trust and confidence, and cross health sector engagement are just a few of the key lessons that have been identified from past emergency responses.

The next major public health emergency in Canada will re-affirm the growing role of the internet and social media in risk communication. It will factor significantly in both the way the public and health leaders communicate about the event. We have learned that perception is reality and that being transparent in risk communication is essential. Being forthcoming at the outset about what we know, what we don't know, and reassuring the public that we will tell them when we do know something new, are critical risk communication lessons for all health leaders. Early, frequent communication of uncertainties is vital to building and maintaining public trust and confidence.

Reflecting back on SARS, despite the relatively limited spread of the disease in Canada, managing uncertainty and fear required a tremendous effort in terms of risk communication, societal mobilization, and health sector coordination. SARS highlighted the need to support and maintain cross health sector preparedness so that the overall health response is seamless and comprehensive. This starts with increasing the number of astute front-line practitioners who are sensitised and equipped to practice "think, tell, test" – that is, thinking about the possibility of an emerging pathogen, telling a local medical officer of health / local public health authorities, and working with clinical colleagues, hospital administrators, public health, and laboratory partners to ensure early detection and rapid containment of cases through appropriate and timely testing. Continuing to build and maintain a skilled and engaged workforce is essential to a robust and flexible response system. Health leaders are in a position to foster this activity not only through new initiatives but also by ensuring that the lessons learned from past experiences are passed on through training and exercises to those entering or taking on new roles within the workforce.

Engaging across the health sector on a regular basis in order to re-confirm roles and responsibilities, conduct joint risk and capability assessments, foster research and provide updates on the status of preparedness activities, is also key to ensuring health sector preparedness and maintaining an ongoing state of readiness. There are operational (e.g. medical evacuation and domestic transportation) and logistical (e.g. supply chain and

stockpiling issues) aspects of a response that require cross-sectoral engagement to address, ideally in advance of an emergency. We have seen the benefit of having contracts in place, for example for the influenza pandemic vaccine supply during the H1N1 pandemic, and have more recently contracted to ensure international medical evacuation capacity. We have also seen the need to be prepared to engage in real-time research in order to ensure the response is as evidence-based as possible. This has translated into advanced planning by organizations like the Canadian Institutes of Health Research (CIHR), for example, to foster rapid ethics reviews during an emergency response. Extending the health sector preparedness to include other sectors/disciplines (e.g. social services, critical infrastructure, security, human resources, people management, regulatory, public safety, justice) is critical to a seamless response.

Post-SARS, emergency management practices have been adopted more widely and the healthcare system has been strengthened to close gaps and minimize risks. There is also a greater recognition of the significant social and economic impacts of public health emergencies and the importance of mitigating these impacts through mechanisms that enhance capabilities. Health leaders would be wise to ensure that emergency management, multi-sectoral coordination, and mutual aid capabilities are well integrated and exercised within their institutional response planning.

National Capacity Building for Emergency Preparedness and Response

The Public Health Agency of Canada (PHAC), established following SARS as the national coordinating body for health emergencies, has made significant investments in order to increase emergency preparedness and response capacity in Canada, build on the lessons learned from past experiences, and facilitate cross-sector preparedness and resiliency. This work has been multi-focal, ranging from the production and updating of plans, protocols, and technical guidance to conducting training, stockpiling vaccines and therapeutics, to running exercises to test current knowledge and capabilities. Many of these efforts are intended to increase the level of preparedness across the breadth of the healthcare sector, not just public

health, and not just for emergencies originating in Canada. Examples include: supporting the strengthening of IPC practices and awareness in both healthcare and community settings; enhancing public health laboratory and border screening capacity; establishing mutual aid and information sharing agreements;[9] clarifying roles, responsibilities and procedures (e.g. how to request and receive aid and emergency provisions) during emergencies.[8] Canada has met the International Health Regulations (IHR) 2005 core capacity requirements[10] and was ranked 5th in the world in the Global Health Security index, assessing global health security and capabilities.[11] While there is a strong existing system in place, ongoing work is still needed to achieve a state of flexible and scalable readiness for the next public health emergency.

The Take-home Message

Health leaders need to prepare for uncertainty during an emergency response by developing, enhancing, and exercising resources – whether it be plans, people or other resources – that can be flexible, scalable and that are built on lessons learned and evidence-based best practices.

Health leaders are well poised to see gaps and reflect on persistent challenges and recurring themes and to look beyond their scope of influence to find creative solutions. Working from the ground up, health leaders should train staff in emergency management principles, ensure corporate memory/lessons learned are passed on and build confidence through regular exercises and drills. Furthermore, staff must be encouraged to contribute to contingency planning by identifying concerns and repositioning them as uncertainties to be addressed through contingency planning.

Although not all health leaders are in a position to allocate resources, especially funding resources, you are influential. While it can be difficult to convince decision-makers to invest upstream in non-specific emergency preparedness resources, it is important to present to them the downstream benefits including risk reduction, medium-long term cost savings, and operational resilience. Pointing out that this investment of time, energy, and resources can

pay-off during normal operations not just during large-scale health emergencies may be one means of fostering support. Emergency planning can help ensure business continuity whenever there is an unexpected surge in resource demands (be it human resources, equipment, physical space, or medical countermeasures) against the backdrop of ever limited, finite supplies. Finally, recognize that the opportunity to address critical gaps is never more urgent than during an emergency.

Every event is an opportunity, given heightened political attention and investment in health capacity during a crisis. We need to build on these gains to both improve routine practice as well as better prepare us for future response.

Given that disease outbreaks and natural disasters impact health responders, individuals, and communities both physically and mentally, we can strengthen future responses by building in contingencies to address mental health impacts.

Throughout this call to action to strengthen health security, I would urge health leaders to integrate a health equity lens and seek meaningful engagement from the communities they serve.

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Declaration of conflicting interests: The author declares that there is no conflict of interest.

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From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-04 1:26 PM
To: MacIntyre, Erin (PHAC/ASPC)
Subject: FW: VIP IT Services

Please enter into my contacts in case I have to access during out of office hours.

From: Safarian, Alain (HC/SC)
Sent: 2019-12-04 10:39 AM
To: Hajdu-p, Patty (HC/SC) ; Lucas, Stephen (HC/SC) ; Sabourin, Pierre (HC/SC) ; Weber, Kendal (HC/SC) ; Hoffman, Abby (HC/SC) ; Saulnier, Marcel (HC/SC) ; Trombetti, Stefania (HC/SC) ; Ianiro, Robert (HC/SC) ; Hollington, Jennifer (HC/SC) ; Brander, Peter (HC/SC) ; Costen, Eric (HC/SC) ; Bogden, Jacqueline (HC/SC) ; Larkin, Randy (HC/SC) ; Dickson, Samantha M (HC/SC) ; Beresford-Green, Debbie (HC/SC) ; Namiesniowski, Tina (PHAC/ASPC) ; Tam, Dr Theresa (PHAC/ASPC) ; Njoo, Howard (PHAC/ASPC) ; Bell, Tammy (PHAC/ASPC) ; Borys, Shelley (PHAC/ASPC) ; Thornton, Sally (PHAC/ASPC) ; Bent, Stephen (PHAC/ASPC) ; Michel, Pascal (PHAC/ASPC) ; Beaudoin, Carlo (PHAC/ASPC) ; Romano, Anna (PHAC/ASPC) ; Elmslie, Kim (PHAC/ASPC) ; Azzi, Bob (HC/SC) ; Cousineau, Eric (HC/SC)
Subject: VIP IT Services

Good morning All,

This is just a friendly reminder about our VIP IT services and how to reach us to receive the most efficient resolutions for time sensitive IT request. For the best service, you may contact us from 7am to 11pm by:

Phone: 613-853-3391
or
Email: vip.phone@canada.ca

Please note that requests not sent directly through us can't expect VIP service and may experience delays.

We're here to help! Have a nice day ☺

Thank you,

Alain Safarian

VIP IT Program Support, Distributed Computing Services NCR, Corporate Services Branch
Health Canada and the Public Health Agency of Canada | Government of Canada
Brooke Claxton Building, Room 0115C
alain.safarian@canada.ca / Tel: 343-550-5888

Soutien au Programme TI VIP, Service informatique distribué RCN, Direction générale des services de gestion
Santé Canada et l'Agence de la santé publique du Canada | gouvernement du Canada
Immeuble Brooke Claxton, Chambre 0115C
alain.safarian@canada.ca / Tél: 343-550-5888

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-02 10:42 AM
To: Ephrem, Bersabel (PHAC/ASPC)
Subject: WAD ?? scarf

Hi there

I was wondering whether you have spare scarf to lend to Tina for the parliamentary reception today.

TT

Sent from my iPhone

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-12 5:48 PM
To: Tremblay, Genevieve (PHAC/ASPC)
Subject: FW: WAD pic - Trio
Attachments: IMG_3068.jpg

Hi there

I can't recall who took this photo and whether you have it.
It not used for my twitter feed but I thought that our 3 wonderful video stars may want a copy.

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

ATIA - 19(1)

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-20 6:33 PM
To: Bogden, Jacqueline (HC/SC)
Subject: RE: Weekly Vaping Associated Lung Illness Update for DMs and MOs -- December 20, 2019

Thanks Jacquie

[redacted]

From: Bogden, Jacqueline (HC/SC)
Sent: 2019-12-20 6:26 PM
To: Tam, Dr Theresa (PHAC/ASPC) ; Namiesniowski, Tina (PHAC/ASPC) ; Lucas, Stephen (HC/SC)
Cc: Romano, Anna (PHAC/ASPC) ; Trombetti, Stefania (HC/SC) ; Ianiro, Robert (CFIA/ACIA) ; Van Loon, James (HC/SC) ; Beaton, Dana (HC/SC) ; Costen, Eric (HC/SC) ; Hollington, Jennifer (HC/SC) ; MacKenzie, Sara (HC/SC) ; Neeley, Nick (HC/SC) ; Brydon, Jordan (HC/SC) ; White, Belinda (HC/SC) ; Gallagher, Gerry (PHAC/ASPC) ; Wen, Vanessa (HC/SC) ; Thakkar, Bhavik (HC/SC)
Subject: Weekly Vaping Associated Lung Illness Update for DMs and MOs -- December 20, 2019

Stephen, Tina and Theresa,

Please find attached the short weekly update for MO. As usual, this version includes the latest data released from CDC yesterday and the most up to date information on number of cases and incidents reported to date. It also includes a detailed update on our communications and public education efforts, including the fact that our advertising campaign is live again now.

Final note, the CDC updated their website this afternoon following the release of some additional data analysis. Key take-a-ways from CDC site:

- Syndromic data on emergency department visits suggest that the vaping associated lung injury outbreak began in June 2019. Cases have been declining since a peak in September. This data align with recently released epidemiologic data suggesting that the number of new hospitalized cases has also been declining.
- New laboratory data support previous findings that vitamin E acetate is closely associated with the lung injury illnesses.
- Although the CDC noted that there is a need for continued vigilance as new national data show that certain groups of patients released from the hospital are more likely to be re-hospitalized or die. Those who were re-admitted or died following hospital discharge indicate that some chronic medical conditions (e.g., cardiac disease, chronic pulmonary disease and diabetes) as well as age might be risk factors for higher morbidity and mortality among some patients.
- As a result, the CDC has updated its guidance to clinicians to minimize these outcomes. The updated guidance recommends that hospitalized patients be documented as clinically stable for 24-48 hours prior to discharge. Patients should have a follow-up visit, optimally within 48 hours of discharge – a shorter time than the previous 1-2 weeks.

FYI – also attached is the AP story on CBC website on the above.

Next steps: Vanessa could provide the attached document to MO for their information.

Jacquie

From: Malkinson, Agnes (HC/SC) on behalf of Media Monitoring / Suivi des Medias (HC/SC)
Sent: 2019-12-20 4:10 PM
Subject: (INFO) AP: 'Vast majority' of vaping illnesses blamed on vitamin E in U.S.

Distribution group/Groupe de distribution: HC.F PEIA Vaping / Vapotage AREP F.SC

December 20, 2019
'Vast majority' of vaping illnesses blamed on vitamin E in U.S.
Associated Press; CBC News

Vaping injuries taper off in U.S. as health officials update their advice to doctors

Health officials now blame vitamin E acetate for the "vast majority" of cases in the U.S. outbreak of vaping illnesses and have changed their advice to doctors about monitoring patients more closely after they go home from the hospital.

Vaping illnesses can get worse, even deadly, after patients leave the hospital and doctors should check on patients within two days of sending them home, according to a study of cases.

The U.S. Centers for Disease Control and Prevention announced the updated advice Friday. The two-day followup after hospital discharge is shorter than the previous recommendation of one to two weeks.

The new advice is based on a close look at about three per cent of patients who returned to the hospital after discharge and seven who died after hospital discharge.

Compared to other vaping illness patients, those who went back to the hospital were more likely to have chronic conditions such as diabetes, heart disease or other breathing problems such as sleep apnea. Those who died after hospital discharge were more likely to be 50 or older.

The CDC also released new information that continues to point to a culprit: vitamin E acetate, a thickening agent that's been added to illicit tetrahydrocannabinol or THC vaping liquids. THC is the chemical in marijuana that makes users feel high.

A report published in the New England Journal of Medicine identified the substance in the lung fluid of 48 out of 51 vaping illness patients and did not find it in the lung fluid of healthy people. Vitamin E acetate also has been found in vaping product samples.

In the strongest language yet about what's caused the outbreak, Dr. Anne Schuchat of the CDC told reporters during a telephone briefing Friday that it is her "conclusion" that vitamin E acetate caused the illness in "the vast majority of patients."

In a separate study in the CDC's Mortality and Morbidity Weekly Report, of the 2,409 people whose cases were reported to the CDC as of Dec. 10, a total of 31 patients who had been discharged got sick again and had to be readmitted to the hospital, and seven people died shortly after discharge.

Patients who got sick after discharge tended to have a history of heart disease, respiratory conditions and diabetes. Those who died after discharge were more likely to be 50 or older.

The U.S. outbreak of vaping-related lung injuries continues, but new cases are on the decline. More than 2,500 cases of vaping illness have been reported by all 50 states. There have been 54 deaths and more deaths are under investigation.

The Public Health Agency of Canada said that as of Dec. 17, 14 cases of vaping-associated lung illness have been reported. Three occurred in British Columbia, two in New Brunswick, four in Ontario and five in Quebec.

https://www.cbc.ca/news/health/vaping-vitamin-e-1.5404858

Short Update on Vaping-Associated Lung Illness

Background

- Beginning the week of August 19, 2019, increased media reporting highlighted a series of severe pulmonary illnesses in the United States linked to the use of vaping products.
- As of December ~~10~~17, 2019, the United States Centers for Disease Control and Prevention (US CDC) are reporting 2,~~409~~ 506 confirmed and probable cases of lung injury from all 50 states, the District of Columbia, and 2 U.S. territories. Fifty~~ two~~ four (54) deaths have been confirmed in ~~26~~ 27 states and the District of Columbia. *Note: ~~These~~ Increases represent cases that have occurred since the beginning of the outbreak and not necessarily people who have become ill or who have died since the previous update. Starting December 4, CDC ~~will~~is ~~be~~ reporting on hospitalized cases.*
- Data suggest the outbreak might have peaked in mid-September. However, states continue to report new cases, including deaths, to CDC on a weekly basis.
- To date, the Health Portfolio is not aware of the emergence of clusters of vaping-associated lung illness outside of North America.

Current status in Canada [Current to 16:00 December ~~12~~18, 2019]

Information suitable for public disclosure

Five **confirmed** cases (four in Quebec, one in Ontario) (no change since the December ~~6~~13, 2019 update) and nine **probable** cases (two in New Brunswick, three in British Columbia and three in Ontario, and one in Quebec) (no change since the December ~~6~~13, 2019 update) have been reported by a provincial or territorial health authority to the Health Portfolio.~~*~~*

- The incident described in the media by the Middlesex-London Medical Officer of Health on September 18, 2019, is the confirmed case that was reported by Ontario and was previously reported to Health Canada through the consumer product safety incident reporting system.
- The Public Health Agency of Canada (PHAC) is working closely with provincial and territorial health authorities, all of which have agreed to report probable or confirmed cases to PHAC should any be identified within their respective jurisdictions.
- PHAC and the Council of Chief Medical Officers of Health have convened an FPT Task Group on Severe Pulmonary Illnesses Associated with Vaping. A Canadian national case definition for Vaping Associated Pulmonary Illness has been developed and shared with all provincial and territorial health authorities. A common approach to case investigation is being developed.
- In addition, federal surveillance databases are being monitored for any potentially relevant incidents. These databases include consumer product incident reports, cannabis and health

~~* For the purpose of tracking at the federal level, health events related to VAPI are placed into one of 5 categorizes.~~

- ~~Incident under review – meaning the Public Health Agency of Canada or the implicated province/territory is in the process of making a determination about the need to investigate the case~~
- ~~Incident under investigation – meaning a regional or provincial health authority is investigating the incident to determine if it meets the case definition~~
- ~~Probable case – meaning the definition for a 'probable case' has been met~~
- ~~Confirmed case – meaning the definition for a 'confirmed case' has been met~~
- ~~Ruled out – meaning the incident was determined to be unrelated to VAPI~~

product adverse reaction reports, and a hospital-based injury and poisoning sentinel surveillance system. Regional poison control centres have also been alerted and asked to report any potential incidents. Relevant incidents are referred to provincial or territorial health authorities for further review and/or investigation to determine if they meet the national case definition.

- A small number of incidents are currently under investigation by provincial health authorities.
  - ~~o~~ Most provinces have established mechanisms to require reporting within their respective jurisdictions. In jurisdictions where the illness is not reportable, other mechanisms have been used to communicate with health practitioners on case identification and information sharing, should cases be identified.
  - o

Details below have not been publicly disclosed and are provided for internal situational awareness only)

- *A total of ~~30~~ 31 Canadian incidents considered plausibly related to vaping-associated lung illness have been reported to the Health Portfolio, as follows:*
  - *~~6~~ 9 incidents have been **ruled out*** (1 each in Alberta and BC, ~~and~~ 3 in Quebec~~,~~ and 4 in Ontario ~~and Alberta, 3in Ontario~~)*
  - *~~2~~ 1 incident is~~s are~~ **under review***
  - *1 incident is not being investigated (incident from 2018 in Ontario)**
  - *~~8~~ 6 incidents are **under investigation*** by provincial or territorial health authorities (1 each in ~~Ontario,~~ BC, Quebec, and Newfoundland and Labrador, and 3 in Alberta~~, and 2 in Quebec~~)*
  - *9 incidents have been deemed **probable*** cases (1 in Quebec, 2 in New Brunswick, 3 each in BC and ~~3 in~~ Ontario ~~and 1 in Quebec~~)*
  - *5 incidents have been deemed **confirmed*** (4 in Quebec and 1 in Ontario)*
- ***Note that local and provincial authorities may be investigating incidents that have not been reported to Health Canada or the Public Health Agency of Canada.** For a variety of reasons (logistics, privacy, legal), most provincial and territorial authorities will only report probable or confirmed cases to PHAC.*
- *Twelve (12) of the above-mentioned incidents were reported to the Health Canada through the consumer product safety incident reporting system.*
- *Preliminary information shared by the provinces indicates:*
  - *Canadian patients include 4 adults over 50 years old, 3 adults aged 40 to 49, 4 aged between 20 to 34 years, and 3 youth aged 15 to 19 years; ~~seven~~ 7 are male and ~~seven~~ 7 are female.*
  - *Of the symptomatic information available, four cases presented with respiratory symptoms only (shortness of breath, cough), while ten cases presented with respiratory, gastrointestinal and/or constitutional symptoms.*

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* *For the purpose of tracking at the federal level, health events related to VAPI are placed into one of 5 categorizes.*

- *Incident under review – meaning the Public Health Agency of Canada or the implicated province/territory is in the process of making a determination about the need to investigate the case*
- *Incident under investigation – meaning a regional or provincial health authority is investigating the incident to determine if it meets the case definition*
- *Probable case - meaning the definition for a 'probable case' has been met*

- *Symptom onset was between May and November 2019. Eleven (11) cases were hospitalized; all but one are now recovering at home. Median number of days between symptom onset and hospitalization is ~~seven~~ 7 (range = 0 to 102 days).*
- *Seven cases (in three provinces: BC, ON, and QC) reported vaping nicotine only; three cases reported vaping THC only; one case reported vaping flavoured liquid only; and three cases vaped a variety of substances, including THC and nicotine.*
- ~~*Seven cases reported vaping nicotine only (4 in Quebec, 2 in Ontario, 1 in BC); three reported vaping THC only (2 in BC, 1 in Ontario); one reported vaping flavoured liquid only (New Brunswick); and three cases vaped a variety of substances, including THC and nicotine (One each in Ontario, Quebec and New Brunswick).*~~ *Four cases reported buying their vaping products in Canada; two reported buying online; and information about purchase location is not available for ~~eight~~ 8 cases*

Communications

- ~~The **Vaping-associated lung illness page was updated December 12** to reflect one new case in ON along with available epi data, reported to PHAC last week. The total case count on the page is now 14.~~
- ~~**Minister's talking points on VAPI** (and youth vaping), along with departmental media lines and Qs&As on VAPI have been updated and are in approvals.~~
- ~~**Vaping received a heavy volume** of mainly balanced media coverage from to December 5 to December 12, 2019. We have received **173 media calls** since September 16. Media continue to report on the various measures P/Ts have announced to address the issue of vaping within their jurisdictions.~~
- ~~**The Department plans to launch the next wave of advertising on December 20** with Search Engine Marketing (SEM) and YouTube pre-roll ads. We are beginning with these media~~

- *Confirmed case – meaning the definition for a 'confirmed case' has been met*
- *Ruled out – meaning the incident was determined to be unrelated to VAPI*

~~platforms as they are quickest to implement, have ad availability, and have proven to be successful to reach both parents and youth.~~

- ~~The **Consider the Consequences of Vaping experiential event tour ended December 9**. The tour visited 130 schools in Q3 for a total of 243 school visits and 18 teen-oriented community events since the tour launched in February 2019. More than 50,000 teens have taken part in the tour so far. The tour will resume in January 2020 and run until April 2020, visiting an additional 130 middle schools and 5 teen-oriented events (4 will be held in Quebec).~~
- ~~Three youth influencers and one parent influencer have posted content. Since December 11, influencer content has received more than 84,400 likes and 326 comments. One more youth influencer will launch their content early in the new year~~The **Vaping-associated lung illness page was updated on December 19:** no new cases, only a change in date to December 17. The total case count on the page remains at 14.
- **Minister's talking points on VAPI** (and youth vaping), along with departmental media lines and Qs&As on VAPI are approved.
- **The vaping announcement of December 19 received good media pick-up.** Much of the coverage focused on the promotions rules. There were some reports quoting health advocates stating that the Government is not going far enough. There were also some reports on future Government regulations related to flavours. The Canadian Cancer Society, the Canadian Medical Association, and the Quebec Coalition for Tobacco Control issued news releases in response to the vaping announcement. Since September 16, we have received **194 media calls**.
- **The Department launched the next wave of advertising on December 20** with Search Engine Marketing and YouTube ads, and will continue rolling out ads in the New Year, with top performers from past campaigns on YouTube, Twitch, Snapchat and Facebook.
- The campaign will also introduce **new digital ads on news websites** in January and **television ads** in March.
- ~~.~~

Current status in the United States

- As of December ~~10~~17, 2019, the United States Centers for Disease Control and Prevention (US CDC) are reporting 2,~~409~~ 506 confirmed and probable cases of lung injury from all 50 states, the District of Columbia, and 2 U.S. territories. Fifty-four (54) ~~two~~ deaths have been confirmed in ~~26~~ 27 states and the District of Columbia. *Note: ~~These~~ increases represent cases that have occurred since the beginning of the outbreak and not necessarily people who have become ill or who have died since the previous update. Starting December 4, CDC ~~will~~ is only ~~be~~ reporting on hospitalized cases.*
- States are completing their own investigations and verification of US cases based on US CDC's standardized case definitions.
- Data suggest the outbreak might have peaked in mid-September. However, states continue to report new cases, including deaths, to CDC on a weekly basis.
- Data collected by CDC indicates:
    - 95% of cases were hospitalized, and 5% were not hospitalized (based on 2,016 patients).
    - 67% were male (based on 2,155 patients).
    - 78% were under 35 years old, with a median age of 24 years (range 13 to 78, based on 2,159 patients).
- Among 1,782 patients with information on substances used:
    - 80% reported using THC-containing products; 35% reported exclusive use of THC-containing products.

  - 54% reported using nicotine-containing products; 13% reported exclusive use of nicotine-containing products.
  - 40% reported both THC- and nicotine-containing product use.
  - 5% reported no THC-, nicotine-, or CBD-containing product use.
- Chemical exposure is believed to be the cause. The product(s) and/or toxic agent(s) involved have not yet been identified, however CDC has identified vitamin E acetate as a chemical of concern. Most patients report a history of using THC-containing products. The latest national and regional findings suggest products containing THC play a major role in the outbreak.
- Among hospitalized patients, the most commonly reported product brand included Dank Vapes (56%), followed by TKO (15%), Smart Cart (13%), and Rove (12%). However, regional differences in THC-containing product use were noted.
- CDC has released results from the analysis of 29 bronchoalveolar lavage (BAL) samples collected from patients across 10 states. All samples contained vitamin E acetate. This is the first direct evidence of a potential toxic agent at the site of injury.
- Recently published analyses provide additional evidence of a role for vitamin E acetate in the outbreak. Minnesota authorities analyzed a group of illicit THC products seized in 2018 and another group of samples seized in 2019; all 2019 samples contained vitamin E acetate, while none of the 2018 samples did. Testing of patient samples found that 11 of the 12 patients had submitted a sample that contained vitamin E acetate.
- A study examining potential risk factors in Illinois patients was recently published and found that, compared to a set of survey respondents selected as a reference group, patients had 2-fold higher odds of exclusive THC use, 3-fold higher odds of frequent use, 9-fold higher odds of obtaining products from informal sources, and 8.5-fold higher odds of using 'Dank Vapes' cartridges.
- Testing of product samples is taking place at the US FDA Forensic Chemistry Centre, the Wadsworth Center in New York, the California Department of Public Health (CDPH) Laboratory, the Utah Public Health Laboratory, and the CDC.
  - The FDA indicates that most of the samples tested by states or by the FDA have been identified as vaping products containing THC, and further, many of those samples with THC tested also contained significant amounts of vitamin E acetate.

From:	Jones, Luke (PHAC/ASPC)
Sent:	2019-12-05 6:34 PM
To:	Charos, Gina (PHAC/ASPC); Pearson, Michael (PHAC/ASPC)
Cc:	Elmslie, Kim (PHAC/ASPC); Hollington, Jennifer (HC/SC); Namiesniowski, Tina (PHAC/ASPC); Tafaghod, Marzieh (HC/SC); Faustin, Isabelle (PHAC/ASPC); King, Elisabeth (PHAC/ASPC); Palanque, Nicolas (PHAC/ASPC); Murseli, Lissa (HC/SC); Tam, Dr Theresa (PHAC/ASPC); Bell, Tammy (PHAC/ASPC); Bent, Stephen (PHAC/ASPC)
Subject:	RE: WHO measles report and Min/parliament

Hi Gina,

Here is the WHO news release:

https://www.who.int/news-room/detail/05-12-2019-more-than-140-000-die-from-measles-as-cases-surge-worldwide

Sent from my Bell Samsung device over Canada's largest network.

-------- Original message --------

From: "Charos, Gina (PHAC/ASPC)"

Date: 2019-12-05 6:29 p.m. (GMT-05:00)

To: "Pearson, Michael (PHAC/ASPC)"

Cc: "Elmslie, Kim (PHAC/ASPC)" , "Hollington, Jennifer (HC/SC)" , "Namiesniowski, Tina (PHAC/ASPC)" , "Tafaghod, Marzieh (HC/SC)" , "Faustin, Isabelle (PHAC/ASPC)" ,

"King, Elisabeth (PHAC/ASPC)" , "Palanque, Nicolas (PHAC/ASPC)" , "Jones, Luke (PHAC/ASPC)" , "Murseli, Lissa (HC/SC)" , "Tam, Dr Theresa (PHAC/ASPC)" , "Bell, Tammy (PHAC/ASPC)" , "Bent, Stephen (PHAC/ASPC)"

Subject: Re: WHO measles report and Min/parliament

Do you have the report?

Sent from my iPhone

> On Dec 5, 2019, at 6:22 PM, Pearson, Michael (PHAC/ASPC) wrote:
>
> Hi Kim, Gina, Jen. My guess is this story will require a QP note. Assume comms is drafting lines as well. We know [redacted] at WHO in case you want us to reach out to her. Let us know if OIA can assist with that aspect of the story.
>
> M

From: Tam, Dr Theresa (PHAC/ASPC)
Sent: 2019-12-16 8:03 PM
To: Pearson, Michael (PHAC/ASPC); Lucas, Stephen (HC/SC); Namiesniowski, Tina (PHAC/ASPC)
Cc: Palanque, Nicolas (PHAC/ASPC); Murseli, Lissa (HC/SC); Jones, Luke (PHAC/ASPC); Sharma, Ranu (PHAC/ASPC); Johnstone, Marnie (PHAC/ASPC); Bell, Tammy (PHAC/ASPC); Gorber, Timna (PHAC/ASPC)
Subject: RE: WHO-Canada 2020 Strategic Policy Dialogue - Geneva meetings last week

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Thanks Michael for getting this great initiative underway and the summary.

Sounds like a very productive 2 days. I have some insights into the health security area and the WHO transformation as it relates to the WHO Health Emergencies program but not the other areas so I look forward to further discussions on the planning and participation in the dialogue to come.

TT

From: Pearson, Michael (PHAC/ASPC)
Sent: 2019-12-16 5:53 PM
To: Lucas, Stephen (HC/SC) ; Namiesniowski, Tina (PHAC/ASPC) ; Tam, Dr Theresa (PHAC/ASPC)
Cc: Palanque, Nicolas (PHAC/ASPC) ; Murseli, Lissa (HC/SC) ; Jones, Luke (PHAC/ASPC) ; Sharma, Ranu (PHAC/ASPC) ; Johnstone, Marnie (PHAC/ASPC) ; Bell, Tammy (PHAC/ASPC) ; Gorber, Timna (PHAC/ASPC)
Subject: WHO-Canada 2020 Strategic Policy Dialogue - Geneva meetings last week

My overall takeaway is a positive one. Co-led between GAC (CIDA side) and ourselves in the first joined up approach in apparently many years, we crammed in a dozen meetings in under two days with a mix of senior level WHO officials (mostly ADGs, so we saw the majority of Tedros' equivalent to an Executive Committee), plus a long discussion with about 10 health counsellors from member-states representing every region of the world. We also met separately with a medical doctor/professor from Montreal but based in Geneva who had a more contrarian view on how the WHO (and member-states) address health emergencies.

Without exception, all Secretariat interlocutors were positive about Canada's role at the WHO, keen to restart the strategic dialogue and hoping it could become a regular (annual or biennial) occurrence. The fact that our overall $ contributions to the organization have declined in relative terms (we have slipped from top 5 to 10th in the last few years) was barely mentioned. Instead, interlocutors were impressed with the wide array of collaboration that exists with "trusted" partner Canada, including the fact that we have 33 WHO collaborating centres, and wanted to know how we could work more together. A lot of emphasis was placed on how incremental or seed Canadian funding has been very effective in leveraging bigger donors and contributions.

We learned a significant amount about how the transformation process is actually working (or not) at the WHO, as well as best practices in their varied experiences with other member-state dialogues. A model that may work best for Canada is one which combines a series of focused dialogue meetings with broader outreach activities that allows senior WHO (and Canadian) experts to share experiences and stories with a wider Canadian audience.

We discussed a number of potential themes for the 2020 dialogue (still looking at late Feb/early March, in Ottawa). The list and/or topics underneath each could be shortened, especially if we see this as becoming a more regular process.

1) Impacts of climate change on health. The WHO is trying to catch up here.
2) Health security, including infectious diseases/immunization, plus health emergency prep and response (increasing public health security by 1 billion people is one of the WHO's 'three billions' targets). Much of this discussion was sobering, if not depressing.
3) UHC (increasing those covered is another 1 of the 3 billions) and the role of regional and country-level WHO bodies in supporting PHC delivery. This is a high profile priority for Tedros. One element discussed was how to ensure WHO was not competing with other international fora in the global health space or ensuring complementarity (eg, with G7/20 and GHSA/I).
4) Research and scientific advice, cross-cutting various issues such as digital health, the role of AI, integrating scientific research/advice, climate change. WHO has a new Chief Science Officer in place only since March.
5) Health promotion and healthy living. Reducing the number suffering from NCDs is the third and we discovered least well-defined/resourced 1 billions target.
6) WHO transformation – enhancing and measuring institutional effectiveness while ensuring cost and other efficiencies. This is Tedros' key structural/UN reform deliverable and the one that at least member-state interlocutors are the most sceptical about.

With all themes the emphasis should be on mutually agreed priority-setting, how to evolve the central normative technical work of the Organization, securing or maintaining necessary political direction/support and improving decentralized ground-level delivery. In addition, how partnership in support of these goals between Canada and the WHO could be enhanced, recognizing limited resources. They also recognized our interest in strengthening coherence and coordination across the range of activities Canada was engaged in and how we could utilize the dialogue to advance that goal.

OIA in coordination with GAC will be preparing a more detailed report on the scoping discussions in the near future for broader distribution. In consultation within the HP as well as GAC, we will recommend an approach/agenda for the 2020 dialogue that we could hopefully discuss with you as early as the week of January 6th. It will be necessary to advise the WHO before mid-January on proposed dates and agenda so they can decide who will participate from their side and make logistical arrangements. We will also reflect some of the above in the memo we are working on for the minister that seeks her concurrence for participation in the WHA next May. That memo will be ready by mid-January.

Happy to discuss further in upcoming bilats.

Michael