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Esteves, Dina (HC/SC)

From: Vecchio, Karen - M.P. <Karen.Vecchio@parl.gc.ca>
Sent: 2021-10-26 2:01 PM
To: hcminister.ministresc; Duclos, Jean-Yves - Député
Cc: Vecchio, Karen - M.P.
Subject: Letter from MP Vecchio
Attachments: 2021 10 26 Health RE Alternative Vaccine Timelines.pdf

Dear Minister,

Please find attached a letter from MP Vecchio regarding updated timelines for specific vaccine applications currently being reviewed by Health Canada.

Congratulations on your appointment.

Sincerely,

Scott Bandy
Legislative Assistant
Office of Karen Vecchio, MP
Elgin-Middlesex-London
House of Commons
613-990-7769

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A2022001224

ATIA - 19(1)

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HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Karen Vecchio
Member of Parliament
Elgin—Middlesex—London

October 26, 2021

TO: The Honourable Jean-Yves Duclos
Minister of Health

Dear Minister,

I have recently been contacted by a number of constituents who have questions regarding Health Canada's approval of additional vaccines. Specifically, constituents have been requesting more information on when Canadians can expect the Meidcago and Novavax to complete their review process. I understand that these companies have submitted vaccine applications to be considered for use in Canada and that these applications are currently under review at Health Canada.

I am hoping that you are able and willing to provide an update on these applications, and report on any timeframe within which my constituents can expect their approval. As some Canadians may prefer these potential vaccines over the currently approved suite of vaccines, it is important that Canadians have options available to them. This will ensure that more Canadians feel comfortable getting vaccinated, and help Canada reach its vaccination targets to protect against COVID-19. This is especially important as the federal government and provinces continue to implement restrictions for those who remain unvaccinated.

Thank you for looking into this, and congratulations on your recent appointment as Minister for Health. I look forward to continuing our work together in the days ahead.

Sincerely,

[redacted]

Karen Vecchio
Member of Parliament
Elgin-Middlesex-London

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Ottawa, Ontario K1A 0A6
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www.karenvecchiomp.ca

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Dillon, Megan (HC/SC)

From: Falk, Ted - M.P. <Ted.Falk@parl.gc.ca>
Sent: 2021-10-28 2:31 PM
To: hcminister.ministresc
Subject: Constituent request
Attachments: Health Minister Inquiry, October 28, 2021.pdf

Good afternoon,

On behalf of MP Ted Falk, we have a constituent who is asking about natural immunity and the EI exclusion for the unvaccinated.

Please kindly reply to us directly and we'll forward your reply to the constituent.

Thank you for your attention to this request.

Sincerely,

Mary-Elsie Wolfe
Parliamentary Assistant
Office of Ted Falk | MP for Provencher
613-992-3128
Ted.Falk@parl.gc.ca

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HOUSE OF COMMONS
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Fax.: 204-346-9874
ted.falk.c1@parl.gc.ca

Ted Falk
Member of Parliament / Député Provencher

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Téléc.: 613-995-1049
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www.tedfalk.ca

October 27, 2021

The Honourable Jean-Yves Duclos
Minister of Health

RE: Natural immunity and EI exclusion for the non-vaccinated

Dear Minister Jean-Yves Duclos,

Congratulations once again on your new appointment! I write on behalf of one of my constituents who raised specific questions about EI and the government's response to natural immunity. I am posing those questions on his behalf below.

1) Immunity vs Vaccine. Why is the government not considering "all" science and considering natural immunity? There are several prominent studies that show natural immunity is superior to vaccines and can be easily detected. If we account for the people who have recovered from this virus, our immunity rates would be much higher than they're saying they are. This would also mean less people fired in the coming months, meaning our economy can continue to grow. Don't traditional vaccines work with our natural immunity?

2) According to a recent statement, once public servants are fired for their fundamental medical right to choose treatment, they will not be eligible for employment insurance. For the government to threaten to deny this service is this not an ethical breach of trust and use of the public service for political means?

As our constituent has asked that we maintain confidence, please send your reply to our office and we will convey your answers accordingly.

Thank you in advance for your attention to this request.

[redacted]

Ted Falk
Member of Parliament for Provencher

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Parent, Lyne (HC/SC)

From: Prime Minister | Premier Ministre <PM@pm.gc.ca>
Sent: 2021-11-01 1:50 PM
To: CFNU President
Cc: hcminister.ministresc
Subject: Office of the Prime Minister / Cabinet du Premier ministre
Attachments: image003_UniqueID_2.png; 2021-10-21 _CFNU_to_PM_Trudeau_COID_Booster_Shots_for_Health_Care_Workers.pdf

Dear Ms. Silas:

On behalf of Prime Minister Justin Trudeau, I would like to acknowledge receipt of your correspondence of October 21, 2021, regarding COVID-19 booster shots for frontline health care workers.

Thank you for writing to the Prime Minister. You may be assured that your comments, offered on behalf of the Canadian Federation of Nurses Unions, have been carefully reviewed.

I have taken the liberty of forwarding copies of your email and attached letter to the Honourable Jean-Yves Duclos, Minister of Health, for his information and consideration.

Once again, thank you for writing.

A. Noël
Executive Correspondence Officer/Agente de correspondance Executive Correspondence Services/ Services de la correspondance de la haute direction

>>> From : CFNU President president@nursesunions.ca Received : 21 Oct 2021 >>>

>>> Subject : Appeal to support our call to NACI for booster shot to all frontline health care workers >>>>

Dear Prime Minister Trudeau,

Please find my letter attached for your kind attention.

Sincerely yours,

Linda Silas, President
Canadian Federation of Nurses Unions
2841 Riverside Drive, Ottawa, ON K1V 8X7
1-800-321-9821 | 613-526-4661
[redacted]@nursesunions.ca<mailto[redacted]@nursesunions.ca>
nursesunions.ca | fcsii.ca
[cid:image002.png@01D48BBD.1B604200]

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CANADIAN FEDERATION OF NURSES UNIONS

WWW.NURSESUNIONS.CA
INFO@NURSESUNIONS.CA

2841 RIVERSIDE DRIVE
OTTAWA, ONTARIO K1V 8X7
CANADA

T 613-526-4661
F 613-526-1023

1-800-321-9621

October 21, 2021

The Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Prime Minister:

As the national voice of nurses across the country, the Canadian Federation of Nurses Unions (CFNU) appeals to the federal government to support our call for the National Advisory Committee on Immunization (NACI) to recommend that provinces and territories offer the Pfizer-BioNTech COVID-19 booster shot to all frontline direct care health care workers who received their second vaccine dose more than six months ago.

With health care worker shortages reported in every province and a health system on the brink of collapse in many jurisdictions, Canada cannot afford to lose a single health care worker to illness.

As they care for their patients, residents and clients every day, nurses and other health care workers are at high risk for exposure to COVID-19. In light of their direct contact with the sickest patients, health care workers should be afforded the highest level of protection – both to avoid contracting an illness with the potential for severe illness and life-changing long-term effects, and to avoid transmitting it to their patients, colleagues and families.

It has now been up to ten months since the first vaccine doses were administered to health care workers.

New evidence published in *The Lancet* indicates that the Pfizer-BioNTech vaccine's effectiveness against all SARS-CoV-2 infections fell **from 88% during the first month after receiving two vaccine doses to 47% after six months.** Its effectiveness against hospitalizations remained high at 90% overall against all variants. The study also recognized that the Delta variant poses a significant and ongoing threat. An analysis released recently in *CMAJ* shows the Delta variant increases the risk of hospitalization by 108%, ICU admissions by 235% and death by 133% when compared to the original strain.

Following evidence of the efficacy and safety of third doses, the U.S. Centers for Disease Control and Prevention has recommended a third dose of Pfizer-BioNTech vaccine be offered to health care workers. The UK's National Health Service is also making the booster shot available to workers in its health care system. Finally, earlier this month, the European

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Medicines Agency concluded that booster doses "may be considered at least 6 months after the second dose for people aged 18 years and older".

The Canadian Federation of Nurses Unions continues to advocate for a universal vaccination strategy and a global vaccination effort centered on equity and science. The science clearly shows that vaccines are effective at preventing severe illness, hospitalization and death from COVID-19, including the Delta variant.

Of course, vaccines are not a panacea, and public health measures must remain in place for the foreseeable future. Health care employers must apply a multifaceted approach to protecting workers, including vaccines, infection control measures (including appropriate ventilation and dedicated COVID units), and the use of optimal personal protective equipment with respiratory protection (N95 masks or higher) against aerosol transmission.

Canada's nurses call on you to support our appeal to the National Advisory Committee on Immunization and to partner with us in our efforts to bring about safer workplaces for health care workers.

Yours sincerely,

[redacted]

Linda Silas, CFNU President

Cc.: Dr. Shelley Deeks, Chair of National Advisory Committee on Immunization
Yvette Coffey, President, Registered Nurses' Union Newfoundland & Labrador
Janet Hazelton, President, Nova Scotia Nurses' Union
Paula Doucet, President, New Brunswick Nurses Union
Barbara Brookins, President, Prince Edward Island Nurses' Union
Vicki McKenna, President, Ontario Nurses' Association
Darlene Jackson, President, Manitoba Nurses Union
Tracy Zambory, President, Saskatchewan Union of Nurses
Heather Smith, President, United Nurses of Alberta

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Dillon, Megan (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-11-08 11:46 AM
To: hcminister.ministresc
Subject: TR: Correspondence -Mark Strahl
Attachments: Minister Jean-Yves Duclos.pdf

De : Strahl, Mark - M.P. <Mark.Strahl@parl.gc.ca>
Envoyé : 5 novembre 2021 14:42
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : Correspondence -Mark Strahl

Attached, please find correspondence from Mark Strahl, MP.

Sincerely,

Office of Mark Strahl
Member of Parliament for Chilliwack—Hope
102-7388 Vedder Road, Chilliwack, BC V2R 4E4
604-847-9711 markstrahl.com

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Constituency
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Mark Strahl, MP
CHILLIWACK—HOPE

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900 Valour Bldg
Ottawa ON K1A 0A6
Tel.: 613-992-2940
Fax: 613-944-9376
www.markstrahl.com
mark.strahl@parl.gc.ca

November 5, 2021

The Honourable Jean-Yves Duclos P.C., M.P.
Minister of Health
Suite: 307
Confederation Building
House of Commons
Ottawa ON K1A 0A6

jean-yves.duclos@parl.gc.ca

Dear Minister Duclos,

Recently, I met with a constituent of mine who is interested in receiving the Medicago COVID-19 vaccine.

I have a number of constituents who are willing to be vaccinated but are looking to an alternative to the current mRNA vaccines. It would be appreciated if you could inform me as to what efforts your department is taking to making alternative vaccines available to Canadians such as the one being developed by Medicago.

Thank you for your prompt attention to this urgent request.

Sincerely,

[redacted]

Mark Strahl, MP
Chilliwack–Hope

Encl.

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Dillon, Megan (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-11-09 12:57 PM
To: hcminister.ministresc
Subject: TR: Letter and Enclosure from the Honourable Christine Elliott, Deputy Premier and Minister of Health, and the Honourable Sylvia Jones, Solicitor General
Attachments: 132-2021-5121_Deputy Premier and SG Outgoing.pdf; 132-2021-5121 _Enclosure_Appendix 1_ORI 3.0 Communities.pdf

De : SOLGEN Correspondence <SOLGEN.Correspondence@ontario.ca>
Envoyé : 9 novembre 2021 12:56
À : Blair, Bill - M.P. <Bill.Blair@parl.gc.ca>; Mendicino, Marco - M.P. <Marco.Mendicino@parl.gc.ca>; Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : Letter and Enclosure from the Honourable Christine Elliott, Deputy Premier and Minister of Health, and the Honourable Sylvia Jones, Solicitor General

Please see attached a letter and enclosure from the Honourable Christine Elliott, Deputy Premier and Minister of Health, and the Honourable Sylvia Jones, Solicitor General. The text of the letter also appears below. Thank you.

132-2021-5121
By email

November 9, 2021

The Honourable Bill Blair
President of the Queen's Privy Council for Canada and
Minister of Emergency Preparedness
House of Commons
Ottawa ON K1A 0A6
bill.blair@parl.gc.ca

The Honourable Marco E. L. Mendicino
Minister of Public Safety
House of Commons
Ottawa ON K1A 0A6
marco.mendicino@parl.gc.ca

The Honourable Jean-Yves Duclos
Minister of Health
House of Commons
Ottawa ON K1A 0A6
jean-yves.duclos@parl.gc.ca

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Dear Minister Blair, Minister Mendicino and Minister Duclos:

Ontario continues to ensure adequate and timely vaccine rollout across the province, including in remote fly-in First Nation (FN) communities. As a major part of our COVID-19 response and in support of these remote fly-in FN communities, we intend to launch Operation Remote Immunity (ORI) 3.0 in an effort to administer third doses and in anticipation of vaccination approvals for children in the 5 to 11 age group.

Specifically, ORI 3.0 will encompass the following parameters:

- Third doses for all eligible adults;
- First and second doses for children ages 5-11;
- First and second doses for those aged 12 and over that have not yet been vaccinated and have indicated they wish to receive vaccinations; and
- Dependent on community agreement to co-administration, flu vaccine may also be made available at the clinics for administration of both the COVID-19 and flu vaccinations.

These vaccinations are essential and support safer transit to and from remote fly-in FN communities. While Ornge was tasked by the province to lead ORI 1.0 and 2.0, Sioux Lookout First Nation Health Authority (SLFNHA) and the Weeneebayko Area Health Authority (WAHA) will lead the implementation of ORI 3.0 in their respective communities with the support of First Nations Inuit Health Branch (FNIHB), the northern Public Health Units (PHUs) and Ornge. At present, 31 fly-in FN communities and Moosonee (municipality) have been included in this group (see Appendix 1).

ORI 3.0 Request

To support the ORI 3.0 program, SLFNHA and WAHA will be mobilizing vaccination teams along with other Human Health Resources (HHR) (e.g., (FNIHB) Nurses, Calian nurses contracted through the province). The FN communities are expected to plan and prepare for the coordination of community members to successfully support the program. As with ORI 1.0 and 2.0, resources, capacity and experience to support local planning and operations vary across remote fly-in FN communities. Therefore Ontario, on behalf of SLFNHA and WAHA, is requesting the assistance of the Federal Government, as was requested for ORI 1.0 and 2.0, for the vaccination campaign which is scheduled to commence on November 15, 2021, and the associated planning efforts in the lead-up to it.

As evidenced through the implementation of ORI 1.0 and 2.0, the assistance of the Canadian Armed Forces (CAF) members with tactical and operational expertise has proved invaluable to the success of the program. Canadian Rangers are leaders within their communities and Ontario's remote FN communities have come to trust and rely on them through the support they have provided during ORI 1.0 and 2.0 as well as other emergencies within the COVID-19 context. These Canadian Armed Forces (CAF) members help in providing local and cultural knowledge and bring operational experience and dedication that boosts confidence within communities and facilitates the arrival of those external health professionals which make up the vaccination teams.

Each remote fly-in FN community will differ in its needs, and SLFNHA/WAHA will identify the specific CAF support requirements of each community in cooperation with the Joint Task Force Central (JTFC). JTFC and SLFNHA/WAHA will be communicating directly with one another on CAF support requirements.

Tasks requested of the Rangers in support of this vaccination campaign are:

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- General logistics support, including transportation of personnel, community members and materials;
- Local coordination including translation, integration of mobile vaccination teams and distribution of information and educational materials; and
- Administrative support, including conducting COVID-19 pre-screening questionnaires, reception and other general support to planning and operations.

CAF members will remain under military command at all times. All tasks and community-specific requirements during deployment will be coordinated between JTFC and SLFNHA/WAHA. CAF members will not be requested to provide security, administer vaccines, provide medical care, or assist with other outbreak-related emergencies.

The support of the Canadian Rangers is being requested until March 31, 2022, with the option to extend by an additional month subject to a reassessment to be completed no later than March 15, 2022. Completion of the operation will provide significant health mitigation measures to remote FN communities to help protect these communities from COVID-19 but also provide another layer of health protection through flu vaccinations. The PEOC will formally notify JTFC, the COVID-19 National Operations Centre (NOC), Public Safety Canada – Ontario Region, and the Government Operations Centre (GOC) of termination on the date the Request for Federal Assistance expires or earlier should the vaccination clinics be completed ahead of schedule.

We appreciate your consideration of this urgent request and your assistance to date.
Should you have any questions or require further information on this matter, please contact Teepu Khawja, Assistant Deputy Minister and Chief, Emergency Management Ontario, at: Teepu.Khawja@ontario.ca.

Sincerely,

Christine Elliott
Deputy Premier and Minister of Health

Sylvia Jones
Solicitor General

Enclosure

c: The Honourable Patty Hajdu
Minister of Indigenous Services and Minister responsible for the Federal Economic Development Agency for Northern Ontario
Government of Canada

The Honourable Anita Anand
Minister of National Defence
Government of Canada

The Honourable Dominic LeBlanc
Minister of Intergovernmental Affairs, Infrastructure and Communities
Government of Canada

The Honourable Greg Rickford
Minister of Indigenous Affairs

Mario Di Tommaso, O.O.M.
Deputy Solicitor General, Community Safety

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Ministry of the Solicitor General

Dr. Catherine Zahn
Deputy Minister of Health
Ministry of Health

Lynn Betzner
Deputy Minister of Intergovernmental Affairs and
Associate Secretary of The Cabinet

Shawn Batise
Deputy Minister of Indigenous Affairs
Ministry of Indigenous Affairs

James Morris, Executive Director
Sioux Lookout First Nation Health Authority

Lynne Innes, President & Chief Executive Officer
Weeneebayko Area Health Authority

Dr. Homer Tien
President and CEO, Ornge

Confidentiality Warning: This email contains information intended only for the use of the individual named above. If you have received this email in error, we would appreciate it if you could advise us through the Ministry of the Solicitor General's website at http://www.mcscs.jus.gov.on.ca/english/contact_us/contact_us.asp and destroy all copies of this message. Thank you.

If you have any accommodation needs or require communication supports or alternate formats, please let us know.

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Ministry of Health

Office of the Deputy Premier
and Minister of Health

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Telephone: 416 327-4300
Facsimile: 416 326-1571
www.ontario.ca/health

Ministère de la Santé

Bureau du vice-premier ministre
et du ministre de la Santé

777, rue Bay, 5e étage
Toronto ON M7A 1N3
Téléphone: 416 327-4300
Télécopieur: 416 326-1571
www.ontario.ca/sante

Solicitor General

Office of the Solicitor General

25 Grosvenor Street, 18th Floor
Toronto ON M7A 1Y6
Tel: 416 326-5000
Toll Free: 1-866-517-0571
SOLGEN.Correspondence@ontario.ca

Solliciteur général

Bureau du solliciteur général

25, rue Grosvenor, 18e étage
Toronto ON M7A 1Y6
Tél. : 416 326-5000
Sans frais : 1-866-517-0571
SOLGEN.Correspondence@ontario.ca

Ontario

132-2021-5121
By email

November 9, 2021

The Honourable Bill Blair
President of the Queen's Privy Council for Canada and
Minister of Emergency Preparedness
House of Commons
Ottawa ON K1A 0A6
bill.blair@parl.gc.ca

The Honourable Marco E. L. Mendicino
Minister of Public Safety
House of Commons
Ottawa ON K1A 0A6
marco.mendicino@parl.gc.ca

The Honourable Jean-Yves Duclos
Minister of Health
House of Commons
Ottawa ON K1A 0A6
jean-yves.duclos@parl.gc.ca

Dear Minister Blair, Minister Mendicino and Minister Duclos:

Ontario continues to ensure adequate and timely vaccine rollout across the province, including in remote fly-in First Nation (FN) communities. As a major part of our COVID-19 response and in support of these remote fly-in FN communities, we intend to launch Operation Remote Immunity (ORI) 3.0 in an effort to administer third doses and in anticipation of vaccination approvals for children in the 5 to 11 age group.

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These vaccinations are essential and support safer transit to and from remote fly-in FN communities. While Ornge was tasked by the province to lead ORI 1.0 and 2.0, Sioux Lookout First Nation Health Authority (SLFNHA) and the Weeneebayko Area Health Authority (WAHA) will lead the implementation of ORI 3.0 in their respective communities with the support of First Nations Inuit Health Branch (FNIHB), the northern Public Health Units (PHUs) and Ornge. At present, 31 fly-in FN communities and Moosonee (municipality) have been included in this group (see Appendix 1).

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To support the ORI 3.0 program, SLFNHA and WAHA will be mobilizing vaccination teams along with other Human Health Resources (HHR) (e.g., (FNIHB) Nurses, Calian nurses contracted through the province). The FN communities are expected to plan and prepare for the coordination of community members to successfully support the program. As with ORI 1.0 and 2.0, resources, capacity and experience to support local planning and operations vary across remote fly-in FN communities. Therefore Ontario, on behalf of SLFNHA and WAHA, is requesting the assistance of the Federal Government, as was requested for ORI 1.0 and 2.0, for the vaccination campaign which is scheduled to commence on November 15, 2021, and the associated planning efforts in the lead-up to it.

As evidenced through the implementation of ORI 1.0 and 2.0, the assistance of the Canadian Armed Forces (CAF) members with tactical and operational expertise has proved invaluable to the success of the program. Canadian Rangers are leaders within their communities and Ontario's remote FN communities have come to trust and rely on them through the support they have provided during ORI 1.0 and 2.0 as well as other emergencies within the COVID-19 context. These Canadian Armed Forces (CAF) members help in providing local and cultural knowledge and bring operational experience and dedication that boosts confidence within communities and facilitates the arrival of those external health professionals which make up the vaccination teams.

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The support of the Canadian Rangers is being requested until March 31, 2022, with the option to extend by an additional month subject to a reassessment to be completed no later than March 15, 2022. Completion of the operation will provide significant health mitigation measures to remote FN communities to help protect these communities from COVID-19 but also provide another layer of health protection through flu vaccinations. The PEOC will formally notify JTFC, the COVID-19 National Operations Centre (NOC), Public Safety Canada – Ontario Region, and the Government Operations Centre (GOC) of termination on the date the Request for Federal Assistance expires or earlier should the vaccination clinics be completed ahead of schedule.

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Sincerely,

[redacted]

Christine Elliott
Deputy Premier and Minister of Health

[redacted]

Sylvia Jones
Solicitor General

…/4

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Enclosure

c: The Honourable Patty Hajdu
Minister of Indigenous Services and Minister responsible for the Federal Economic Development Agency for Northern Ontario
Government of Canada

The Honourable Anita Anand
Minister of National Defence
Government of Canada

The Honourable Dominic LeBlanc
Minister of Intergovernmental Affairs, Infrastructure and Communities
Government of Canada

The Honourable Greg Rickford
Minister of Indigenous Affairs

Mario Di Tommaso, O.O.M.
Deputy Solicitor General, Community Safety
Ministry of the Solicitor General

Dr. Catherine Zahn
Deputy Minister of Health
Ministry of Health

Lynn Betzner
Deputy Minister of Intergovernmental Affairs and
Associate Secretary of The Cabinet

Shawn Batise
Deputy Minister of Indigenous Affairs
Ministry of Indigenous Affairs

James Morris, Executive Director
Sioux Lookout First Nation Health Authority

Lynne Innes, President & Chief Executive Officer
Weeneebayko Area Health Authority

Dr. Homer Tien
President and CEO, Ornge

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Appendix 1: List of fly-in communities in scope for Operation Remote Immunity 3.0

Number	Community
1.	Weenusk/Peawanuck
2.	Neskantaga
3.	Webequie
4.	Slate Falls
5.	Muskrat Dam
6.	Fort Severn
7.	Kashechewan
8.	Nibinamik
9.	Wapekeka
10.	Sachigo Lake
11.	Cat Lake
12.	Poplar Hill
13.	Attawapiskat
14.	North Caribou Lake
15.	Wawakapewin
16.	Kasabonika
17.	Keewaywin (Koocheching)
18.	Mishkeegogamang
19.	Fort Albany
20.	Wunnumin Lake
21.	King Fisher Lake
22.	Bearskin Lake
23.	Marten Falls
24.	Eabametoong
25.	KI
26.	North Spirit Lake
27.	Deer Lake
28.	Sandy Lake
29.	Pikangikum
30.	MoCreebec
31.	Moose Cree
32.	Moosonee

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-11-15 10:46 AM
To: hcminister.ministresc
Subject: TR: Constituent Inquiry Regarding Natural COVID-19 Immunity
Attachments: [redacted] COVID Antibodies.PDF

De : Epp, Dave - M.P. <Dave.Epp@parl.gc.ca>
Envoyé : 12 novembre 2021 11:37
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : Constituent Inquiry Regarding Natural COVID-19 Immunity

Dear Minister,

Please see attached a letter from one of my constituents, [redacted] outlining the difficulties facing Canadians who have achieved natural immunity and antibodies through prior infection equal to or greater than that provided by two doses of an approved COVID-19 vaccine.

This immunity was recently recognized by the Chief Medical Officer of Health of Ontario, Dr. Kieran Moore.

What resources are available to provide to constituents such as [redacted] on how or if the federal government intends to recognize natural immunity from COVID-19?

Sincerely,
Dave

Dave Epp

Member of Parliament
Chatham-Kent—Leamington

Tel: 888 326 9655

Email: dave.epp@parl.gc.ca

Website: www.DaveEppMP.ca

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October 22, 2021

Dear Mr. Dave Epp,

My name is [redacted] Im from [redacted] On. I am writing to you today voicing my frustration how difficult it is travelling as a Canadian that has Covid 19 with natural immunity and high levels of antibodies.

[redacted]

My question is why isn't the Canadian government recognizing natural immunity and antibodies? And why monoclonal antibodies aren't being used?

Canadians with antibodies shouldn't have to miss [redacted] work when they pose no more of a health risk to the double vaccinated Canadians if anything they have longer lasting and higher levels of protection.

So many jobs are being lost in Canada especially from people that had previous covid infections with high antibody levels such as the health care sector which is already understaffed these policies need to change now !! when talking anything vaccinated in policies natural immunity should be added as equal or better then the vaccine .

The Canadian Government needs to start believing in science again to allow so many Canadians their God given rights and freedoms back.

[redacted]

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Esteves, Dina (HC/SC)

From: Larocque, Julie R (HC/SC)
Sent: 2021-11-29 10:12 AM
To: hcminister.ministresc
Subject: FW: Incoming VIP correspondence
Attachments: 20211126165244075.pdf

From: Champagne, Christine (HC/SC) <christine.champagne@hc-sc.gc.ca>
Sent: 2021-11-26 5:06 PM
To: HC.F ECD-Liaison / DCHG F.SC <hc.ecd-liaison-dchg.sc@hc-sc.gc.ca>
Cc: Browne, Robert (HC/SC) <robert.browne@hc-sc.gc.ca>
Subject: Incoming VIP correspondence

Hello ECD,

Please find attached the incoming VIP correspondence from MP Rosemarie Falk (Battlefords – Lloydminister, Saskatchewan) (Digitals version)

Thank you | Merci

Christine Champagne (She / Elle)
Correspondence Officer | Officier de Correspondance |
Deputy Minister's Office | Bureau du Sous-Ministre
Health Canada | Santé Canada
Government of Canada | Gouvernement du Canada
christine.champagne@canada.ca | 613-612-9509
Government of Canada / Gouvernement du Canada

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Constituency Office
#3, 4304—40 Avenue
Lloydminster, SK S9V 2H1
Tel: 306-825-5005
Toll Free: 1-888-825-4944
Fax: 306-825-5011
Web: RosemarieFalkMP.ca

ROSEMARIE FALK, M.P.
BATTLEFORDS–LLOYDMINSTER

Parliamentary Office
Room 184 Confederation Bldg.
House of Commons
Ottawa, ON K1A 0A6
Tel: 613-995-7080
Fax: 613-996-8472
Rosemarie.Falk@parl.gc.ca

October 29, 2021

The Honourable Jean Yves Duclos, PC, MP
Minister of Health
House of Commons
Ottawa, ON K1A 0A6

Dear Minister:

Enclosed is correspondence I have received from a constituent, [redacted] Saskatchewan.

[redacted] has contacted me regarding the availability of clear information on the COVID-19 virus. It would be helpful if there was clear information on the federal government website on how the virus was isolated, testing data, vaccinations, and masking. This information would also go along way of alleviating some of the vaccination hesitancy many Canadians continue to experience.

I have assured [redacted] that his comments would be brought to your direct attention for consideration and comment.

Thanking you in advance for your attention to this matter.

Sincerely,

[redacted]

Rosemarie Falk, MP
Battlefords-Lloydminster

REC
09 NOV. 2021
Rép:

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Good day Rosemarie, I am in need of some assistance.
I am wondering if you are able to point me in the right direction on the isolation of the sars-cov2 virus that causes COVID-19?
From my understanding from the onset of this pandemic, we as Canadians were told by the World Health Organization and China that we were under attack from a virus and a pandemic was instituted.
My question is did Canada ever send a delegation to China to confirm the isolation of this virus? Do we in fact with 100% conformation that this virus was isolated? If so why was it never displayed to the world? Are we taking the WHO and China's word for it?
What are we basing our testing and variants off of if we don't have a baseline?
I hope you understand my concern with this as I am sure you have heard from many about this.
We are essentially killing people with these forced lockdowns and vaccine mandates, especially the vaccines, and I am just wondering what we are basing this off of? We are masking our kids our PRE-SCHOOL children, which is child abuse and people should be jailed, based off of nothing?!
All I am told is shut up, "don't you watch the news" and get the jab. I have asked Sask health and they refuse to answer, not very promising for someone trying to make an informed decision. Anything you can help me with would be greatly appreciated. Thanks!

REÇU le
09 NOV. 2021
Rép: _____

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FAMILIES FOR CHOICE

We, the undersigned, state:

We urge you not to implement any mandate requiring children ages 5-11 to be vaccinated against COVID-19. We urge you to repeal any current mandates that apply to children ages 12-17.

We are families, **vaccinated and unvaccinated against COVID-19**, united in our mission to safeguard the rights of families to choose whether and when to vaccinate their children against COVID-19. We profoundly believe that each family's **choice**, however made, should not affect its children's ability to attend school, access services, or participate in extracurricular activities and organized sports.

All children must be treated equally, regardless of their COVID-19 vaccination status. COVID-19 vaccination status should never be a basis upon which to exclude or segregate children.

COVID-19 poses **low risk to healthy children**. We do not yet know if COVID-19 vaccines are free from long-term harm. Vaccine safety and efficacy data for children under the age of 12 is in its infancy and based on relatively small trial participant numbers.

Whether and when to vaccinate a child must remain a purely personal medical decision, left to that child's family. Mandates either coerce families into vaccinating children, despite their hesitations to do so, or result in the segregation and alienation of children who remain unvaccinated. Neither of these outcomes should occur in Canada today, particularly given the low risk COVID-19 poses to healthy children.

The negative impacts to children of restricting access to education, services, activities and sports have been made abundantly clear in the lockdowns that occurred earlier in the pandemic. These consequences will worsen for children if they are prevented from participating in society because of their COVID-19 vaccination status.

Given the low risk that COVID-19 poses to healthy children, families must be allowed to choose whether and when to vaccinate their children, without societal consequences. We urge you not to implement any mandate requiring children ages 5-11 to be vaccinated against COVID-19. We also urge you to repeal any current mandates that apply to children ages 12-17.

Sincerely,

Families For Choice

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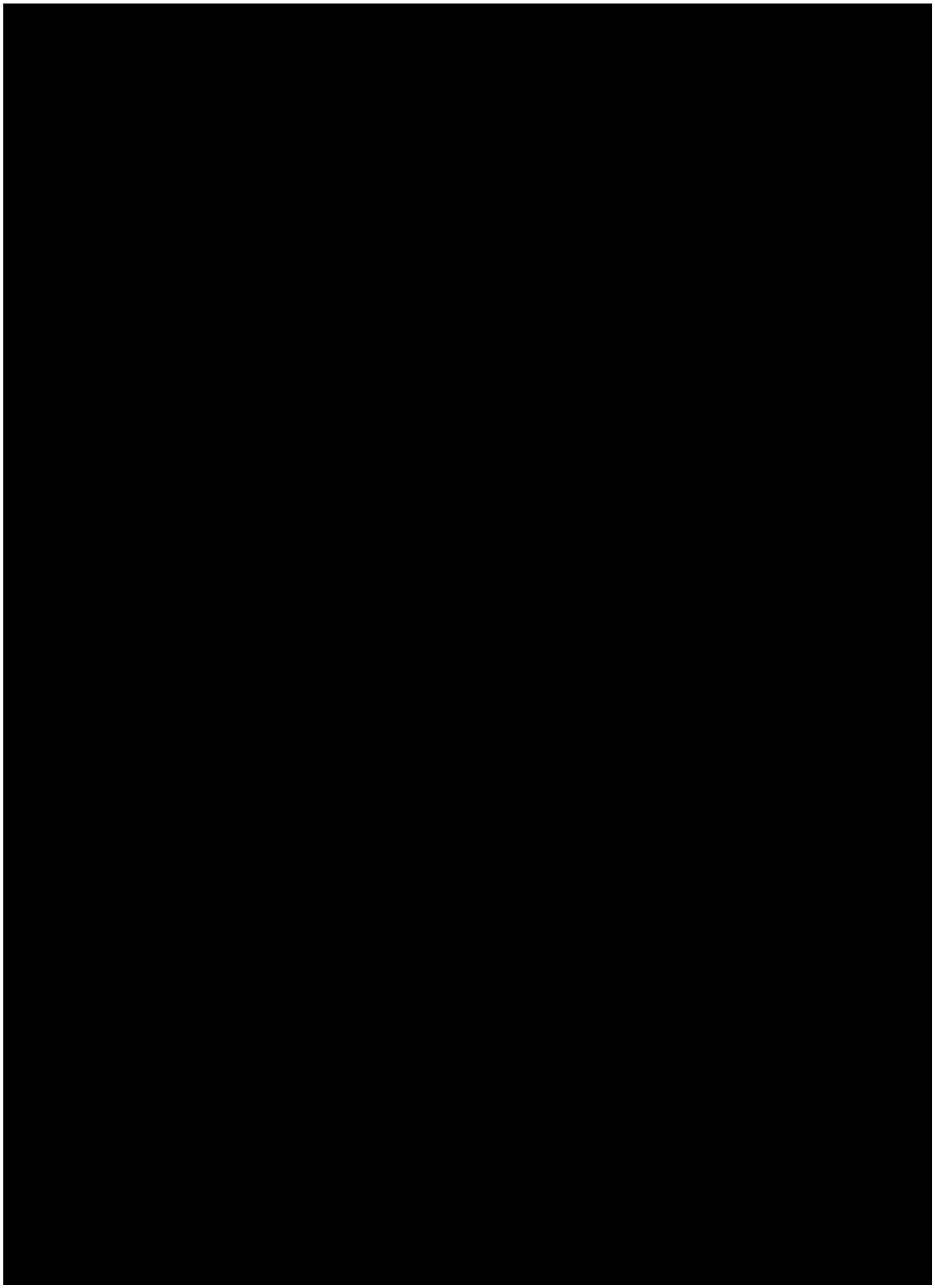

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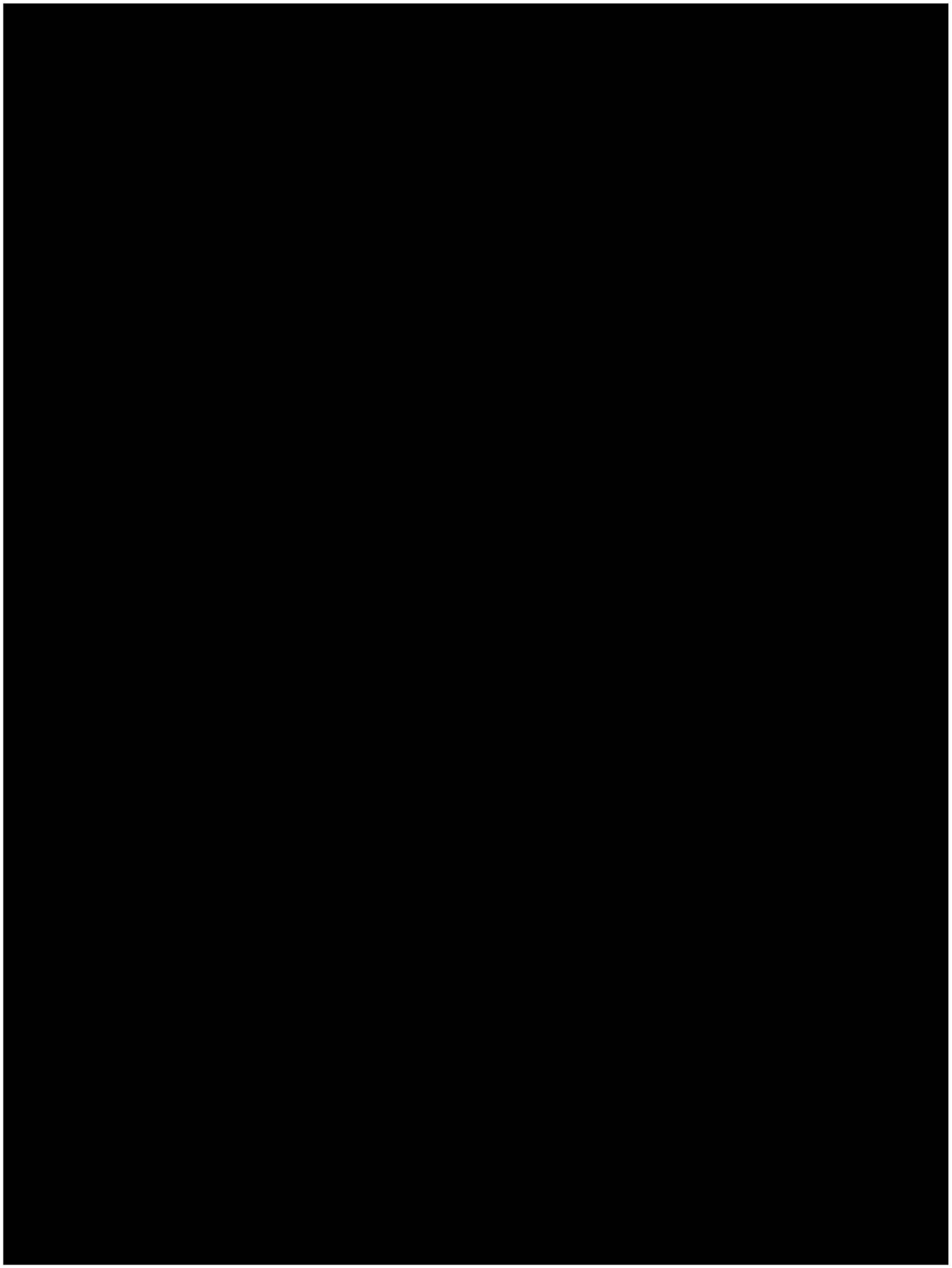

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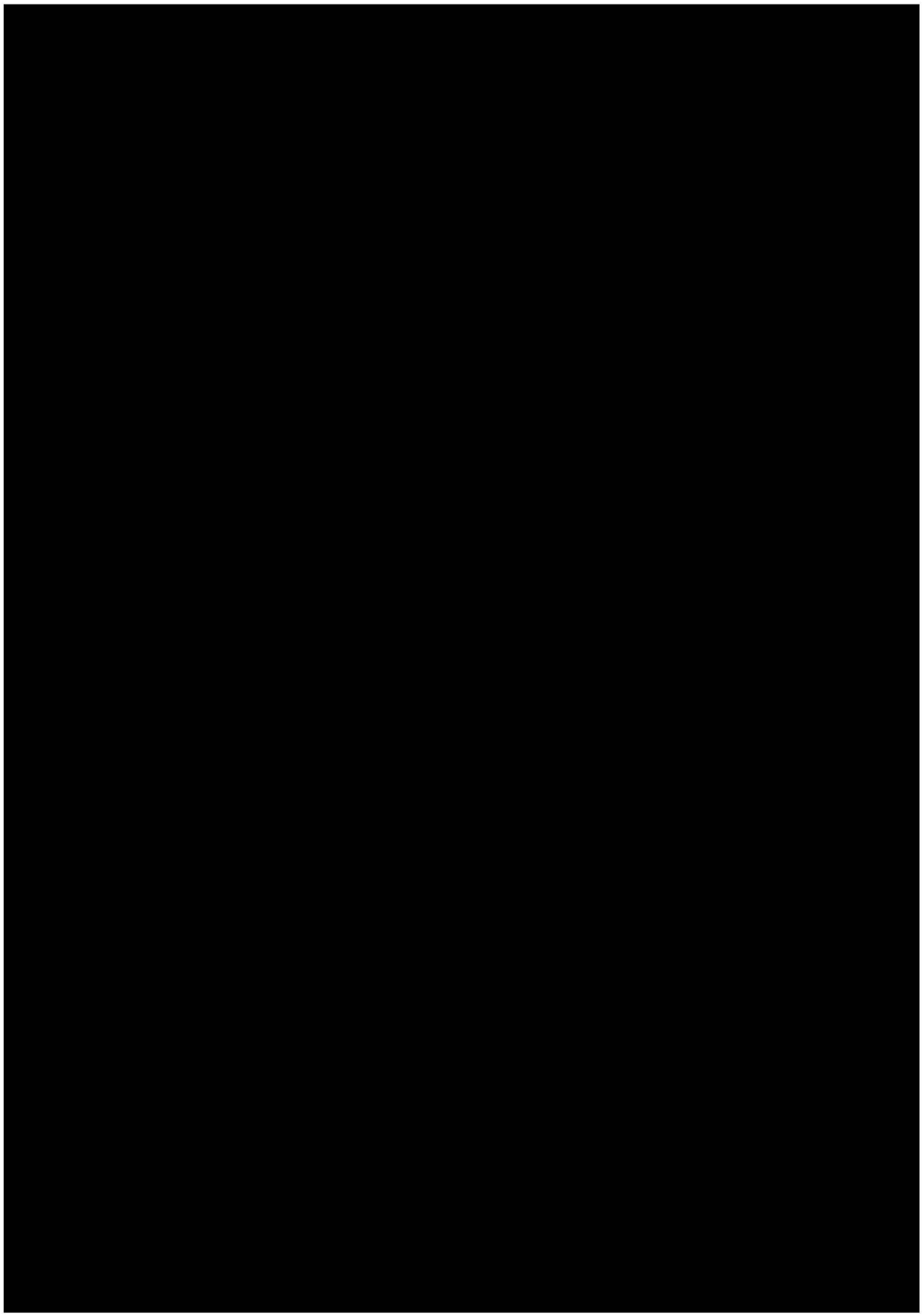

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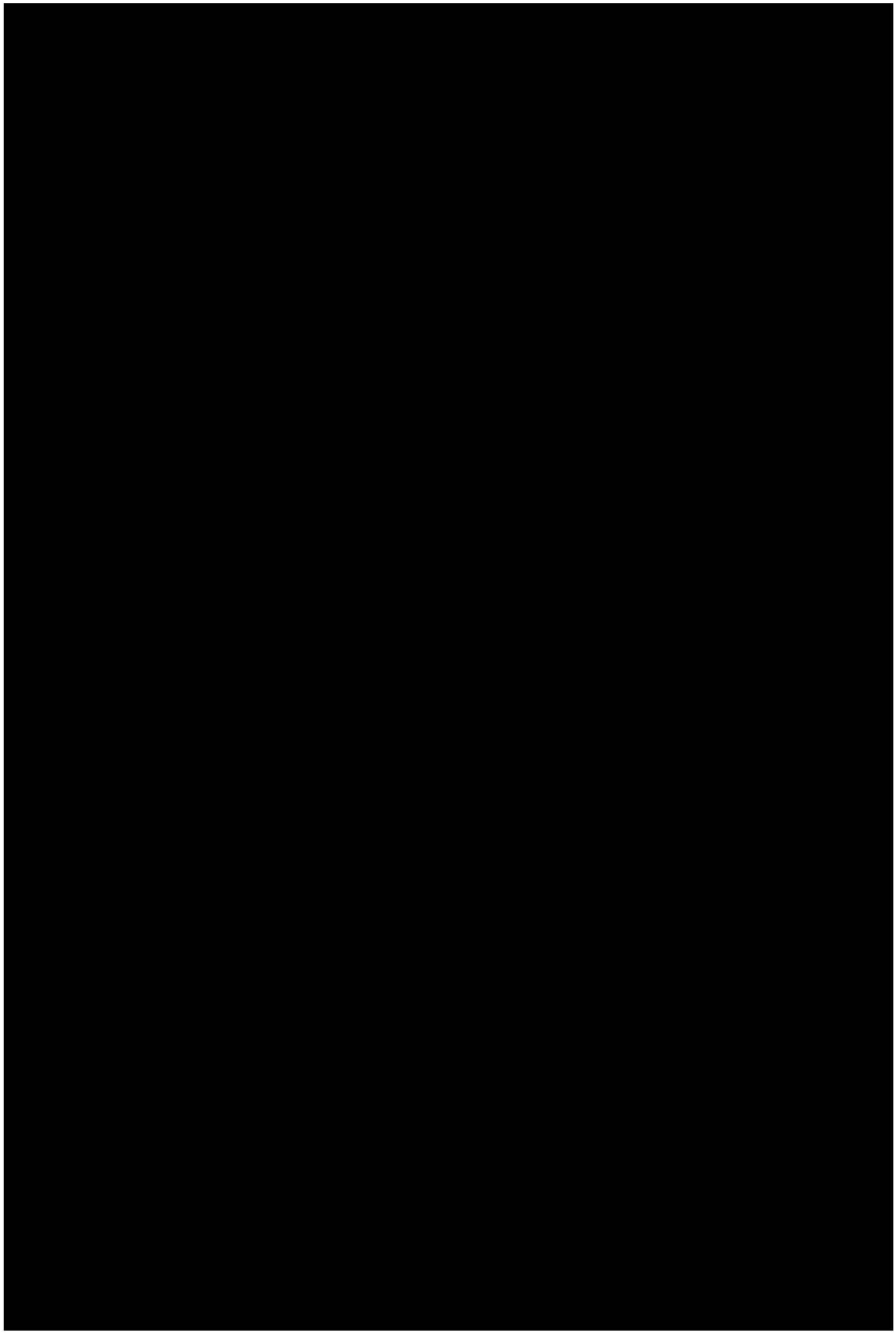

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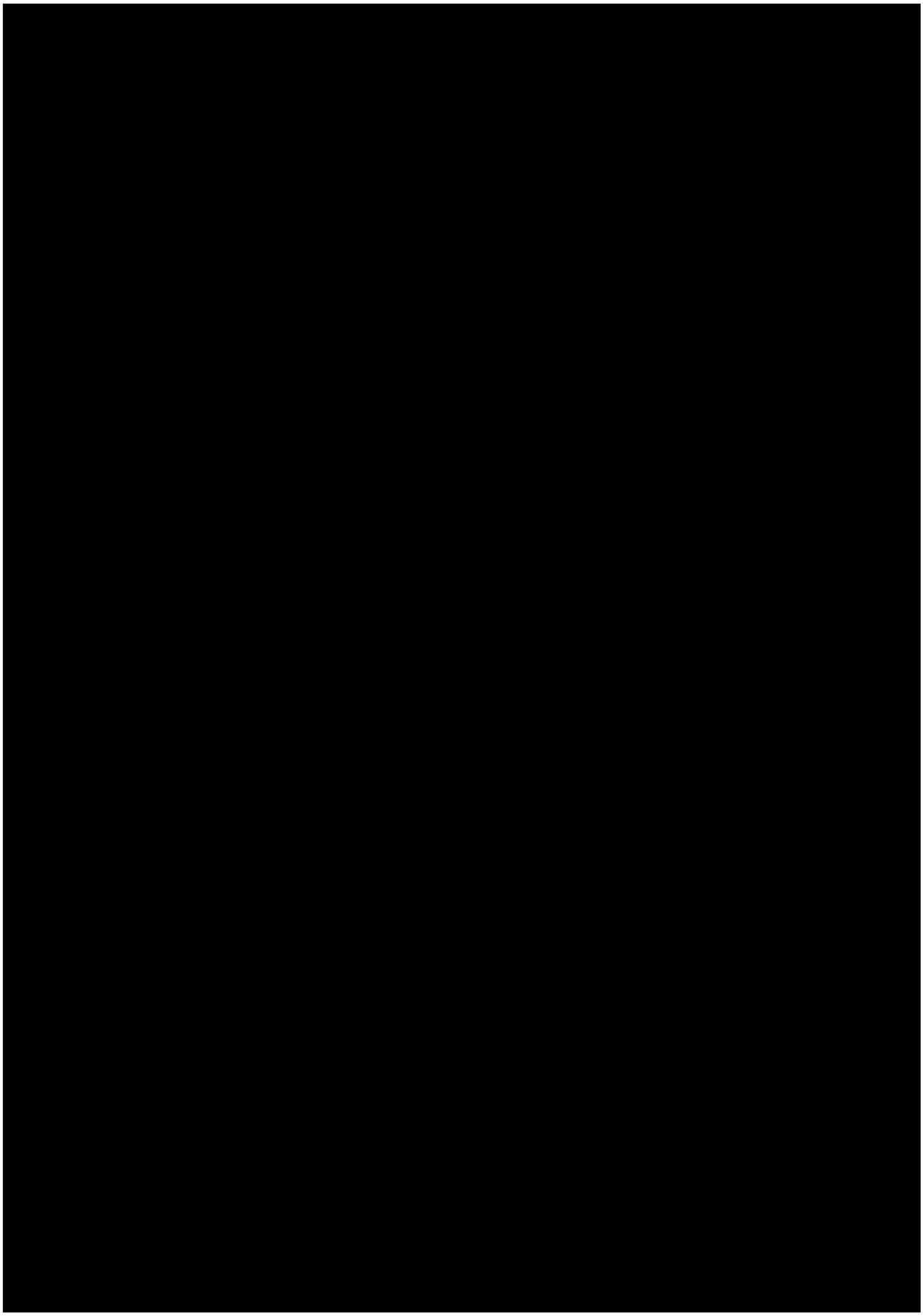

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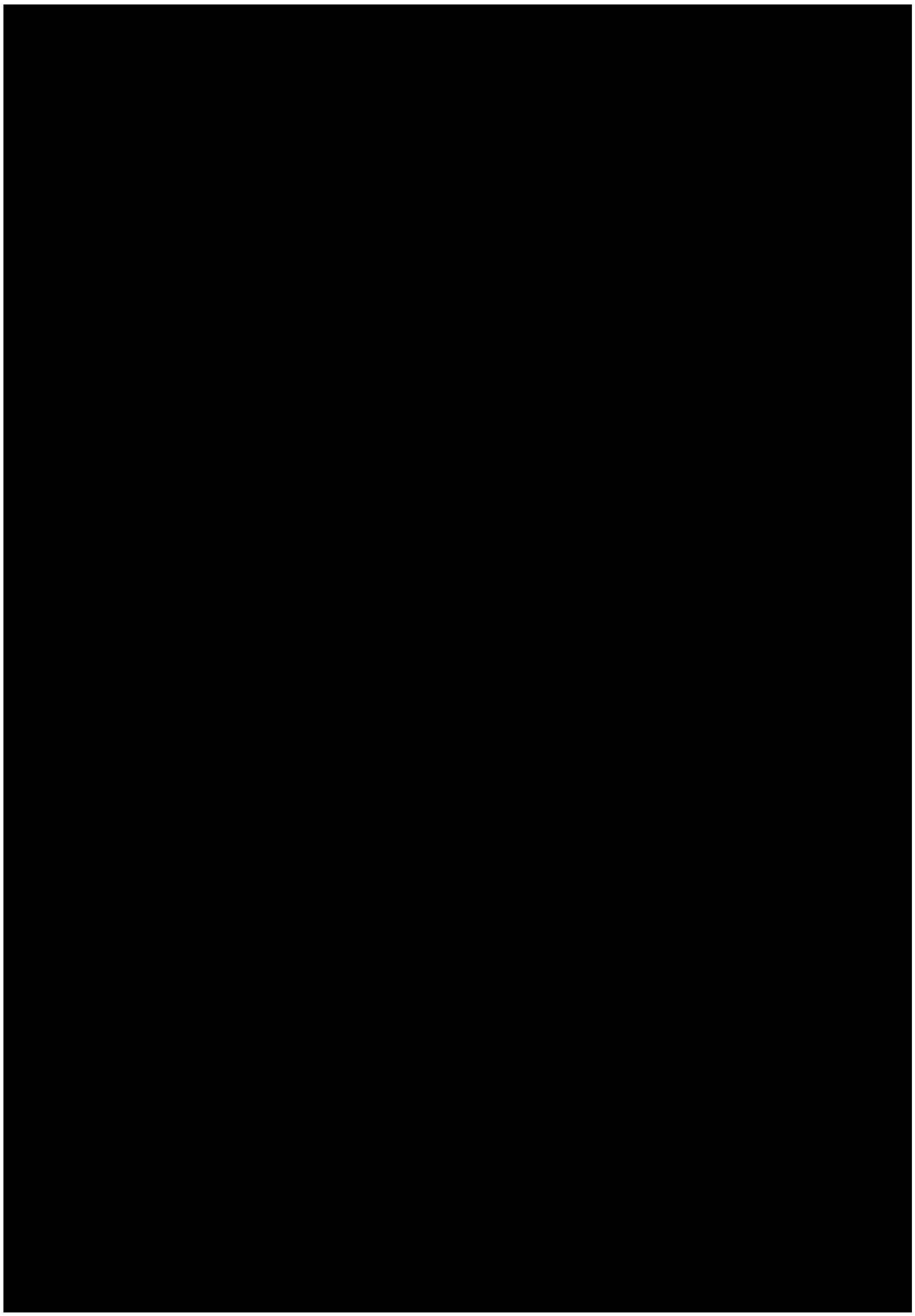

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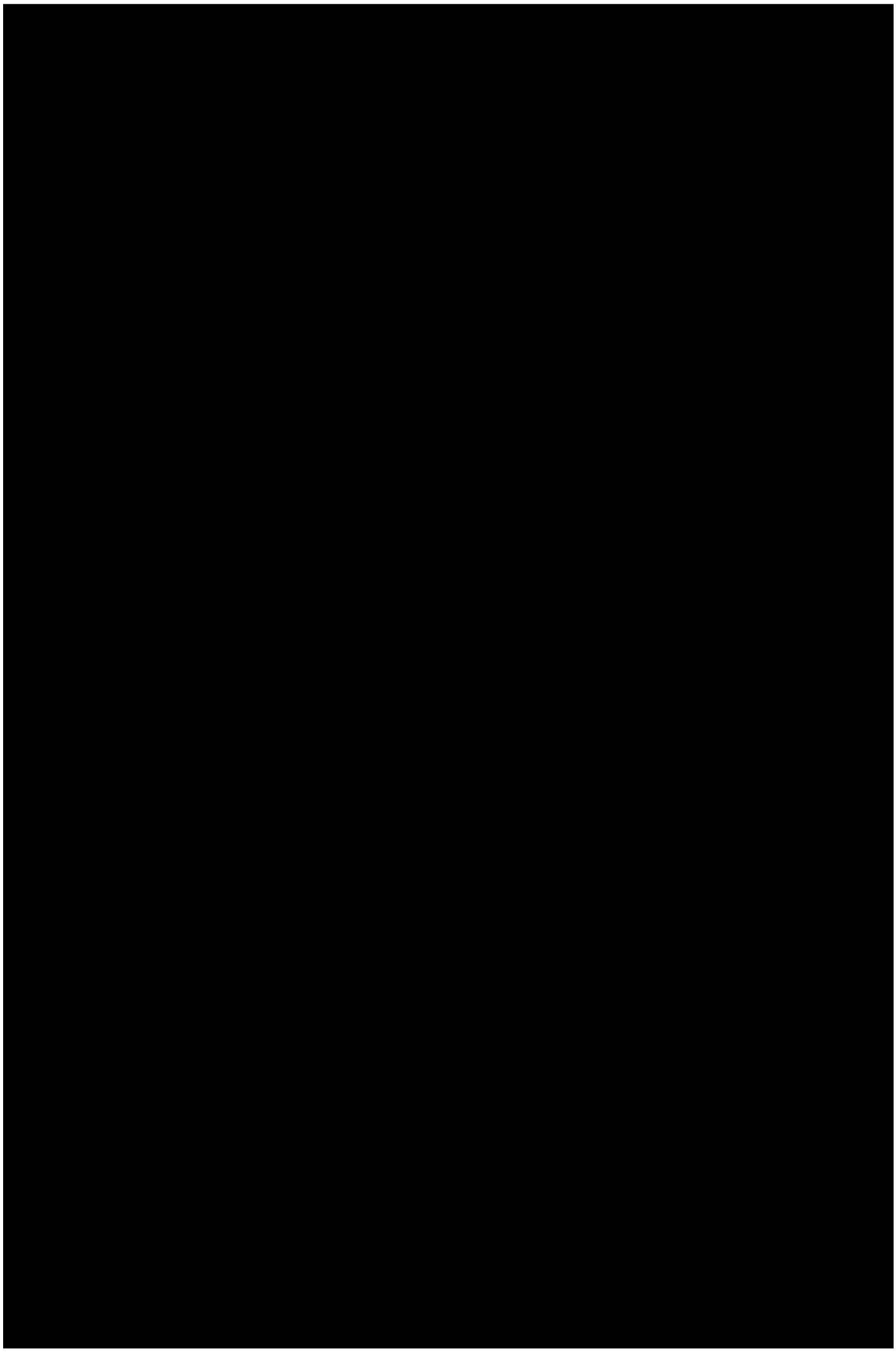

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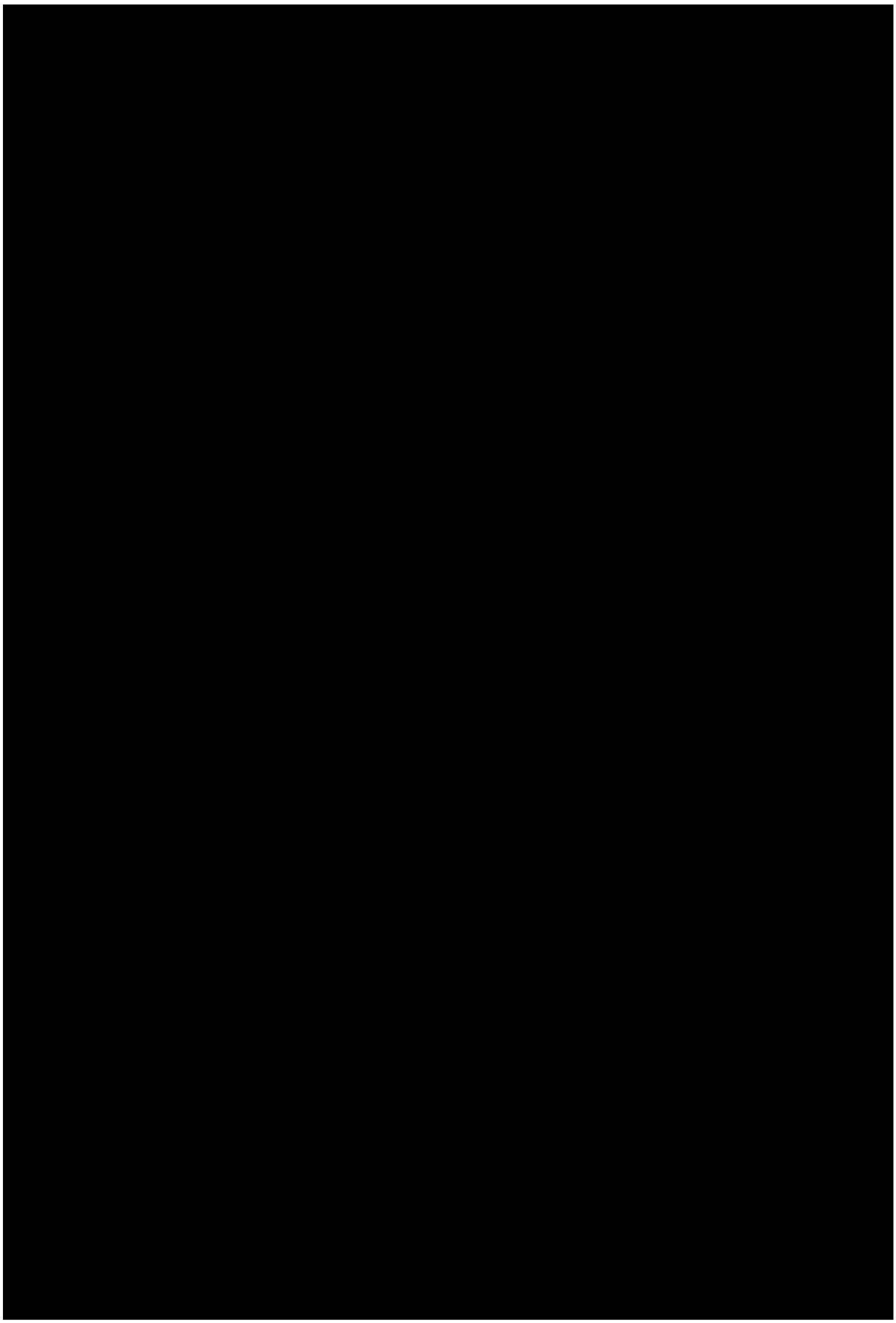

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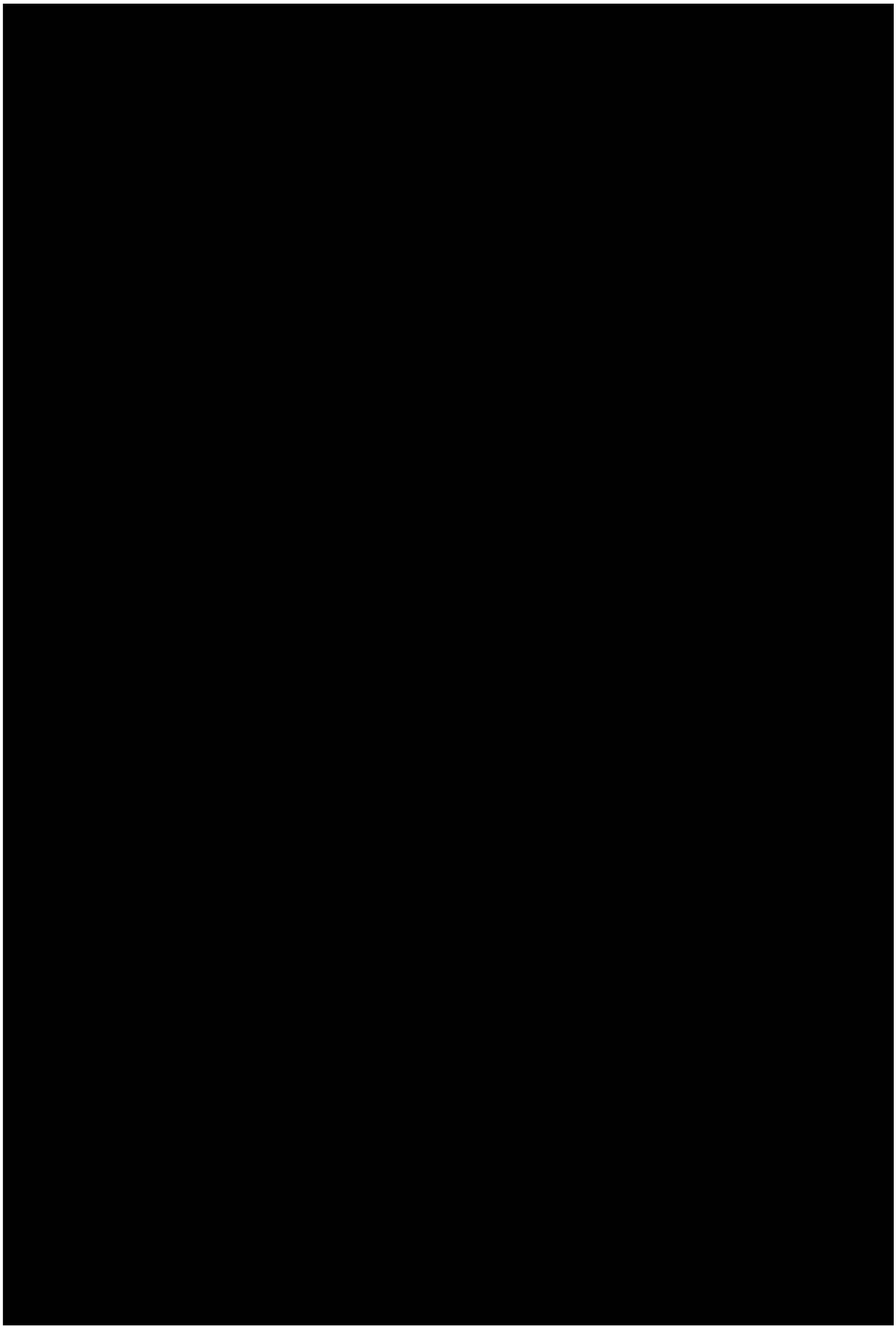

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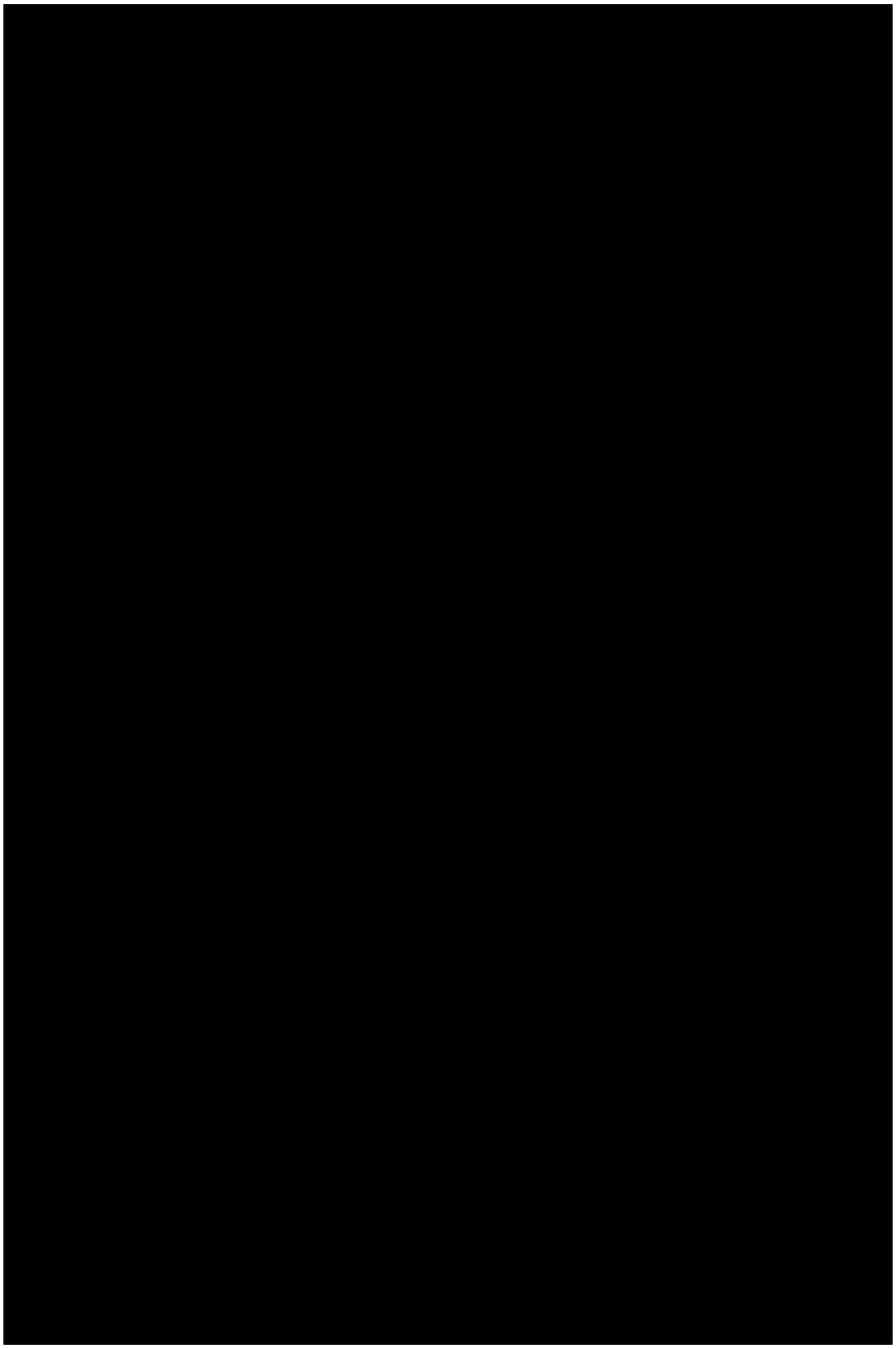

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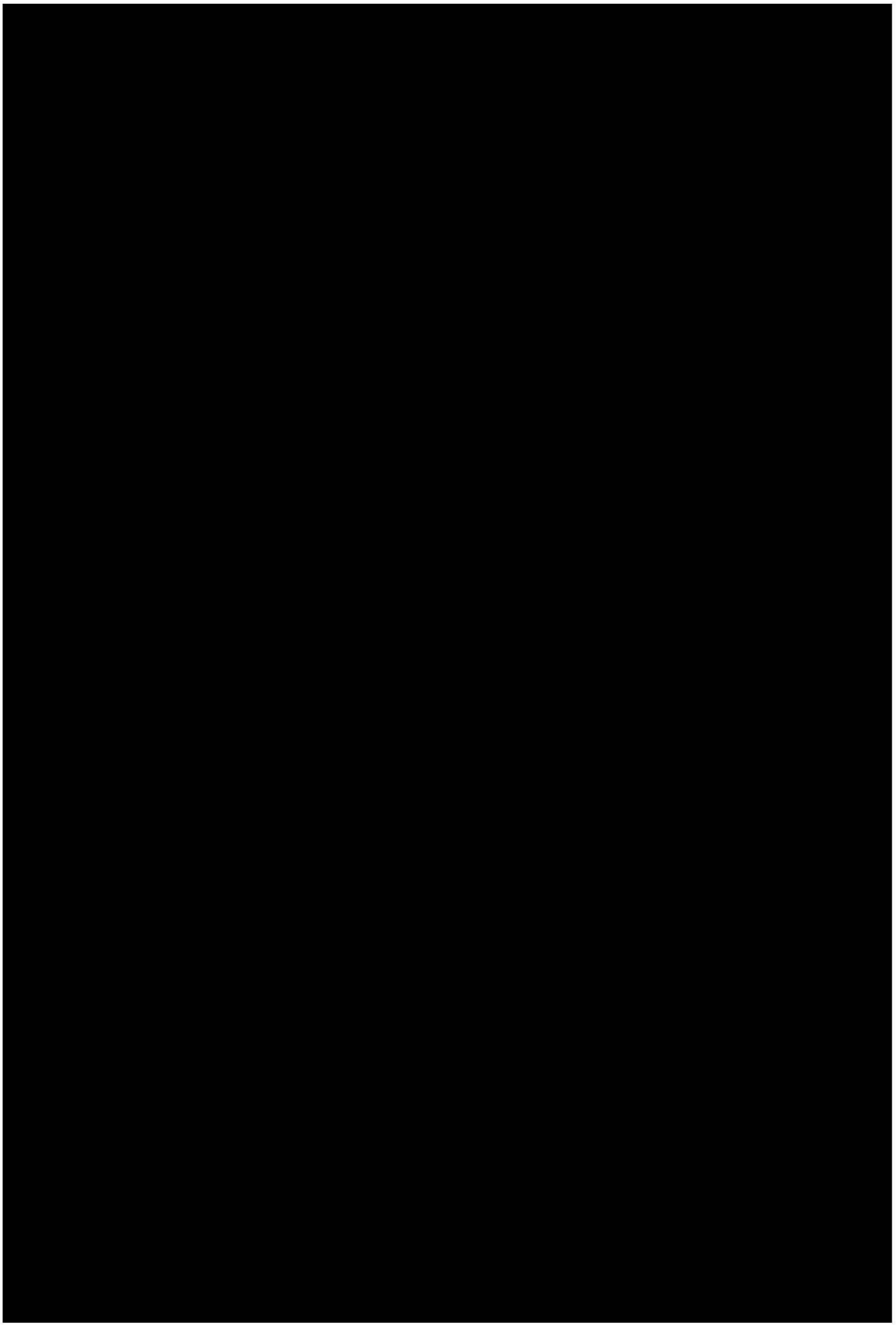

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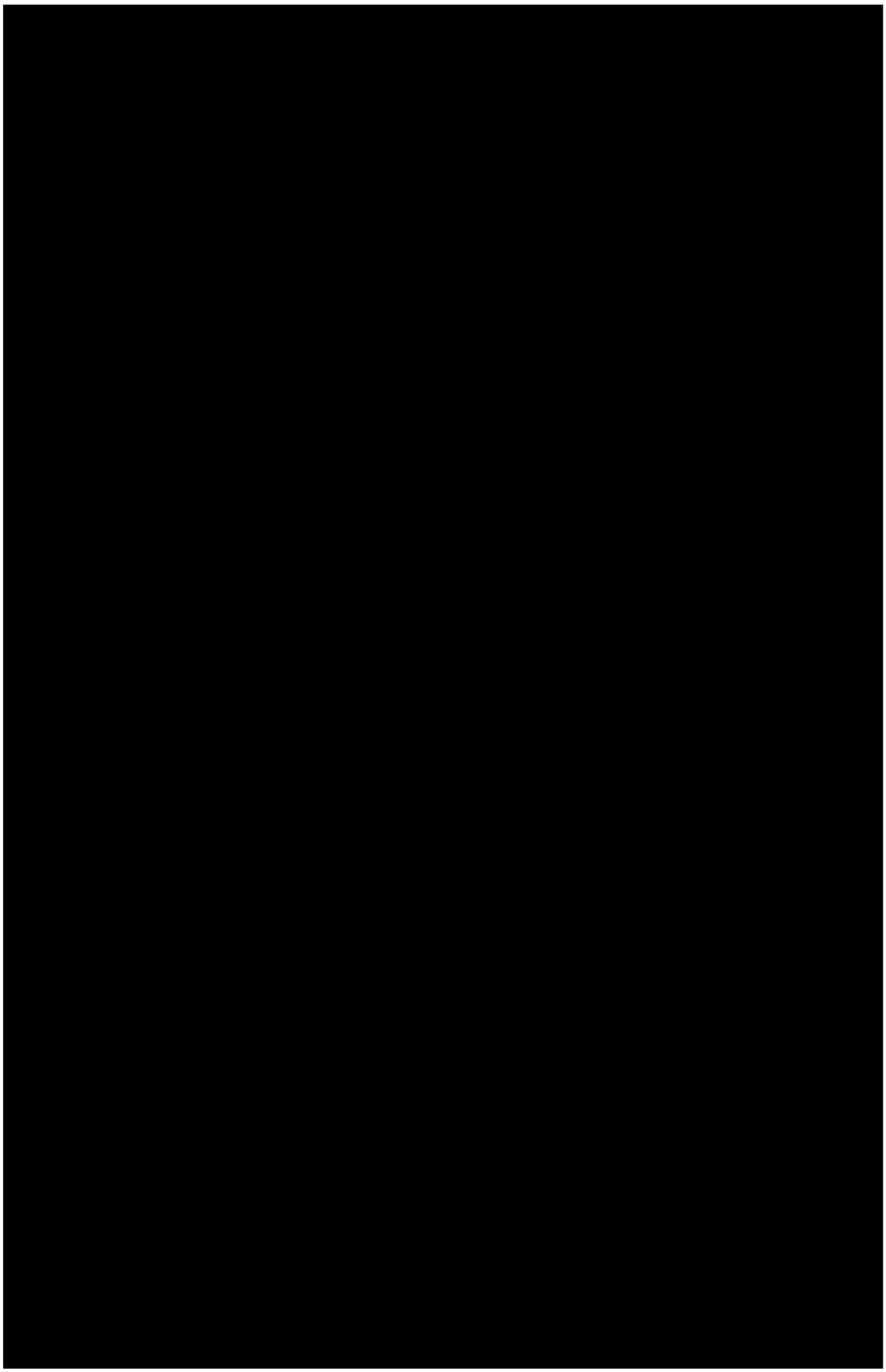

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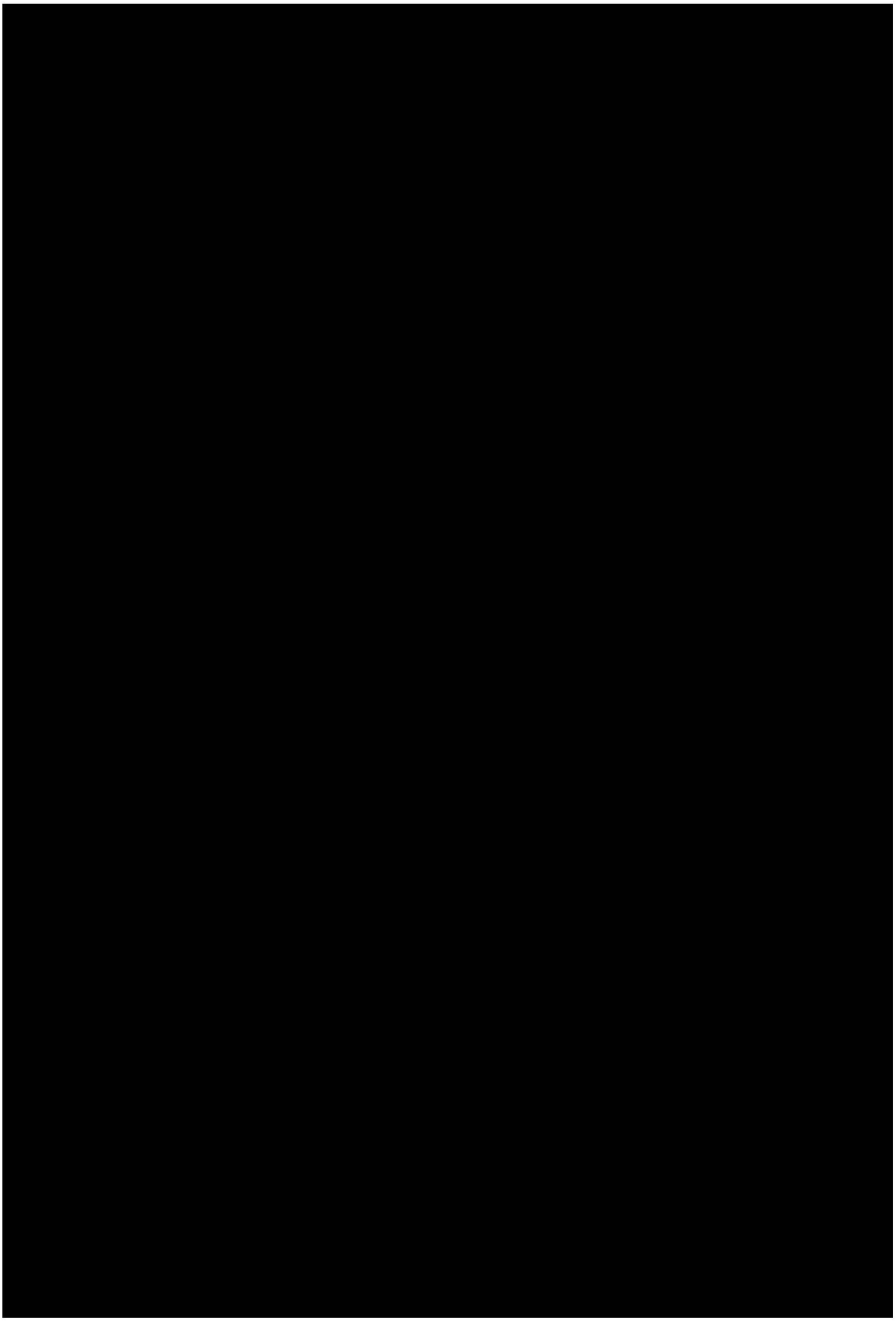

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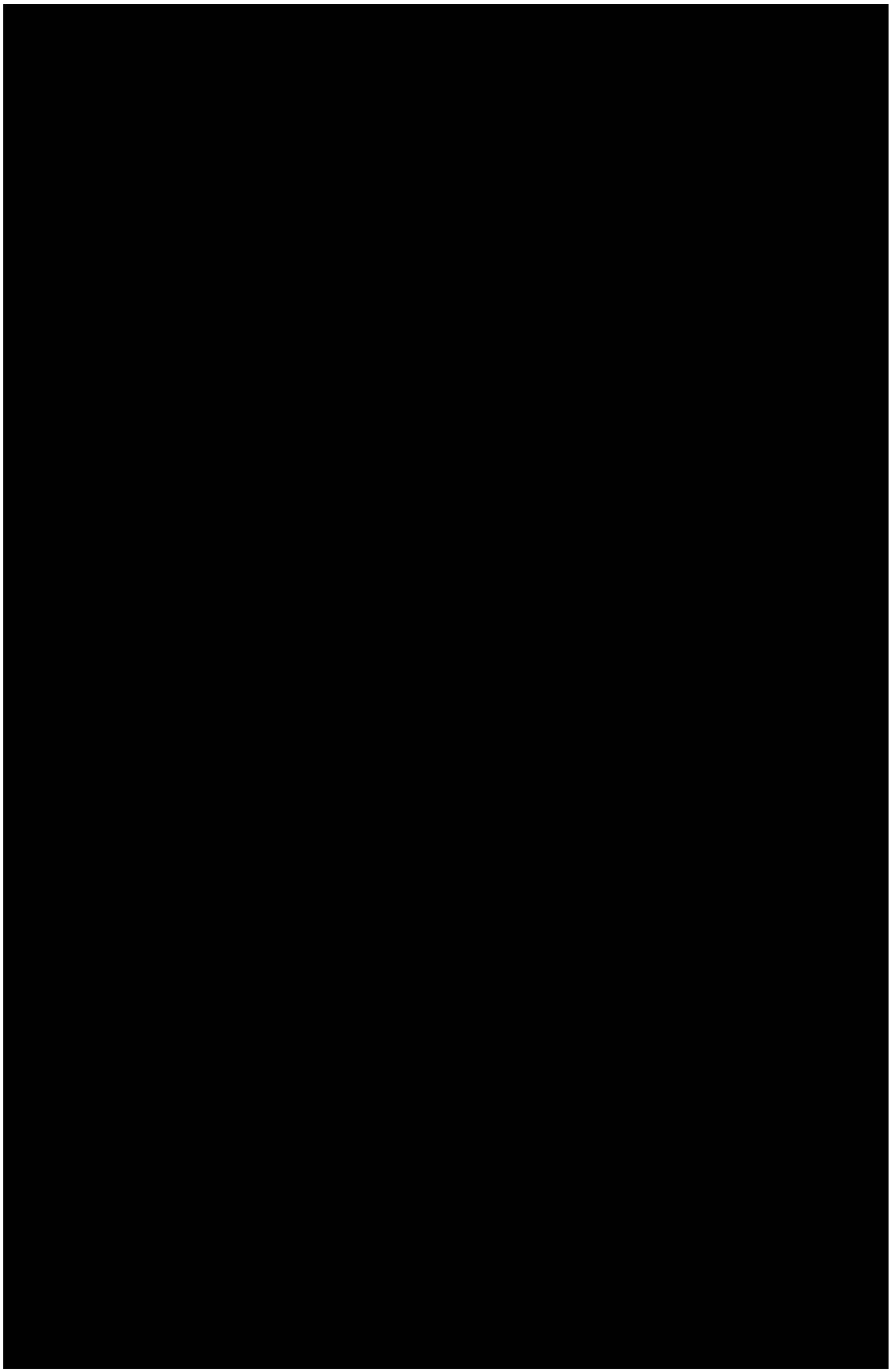

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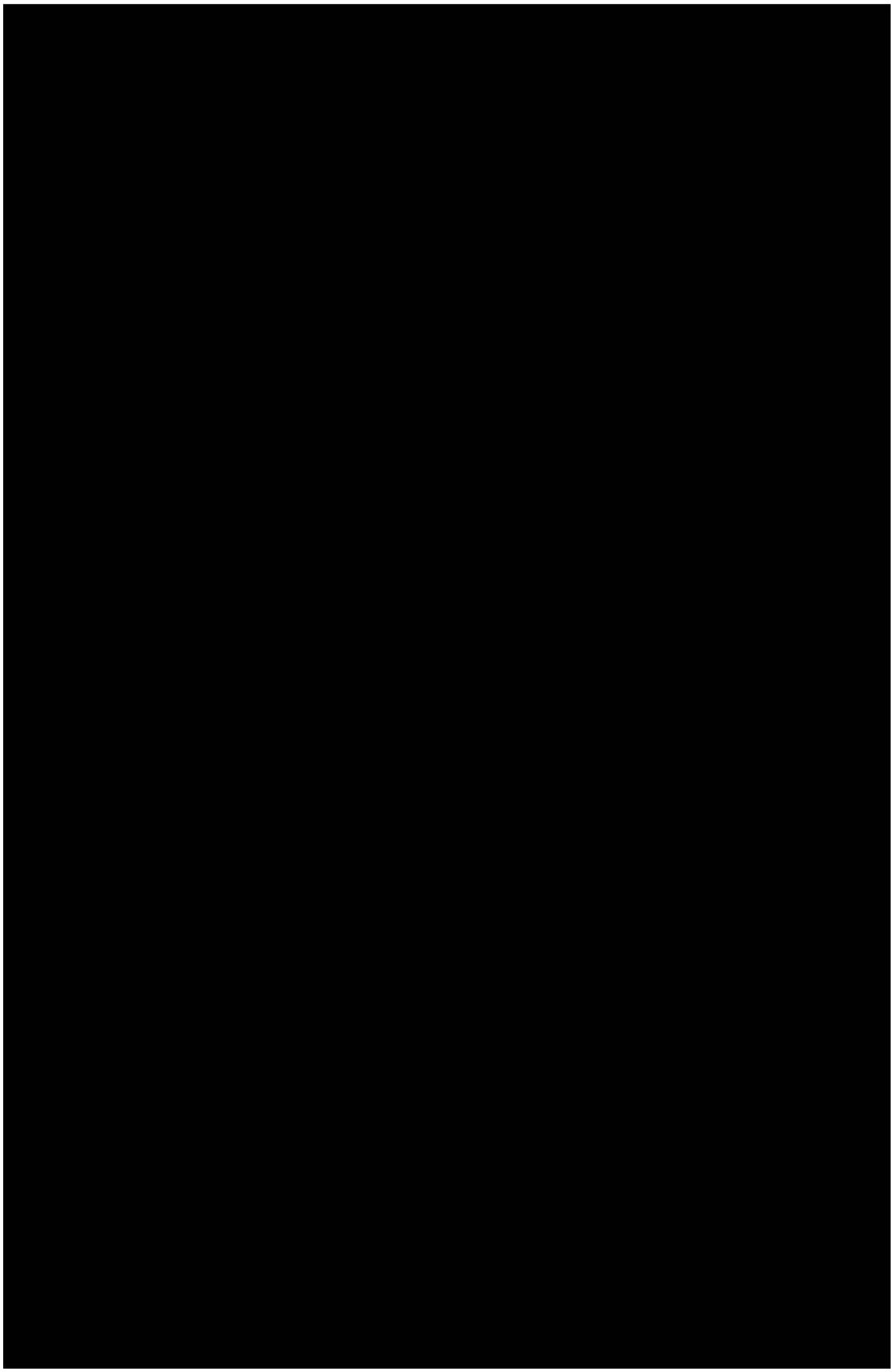

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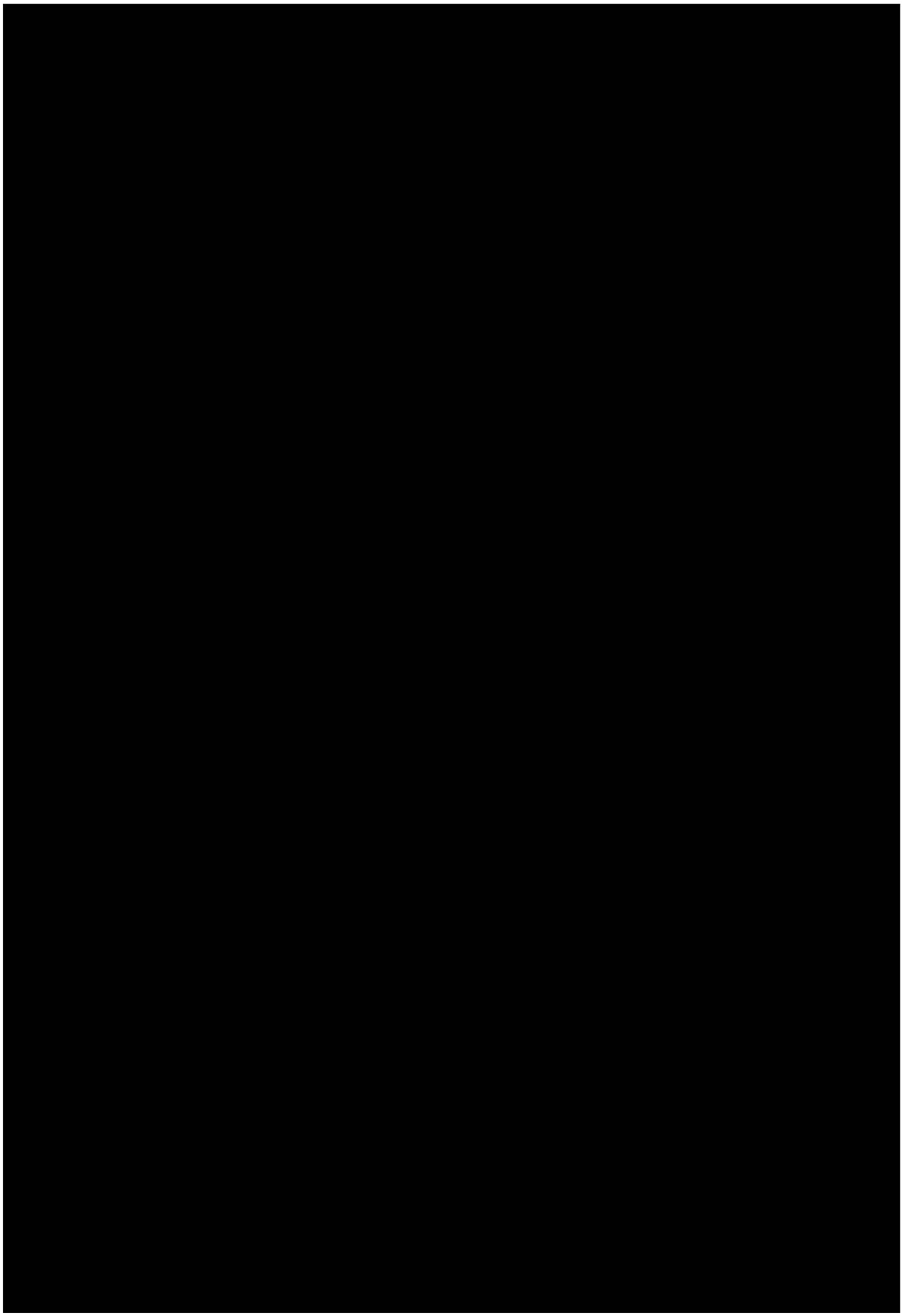

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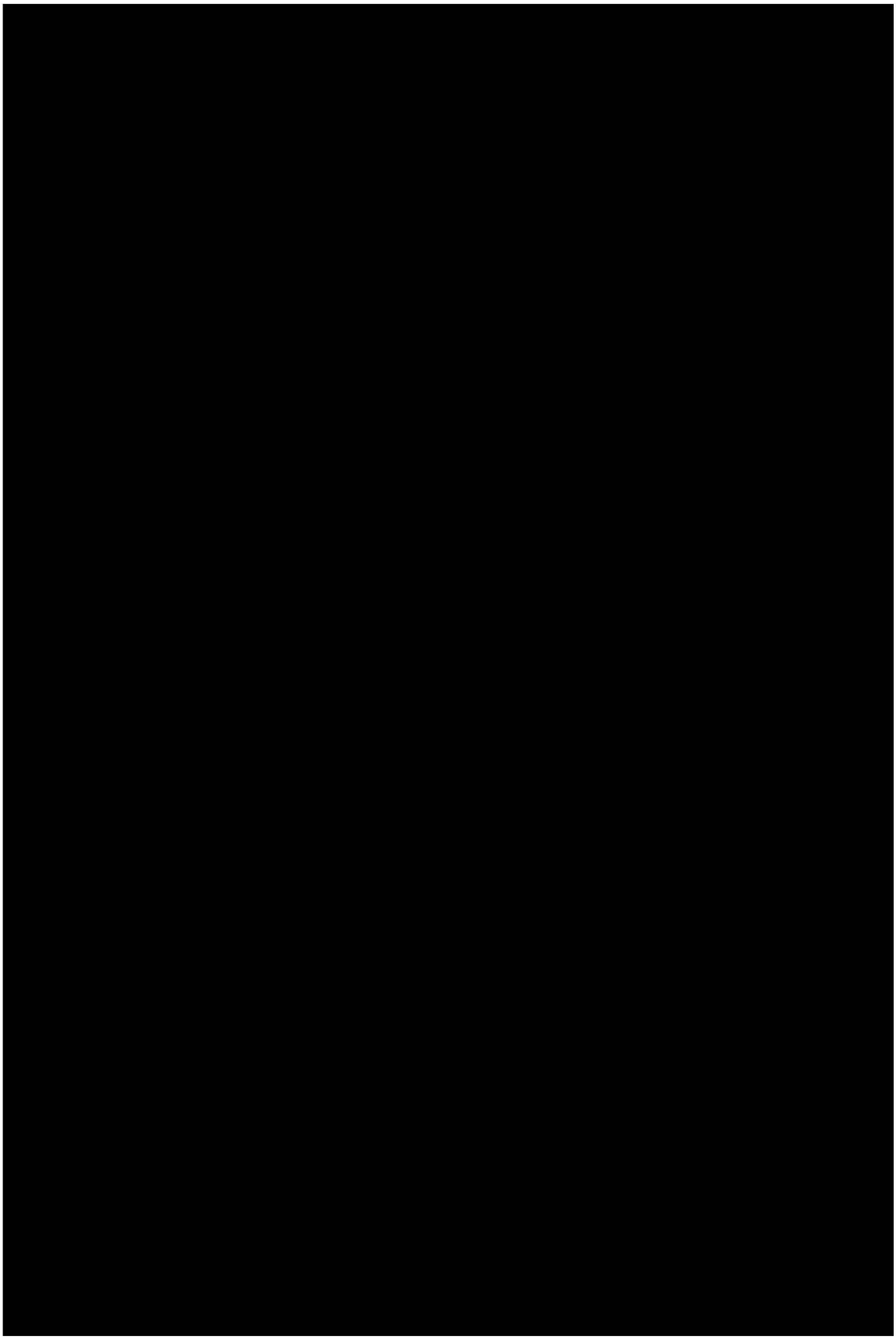

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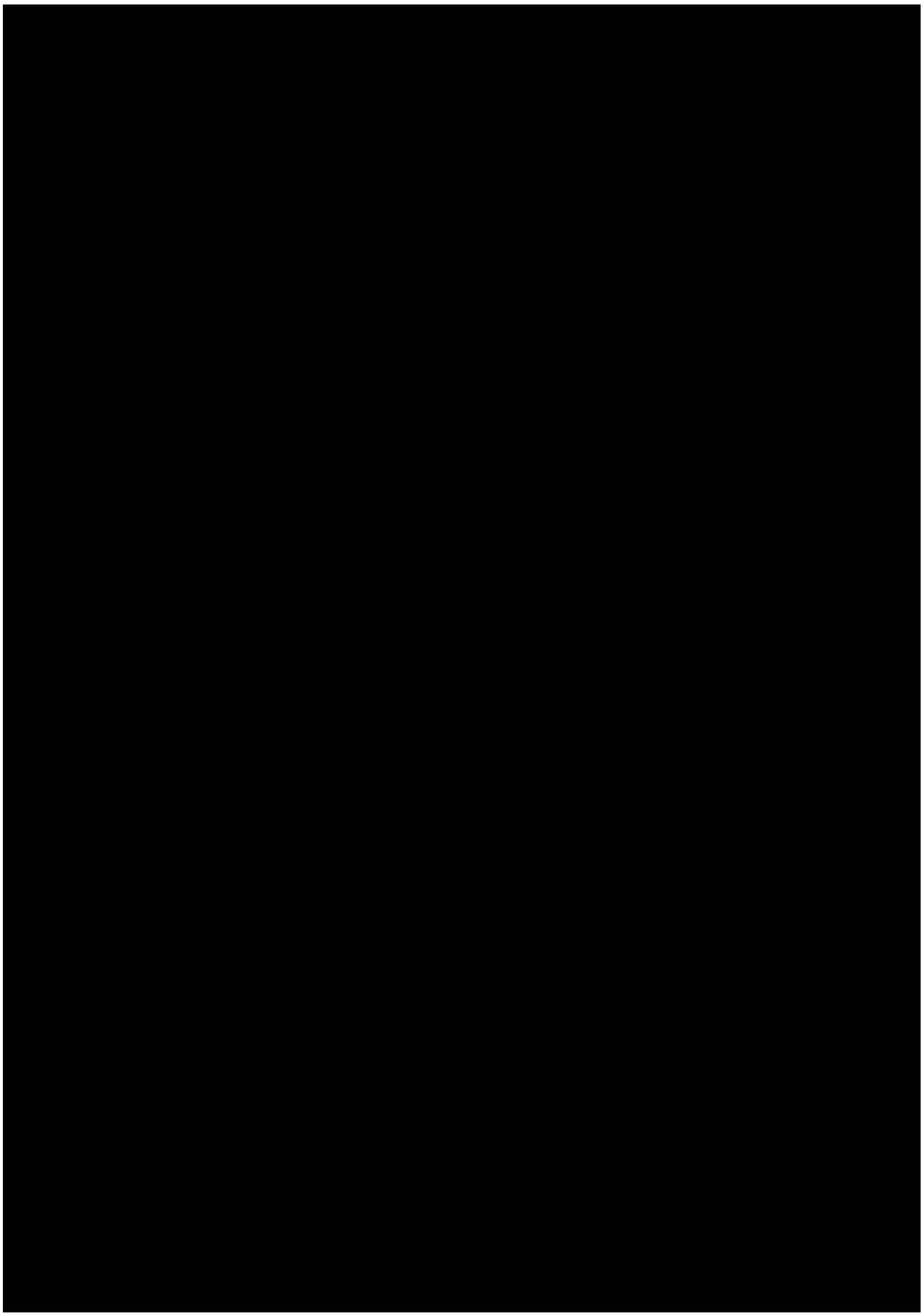

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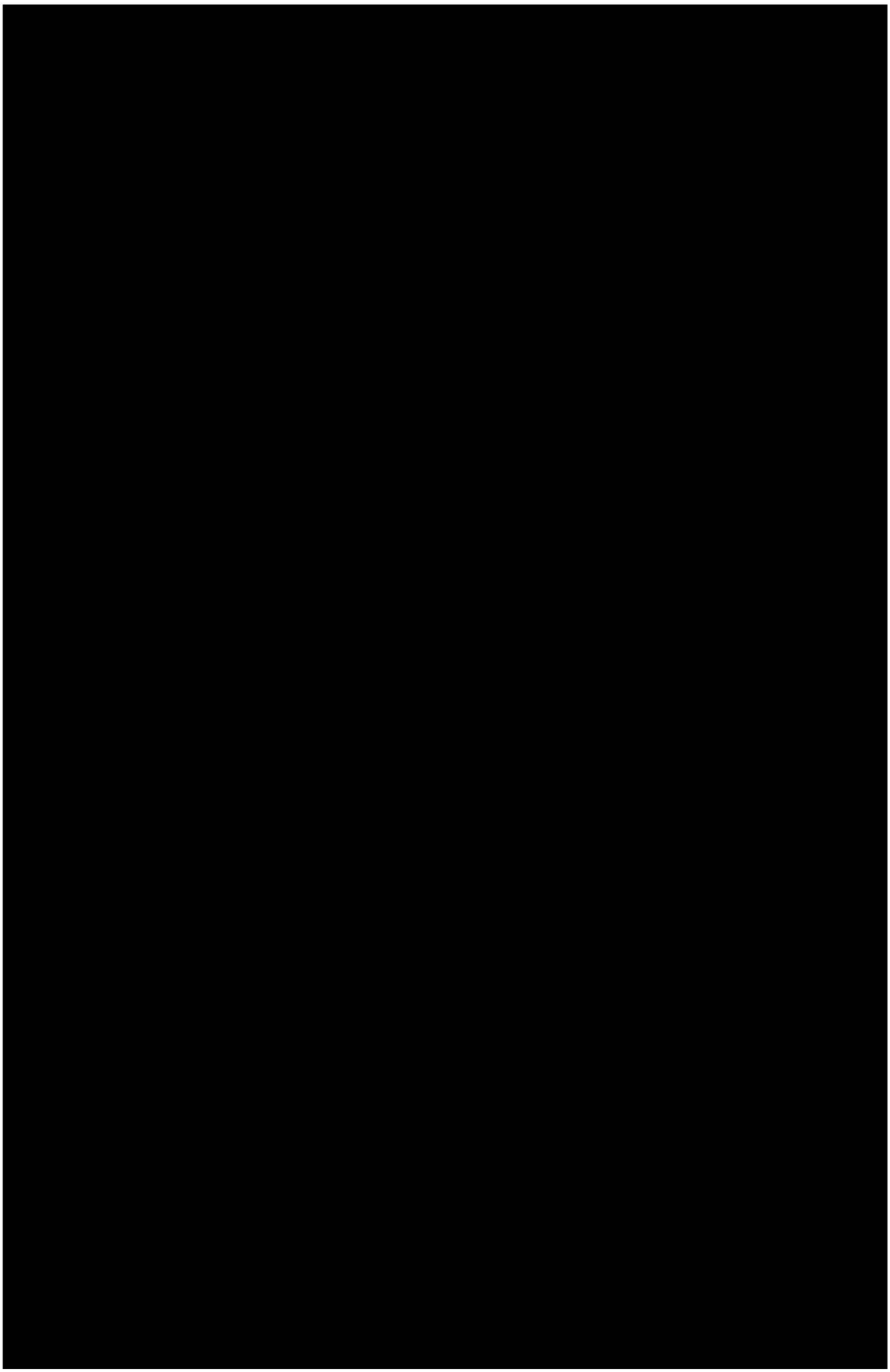

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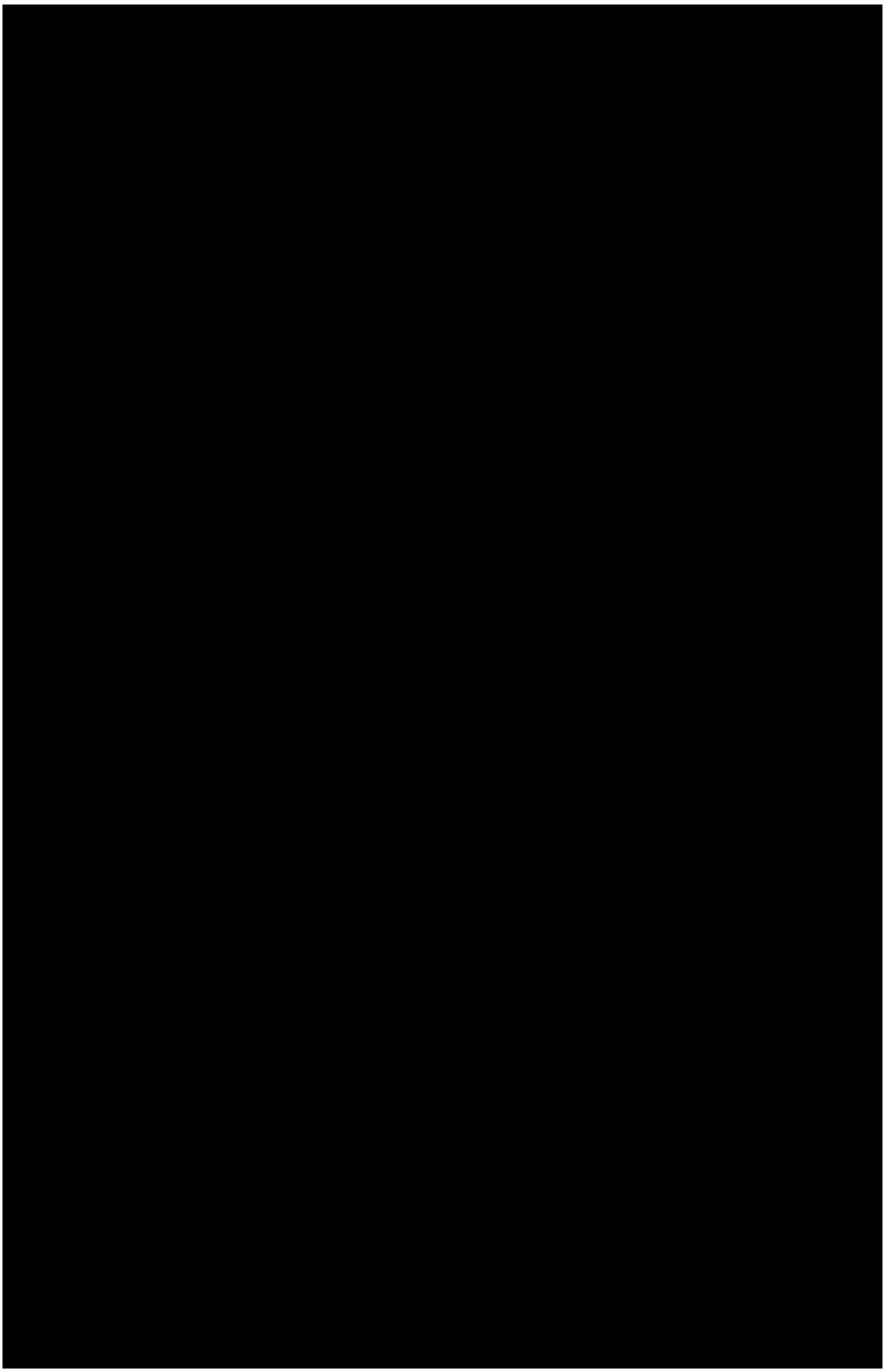

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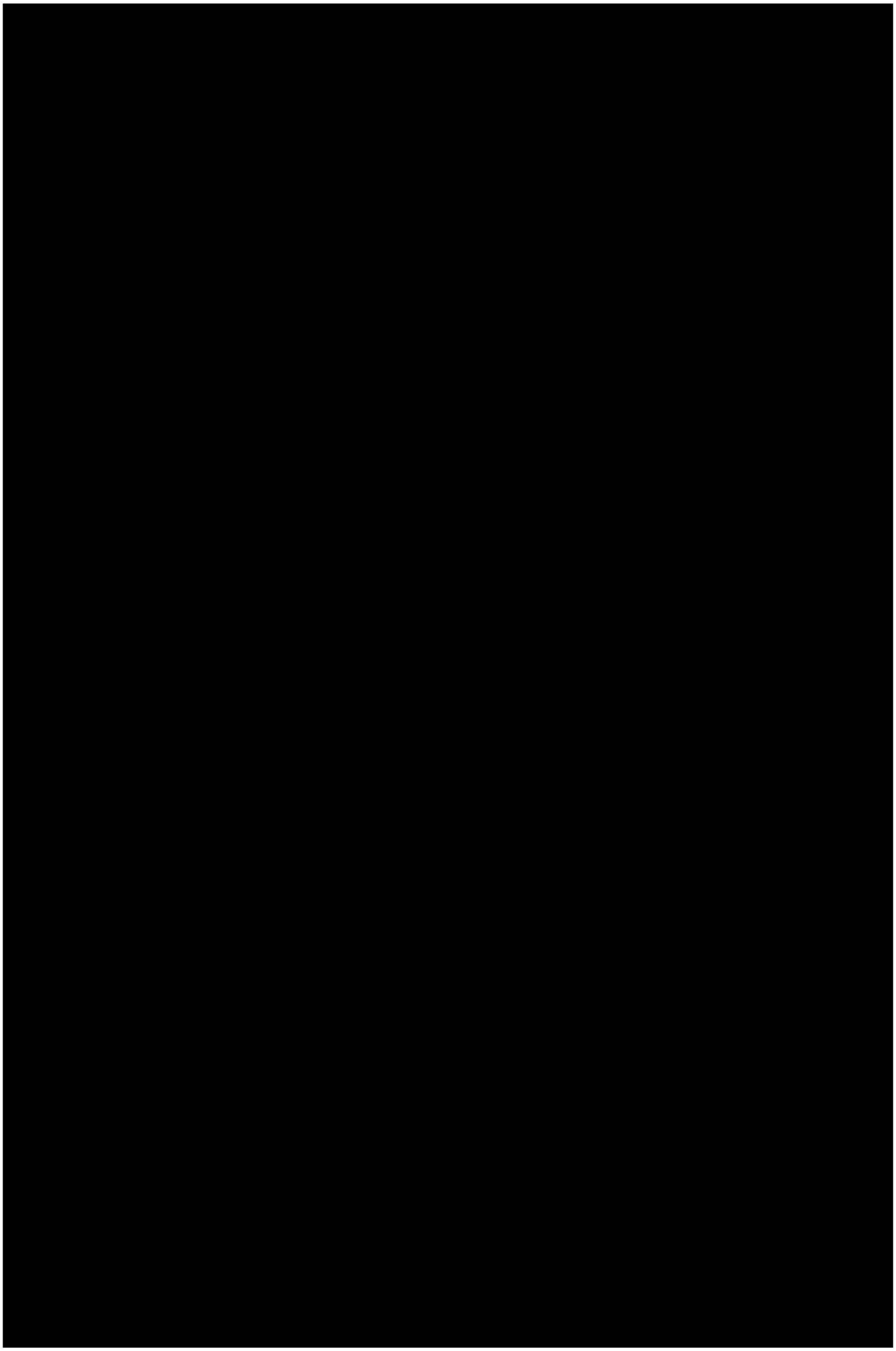

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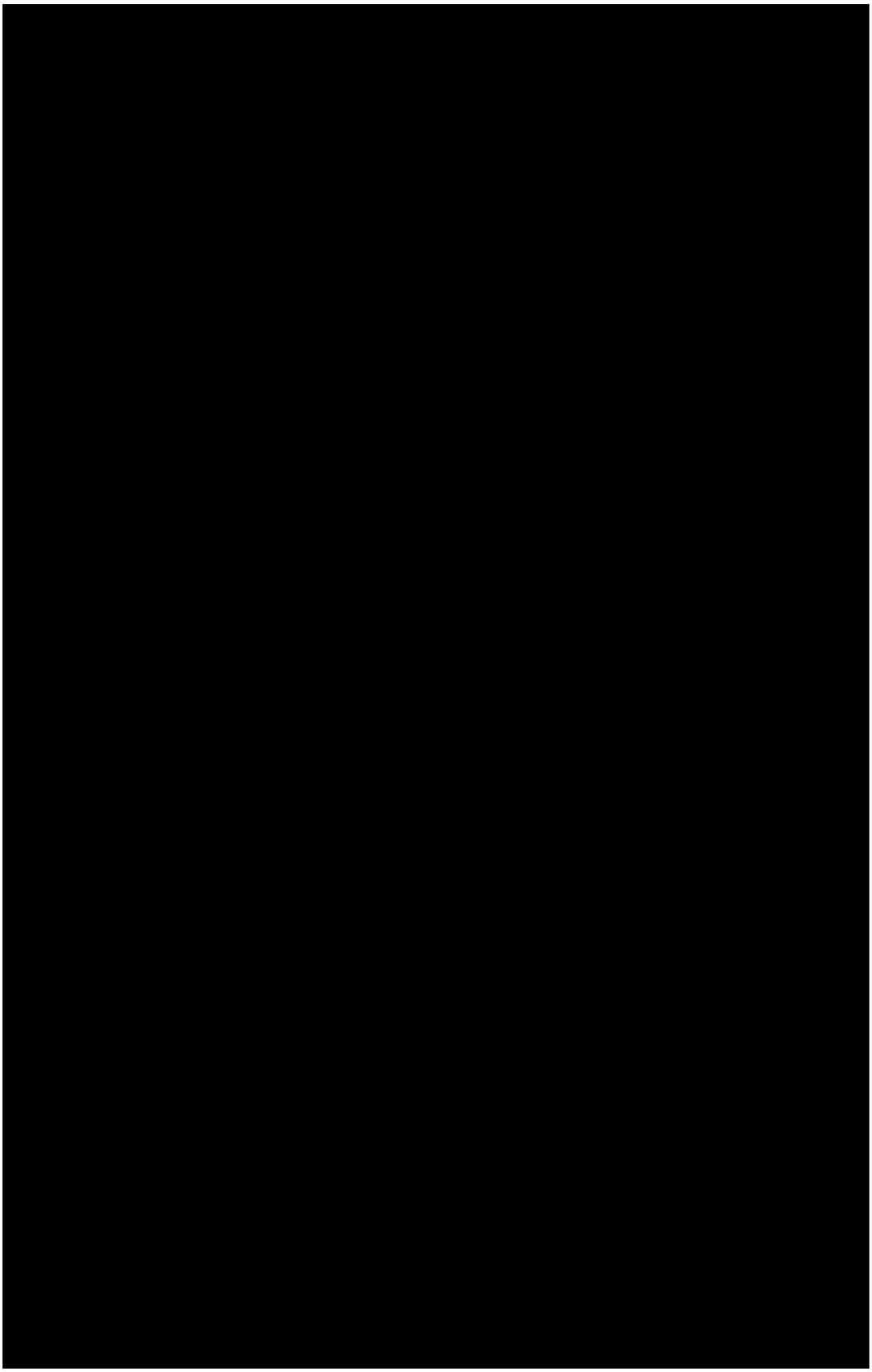

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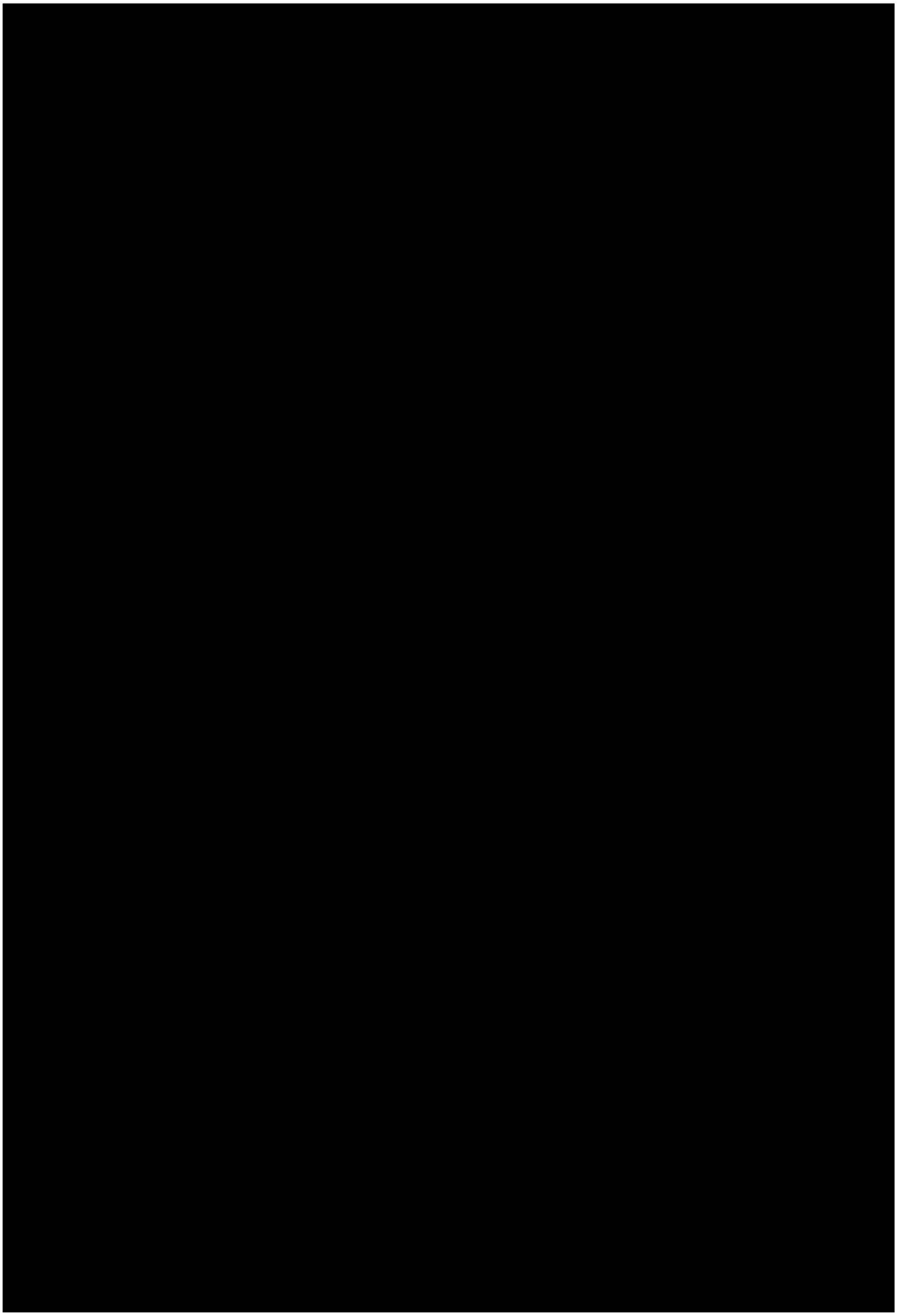

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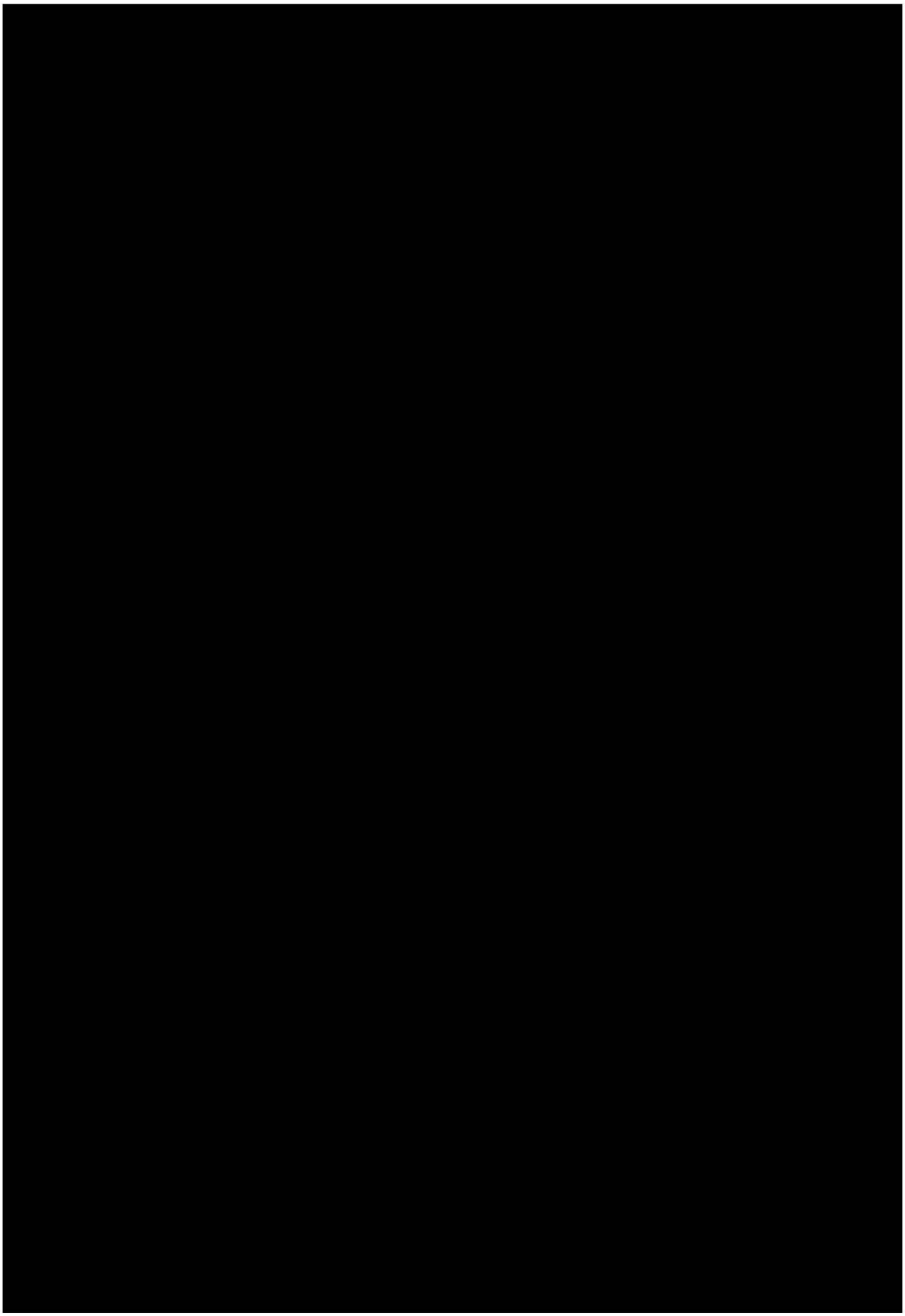

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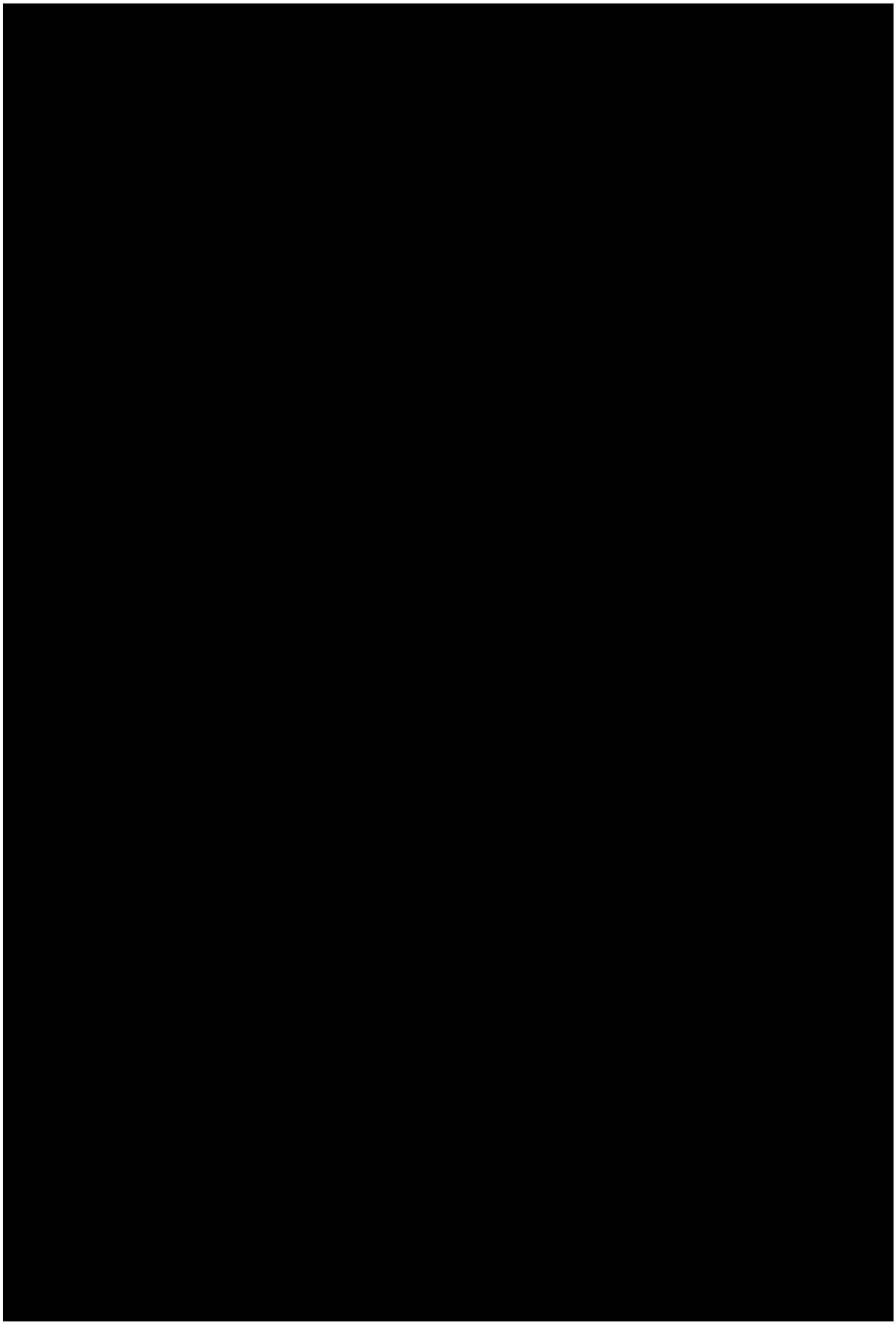

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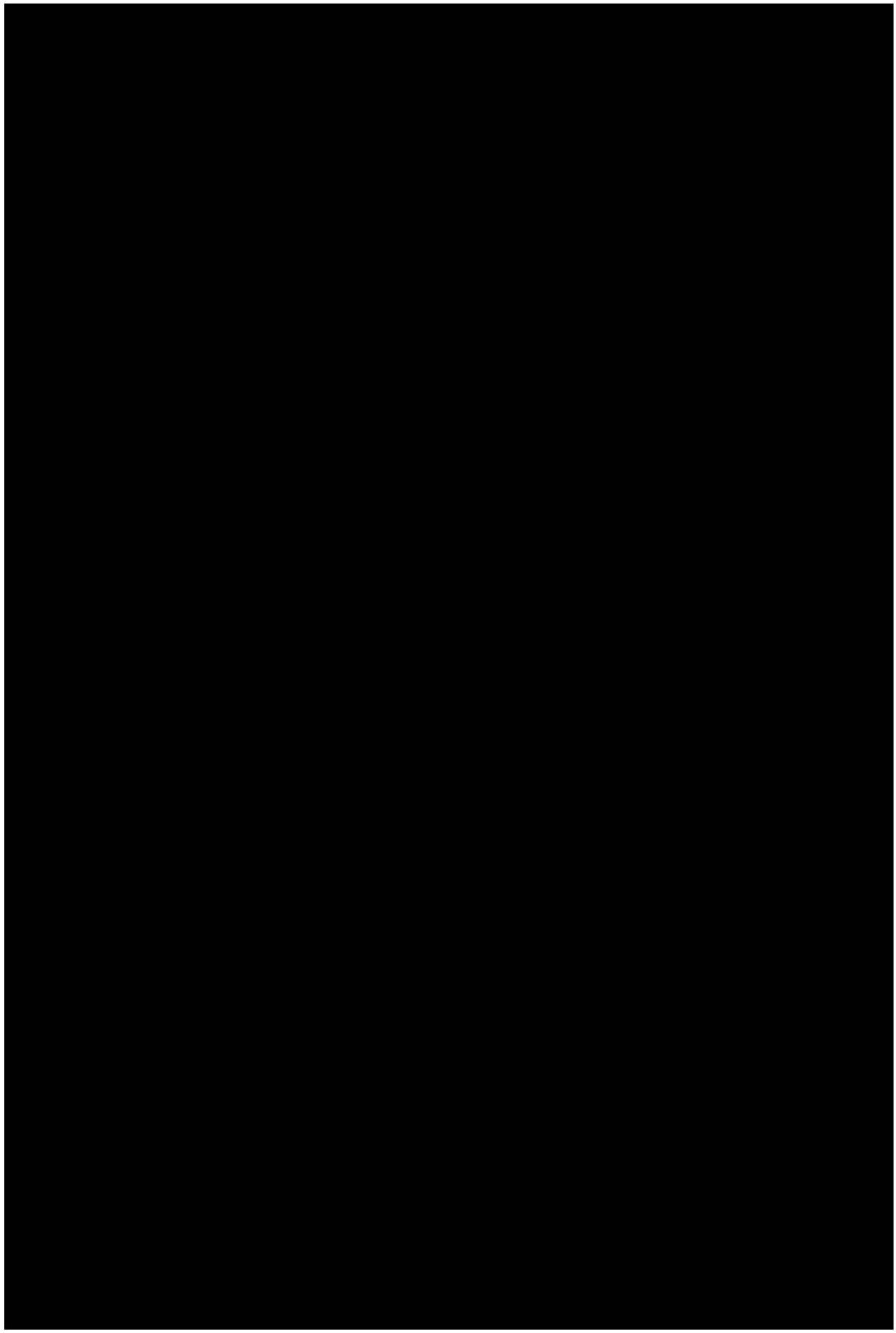

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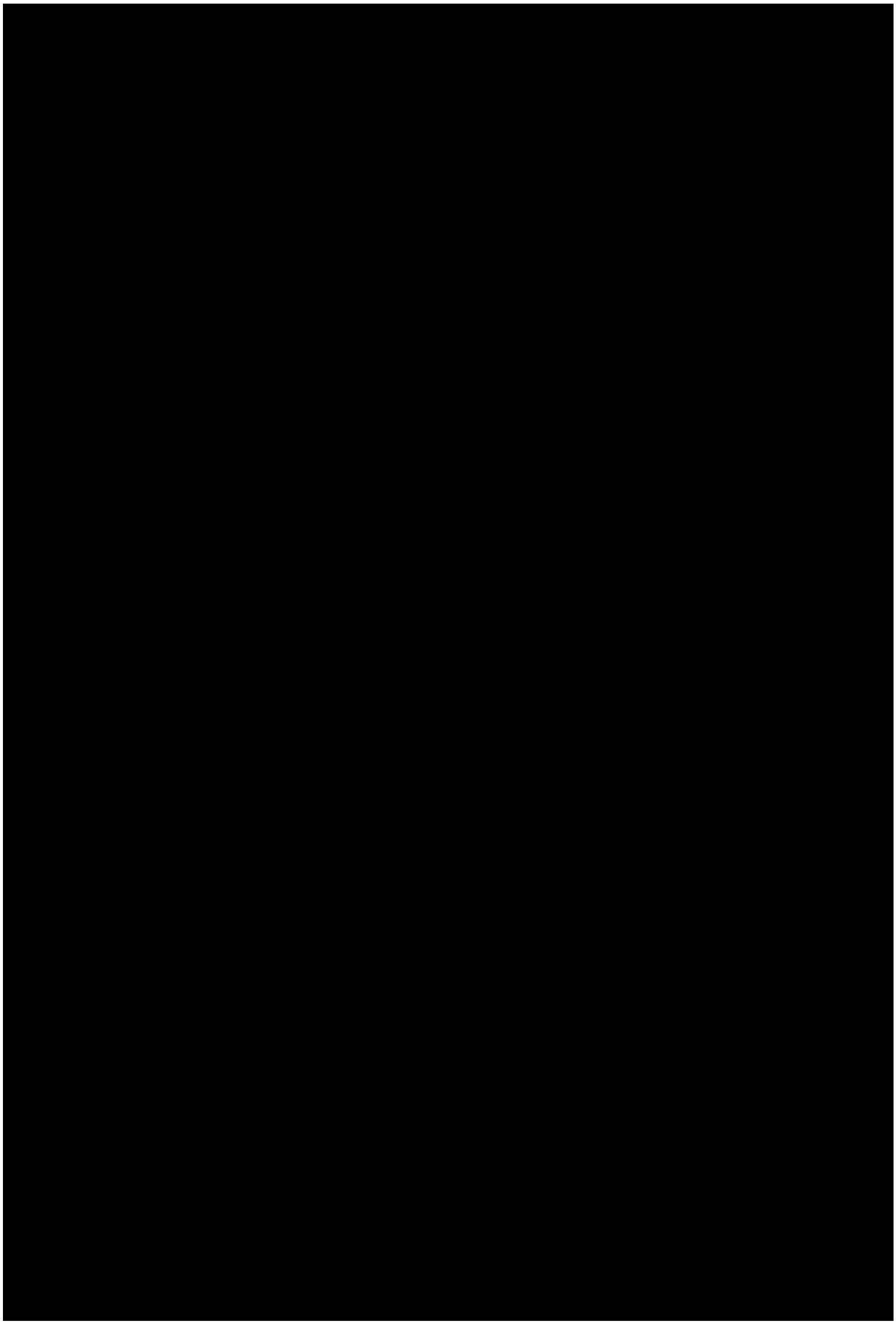

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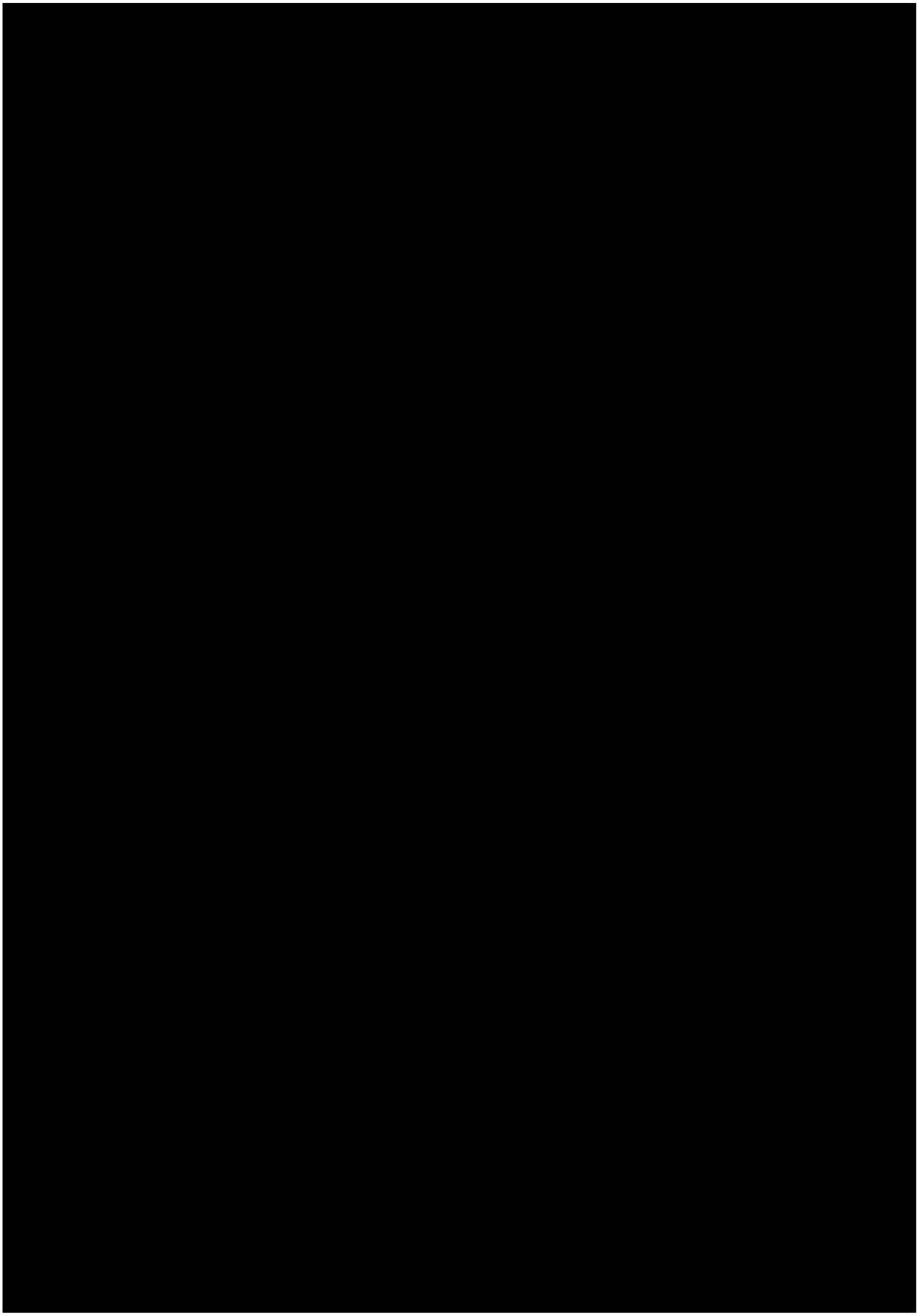

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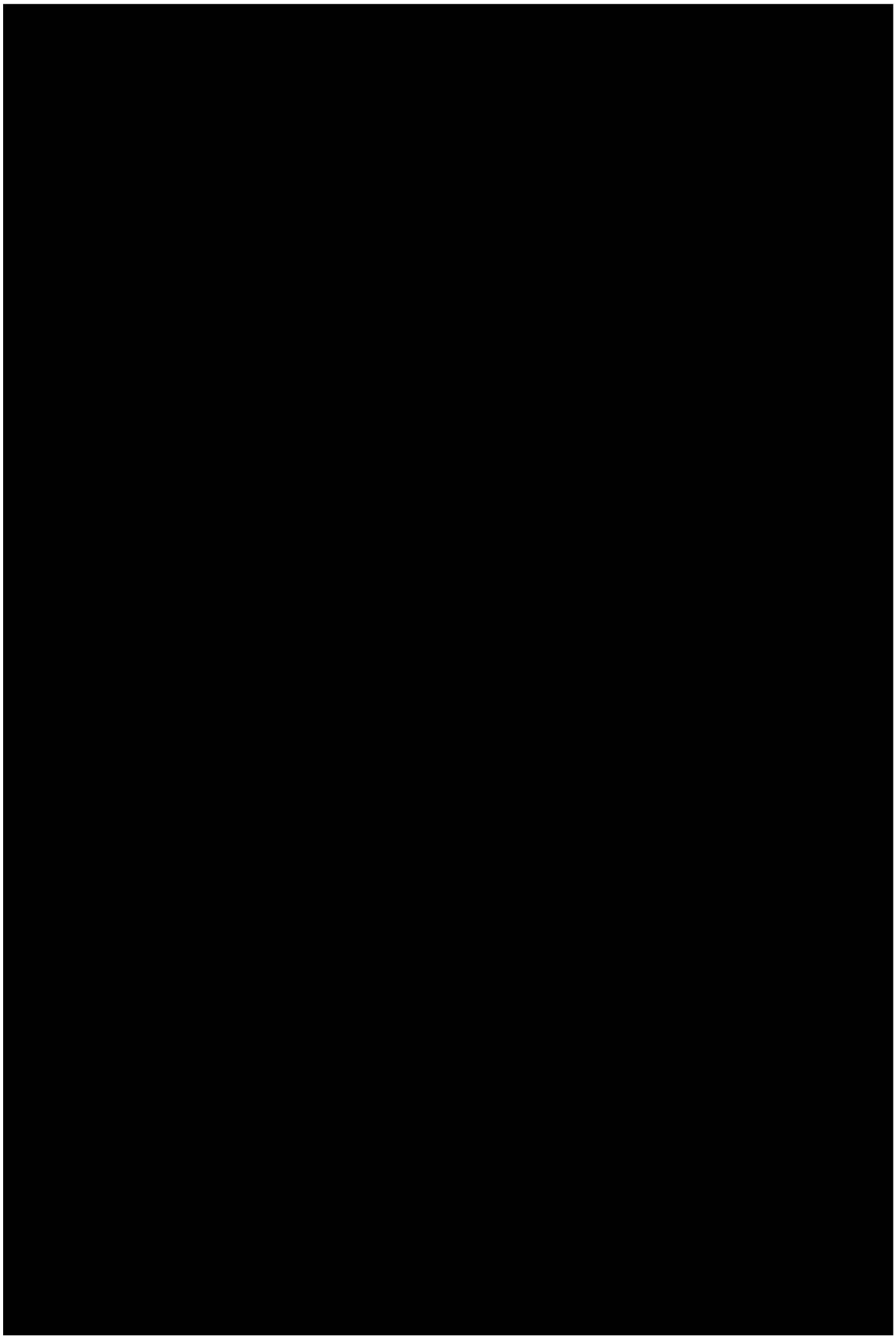

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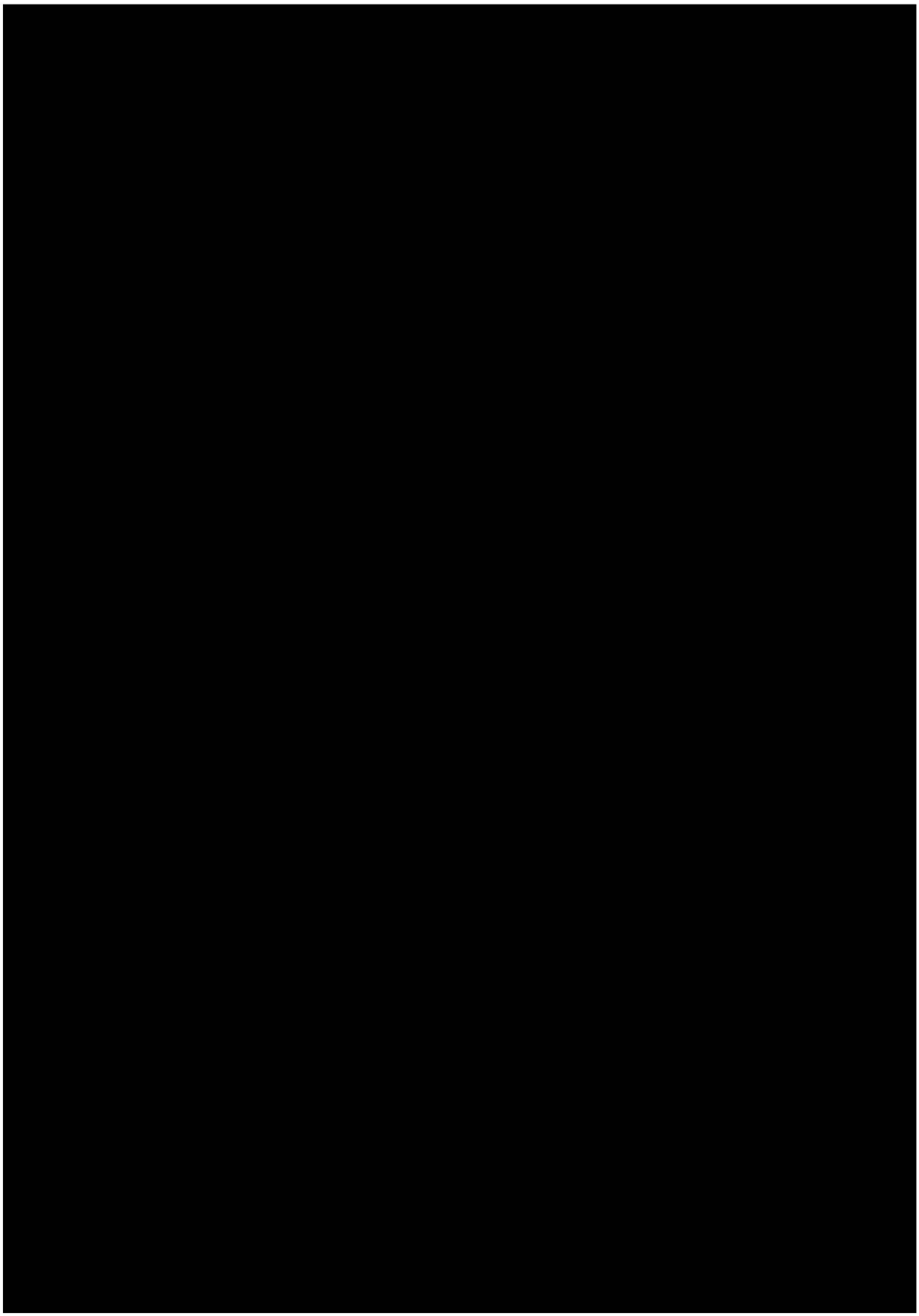

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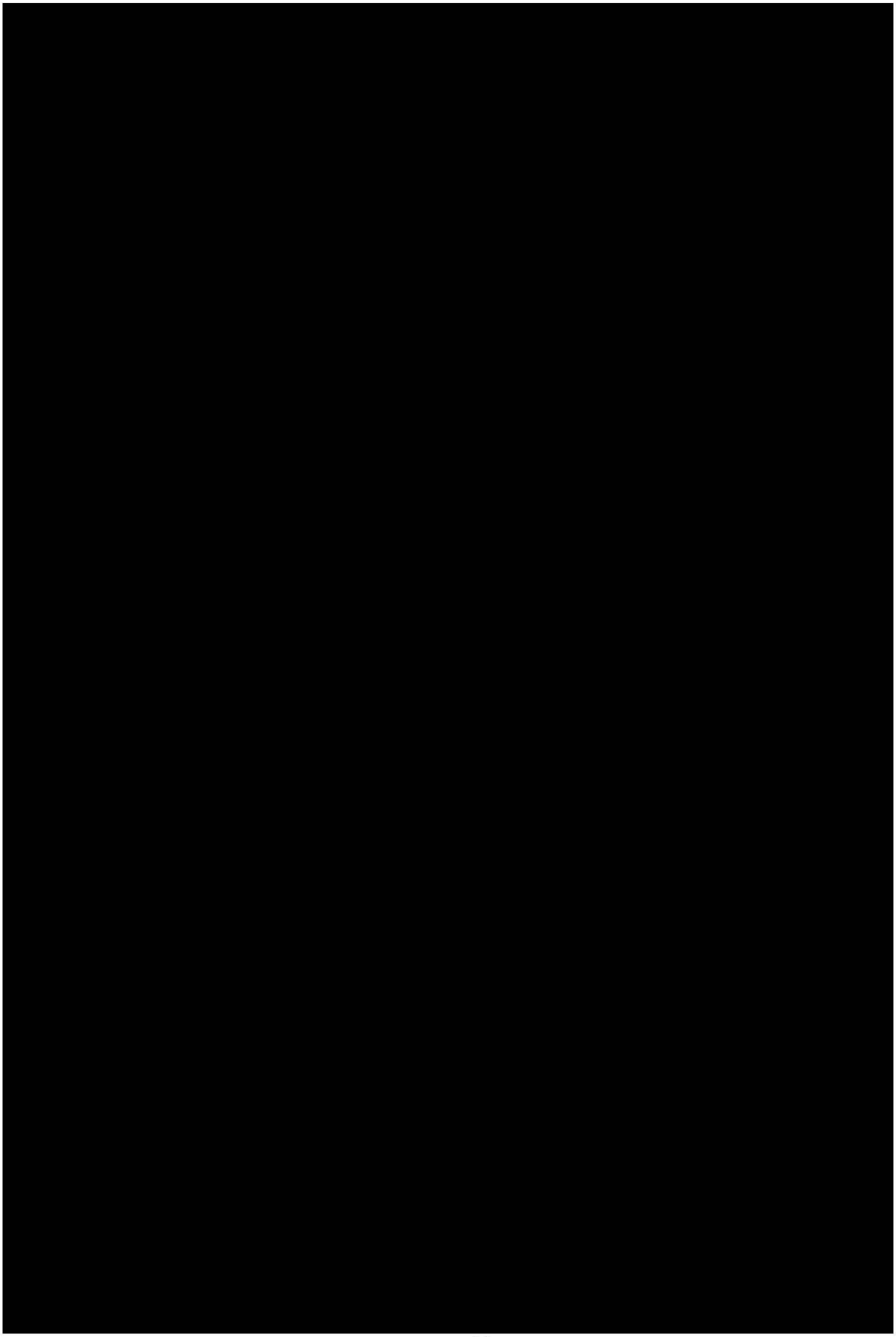

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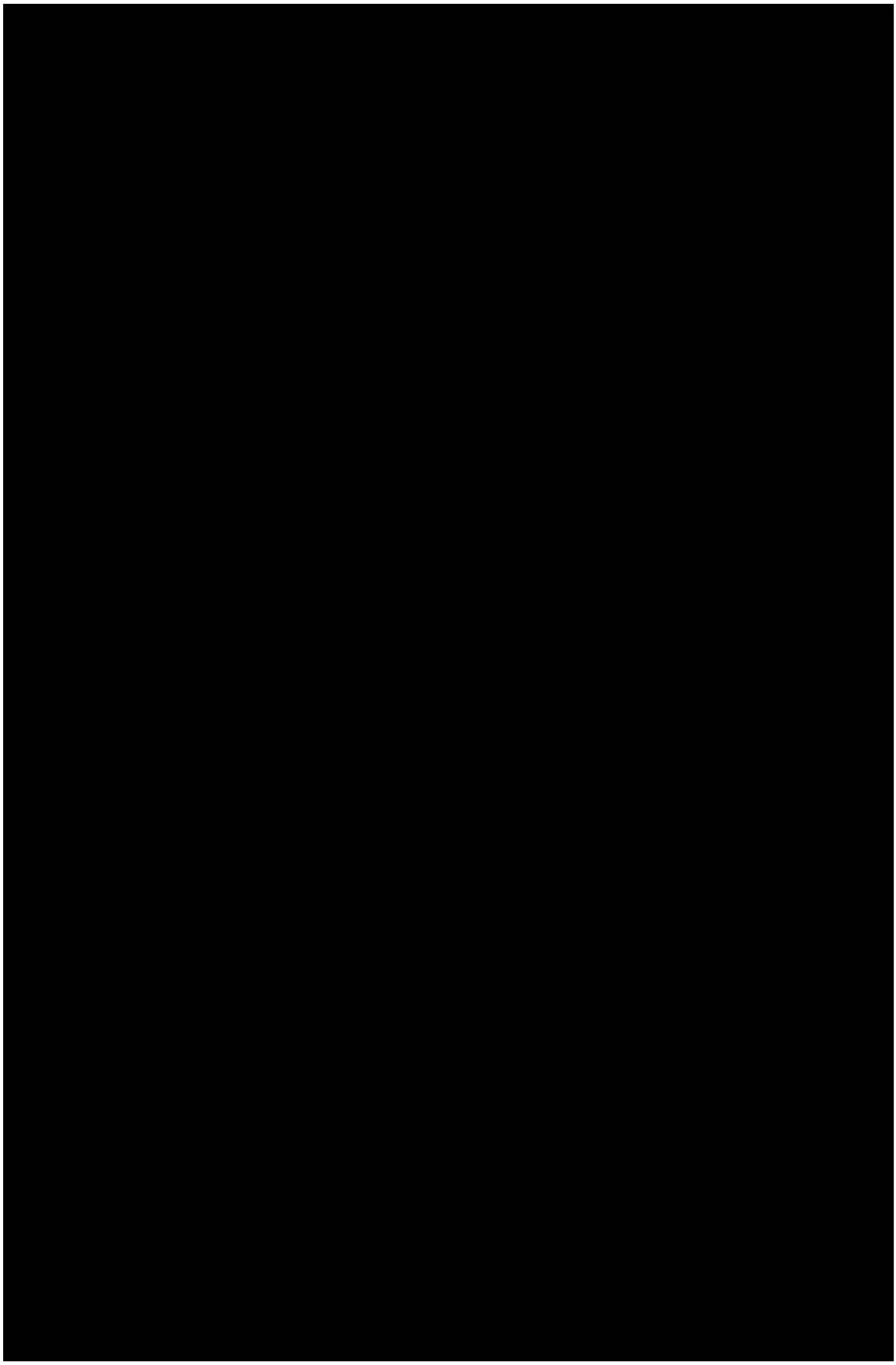

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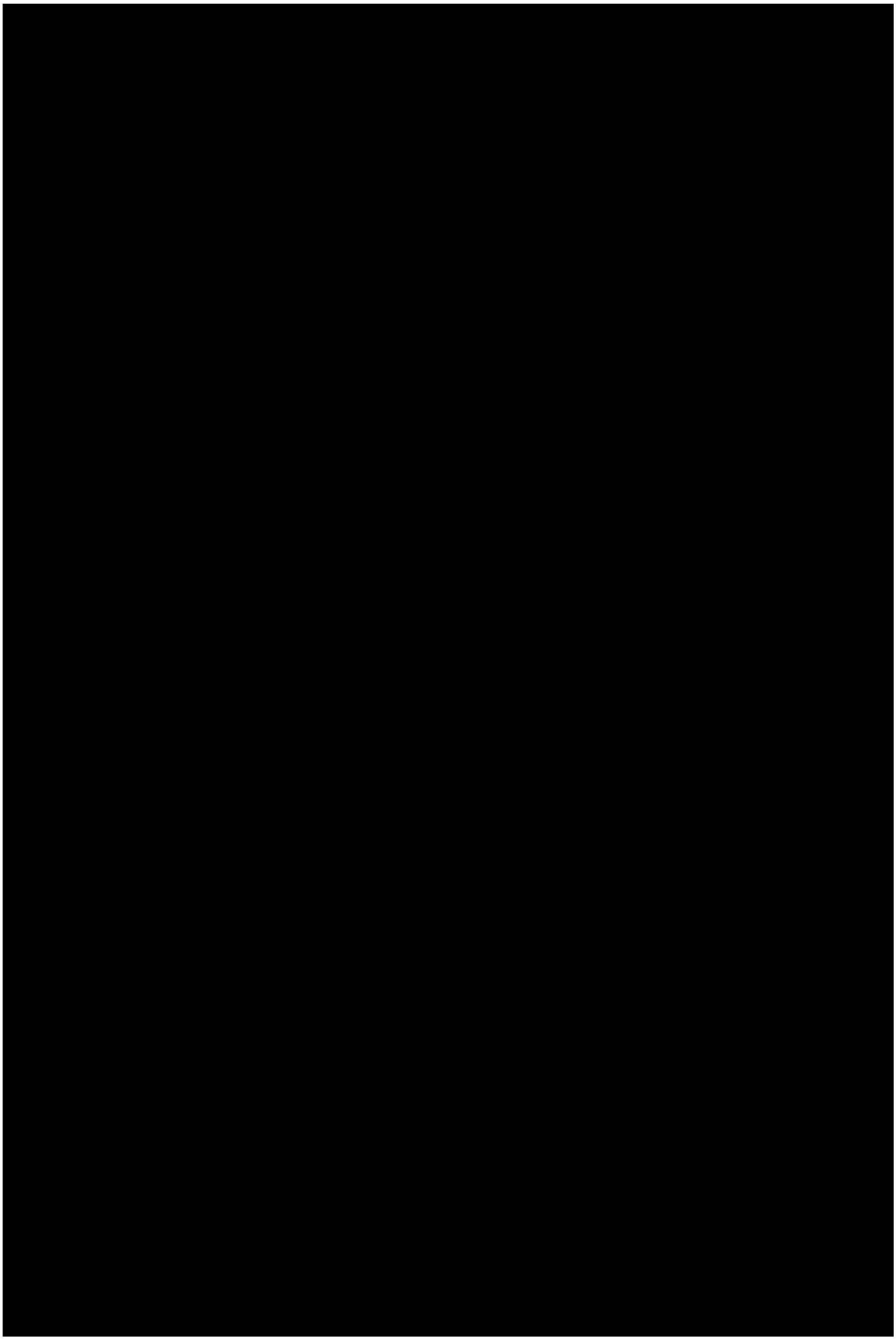

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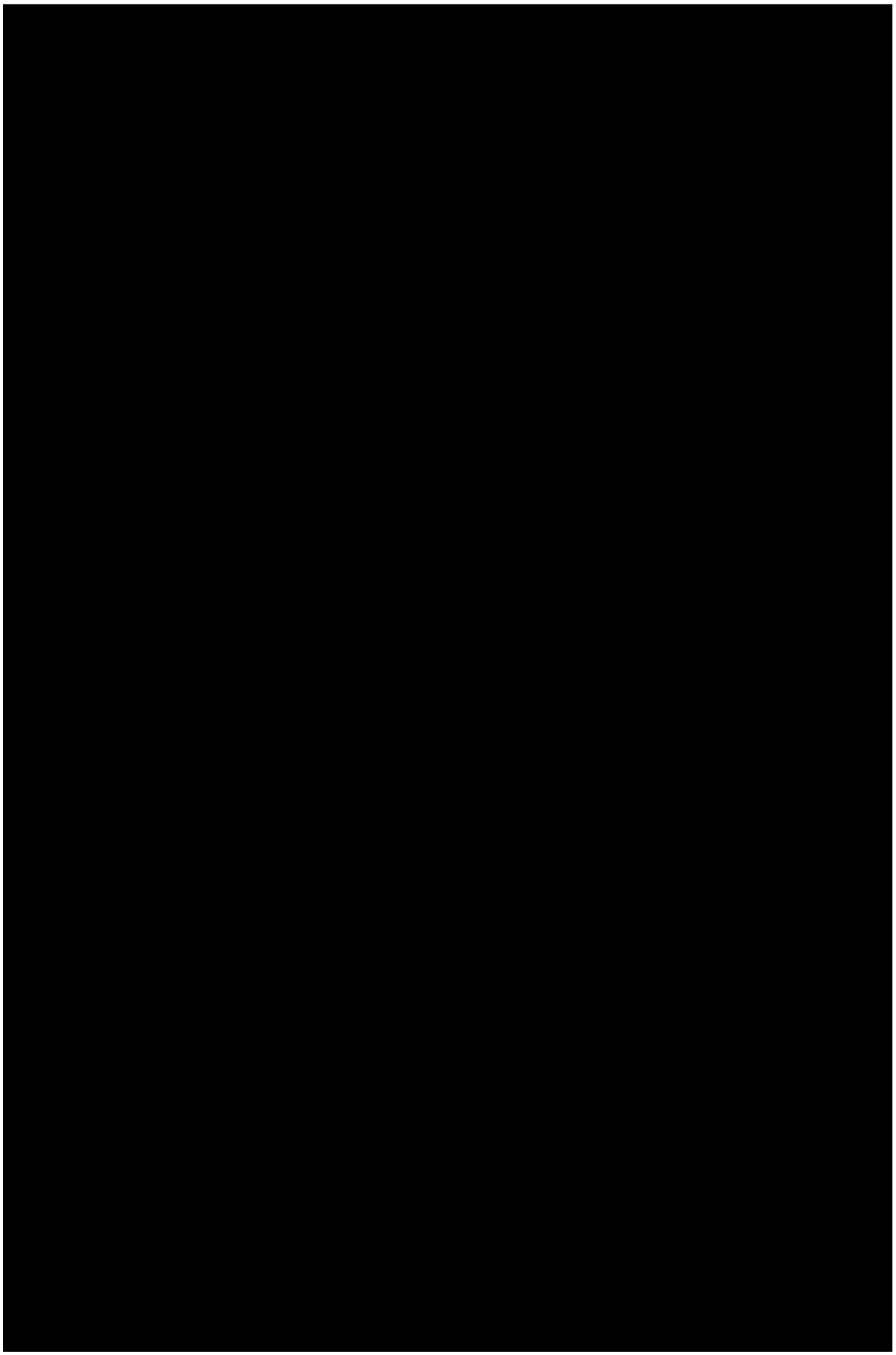

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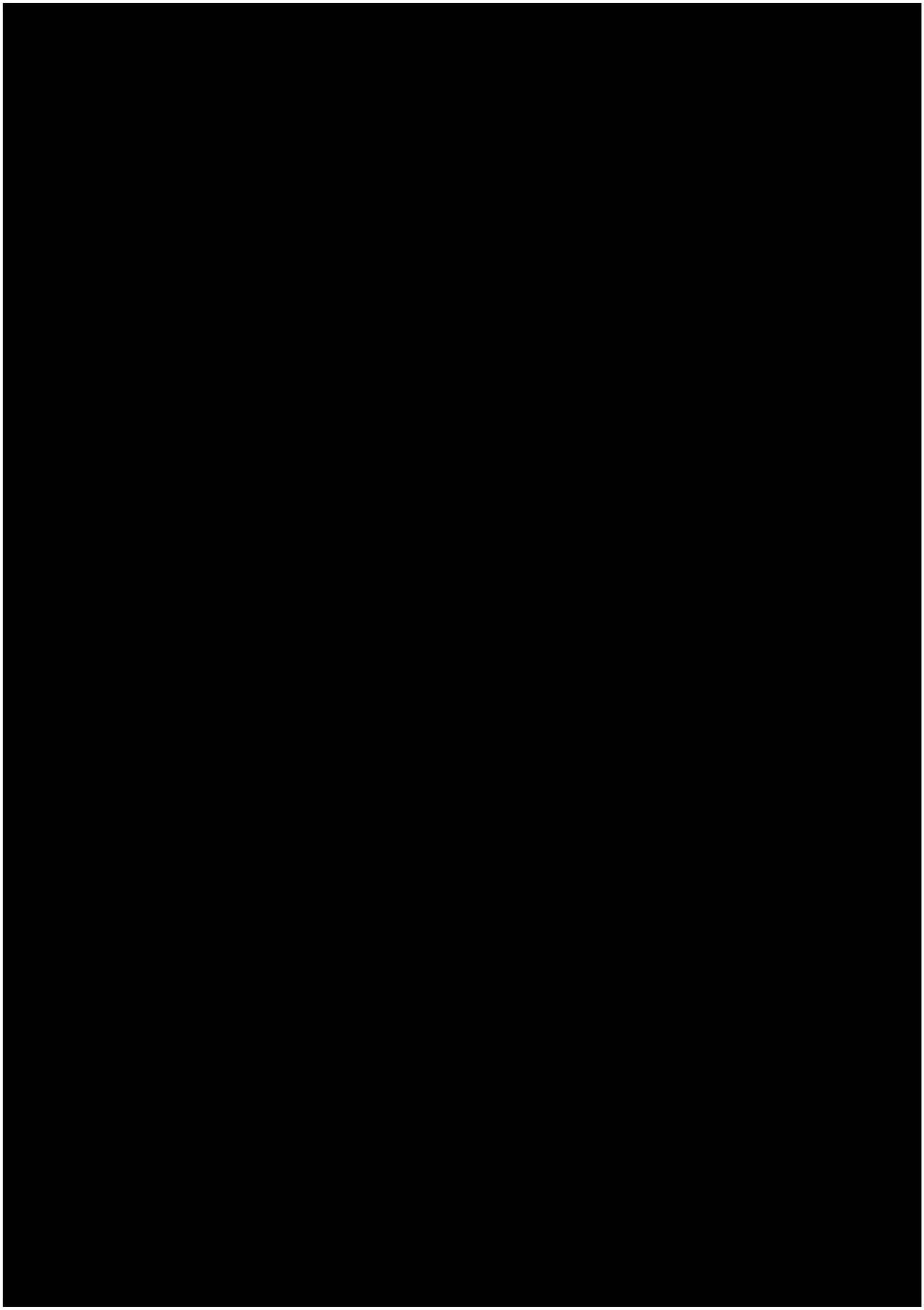

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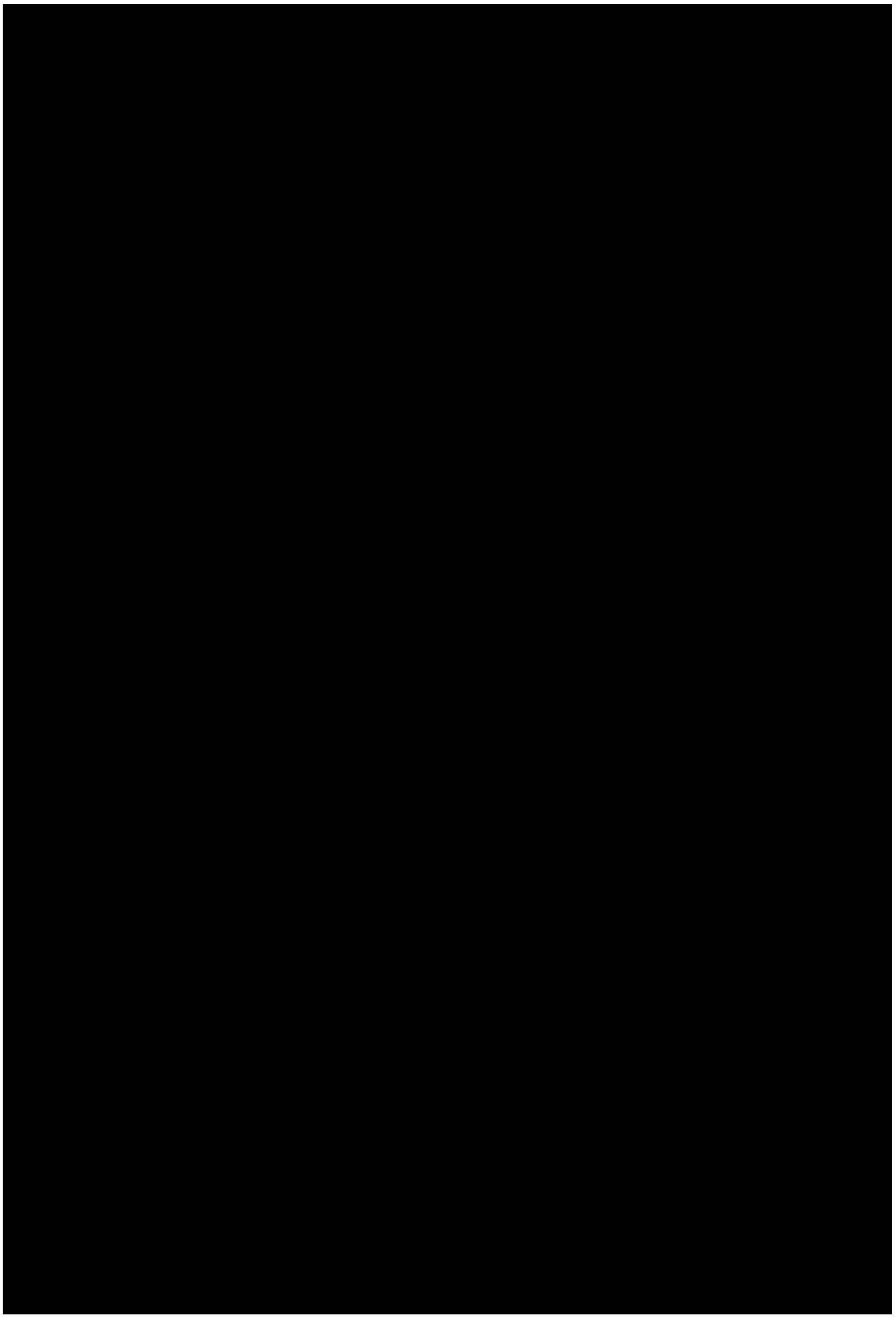

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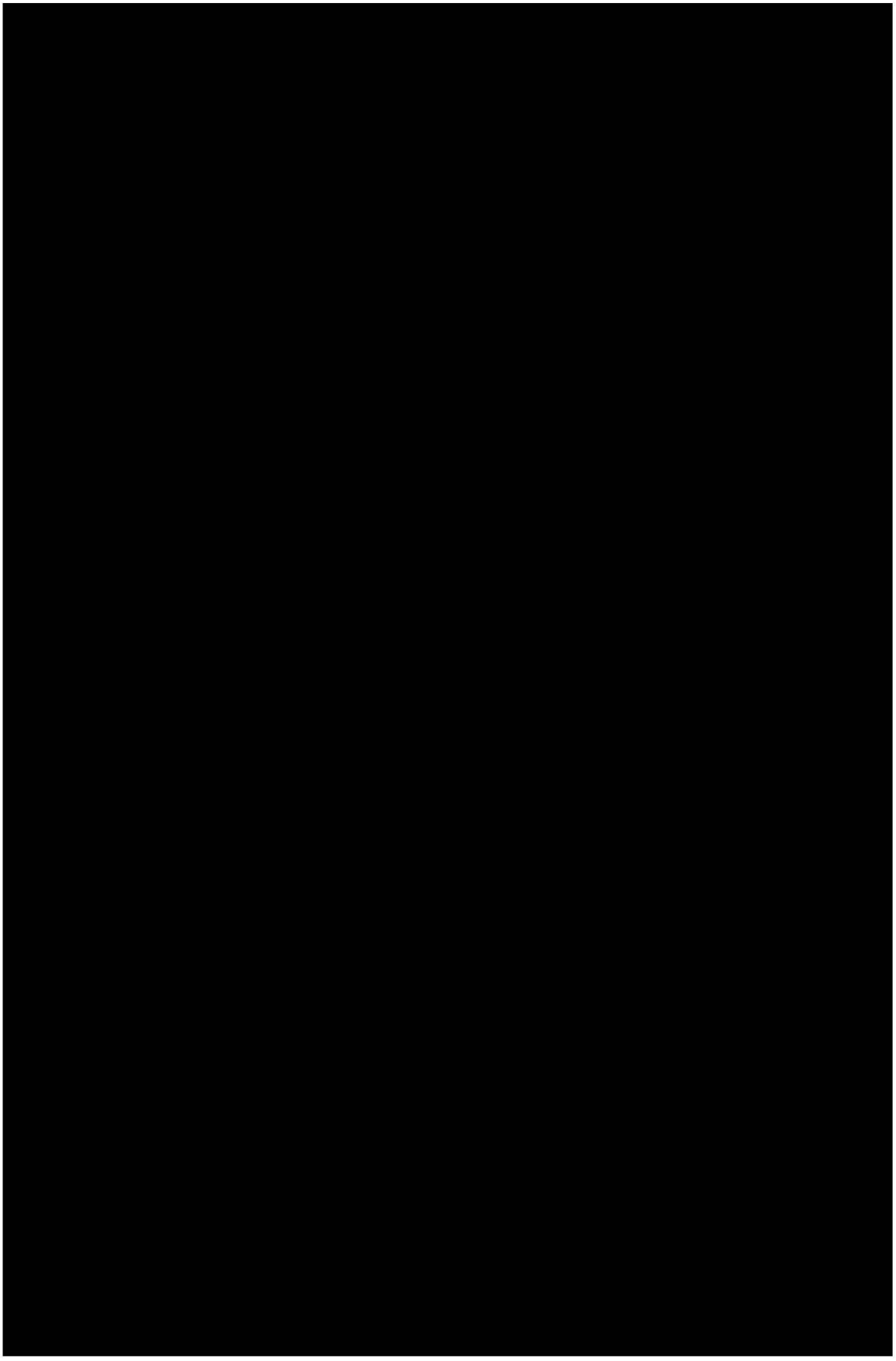

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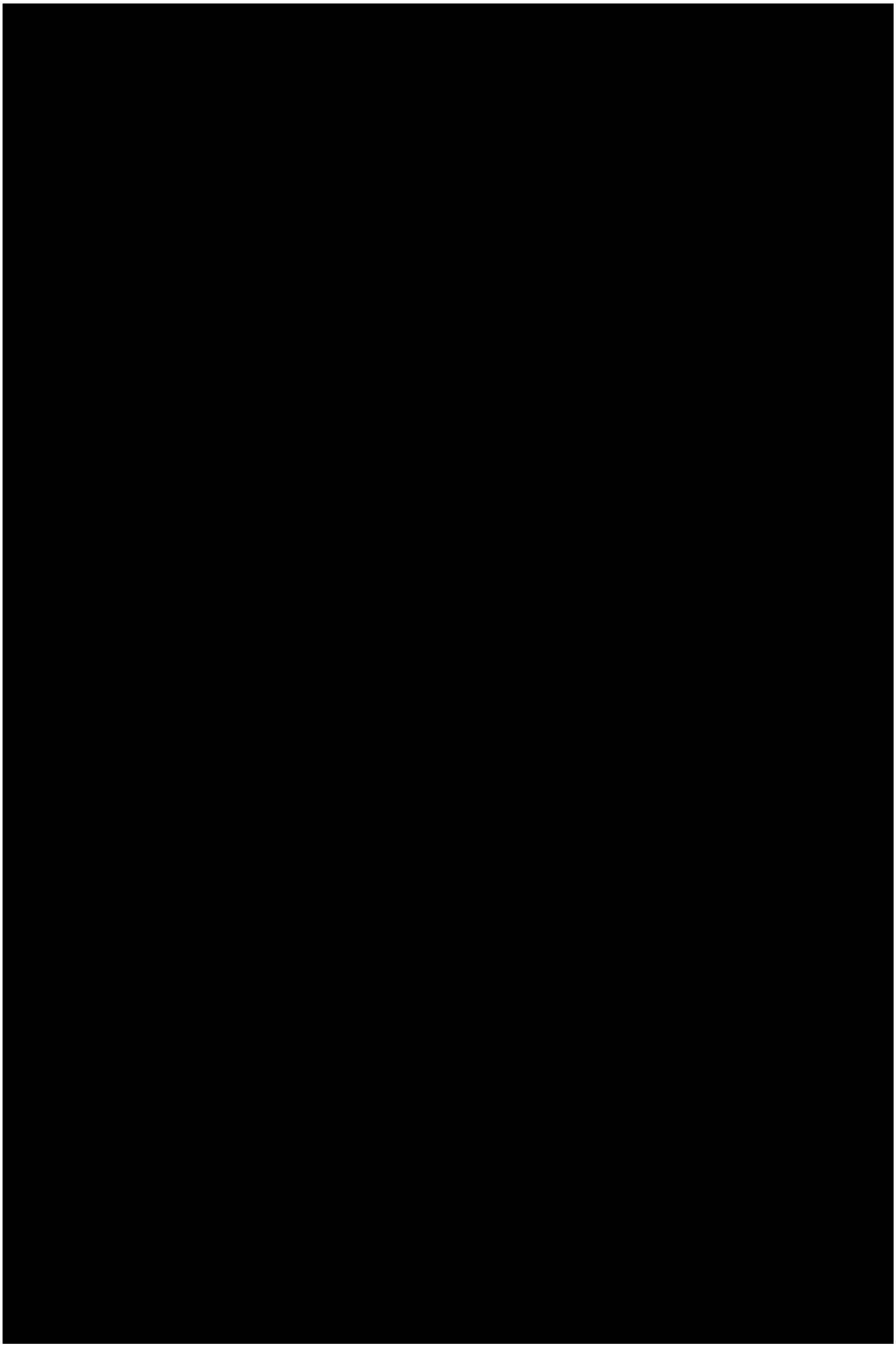

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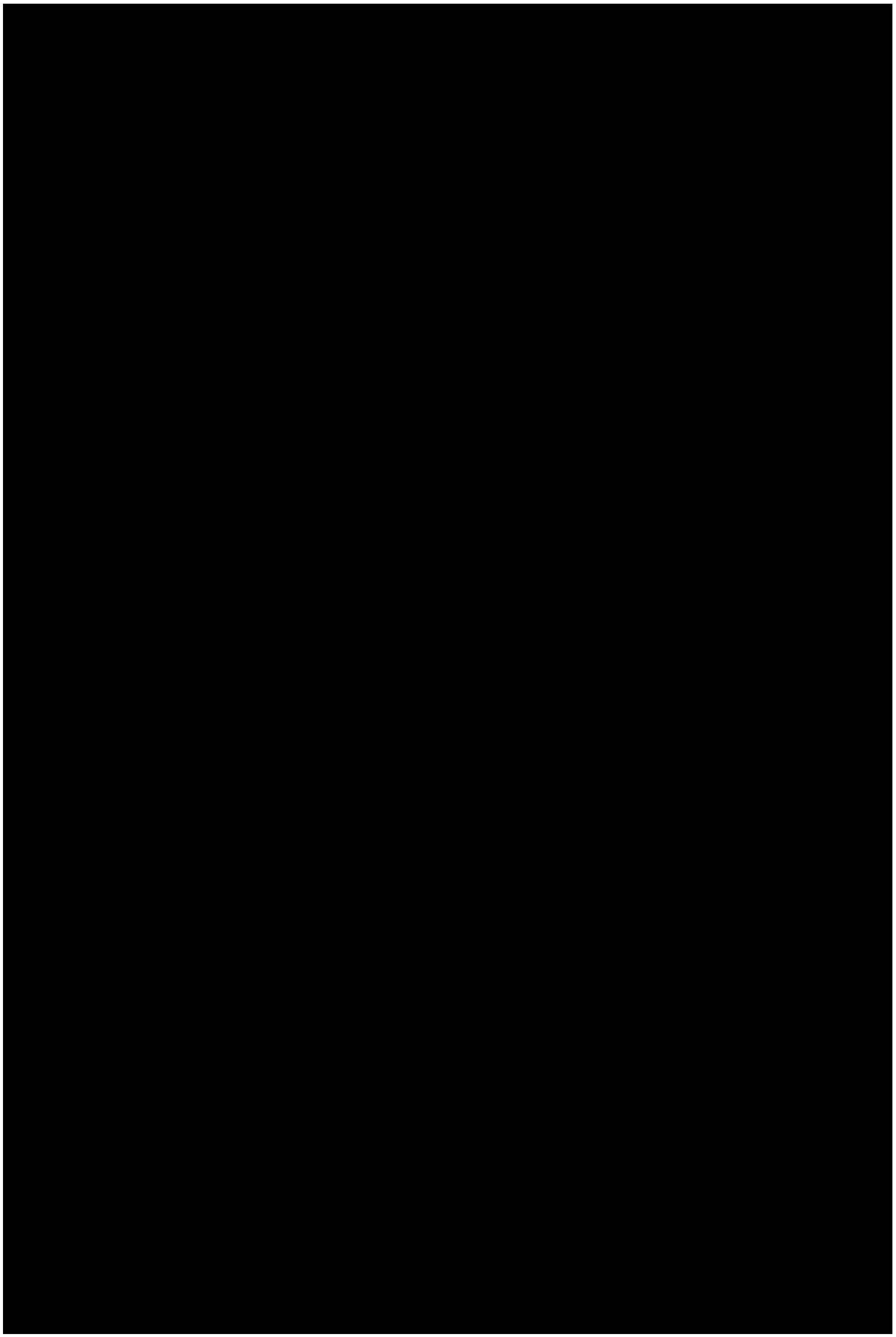

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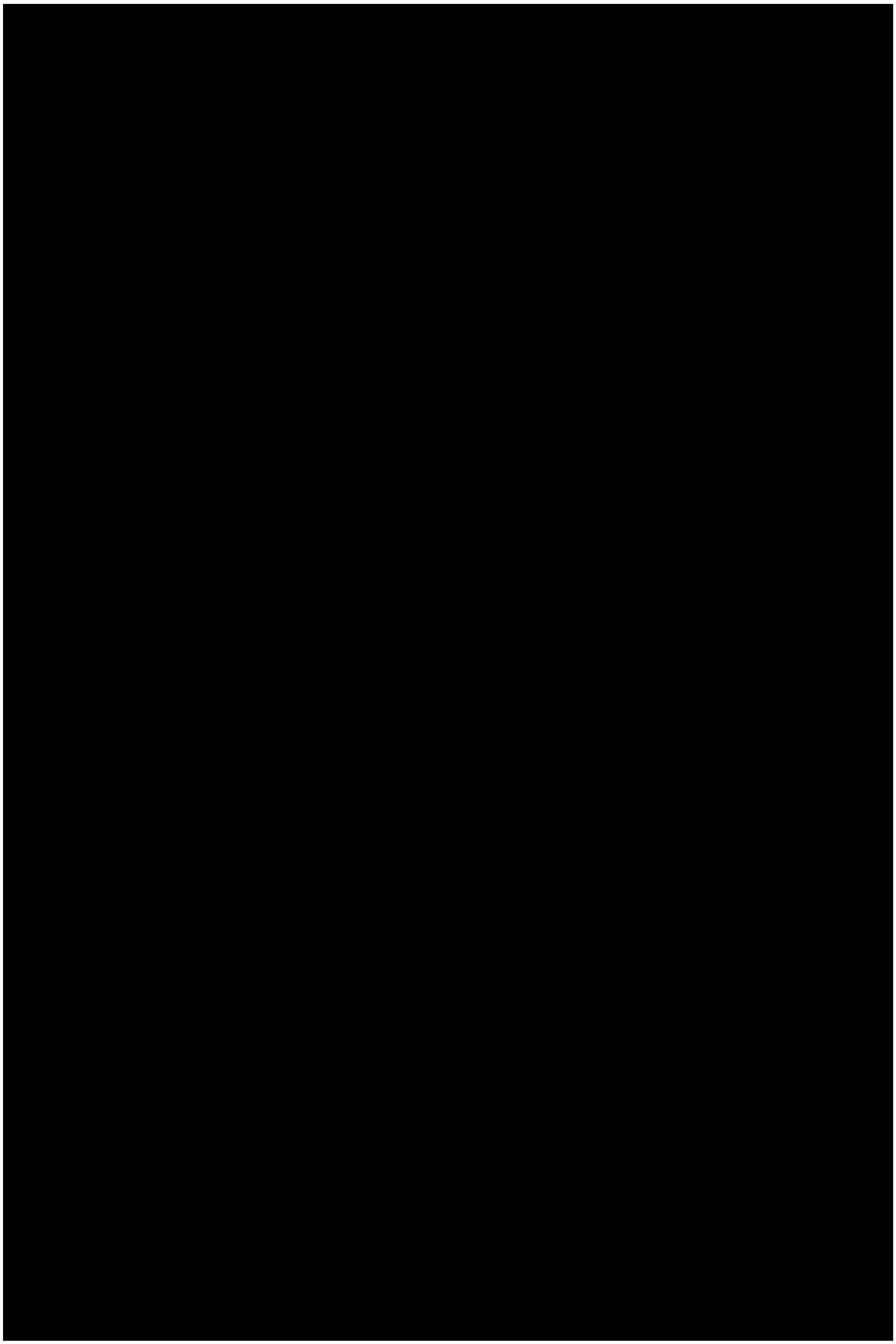

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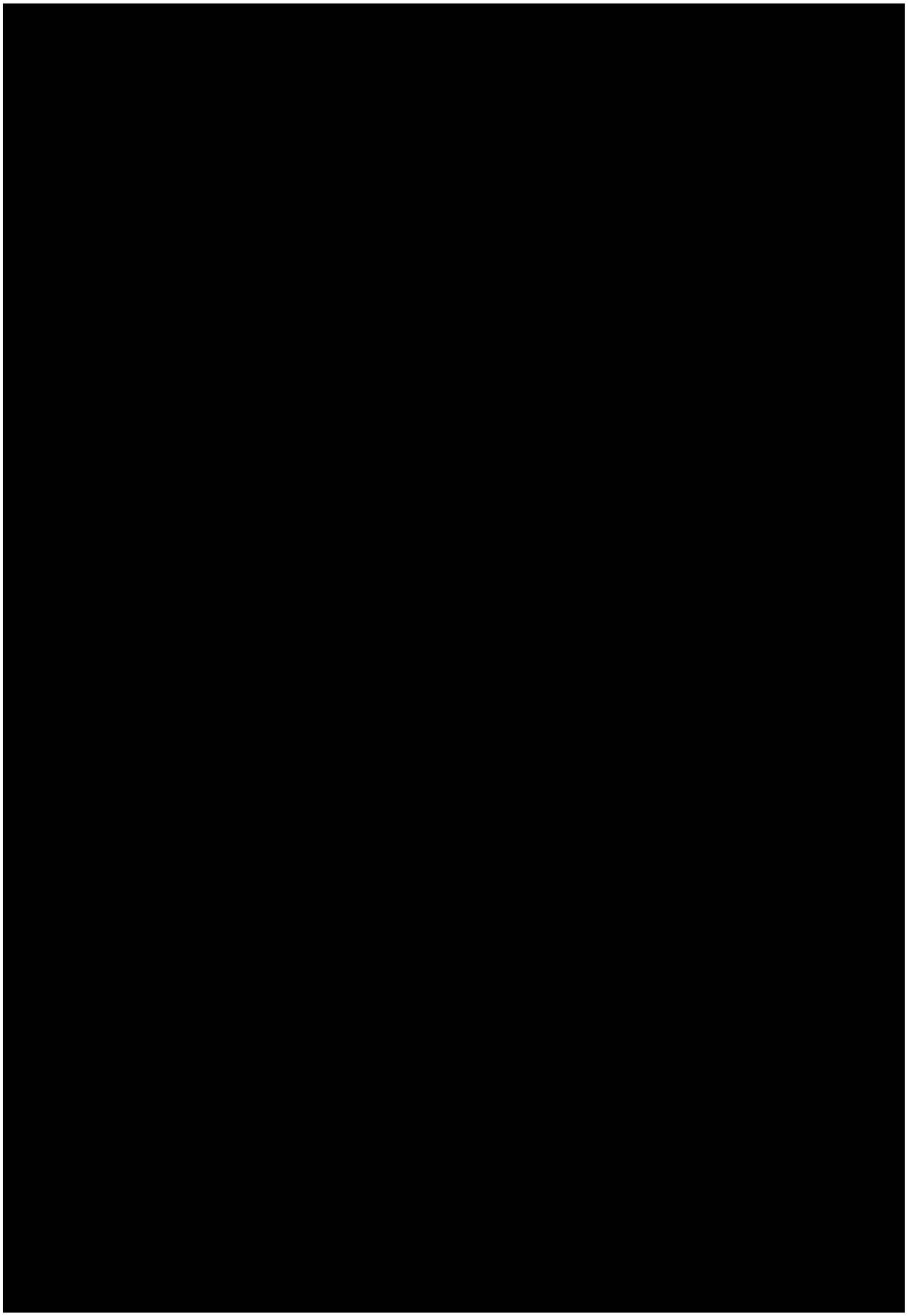

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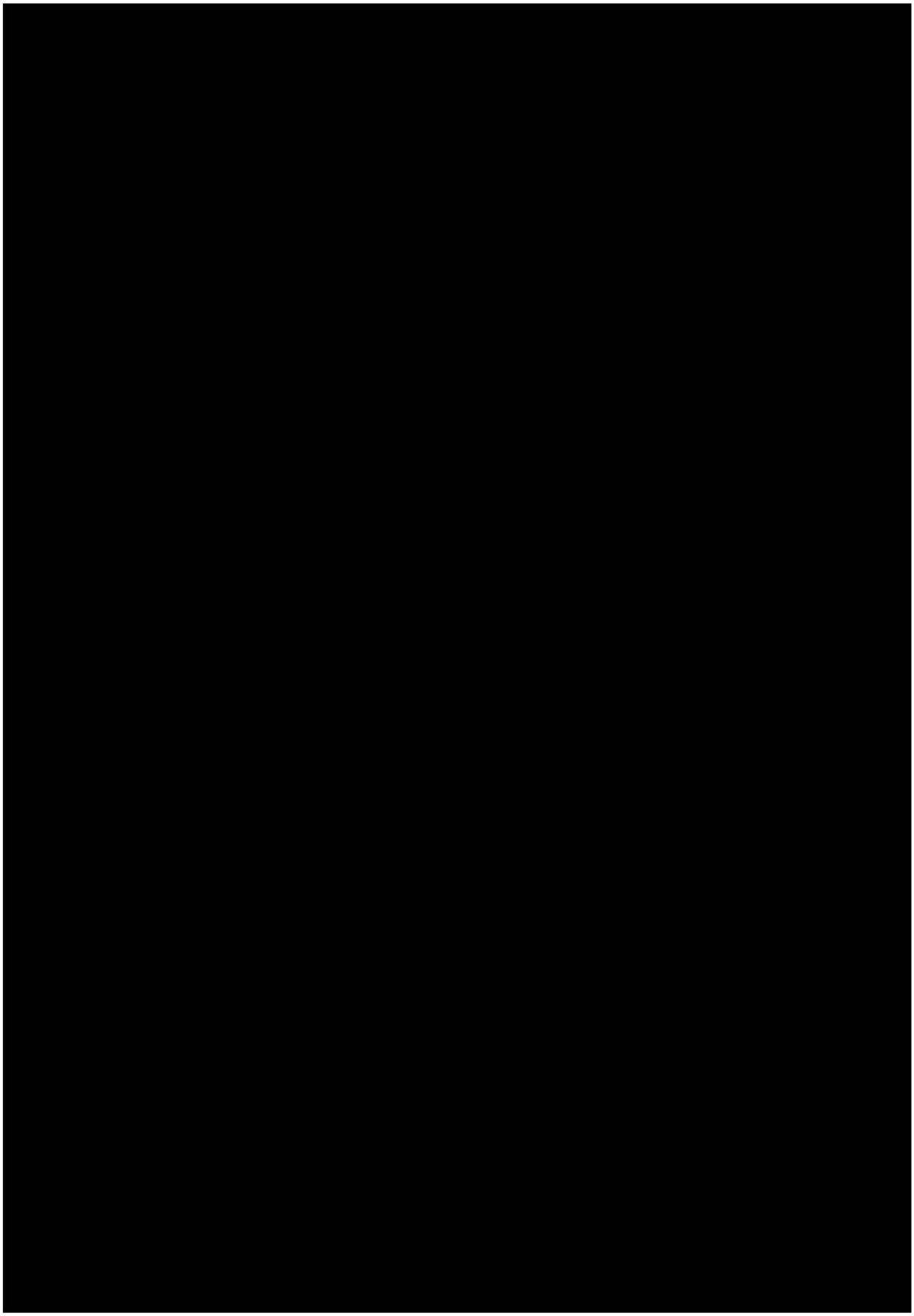

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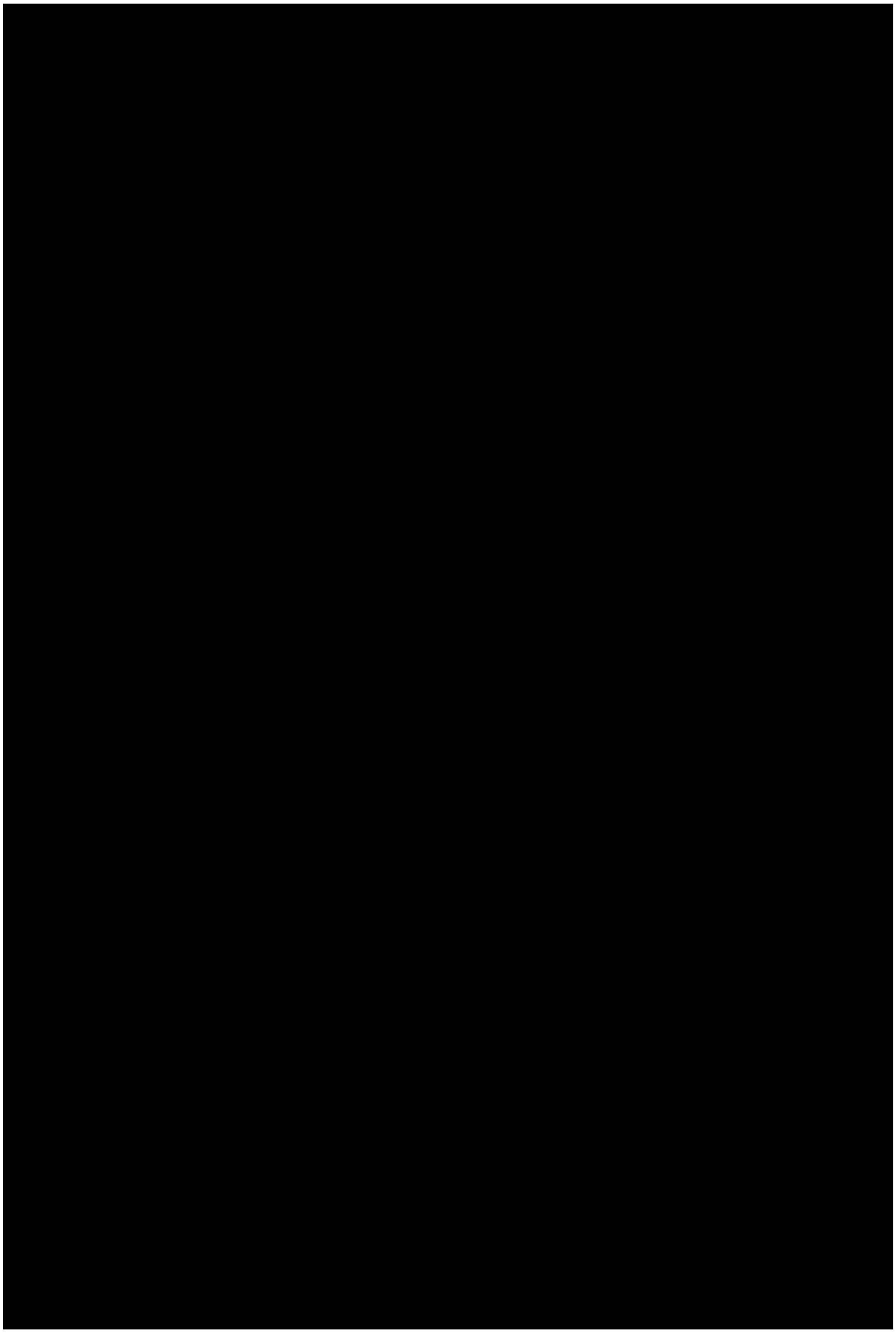

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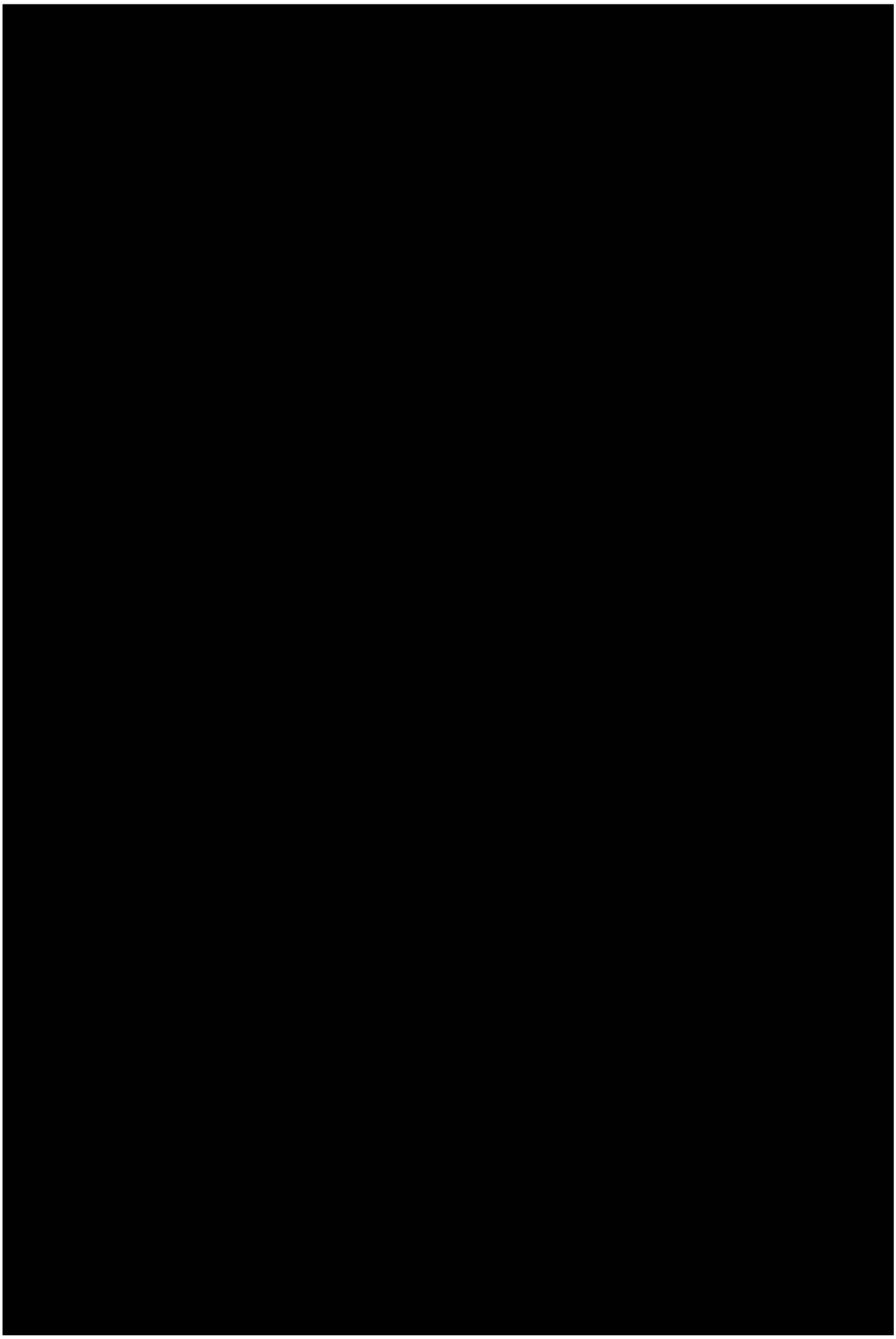

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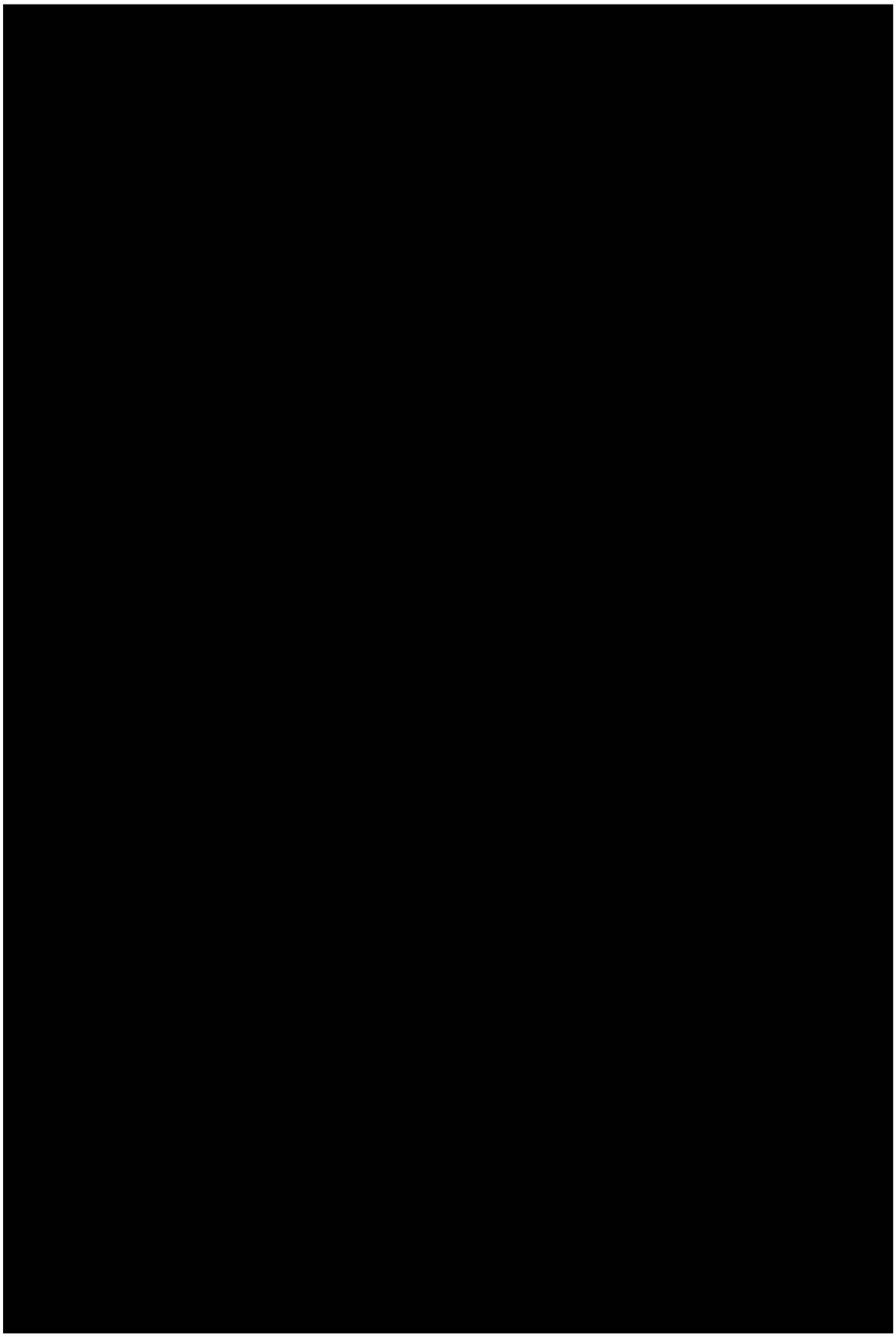

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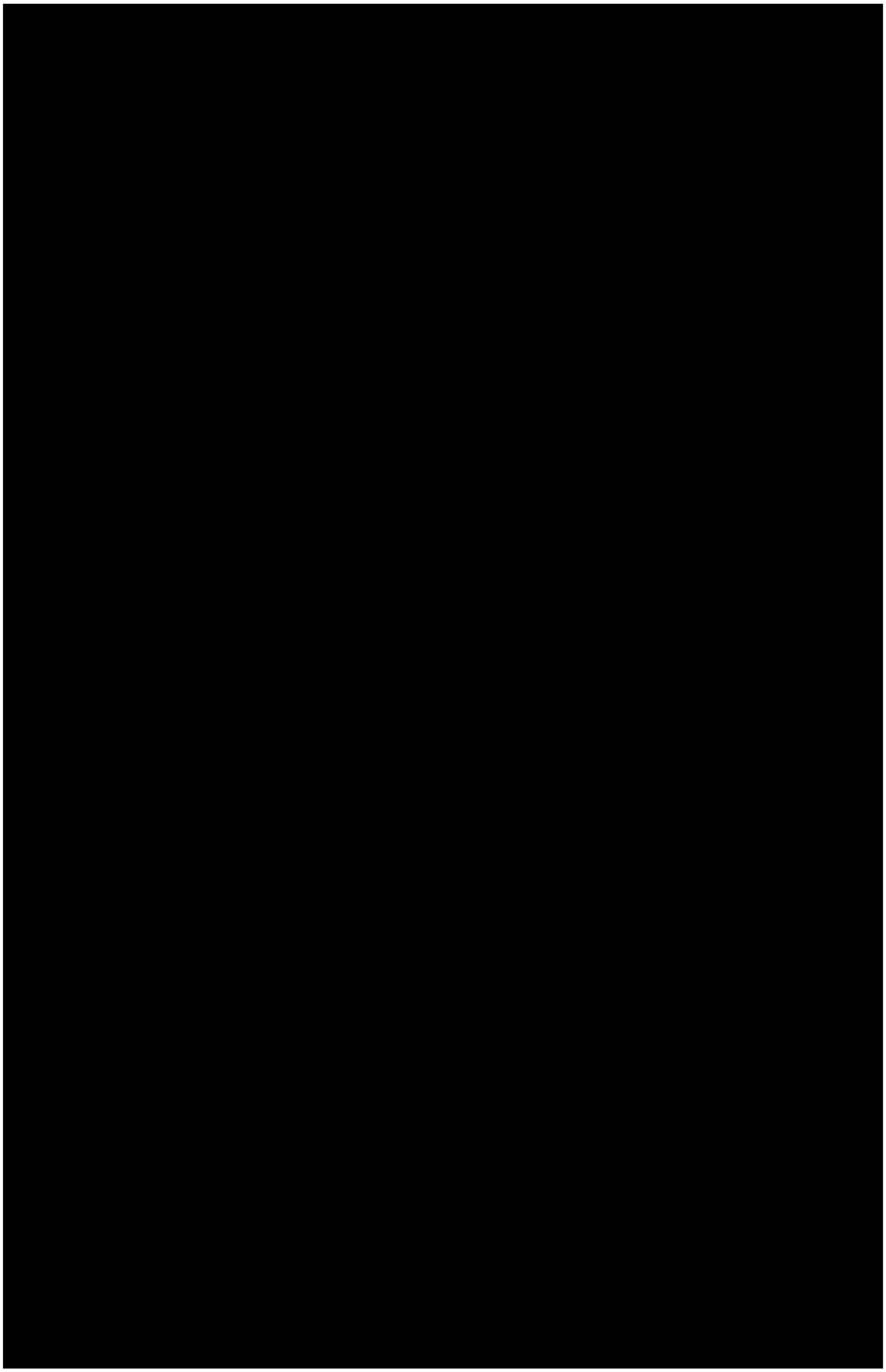

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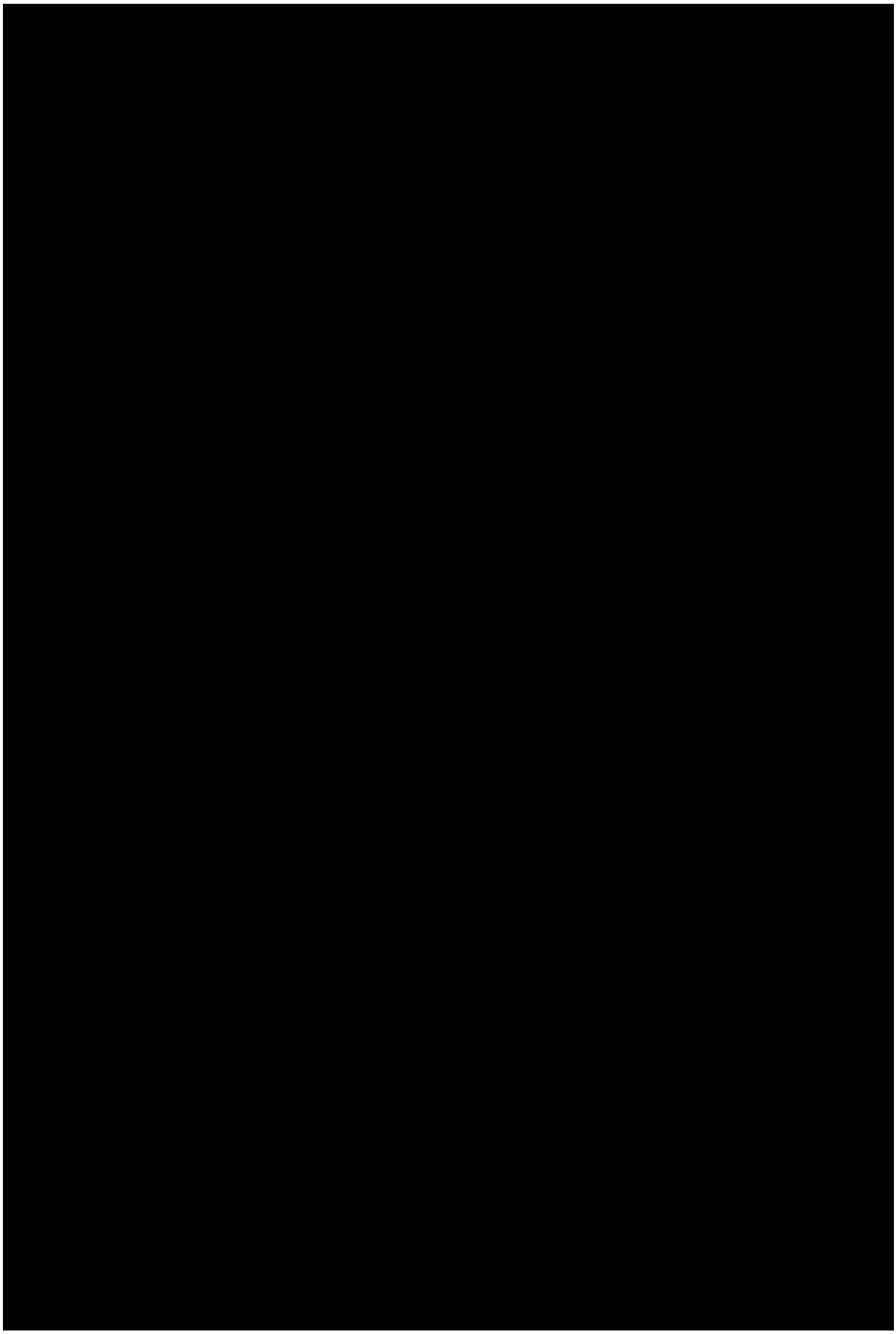

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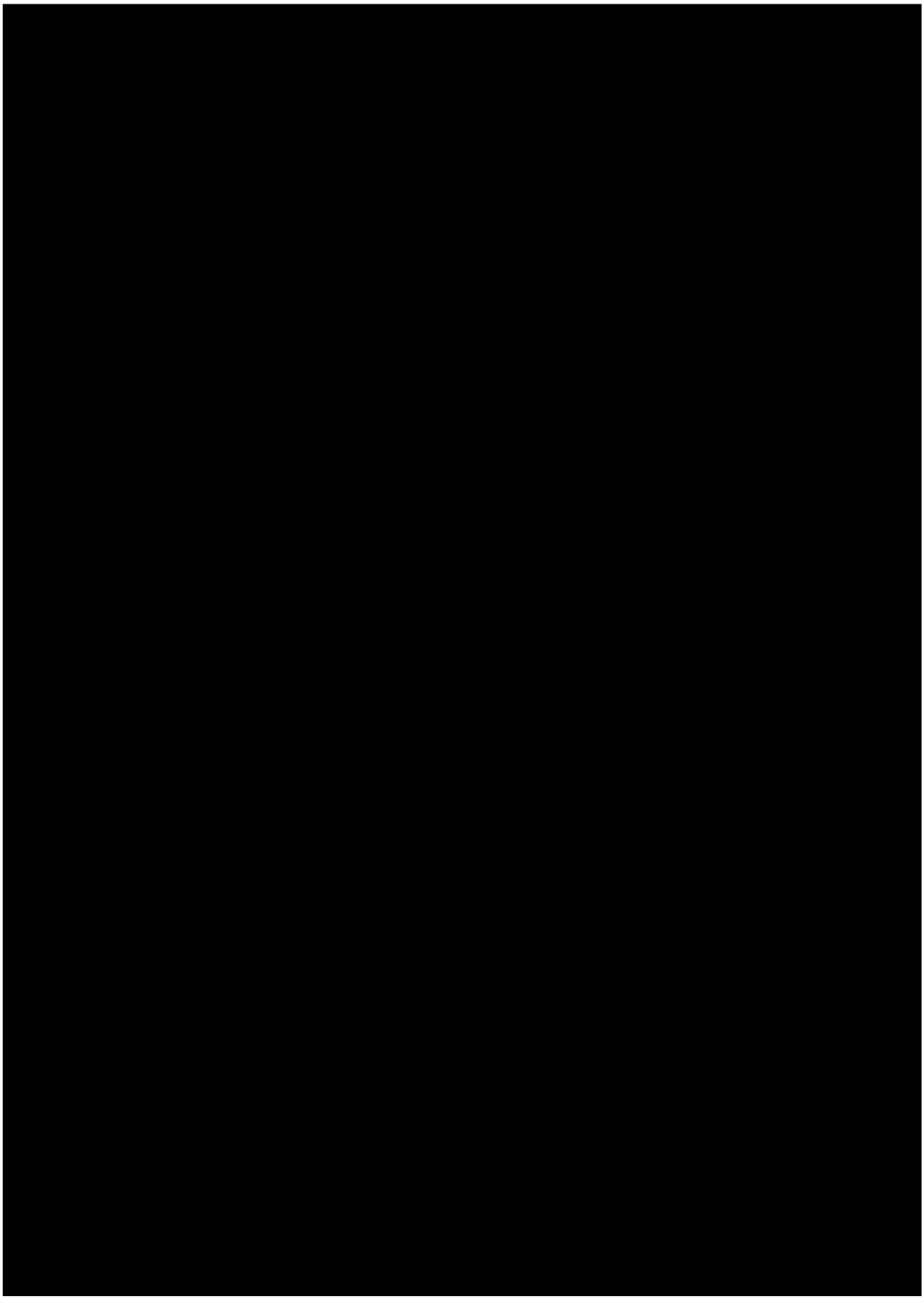

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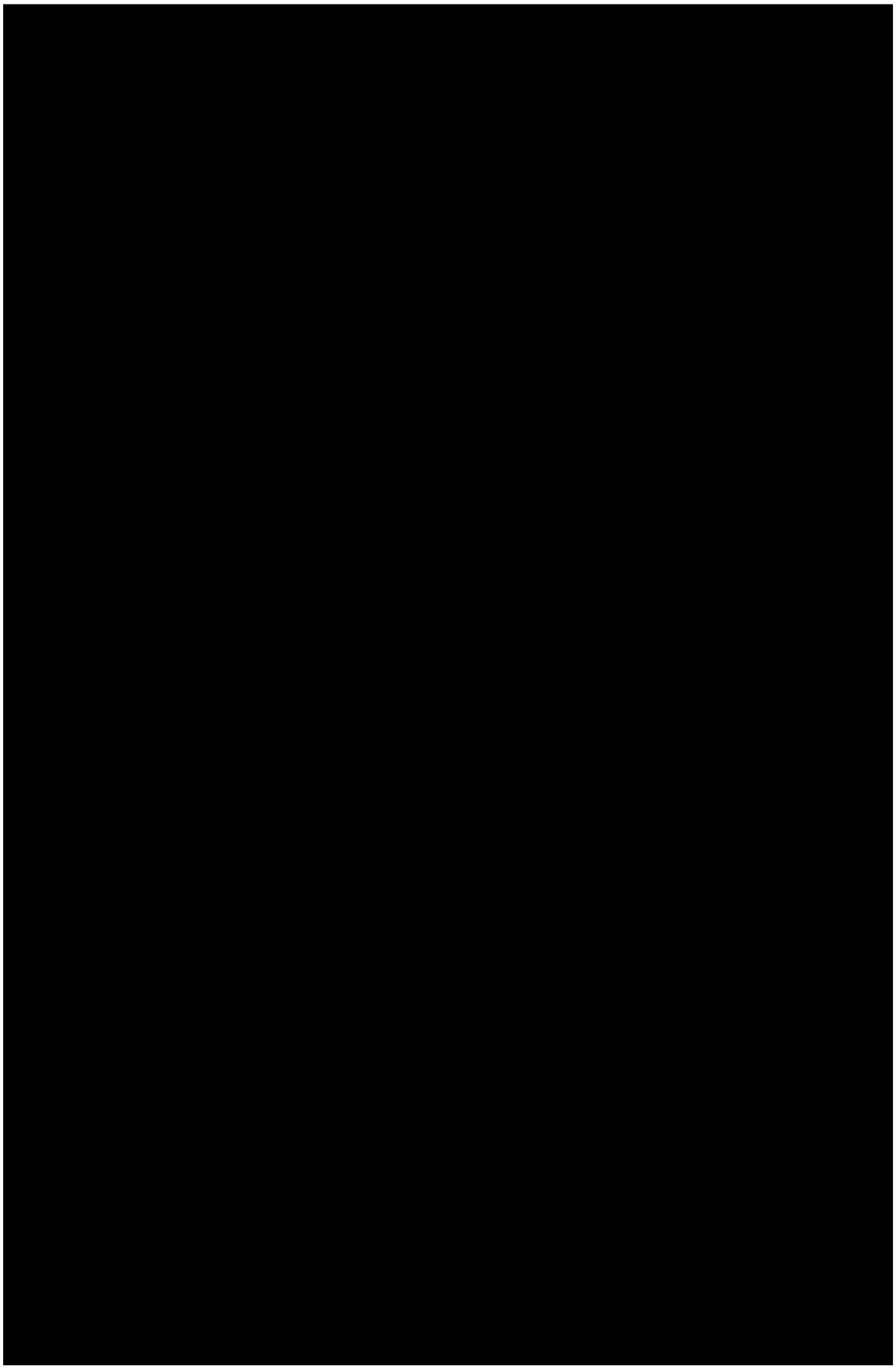

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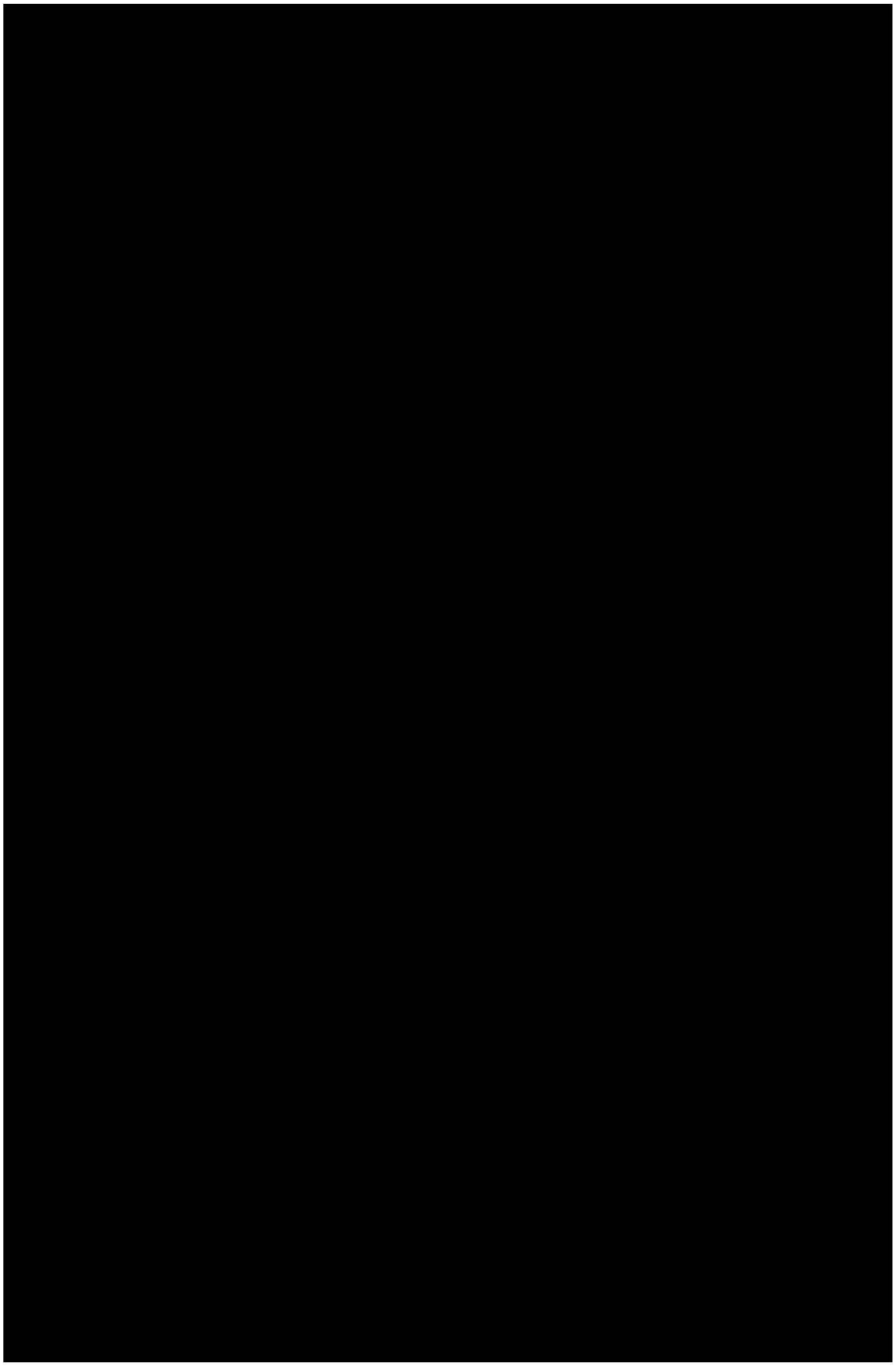

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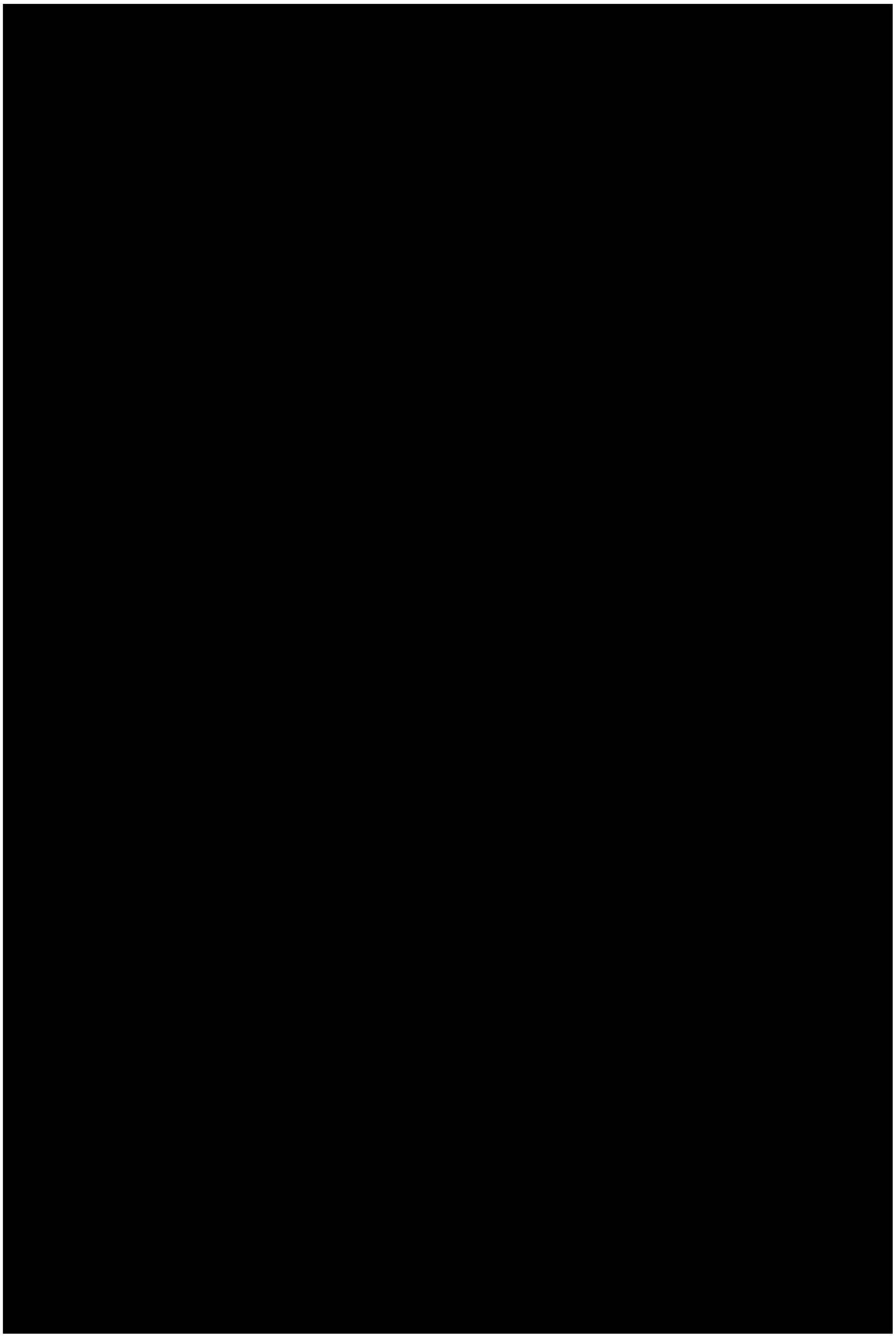

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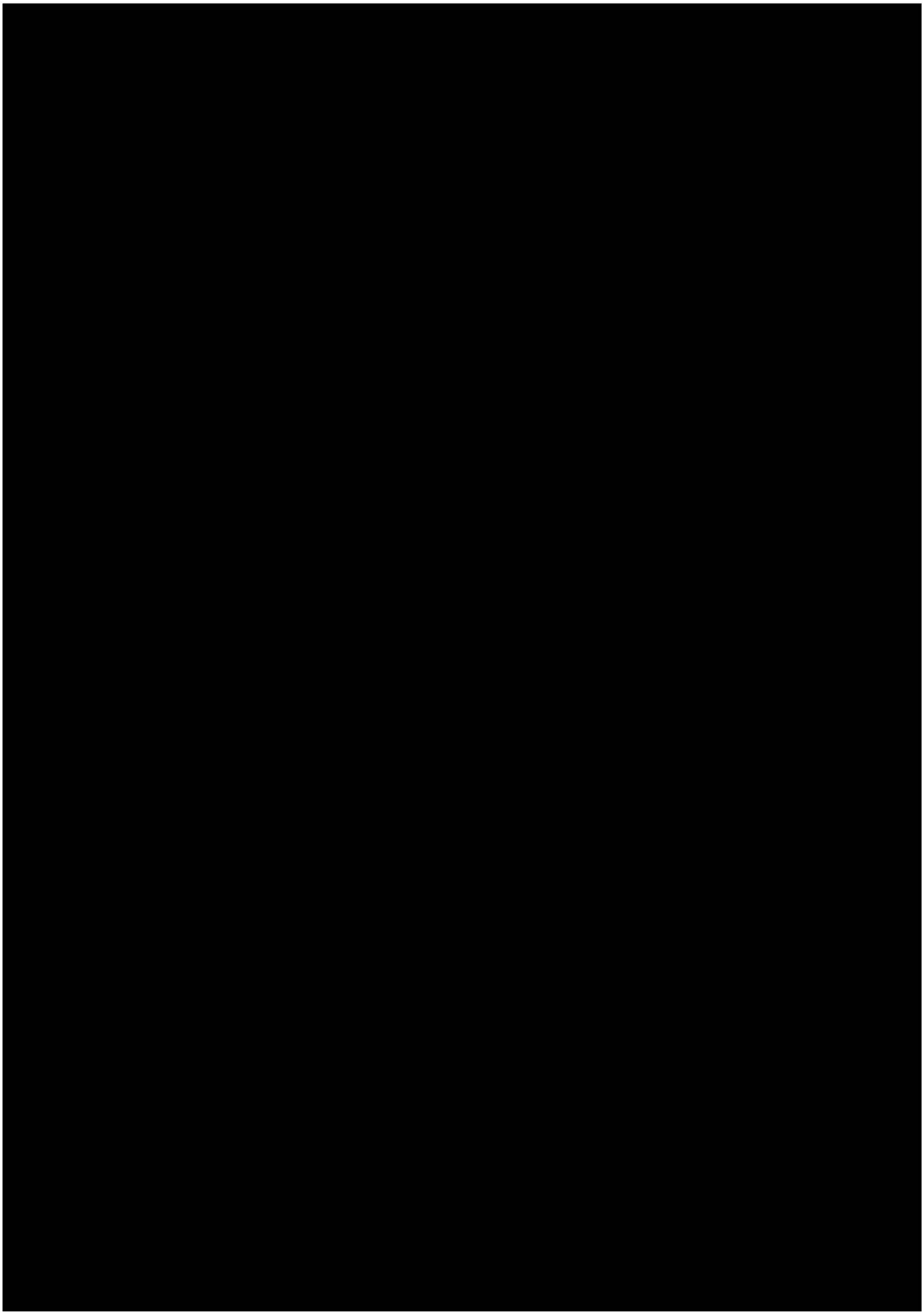

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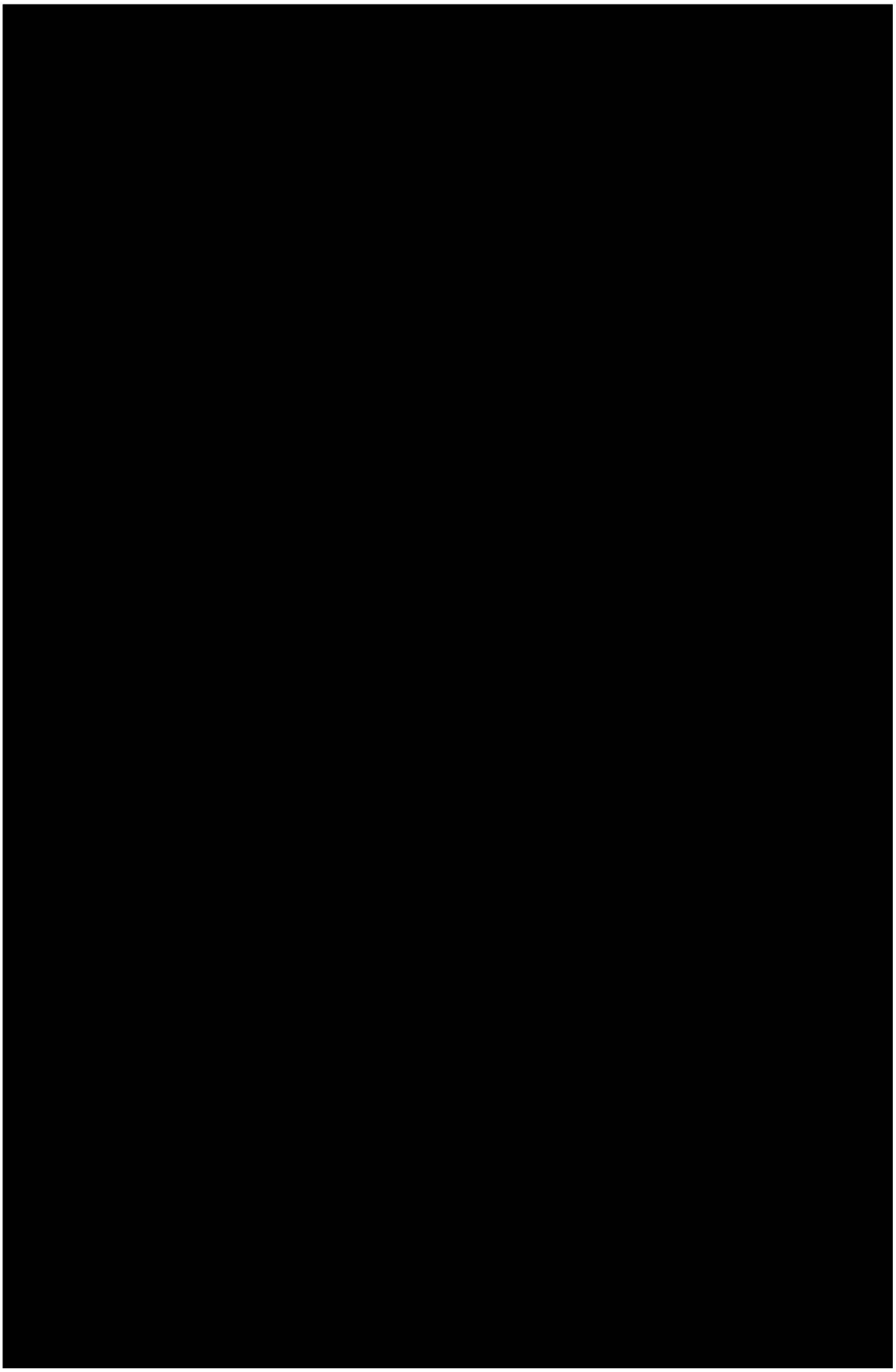

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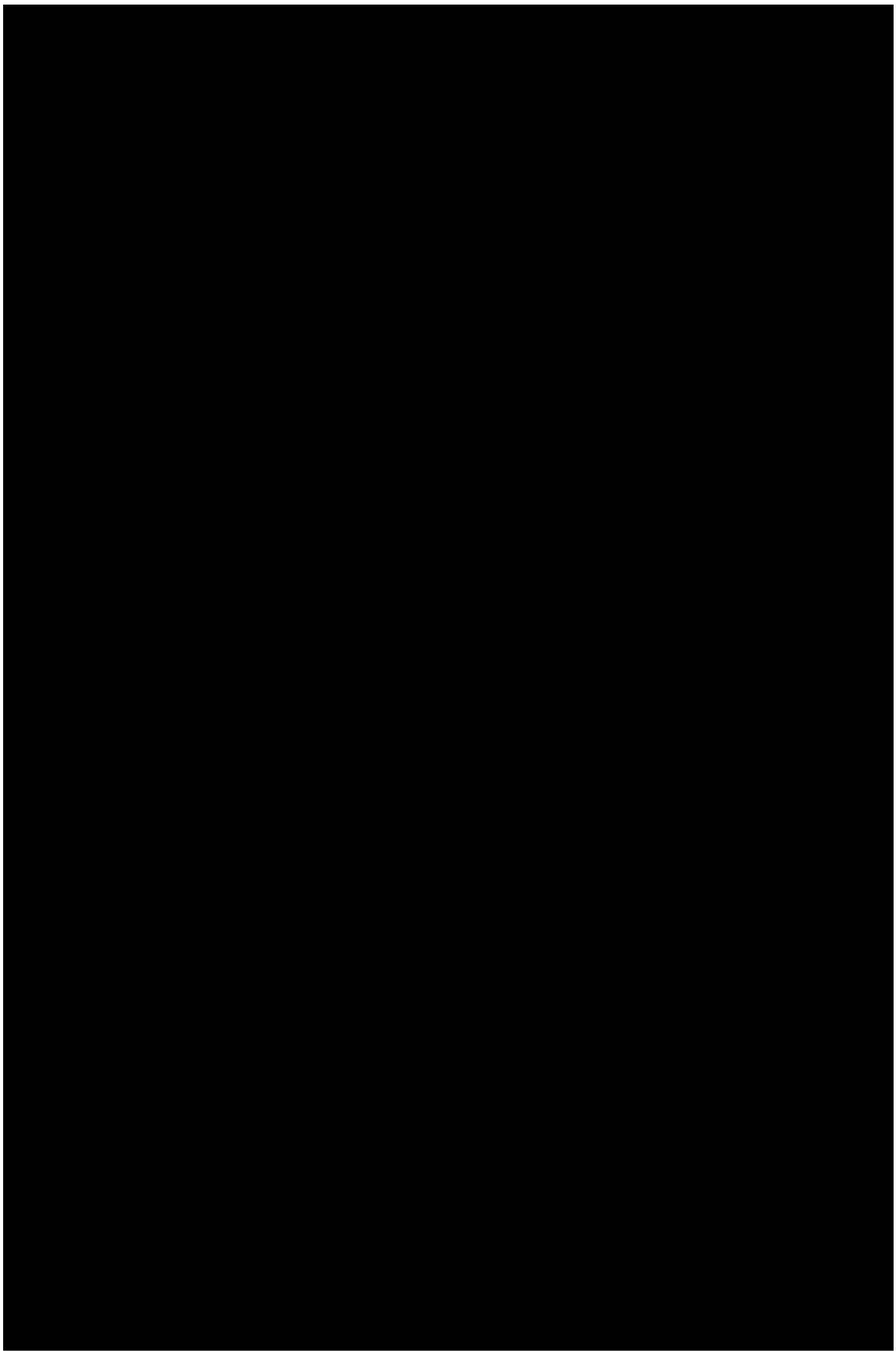

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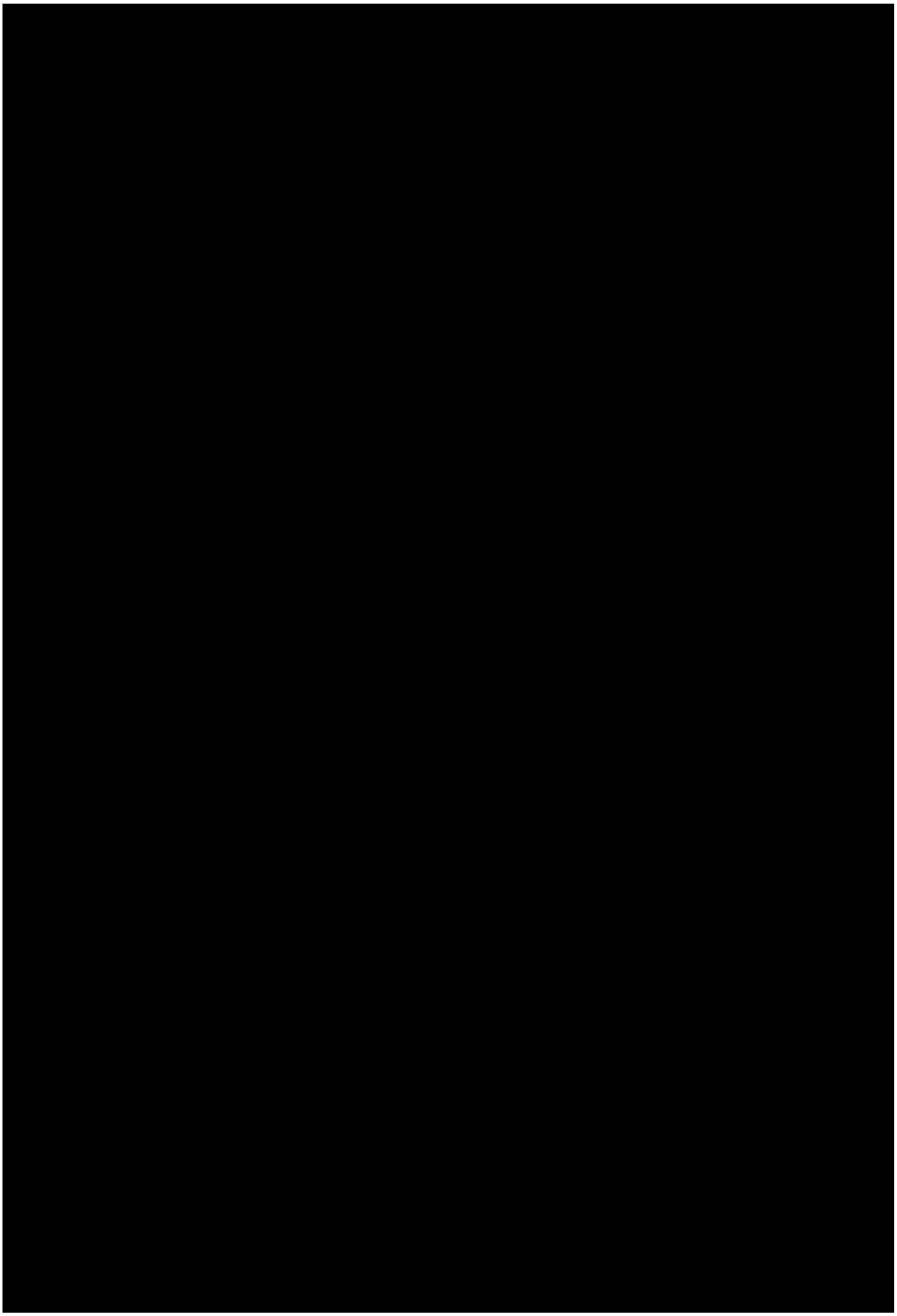

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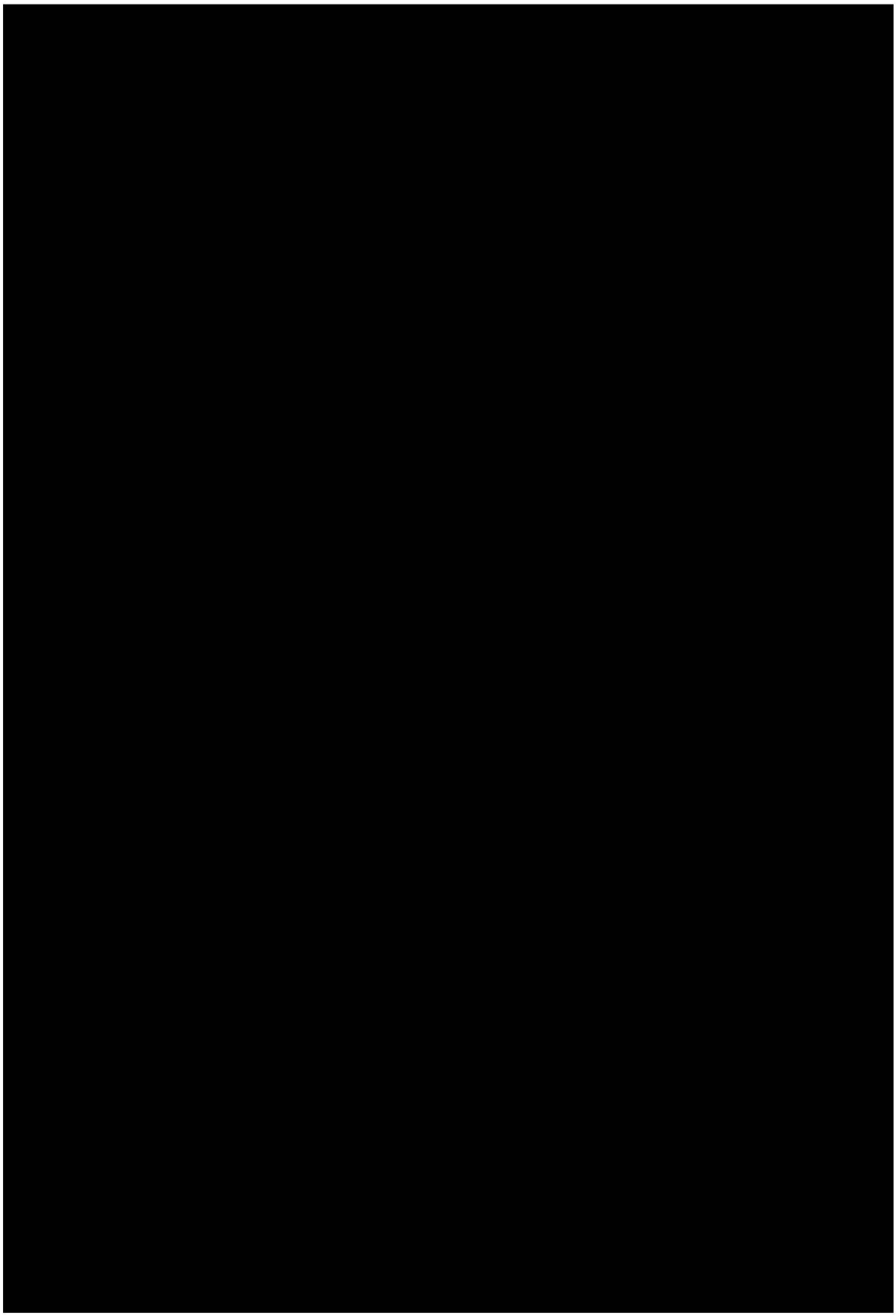

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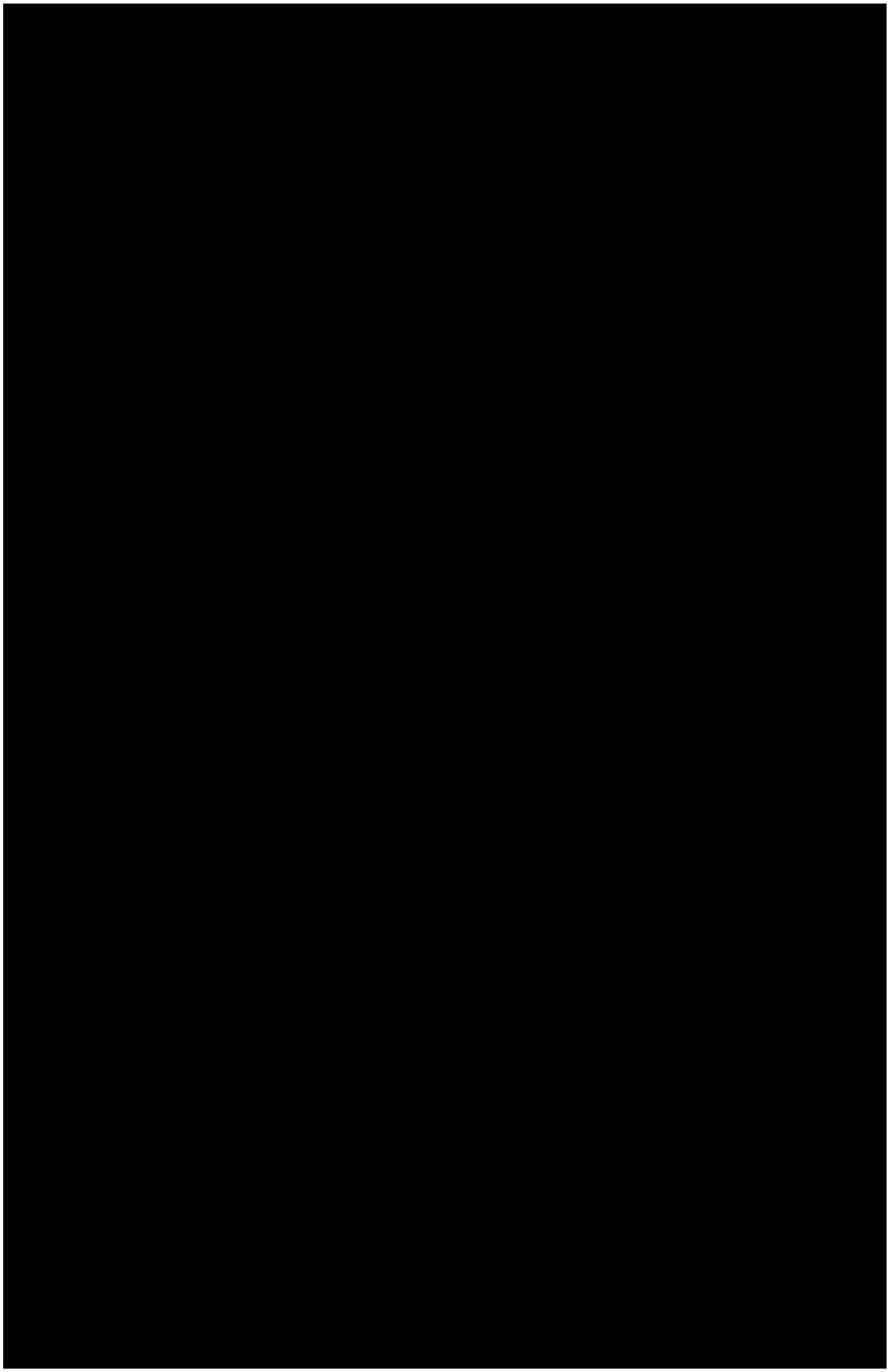

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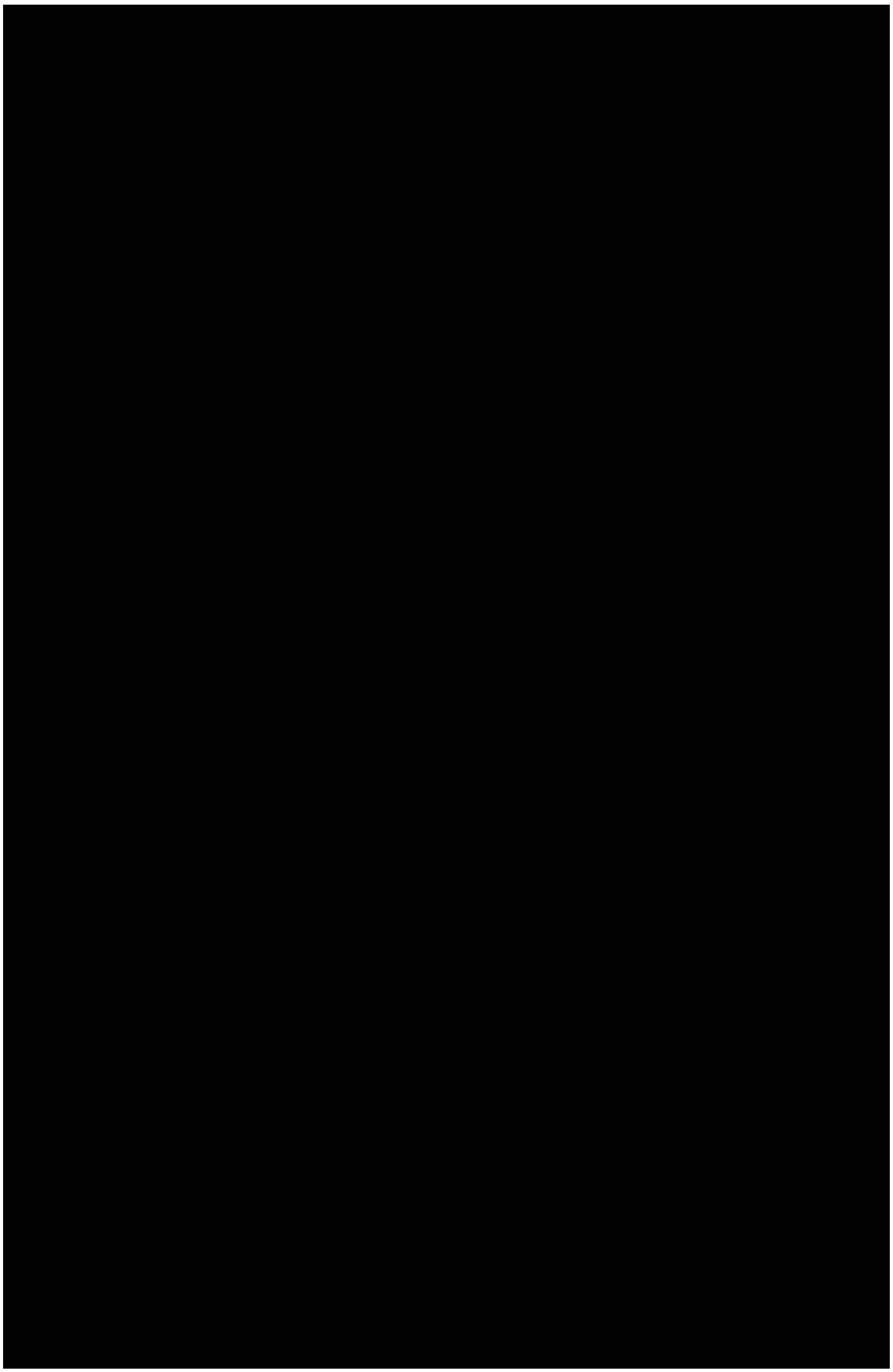

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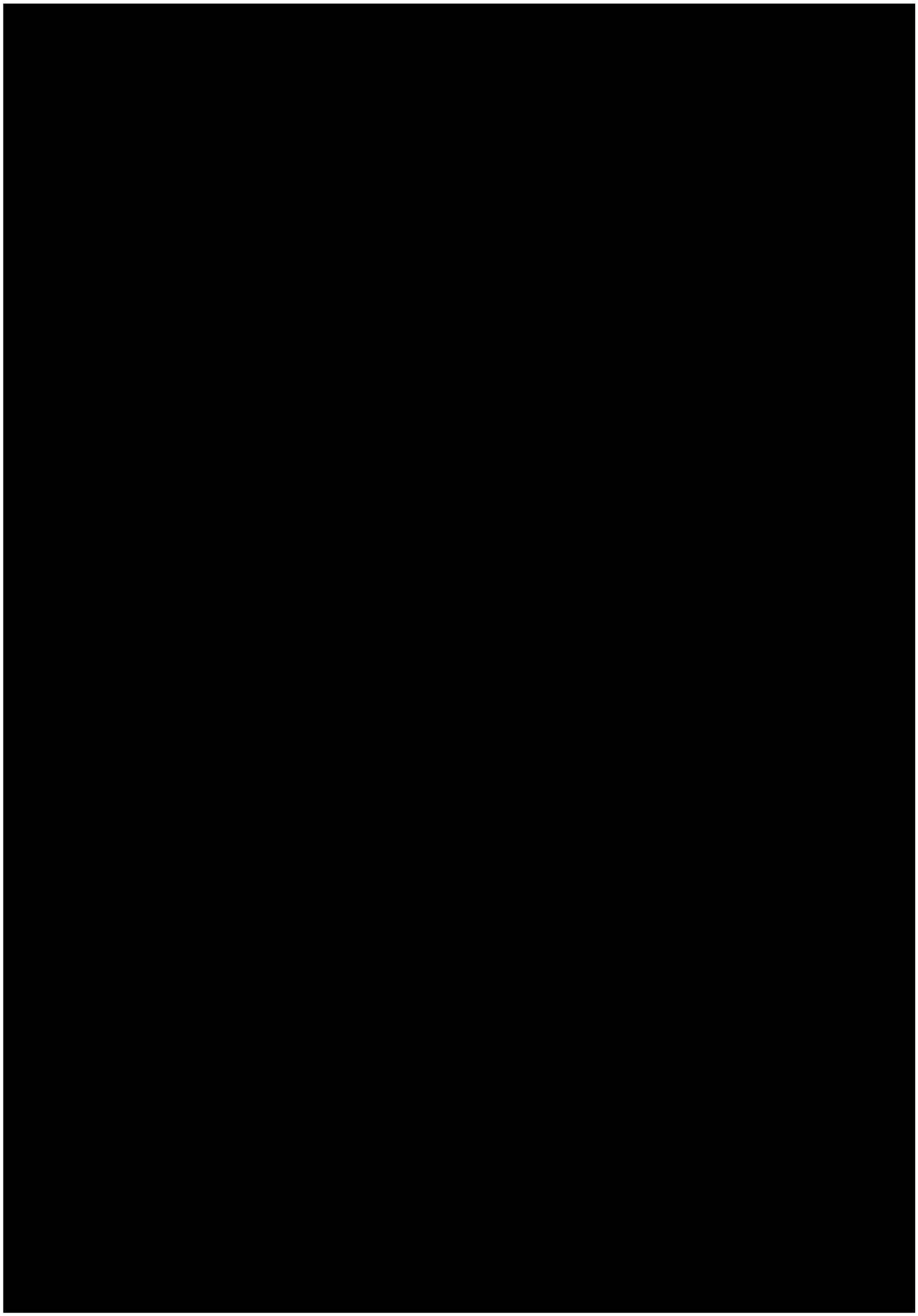

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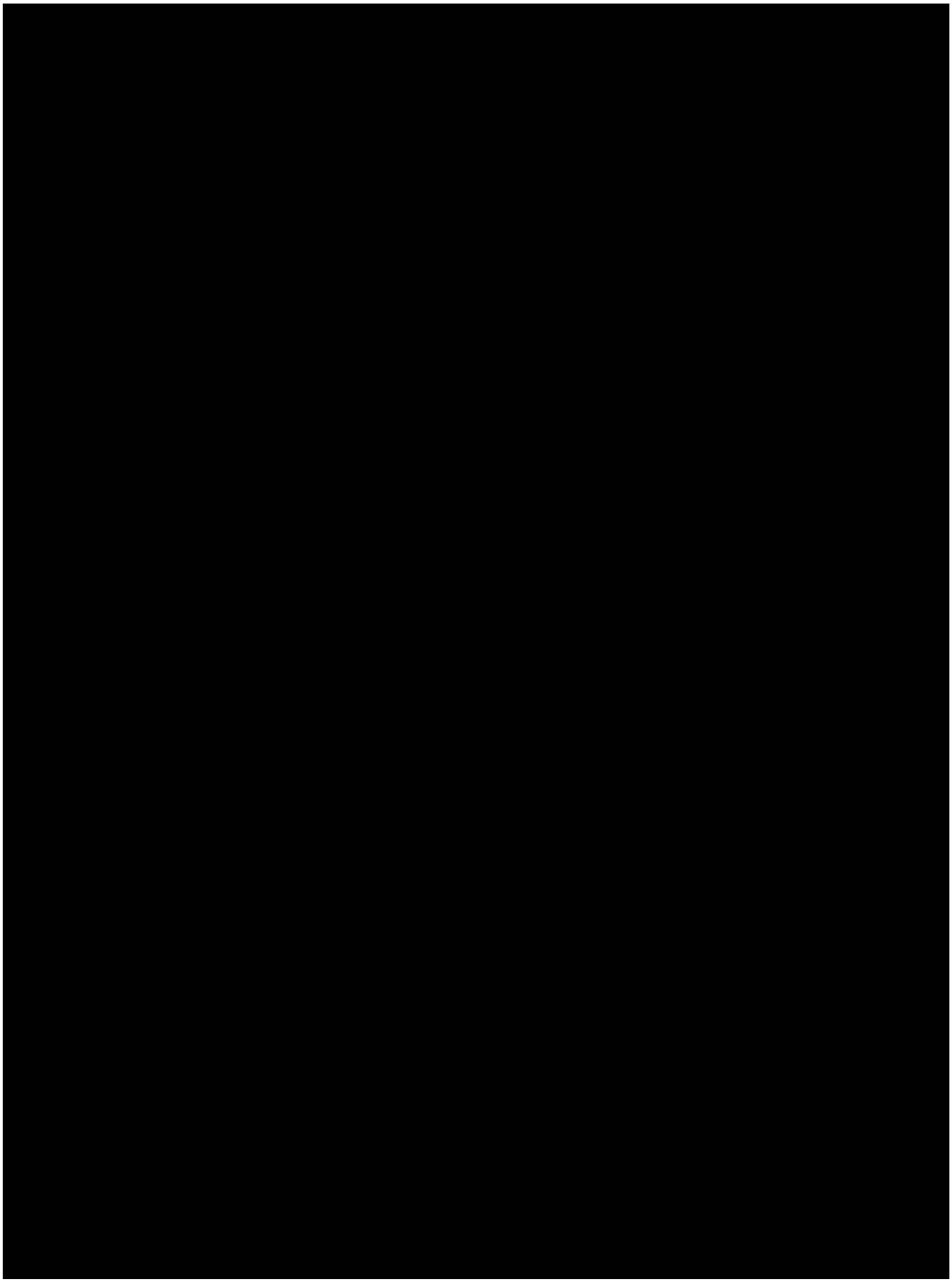

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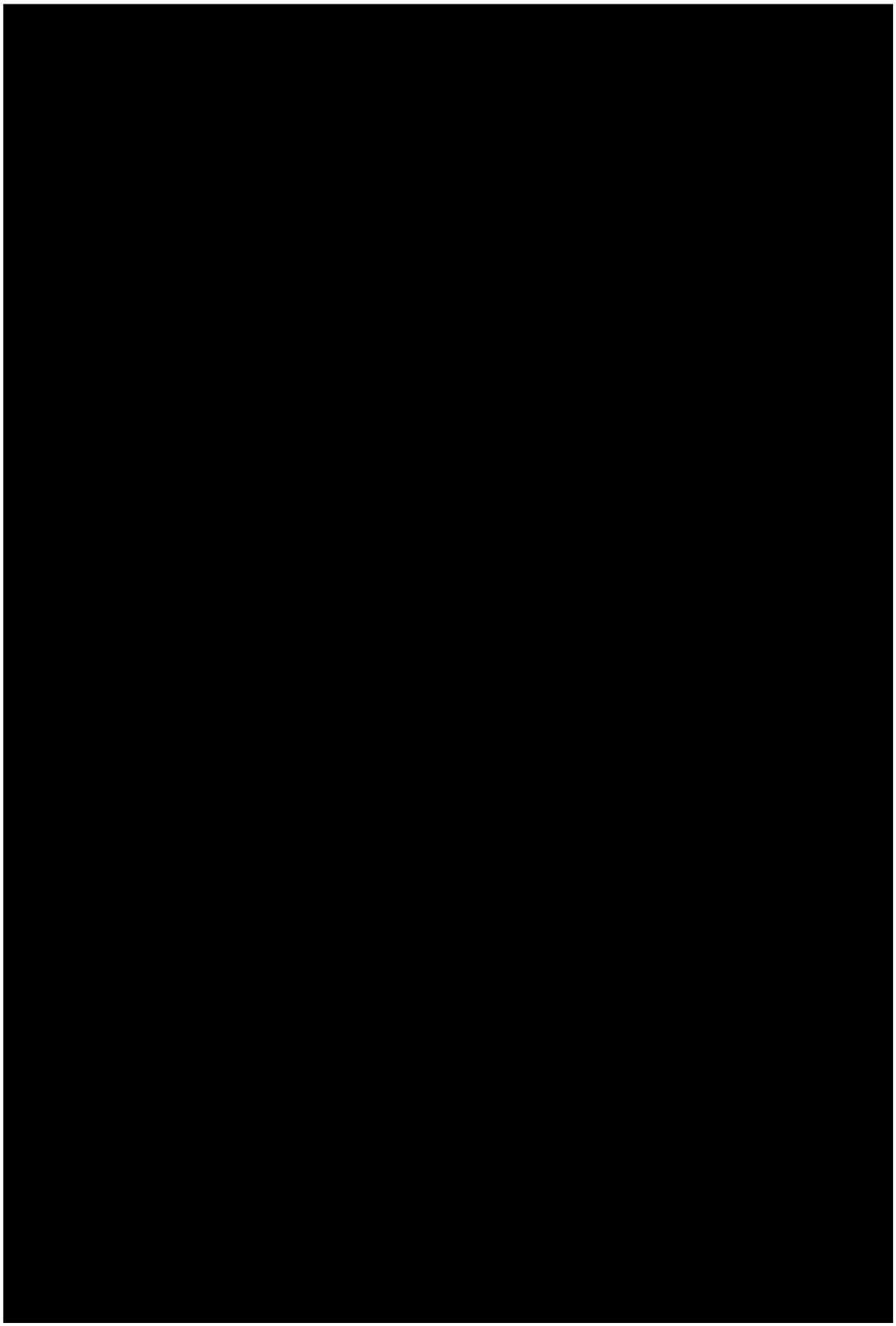

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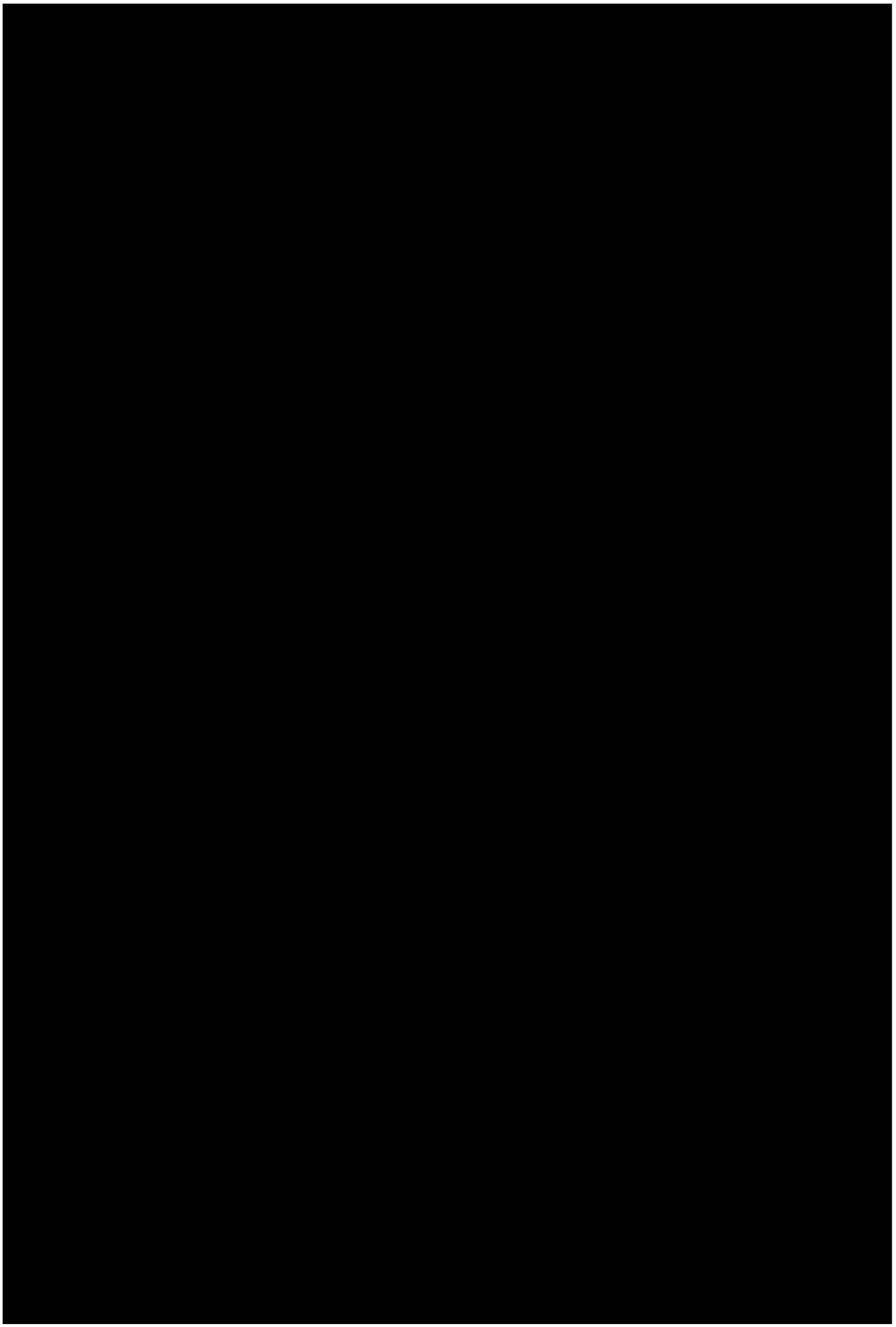

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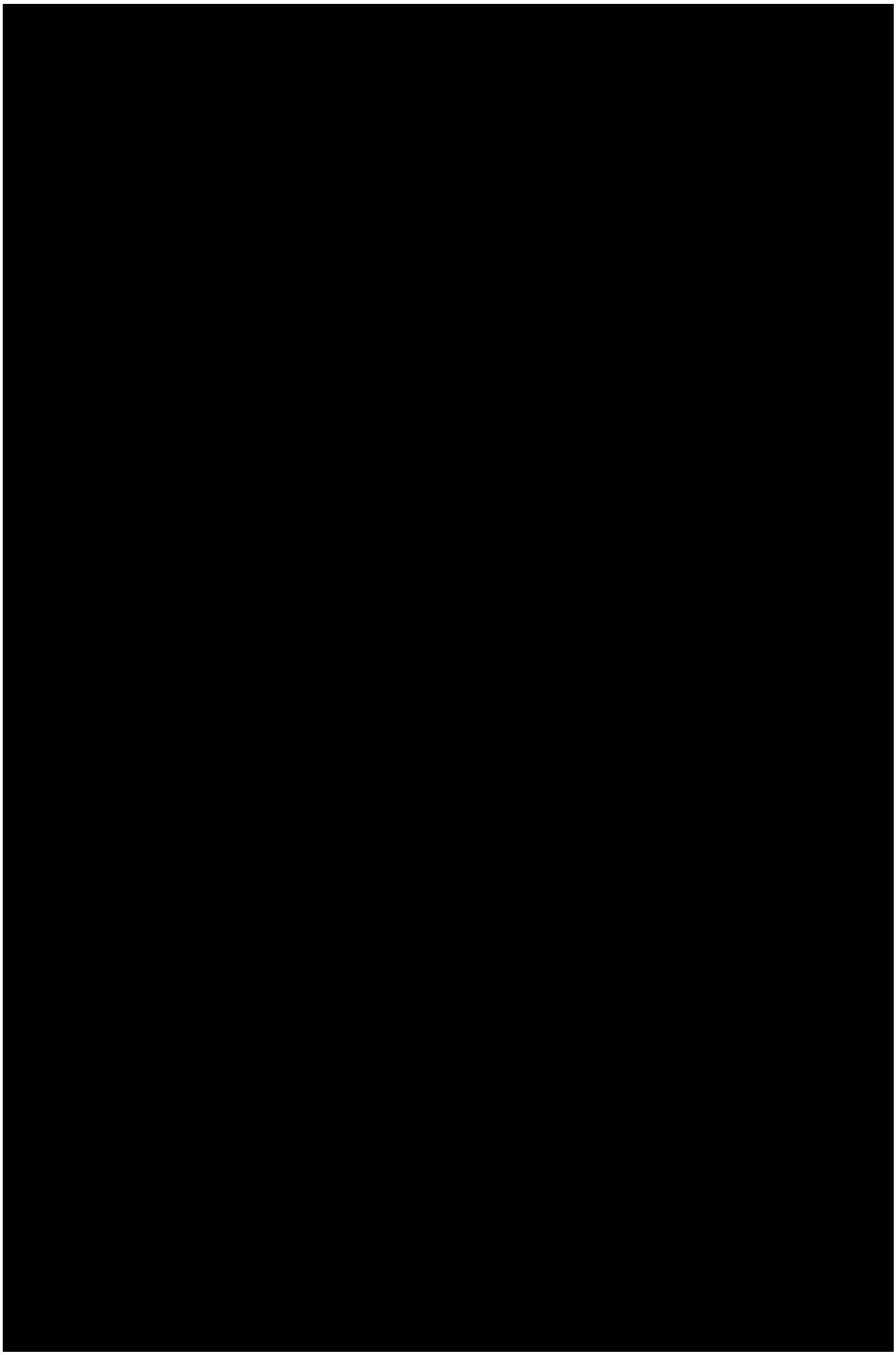

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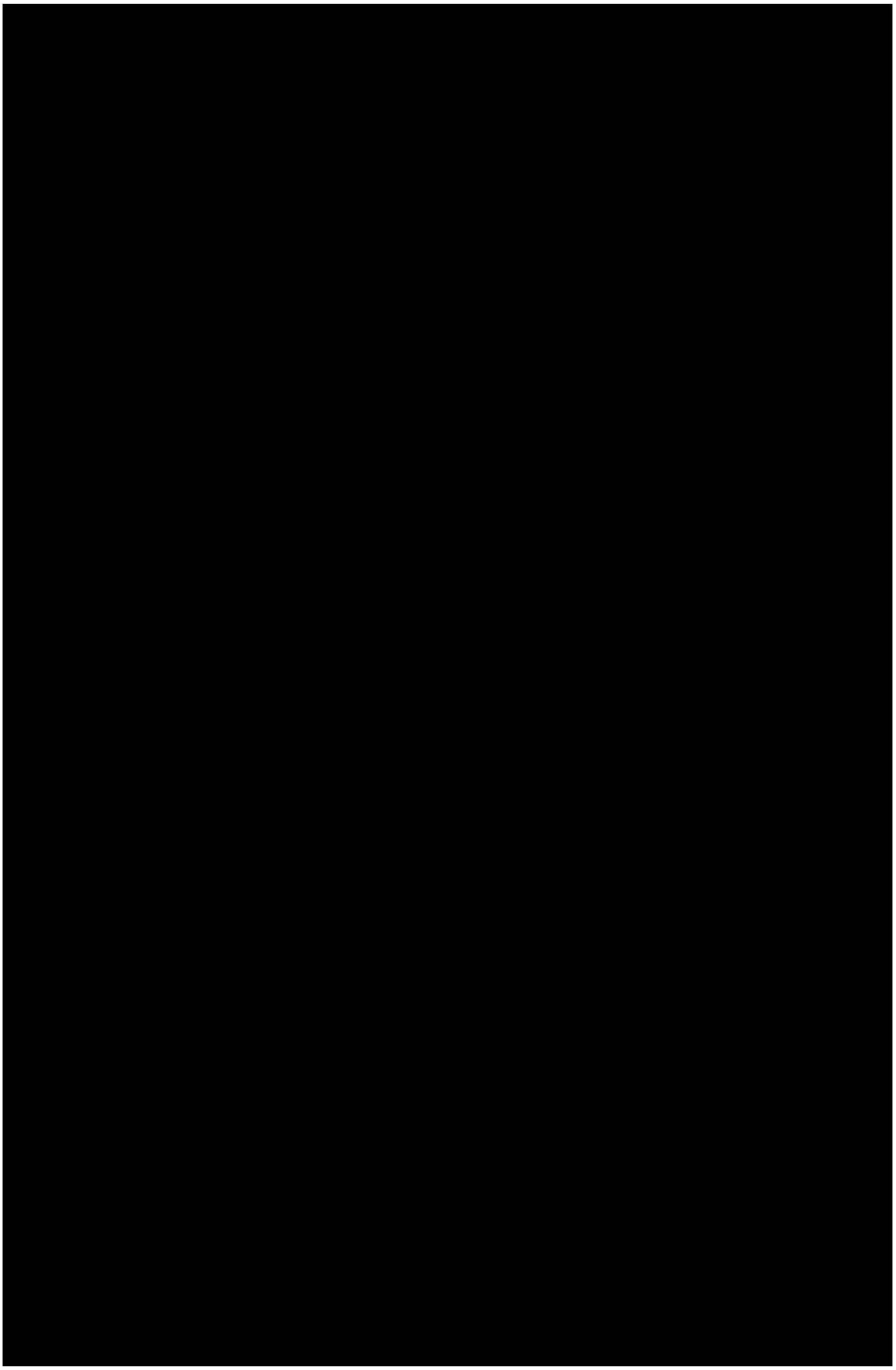

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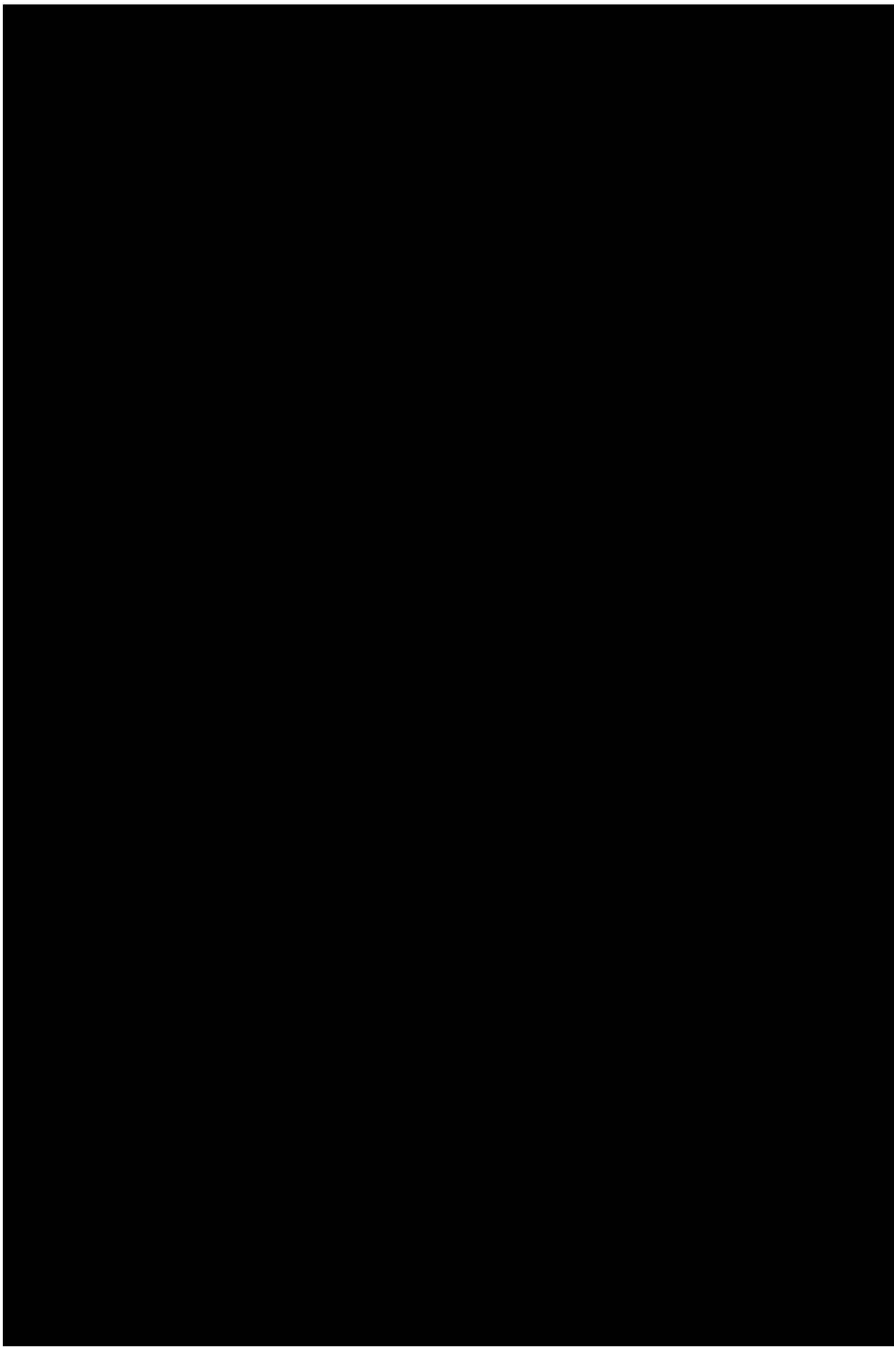

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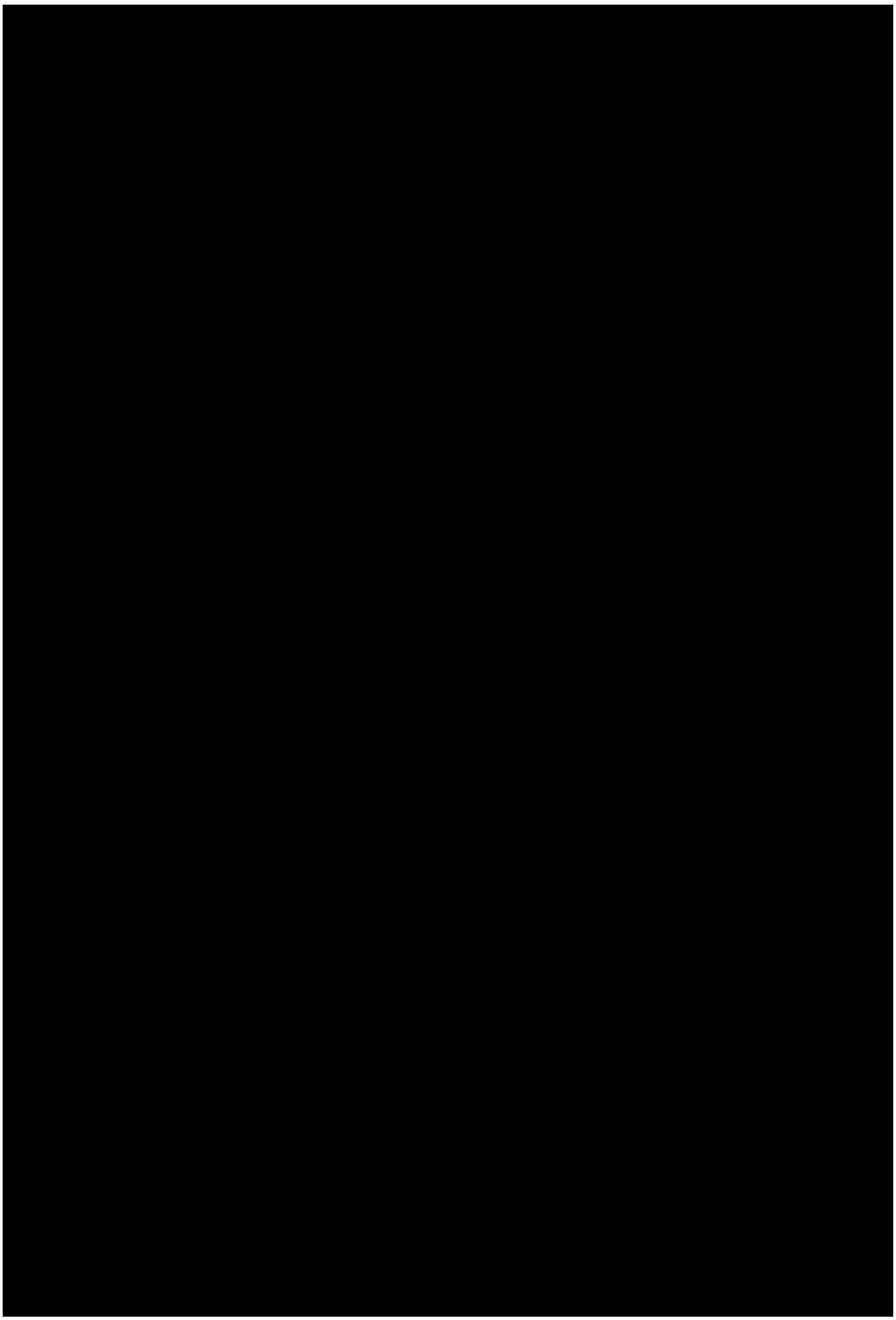

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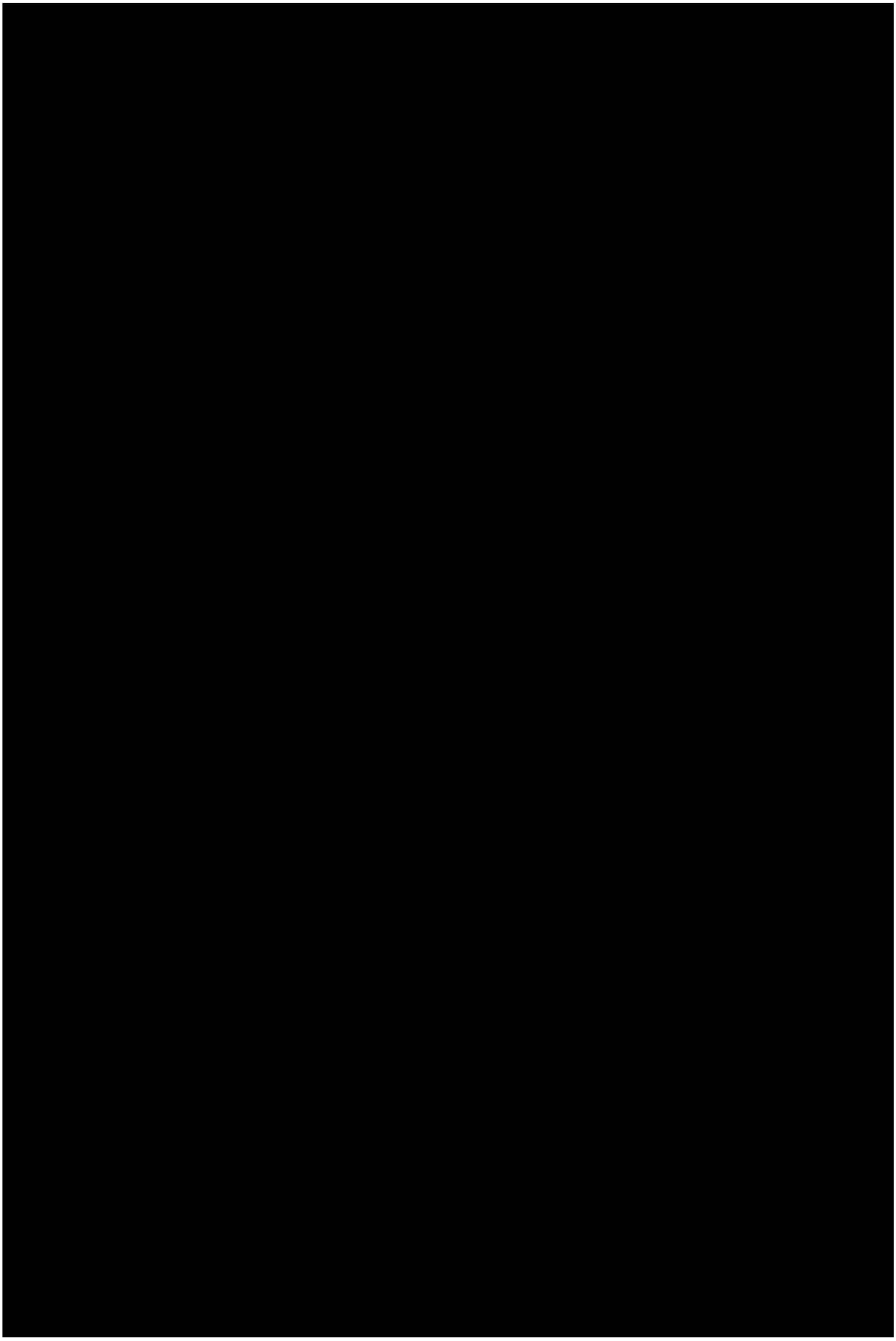

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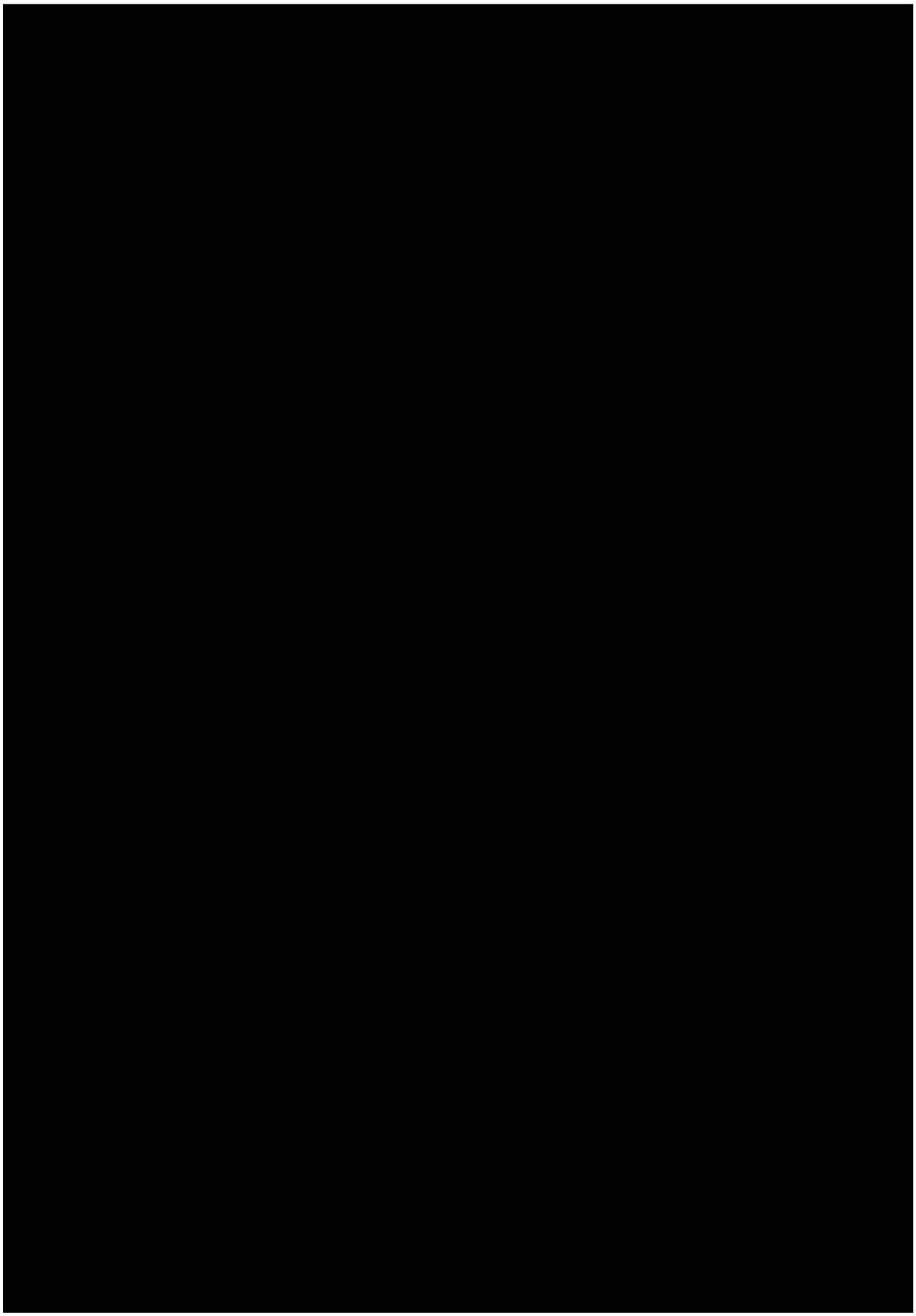

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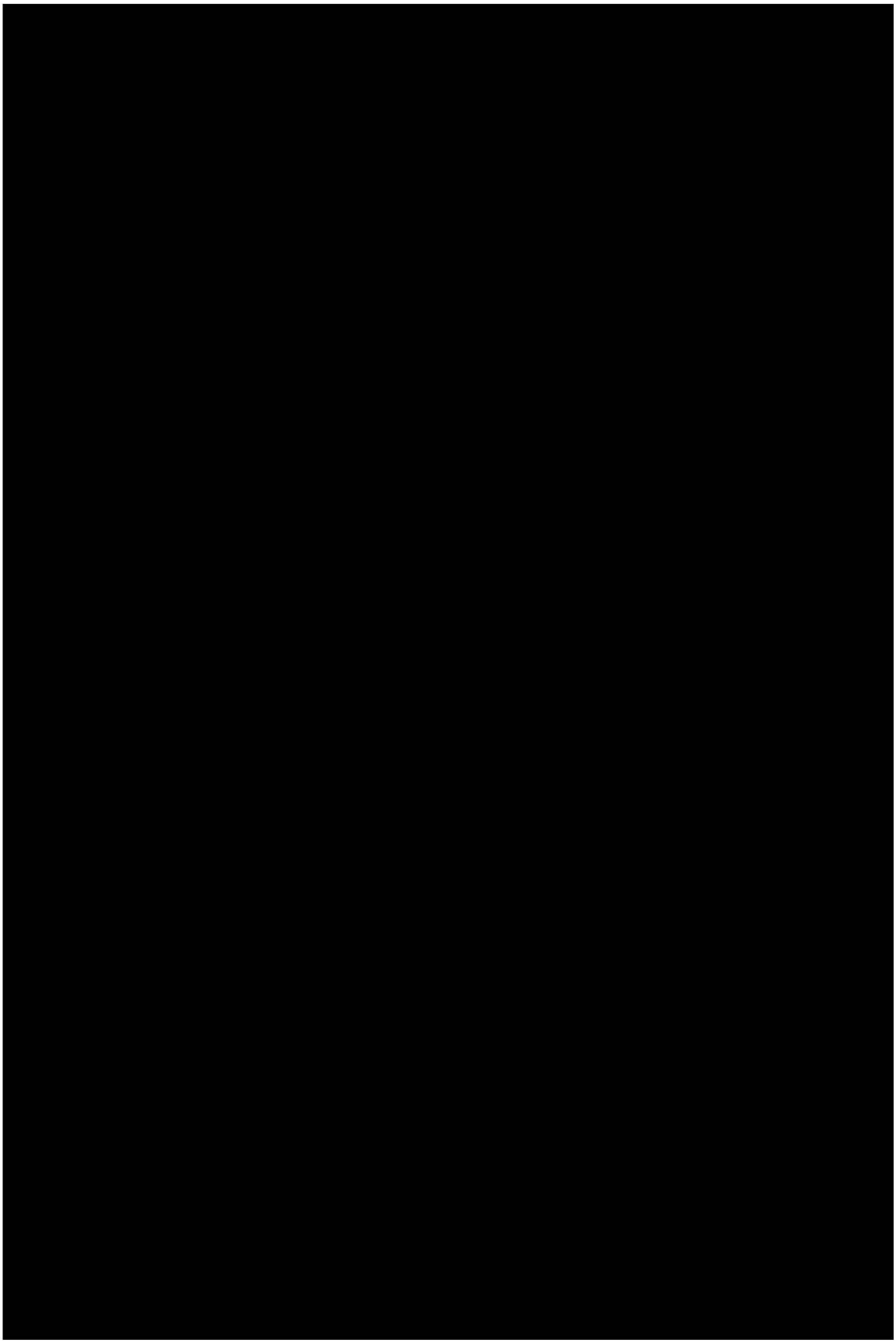

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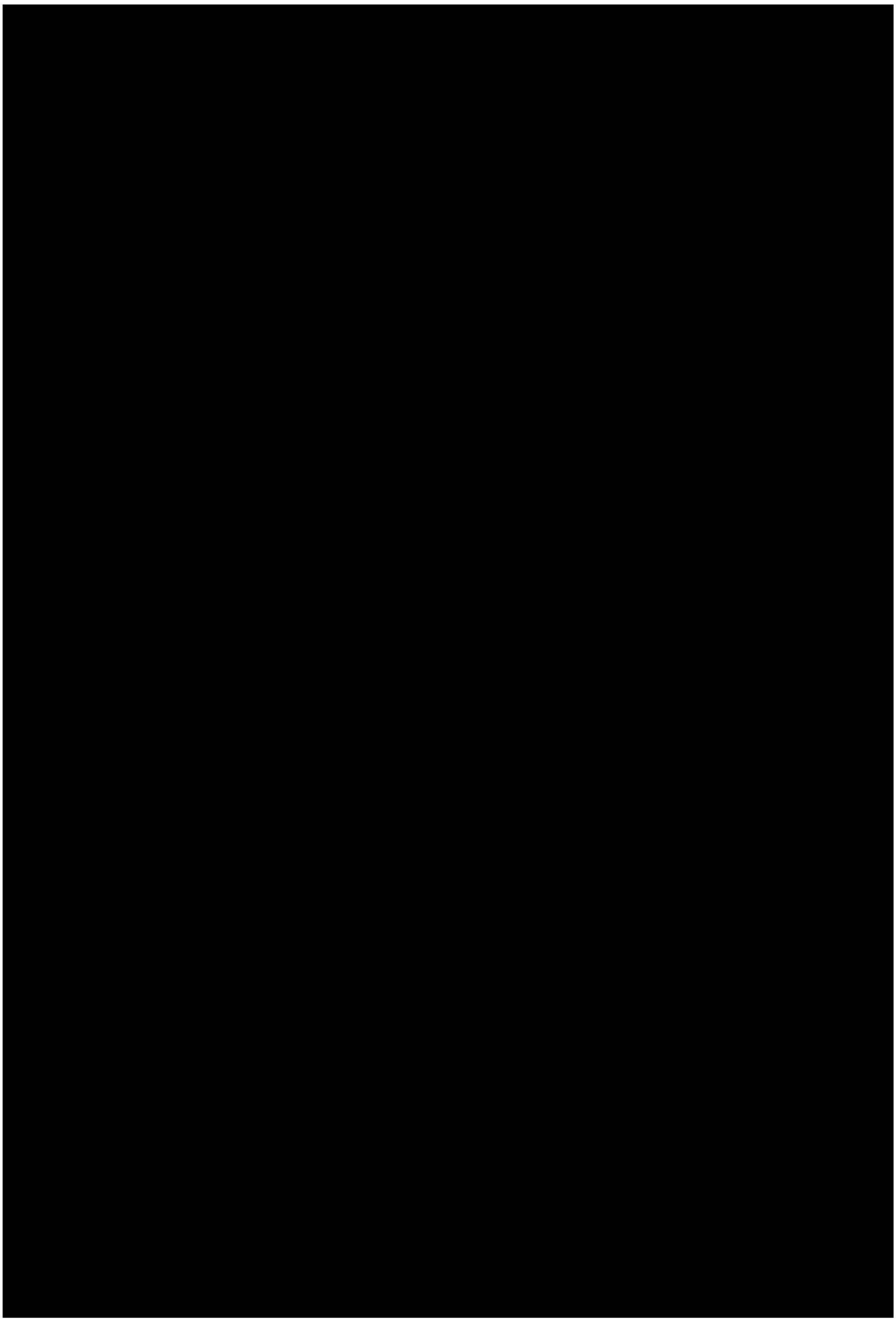

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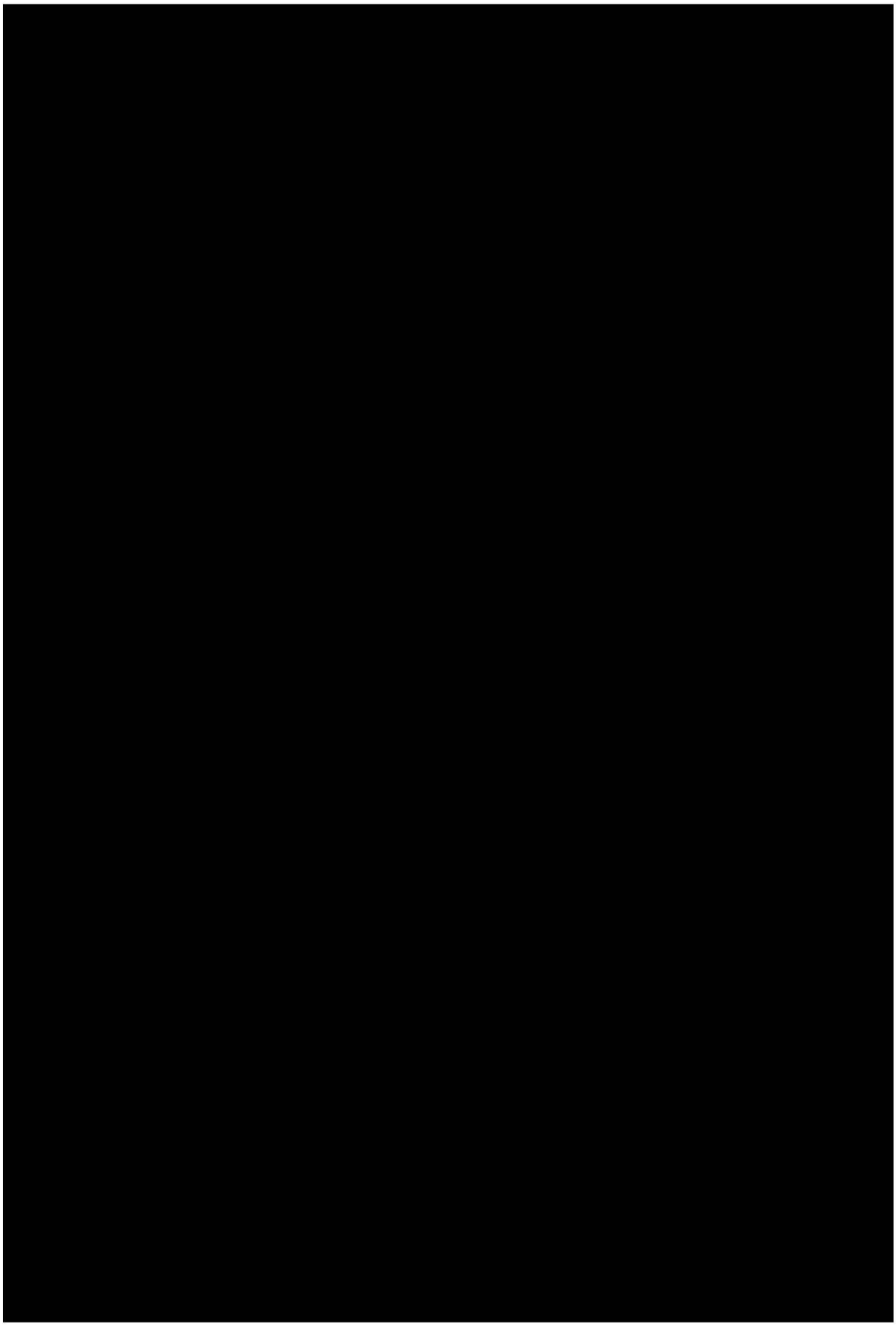

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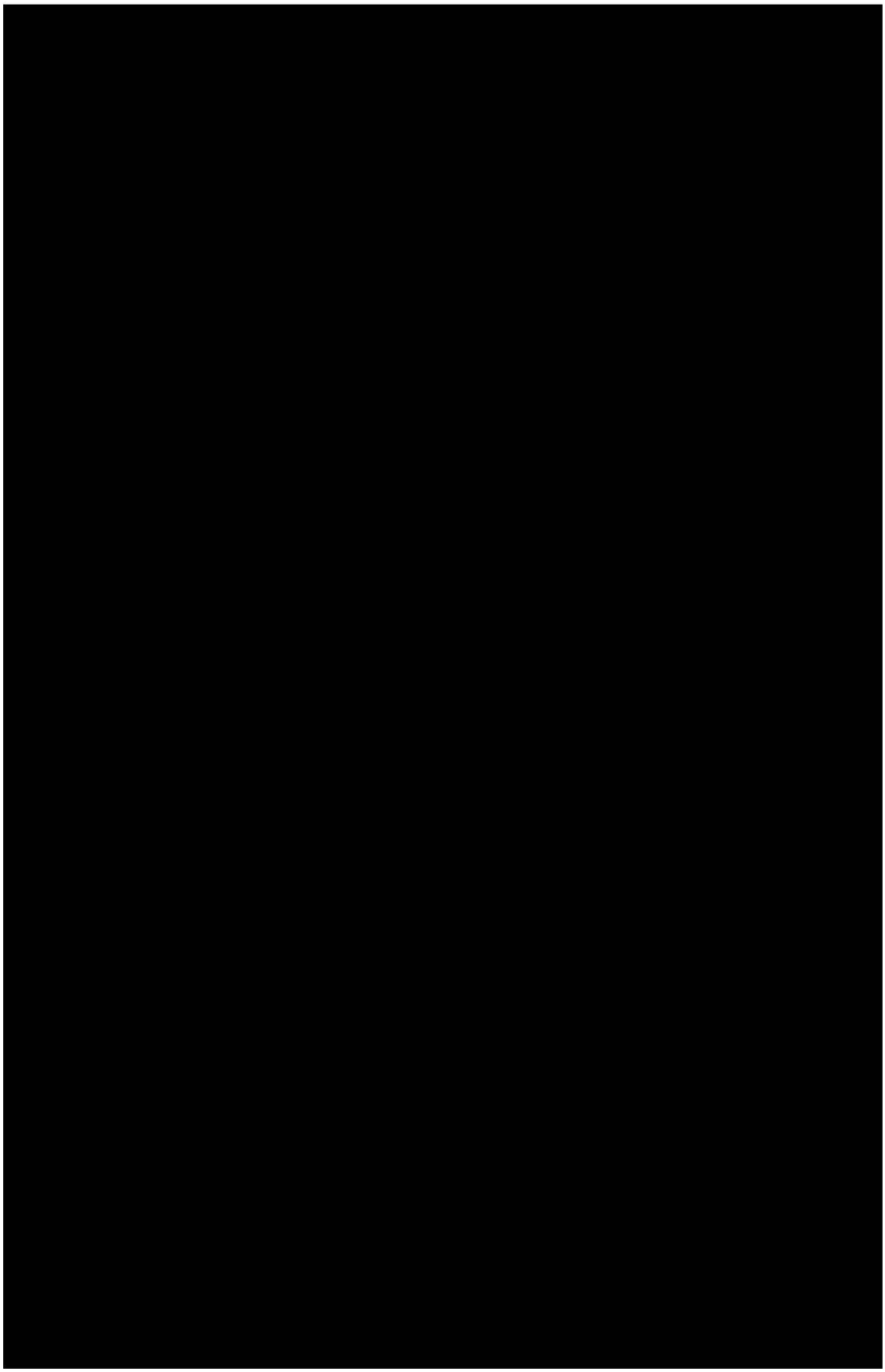

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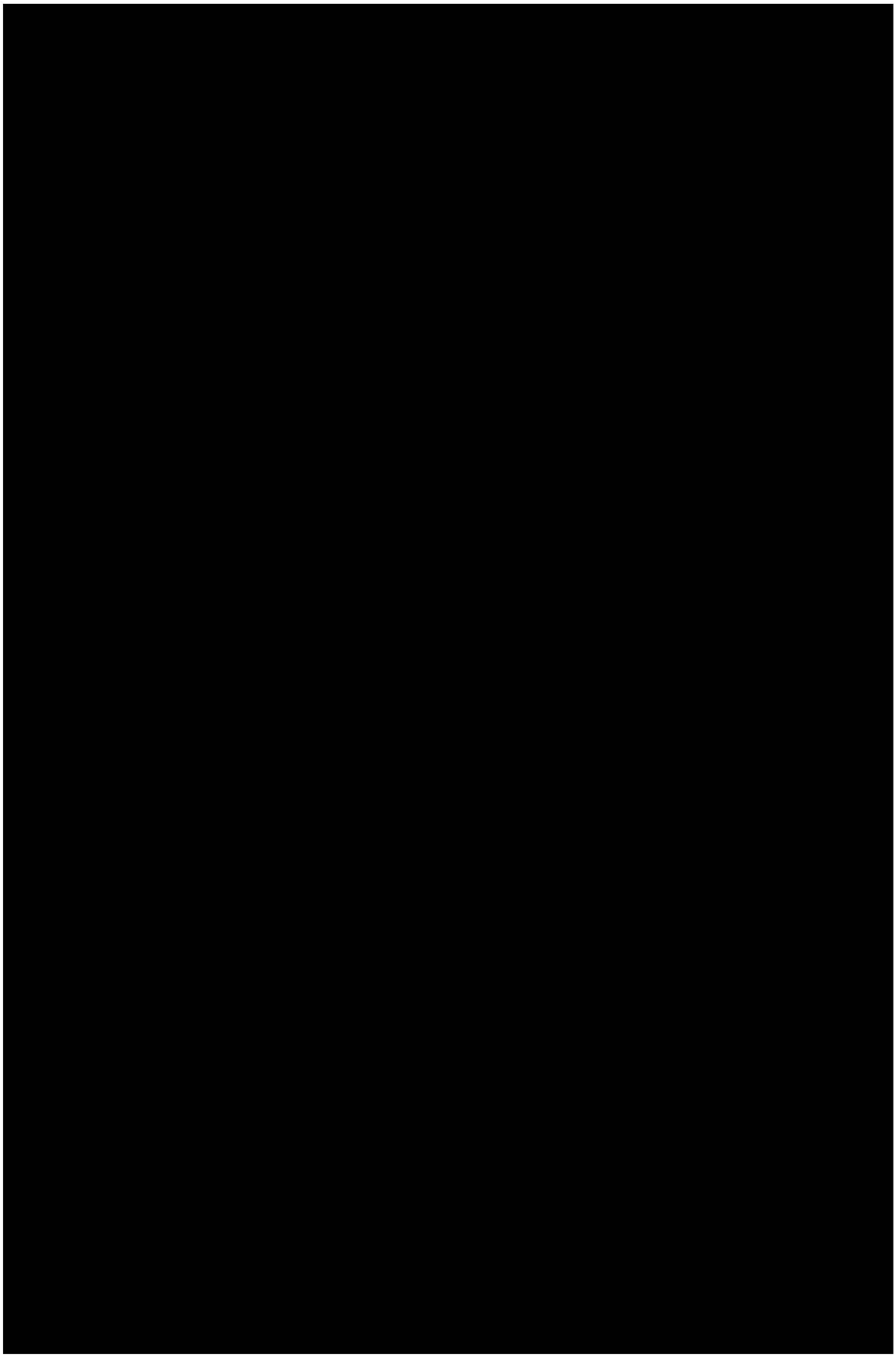

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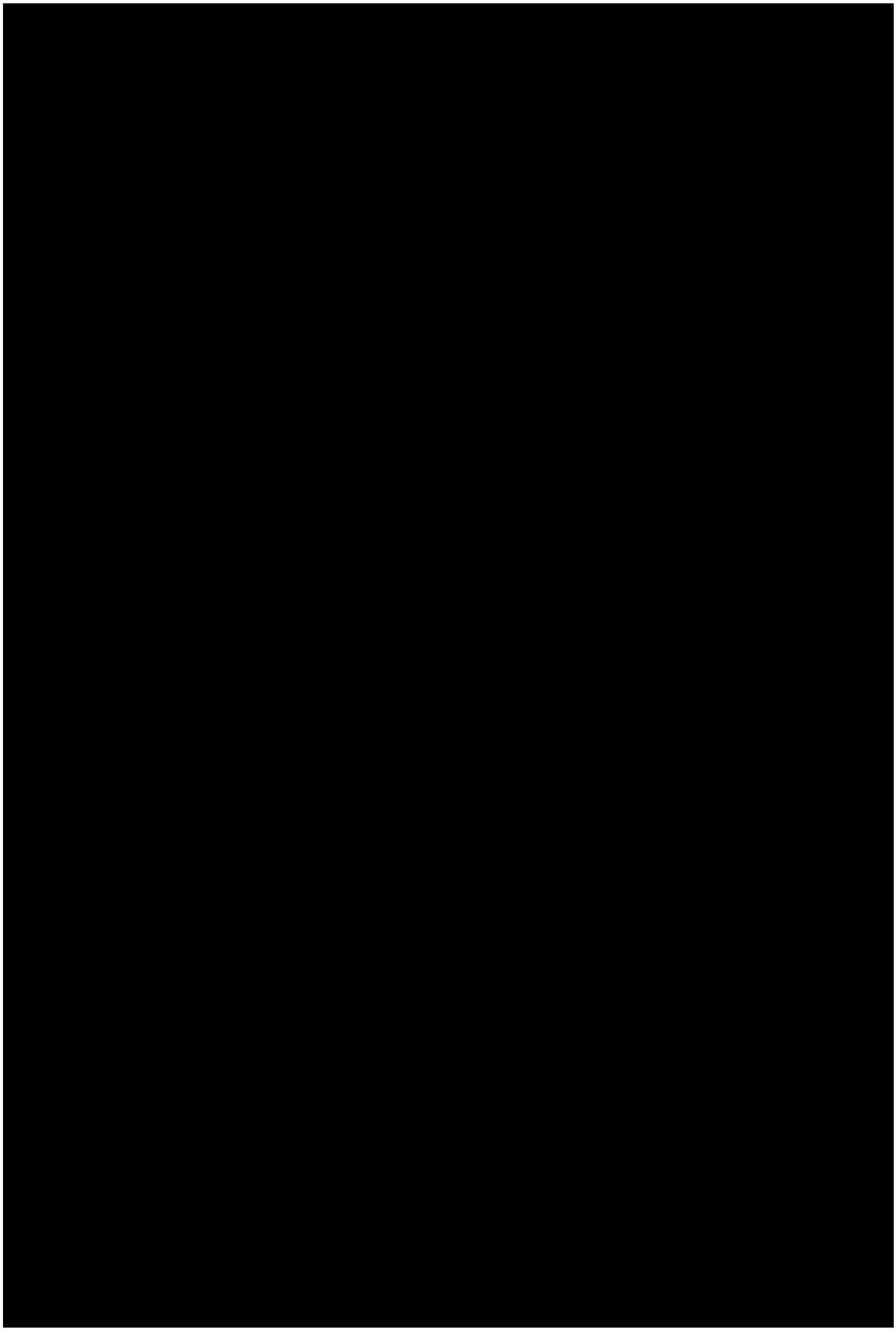

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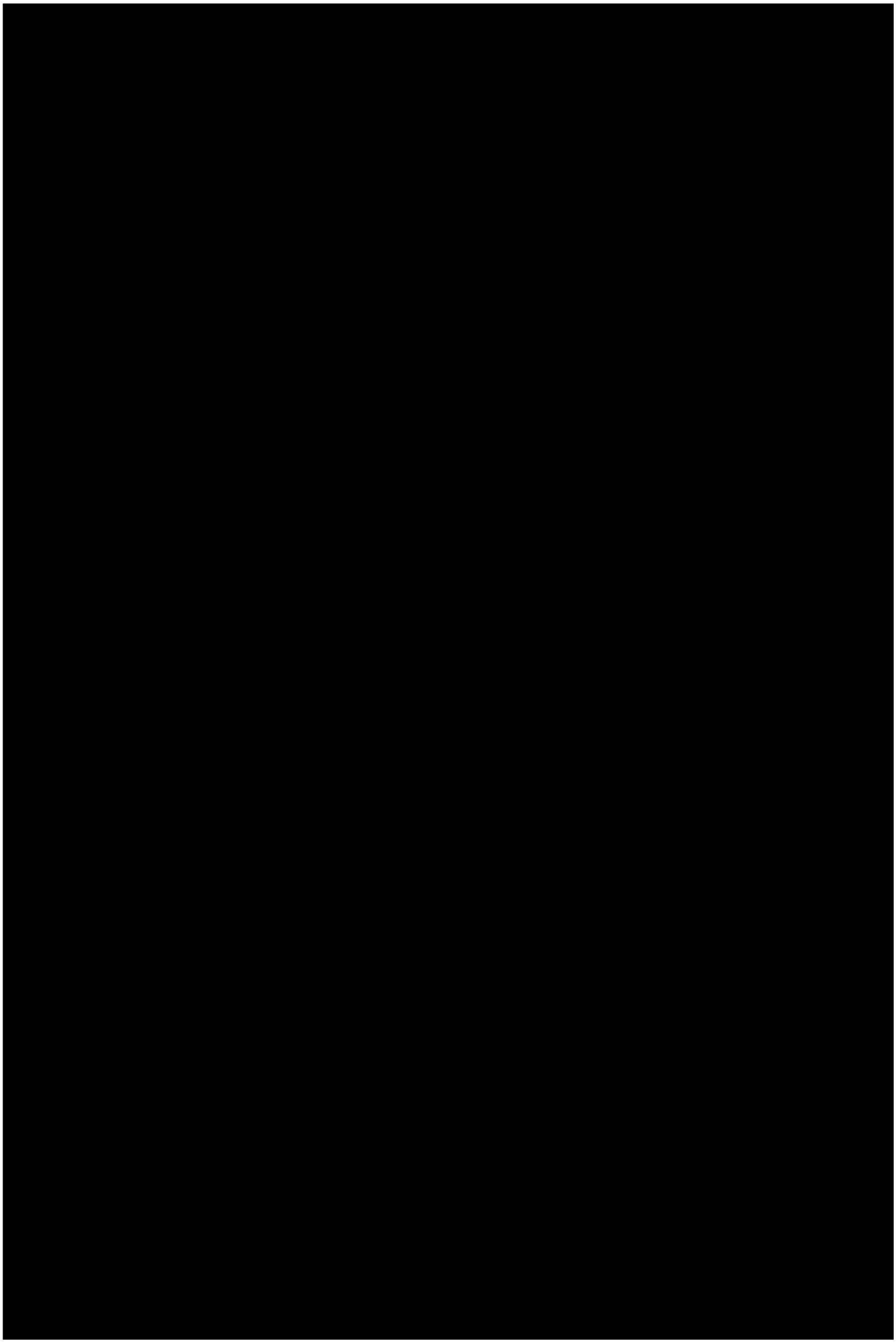

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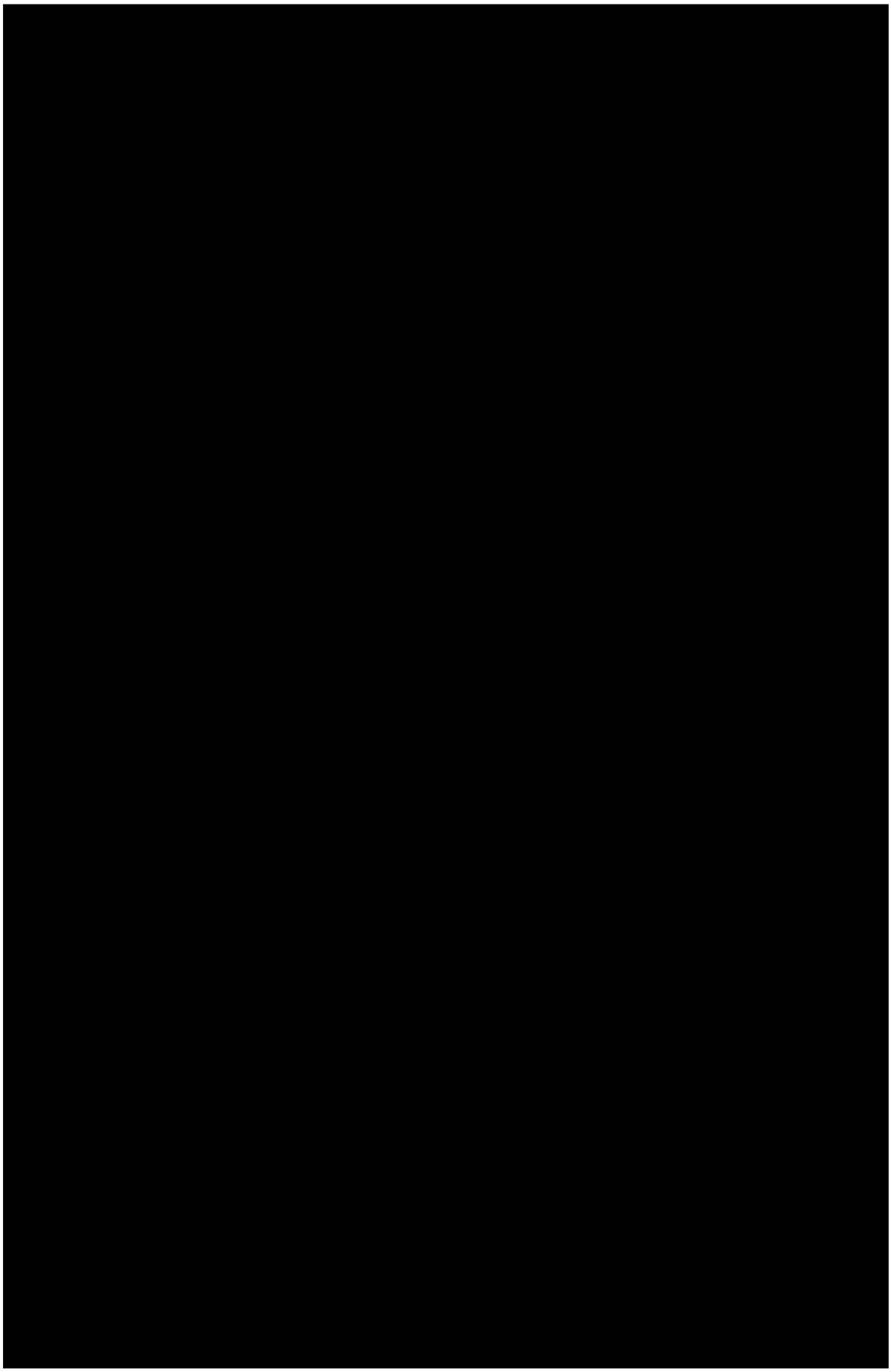

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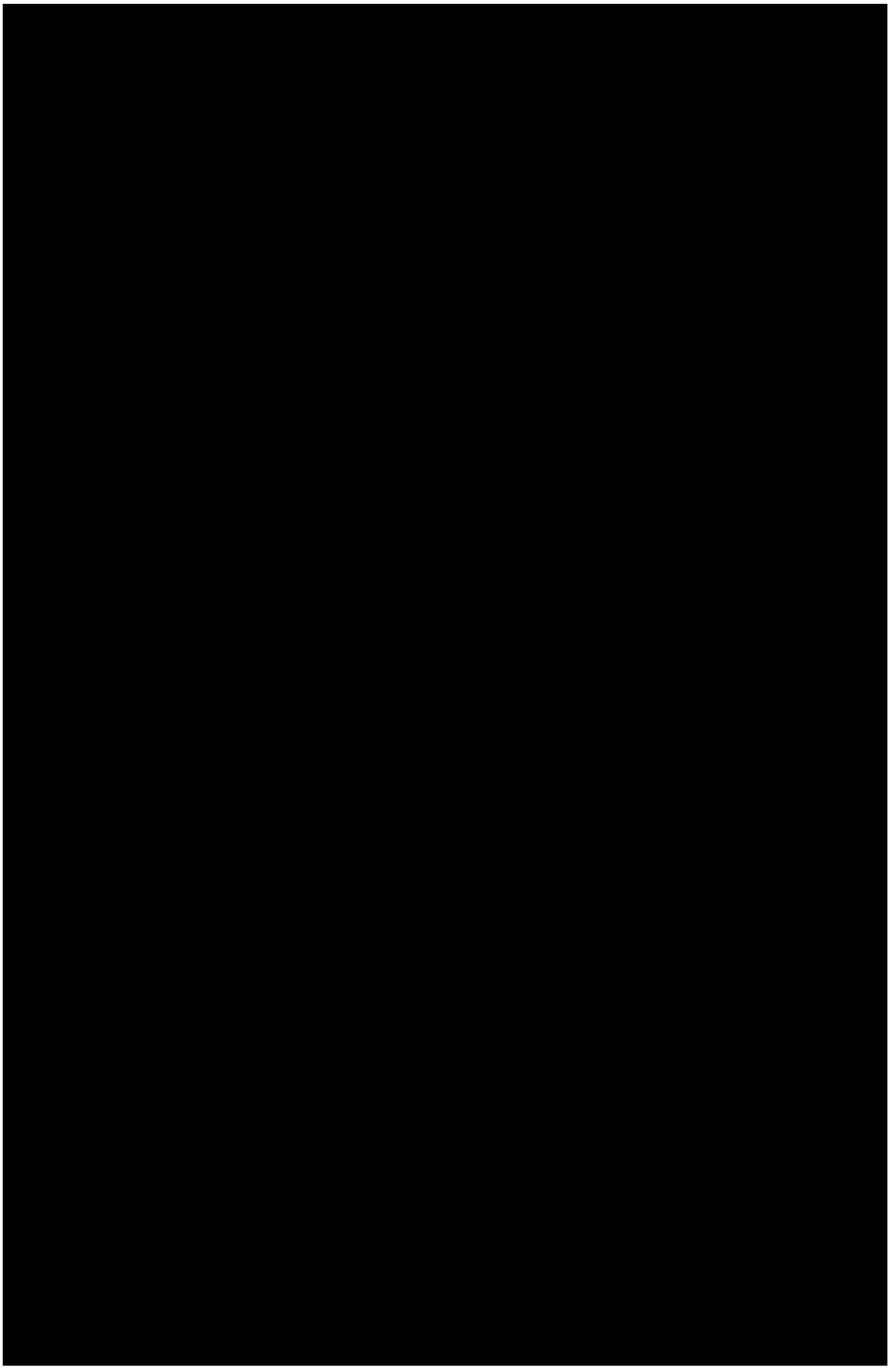

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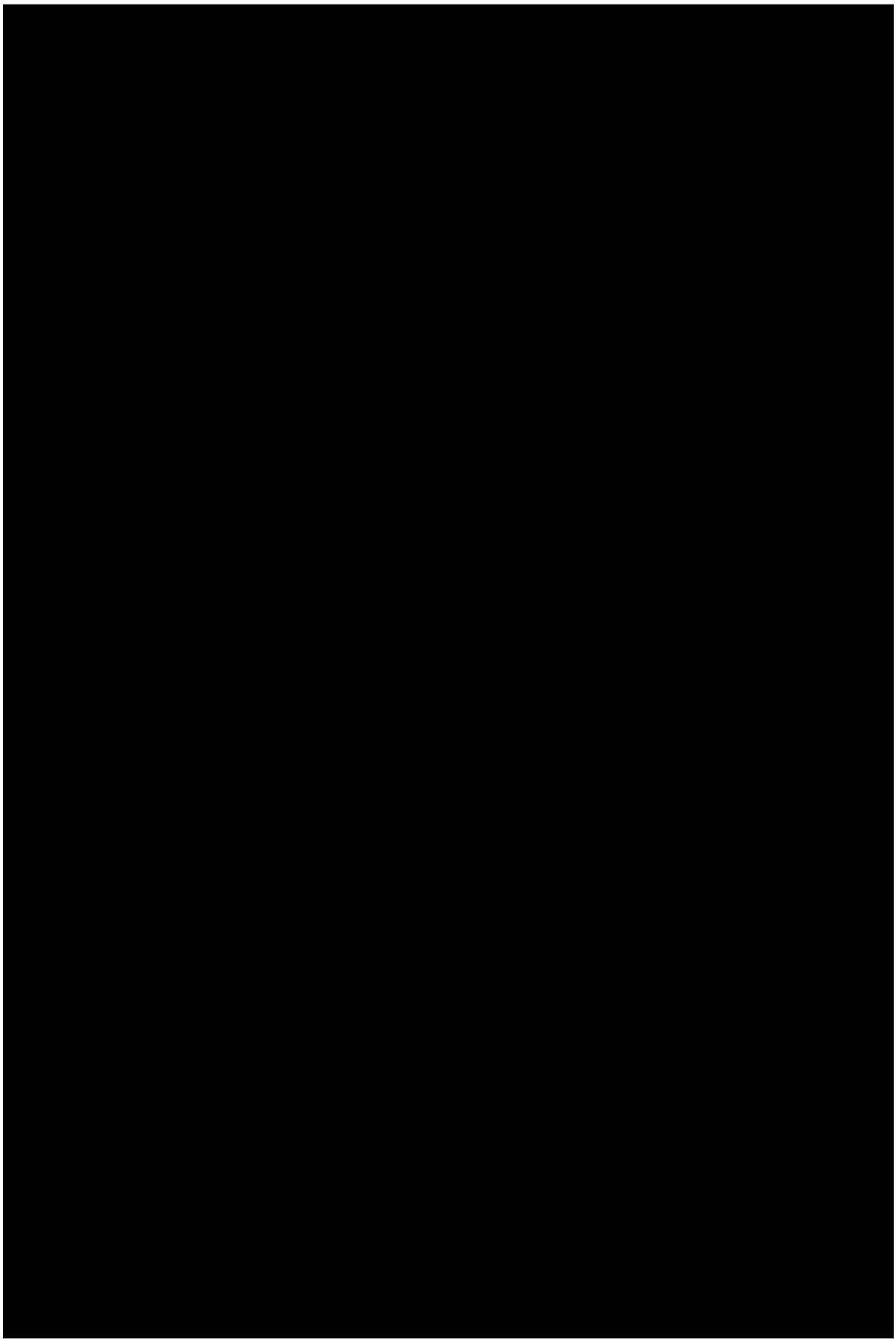

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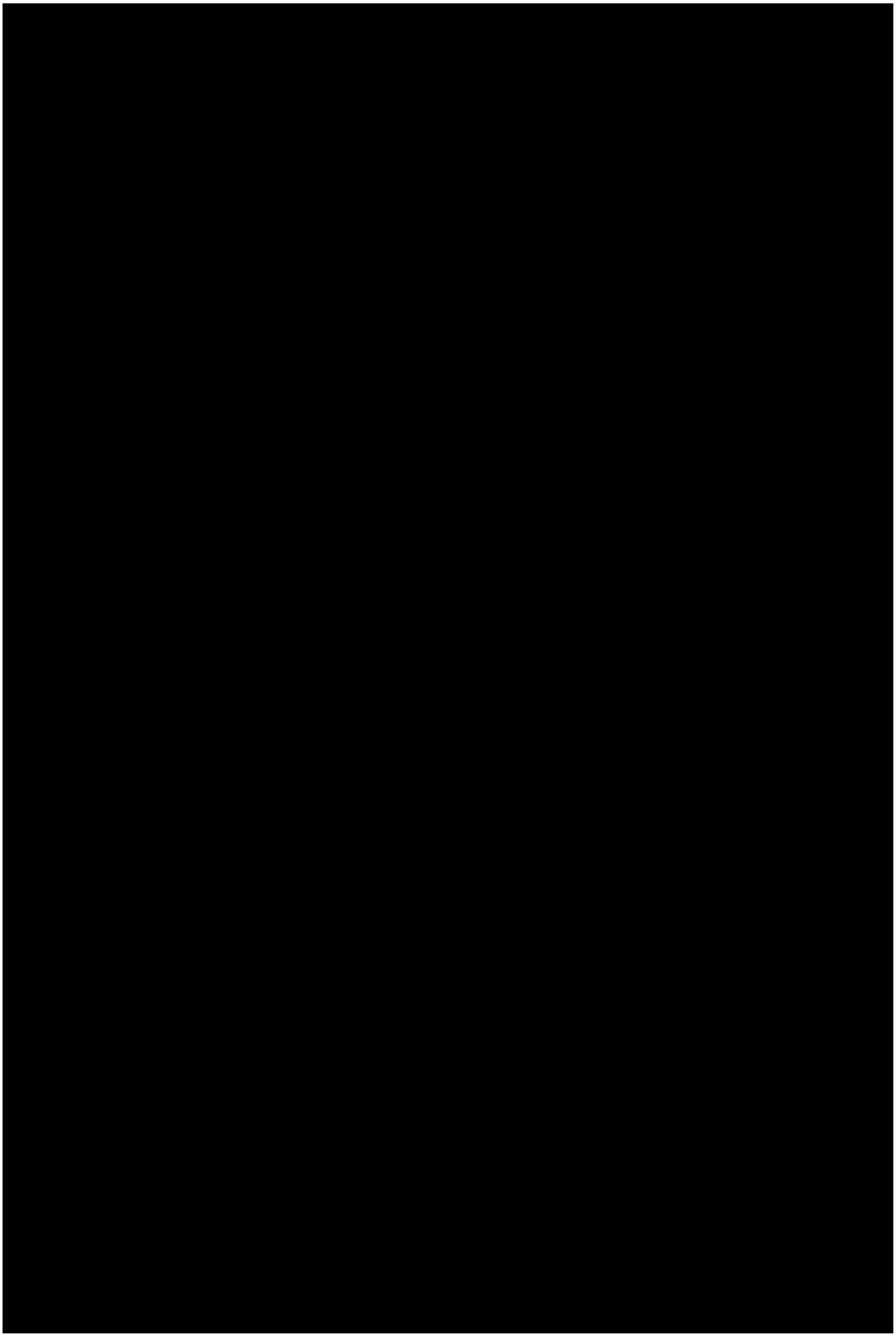

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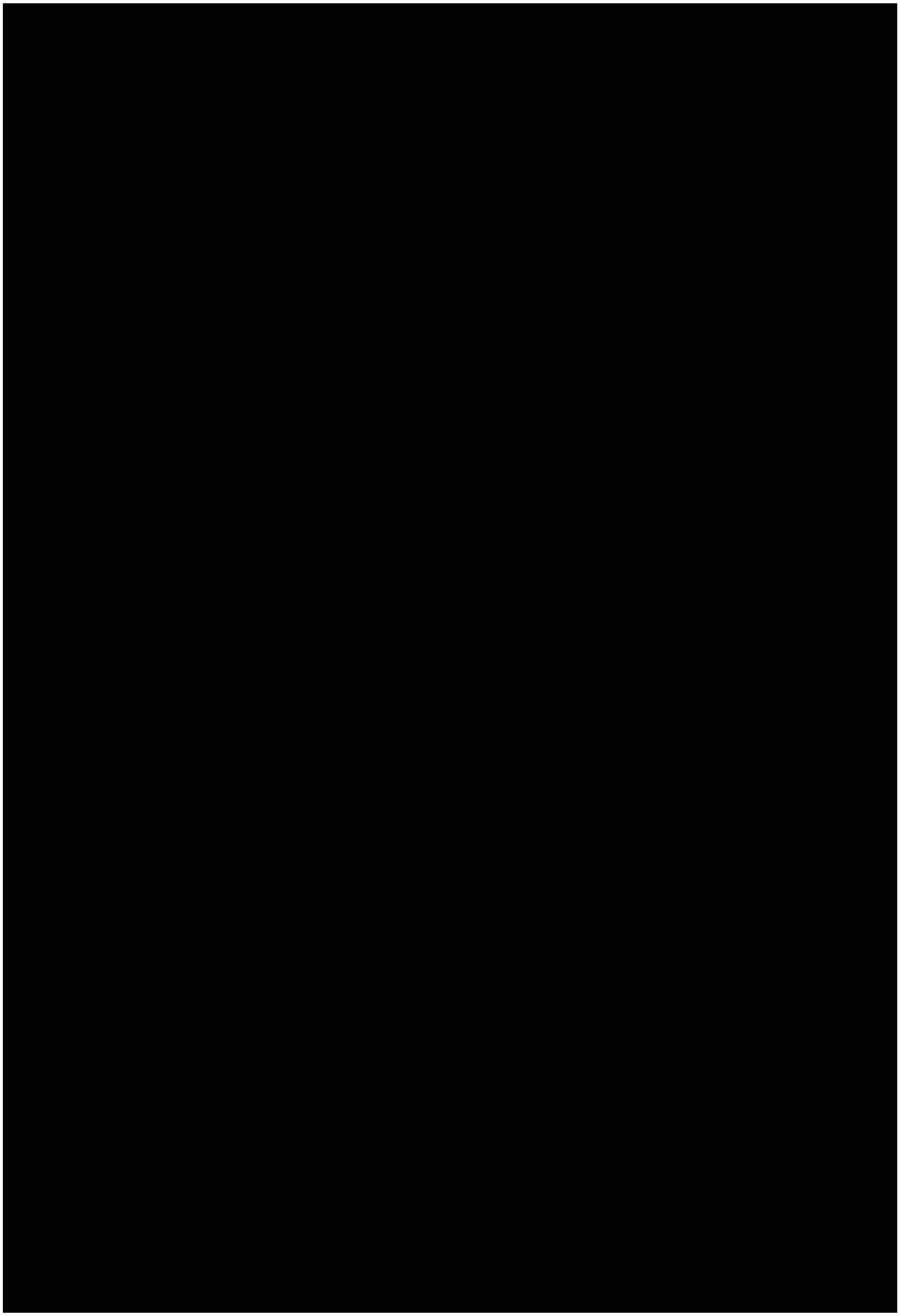

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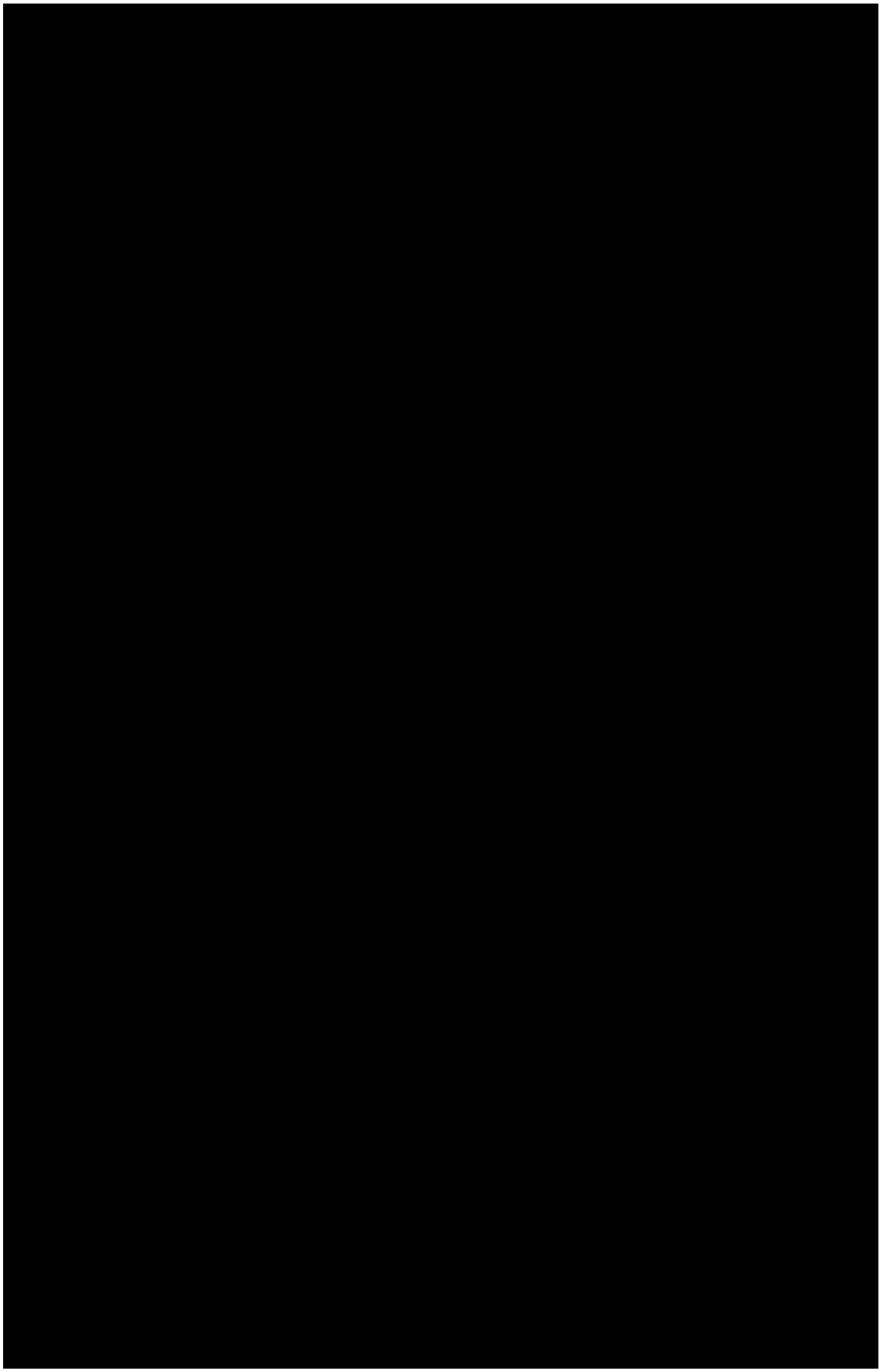

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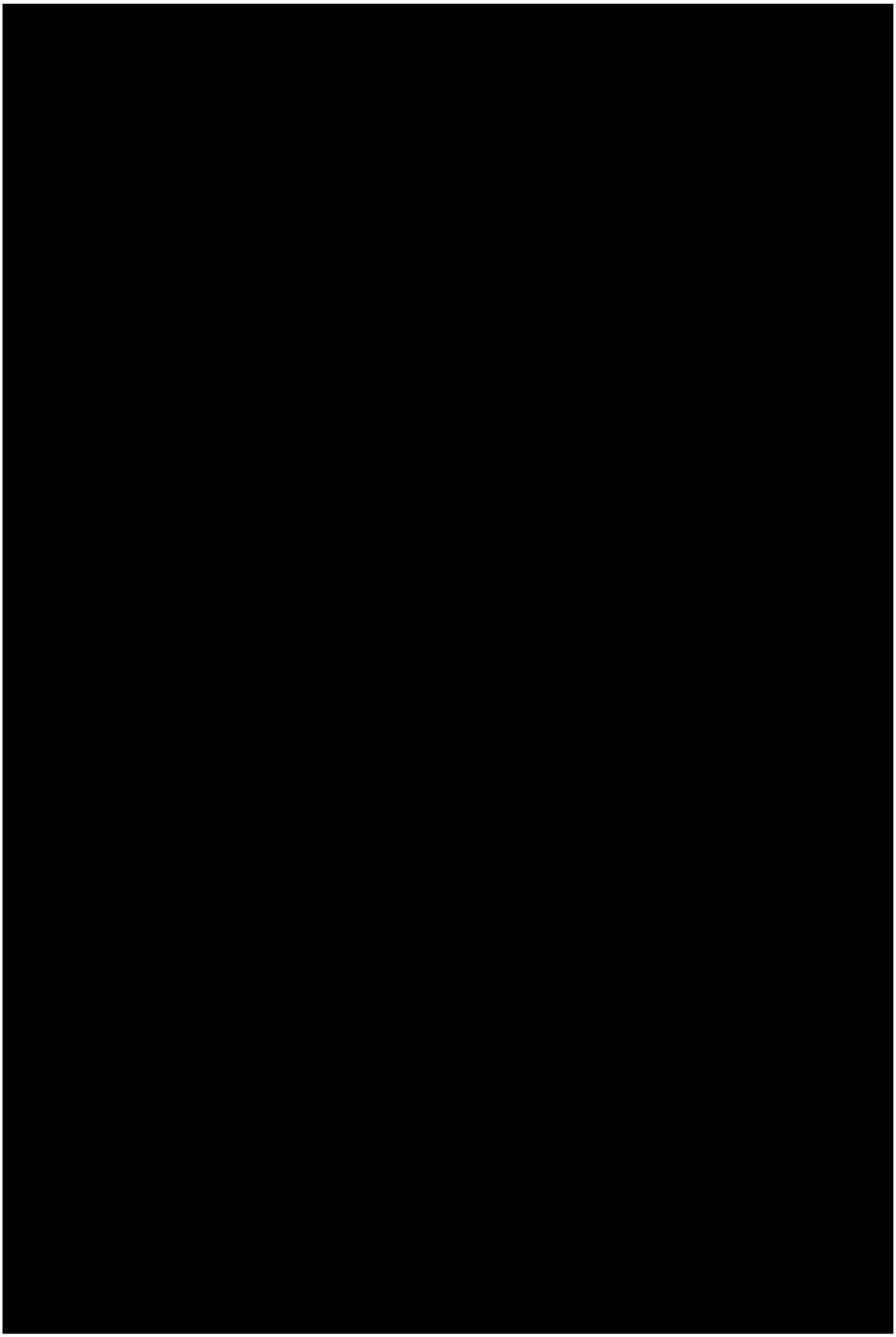

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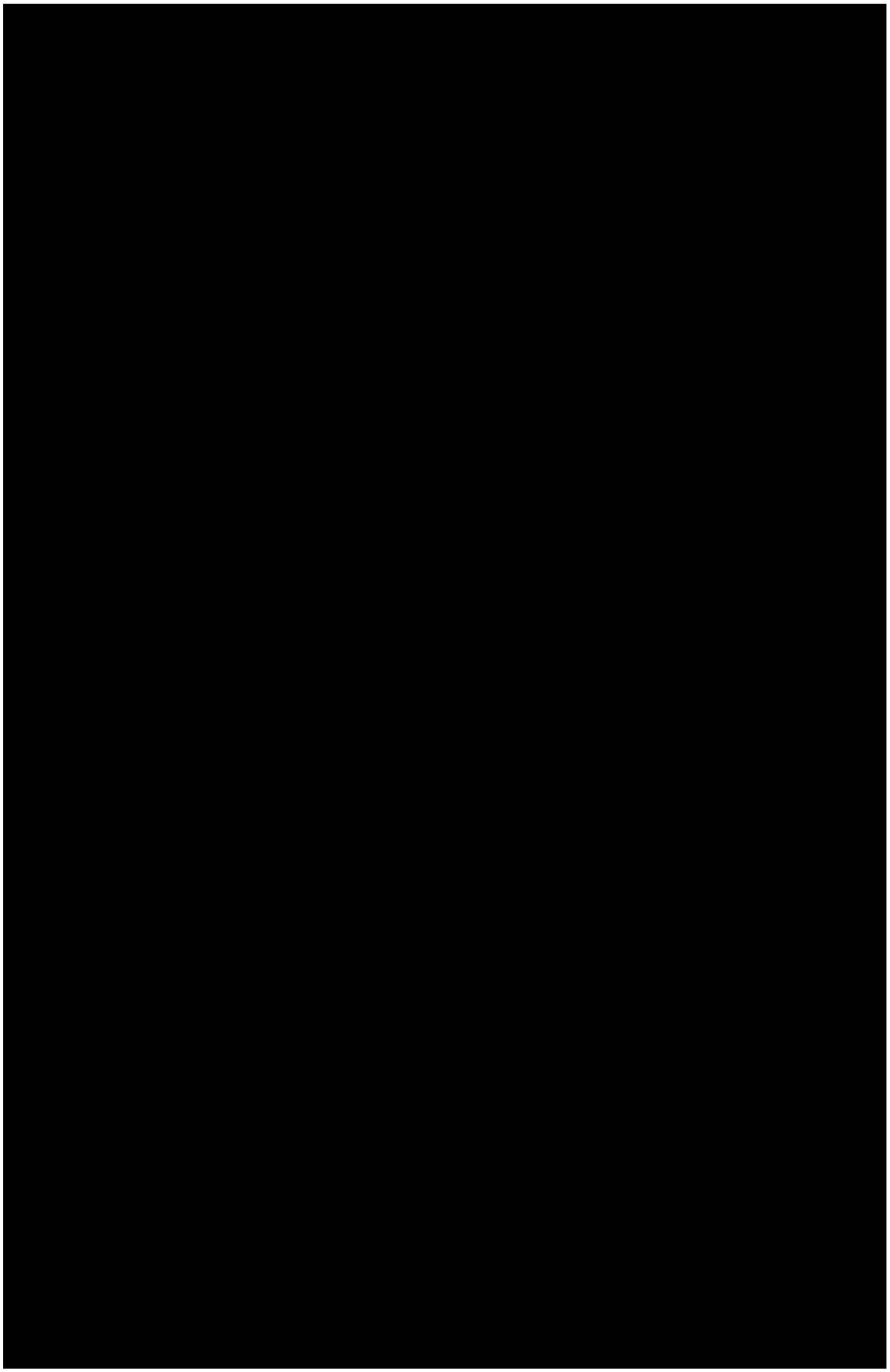

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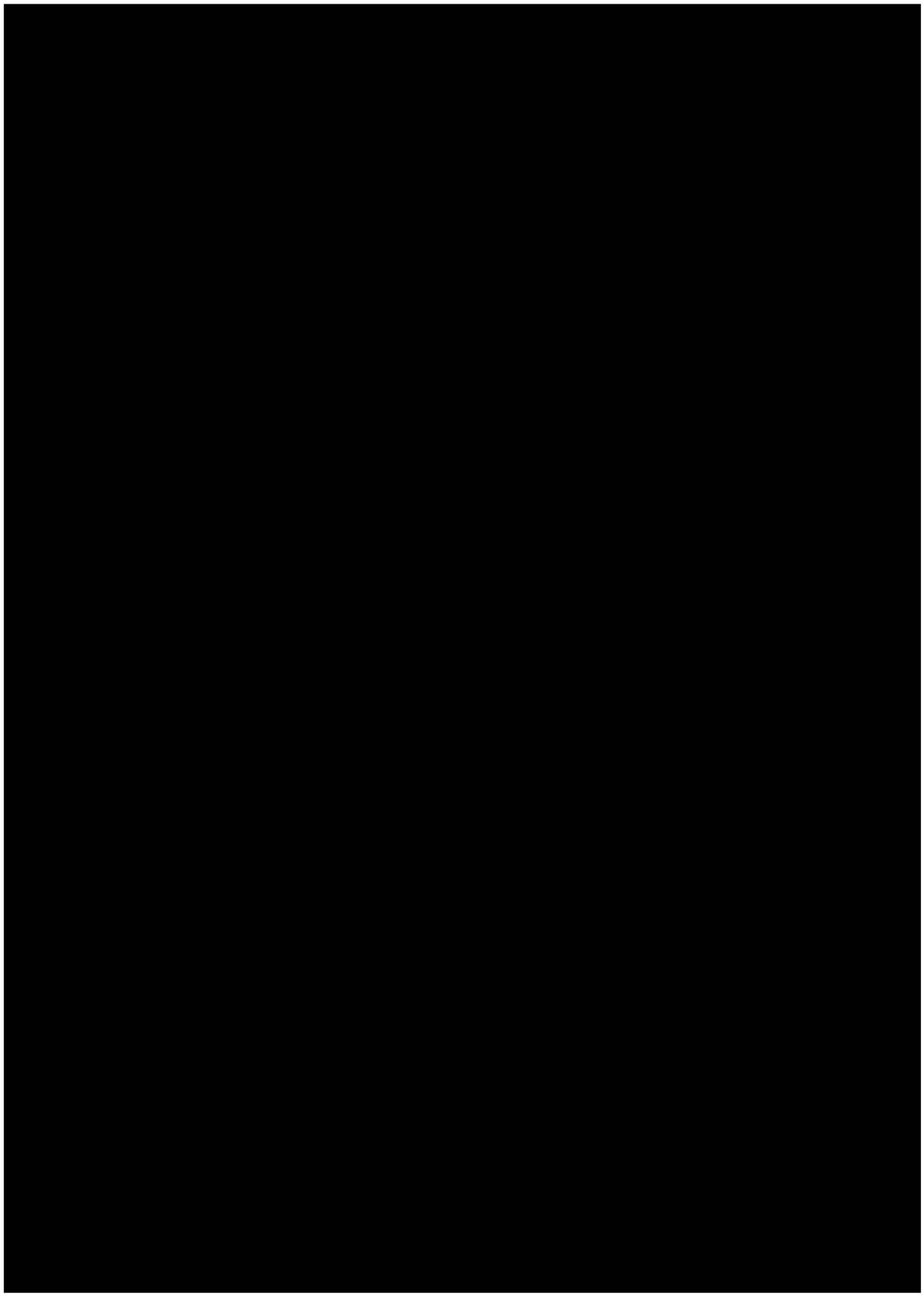

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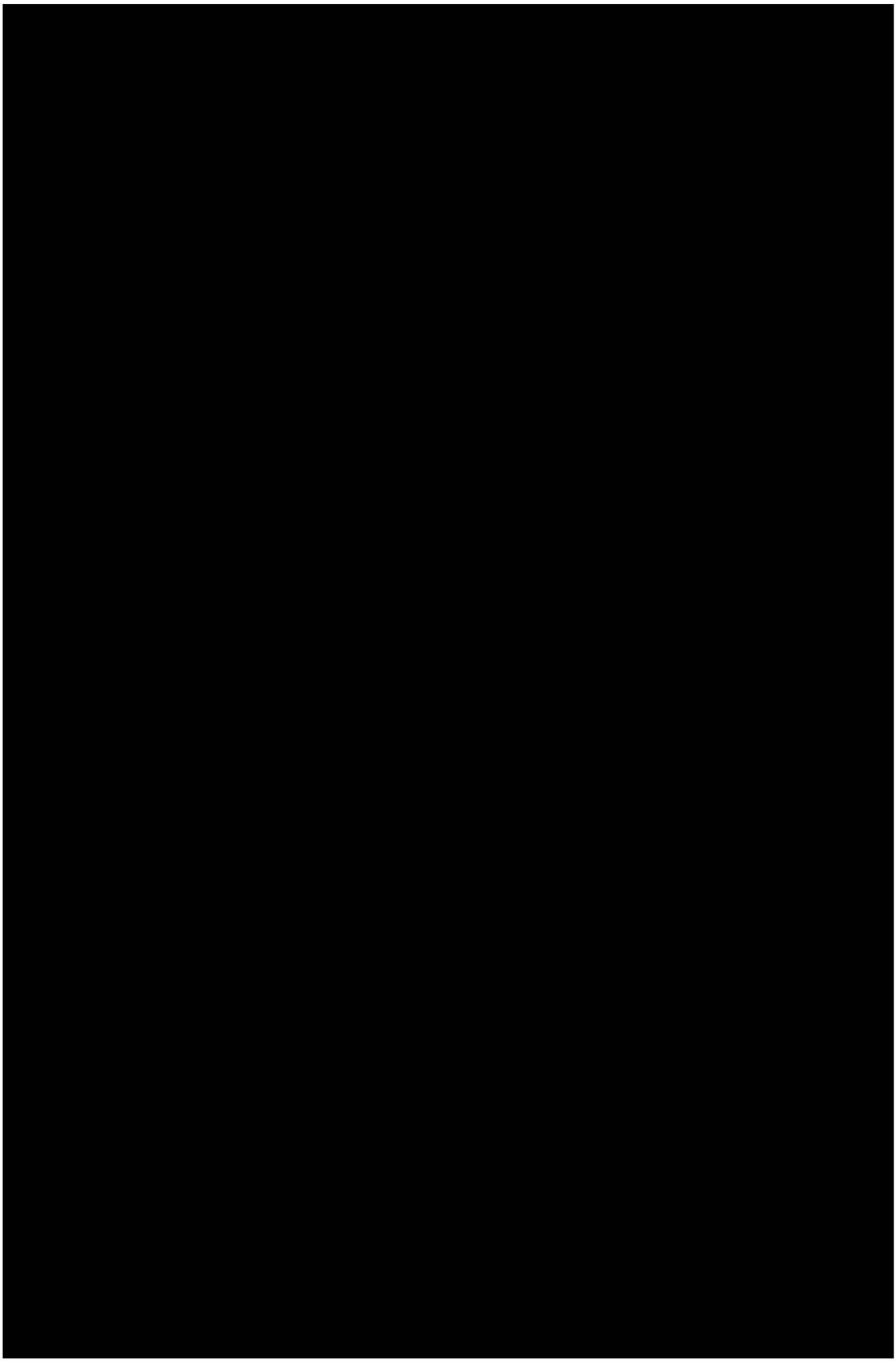

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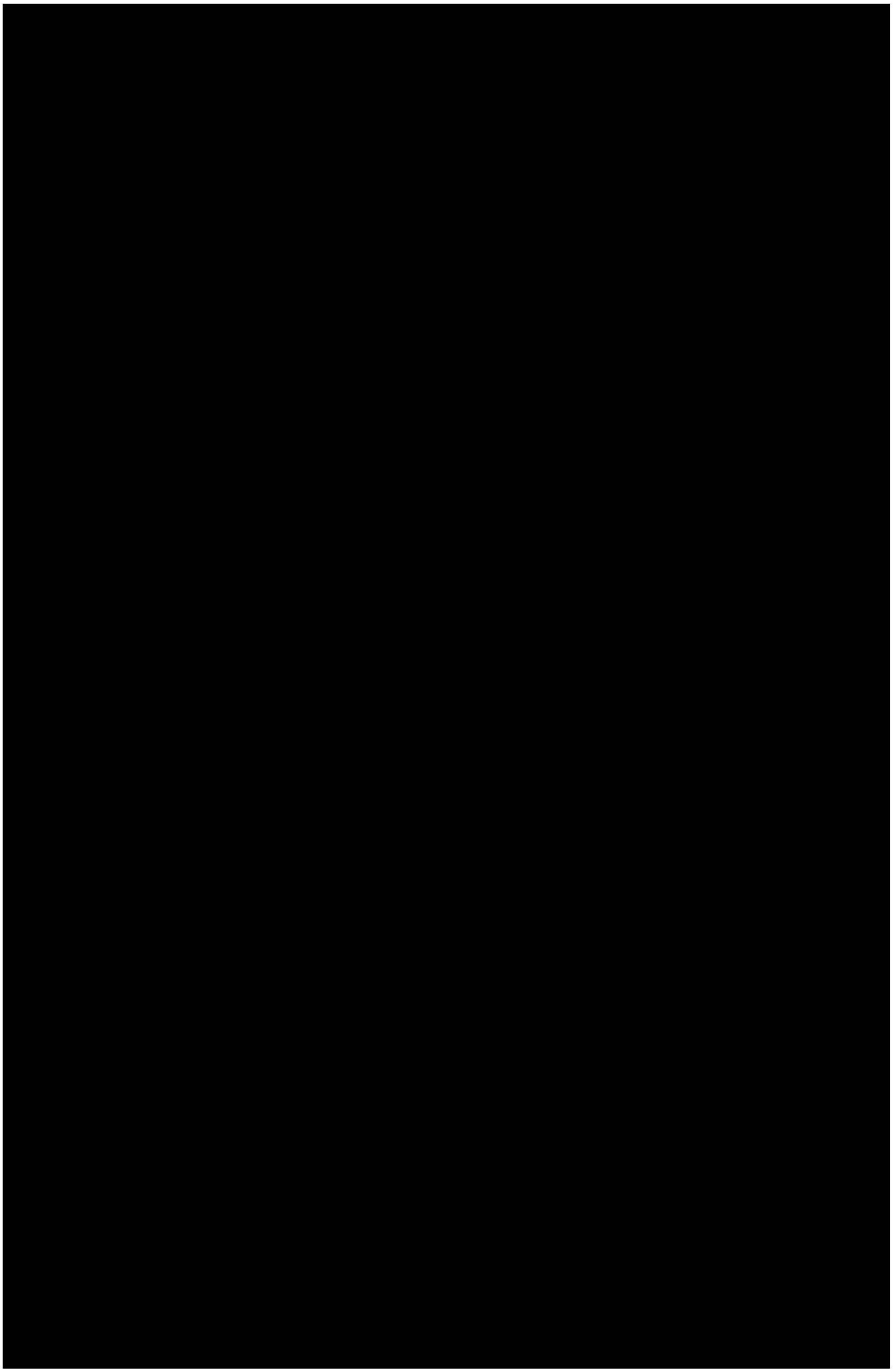

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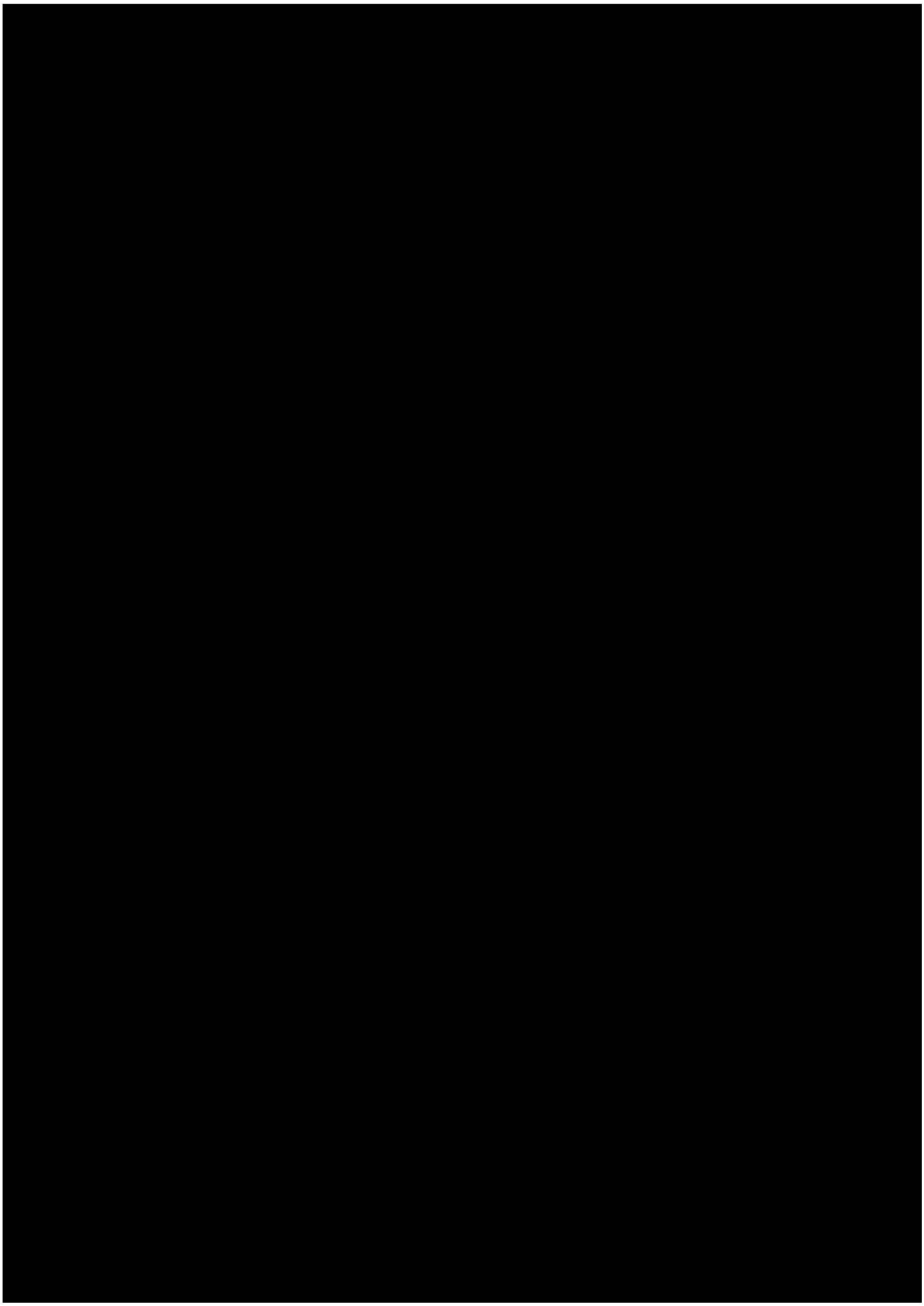

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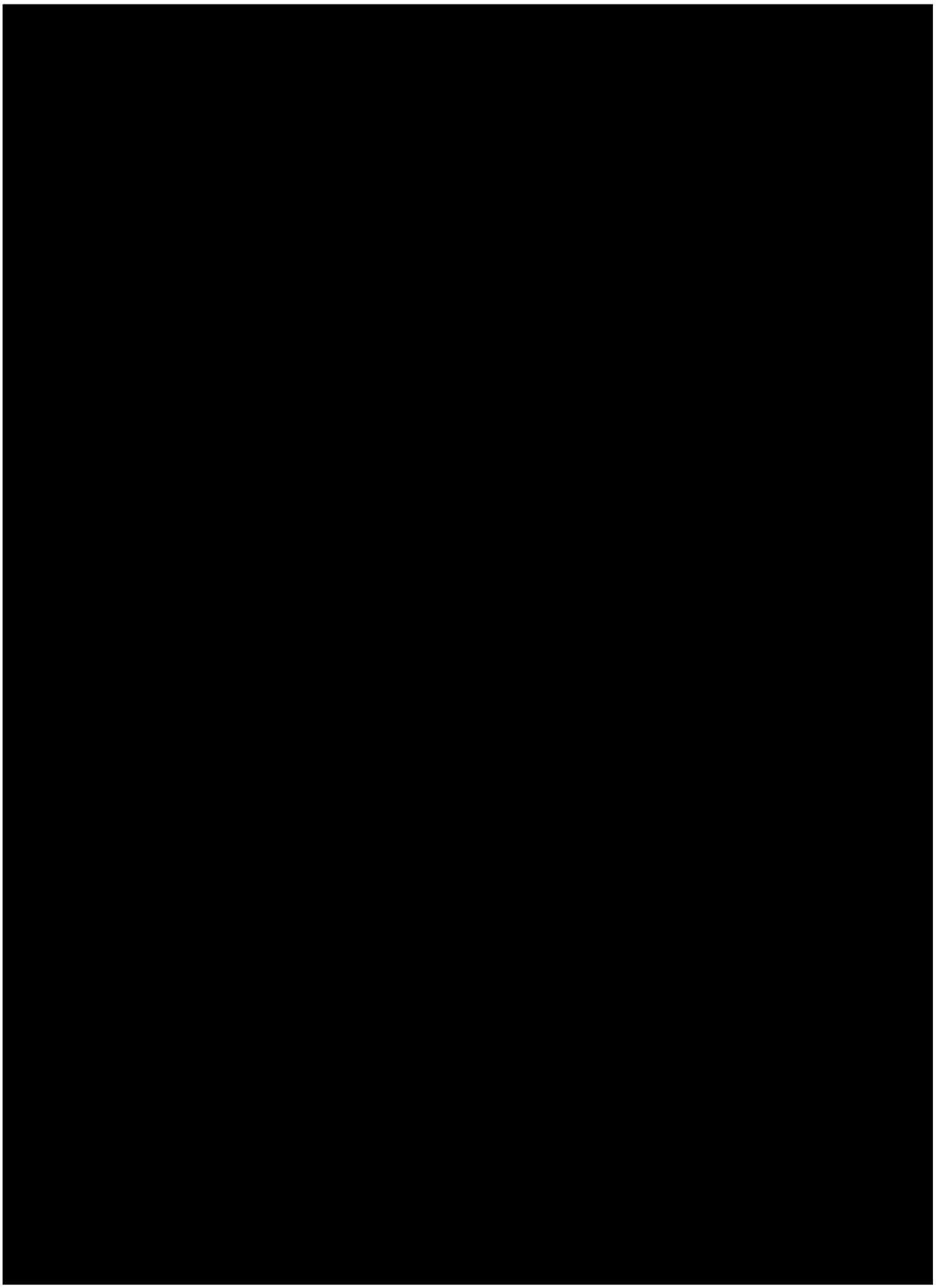

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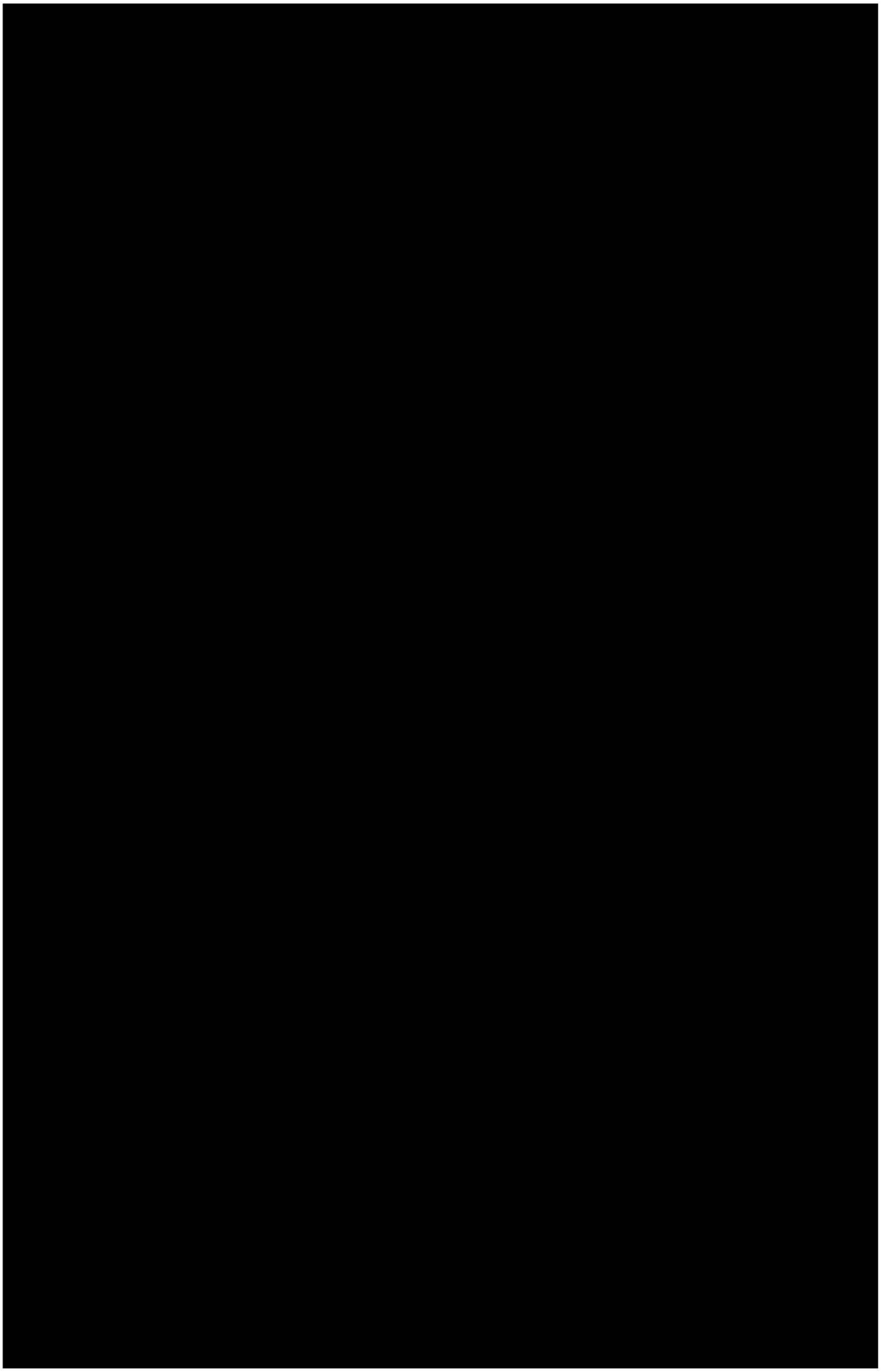

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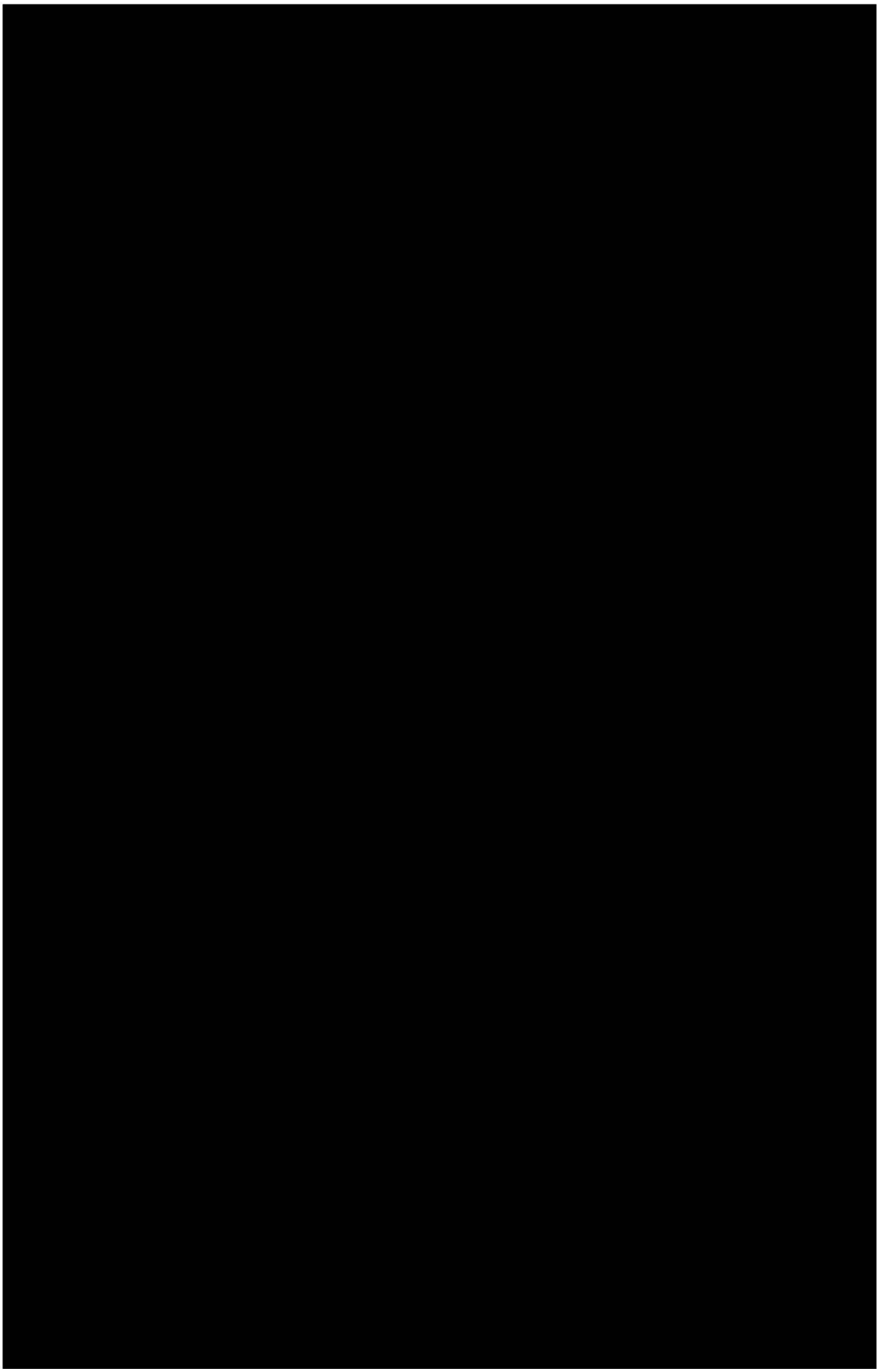

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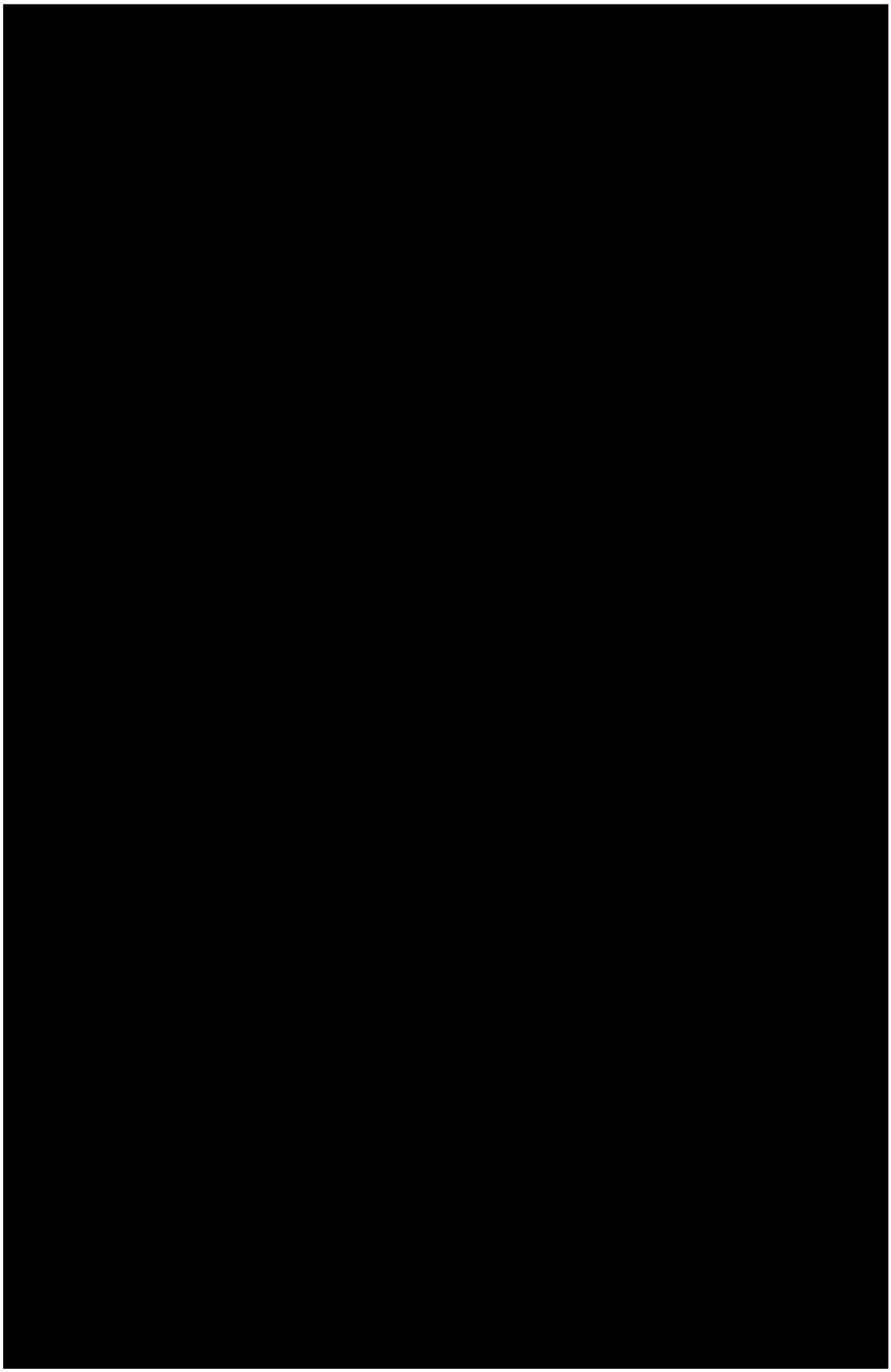

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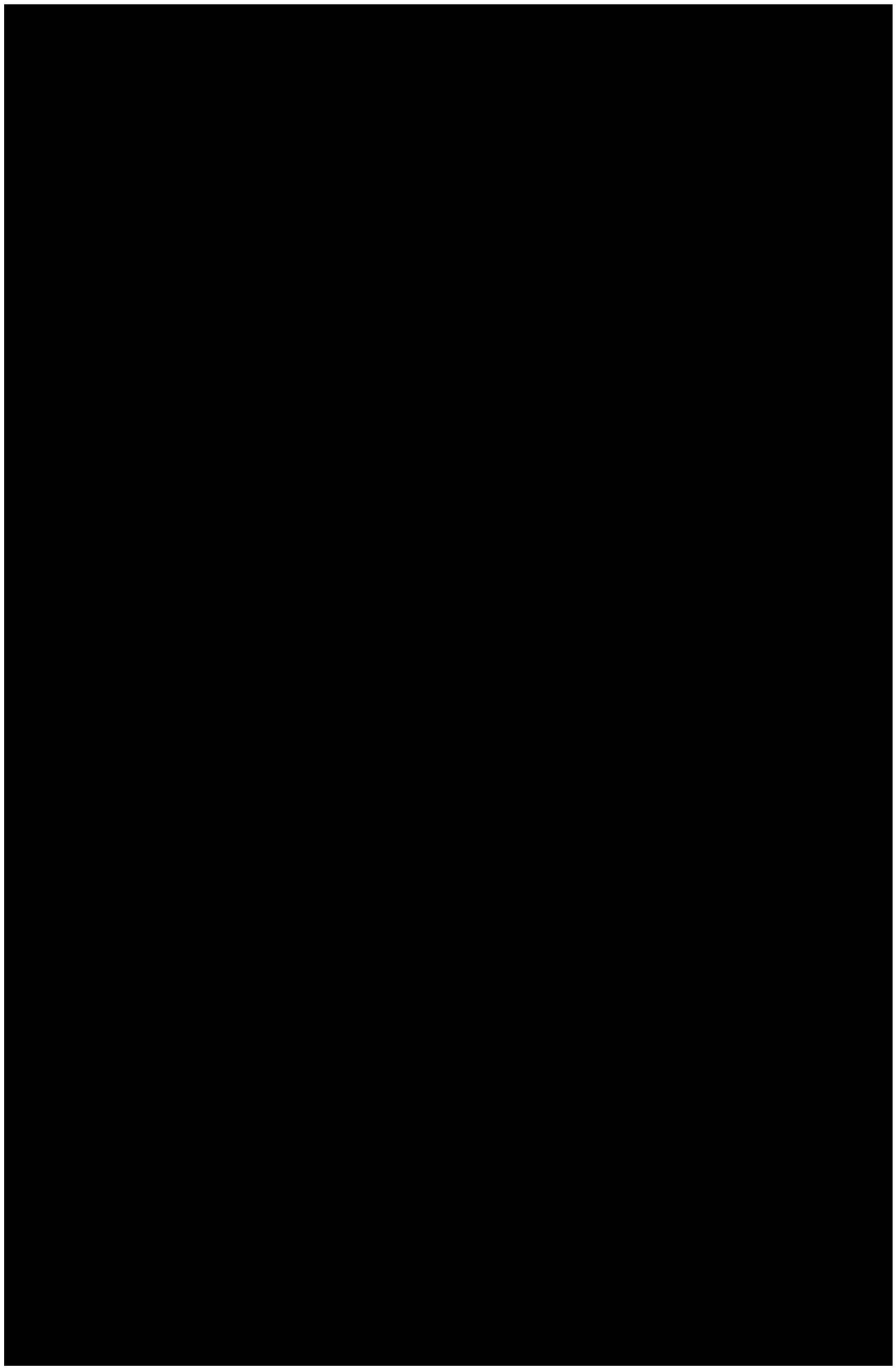

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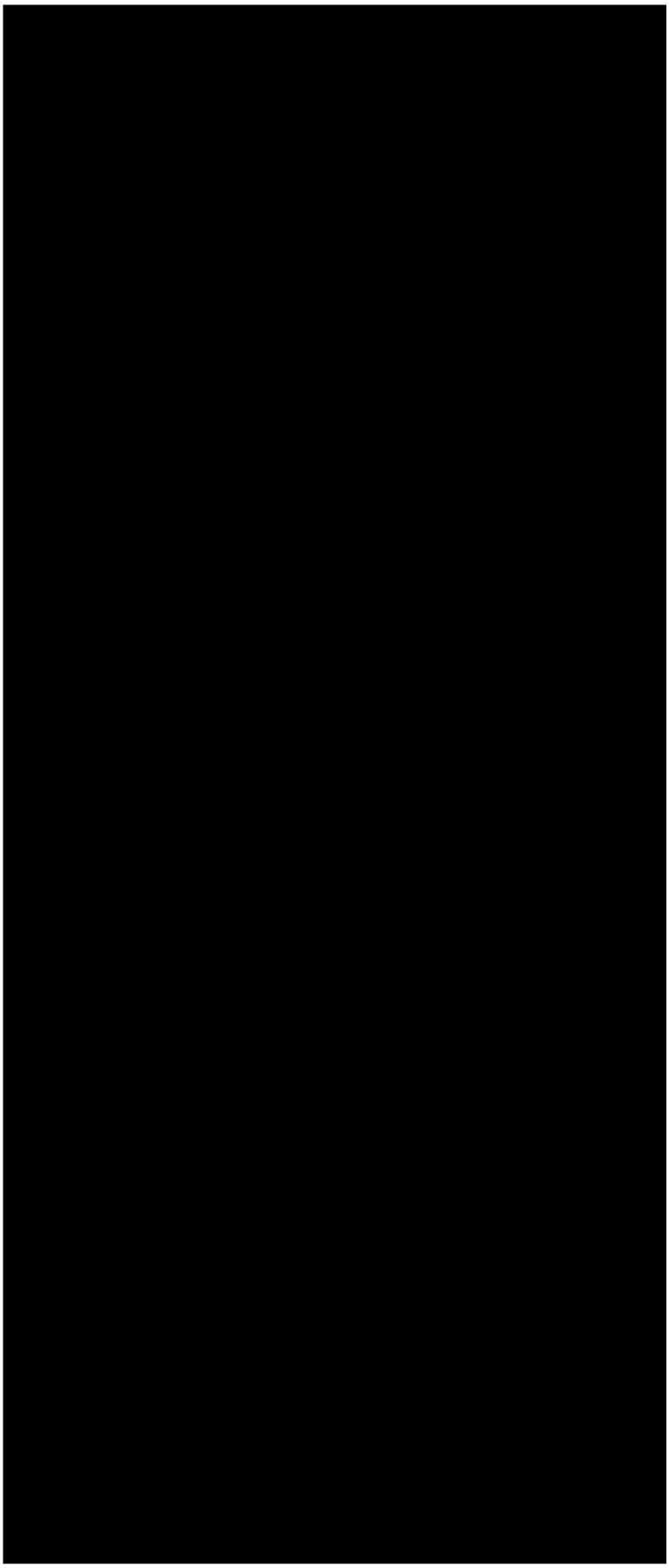

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-11-30 8:52 AM
To: hcminister.ministresc
Subject: TR: Families For Choice: Immediate Action Required
Attachments: FamiliesforChoicePetition-Nov29.pdf

De : [redacted]@familiesforchoice.ca>
Envoyé : 29 novembre 2021 18:02
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : Families For Choice: Immediate Action Required

Dear Minister Duclos,

Please find enclosed our letter in opposition to vaccine mandates for all children, signed by 12,401 people. Families For Choice was formed by families, vaccinated and unvaccinated against COVID-19, united in our mission to safeguard the rights of families to choose whether and when to vaccinate their kids against COVID-19.

Vaccine mandates cause harm to children. They exclude and segregate children. They prevent children from doing the things they love and need to do. This is not how our society should treat children, ever.

We urge you not to implement any vaccine mandate for children and to repeal any existing vaccine mandate you may already have implemented.

Please visit our website familiesforchoice.ca for more information on our group and the harm vaccine mandates are causing to children.

Sincerely,

[redacted]

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Bourke, Phil (HC/SC)

From: hcminister.ministresc
Sent: 2022-02-07 4:03 PM
To: [redacted]@familiesforchoice.ca
Subject: In response to your correspondence / 21-015062 - 719
Attachments: ECD - P & T Ministers of Health (e).pdf

Dear [redacted]

This is further to your correspondence of November 29, 2021, addressed to the Honourable Jean-Yves Duclos, Minister of Health, concerning mandatory vaccination for children against the 2019 novel coronavirus (COVID-19). We regret the delay in responding.

Health care is a shared responsibility between the Government of Canada and the provinces and territories; while the federal government provides financial support to the provinces and territories for health care services, the responsibility for matters related to the administration and delivery of these services falls within provincial and territorial jurisdiction.

Therefore, you should contact your provincial or territorial minister of Health. A list is attached for your information.

Thank you for writing.

Yours sincerely,

Health Canada
Executive Correspondence Division

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Ghaly, Maggy (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-12-02 2:59 PM
To: hcminister.ministresc
Subject: TR: Constituent Concerns In Peterborough-Kawartha

De : Paul-Girdwood, Cyndie (Ferreri, Michelle - MP) <cyndie.paul-girdwood.484@parl.gc.ca>
Envoyé : 2 décembre 2021 14:44
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Cc : [redacted]@icloud.com
Objet : Constituent Concerns In Peterborough-Kawartha

Dear Honourable Minister Duclos,

I am writing today on behalf of one of our constituents, [redacted]

[redacted] reached out to our office this morning to express his concerns regarding the vaccination protocol for Covid-19. While he is willing to have a vaccination, he is genuinely afraid of having the shot because of consequences suffered by people near to him. [redacted] would like to know what assurances the Ministry of Health can offer to him regarding legal responsibility should he suffer a serious consequence as a result of vaccination.

Thank you for your kind attention to this inquiry.

Best wishes,

Cyndie Paul-Girdwood
Office Manager
Michelle Ferreri
Member of Parliament
Peterborough-Kawartha
p: 705-750-8614
e: cyndie.paul-girdwood.484@parl.gc.ca

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Assistant 1 <Jean-Yves.Duclos.A1@parl.gc.ca>
Sent: 2021-12-07 2:00 PM
To: hcminister.ministresc
Subject: TR: [redacted] - Constituent of Calgary Centre
Attachments: 2021-12-03 Ministers Duclos & Lebouthillier - [redacted].pdf; Canada VISP-[redacted].pdf

Importance: High

De : Pap, Shaney (McLean, Greg - MP) <Shaney.pap.704@parl.gc.ca>
Envoyé : 7 décembre 2021 10:39
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>; Lebouthillier, Diane - Députée <Diane.Lebouthillier@parl.gc.ca>
Cc : Lebouthillier, Diane - Assistant 1 <Diane.Lebouthillier.A1@parl.gc.ca>; Duclos, Jean-Yves - Assistant 1 <Jean-Yves.Duclos.A1@parl.gc.ca>; Pap, Shaney (McLean, Greg - MP) <Shaney.pap.704@parl.gc.ca>
Objet : [redacted] - Constituent of Calgary Centre
Importance : Haute

FROM THE DESK OF GREG MCLEAN, M.P. CALGARY CENTRE

Dear Ministers,

Please see attached letter regarding our constituent [redacted]
[redacted] can be reached at
[redacted]
Calgary, AB T[redacted]
[redacted]

We are also enclosing her Canada Vaccine Injury Assessment form.

Regards,

House of Commons
Chambre des communes
Canada

Shaney Pap

Constituency & Casework Manager | Gestionnaire de circonscription & de traitement de dossiers
Office of Greg McLean, M.P. | Cabinet de Greg McLean, député
Calgary Centre | ¢algary-Centre

#445, 1414 – 8 Street SW Calgary, AB T2R 1J6
+1 403-244-1880
shaney.pap@parl.gc.ca | greg.mclean@parl.gc.ca

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Ottawa
Parliament Buildings
Ottawa, Ontario K1A 0A6

+1 613-995-1561

House of Commons
Chambre des communes
Canada

Greg McLean
Member of Parliament
Calgary Centre

Community Office
Suite 445
1414 – 8th Street SW
Calgary, Alberta T2P 1E4

+1 403-244-1880

December 3, 2021

The Honourable Jean-Yves Duclos, P.C., M.P.
Minister of Health
House of Commons
Ottawa, Ontario
Via email: jean-yves.duclos@parl.gc.ca

The Honourable Diane Lebouthillier, P.C., M.P.
Minister of National Revenue
House of Commons
Ottawa, Ontario
Via email: Diane.lebouthillier@parl.gc.ca

Dear Ministers Duclos and Lebouthillier,

Re: [redacted] – Constituent Calgary Center

I am writing to you on behalf of one of my Constituent who has run into a roadblock and my office has been working with her for the last 3 months.

Here is Ms. [redacted]'s situation:

[redacted] (The doctor signed off on that being the cause).

[redacted]

[redacted] No one seemed to know about the VISP Program; she found it in the Revenue Canada Website. As it turns out, it could take up to a year for VISP to approve her application.

The government knew there were these potential risks and it had time to put things into place. Ms. [redacted]

[redacted]

greg.mclean@parl.gc.ca | GregMcLeanMP.ca

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Ministers Duclos and Lebouthillier, we kindly request assistance in having her VISP application expedited so she may get on with life.

Should you have any questions, please do not hesitate to contact me directly via email at greg.mclean@parl.gc.ca or by phone at 403-244-1880.

Sincerely,

[redacted]

Greg McLean, MP
Calgary Centre

/sp

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Forms Overview

Canada Vaccine Injury Support Program

Step 1: To submit a claim to the Vaccine Injury Support Program, please complete the forms below.

- ☑ Form 1 - Intake Form*
- ☑ Form 2 – Medical Assessment Form
- ☑ Proof of Vaccination

* If submitting on behalf of someone else, Form 1 requires "APPENDIX A – Authorized Representative Form" to be completed.

Step 2: Once **Step 1** forms have been submitted, are complete and meet eligibility criteria, additional information will be required as eligible claims will be individually assessed by medical experts.

- The process will include a review of all required and relevant historical medical documentation, as well as current medical evidence, to determine if there is a probable link between the injury(ies) and the vaccine.
- If there is a probable link, the medical experts will also assess the severity and probable duration of the injury(ies). This information will be used to determine the type(s) and level(s) of financial support awarded to the individual or their survivor(s).

The personal information requested in these forms are being collected by the Vaccine Injury Support Program (VISP) administrator in accordance with and protected by the provisions of the Privacy Policy available at vaccineinjurysupport.ca. The VISP administrator is collecting, processing, storing, and sharing personal information to process claims. The collection of the personal information is necessary to support the claim submitted.

Please complete and submit the forms listed above ONLY if you meet the following eligibility criteria:

- Serious and permanent injury;
- Vaccinated in Canada**;
- Received a Health Canada authorized vaccine; and
- Vaccination date is on or after December 8, 2020.

** For vaccination administered in Quebec, please refer to Quebec Vaccine Injury Compensation Program (https://www.quebec.ca/en/health/advice-and-prevention/vaccination/vaccine-injury-compensation-program).

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St. Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc.

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Vaccine Injury Support Program

Form 1 – Intake Form

PROTECTED B (when completed)

Intake Form

Canada Vaccine Injury Support Program

(to be completed by the injured party or the injured party's authorized representative)

Please complete all fields of the following form for vaccinations administered in Canada on or after December 8, 2020. If you are representing an injured party, someone who is deceased, a minor or someone that cannot represent themselves, please complete Appendix A – Authorized Representative Form.

For vaccinations administered in Québec, please refer to Québec's Vaccine Injury Compensation Program. (https://www.quebec.ca/en/health/advice-and-prevention/vaccination/vaccine-injury-compensation-program).

1 IDENTIFICATION AND CONTACT INFORMATION OF THE INDIVIDUAL SUBMITTING THE CLAIM

Note: please select all options that apply.

Identity of the individual submitting the claim	☒ Injured Party	The individual who received a Health Canada authorized vaccine, administered in Canada, on or after December 8, 2020.
	☐ Beneficiary	The beneficiary is the individual who is determined to be eligible and would ultimately receive financial support. The beneficiary can be the injured party, or in the cases where the injured party is deceased; the beneficiary may be a family member of the injured party (ex. spouse, children, dependent, etc.).
	☐ Authorized Representative	The authorized representative is an individual authorized to complete the claim on behalf of either the beneficiary or injured party. (if applicable, please complete Appendix A).

Note: please complete the following information if you selected ONLY beneficiary.

Surname (last name)	Given name(s)
[redacted]	

Relationship to injured party

(Spouse, Father, Mother, Child, Legal Guardian, etc.)

Preferred language

☐ English
☐ French

Mailing address

Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code

Email address	Primary telephone	Secondary telephone (if applicable)

2 IDENTIFICATION AND CONTACT INFORMATION OF THE INJURED PARTY

Note: all information is required to be completed, unless otherwise specified.

[redacted]

Calgary | AB | Canada | T[redacted]

City | Prov/Terr. | Country | Postal Code

Mailing address (if different from current residential address) ☒ Check if the same as above

Number/Street (include apt # if applicable)	City	Prov/Terr.	Country	Postal Code

Email address	Primary telephone	Secondary telephone (if applicable)
[redacted]@Gmail.com	[redacted]	

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4 IDENTIFICATION OF THE INJURED PARTY'S USUAL ATTENDING PHYSICIAN OR FAMILY PHYSICIAN

Note: if the Injured Party does not have a usual attending physician or family physician skip this section.

Name of physician: [redacted]

Hospital / clinic name: [redacted]

Location

[redacted] Calgary Ab Canada T[redacted]

Number/Street (include apt # if applicable) | City | Prov/Terr. | Country | Postal Code

Contact Information

Primary telephone [redacted]

Secondary telephone (if applicable)

5 COMMENTS

Note: if no additional comments, skip this section.

Other Comments:

Warning: Any false or misleading statement contained with respect to the submitted claim or any supporting document, including the concealment of any material fact, may result in the refusal to process the claim.

By signing this form, I declare that all the information provided above is true and completed to the best of my knowledge.

[redacted]

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St., Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca

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Place of birth

Calgary (City) | Alberta (Prov./Terr. (if applicable)) | Canada (Country)

[redacted]

Identification of the hospital(s) or clinic(s) providing care after the vaccination:

Description of the symptoms of adverse effects and/or injuries following vaccination

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Form 2 – Medical Assessment Form

PROTECTED B (when completed)

Vaccine Injury Support Program

Medical Assessment Form
Canada Vaccine Injury Support Program

(to be completed by the licensed physician assessing the Injured Party)

This form must be completed by a licensed physician assessing the Injured Party. Please complete all fields of the following form.

1 PHYSICIAN INFORMATION

Note: All information is required to be completed, unless otherwise specified.

Physician's surname (last name)	Phy[redacted]
[redacted]	

Primary address (of clinic/hospital/practice)

[redacted] | Calgary | AB | Canada | T[redacted]

Number/Street (include apt # if applicable) | City | Prov/Terr. | Country | Postal Code

Mailing address (if different from above) ☐ Check if the same as above

[redacted]@ahs.ca | Ca | | | |

Number/Street (include unit # if applicable) | City | Prov./Terr. | Country | Postal Code

Email address	Primary telephone	Secondary telephone (if applicable)
[redacted]@ahs.ca	[redacted]	

Medical license number or licensed practice number

[redacted]

Preferred language

☒ English

☐ French

2 PATIENT (INJURED PARTY) INFORMATION

Note: All information is required to be completed, unless otherwise specified.

Patient's surname (last name)	Patient's given name(s)
[redacted]	[redacted]

Date of birth

1968-[redacted]

YYYY-MM-DD

3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY

Note: All information is required to be completed, unless otherwise specified.

[redacted]

Location where vaccination occurred

Province or Territory where vaccination occurred

Alberta.

Province or Territory

Name of the individual who administered the vaccine (if known)

[redacted]

(1st, 2nd, etc.) (if known)

Manufacturer name (if known)

[redacted]

(ex. Pfizer, GlaxoSmithKline, Sanofi Pasteur etc.)

Date symptoms first appeared

[redacted]

(YYYY-MM-DD)

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Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED B (when completed)

Patient status:

☐ Deceased ☐ Recovered
☐ Unknown ☑ Recovering
☐ Other

If deceased, was an autopsy done? (complete if yes, or write future date if an autopsy is planned)

(YYYY-MM-DD)

Description of adverse effects and/or injuries following vaccination (initial and persistent):

Instructions – Attach copies of ALL available documents (including imaging reports, Emergency Department and/or specialist consultations, injury assessment, discharge summary, clinical notes, laboratory reports and autopsy reports) and then complete

[redacted]

FIRST MEDICAL CONSULTATION

Note: all information is required to be completed, unless otherwise specified.

[redacted]

ADDITIONAL MEDICAL CONSULTATION(S)

Note: all information is required to be completed, unless otherwise specified.

Name of medical professional 2	Location	Primary telephone
	(private doctor office, hospital etc.)	
Name of medical professional 3	**Location**	**Primary telephone**
	(private doctor office, hospital etc.)	

Identification of the hospital(s) or clinic(s) providing care after the vaccination:

[redacted]

Description of the symptoms of adverse effects and/or injuries following vaccination:

[redacted]

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Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED B (when completed)

4 PATIENT MEDICAL HISTORY

Note: all information is required to be completed, unless otherwise specified.

Have you ever examined or treated this patient before the onset of the injury and/or disease potentially related to the vaccination? [redacted]

Is there any relevant medical history or a cumulative patient profile (CPP)? Check no, if not applicable.

Please complete the following table:

Criteria	Finding	Remarks (If yes, provide details)
History of similar events	[redacted]	
Adverse events following immunization (AEFI) (vaccination)		
History of allergy to vaccine, drug, or food		
Pre-existing illness (30 days)/congenital		
History of hospitalization in the last 30 days, with cause		
Patient currently on concomitant medication? (If yes, name drug, indication, doses, and treatment dates)		
Family history of any disease (relevant to AEFI) or allergy?		
For women: Currently pregnant? ☐ Yes (Specify number o … ☐ Unknown Currently Breastfeeding? ☐ Yes ☐ No		
For infants: The birth was: ☐ Full-term ☐ Pre-term ☐ Post-term Birth Weight: _____(lbs), _____(oz) Delivery: ☐ Normal ☐ Cesarean ☐ Assisted (forceps, vacuum, etc.) ☐ Complications (Specify): _____		

Additional Comments

NOTE - Specifics on adverse effects and/or injuries following vaccination will be completed above and do not need to be added here.

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5 COMMENTS

Note: if no additional comments, skip this section.

[redacted]

Warning: Any false or misleading statement contained with respect to the submitted claim and any supporting document, including the concealment of any material fact, may result in the refusal to process the claim.

By signing this form, I declare that all information provided above is true and completed to the best of my knowledge.

Signature of the physician

[redacted]

Physician Signature Date (YYYY-MM-DD)

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St. Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca.

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[redacted]
Calgary, AB T
Tel: [redacted] Fax: [redacted]

[redacted]

[redacted]
Calgary,AB T [redacted]

[redacted]
DOB: [redacted] 1968
Age: 53 years (F)

NON-DRUG Rx - **Medical note**

Details:

[redacted]

Signature: [redacted]

Page 1 of 1

** Please take this prescription to your pharmacist **

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Record of Immunization

[redacted]

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Alberta Health Services

Discharge Summary - [redacted]

CONFIDENTIAL

[redacted]

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Esteves, Dina (HC/SC)

From: Board of Health <boh@toronto.ca>
Sent: 2021-12-19 11:16 AM
To: 'pm@pm.gc.ca'; 'justin.trudeau@parl.gc.ca'
Cc: hcminister.ministresc; 'melanie.joly@parl.gc.ca'; 'iga.minister-ministre.aig@pco-bcp.gc.ca'
Subject: Correspondence from the Toronto Board of Health Regarding Black Scientists' Task Force on Vaccine Equity Update (Item HL31.2)
Attachments: HL31.2 - Letter to Prime Minister.pdf

Dear Prime Minister:

Please find attached correspondence from the Toronto Board of Health regarding Black Scientists' Task Force on Vaccine Equity Update (Item HL31.2).

Please feel free to contact me if you have any questions or need additional information.

Sincerely,
Julie

[redacted]
Toronto Board of Health
City Clerk's Office
City of Toronto

416-397-7769

Confidentiality Notice: This e-mail and attachment(s) may contain confidential and privileged information. If you are not the intended recipient, please notify the sender immediately by return e-mail, delete this e-mail and destroy any copies. Any distribution or use of this information by a person other than the intended recipient is unauthorized and may be illegal.

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TORONTO

John D. Elvidge
City Clerk

City Clerk's Office

Secretariat
[redacted]
Toronto Board of Health
Toronto City Hall, 10th Floor, West Tower
100 Queen Street West
Toronto, Ontario M5H 2N2

[redacted]
Fax: 416-392-1879
E-mail: boh@toronto.ca
Web: www.toronto.ca/council

November 26, 2021

SENT VIA E-MAIL
pm@pm.gc.ca and justin.trudeau@parl.gc.ca

The Right Honourable Justin Trudeau, P.C., M.P. (Papineau)
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, Ontario K1A 0A2

Dear Prime Minister:

Subject: Black Scientists' Task Force on Vaccine Equity Update (Item HL31.2) (see Part 1 of Toronto City Council's decision on page 1 which is addressed to the Government of Canada)

Toronto City Council, during its meeting on November 9, 10 and 12, 2021, considered Item HL31.2 and adopted the following:

1. City Council request the Government of Canada and the Public Health Agency of Canada to apply a global health lens to the global and Canadian vaccine response, including measures and resources to scale up vaccine production and access for regions with low vaccination coverage and to assist provinces and municipalities to develop a global health lens for the local pandemic response.

2. City Council reiterate the request of the Ontario Ministry of Health to take action to mandate and facilitate the collection of socio-demographic data by all vaccination providers, to mandate that the Ontario Health Data Platform support the use of this equity data and to make this data routinely available to local Public Health Units for assessment and planning.

3. City Council request the City Manager, in consultation with the Medical Officer of Health, to continue to support race-based data collection, regular reporting and community collaboration by the City of Toronto and Toronto Public Health to inform immediate and culturally-competent responses to the mental health burden of COVID-19 and the uptake of COVID-19 vaccination.

4. City Council request the City Manager, in consultation with the Medical Officer of Health, to work with their counterparts in other levels of governments and mental health care providers to ensure that the COVID-19 mental health response is maintained, scaled up and appropriately adapted for the post-pandemic recovery phase, including reducing stigma and other barriers to access through anti-Black

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racism capacity building and accountability.

The Toronto Board of Health, during its meeting on October 25, 2021, also:

1. Reiterated the request of the Ontario Ministry of Health to take action to mandate and facilitate the collection of socio-demographic data by all vaccination providers, to mandate that the Ontario Health Data Platform support the use of this equity data and to make this data routinely available to local Public Health Units for assessment and planning.

To view this item and background information online, please visit:

- http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2021.HL31.2.

Yours sincerely,

[redacted]

Toronto Board of Health

cc (via e-mail):

- The Honourable Jean-Yves Duclos, P.C., M.P. (Québec), Minister of Health
- The Honourable Mélanie Joly, P.C., M.P. (Ahuntsic-Cartierville), Minister of Foreign Affairs
- The Honourable Dominic Leblanc, P.C., M.P. (Beauséjour), Minister of Intergovernmental Affairs, Infrastructure and Communities
- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-12-21 11:41 AM
To: hcminister.ministresc
Subject: TR: Amnistie internationale / Agenda pour les droits humains / pandémie
Attachments: Lettre_MSanté_Duclos_20-12-2021.pdf; Amnistie_internationale_Agenda 2021.pdf

De : France-Isabelle Langlois <[redacted]@amnistie.ca>
Envoyé : 20 décembre 2021 16:36
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : Amnistie internationale / Agenda pour les droits humains / pandémie

Monsieur le Ministre de la Santé,

Nous désirons attirer votre attention sur les graves inégalités et enjeux de droits humains qui sévissent au Canada, et qui ont été exacerbés par la pandémie. Nous vous demandons d'en faire des préoccupations au cœur des politiques de votre ministère. Vous trouverez à cet effet, en pièces-jointes, une lettre que nous vous adressons ainsi que notre Agenda pour les droits humains 2021.

Nous nous réjouissons de constater dans votre lettre de mandat que vous a adressé le premier ministre du Canada, Monsieur Justin Trudeau, qu'il vous est demandé *« de continuer à renforcer les efforts internationaux visant à ce que la population mondiale ait un accès à des mesures de lutte contre la COVID-19, y compris des vaccins, des interventions thérapeutiques et des systèmes de santé solidifiés »*, en collaboration la ministre des Affaires étrangères, et le ministre du Développement international.

Alors qu'Amnistie était déjà préoccupée avant la pandémie par bon nombre d'enjeux de droits humains, force est de constater que la crise sanitaire a révélé à quel point les droits peuvent être facilement érodés en pareille circonstance, et tout particulièrement le droit à la santé. Et ce, non seulement à l'étranger, mais également au Canada. Après près de deux ans de restrictions, qui ont miné et exacerbé les inégalités, un nouveau niveau d'urgence a été atteint, tandis que la pandémie semble loin de se terminer. C'est pour ces raisons que nous demandons à votre ministère de placer les droits humains au centre de chaque plan d'urgence comme de chaque plan de reprise et de chaque mesure budgétaire, afin de s'assurer que personne ne soit laissé pour compte.

Il va sans dire que nous sommes toujours préoccupés par les impacts de la pandémie qui continuent de sévir non seulement au Canada, mais à travers le monde. Nous vous enjoignons de jouer un rôle de leader positif et affirmé en matière d'équité vaccinale et d'accès à tous les traitements. Amnistie internationale appelle de nouveau tous les membres de l'OMC à accepter immédiatement la proposition de dérogation à l'Accord sur les ADPIC pour les produits de santé liés à la pandémie de COVID-19.

Nous demeurons à votre disposition pour une discussion approfondie.

En terminant, Monsieur le Ministre, veuillez accepter nos souhaits les plus sincères pour 2022, pour vous et votre famille.

Nous vous prions d'agréer, Monsieur le Ministre de la Santé, l'expression de nos sentiments distingués,

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France-Isabelle Langlois
Directrice générale

Amnistie internationale Canada francophone
+1 514.766.97.66 poste [redacted]
+1 514.774.7527
Maison du développement durable
50 rue Ste Catherine ouest, bureau 500
Montréal (Québec) H2X 3V4

Faites un don maintenant, Amnistie ça marche et c'est indépendant de tout sauf de vous.

AMNISTIE INTERNATIONALE

Si vous ne désirez plus recevoir de courriel de ma part, veuillez m'aviser en m'envoyant un courriel ayant pour objet « Me supprimer de vos contacts ».

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AMNISTIE INTERNATIONALE

Montréal, 20 décembre 2021

L'honorable Jean-Yves Duclos, C.P., député
Ministre de la Santé
Chambre des communes
Ottawa (Ontario) K1A 0A6

Objet : Agenda des droits humains 2021, un outil pour aider le Canada à évaluer le respect de ses obligations en matière de droits humains, notamment dans sa réponse à la pandémie.

Monsieur le Ministre de la Santé,

C'est au nom des 100 000 sympathisants et sympathisantes francophones d'Amnistie internationale au Canada que nous vous écrivons aujourd'hui. Nous désirons attirer votre attention sur les graves inégalités et enjeux de droits humains qui sévissent au Canada, et qui ont été exacerbés par la pandémie. Nous vous demandons d'en faire des préoccupations au cœur des politiques de votre ministère.

Nous nous réjouissons de constater dans votre lettre de mandat que vous a adressé le premier ministre du Canada, Monsieur Justin Trudeau, qu'il vous est demandé *« de continuer à renforcer les efforts internationaux visant à ce que la population mondiale ait un accès à des mesures de lutte contre la COVID-19, y compris des vaccins, des interventions thérapeutiques et des systèmes de santé solidifiés »*, en collaboration la ministre des Affaires étrangères, et le ministre du Développement international.

Alors qu'Amnistie était déjà préoccupée avant la pandémie par bon nombre d'enjeux de droits humains, force est de constater que la crise sanitaire a révélé à quel point les droits peuvent être facilement érodés en pareille circonstance, et tout particulièrement le droit à la santé. Et ce, non seulement à l'étranger, mais également au Canada. Après près de deux ans de restrictions, qui ont miné et exacerbé les inégalités, un nouveau niveau d'urgence a été atteint, tandis que la pandémie semble loin de se terminer. C'est pour ces raisons que nous demandons à votre ministère de placer les droits humains au centre de chaque plan d'urgence comme de chaque plan de reprise et de chaque mesure budgétaire, afin de s'assurer que personne ne soit laissé pour compte.

50, RUE STE-CATHERINE OUEST, BUREAU 500
MONTRÉAL (QUÉBEC) H2X 3V4
TÉLÉPHONE 514.766.9766
SANS FRAIS 1.800.565.9766
www.amnistie.ca

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Il va sans dire que nous sommes toujours préoccupés par les impacts de la pandémie qui continuent de sévir non seulement au Canada, mais à travers le monde. Nous vous enjoignons de jouer un rôle de leader positif et affirmé en matière d'équité vaccinale et d'accès à tous les traitements. Amnistie internationale appelle de nouveau tous les membres de l'OMC à accepter immédiatement la proposition de dérogation à l'Accord sur les ADPIC pour les produits de santé liés à la pandémie de COVID-19.

Comme vous le savez, les effets négatifs de la pandémie ont touché de manière disproportionnée les populations vulnérables et celles vivant dans des situations précaires, notamment : les peuples autochtones, les communautés noires et racialisées, les femmes, les personnes âgées, les travailleuses et travailleurs du sexe, les demandeurs et demandeuses d'asile ainsi que les personnes migrantes.

C'est dans ce contexte que nous vous présentons notre Agenda pour les droits humains 2021 pour le Canada, réalisé conjointement par les deux sections d'Amnistie internationale au Canada (la section anglophone, et la section francophone). Lequel se veut un outil permettant d'évaluer le respect des obligations du Canada en matière de droits humains au cours de l'année écoulée, et de proposer aussi des recommandations pour des réformes et des gestes à poser, au tant dans le contexte de la crise sanitaire en cours que pour la suite des choses.

En partageant cet outil, nous mettons au défi le gouvernement du Canada d'adopter une approche centrée sur les droits humains pour faire face aux retombées de la pandémie, comme nous l'avions demandé dès le début de celle-ci, et nous vous demandons de démontrer concrètement comment vous comptez le faire. L'Agenda pour les droits humains 2021 présente un total de 58 recommandations concrètes que nous soumettons à votre attention afin que des mesures tout aussi concrètes soient prises.

Il nous ferait plaisir, Monsieur le Ministre, de nous entretenir de vive voix avec vous des enjeux et préoccupations que nous présentons. Nous invitons les membres de votre équipe à prendre rendez-vous avec ma collègue, [redacted], responsable de campagnes, en écrivant à [redacted]@amnistie.ca, ou au [redacted]

En terminant, Monsieur le Ministre, veuillez accepter nos souhaits les plus sincères pour 2022, pour vous et votre famille.

Nous vous prions d'agréer, Monsieur le Ministre de la Santé, l'expression de nos sentiments distingués,

[redacted]

France-Isabelle Langlois
Directrice générale d'Amnistie internationale Canada francophone

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AGENDA 2021 DES DROITS HUMAINS

DÉMASQUER LES ATTEINTES AUX DROITS HUMAINS AU CANADA

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INTRODUCTION

Amnistie internationale est inquiète de la situation des droits humains au Canada. Nous l'étions avant la pandémie, nous le sommes davantage maintenant. De fait, les 18 derniers mois auront démontré à quel point les droits et la démocratie sont fragiles, non seulement dans le monde, mais au Canada également.

Les réponses mises de l'avant par les gouvernements du Canada pour faire face à la crise sanitaire ont eu un impact sérieux, parfois dévastateur, sur les droits humains, notamment sur les droits économiques, sociaux et culturels. Et les effets négatifs ont été disproportionnés pour les personnes vulnérables ou vivant en situation de précarité dont les membres des peuples autochtones et des communautés noires et racialisées, les femmes, les personnes âgées, les travailleurs et travailleuses du sexe, les personnes demandeuses d'asile et les personnes migrantes.

La situation d'urgence extraordinaire dans laquelle nous a plongé la pandémie a révélé les trous béants de notre filet social créés par le désinvestissement chronique dans tous les secteurs : emploi, éducation, santé et sécurité, protection contre les violences basées sur le genre, lutte contre le racisme et le racisme systémique, et autres discriminations.

C'est dans ce contexte de pandémie mondiale qu'Amnistie internationale présente son Agenda des droits humains 2021. Il s'agit d'un outil permettant à la fois d'évaluer le respect des obligations des gouvernements du Canada en matière de droits humains au cours de l'année écoulée, et de proposer aussi des recommandations pour des réformes et des gestes à poser, autant dans le contexte de la crise sanitaire en cours que pour la suite des choses.

L'Agenda pour les droits humains 2021 d'Amnistie internationale démontre clairement que la pandémie a eu un impact disproportionné sur les détenteurs de droits déjà victimes de discrimination systémique. La santé est corollaire de déterminants sociaux tels que la pauvreté, l'accès aux soins et services, et les obstacles fondés sur la discrimination. En ce sens, la pandémie a affecté les différentes populations et groupes identitaires de différentes manières.

À ce propos, la Haute-Commissaire des Nations unies aux droits de l'homme, Michelle Bachelet, avait déclaré[1], dès avril 2020 que :

> ***« COMPTE TENU DE LA NATURE EXCEPTIONNELLE DE LA CRISE, IL EST CLAIR QUE LES ÉTATS ONT BESOIN DE POUVOIRS SUPPLÉMENTAIRES POUR Y FAIRE FACE. CEPENDANT, SI L'ÉTAT DE DROIT N'EST PAS RESPECTÉ, LA SITUATION D'URGENCE SANITAIRE RISQUE DE DEVENIR UNE CATASTROPHE DES DROITS DE L'HOMME, DONT LES EFFETS NÉFASTES SURPASSERONT PENDANT LONGTEMPS LA PANDÉMIE ELLE-MÊME. »***

Après plus d'un an de mesures contraignantes ayant miné les droits humains et exacerbé les inégalités vécues par les personnes en situation de précarité, il est temps que tous les gouvernements du Canada adoptent une approche centrée sur les droits humains pour aborder les répercussions de la pandémie.

[1] HCDH, Covid-19 : les mesures exceptionnelles ne doivent pas servir à couvrir les abus et les violations des droits de l'homme – Michelle Bachelet, 2020, *https://www.ohchr.org/FR//NewsEvents/Pages/DisplayNews.aspx?NewsID=25828&LangID=F*

C'est dans cet esprit que les deux sections d'Amnistie internationale Canada proposent des recommandations d'action dans douze champs d'intervention, lesquelles constituent un seuil minimum d'engagement :

1 | DISCRIMINATION ET RACISME SYSTÉMIQUE page 4

2 | DROITS DES PEUPLES AUTOCHTONES page 6

3 | DROITS DES PERSONNES DEMANDEUSES D'ASILE page 12

4 | DROITS DES PERSONNES MIGRANTES À STATUT PRÉCAIRE OU SANS STATUT page 14

5 | DROITS DES FEMMES page 16

6 | DROITS DES PERSONNES LGBTQ2S page 20

7 | ACTEURS ÉCONOMIQUES ET DROITS HUMAINS page 24

8 | JUSTICE CLIMATIQUE page 27

9 | VENTES D'ARMES page 30

10 | RÉSIDENCES DE SOINS DE LONGUE DURÉE page 32

11 | CANADIENS ET CANADIENNES DÉTENU·E·S À L'ÉTRANGER page 34

12 | PERSONNES DÉFENSEURES DES DROITS HUMAINS AU CANADA page 36

CLAUSE DE NON-RESPONSABILITÉ

L'Agenda des droits humains d'Amnistie internationale est un outil servant à évaluer l'état des droits humains au Canada, et notamment, au regard de l'impact de la pandémie de COVID-19. Tout en reconnaissant que celle-ci a affecté l'ensemble de la population, il appert néanmoins que les différents groupes n'ont pas tous été affectés de la même manière. Nous avons donc fait le choix de nous concentrer dans ce document sur certains groupes parmi les plus vulnérables en matière de droits.

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1 | DISCRIMINATION ET RACISME SYSTÉMIQUE

Le racisme systémique a un impact sur la réalisation des droits humains dans tous les secteurs, tels que le révèle l'Agenda pour les droits humains 2021 d'Amnistie internationale.

Le racisme systémique[2] concerne l'ensemble de la structure sociétale des institutions, des lois et des politiques qui maintiennent un système d'inégalités privilégiant ou réprimant différents groupes de la société sur la base de la « race » qui leur est assignée. Ces disparités accordent des privilèges aux personnes blanches et minent les droits des Autochtones, des personnes noires et des personnes racialisées.

Après l'horrible meurtre filmé en direct de George Floyd commis par des policiers aux États-Unis en 2020, des Canadiens et des Canadiennes de partout au pays se sont joints aux manifestations antiracistes dénonçant le racisme anti-noir et la violence policière.

En 2020, le rapport provisoire de la Commission ontarienne des droits de la personne sur le racisme anti-noir au sein des corps policiers a démontré que les personnes noires à Toronto sont jusqu'à vingt fois plus susceptibles d'être abattues par la police que les personnes blanches. Selon une étude du Vancouver Police Board, les Autochtones et les personnes noires sont considérablement surreprésentées lors des contrôles aléatoires effectués par le service de police de Vancouver. En 2017, 16 % de tous les contrôles de rue concernaient des Autochtones, alors qu'ils représentent 2 % de la population de Vancouver. Les personnes noires représentaient 4 % des contrôles de rue alors qu'ils représentent 1 % de la population.

Plus récemment au Canada, la découverte de centaines de fosses communes d'enfants autochtones près des pensionnats autochtones, les sévices infligés à une femme autochtone dans un hôpital du Québec ayant provoqué sa mort, et l'assassinat, présumé prémédité, d'une famille musulmane à London en Ontario, ont déclenché un vaste courant d'indignation et de mobilisation. Ces manifestations témoignent d'un mouvement national de dénonciation du racisme et du racisme systémique au Canada, et de leurs terribles impacts sur la société, les institutions, les personnes et la culture.

Tant le gouvernement fédéral que les gouvernements provinciaux sont appelés à mettre en œuvre urgemment des mesures concrètes pour s'attaquer au racisme et au racisme systémique. Partout au pays, des membres élus des gouvernements ainsi que des responsables des forces policières continuent de nier l'existence du racisme systémique et de ses profonds impacts sur les droits humains au Canada.

Il est vrai que le gouvernement canadien a pris d'importantes mesures, y compris celles de renforcer sa stratégie de lutte contre le racisme[3] et d'ajouter des fonds additionnels pour des projets de lutte contre le racisme[4] dans tout le pays. Toutefois, ces initiatives ne proposent ni échéanciers, ni objectifs, ni actions concrètes. Plusieurs gouvernements provinciaux ont aussi développé des stratégies, des projets, et d'autres initiatives de lutte contre le racisme, dont le rapport du Groupe d'action contre le racisme[5] du gouvernement du Québec. Malheureusement, ce rapport manque de vision globale quant aux mesures proposées, et le gouvernement du Québec refuse toujours de reconnaître l'existence du racisme systémique. Toujours au Québec, la Loi sur la laïcité, mieux connue sous le vocable de Loi 21[6] restreint le port de signes religieux visibles dans les services publics, ciblant de manière disproportionnée les membres de groupes religieux minoritaires, et notamment les femmes, limitant d'autant leur accès à l'emploi dans certains secteurs, dont les services publics. Cependant, le gouvernement du Québec réaffirme que l'inclusion et la diversité constituent des éléments importants de la société québécoise. Afin de concrétiser cette affirmation, il est alors primordial que le gouvernement du Québec commence par reconnaître l'existence du racisme systémique. Cette reconnaissance doit s'accompagner de plans d'action tenant compte des réalités spécifiques aux Autochtones, aux personnes noires et aux personnes racialisées, devant être élaborés en consultation et en coopération avec les communautés et les groupes concernés.

Amnistie reconnaît le travail des organisations qui représentent les communautés autochtones, noires et autres groupes racialisés, ethniques et religieux, qui ont été aux premières lignes pour dénoncer le racisme systémique depuis de nombreuses années. L'organisation se positionne en soutien aux revendications légitimes de ces groupes en matière de lutte contre le racisme systémique.

AMNISTIE INTERNATIONALE DEMANDE AUX GOUVERNEMENTS DU CANADA

- **De reconnaître l'existence du racisme systémique et, en étroite collaboration avec les communautés noires et racisées, élaborer un plan pour y faire face, comprenant la collecte et la publication de données désagrégées et anonymisées fondées sur la race, l'origine ethnique, la religion et autres identités, suivant un consentement libre et éclairé.**
- **De s'engager dans de larges consultations portant sur les initiatives menées par les communautés concernées, réinventant et proposant de nouvelles approches transformatrices de la façon d'assurer la sécurité publique et d'établir et répartir les financements.**
- **D'interdire les pratiques de fichage, de contrôles de routine et de profilage racial par la police.**
- **D'interdire l'utilisation de technologies de reconnaissance faciale par la police pour la surveillance de masse.**
- **De repenser en profondeur les mécanismes de surveillance de la police et veiller à ce qu'ils soient dotés de ressources et d'un mandat adéquat, et que les représentants des organes de contrôle soient nommés de façon le plus représentative possible et selon des principes de pluralité.**
- **De fournir un financement adéquat aux organisations et mouvements menés par les communautés directement touchées par et travaillant sur le racisme.**

[2] Racisme et la Discrimination Raciale – Discrimination systémique (fiche), Commission ontarienne des droits de la personne, *http://www.ohrc.on.ca/fr/racisme-et-la-discrimination-raciale-discrimination-systémique-fiche*

[3] Construire une fondation pour le changement : La stratégie canadienne de lutte contre le racisme 2019-2022, *https://www.canada.ca/fr/patrimoine-canadien/campagnes/mobilisation-contre-racisme/strategie-contre-racisme.html*

[4] Bâtir un Canada plus inclusif : le gouvernement du Canada annonce un financement pour des projets de lutte contre le racisme partout au pays, 15 octobre 2020, *https://www.canada.ca/fr/patrimoine-canadien/nouvelles/2020/10/batir-un-canada-plus-inclusif-le-gouvernement-du-canada-annonce-un-financement-pour-des-projets-de-lutte-contre-le-racisme-partout-au-pays.html*

[5] Groupe d'action contre le racisme, *https://www.quebec.ca/gouv/politiques-orientations/groupe-action-contre-racisme*

[6] Loi sur la laïcité de l'État, Assemblée Nationale du Québec, 42ème Législature, 1ère Sess., *http://m.assnat.qc.ca/fr/travaux-parlementaires/projets-loi/projet-loi-21-42-1.html*

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2 | DROITS DES PEUPLES AUTOCHTONES

La Commission de vérité et réconciliation[7], l'Enquête nationale sur les femmes et les filles autochtones disparues et assassinées[8], la Commission d'enquête sur les relations entre les Autochtones et certains services publics au Québec[9] ainsi que d'autres initiatives ont permis de dévoiler l'étendue de l'oppression coloniale et actuelle des Premières nations, des Métis et des Inuits du Canada, et de formuler des centaines de recommandations visant la justice, la réparation et la réconciliation pour l'ensemble des discriminations et violences subies par les peuple autochtones du Canada jusqu'à ce jour.

Le racisme systémique envers les peuples autochtones au Canada s'exprime de diverses manières et à divers niveaux, notamment par : la violence policière; la surreprésentation d'Autochtones dans les systèmes de protection de l'enfance et de justice pénale; les niveaux stupéfiants de violences vécues par les femmes, les filles et les personnes 2ELGBTQQIA autochtones; les services sociaux, notamment d'eau potable, de santé et d'éducation insuffisants, inadéquats, non culturellement adaptés et discriminatoires; l'attribution de permis d'exploitation des ressources sans consentement libre, préalable et éclairé; ainsi que la dislocation et la déconnexion de la terre et de la culture. Sans compter le trauma intergénérationnel hérité du système des pensionnats autochtones.

C'est dans ce contexte que les peuples autochtones continuent d'affirmer leurs droits, en défendant leurs terres contre l'exploitation des ressources sans leur consentement; en interpelant les tribunaux afin d'obtenir réparation pour les torts causés; en rétablissant leur autorité sur la protection de l'enfance au sein de leurs communautés; en démontant leur leadership climatique par des projets innovants d'énergie renouvelable.

Toutefois, il reste encore au Canada à entreprendre des actions concrètes pour s'attaquer au trauma intergénérationnel et aux pratiques de discrimination toujours en cours à l'égard des peuples autochtones.

LA PANDÉMIE DE COVID-19

Pendant la pandémie de COVID-19, les communautés autochtones ont dû faire face à des menaces et à des défis uniques qui les mettaient à plus haut risque[10] de contracter le virus et d'être hospitalisées. Parmi ces défis, on retrouve le manque d'équipements et de services de santé et et les logements sous-financés et surpeuplés. Malgré ces difficultés, les communautés ont développé des solutions efficaces afin de répondre à leurs besoins en tenant compte des ressources disponibles, incluant des visites aux personnes aînées afin qu'elles ne soient pas isolées, la distribution de nourriture et de remèdes traditionnels, et l'élaboration de plans d'urgence.

En 2020, en raison de la pandémie, l'Union des chefs indiens de la Colombie-Britannique a demandé au gouvernement de la province[11] de stopper la construction du Site C du barrage hydro-électrique et du projet de gazoduc Coastal Gaslink pour des raisons de santé et de sécurité.

LA DÉCLARATION DES NATIONS UNIES SUR LES DROITS DES PEUPLES AUTOCHTONES

En juin 2021, le projet de loi C-15[12], pour la mise en œuvre dans la législation canadienne de la Déclaration des Nations unies sur les droits des peuples autochtones a été adopté. Le Canada doit maintenant travailler en collaboration avec les peuples autochtones pour sa mise en œuvre effective.

PENSIONNATS AUTOCHTONES

Depuis mai 2021, les restes de plus de 1 300 enfants autochtones enterrés dans seulement quatre des 139 anciens pensionnats ont été découverts, et il est vraisemblable qu'on en trouvera encore d'autres. Le rapport final de la Commission de vérité et réconciliation du Canada estimait qu'environ 6 000 enfants étaient morts dans les pensionnats autochtones, et ce chiffre pourrait même être encore plus élevé.

Le Canada est responsable de la création du système des pensionnats autochtones qui visait à assimiler les peuples autochtones par le biais de l'éradication des cultures, des langues et du lien social communautaire. Le Canada doit donc maintenant assumer sa pleine responsabilité de manière urgente et concrète quant au trauma intergénérationnel, des préjudices, et des pratiques discriminatoires à l'encontre des peuples autochtones.

RACISME SYSTÉMIQUE DANS LE SYSTÈME DE SANTÉ

Le racisme systémique est présent dans les systèmes de santé partout à travers le pays.

La mort de Joyce Echaquan, Atikamekw de la communauté de Manawan, survenue dans des circonstances plus que troublantes à l'hôpital de Joliette au Québec le 28 septembre 2020, a indigné l'ensemble de la population canadienne. Avant de mourir, elle aura réussi à filmer et diffuser en direct sur les réseaux sociaux les traitements racistes dont elle faisait l'objet de la part de travailleuses de la santé.

Après sa mort, la Nation Atikamekw a élaboré le Principe de Joyce[13], visant à assurer aux personnes autochtones un accès équitable, sécuritaire, sans discrimination, à tous les services de santé et des services sociaux. Le gouvernement du Canada a accordé son appui au Principe de Joyce, tandis que le gouvernement du Québec niant l'existence du racisme systémique envers les peuples autochtones, s'y refuse.

Cependant, l'Ordre des infirmières et des infirmiers du Québec (OIIQ) a reconnu, le 14 juillet 2021, qu'il y avait effectivement du racisme systémique envers les Premières nations et les Inuits au sein du système de santé et de services sociaux.

[7] Commission de Vérité et Réconciliation du Canada, *https://nctr.ca/a-propos/histoire-de-la-cvr/site-web-de-la-cvr/?lang=fr*

[8] Réclamer notre pouvoir et notre place: Le rapport final sur l'ENFFADA, 2019, Enquête nationale sur les femmes et les filles autochtones disparues et assassinées (ENFFADA), *https://www.mmiwg-ffada.ca/fr/final-report/*

[9] Commission d'enquête sur les relations entre les Autochtones et certains services publics : écoute, réconciliation et progrès, Rapport final, 2019, *https://www.cerp.gouv.qc.ca/fileadmin/Fichiers_clients/Rapport/Rapport_final.pdf*

[10] Angela Sterritt, 'COVID-19 cases among First Nations in some B.C. regions double rest of population', CBC News, 17 décembre 2020, *www.cbc.ca/news/canada/british-columbia/COVID-19-cases-in-some-first-nations-double-non-first-nations-1.5845679*

[11] Union of BC Indian Chiefs, Open Letter: Call for the Halting of Site C Construction Due to the COVID-19 Outbreak, 2020, *www.ubcic.bc.ca/open_letter_call_for_the_halting_of_site_c_construction_due_to_the_covid_19_outbreak*

[12] Projet de Loi C-15, Loi concernant la Déclaration des Nations Unies sur les droits des peuples autochtones, 2ème Sess., 43ème Législature, 2020, assented to 21 juin 2021, *https://www.parl.ca/LegisInfo/BillDetails.aspx?billId=11007812&Language=F*

[13] Principe de Joyce, Mémoire présenté par le Conseil des Atikamekw de Manawan et le Conseil de La Nation Atikamekw au Gouvernement du Canada et au Gouvernement du Québec, novembre 2020, *https://principedejoyce.com/sn_uploads/principe/Principe_de_Joyce__FR.pdf*

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DROITS TERRITORIAUX

En décembre 2020, la Pinède d'Oka a été inscrite[14] au Répertoire du patrimoine culturel du ministère de la Culture et des Communications du Québec, sans le consentement libre, préalable et éclairé de la Nation kanien'kehá:ka de Kanehsatà:ke.

En janvier 2020, la Gendarmerie royale du Canada (GRC) exécutait une injonction obtenue par Coastal Gaslink lui permettant de déloger les défenseurs de la terre Wet'suwet'en et leurs sympathisant·e·s, qui avaient érigé une barricade afin d'empêcher les travailleurs de se rendre au chantier du gazoduc.

Les chefs héréditaires, responsables de la sauvegarde du territoire traditionnel, n'avaient pas consenti à ce gazoduc. Le recours aux unités tactiques de la police, aux tireurs d'élite et à de l'équipement lourd pour déloger les protestataires pacifiques et non armés, a entraîné une condamnation internationale du Canada.

Le Comité des Nations unies pour l'élimination de la discrimination raciale a demandé[15] à maintes reprises au Canada de cesser la construction des pipelines Coastal Gaslink et Trans Mountain, et celle du barrage du Site C en Colombie-Britannique, faute d'avoir obtenu un consentement libre, préalable et éclairé. Le comité a aussi demandé[16] au Canada de cesser de recourir à la force létale à l'encontre des défenseur·e·s de la terre. Le Canada n'a pas répondu aux demandes du comité, et la construction des projets contestés s'est poursuivie.

DROITS RELATIFS AUX TRAITÉS

En octobre 2020, en Nouvelle-Écosse, les pêcheurs mi'kmaw ont été violemment attaqués par des pêcheurs blancs pour avoir exercé leurs droits de pêche au homard, obtenus de longue date en vertu de traités[17]. Or, les agents de la Gendarmerie royale du Canada (GRC) n'ont pas bronché lorsque des pierres ont été lancées aux pêcheurs mi'kmaw alors qu'ils étaient physiquement entravés, que leurs véhicules et deux de leurs hangars à homards étaient incendié. Le Comité des Nations unies pour l'élimination de la discrimination raciale a demandé au Canada[18] d'enquêter sur ces violences à caractère raciste, afin de prévenir d'autres agissements de la sorte et de protéger et garantir les droits de pêche des Mi'kmaw.

PROJETS D'EXPLOITATION DES RESSOURCES NATURELLES

Depuis 2018, des femmes secwepemc, défenseures de la terre et de l'eau, ont établi un camp sur la Blue River en Colombie-Britannique pour protester contre la construction de campements pour les travailleurs du projet d'expansion Trans Mountain Expansion (TMX), En 2021, plusieurs hommes s'en sont pris violemment à elles. Ces femmes s'opposent tant à l'expansion de l'oléoduc, auquel n'ont pas consenti l'ensemble des communautés Secwepemc établies sur le territoire, qu'à l'augmentation des risques de violence[19] à l'égard des femmes, des filles et des personnes 2ELGBTQQIA autochtones que de tels campements de travailleurs génèrent.

L'Enquête nationale sur les femmes et les filles autochtones disparues et assassinées avait souligné l'augmentation des risques d'agression sexuelle, de violence domestique et de racisme qu'entraînent les camps de travailleurs liés aux gazoducs et aux oléoducs, aux barrages hydroélectriques et à l'exploitation minière, et avait recommandé que les gouvernements réalisent des analyses de genre dans le cadre des évaluations d'impact, avant d'octroyer des permis pour de tels développements industriels. Plus tard, le Comité pour l'élimination de la discrimination raciale des Nations unies a demandé[20] la suspension du projet TMX jusqu'à ce que le Canada ait obtenu le plein consentement des Secwepemc.

[14] Site patrimonial de la Pinède d'Oka, Province de Québec Municipalité d'Oka, 2020, *www.patrimoine-culturel.gouv.qc.ca/rpcq/detail.do?methode=consulter&id=232095&type=bien*

[15] Nations unies, Comité pour l'Élimination de la Discrimination Raciale, Letter to Permanent Representative of Canada to the United Nations Office on the development of the C dam project, the approval of the Trans Mountain Pipeline Expansion project in British Columbia as well as the Coastal GasLink Pipeline, 24 novembre 2020, UN Doc CERD/EWUAP/102 session/2020/MJ/CS/ks, *tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/CAN/INT_CERD_ALE_CAN_9296_E.pdf*

[16] Comité pour l'Élimination de la Discrimination Raciale, Prevention of Racial Discrimination, Including Early Warning and Urgent Action Procedure, Hundredth session, 2801st Meeting, 13 décembre 2019, *https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/CAN/INT_CERD_EWU_CAN_9026_E.pdf*

[17] Amnesty International Canada (Section anglophone), "The fishing battle is not about lobster - it's about treaties," 19 octobre 2020, *amnesty.ca/blog/the-fishing-battle-is-not-about-lobster-its-about-treaties/*

[18] Comité pour l'Élimination de la Discrimination Raciale, Letter to Permanent Representative of Canada to the United Nations Office on the development to respect and protect rights of Mi'kmaw fishers and prevent further violence, 30 avril 2021, UN Doc. *CERD/EWUAP/103rd Session/2021/MJ/CS/ks, tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/CAN/INT_CERD_ALE_CAN_9398_E.pdf*

[19] The Firelight Group avec Lake Babine Nation et Nak'azdli Whut'en, Indigenous Communities and Industrial Camps Promoting Healthy Communities in Settings of Industrial Change, 2017, *firelight.ca/wp-content/uploads/2016/03/Firelight-work-camps-Feb-8-2017_FINAL.pdf*

[20] Supra, note 16.

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POUR UNE RÉCONCILIATION PLEINE ET ENTIÈRE DÈS MAINTENANT

AMNISTIE INTERNATIONALE DEMANDE AUX GOUVERNEMENTS DU CANADA

- De mettre en œuvre les 94 appels à l'action de la Commission de vérité et réconciliation du Canada, et de publier un plan détaillé de mise en œuvre accompagné d'un échéancier.
- De mettre en œuvre les 231 appels à la justice de l'Enquête nationale sur les femmes et les filles autochtones disparues ou assassinées, et de publier un plan détaillé de mise en œuvre accompagné d'un échéancier.
- D'accepter toute enquête internationales sur les crimes commis dans le cadre des anciens pensionnats et coopérer pleinement avec les mécanismes internationaux des droits humains de supervision.
- D'accorder, lorsque requis par les communautés concernées, le financement adéquat pour permettre l'investigation des cimetières d'anciens pensionnats ou écoles autochtones et de s'assurer que les communautés autochtones en contrôlent l'accès, selon leurs propres règles et coutumes.
- De continuer à financer les organisations autochtones offrant des services communautaires, en santé mentale et de lutte contre les dépendances aux membres des Premières Nations, des Métis et des Inuits, afin de les aider à composer avec les traumatismes intergénérationnels et les préjudices causés par les politiques et les pratiques coloniales historiques toujours en cours, en s'assurant que les programmes soient culturellement sécuritaires et accessibles et qu'ils soient offerts dans les langues autochtones.
- De mettre en œuvre les recommandations des Nations unies de suspendre les projets de développement des ressources n'ayant pas obtenu le consentement libre, préalable et éclairé des communautés touchées.
- De mettre fin aux processus judiciaires concernant les enfants des Premières Nations et de se conformer à la décision du Tribunal canadien des droits de la personne de 2020 sur le financement des services de protection de l'enfance.
- De mettre en œuvre les appels à l'action du Plan Spirit Bear de la Société de soutien à l'enfance et à la famille des Premières Nations du Canada, ainsi que le principe de Jordan sur sur le racisme.
- D'exhorter l'Église catholique à rendre publiques toutes les archives des pensionnats autochtones, et à reconnaître et réparer les torts causés par la doctrine de la découverte et sa collaboration à la politique des pensionnats autochtones, aux survivant·es et à leurs descendant·es.
- De limiter l'octroi d'injonctions aux entreprises en tant que mesure pour suspendre temporairement les disputes sur les droits fonciers, et de plutôt respecter le droit à l'auto-détermination des peuples autochtones, tel que défini dans la Déclaration des Nations unies sur les droits des peuples autochtones, la jurisprudence et le droit international coutumier.

AMNISTIE INTERNATIONALE DEMANDE AU QUÉBEC

- De mettre en œuvre la totalité des 142 appels à la justice de la Commission d'enquête sur les relations entre les Autochtones et certains services publics au Québec, et de prendre les mesures nécessaires en vue d'une véritable réparation.

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3 | LES DROITS DES PERSONNES DEMANDEUSES D'ASILE

Encore récemment, sous couvert de la pandémie de COVID-19, le Canada continuait de saper les droits des personnes réfugiées qui demandent sa protection à leur arrivée au pays.

Même si le Canada a annoncé[21] récemment un nouveau programme visant la réinstallation de 250 personnes défenseures des droits humains en tant que personnes réfugiées, le droit d'asile au Canada a sévèrement été réduit au cours des dernières années. Le projet de loi omnibus C-97 est venu modifier[22] la loi canadienne sur les personnes réfugiées en limitant l'étendue de la protection à leur égard et en ajoutant un facteur arbitraire de discrimination vis-à-vis des personnes demandeuses d'asile, introduisant ainsi un système de protection à deux vitesses. L'Entente sur les tiers pays sûrs continue d'être contestée devant les tribunaux, et les violations des droits humains continuent de se produire dans les centres de détention pour personnes migrantes. La Cour d'appel fédérale a renversé une décision[23] de juillet 2020 de la Cour fédérale du Canada qui constatait que des personnes refoulées dans le cadre de l'entente des tiers pays sûrs étaient détenues arbitrairement aux mains des autorités étasuniennes, dans des conditions qui ébranlent les consciences. Amnistie internationale, le Conseil canadien pour les réfugiés, et le Conseil canadien des Églises cherchent actuellement à faire renverser cette décision par la Cour suprême du Canada. Le 20 mars 2020, le Canada adoptait[24] un moratoire sur les personnes entrant au Canada à partir des États-Unis afin de demander l'asile. Cette mesure a été renouvelée 19 fois, sans que le Parlement n'en soit saisi. Non seulement ce moratoire est contraire aux principales considérations juridiques[25] du Haut-Commissariat des Nations unies pour les réfugiés quant à leur protection en contexte de COVID-19, mais le rapport[26] sur les impacts de la COVID-19 du Comité permanent de la citoyenneté et de l'immigration de la Chambre des communes recommandait aussi que le Canada « permette aux réfugiés et aux demandeurs d'asile d'entrer au Canada, sans égard à leur pays d'origine ou à leur nationalité, en exigeant toutefois qu'ils respectent toutes les exigences en matière de santé publique ».

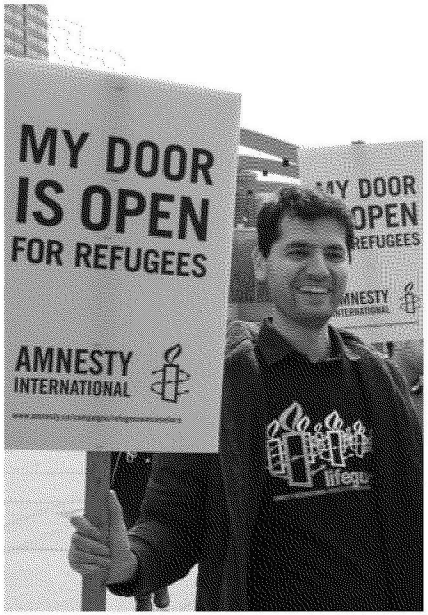
Au même moment, il était pourtant permis à d'autres personnes voyageant à partir des États-Unis d'entrer au Canada, soit des athlètes, des personnes disposant d'un « visa de compassion », ainsi que les membres des familles de résident·e·s permanent·es et de citoyen·ne·s canadien·nes. Aucun justificatif de santé publique n'a été fourni par le gouvernement pour l'exclusion des personnes demandeuses d'asile.

En juin 2021, Amnistie internationale et Human Rights Watch ont publié un rapport[27] sur les pratiques de détention liées à l'immigration au Canada, documentant les différentes façons dont le système discrimine les communautés racialisées et les personnes présentant des difficultés psychosociales.

Depuis 2016, plus de 300 personnes migrantes ont été placées en détention pour plus d'une année, et les prisons provinciales de tout le pays sont utilisées comme lieux de détention, même si les personnes migrantes détenues le sont sur des bases administratives plutôt que criminelles. Le rapport constate aussi des mauvais traitements à l'égard de personnes immigrantes détenues aux mains de l'Agence des services frontaliers du Canada, une agence qui n'est toujours pas dotée d'un mécanisme de surveillance civile indépendant. Même si deux projets de loi (C-3[28] et C-98[29]) ont été déposés par le gouvernement au cours de sessions parlementaires antérieures, aucune législation concernant la surveillance n'est sur la table en ce moment. Tout au long de la pandémie, le Canada a libéré un bon nombre de personnes migrantes détenues, en raison des risques liées à la pandémie de COVID-19, démontrant ainsi que les alternatives à la détention avaient été sous-utilisées.

AMNISTIE INTERNATIONALE DEMANDE AU CANADA

- **D'abroger l'Entente sur les tiers pays sûrs.**
- **De rétablir la protection des personnes réfugiées demandeuses d'asile, conformément aux obligations du Canada en matière de droit international.**
- **D'abolir progressivement les pratiques de détention liées à l'immigration au Canada.**



[21] Immigration, Réfugiés et Citoyenneté Canada, Protéger les défenseurs des droits de la personne à risque, 2021, *https://www.canada.ca/fr/immigration-refugies-citoyennete/nouvelles/2021/07/proteger-les-defenseurs-des-droits-de-la-personne-a-risque.html*

[22] Amnesty International Canada (Section anglophone), Submission to the House of Commons Standing Committee on Citizenship and Immigration: Clause 306 of Bill C-97, the Budget Implementation Act, 2019, No 1, 2019, *www.ourcommons.ca/Content/Committee/421/CIMM/Brief/BR10478967/br-external/AmnestyInternationalCanada-e.pdf*

[23] Conseil canadien des réfugiés c. Canada (Citoyenneté et Immigration) (CF 770), Cour Fédérale du Canada (2020), *https://decisions.fct-cf.gc.ca/fc-cf/decisions/fr/item/482757/index.do*

[24] Décret N°2020-0161 du Gouverneur en Conseil du Canada, *https://decrets.canada.ca/attachment.php?attach=38958&lang=fr*

[25] Haut Commissariat des Nations Unies pour les Réfugiés, Key Legal Considerations on access to territory for persons in need of international protection in the context of the COVID-19 response, 2020, *www.refworld.org/docid/5e7132834.html*

[26] Comité permanent de la citoyenneté et de l'immigration, L'Immigration au Temps de la Covid-19 : Enjeux et Défis, 2021, *https://www.noscommunes.ca/Content/Committee/432/CIMM/Reports/RP11312743/cimmrp05/cimmrp05-f.pdf*

[27] Amnistie Internationale et Human Rights Watch, Je ne me sentais pas comme un être humain : La détention des personnes migrantes au Canada et son impact en matière de santé mentale, 2021, *https://www.amnesty.org/fr/documents/amr20/4195/2021/fr/*

[28] Projet de Loi C-3, Loi modifiant la Loi sur la Gendarmerie royale du Canada et la Loi sur l'Agence des services frontaliers du Canada et apportant des modifications corrélatives à d'autres lois, 1re session 43e législature, 2019 (Dépôt et première lecture à la Chambre des communes 27 janvier 2020). *https://www.parl.ca/LegisInfo/BillDetails.aspx?billId=10613928&Language=F*

[29] Projet de Loi C-98, Loi modifiant la Loi sur la Gendarmerie royale du Canada et la Loi sur l'Agence des services frontaliers du Canada et apportant des modifications corrélatives à d'autres lois, 1re session, 42e législature, 2015 (Première lecture au Sénat 20 juin 2019). *https://www.parl.ca/LegisInfo/BillDetails.aspx?billId=10449322&Language=F*

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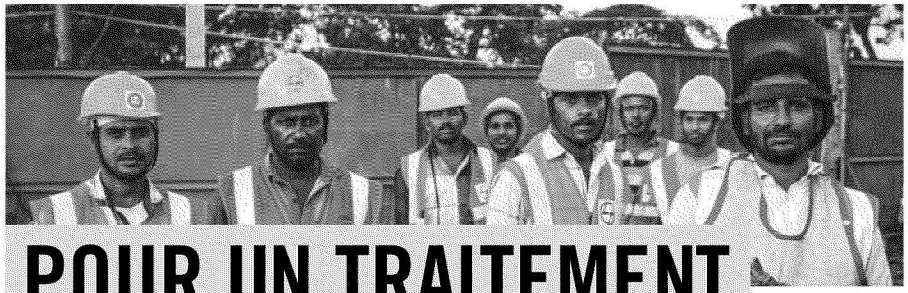
4 | DROITS DES PERSONNES MIGRANTES À STATUT PRÉCAIRE OU SANS STATUT

Le statut juridique précaire de plusieurs personnes migrantes signifie qu'elles ne peuvent exercer ni bénéficier de leurs droits humains, en particulier de leurs droits économiques, sociaux et culturels. Dans de nombreux cas, ces personnes ont un statut d'immigration précaire, ou n'ont aucun statut légal, ce qui les rend d'autant plus vulnérables au non-respect de leurs droits.

En décembre 2020, le gouvernement fédéral et le gouvernement du Québec ont lancé un programme spécial pour régulariser les statuts, et ouvrir la voie vers la résidence permanente, aux personnes demandeuses d'asile ayant prodigué des soins de santé pendant la pandémie de COVID-19. L'objectif affiché de ce programme est la reconnaissance de la contribution d'un grand nombre de travailleurs et travailleuses migrantes essentielles pendant la pandémie. Cependant, dans les faits, le programme ne vise que les personnes demandeuses d'asile ayant occupé certains postes dans les soins de santé, pendant certaines heures et semaines précises et seulement au cours de la première vague.

La pandémie a rappelé l'importance souvent sous-estimée des personnes migrantes, tant à titre de travailleurs et travailleuses qu'à titre de membre de la société en général. Elle a aussi révélé que ces personnes étaient très souvent exploitées et n'avaient pas toujours accès aux services essentiels, comme des soins de santé. Un rapport réalisé[30] par la Table de concertation des organisations au service des personnes réfugiées et immigrantes (TCRI) a révélé que des personnes demandeuses d'asile se sont vu refuser l'accès aux cliniques de dépistage, alors qu'elles ont droit aux services de santé publics et malgré le fait que la Régie de l'assurance maladie du Québec ait émis une directive rendant le dépistage et les soins liés à la COVID-19 gratuits pour tous[31].

Les personnes migrantes à statut précaire ou sans statut connaissent aussi de nombreuses barrières à l'emploi[32]. Leur manque d'expérience de travail au Canada, la non-reconnaissance de leurs qualifications et de leurs compétences acquises à l'étranger, les barrières de langue et la discrimination font en sorte qu'elles peuvent être forcées d'accepter des emplois sous-payés et des conditions de travail déplorables. Elles sont souvent recrutées par des agences d'emplois temporaires qui les ciblent tout particulièrement puisque, faute d'options, elles sont contraintes d'accepter de mauvaises conditions offertes. Elles se voient alors confinées à des emplois précaires n'offrant que peu ou pas de stabilité ni de possibilités d'avancement, accentuant d'autant les inégalités. De fait, la précarité de leur statut et la peur de perdre la possibilité de rester au Canada les découragent de dénoncer les violations de leurs droits relatifs au travail[33]. Même si ces personnes recrutées par les agences sont en principe couvertes par la Loi sur la santé et la sécurité au travail[34], la reconnaissance et la protection de leur droits est souvent difficile, particulièrement dans le secteur de la santé, y compris dans les résidences et les centres de soins de longue durée. De nombreux rapports et de nombreux médias ont pu constater que les employeurs de plusieurs de ces institutions ne respectaient pas les consignes de santé et de sécurité au travail, pourtant critiques pendant la pandémie.



POUR UN TRAITEMENT HUMAIN, DIGNE ET ÉQUITABLE

AMNISTIE INTERNATIONALE DEMANDE AU CANADA ET AU QUÉBEC

- **De reconnaître le caractère essentiel du travail réalisé par les personnes migrantes et les rendre toutes admissibles au Programme spécial de régularisation du gouvernement, en permettant aux personnes migrantes à statut précaire, temporaire ou irrégulier de présenter une demande de résidence permanente.**
- **D'adopter une stratégie garantissant que les droits humains des personnes migrantes, incluant leurs droits économiques sociaux et culturels, soient respectés, en régularisant leur statut.**

[30] Table de concertation des organismes au service des personnes réfugiées et immigrantes (TCRI), "Demandeurs d'asile travaillant dans les services essentiels: près de 400 témoignages," 17 septembre 2020, *tcri.qc.ca/images/publications/memoires/2020/Rapport_de_recherche_DA_travaillant_dans_les_services_essentiels_TCRI.pdf*

[31] Voir *www.ramq.gouv.qc.ca/fr/salle-presse/questions-reponses-nos-services-pandemie*

[32] Supra, note 30.

[33] Ibid.

[34] Loi sur la Santé et la Sécurité du Travail (RLRQ, chapitre S-2.1), *http://legisquebec.gouv.qc.ca/fr/showdoc/cs/S-2.1*

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5 | DROITS DES FEMMES

Au Canada, les femmes, les filles et les personnes d'autres identités de genre sont plus à risque de connaître la discrimination et la violence que les hommes et les garçons. En outre, les femmes autochtones, noires, racialisées, LGBTI, nouvellement arrivées, migrantes et réfugiées, les femmes âgées, celles aux prises avec un handicap, dépendantes aux drogues ou travaillant dans l'industrie du sexe sont affectées de manière disproportionnée par la discrimination et la violence fondée sur le genre. Les niveaux de violence fondée sur le genre, et en particulier la violence sexuelle, se sont maintenus au fil des ans, tandis qu'une fraction seulement de ces incidents est rapportée à la police, et que les auteurs de ces actes sont rarement reconnus coupables. La discrimination fondée sur le genre signifie aussi que ce sont les femmes qui portent le fardeau du travail non rémunéré, comme de prendre soin des proches, et qu'elles sont en moyenne moins bien rémunérées que les hommes.

Depuis 2015, le gouvernement fédéral a pris des mesures ciblées pour s'attaquer aux inégalités de genre au Canada. Ces mesures sont bienvenues, mais il faut aller plus loin et proposer des mesures clairement centrées sur les besoins des personnes les plus touchées, si on veut véritablement s'attaquer aux inégalités de genre, à la discrimination et à la violence.

LA PANDÉMIE DE COVID-19

La pandémie de COVID-19 a exacerbé les inégalités de genre. Au cours de la pandémie, les femmes ont connu des niveaux accrus de violence et un accès réduit aux services de soutien[35].Les femmes ont été sur la ligne de front de la pandémie, elles occupent des emplois historiquement « genrés », dans la santé, les services de garde, l'éducation, la vente au détail, l'entretien ménager.

La majorité du travail de première ligne était fait par des femmes immigrantes, et racialisées, sans papiers, et à faible revenu. En raison des restrictions liées à la Covid-19, dont le confinement, les femmes devaient absorber la surcharge de travail liée aux soins familiaux et aux tâches domestiques. Cette situation a entraîné un nombre record[36] de femmes ayant quitté le marché du travail, tandis que celles qui retournaient au travail ont été moins nombreuses et l'ont fait de façon plus lente que les hommes.

Les organisations faisant la promotion de l'égalité ont demandé une relance économique féministe après la pandémie[37] pour s'assurer que les plans de relance du gouvernement se penchent sérieusement sur les inégalités de genre, largement révélées pendant la pandémie et y remédient. Répondant aux appels en faveur d'une relance féministe post-pandémie, le Canada a lancé, en mars 2021, un Groupe de travail sur les femmes dans l'économie[38]. Le budget fédéral 2021-2022 contient un engagement[39] de plus de 27 milliards de dollars sur cinq ans en vue de la création d'un système national de services de garde abordables pour les familles.

VIOLENCE FONDÉE SUR LE GENRE

En septembre 2020, le gouvernement fédéral s'est engagé de nouveau[40] à élaborer un Plan d'action national pour mettre fin à la violence fondée sur le genre, mais n'a fourni aucun détail sur le processus envisagé. En juin 2021, sous la direction d'Hébergement Femmes Canada, un groupe de leaders en matière de violences faites aux femmes et fondées sur le genre a publié un rapport[41] pour accompagner la mise en place de ce Plan d'action national, tandis que les organisations de la société civile de manière générale pressent le gouvernement afin qu'il tienne sa promesse d'agir.

VIOLENCE ENVERS LES FEMMES ET LES FILLES AUTOCHTONES

Au Canada, les femmes et les filles autochtones — tant sur les réserves qu'en milieu urbain, et sans égard à l'âge ou au statut socioéconomique — sont au moins trois fois[42] plus à risque de subir de la violence, et au moins six[43] fois plus à risque d'être assassinées, que les femmes et les filles allochtones. En juin 2021, deux ans après la publication du rapport final de l'Enquête nationale sur les femmes et les filles autochtones disparues ou assassinées, le gouvernement fédéral lançait un Plan d'action national[44] pour la mise en œuvre des 231 appels à la justice, assorti d'un budget de cinq milliards de dollars.

Une étude[45] réalisée au début de la pandémie par l'Association des femmes autochtones du Canada a démontré que les femmes autochtones avaient davantage peur de la violence qu'elles étaient susceptibles de subir que de contracter la COVID-19, souligne l'urgence d'un tel plan. Le Plan d'action national présente un bon résumé de certains engagements à court terme du gouvernement, mais ne propose aucune mesure d'imputabilité[46] ni de plan détaillé et d'échéancier en lien avec les appels à la justice.

[35]Canadian Women's Foundation, Inuit Women of Canada, Women's Shelters Canada, Anita Olsen-Harper et Jihan Abbas, Resetting Normal: Systemic Gender-Based Violence and the Pandemic, 2020, *fw3s926r0g42i6kes3bxg4i1-wpengine.netdna-ssl.com/wp-content/uploads/2020/12/20-08-CWF-ResettingNormal-Report3_v5.pdf, pp. 22-27*

[36]Canadian Women's Foundation, Canadian Centre for Policy Alternatives, Ontario Nonprofit Network, et Fay Faraday, Resetting Normal: Women, Decent Work and Canada's Fractured Care Economy, 2020, *fw3s926r0g42i6kes3bxg4i1-wpengine.netdna-ssl.com/wp-content/uploads/2020/07/ResettingNormal-Women-Decent-Work-and-Care-EN.pdf*

[37]YWCA, Gender and the Economy, A Feminist Recovery Plan for Canada, *www.feministrecovery.ca/*

[38]Ministère des Finances Canada, Le gouvernement annonce les membres d'un nouveau Groupe de travail sur les femmes dans l'économie, 2021, *https://www.canada.ca/fr/ministere-finances/nouvelles/2021/03/le-gouvernement-annonce-les-membres-dun-nouveau-groupe-de-travail-sur-les-femmes-dans-leconomie.html*

[39]Un Enfant Une Place, La feuille de route du Canada vers des garderies abordables pour TOUT LE MONDE, 2021, *https://timeforchildcare.ca/2021/08/10/la-feuille-de-route-du-canada-vers-des-garderies-abordables-pour-tout-le-monde/?lang=fr*

[40]Gouvernement du Canada, Un Canada plus fort et plus résilient, Discours du Trône ouvrant la 2e session de la 43e législature du Parlement Canadien, 2020, *https://www.canada.ca/content/dam/pco-bcp/documents/pm/SFT_2020_FR_WEB.pdf*

[41]Women's Shelters Canada, Amanda Dale, PhD, Krys Maki, PhD, et Rotbah Nitia, Roadmap for the National Action Plan on Violence Against Women and Gender-Based Violence: A Report to Guide the Implementation of a National Action Plan on Violence Against Women and Gender-Based Violence, 2021, *nationalactionplan.ca/wp-content/uploads/2021/06/NAP-Final-Report.pdf*

[42]Jillian Boyce, La victimisation chez les Autochtones au Canada, Statistique Canada, 2014, *https://www150.statcan.gc.ca/n1/pub/85-002-x/2016001/article/14631-fra.htm*

[43]Joel Roy et Sharon Marcellus, L'homicide au Canada, 2018, Statistique Canada, 2018, *https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00016-fra.htm*

[44]Gouvernement du Canada, Plan d'action national 2021 pour les femmes, les filles et les personnes 2ELGBTQQIA+ autochtones disparues et assassinées : Mettre fin à la violence contre les femmes, les filles et les personnes 2ELGBTQQIA+ autochtones, 3 juin 2021, *https://mmiwg2splus-nationalactionplan.ca/wp-content/uploads/2021/06/NAP_Report_FR.pdf*

[45]Native Women's Association of Canada, The Impacts of COVID-19 on Indigenous Women and Gender Diverse People in Canada, 2020, *www.nwac.ca/resource/the-impacts-of-COVID-19-on-indigenous-women-and-gender-diverse-people-in-canada-survey/*

[46]Amnesty International Canada, Moving from rhetoric to action to end violence against First Nations, Métis, and Inuit women, girls and two-spirit people, 9 juin 2021, *https://www.amnesty.ca/blog/moving-from-rhetoric-to-action-to-end-violence-against-first-nations-metis-and-inuit-women-girls-and-two-spirit-people/*

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STÉRILISATION CONTRAINTE OU FORCÉE

La stérilisation forcée, une forme de violence fondée sur le genre, se produit lorsqu'une personne est stérilisée à son insu ou sans son consentement. La stérilisation contrainte se produit lorsqu'une personne consent à la stérilisation suite à des informations erronées ou des tactiques coercitives. Ces deux formes de stérilisation touchent de manière disproportionnée les femmes autochtones du Canada en raison du racisme systémique envers les Autochtones présent dans le système de santé. On ignore combien de femmes autochtones ont été stérilisées sans leur consentement au Canada, mais il existe des preuves irréfutables[47] que cette pratique n'a jamais cessé.

En 2018, le Comité des Nations unies contre la torture affirmait[48] que la stérilisation forcée et contrainte des femmes au Canada était une forme de torture et appelait le Canada à enquêter sur les cas présumés, à mettre fin à cette pratique, et à rendre justice aux survivantes. En juin 2021, le Comité sénatorial permanent des droits de la personne a publié son rapport[49] concernant cette pratique, demandant une étude plus approfondie de la question et des actions de la part du gouvernement. L'attention portée au racisme systémique dans les systèmes de santé au Canada est certes bienvenue et nécessaire, mais elle ne peut se substituer à des actions précises pour stopper les stérilisations forcées et contraintes.

À ce jour, le Canada n'a toujours pas mis en œuvre les recommandations formulées en 2018 par le Comité contre la torture des Nations unies.

DROITS DES TRAVAILLEUSES ET TRAVAILLEURS DU SEXE

La criminalisation du travail du sexe[50] constitue une barrière à la réalisation des droits humains[51] des personnes œuvrant dans l'industrie du sexe au Canada. Celles-ci sont majoritairement des femmes et des personnes LGBTQ2S, faisant partie des groupes parmi les plus marginalisés et les plus stigmatisés de la société. Les travailleuses et travailleurs du sexe sont confrontés à des risques accrus de violence et de sévices, et les crimes à leur égard, quand ils sont rapportés, font rarement l'objet d'enquêtes et demeurent souvent impunis.

La plupart des travailleuses et travailleurs du sexe ont brutalement perdu leurs revenus[52] à la suite des mesures de confinement liées à la COVID-19 dans tout le Canada. Mais contrairement à celles et ceux des autres industries, les travailleuses et travailleurs du sexe n'ont généralement pas pu avoir accès aux prestations d'urgence[53] en raison de la criminalisation de leur travail.

[47] Amnistie Internationale, Mémoire d'Amnistie Internationale au comité sénatorial permanent des droits de la personne dans le cadre de l'étude sur la stérilisation sans consentement, 1er avril 2019, *https://sencanada.ca/content/sen/committee/421/RIDR/Briefs/AmnestyInternational_Brief_f.pdf*

[48] Committee against Torture, Concluding observations on the seventh periodic report of Canada, *https://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/CAN/CAT_C_CAN_CO_7_33163_E.pdf*

[49] Sénat du Canada, Comité sénatorial permanent des droits de la personne, «La stérilisation forcée et contrainte de personnes au Canada," 3 juin 2021, *https://sencanada.ca/fr/comites/rapport/94746/43-2*

[50] Amnistie Internationale utilise le terme « travail du sexe « pour désigner l'échange de services sexuels (impliquant des actes sexuels) entre adultes consentants contre une certaine forme de rémunération, les conditions étant convenues entre le vendeur et l'acheteur. Lorsque le consentement est absent pour des raisons telles que la menace ou le recours à la force, la tromperie, la fraude, l'abus d'autorité ou l'implication d'un enfant, cette activité constitue une violation des droits humains et doit être considérée comme une infraction pénale, Voir *https://www.amnesty.org/fr/documents/pol30/4063/2016/fr/*

[51] Amnistie Internationale, Position d'AI relative à l'obligation des états de respecter, protéger et mettre en œuvre les droits humains des travailleuses et travailleurs du sexe, (POL 30/4062/2016, p. 2), 26 mai 2016, *https://www.amnesty.org/fr/documents/pol30/4062/2016/fr/*

[52] Amnesty International Canada, Amnesty International, Canada's exclusion of sex workers from COVID-19 emergency income supports is shameful and violates human rights, 25 juin 2020, *https://www.amnesty.ca/news/canadas-exclusion-of-sex-workers-from-covid-19-emergency-income-supports-is-shameful-and-violates-human-rights/*

[53] Amnesty International Canada (English Section), Canada must protect the rights of sex workers during COVID-19 by ensuring access to emergency income supports, 4 juin 2020, *https://www.amnesty.ca/blog/canada-must-protect-the-rights-of-sex-workers-during-covid-19-by-ensuring-access-to-emergency-income-supports/*

En mars 2021, l'Alliance canadienne pour la réforme des lois sur le travail du sexe et quelques requérants individuels ont déposé un avis de requête[54] dans le but de faire abolir les lois canadiennes criminalisant le travail du sexe, en violation avec les droits constitutionnels à la sécurité, à l'autonomie personnelle, à la vie, à la liberté, à la liberté d'expression et d'association, ainsi qu'à l'égalité.

AMNISTIE INTERNATIONALE DEMANDE AU CANADA

- **De remplir sa promesse d'élaborer un Plan d'action national sur la violence fondée sur le genre, doté de ressources suffisantes.**
- **De publier rapidement les plans de mise en œuvre et de reddition de comptes pour le Plan d'action national concernant les femmes, les filles et les personnes 2ELGBTQQIA autochtones disparues ou assassinées.**
- **De mettre en œuvre les recommandations du Comité contre la torture des Nations unies afin de mettre fin aux stérilisations forcées et contraintes.**
- **De décriminaliser le travail du sexe.**

AMNISTIE INTERNATIONALE DEMANDE AUX GOUVERNEMENTS DU CANADA

- **D'élaborer des plans pour une relance économique intersectionnelle féministe post-pandémie.**

[54] Centre de documentation sur l'éducation des adultes et la condition féminine, Des groups de défense des droits des travailleur-euses du sexe lancent une contestation, 6 avril 2021, *http://cdeacf.ca/actualite/2021/04/06/groupes-defense-droits-travailleur-euses-sexe-lancent*

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6 | DROITS DES PERSONNES LGBTQ2S

Bien que de grands progrès aient été réalisés au cours des dernières décennies pour promouvoir et protéger les droits des personnes LGBTQ2S, de l'égalité en matière de mariage aux protections des droits spécifiques des personnes transgenres, l'homophobie et la transphobie sont toujours solidement enracinées. Les personnes LGBTQ2S connaissent plus de discrimination et de violence que les personnes hétérosexuelles et cisgenres; et les personnes transgenres et non binaires font face à une sévère discrimination. Les personnes LGBTQ2S font aussi face à des discriminations les empêchant d'accéder aux services de santé, générant ainsi beaucoup d'itinérance, de pauvreté, d'isolement social, et des niveaux élevés de harcèlement et de violence. En raison de leurs identités multiples et intersectionnelles, les droits des femmes trans noires et racialisées sont particulièrement à risque d'être violés.

Une réponse coordonnée du gouvernement est nécessaire pour mettre fin à ces violations des droits humains.

LA PANDÉMIE DE COVID-19

La pandémie de COVID-19 a davantage exacerbé les inégalités[55] vécues par les personnes LGBTQ2S, dont les barrières à l'accès aux soins de santé, l'itinérance, la pauvreté, l'isolement social, le harcèlement et la violence.

L'accès à des traitements d'affirmation de genre ainsi qu'à des services de santé sexuelle et reproductive a été dramatiquement réduit ou réorienté, pour répondre à la COVID-19. Certaines personnes ont eu des difficultés[56] à obtenir leurs médications. Les restrictions de la santé publique ont entravé l'accès aux familles choisies, aux groupes de soutien et aux services sociaux, y compris ceux procurant de la nourriture et des médicaments, en violation au droit à la santé.

THÉRAPIE DE CONVERSION

En octobre 2020, le Canada déposait un projet de loi pour interdire les thérapies de conversion[57] (projet de loi C-6) qui vise à modifier l'orientation sexuelle d'une personne ou à en réprimer l'identité ou l'expression de genre. Le projet de loi était toujours à l'étude devant le Sénat au moment du déclenchement des élections fédérales le 15 août 2021.

DROITS DES PERSONNES INTERSEXES

Certaines personnes sont nées avec des caractéristiques sexuelles qui diffèrent des normes généralement établies de « masculin » et de « féminin », et plusieurs d'entre elles sont soumises à des interventions pour « normaliser » leur corps, par la chirurgie ou des traitements hormonaux. Au Canada, des enfants intersexes font souvent l'objet de chirurgies non urgentes, invasives et irréversibles, et de traitements hormonaux pouvant causer des dommages physiques et psychologiques à court, moyen et long terme. De fait, le Code criminel du Canada[58] permet aux parents et aux médecins d'entreprendre des chirurgies esthétiques non consenties sur des enfants intersexes.

En 2018, l'organisation LGBTQ2S Egale enjoignait[59] le gouvernement du Canada d'adhérer aux standards internationaux de droits humains en apportant les modifications nécessaires au Code criminel pour que soient interdites les chirurgies non consensuelles et médicalement inutiles sur les enfants intersexes. Au moment de la publication de ce rapport, le Canada n'a toujours pas mis en œuvre ces recommandations.

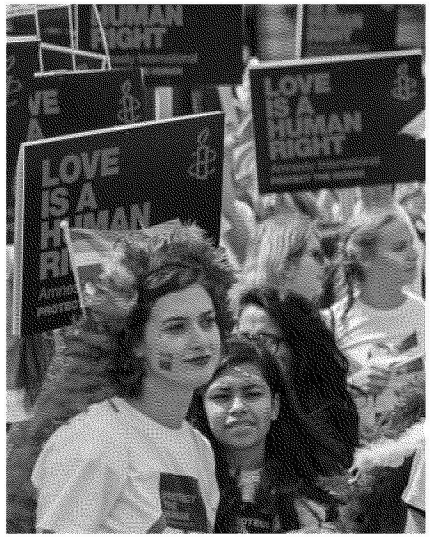
Au Québec, le gouvernement vient de proposer une vaste réforme du Code civil et de la loi de la famille. Le texte du projet de loi 2 prévoit qu'une personne ne pourra changer son identité de genre sur son acte de naissance que si elle a «des traitements médicaux et des interventions chirurgicales impliquant une modification structurale de ses organes sexuels». Une exigence qui avait pourtant été abolie du Code civil en 2013.

TRANSPHOBIE

Certains groupes « féministes » au Canada excluent volontairement les personnes transgenres. Pour contrer l'augmentation de ces réactions anti-trans, plus d'une centaine d'organisations ont signé, en mai 2021, une lettre commune[60] affirmant que leur féminisme était totalement inclusif des personnes transgenres. La discrimination envers les personnes transgenres dans les espaces féministes est un indicateur de l'envergure et de l'étendue de la discrimination et de la violence vécues par les personnes transgenres dans la société.

PLAN D'ACTION NATIONAL LGBTQ2S

En novembre 2020, le Canada lançait une démarche pour élaborer un Plan d'action LGBTQ2[61], afin de mieux comprendre les enjeux et de coordonner les actions du gouvernement fédéral pour combattre l'homophobie et la transphobie. Le processus de consultation de la société civile s'est terminé en juillet 2021, mais le plan d'action n'a pas encore été publié.



[55] Innovative Research Group et Egale, Impact of COVID-19: Canada's LGBTQI2S Community in Focus, 6 avril 2020, *egale.ca/wp-content/uploads/2020/04/Impact-of-COVID-19-Canada%E2%80%99s-LGBTQI2S-Community-in-Focus-2020-04-06.pdf*

[56] Innovative Research Group, African-Canadian Civic Engagement Council, et Egale "Second National Report: The Impact of COVID-19 on Canada's LGBTQI2S Community," 27 août 2020, *egale.ca/egale-in-action/covid19-impact2/#FullReport*

[57] Projet de Loi C-6, Loi modifiant le Code criminel (thérapie de conversion), 2e session, 43e législature, (Deuxième lecture au Sénat 28 juin 2021), *https://www.parl.ca/LegisInfo/BillDetails.aspx?billId=10871883&Language=F*

[58] Code Criminel, L.R.C 1985, ch C-46, art 268(3), *https://laws-lois.justice.gc.ca/eng/acts/c-46/section-268.html*

[59] Eagle Canada, Egale Canada urges the Federal Government to meet domestic and International Human Rights requirements of Intersex People on International Intersex Awareness Day, 26 octobre 2018, *egale.ca/awareness/egale-canada-urges-the-federal-government-to-meet-domestic-and-international-human-rights-requirements-of-intersex-people-on-international-intersex-awareness-day/*

[60] Notre féminisme inclut les personnes trans, lettre commune, 4 mai 2021, *https://www.actioncanadashr.org/fr/nouvelles/2021-05-04-notre-feminisme-inclut-les-personnes-trans*

[61] Gouvernement du Canada, "Prenez part au Plan d'action LGBTQ2," 2020, *https://www.canada.ca/fr/patrimoine-canadien/campagnes/sois-toi-meme/plan-action-lgbtq2.html*

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RECONNAÎTRE, PROTÉGER ET PROMOUVOIR LES DROITS DES PERSONNES LGBTQ2S

AMNISTIE INTERNATIONALE DEMANDE AUX GOUVERNEMENTS DU CANADA

- De s'assurer que les plans de relance post-pandémie soient totalement inclusifs des personnes LGBTQ2S.
- De promouvoir activement un féminisme inclusif des personnes trans dans tous les programmes et politiques gouvernementales.
- De mettre en œuvre des mesures pour protéger les enfants intersexes contre les interventions et les traitements médicaux non nécessaires et réalisés sans leur libre et plein consentement.
- D'adopter rapidement le projet de loi C-6 sur les thérapies de conversion.
- De lancer publiquement le Plan d'action LGBTQ2, assorti de ressources suffisantes.

AMNISTIE INTERNATIONALE DEMANDE AU QUÉBEC

- De réviser son projet de loi 2 modifiant le Code civil et réformant le droit de la famille, et de renoncer à imposer l'obligation pour les personnes trans et non binaires d'une intervention médicale, pour pouvoir changer le marqueur de sexe sur leur acte de naissance.

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7 | ACTEURS ÉCONOMIQUES ET DROITS HUMAINS

La pandémie a révélé l'importance accordée aux intérêts économiques des entreprises, au détriment de la santé et de la sécurité des communautés et des travailleuses et des travailleurs.

Or, les entreprises canadiennes ont en tout temps l'obligation de protéger les personnes à leur emploi[62], pandémie ou non, et l'État doit veiller à ce qu'elles respectent leurs obligations.

De nombreux pays, dont le Canada, ont considéré les domaines de la construction et de l'exploitation des ressources naturelles comme des secteurs « essentiels » et ont autorisé la poursuite de leurs opérations tout au long de la pandémie, avec très peu de contrôle tant de la part du gouvernement canadien.

Des milliers de personnes ont contracté la COVID-19[63] sur des sites d'activités pétrolières, gazières, minières et de construction partout dans le monde. Le peu d'information publique disponible et le manque d'encadrement exercé par les gouvernements nous empêchent d'avoir un portrait juste de l'état réel de la contamination. De plus, dans de nombreux pays où les sociétés canadiennes ont leurs opérations, l'accès aux soins de santé et aux vaccins se fait rare.

Le Canada continue de soutenir les entreprises canadiennes dans une centaine de pays à l'étranger, sans disposer de garanties ou de lois adéquates pour protéger les droits humains et l'environnement[64], ou exiger une diligence raisonnable de la part des entreprises canadiennes et de leurs filiales. Des groupes de la société civile canadienne et leurs partenaires demandent au Canada d'adopter une loi de diligence raisonnable en matière de droits humains et d'environnement afin que d'assurer l'imputabilité des compagnies lorsqu'elles se rendent responsables de violations de droits humains ou de dommages à l'environnement.

Tout au long de la pandémie, d'un bout à l'autre du Canada, des travailleurs ont continué de se rendre en zone éloignée dans des camps de travail de projets[65] d'extracion et de construction. Malgré les risques de transmission, notamment lors des voyages aériens, les gouvernements ont autorisé les multiples allers-retours de cette main-d'œuvre pour maintenir ces opérations jugées « essentielles ».

Des groupes de la société civile, le BC Building Trades Council[66] et des organisations autochtones[67] ont demandé au gouvernement fédéral et aux gouvernements provinciaux de ralentir le travail sur les chantiers des mégaprojets, et de prioriser la santé et la sécurité de la main-d'œuvre et des communautés. Mais les activités des mégaprojets comme le Barrage du Site C[68] et le gazoduc Coastal Gaslink ont été maintenues, et des cas de transmissions ont effectivement été déclarés. Sur le site du projet de sables bitumineux de Kearl Lake, une flambée de cas s'est répandue dans quatre provinces et a causé la mort de deux personnes aînées d'une communauté Dene isolée, en Saskatchewan.

En décembre 2020, la responsable provinciale de la santé publique en Colombie-Britannique, Dre Bonnie Henry, a émis une ordonnance[69], en vertu de la Loi de la santé publique, visant à réduire le nombre de travailleurs sur les sites des grands projets tels le Site C, le projet TMX et Coastal Gaslink, à la lumière des risques accrus de transmission entre la main-d'œuvre et les communautés environnantes.

Les risques de contamination encourus par les Autochtones vivant près de ces grands projets de développement ou y travaillant sont plus élevés[70] que pour le reste de la population, en raison notamment du sous-financement chronique du logement, des services d'eau potable, des infrastructures et des services de santé. Sans compter sur l'impact négatif induit à la sécurité alimentaire et aux pratiques culturelles traditionnelles.

ÉCONOMIE À LA DEMANDE

La sécurité et la santé des travailleuses et travailleurs de l'« économie à la demande», appelée *gig economy* en anglais, à l'emploi d'entreprises d'achat et de livraison en ligne, telles Amazon, ont gravement été mises à risque au cours de la pandémie.

Amazon est l'un des services d'achat et de livraison en ligne les plus utilisés dans le monde, et son PDG, Jeff Bezos, est maintenant la personne la plus riche au monde.

Au cours de la pandémie, les profits de l'entreprise ont grimpé en flèche alors que ses 200 millions d'abonnés, confinés à la maison à la demande des gouvernements, s'y faisaient livrer divers biens de consommation. Amazon a aussi signé des ententes avec différents gouvernements dans le monde pour assurer la livraison de matériel et d'équipements liés à la gestion de la pandémie. Le gouvernement du Canada a signé une telle entente[71] pour des équipements de protection individuelle et d'autres fournitures aux hôpitaux et municipalités de tout le pays.

Malgré les profits réalisés pendant la pandémie, les travailleuses et travailleurs d'Amazon ont dû se battre pour assurer leur sécurité. Dans plusieurs pays, des défaillances dans les mesures de dépistage, de distanciation, et dans les protocoles de santé et sécurité ont été rapportés dans plusieurs centres de l'entreprise. Chez Amazon Canada les travailleuses et travailleurs ont rapporté les mêmes préoccupations de santé et sécurité : distanciation physique et équipements de protection individuels insuffisant, accès déficient aux installations sanitaires, absence d'information sur les cas positifs. Amazon Canada et des fonctionnaires de la santé publique ont refusé de rendre publique l'information sur les tests positifs.

De nombreux ouvriers et ouvrières d'usine en Ontario sont des personnes issues de l'immigration récente, souvent racialisées, qui subissent une énorme pression économique pour continuer à travailler, malgré leur inquiétude face à la COVID-19. En même temps la compagnie s'opposait aux tentatives de syndicalisation

[62] Amnesty International, As they emerge from lockdown, businesses must protect their workers, 21 mai 2020, *https://www.amnesty.org/en/documents/pol30/2383/2020/en/*

[63] Earthworks et al., Voices from the Ground, How the Global Mining Industry is Profiting from the COVID-19 Pandemic, juin 2020, *https://miningwatch.ca/sites/default/files/covid-19_and_mining_snapshot_report_-_web_version.pdf*

[64] Voir *https://cnca-rcrce.ca/campaigns/business-human-rights-legislation-hrdd/*

[65] Fondation David Suzuki, Governments must close resource project work camps near rural, Indigenous communities amid COVID-19, 29 avril 2020, *https://davidsuzuki.org/press/governments-must-close-resource-project-work-camps-near-rural-indigenous-communities-amid-covid-19/*

[66] Voir *bcbuildingtrades.org/building-trades-council-calls-for-scaling-down-of-remote-camp-megaprojects/*

[67] Open Letter: Designation of Oil and Gas Work as "non-Essential" is Critical for Protecting the Lives and Rights of Vulnerable First Nations Facing COVID-19, 8 décembre 2020, *https://www.ubcic.bc.ca/open_letter_designation_of_oil_and_gas_work_as_non_essential_is_critical_for_protecting_the_lives_and_rights_of_vulnerable_first_nations_facing_covid_19*

[68] Amnistie Internationale, Canada: Le Point de Non-Retour: Les Droits des Peuples Autochtones du Canada Menacés par le Barrage du Site C, 8 août 2016, *https://www.amnesty.org/fr/documents/amr20/4281/2016/fr/*

[69] Government of British Columbia, Order of the Provincial Health Officer, Industrial Projects Restart, 29 décembre 2020, *www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/COVID-19/archived-docs/COVID-19-pho-order-industrial-projects-december-29.pdf*

[70] Sarah Cox, 'Send everybody home': potential coronavirus outbreak at Site C dam a threat to Fort St. John, local officials say, The Narwhal, 26 mars 2020, *https://thenarwhal.ca/send-everybody-home-potential-coronavirus-outbreak-at-site-c-dam-a-threat-to-fort-st-john-local-officials-say/*

[71] Services publics et Approvisionnement Canada, Le gouvernement du Canada collabore avec Amazon pour aider à obtenir de l'équipement de protection individuelle pour les travailleurs de la santé de première ligne, 3 avril 2020, *https://www.canada.ca/fr/services-publics-approvisionnement/nouvelles/2020/04/le-gouvernement-du-canada-collabore-avec-amazon-pour-aider-a-obtenir-de-lequipement-de-protection-individuelle-pour-les-travailleurs-de-la-sante-de.html*

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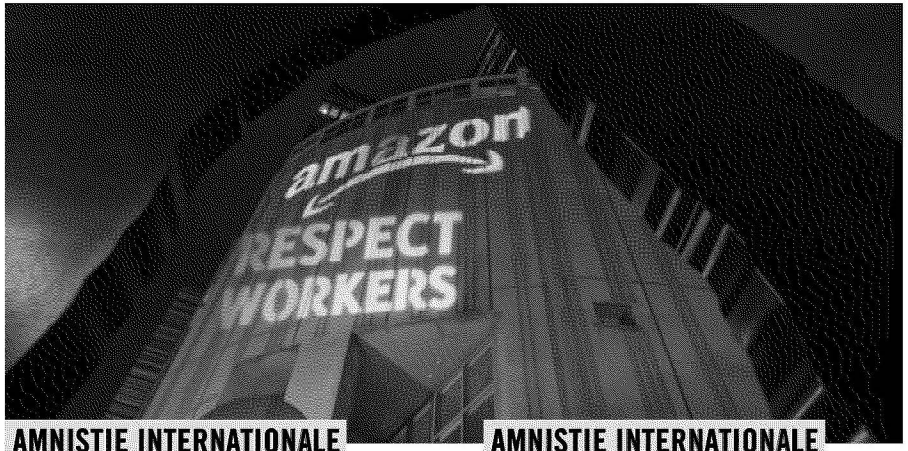
de ses employé·e·s, par des tactiques douteuses, incluant l'espionnage des leaders[72] des campagnes de syndicalisation.

Tandis qu'Amazon s'implante de plus en plus au pays, le Canada doit donc demeurer vigilant parce que ce n'est pas dans la nature de cette entreprise d'offrir de bonnes conditions de travail et de respecter les droits de ses employé·e·s.



AMNISTIE INTERNATIONALE DEMANDE AU CANADA

- **De stopper immédiatement la construction du barrage du Site C et des pipelines Coastal Gaslink et Trans Mountain, et de chercher à obtenir le consentement libre, préalable et éclairé des Secwepemc et des Wet'suwet'en, et d'autres peuples autochtones touchés par ces projets.**
- **De veiller à ce que les compagnies sous contrat avec le gouvernement fournissent les services nécessaires pendant la pandémie de COVID-19 pour protéger la santé et la sécurité des travailleurs et travailleuses et respecter les droits du travail, dont celui de se syndiquer.**

AMNISTIE INTERNATIONALE DEMANDE AUX ENTREPRISES

- **De fournir à leur personnel et à leurs prestataires des mesures de réparation appropriées, pouvant inclure, sans s'y limiter, des compensations financières, la réintégration, et la prévention de futurs préjudices, quand il est démontré qu'elles ont failli à leurs obligations de fournir des conditions de travail sécuritaires et de protéger leurs travailleurs et travailleuses à l'exposition à la COVID-19.**
- **De cesser de harceler ceux et celles qui soulèvent les questions de santé et sécurité.**
- **De respecter le droit des travailleurs et travailleuses à se syndiquer et de cesser toute manœuvre de surveillance et d'intimidation.**

[72] Amnistie Internationale, Amazon doit respecter les droits syndicaux des travailleurs et travailleuses, 13 octobre 2020, *https://www.amnesty.org/fr/latest/research/2020/10/time-for-amazon-to-respect-workers-right-to-unionize/*

8 | JUSTICE CLIMATIQUE

Le climat se dégrade partout dans le monde, et le Canada n'y échappe pas. L'extraordinaire vague de chaleur qui a balayé l'Ouest canadien suivie d'inondations et de centaines de feux de forêt illustre parfaitement l'urgence climatique. Le sixième rapport[73] du Groupe d'experts intergouvernementaux sur l'évolution du climat (GIEC) rappelle que le temps presse. Ce rapport confirme que les changements de température au Canada sont beaucoup plus élevés que la moyenne mondiale et que les conséquences seront variables selon les régions.

Le Canada est l'un des plus grands émetteurs de gaz à effet de serre au monde et il continue de subventionner l'industrie des combustibles fossiles, avec un montant estimé à 1,9 milliard de dollars de subventions en 2020 seulement[74]. Le Canada ne comptabilise pas les émissions de gaz des combustibles qu'il exporte à l'étranger, masquant ainsi son véritable impact sur le climat. Les cibles de réduction des gaz à effet de serre de même que les plans climatiques ne permettront pas de respecter l'objectif de limiter la hausse des températures à 1,5 degré Celsius au-dessus des niveaux préindustriels. Cette cible a été fixée par le GIEC pour éviter les impacts les plus catastrophiques des changements climatiques.

Le Canada ne dispose pas d'une planification adéquate pour réduire l'exploitation des combustibles fossiles.

Les cibles de réduction du Canada pour 2030 sont très en dessous de ce qui devrait être considéré comme une contribution juste du Canada à l'effort mondial[75] pour s'attaquer à la crise. Le Canada aurait pu soutenir davantage l'action climatique en proposant par exemple des mesures de financement climatique. Malheureusement, il n'y a pas d'initiatives de ce type dans la cible déterminée au niveau national (CDN) du Canada.

DISCRIMINATION ET INÉGALITÉS SOCIALES

Les changements climatiques touchent de manière disproportionnée les personnes qui vivent des formes multiples et intersectionnelles de discrimination, comme les femmes et les filles, les communautés autochtones, noires et racialisées, les personnes vivant avec un handicap, de même que les jeunes générations. C'est pourquoi, en 2018, le groupe environnemental EnJeu a déposé un recours collectif[76] contre le gouvernement canadien, au nom de tous les jeunes Québécois·e·s de moins de 35 ans, alléguant des violations de leurs droits en vertu de la Charte canadienne des droits et libertés et de la Charte des droits et libertés du Québec, pour non-respect des cibles d'émissions de réduction des gaz à effet de serre.

En juillet 2019, la Cour supérieure du Québec a refusé d'accorder l'autorisation d'exercer une action collective pour la justice climatique. EnJeu a porté la cause en appel, et a fait valoir ses arguments en février 2021 devant la Cour d'appel du Québec. La Cour n'a toujours pas rendu sa décision.

[73] Groupe d'experts intergouvernemental sur l'évolution du climat, AR6 climate change 2021: the physical science basis, 7 août 2021, *https://www.ipcc.ch/languages-2/francais/*

[74] Vanessa Corkal, "Fossil fuel subsidies in Canada: COVID-19 edition," International Institute for Sustainable Development, 25 février 2021, *https://www.iisd.org/publications/fossil-fuel-subsidies-canada-covid-19*

[75] Réseau Action Climat, La nouvelle contribution déterminée au niveau national du Canada ne reflète pas la plus grande ambition possible, 12 juillet 2021, *https://climateactionnetwork.ca/2021/07/12/la-nouvelle-contribution-determinee-au-niveau-national-du-canada-ne-reflete-pas-la-plus-grande-ambition-possible/?lang=fr*

[76] Amnesty International Canada (Section anglophone), Environnement jeunesse (EnJeu) v. Attorney General of Canada, 26 février 2020), *www.amnesty.ca/legal-brief/environnement-jeunesse-enjeu-v-attorney-general-canada*

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Au cours des deux dernières années, le gouvernement fédéral et les gouvernements provinciaux du Canada ont ignoré les inquiétudes des peuples autochtones quant aux impacts climatiques des projets de pipelines et de leur extension, de même que des projets de fracturation hydraulique, et ont autorisé leur poursuite. Dans de nombreux cas, cela a provoqué de graves conflits. Les défenseur·e·s de l'environnement autochtones s'inquiètent de l'accès à l'eau potable, à la sécurité alimentaire, aux médicaments traditionnels, des dommages à la santé humaine, et de la perte des activités de chasse, de pêche ainsi que des pratiques cérémonielles liées au territoire.

Certains ont demandé d'instaurer des « zones d'exclusion » de l'exploitation minière, forestière, et d'autres activités extractives à grande échelle, comme stratégie de protection des habitats et des cours d'eau essentiels.

TRANSITION VERS UNE ÉNERGIE JUSTE

Le Canada s'est engagé à investir des millions de dollars dans des énergies propres, des véhicules à zéro émission, et la création d'un million d'emplois dans ce secteur. Mais, à moins de mettre en place des mesures adéquates de protection des droits humains, la ruée pour l'extraction des minéraux nécessaires à la transition énergétique pourrait nuire aux communautés qui portent déjà, de manière disproportionnée, le fardeau de la crise climatique.

La transition énergétique du Canada ne doit pas se faire au détriment des droits humains et d'un environnement sain pour les communautés qui extraient et traitent les minerais utilisés dans les panneaux solaires, les autos électriques et les turbines éoliennes.

DES CHANGEMENTS MAJEURS DOIVENT S'OPÉRER POUR PROTÉGER L'HUMANITÉ ET LA PLANÈTE

AMNISTIE INTERNATIONALE DEMANDE AU CANADA

- **De réaliser l'objectif zéro émission d'ici 2030.**
- **D'éliminer progressivement l'utilisation des combustibles fossiles d'ici 2030.**
- **De cesser la production et l'utilisation de combustibles fossiles et d'autres formes de production les plus polluantes, comme le charbon, la tourbe, la fracturation hydraulique et les sables bitumineux dès que possible, mais au plus tard en 2030, et de mettre fin immédiatement aux subventions pour les projets de combustibles fossiles.**
- **De travailler immédiatement à l'élaboration de plans concrets, à long terme, qui respectent les droits humains et qui mettent l'accent sur les savoirs autochtones, pour assurer une transition juste et durable vers une énergie renouvelable.**
- **D'augmenter le financement et le soutien aux initiatives climatiques fondées sur une approche de droits humains, y compris le transfert technologique, dans les pays moins nantis, incapables d'entreprendre par eux-mêmes les mesures nécessaires d'atténuation et d'adaptation aux changements climatiques.**

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9 | VENTES D'ARMES

Le Canada exporte des armes vers des zones où elles pourraient être utilisées pour commettre des violations graves de droits humains. Des organisations de la société civile canadienne protestent depuis longtemps contre ces ventes d'armes, qui se poursuivent néanmoins à un rythme soutenu.

Les exportations d'armes représentent une industrie de plusieurs milliards de dollars[77] pour le Canada. En 2020, le Canada a exporté pour 1,96 milliard de dollars en technologies et équipements militaires contrôlés, dont 1,31 milliard de dollars vers l'Arabie saoudite seulement.

Le Canada rapporte que : « Tout au long de la pandémie de COVID-19, le traitement des demandes de licences d'exportation et de courtage a été considéré comme un service prioritaire. »[78] Effectivement, en avril 2020, le ministre des Affaires étrangères, François-Philippe Champagne, et l'ancien ministre des Finances, Bill Morneau, déclaraient qu'ils avaient renégocié les conditions du contrat de ventes d'armes à l'Arabie saoudite de 14 milliards de dollars. Au même moment, ils annonçaient[79] que le Canada allait créer un groupe consultatif d'experts indépendants chargé d'examiner les meilleures pratiques concernant les exportations d'armes et d'engager des discussions multilatérales pour l'établissement d'un régime d'inspection international. Toutefois, aucune avancée n'a encore été annoncée sur l'une ou l'autre de ces initiatives.

Toujours en avril 2020, le Canada publiait son Rapport final[80] sur les permis d'exportation vers l'Arabie saoudite. L'examen du gouvernement n'est pas conforme aux obligations internationales du Canada en vertu du Traité sur le commerce des armes, et ne s'appuie sur aucun rapport des organisations de droits humains pour déterminer si les armes canadiennes sont utilisées pour commettre des violations de droits humains dans le cadre de la guerre au Yémen menée par l'Arabie saoudite. En septembre 2020, le Groupe d'éminents experts internationaux et régionaux sur le Yémen condamnait[81] le Canada pour avoir exporté des armes à des parties impliquées dans le conflit au Yémen, contribuant ainsi à perpétuer la guerre. Amnistie internationale et Project Ploughshares ont publié en août 2021 un rapport[82] documentant le manque de rigueur de l'évaluation faite par le Canada.

En juin 2021, le Comité permanent de la Chambre des communes sur les Affaires étrangères et le développement international publiait un rapport sur le contrôle des exportations d'armes canadiennes. Celui-ci recommandait que « les obligations juridiques nationales et internationales du Canada représentent le facteur qui l'emporte sur toutes les autres considérations éclairant la politique du gouvernement du Canada sur les exportations d'armes, y compris l'évaluation du risque.[83] »

À la lumière de la grave crise des droits humains que vit la Colombie, et de la sévère répression des manifestations dans tout le pays[84], Amnistie internationale a demandé[85] au Canada, en juin 2021, de mettre fin au transfert d'armes vers ce pays, par crainte qu'elles ne soient utilisées à l'encontre de la population civile. Les exportations militaires du Canada vers la Colombie ont déjà inclus des hélicoptères et des véhicules blindés. En 2020, la valeur des exportations militaires du Canada vers la Colombie s'élevait à 460 339 de dollars.

AMNISTIE INTERNATIONALE DEMANDE AU CANADA

- **De mettre fin à l'exportation d'équipements militaires lorsqu'il existe un risque que ces équipements soient utilisés pour commettre des violations des droits humains.**
- **De mettre en place, en consultation avec les organisations de la société civile, le groupe consultatif d'experts indépendants pour identifier les meilleures pratiques relatives à l'exportation d'armes.**

[77] Affaires Mondiales Canada, Exportations de marchandises militaires 2020, juin 2021, *https://www.international.gc.ca/trade-commerce/assets/pdfs/controls-controles/reports-rapports/military_goods-2020-marchandises_militaires-fr.pdf*

[78] bid.

[79] Affaires Mondiales Canada, Le Canada revoit son contrat pour la vente de véhicules blindés légers, et renforce son examen de permis d'exportation, 9 avril 2020, *www.canada.ca/en/global-affairs/news/2020/04/canada-improves-terms-of-light-armored-vehicles-contract-putting-in-place-a-new-robust-permits-review-process.html*

[80] Gouvernement du Canada, Rapport final: examen des licences d'exportation vers l'Arabie saoudite, avril 2020, *https://www.international.gc.ca/trade-commerce/controls-controles/memo/annex-a-ksa.aspx?lang=fra*

[81] The Group of Eminent International and Regional Experts on Yemen, UN Human Rights Council, Report of the Group of Eminent International and Regional Experts on Yemen, A/HRC/45/6, 28 septembre 2020, *www.ohchr.org/Documents/HRBodies/HRCouncil/GEE-Yemen/2020-09-09-report.pdf*

[82] Amnistie Internationale et Project Ploughshares, Aucune preuve crédible: L'analyse fautive du Canada sur les exportations d'armes vers l'Arabie saoudite, août 2021, *https://amnistie.ca/sinformer/2021/canada/arabie-saoudite-la-vente-darmes-canada-arabie-saoudite-bafoue-le-droit*

[83] Chambre des communes, Comité permanent des affaires étrangères et du développement international, Évaluer les risques, prévenir les détournements et accroître la transparence : Renforcer les contrôles à l'exportation des armes du Canada dans un monde volatil, juin 2021, *https://www.noscommunes.ca/DocumentViewer/fr/43-2/FAAE/rapport-9*

[84] Amnesty International, Colombia: Cali: in the epicenter of repression: human rights violations during the 2021 national strike in Cali, Colombia, 30 juillet 2021 (Index: AMR 23/4405/2021), *www.amnesty.org/en/documents/amr23/4405/2021/en/*

[85] Amnistie internationale, Le Canada doit suspendre les exportations d'armes vers la Colombie, Communiqué de presse, 28 juin 2021, *https://amnistie.ca/sinformer/2021/colombie/canada-le-canada-doit-suspendre-les-exportations-darmes-vers-la-colombie*

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10 | RÉSIDENCES DE SOINS DE LONGUE DURÉE

Le système des soins de longue durée (SLD) de tout le pays a désespérément besoin de réformes.

On se questionne depuis des années sur ce modèle, mais peu de réformes[86] ont été mises en œuvre, et dans certaines provinces[87], les mécanismes de surveillance ont même été affaiblis. Alors que toute l'attention se portait sur la préparation du système hospitalier au début de la pandémie de COVID-19, les résidences de soins de longue durée pour personnes âgées ont vite été débordées par la première vague. Les conditions de santé sous-jacentes des personnes hébergées dans ces résidences, de mêmes que les contacts étroits entre le personnel et les résident·e·s, le fait que le personnel travaille à plusieurs endroits à la fois, et la nature intrinsèque de ces milieux de vie collectifs, ont fait en sorte que les personnes résidentes couraient un risque disproportionné d'infections[88] et de conséquences graves pouvant entraîner la mort. En août 2020, les personnes résidant dans des centres de soins de longue durée et des maisons de retraite, représentaient plus de 80 %[89] de tous les cas rapportés des décès liés à la COVID-19. En date du 21 juillet 2021, les décès dans ces résidences[90] comptaient encore pour 58 % de tous les décès liés à la COVID-19 au Canada depuis le début de la pandémie, avec 15 205 décès de personnes résidentes et 30 décès de membres du personnel.

Pendant la première vague de la pandémie, les taux incroyablement élevés de décès dans les résidences de soins de longue durée ont fait les manchettes et déclenché de nombreuses études et enquêtes. Manquant de personnel et de supervision adéquate, de nombreuses résidences n'arrivaient pas à faire face à leurs obligations, tant pour leur personnel que pour leurs résident·e·s. Elles ont vite été complètement débordées. La pandémie a démontré que le secteur des soins de longue durée n'avait pas la capacité[91] de fournir les soins de santé et les services sociaux nécessaires à leurs résident·e·s en temps normal, et encore moins en temps de crise sanitaire. Plus de la moitié des résidences rapportaient déjà de graves pénuries de personnel en 2020, et près du tiers manquaient cruellement d'équipements de protection individuelle (ÉPI)[92].

[86] Bureau du conseiller scientifique en chef du Canada, La Covid-19 et les soins de longues durée, Rapport d'un groupe de travail spécial préparé pour la conseillère scientifique en chef du Canada, Été 2020, *https://science.gc.ca/eic/site/063.nsf/vwapj/Soins-longue-duree-et-Covid19_2020.pdf/$file/Soins-longue-duree-et-Covid19_2020.pdf*

[87] Bureau de la vérificatrice générale de l'Ontario, Préparation et gestion en lien avec la COVID-19 Rapport spécial sur la préparation et la réponse à la pandémie dans les foyers de soins de longue durée, 1er avril 2021, *https://auditor.on.ca/fr/content-fr/specialreports/specialreports/COVID-19_ch5readinessresponseLTC_fr202104.pdf*

[88] Supra, note 86, p 6.

[89] Janine Clarke, Répercussions de la pandémie de COVID-19 sur les établissements de soins infirmiers et de soins pour bénéficiaires internes au Canada, 10 juin 2021, page 1 citant l'Institut canadien d'information sur la santé 2020, *https://www150.statcan.gc.ca/n1/pub/45-28-0001/2021001/article/00025-fra.htm*

[90] Voir *https://ltc-covid19-tracker.ca/*

[91] Supra, note 86, p 16.

[92] Supra, note 89, p 2.

Certaines résidences notaient des difficultés[93] à obtenir des conseils et de l'aide pour répondre aux besoins au début de la pandémie. Globalement, le secteur des soins de longue durée s'est retrouvé isolé[94] face à une crise de santé publique inédite, à l'évolution fulgurante.

La vaccination et les nouvelles mesures de prévention des infections ont réduit les éclosions[95] dans les résidences de soins de longue durée, mais ne les ont pas éliminées. Partout au pays, de nombreux groupes de travail, des études et des enquêtes publiques et privées ont été mises en place ou sont en voie de l'être afin d'examiner les impacts de la COVID-19 dans les résidences de soins de longue durée.

À la lumière de la pandémie de COVID-19, il apparait évident que maintenir une offre de soins et de services respectant la dignité et l'intégrité des personnes ayant besoin de soins est une tâche complexe et fragile, particulièrement dans le contexte d'une épidémie majeure.

LE SECTEUR DES SOINS DE LONGUE DURÉE S'EST RETROUVÉ ISOLÉ FACE À UNE CRISE DE SANTÉ PUBLIQUE INÉDITE, À L'ÉVOLUTION FULGURANTE

AMNISTIE INTERNATIONALE DEMANDE AU CANADA ET AUX PROVINCES

- **De s'assurer que les bénéficiaires de soins de longue durée disposent en tout temps de soins de qualité, humains, constants et sécuritaires, centrés sur leurs besoins et leurs droits.**
- **De fournir des ressources adéquates et en temps opportun à tous les niveaux des services de santé pour garantir cette réponse.**
- **De ne pas se servir de la pandémie pour justifier la déshumanisation des soins et des services ou pour manquer à leur responsabilité de protéger les personnes les plusvulnérables de notre société.**
- **De s'assurer que les normes nationales pour le secteur des soins de longue durée (en voie d'élaboration par le Conseil canadien des normes, l'Organisation des normes en santé, et l'Association canadienne de normalisation) incluent une consultation effective avec les parties prenantes, et intègrent le respect des droits humains des personnes résidentes, de leurs proches, et des travailleurs et travailleuses du secteur.**

[93] Supra, note 86.

[94] Ibid.

[95] International Long Term Care Policy Network, The rollout of COVID-19 vaccines in Canadian long-term care homes, 30th March update,1er avril 2021, *www.ltccovid.org/2021/04/01/the-rollout-of-COVID-19-vaccines-in-canadian-long-term-care-homes-30th-march-update/*

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11 | CANADIENS ET CANADIENNES DÉTENU·E·S À L'ÉTRANGER

Plusieurs Canadiens et Canadiennes sont détenu·e·s à l'étranger pour diverses raisons, souvent dans des conditions inhumaines mettant en danger leur vie, leur santé, leur sécurité et en violation du droit international.

Bien que Michael Kovrig et Michael Spavor soient revenus au Canada après une importante campagne de mobilisation pour leur libération, il n'y a eu aucun progrès dans le cas de Huseyin Celil, un citoyen canadien détenu en Chine depuis 2006. Cela suggère une incohérence dans les services consulaires et que certains citoyens canadiens sont laissés pour compte.

Depuis la défaite de « l'État islamique » de Baghouz en mars 2019, plusieurs Canadiens et Canadiennes sont détenu·e·s par les forces kurdes, dans des conditions que les experts des Nations unies associent[96] à de la torture et autres traitements cruels, inhumains ou dégradants, ou à des châtiments. Malgré ces constats, aucune démarche concrète n'a été annoncée par le Canada pour faire cesser les violations des droits humains à leur encontre. À ce jour, le Canada n'a rapatrié qu'une jeune orpheline du nord-est de la Syrie, en octobre 2020, de même qu'une fillette de quatre ans[97], en mars 2021.

Les demandes d'information, dont une demande formelle d'accès à l'information déposée en mars 2020, relativement à l'application de la politique consulaire canadienne concernant des allégations de torture ou de mauvais traitements à l'encontre de citoyens et citoyennes canadien·ne·s à l'étranger, demeurent sans réponse. En juin 2021, le Comité permanent des affaires étrangères et du développement international de la Chambre des communes publiait un rapport[98] recommandant le rapatriement d'enfants canadiens se trouvant au nord-est de la Syrie, alors qu'une opinion complémentaire[99] recommandait que des services consulaires soient offerts à tous les Canadiens et les Canadiennes qui y étaient détenu·e·s. Même si elle n'y est pas détenue officiellement, Nathalie Morin est une citoyenne canadienne bloquée en Arabie saoudite depuis 2005. Amnistie internationale la considère[100] comme une survivante de violence fondée sur le genre. La mère de Nathalie Morin s'est rendue en Arabie saoudite en 2019, dans l'espoir de finaliser les différentes formalités qui devaient permettre à Nathalie et à ses enfants de rentrer au Canada. Mais sans succès, malheureusement.

[96] Bureau du Haut Commissaire des Nations Unies aux droits de l'homme, Syria: UN experts urge 57 States to repatriate women and children from squalid camps, 8 février 2021, *www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26730&LangID=E*

[97] Canadian girl, 4, freed from Syrian detention camp, CBC News, 15 mars 2021, *www.cbc.ca/news/politics/isis-detention-camp-child-canada-1.5949996*

[98] Comité permanent des affaires étrangères et du développement international de la Chambre des Communes, Deuxième volet d'une étude sur les contrecoups de la pandémide de la Covid-19 — Combattre la crise des droits de l'enfant et ranimer l'espoir, 2e session, 43e législature, juin 2021, *https://www.noscommunes.ca/DocumentViewer/fr/43-2/FAAE/rapport-7*

[99] Ibid., p 37.

[100] Amnistie internationale, Elle ne pouvait pas être séparée de ses enfants : Une conversation avec Johanne Durocher, 12 juillet 2021, *https://amnistie.ca/sinformer/2021/canada/elle-ne-pouvait-pas-etre-separee-de-ses-enfants-une-conversation-avec-johanne*

AMNISTIE INTERNATIONALE DEMANDE AU CANADA

- **De fournir les services consulaires adéquats aux Canadiens et Canadiennes détenu·e·s à l'étranger, peu importe les raisons de leur détention.**
- **De tout mettre en œuvre pour que les droits humains des Canadiens et Canadiennes détenu·e·s à l'étranger soient respectés, et qu'ils et elles soient préservé·e·s de procès iniques, de toute forme de torture, traitement inhumain ou cruel, ou toute forme de châtiment, et qu'ils et elles soient préservé·e·s de la peine de mort.**
- **De prendre toutes les mesures légales nécessaires pour mettre fin aux violations des droits humains envers les Canadiens et Canadiennes détenu·e·s au nord-est de la Syrie, tout en s'assurant que ces mesures ne génèrent pas de discrimination en raison du genre, des idées politiques ou de la religion, et qu'elles respectent les droits de l'enfant et le principe de l'unité familiale.**
- **De fournir une assistance consulaire rigoureuse et proactive aux Canadiens et Canadiennes détenu·e·s au nord-est de la Syrie.**
- **De s'assurer, en conformité avec le droit international, de l'imputabilité des personnes détenues, y compris celles qui sont canadiennes et qui auraient pu commettre des crimes internationaux.**
- **De publier son évaluation relative aux allégations de torture et de mauvais traitements des Canadiens et Canadiennes détenu·e·s au nord-est de la Syrie.**
- **De fournir le soutien consulaire et l'engagement diplomatique nécessaires pour permettre à Huseyin Celil et à Nathalie Morin et ses enfants de rentrer au Canada.**

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12 | PERSONNES DÉFENSEURES DES DROITS HUMAINS AU CANADA

Les personnes défenseures des droits humains militent pacifiquement pour la protection des droits humains. Avec la montée de gouvernements populistes à travers le monde, l'espace de la société civile pour défendre les droits se rétrécit de manière importante.

Au niveau mondial, de nombreuses personnes défenseures des droits humains sont criminalisées, stigmatisées, harcelées, violemment ciblées, afin de les réduire au silence. Certaines n'ont d'autre choix que celui de l'exil et cherchent parfois refuge au Canada. Mais les services et le soutien qui leur sont offerts sont insuffisants. Dans notre monde globalisé, les menaces à leur sécurité les suivent souvent jusqu'ici, et le manque de connaissance et de coordination du gouvernement font en sorte que la protection et le soutien qui leur est accordé n'est pas suffisant[101].

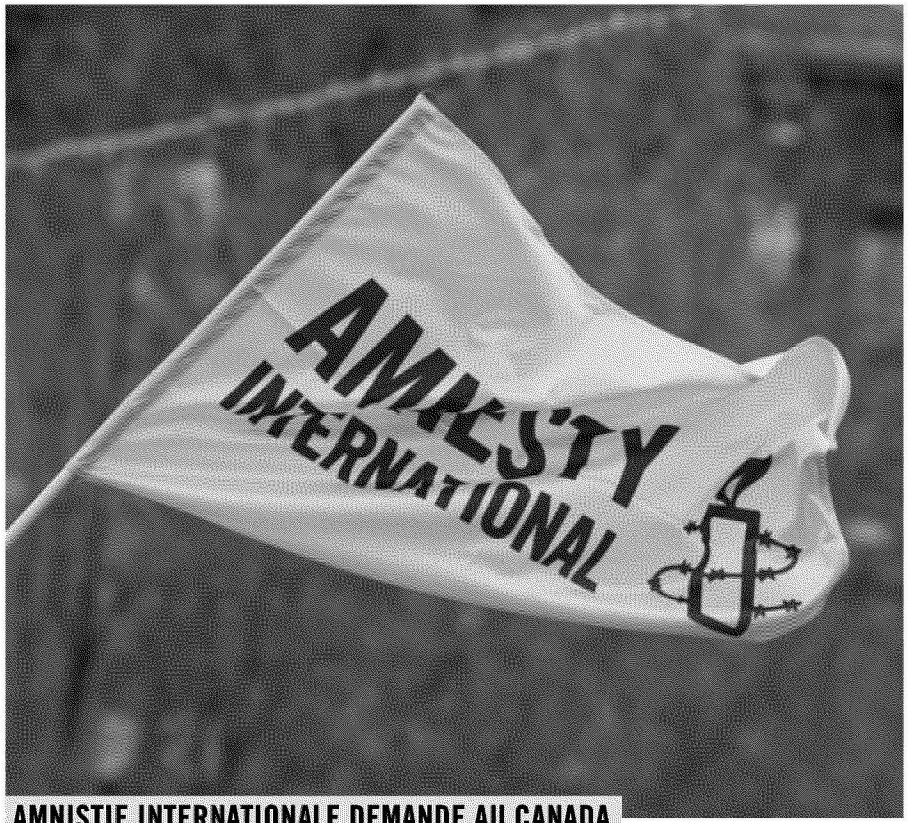
En mars 2020, Sisters Trust Canada a publié un rapport sans précédent[102] sur l'expérience des femmes défenseures des droits humains exilées au Canada.En juin 2021, le Canada donnait suite à son engagement[103] de créer un programme dédié à la réinstallation, sur une base annuelle, de 250 personnes défenseures des droits humains et de leurs familles immédiates. Au printemps 2021, la société civile et le gouvernement se sont rencontrés une première fois afin d'aborder la façon de mieux comprendre et de mieux répondre aux besoins des personnes défenseures des droits humains vivant en exil au Canada.Une meilleure compréhension et de meilleures mesures de la part du gouvernement, établies en étroite collaboration avec les personnes défenseures des droits humains, sont essentielles pour assurer leur sécurité et leur bien-être lorsqu'elles vivent en exil.

L'ESPACE DE LA SOCIÉTÉ CIVILE POUR DÉFENDRE LES DROITS SE RÉTRÉCIT DE MANIÈRE IMPORTANTE

[101] Sisters Trust Canada et UQAM's International Clinic for the Defense of Human Rights, *Women Human Rights Defenders in Exile in Canada, mars 2020.*

[102] Ibid.

[103] Cabinet du Premier Ministre du Canada, Lettre de mandat du ministre de l'Immigration, des Réfugiés et de la Citoyenneté, 13 décembre 2019, *https://pm.gc.ca/fr/lettres-de-mandat/2019/12/13/lettre-de-mandat-du-ministre-de-limmigration-des-refugies-et-de-la*



AMNISTIE INTERNATIONALE DEMANDE AU CANADA

- **De créer un point focal au gouvernement pour coordonner les différentes programmes gouvernementaux d'appui aux personnes défenseures des droits humains vivant en exil au Canada.**
- **De mettre en place, en collaboration avec les personnes défenseures des droits humains, des services et un soutien spécifiques pour mieux répondre à leurs besoins uniques lors de leur réinstallation au Canada.**
- **De mettre en place des mécanismes précis et transparents pour que les personnes défenseures des droits humains puissent dénoncer les menaces à leur sécurité dont elles sont victimes au Canada, et avoir accès à la justice.**

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POUR LA SUITE DES CHOSES

En avril 2020, nous avons mobilisé 300 acteurs de la société civile canadienne afin de proposer 10 principes des droits humains[104] pour guider les gouvernements du Canada dans leur gestion des mesures sanitaires. Aucune province n'a répondu à notre appel, et la réponse du gouvernement fédéral a été plutôt tiède. Nous demandons à tous les paliers de gouvernement au Canada de revoir notre appel.

La COVID-19 n'affecte pas tout le monde également. Les populations marginalisées, déjà à risque, sont les plus touchées. Une analyse intersectionnelle sensible aux enjeux du racisme systémique nous montre que, outre les personnes âgées, les personnes migrantes, noires, racialisées, et les Autochtones sont parmi les plus vulnérables. Il nous reste beaucoup de chemin à parcourir pour construire une société véritablement antiraciste et inclusive. Cette pandémie a aussi révélé que la justice de genre et la justice intersectionnelle sont encore à construire, et que même un virus peut en retarder les avancées. L'augmentation de la violence et des féminicides est accablante.

Nous avons identifié 58 recommandations concrètes. Nous demandons à tous les acteurs clés, responsables de la mise en œuvre, de la protection et de la réalisation des droits humains au Canada, d'y répondre.

Amnistie internationale est également préoccupée du fait que le Canada a échoué à jouer le rôle qu'il aurait dû pour combattre l'inégalité d'accès aux vaccins contre le COVID-19 dans le monde. Une relance économique juste post-pandémie ne pourra se faire que lorsque tout le monde aura un accès universel et équitable aux vaccins. Au plan mondial, nous devons nous rappeler que la plupart des pays n'auront accès à aucun vaccin avant 2023, en raison du manque de ressources. Et même s'ils avaient eu les ressources, les pays occidentaux ont monopolisé les stocks disponibles et même les futures productions. À lui seul, le Canada a acheté des vaccins pour cinq fois sa population.

Nous demandons au gouvernement fédéral nouvellement élu de prendre position sur chacune de ces recommandations et d'informer les Canadiens et les Canadiennes de leurs intentions et de leurs engagements concrets. De même, nous demandons à tous les partis formant l'opposition à la Chambre des communes d'informer les Canadiens et les Canadiennes quant à leur position vis-à-vis celles-ci, et de surveiller leur mise en œuvre par le gouvernement élu.

Amnistie réitère son appel au gouvernement canadien de faire preuve d'un leadership exemplaire en matière de solidarité internationale. Les Canadiens et les Canadiennes ne seront jamais en sécurité tant que le monde ne sera pas complètement protégé.

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[104] Amnistie Internationale, Un appel pour une surveillance des droits humains dans les réponses gouvernementales à la pandémie de Covid-19, 15 avril 2020, *https://amnistie.ca/sinformer/communiques/local/2020/canada/un-appel-pour-une-surveillance-droits-humains-reponses*

À PROPOS

Amnistie internationale est un mouvement mondial regroupant plus de dix millions de sympathisant·e·s, de membres et de militant·e·s dans plus de 150 pays et régions, qui font campagne pour mettre un terme à de graves violations des droits humains.

Notre vision est celle d'un monde où chacun peut se prévaloir de tous les droits énoncés dans la Déclaration universelle des droits de l'homme et d'autres textes internationaux relatifs aux droits humains.

Nous sommes indépendants de toute formation ou idéologie politique, de tout intérêt économique et de toute religion, et notre financement est assuré principalement par les cotisations de nos membres.

Jusqu'à ce chaque personne puisse jouir de tous ses droits, nous poursuivrons nos efforts. Nous ne nous arrêterons que le jour où tout le monde vivra dans la dignité, où tout le monde pourra se faire entendre, et où plus personne ne subira de torture ou de mise à mort.

Nos membres sont au cœur de tous ces efforts. Ils s'attaquent aux problèmes de droits humains par la rédaction de lettres, par des campagnes en ligne et hors ligne, par des manifestations, par des veillées et par du plaidoyer direct auprès de gens de pouvoir et d'influence.

À l'échelle locale, nationale et mondiale, nous nous rassemblons pour mobiliser l'opinion publique et démontrer la solidarité internationale. Ensemble, nous changeons des vies, des lois, des pratiques.

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Esteves, Dina (HC/SC)

From: Main, John <JMain6@GOV.NU.CA>
Sent: 2021-12-22 3:10 PM
To: hcminister.ministresc; Main, John; Duclos.x, Jean-Yves (HC/SC)
Cc: Lam, Joanna (HC/SC)
Subject: RE: Continued efforts and collaboration in response to COVID-19
Attachments: Signed - 2021-12-21 - Min Duclos - NU-Boosters-Continued effort and collaboration in response to COVID-19.pdf

Minister Duclos,

Please find attached a response from Minister Main regarding your letter of December 16, 2021.

Thanks,

Ron

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Ron Elliott
ᒥᓴᑕᒧᑦ ᒪᓂᒪᓕᓗᓂᓴᒧᑦ ᐅᖃᐅᓯᕆᐊᖃᕐᑎᑦ / Ministerial Political Advisor
Ministamut Maligaliqijunik Uqaudjiji / Conseiller Politique Ministériel

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Minista John Main Titirarvinga Titiraqarvia 2410, Iqaluit, Nunavut X0A 0H0	Bureau du ministre John Main C.P. 2410, Iqaluit, Nunavut X0A 0H0

☎: (867) 975-5088 🖷: (867)975-5051 🖃: relliott6@gov.nu.ca

From: hcminister.ministresc <hcminister.ministresc@hc-sc.gc.ca>
Sent: December 16, 2021 8:19 PM
To: Main, John <JMain6@GOV.NU.CA>
Subject: Continued efforts and collaboration in response to COVID-19

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Please find attached correspondence from the Minister of Health.

Thank you
Health Canada - Santé Canada

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A2022001224

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Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble
Nunavut

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Minister of Health
Ministaat Aanniaqtailinirmut
Ministre de la Santé

December 21, 2021

Hon. Jean-Yves Duclos, P.C, M.P.
Minister of Health
Government of Canada
House of Commons
Ottawa, ON
K1A 0K9

Re: Continued effort and collaboration in response to COVID-19 regarding booster dose administration in the territory of Nunavut

Dear Minister,

Thank you for your letter dated December 16, 2021, highlighting the importance of continued effort and collaboration in response to COVID-19 regarding booster dose administration in the territory of Nunavut. I appreciate you taking the time to raise this important issue with me and advocating on behalf of the health of Nunavummiut.

The Government of Nunavut prepared and implemented a robust and well-coordinated vaccination campaign that focused on ensuring we can distribute the vaccine effectively, efficiently, and ethically to all Nunavummiut.

As of December 14, 2021, 95% of Nunavummiut age 12+ had received at least one dose and 84% of Nunavummiut had received at least two doses of a COVID-19 vaccine. Nunavut was also an early adopter and initiated third doses to immunocompromised individuals and those living in congregate settings, booster doses to those age 18+ and vaccination efforts among the 5-11 age group. Nunavut is proud of these accomplishments to date.

The Government of Nunavut continues to advance both its efforts in administering booster doses and vaccine among 5–11-year-olds. I would be remiss, however, if I did not take this opportunity to highlight some of the challenges we currently face. We, like many of our partnering jurisdictions, are facing significant staffing challenges because of the pandemic. Staffing challenges and service reductions pose barriers and challenges to scaling up mass vaccination efforts.

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Titiqakuvia 2410
Iqaluit, Nunavut X0A 0H0
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Iqaluit, Nunavut X0A 0H0
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867-975-5051

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On behalf of the Department of Health, I would like to take this opportunity to extend our sincere gratitude to the federal government for its continued effort and collaboration in response to COVID-19.

Thank you again for bringing forward your concerns. We appreciate your commitment and efforts in advocating on behalf of the health of Nunavummiut.

Matna,

[redacted]

Hon. John Main
Minister of Health
Minister responsible for suicide prevention

Cc: Colleen Stockley, Deputy Minister of Health
Dr. Michael Patterson, Nunavut Chief Public Health Officer

ᑎᑎᖅᑲᕐᕕᐊ 2410
ᐃᖅᓗᐃᑦ, ᓄᓇᕗᑦ X0A 0H0

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Ghaly, Maggy (HC/SC)

From: Browne, Robert (HC/SC)
Sent: 2022-01-04 12:29 PM
To: HC.F ECD-Liaison / DCHG F.SC
Cc: Champagne, Christine (HC/SC)
Subject: To profile (scan - post mail) MP Michael Chong
Attachments: 20220104121911525.pdf

Attached

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Hon. Michael Chong, M.P.
Wellington-Halton Hills

CANADA

L'hon. Michael Chong, député
Wellington-Halton Hills

December 15, 2021

The Honourable Jean-Yves Duclos P.C., M.P.
Minister of Health
70 Colombine Driveway, Tunney's Pasture
Postal Location: 0906C
Ottawa, ON K1A 0K9

Dear Minister Duclos,

I am forwarding an email on behalf of constituents, Mr. Trevor Kurtz and [redacted] They own and operate Brain Kurtz Trucking located in Breslau, Ontario. The attached email outlines his serious concerns about vaccine mandates and their impact on the Canadian trucking sector. I trust that their concerns will be taken into careful consideration and that they will receive a response in due course. Please respond to the following address and copy me on your reply:

Mr. Trevor Kurtz &
[redacted]

Thank you for your attention to this matter. Please do not hesitate to contact me if you have any questions.

Sincerely,

[redacted]

Michael Chong

cc: Mr. Trevor Kurtz, Brian Kurtz Trucking
[redacted] Brian Kurtz Trucking

encl.

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Fergus, ON N1M 2L3
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Ottawa
House of Commons/Chambre des communes
Ottawa, ON K1A 0A6
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Georgetown
205-16, ch. Mountainview Rd. S/sud
Georgetown, ON L7G 4K1
Telephone/Téléphone (905) 702 2597

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Trevor Kurtz
trevor@kurtztrucking.com
[redacted]

HI Michael. I hope you are well. I am reaching out with an update on the US Vaccination requirement for cross border truck drivers.

Well things have gotten much worse. Now Canada is retaliating with a mandate of their own. And to make matters worse Canada is pushing to mandate all federal employers and employees must be fully vaccinated. I have a few drivers and now a few staff members and mechanics seeking work with provincially regulated companies to avoid the mandate. These changes to the law will take 20,000 drivers and many more support staff out of the industry January 15th. This is going to cripple the economy just after Christmas. we will be forced to drop good customers we cannot service. We are very fortunate to be 90% vaccinated there are many carriers who are below 80%. Customers all over Canada will suffer. I am not arguing that this might be the correct move but its happening way to fast. we need time to try and persuade these employees to re-think their decision. We need time to prepare customers for the decrease in available trucks to service their needs. Many employees are so tired of the rules they will just exit the industry. There is not even time to get double vaccinated between now and January. Please do what you can to push this out. We in the industry need time to get prepared.

Sincerely Trevor Kurtz

Brian Kurtz Trucking

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[redacted]

[redacted]

Sent via Email

December 17, 2021

Justin.Trudeau@parl.gc.ca

The Right Honourable Justin Trudeau
Prime Minister
House of Commons
Ottawa, Ontario
K1A 0A6

Chrystia.Freeland@parl.gc.ca

Honourable Chrystia Freeland
Deputy Prime Minister and
Minister of Finance
House of Commons
Ottawa, Ontario
K1A 0A6

Seamus.Oregan@parl.gc.ca

Honourable Seamus O'Regan
Minister of Labour
House of Commons
Ottawa, Ontario
K1A 0A6

marie-claude.bibeau@parl.gc.ca

Honourable Marie-Claude Bibeau
Minister of Agriculture and Agri-Food
House of Commons
Ottawa, Ontario,
K1A 0A6

dominic.leblanc@parl.gc.ca

Honourable Dominic LeBlanc
Minister of Intergovernmental Affairs, Infrastructure and Communities
House of Commons
Ottawa, Ontario
K1A 0A6

Jean-Yves.Duclos@parl.gc.ca

Honourable Jean-Yves Duclos
Minister of Health
House of Commons
Ottawa, Ontario
K1A 0A6

Omar.Alghabra@parl.gc.ca

Honourable Omar Alghabra
Minister of Transport
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Mary.Ng@parl.gc.ca

Honourable Mary Ng
Minister of International Trade
House of Commons
Ottawa, Ontario
K1A 0A6

Filomena.Tassi@parl.gc.ca

Honourable Filomena Tassi

Minister of Public Services and Procurement
House of Commons
Ottawa, Ontario
K1A 0A6

Dear Ministers:

A group of carriers from the [redacted] met with multiple departments today to discuss the impact of imposing both a cross border vaccine mandate as well as a domestic mandate on federally regulated truck drivers/industry.

In that meeting, the industry once again provided examples of what would happen to the supply chain should the industry lose 10-20% of its workforce because of these mandates. As we have explained in the past, carrier delisting of accounts or 'customer rationalization' will occur on a sliding scale based on the driver loss. Some carriers have already reported that between 5-18 percent of their drivers have already been leaving their companies since plans for the border and domestic vaccine mandates were first announced. The used truck market is seeing a significant increase in volumes in some parts of the country as drivers, independent owner-operators and small carriers hand in their keys.

As we expected, rural-based carriers and their customers will suffer the most because of these mandates. But make no mistake, even carriers who have 90% vaccination rates among their driver pools and their customers will be severely impacted. As one of our carriers with a 100 percent vaccination rate said: "I am delisting customers as we speak – and I have all my drivers. Demand is so high, and I have little to no ability to expand

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my fleet. My customer base will suffer; I can't imagine losing 10-20 percent of my workforce in these unprecedented times."

Those who will suffer most from service disruptions or cancellation of service include domestic and US importers/exporters of all sizes who might ship less frequently than major accounts who can adapt by securing dedicated trucks; the more price sensitive/seasonal the product, the higher the level of interruption. Some sectors in the supply chain could see crippling service disruptions while others could risk loosing all access to trucks. This has caused some shippers to be very aggressive in securing trucking services, which has led to rapid and unprecedented transportation inflation. See here for an industry article on recent 'spot' transportation prices.

As the market scrambles to secure quickly depleting trucking capacity and transportation inflation rises, more and more price sensitive/seasonal commodities will be added to the list of freight that could be stranded (see attachment). This is already occurring and will accelerate with less drivers available.

We are leaning that British Columbia, specifically, is suffering disproportionately from the driver shortage. The Government of Canada has done so much to work with the trucking industry to help the supply chain function during the devastating flooding/mudslides. The in-transit project was a symbol of our industry and Ottawa's commitment to work together in difficult times. However, implementing a vaccine mandate for cross-border drivers and federally regulated carriers would make a very challenging situation in B.C. much worse. Load delivery times are taking much longer to and from B.C., requiring more available drivers and drivers' time to move loads. Removing more drivers from the B.C. supply chain as a reaction to the mandate would exacerbate what's already a very precarious supply chain situation on the West Coast.

[redacted] appreciates the Government of Canada navigating these difficult policy waters with us, but we need to strongly reiterate that this is not a trucking issue exclusively. This is, first and foremost, a grave challenge throughout North American supply chains and, ultimately, the Canadian and American consumers who depend on it for food, infrastructure materials and other important products. For some trucking companies and members these mandates could be crippling for operations, but the economic and civic ripple effects would expand far beyond our industry and be felt directly by millions of people through supply shortages and soaring inflation.

[redacted] understands the health and safety motivations for the border and domestic vaccine policies. Our industry has and will always be committed to fighting COVID-19. Throughout this pandemic, our sector has showed to have extremely low exposure and transmission of the virus in the workplace. This has been confirmed by various pilots and enforcement of COVID-19 tests in the Maritimes, Ontario and Alberta and is indicative of what our members have reported.

[redacted]s position regarding vaccines is straightforward – if the government insists on a national mandate for vaccines, then it must truly be national for all eligible Canadians and there should be no reason why only certain citizens, including essential workers like truck drivers, should be singled out. It should not be reasoned that truck drivers cannot be afforded an exemption, despite their critical role in the economy, when millions of Canadians who do not work for a federally-regulated sector will continue to be exempted. The reality is that the national vaccine mandate is national in name only. Many truck drivers who don't leave the industry altogether will simply leave nationally regulated carriers to provincially regulated carriers outside of the federal government's scope, negating the perceived health benefits the government believes would come from a mandate.

[redacted] is urging Public Health look to at the bigger picture pertaining to health risk in our sector. This week, the Chief Public Health officer amended travel bans, proving there is some willingness to consider other factors. While we are not privy to the reasoning for the policy change, the decision seems to embrace a certain level of risk tolerance when measuring the introduction/removal of COVID-19 health measures. The trucking industry is requesting that such a lens be brought to our sector in light of the massive economic consequences at play.
The Chief Public Health Officer also issued a report this week entitled "A Vision to Transform Canada's Public Health System", in which she recognized the role of mental health and the psychological and emotional burdens on Canadians. The Chief Public Health Officer also linked mental health issues with job loss, increased financial pressures and working through the pandemic.

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In closing, many [redacted] members concerned about the tens of thousands of truck drivers who have been misclassified as Driver Inc. contractors who are really employees. ESDC is working on this file, but only the tip of the iceberg has been exposed (see recent Toronto Star story). Enforcement of the domestic mandate among the non-compliant segment of our sector will be highly problematic. With the vaccine mandate, these companies will have even more nefarious incentive to misclassify employees and independent workers. As misclassification of drivers grows, fake vaccine cards will be a hot commodity as unscrupulous carriers will circumvent the rules to maintain driver capacity while enjoying record profits and further exploiting the competitive gap between compliant and non-compliant carriers.

It is not [redacted]s intention to be a spoke in the wheel. We are proud of our record working with the Government of Canada through this pandemic. We are extremely thankful for your support. As we have learned throughout these trying times, it's never too late to reconsider a position in light of new facts and realities. This is an important decision that requires the input of all Cabinet members. [redacted] is strongly urging the Government of Canada and the United States to reconsider implementing the border mandate and domestic mandate on our sector this January.

Sincerely,

[redacted]

Cc: John Horgan, Chair, The Council of the Federation, Premier of British Columbia, premier@gov.bc.ca
Heather Stefanson, Vice-Chair, The Council of the Federation, Premier of Manitoba, premier@leg.gov.mb.ca
Perrin Beatty, President and Chief Executive Officer, Canadian Chamber of Commerce, pbeatty@chamber.ca
Mark Agnew, Senior Vice President, Policy and Government Relations, Canadian Chamber of Commerce, MAgnew@chamber.ca
Bob Costello, Chief Economist & Senior Vice President of International Trade Policy & Cross-Border Operations, American Trucking Associations, bcostello@trucking.org
Nate Giordano, Senior Manager, Americas, U.S. Chamber of Commerce: NGiordano@USChamber.com

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[redacted] Positions on Vaccines

US-Canada Border Vaccine Mandate

[redacted] is imploring Washington and Ottawa to not enforce a vaccine mandate on cross-border trucking in January 2022. [redacted] requests that the Government of Canada and the United States work with the trucking industry and key members of the supply chain on both sides of the border to determine the state of the supply chain and implementation date that would be less harmful to both economies.

Domestic Mandate on Federally Regulated Trucking Companies

[redacted] is requesting that the Government of Canada maintain the exempt status for the trucking industry as granted in the Summer of 2021. The government agreed with the rationale for that exemption on the basis that truck drivers are relatively safe, isolated for most of their work; and a mandate that accelerates the driver shortage would harm the economy. That reasoning is even more pronounced now, in December 2021. Should the Government of Canada proceed with a mandate on trucking, the implementation period needs to be at least 12 months and drivers, mechanics and those working outside should be exempt.

[redacted] and all levels of government are accustomed to adapting and pivoting quickly – while balancing economic heath and public safety – in response to facts and conditions throughout the COVID-19 crisis. This is the nature of public policymaking and a characteristic of strong leadership. But in this case, you are asking our sector – and, more importantly, the entire Canada-US supply chain – to pivot for reasons we cannot support when weighing the health and safety facts of our industry against the extreme economic impact of such a policy shift. We are a sector that has worked diligently and safely throughout the pandemic. Due to the nature of our operations, we have showed very little or no transmission of COVID-19 within the workplace. We are asking that you seriously reconsider your position, not just for the benefit of [redacted] members and the industry at-large, but for all Canadians depending on an increasingly tenuous supply chain.

Driver Turnover as a Result of Vaccine Mandates

- Turnover is as high as it has ever been throughout COVID-19, despite significant pay rate increases and many improvements to equipment and job structure. Vaccine mandates will expedite this turnover.
- Turnover rates as high as 10-18% have been reported since the two vaccine announcements were made this fall.

Seasonal Product Impacts Due to Vaccine Mandates on Trucking Industry

- Products that are moved in high volumes during a specific a time of year and relatively little in other times.
- We worry about our ability to serve seasonal products like food and other critical supplies to remote communities.
- We have no confidence that we would be able to find the added drivers required to complete seasonal lanes – many that are in remote communities. Any seasonal product can bubble in volume at certain times of the year and the industry has no capacity to meet that demand.
- Some examples of seasonal product include, but are not limited to: road salt for winter; farm seed; chemical and fertilizer in spring; fish and perishable crops like sugar beets, potatoes, fruits from BC; de-icer for planes; driveway sealers; bottled water; seasonal retail goods; flu vaccines; groceries before holidays (hams/turkeys etc.); alcohol; cement and brick; animal feed (hay); peat moss; seed; lumber, high-season courier loads (Canada Post/UPS/Fed Ex/Purolator).

Low Margin Freight/ Price Sensitive Freight Impacts

- The complexity of pricing both low margin and price sensitive freight is typically determined by many factors.

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Esteves, Dina (HC/SC)

From: Nater, John - M.P. <John.Nater@parl.gc.ca>
Sent: 2022-01-10 1:57 PM
To: hcminister.ministresc
Subject: Letter from MP John Nater
Attachments: January 10, 2022--Minister Duclos--AstraZeneca boosters.pdf

Good afternoon,

Attached please find a letter addressed to Minister Duclos from John Nater, Member of Parliament.

Thank you.

House of Commons
Chambre des communes
Canada

Jane McKelvie

Parliamentary Assistant
Office of John Nater / Bureau de John Nater
Member of Parliament for Perth—Wellington / Député de Perth—Wellington

Room 564, 180 Wellington Street
Ottawa, Ontario, K1A 0A6
Office | 613-992-6124 Fax | 613-998-7902
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HOUSE OF COMMONS
CHAMBRE DES COMMUNES
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John Nater
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Online
E-Mail: John.Nater@parl.gc.ca
Website: johnnater.ca

The Honourable Jean-Yves Duclos
Minister of Health
House of Commons
Ottawa, ON K1A 0A6

January 10, 2022

Dear Minister,

I am contacting you on behalf of constituents in my riding who would prefer to consistently receive viral-based vaccines such as AstraZeneca.

Many of those who received AstraZeneca or Jansen for their first two doses have no interest in mixing doses, and consequently are delaying their third dose booster.

As both these vaccines are approved for use within Canada, I would appreciate knowing what options are available to those who are seeking consistent doses for their third shot.

I look forward to your response.

Sincerely,

[redacted]

John Nater, MP
Perth—Wellington

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Esteves, Dina (HC/SC)

From: Kwan, Jenny - M.P. <Jenny.Kwan@parl.gc.ca>
Sent: 2022-01-11 1:54 PM
To: hcminister.ministresc
Cc: Davies, Don - M.P.; phac.cpho-acsp.aspc@canada.ca
Subject: Correspondence for Minister Duclos' attention from Vancouver Kingsway MP Don Davies and Vancouver East MP Jenny Kwan
Attachments: 2022-01-11-Kwan Davies-Open Letter -Minister Duclos re COVID vaccine applications.pdf

Dear Minister Duclos,
Please find attached a letter signed jointly by MP Don Davies, NDP Health Critic, and I regarding outstanding applications to Health Canada for the approval of COVID-19 vaccines.
We thank you in advance for your attention to this matter.
Sincerely,
Jenny Kwan

Jenny Kwan
MP for Vancouver East

2572 East Hastings Street
Vancouver, BC
(604) 775-5800

JennyKwanNDP.ca – Facebook – Twitter

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January 11, 2021

The Honourable Jean-Yves Duclos
Minister of Health
Via email: hcminister.ministresc@hc-sc.gc.ca

Open letter re: Outstanding applications for Health Canada approval of COVID-19 vaccines

Dear Minister Duclos,

We write you today about outstanding applications for approval of COVID-19 vaccines. While Health Canada has approved four vaccines for use in Canada, from manufacturers Janssen Inc, AstraZeneca Canada Inc, Pfizer Canada ULC and ModernaTX, Inc, there remain several outstanding applications submitted to Health Canada for approval: from Sanofi Pasteur Limited, Vaccigen Ltd, Medicago, and Novavax Inc. According to Health Canada's website each of these outstanding applications were filed by the drug manufacturers months ago, well before the September 16, 2021 expiry of the *Interim Order Respecting the Importation, Sale and Advertising of Drugs for Use in Relation to COVID-19* which was intended to allow for expeditious authorization of drugs related to COVID-19 while considering urgent public health needs in order to help ensure Canadians have timely access to COVID-19 drugs.

One constituent, a breastfeeding mother of a new child, inquired specifically about the Novavax COVID-19 vaccine and whether she could look forward to its being approved for use in Canada. She wrote to say that she decided to wait on her vaccination until she could be certain of the safety and efficacy of a vaccine, has closely followed Novavax's development, and believes it to have a high level of efficacy and strong safety profile.

While we acknowledge that public health experts in Canada have shared that data shows mRNA COVID-19 vaccines are safe for people who are pregnant or nursing, we also strongly believe that Canada should be deploying a variety of public health tools to stop the spread of COVID, reduce the risk of serious infections and hospitalization, strengthen population immunity, and ultimately end the COVID-19 pandemic. One such tool that could be especially beneficial in our community and for individuals who are vaccine-hesitant or who have concerns about the use of mRNA vaccine technology is the use of alternate vaccine formulations such as the Novavax protein subunit vaccine.

We also note that, for example, the Novavax vaccine is approved for use in 30 countries across the EU and its formulation as manufactured by the Serum Institute of India, COVOVAX, is approved in India, Indonesia & the Philippines. Approval of this vaccine for use by Health Canada would have the additionally beneficial impact of allowing a greater number of foreign nationals to meet the criteria to be considered fully vaccinated in Canada under interim orders on travel and quarantine – an important consideration for individuals who are immigrating to Canada or reuniting with family after long separations. These considerations also extend to the other vaccines for which application awaits a final decision. We would like to report on the progress of these applications to our constituents.

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Therefore, we urge that you please address the outstanding applications to Health Canada for COVID-19 vaccines. Can the public expect a decision or outcome from Health Canada for the outstanding applications for approval of COVID-19 vaccines? If so, when could the public expect to know of Health Canada's decisions? If not, could you please explain why?

We appreciate your consideration of the matter and will look forward to a reply at your earliest convenience.

Sincerely,

[redacted]

Don Davies
MP for Vancouver Kingsway
NDP Critic for Health

[redacted]

Jenny Kwan
MP for Vancouver East
NDP Critic for Immigration, Citizenship and Refugees

Cc:
Dr. Theresa Tam
Chief Public Health Officer
Via email: phac.cpho-acsp.aspc@canada.ca

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A2022001224

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2022-01-14 8:25 AM
To: hcminister.ministresc
Subject: TR: Pfizer Inoculations For COVID-19 – More Harm Than Good
Attachments: NR Pfizer Inoculations For COVID-19 More Harm Than Good 20220113.pdf; Fact Check Pfizer Inoculations For COVID-19 More Harm Than Good 20220113.pdf

De : governmentrelations@canadiancovidcarealliance.org <governmentrelations@canadiancovidcarealliance.org>
Envoyé : 13 janvier 2022 17:33
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : Pfizer Inoculations For COVID-19 – More Harm Than Good

Dear Minister Duclos,

Attached, please find a news release and presentation prepared by the Canadian Covid Care Alliance (CCCA), concerning the recently released results of Pfizer's 6-month clinical trial for its COVID-19 vaccine.

Pfizer's own clinical trial data demonstrates that their biological products are **causing more harm than good** contrary to the repeated claims of public health officials that these products are "safe and effective."

In addition, the data shows that the Pfizer trials that were required to obtain interim approval for them to be used in Canada and elsewhere were inadequately designed to prove the safety and clinical efficacy of the COVID-19 vaccines, and suffered from poor trial execution and imbalanced reporting, which could have misled the government regulators including Health Canada, policymakers like yourself, and the general public.

We respectfully request that you carefully review and consider the presentation, seek out independent expert advice on the material we have presented and other supporting materials that we can provide, and work to revise your government's policies and mandates accordingly, and in particular:

- That you seek an immediate halt to the vaccination of children, who derive no benefit from the injections, but bear all the risks of serious injury and potentially even death;
- That emphasis be placed on early treatment of the disease in accordance with existing, proven treatment protocols, and that the restrictions placed on doctors by their governing bodies limiting their treatment options be terminated immediately;
- And, that, just as the European Union and many other jurisdictions have done, your government's health policy be revised to fully incorporate recognition that many Canadians have developed effective and lasting natural immunity to the virus from natural exposure.

We invite you to review other evidence-based scientific articles on our website: www.CanadianCovidCareAlliance.org. We also welcome your questions. Note that an additional file addressing the recent AFP "fact check" of the presentation is also attached.

Sincerely,

David Ross, FCPA FCA
President, Canadian Covid Care Alliance

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A2022001224

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on behalf of Canadian Covid Care Alliance members

Presentation link with voiceover: https://www.canadiancovidcarealliance.org/media-resources/the-pfizer-inoculations-for-covid-19-more-harm-than-good-2/

PDF presentation slides only: https://www.canadiancovidcarealliance.org/media-resources/the-pfizer-inoculations-for-covid-19-more-harm-than-good/

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News Release

The Pfizer Inoculations For COVID-19 – More Harm Than Good

January 13, 2022

(MONCTON, NB) – The presentation "The Pfizer Inoculations For COVID-19 – More Harm Than Good" by the Canadian Covid Care Alliance explains how Pfizer's own data shows that their Covid-19 inoculation is causing greater harm than the public was informed about.

The Canadian Covid Care Alliance represents over 500 independent doctors, scientists, and health care practitioners committed to providing quality, balanced, evidence-based information to the Canadian public about Covid-19 so that hospitalizations can be reduced, lives saved and our country safely restored to normal as quickly as possible.

The most important premise in medicine is: first, do no harm. The federal, provincial and municipal governments in Canada have a responsibility to protect the health of Canadians as well as their Charter Rights and Freedoms. Any medical interventions approved by Health Canada must first be proven safe.

Due diligence in research, as well as adherence to established doctor/patient protocols, informed consent, and scientific inquiry are essential to carrying out that responsibility. Deviating from those practices, causing harm, and failing to disclose risks of harm is negligent at best.

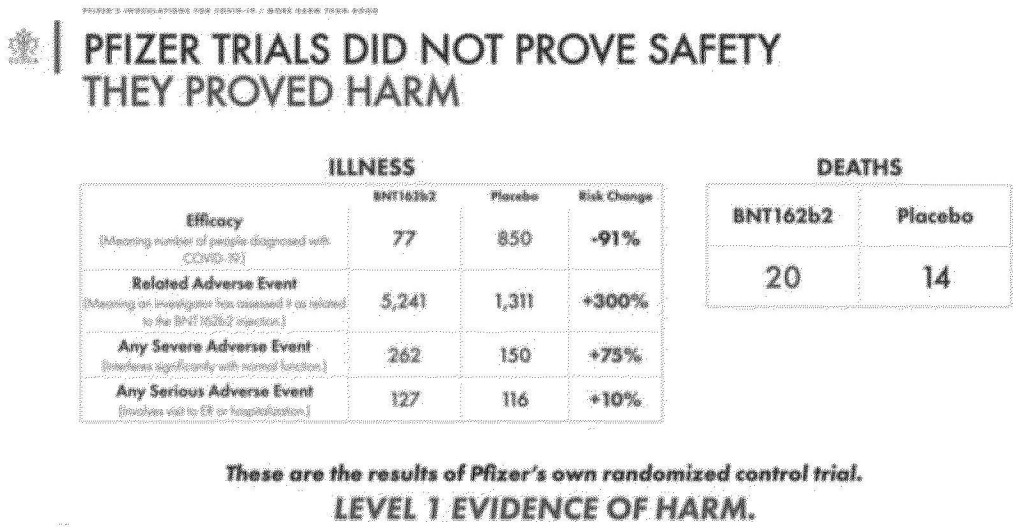
The highest form of scientific evidence – Level 1 evidence: data from Pfizer's own randomized controlled trial – showed that the reported benefit in COVID-19 case reductions came at the cost of increased sickness, and maybe even death.

The evidence shows the following increases in risk of illness:

- Related Adverse Events (as determined by an investigator) +300%
- Any Severe Adverse Event (significant interference with normal function) +75%
- Any Serious Adverse Event (ER visit or hospitalization) +10%

It also showed an increased number of deaths in inoculation recipients including those who had been in the placebo group who crossed over to receive the vaccine:

20 participants who took the inoculation vs.14 in the placebo group.



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Instead of proving these inoculations were safe, as they were supposed to do, the Level 1 evidence showed they caused harm and potentially increased death.

The public was led to believe that vaccines would protect them from disease and possible death, but the data that the regulators relied on did not show this. It not only showed an inability to improve survival but showed a numerical increase in death with crossover.

The trial also had some significant limitations. Among other things:

- the individuals in Pfizer's trial did not represent the population at greatest risk from Covid-19;
- it had an inadequate control group and used low-quality safety science;
- it focused on the wrong clinical endpoints (should have focused on reducing severe illness, stopping transmission, and all-cause mortality);
- it used a non-standard test to assess infection and did not consistently test all participants
- it was unblinded after only two months and the control group was offered the inoculation eliminating any chance of measuring long-term harm
- it was also rife with data integrity issues including loss of data and unblinding of patients

These products were inadequately and sub-optimally tested on the healthy and then given to the frailest members of society, with no way of evaluating the long-term harm.

While Pfizer's research has been used by health policy makers to justify mandating vaccination, the study did not include a lot of different types of people like pregnant women, those who are immunocompromised, and those who are naturally immune among others. More importantly there is no evidence that this product reduces disease transmission.

Even worse, adolescents and children who are at a near 0% risk of death from COVID-19 and at very low risk of severe illness are being mandated to receive this inoculation. The Pfizer studies in children and adolescents, which should have followed the highest possible safety science, had even more limitations. The studies were small, not placebo controlled, and not even designed to assess COVID-19. Even worse early safety data from the adolescent trial already show a 249% increase risk in severe adverse events and a 299% increase in serious adverse events in those receiving the inoculation. The company also admits the inoculations will cause myocarditis (irreversible damage to the heart with a mortality rate possibly as high as 20% at 6.5 years) in this group that has negligible risk from COVID-19.

How can we justify exposing any child to the risk of life altering severe events like those experienced by teenager Maddie de Garay – a 12-year-old participant who was hospitalized within 24 hours of her second dose and is now confined to a wheelchair and must eat from a feeding tube. In their report, Pfizer described her outcome as "functional abdominal pain."

How many Canadians would have chosen to take this product, or would have given it to their children, had they known it was not able to prevent transmission, was only able to confer a net benefit of 4% at six-months, could result in an increased risk of severe adverse events, and knowing that it was never tested on the most vulnerable members of society?

NOTE: Pfizer's claim of 95% efficacy is only a reference to Relative Risk Reduction (RRR) but the FDA notes that "patients are unduly influenced when risk information is presented using a relative risk approach [as] this can result in suboptimal decisions." The overall net benefit or Absolute Risk Reduction (ARR) (the FDA's recommended way of evaluating efficacy) observed in the trial was only 0.84%.

Contact: governmentrelations@canadiancovidcarealliance.org

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Fact Checking The Fact Checkers

In late December we were pleased to launch our video "More Harm than Good" which was inspired by our Critique of the Thomas *et al.* 2021 NEJM Publication which has recently been submitted for publication. Since then, we've received some great feedback, some requests for clarification and some critical reviews including a Fact Check by AFP. In the spirit of open scientific discourse and debate we present our responses to the AFP check in this below.

About AFP: *AFP is stated to be a for profit organization that seeks to give French and foreign users precise, impartial and trustworthy information in a regular, uninterrupted manner. It must, in no circumstances, fall under the control of an ideological, political or economic group. The AFP fact checked our video on January 4, 2021 and their full analysis can be found* HERE.

Despite their stated objectives, AFP's board of directors has five members with direct political ties, two members from government owned radio and television, and three government representatives: the minister of finance, the minister of foreign affairs and the Director General of Media and Cultural Industries who is appointed by the minister of culture (AFP, Board of Directors). It is difficult to imagine how the AFP can remain politically neutral while much of its funding comes from the French government (Allsop, Columbia Journalism Review) and a number of its ministers sit on the board of directors. Their one-sided, pro-narrative response lacks scientific rigour, and certainly does not reflect AFP's stated commitment to the dissemination of trustworthy and impartial information.

AFP 1: Animal testing was skipped. *"The video claims that animal testing was "skipped" during the vaccine's development, leading to compromised safety. That is false. Pfizer-BioNTech tested the mRNA shot on rhesus macaques and that data was reviewed by Health Canada prior to authorization of the vaccine. Although the COVID-19 shots are the first to use mRNA technology, research on it started in the early 1990s, and included promising tests on animals.'*

Preclinical testing is conducted to prove the short and long-term safety and efficacy of the vaccine in animal models before assessment in humans. Although some animal studies of BNT162b2 were conducted, to expedite development, these studies were done in tandem with the clinical trials and in some instances toxicology data from the lipid nanoparticle carrier components of the vaccine were accepted in lieu of BNT162b2 data (Pfizer/BioNTech FDA EUA Presentation.) The short and long-term safety results of the inoculation in humans was unknown at the time of clinical trial recruitment. In fact, at the time of FDA EUA approval in December 2020, only unpublished short term outcomes from two toxicology studies and one immunogenicity trial were available. Studies assessing reprotoxicity and teratogenicity were ongoing and no genotoxicity or oncotoxicity studies were underway. What this means is that the animal testing which is usually completed prior to assessment in humans to ensure both the short and long-term safety of the inoculation was skipped and some safety questions such as whether the inoculations could alter the human genome or cause cancer remained unanswered at the time of approval.

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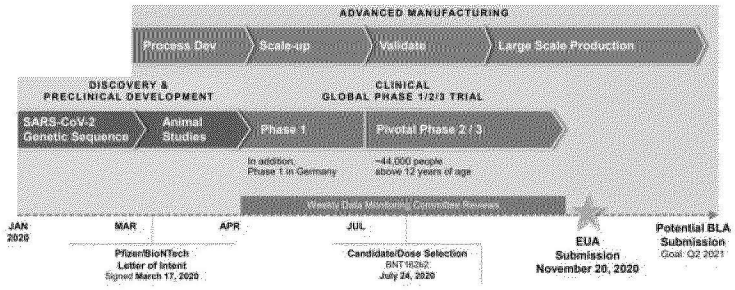

Key Nonclinical Studies with BNT162b2

Study No.	Study Description	Key Message
Toxicology Studies		
38166	17-Day, 2 or 3 Dose (1 Dose/Week) IM Toxicity in Rats With a 3 Week Recovery Period	Completed with no safety concerns
20GR142	17-Day IM Toxicity Study of BNT162b2 and BNT162b3c in Wistar Han Rats with a 3-Week Recovery	Completed with no safety concerns
20256434	A Combined Fertility and Developmental Study (Including Teratogenicity and Postnatal Investigations) of BNT162b1, BNT162b2 and BNT162b3 by the Intramuscular Route in the Wistar Rat	Ongoing with preliminary results mid-December 2020
Pharmacology Studies		
VR-VTR-10671	BNT162b2 Immunogenicity and Evaluation of Protection against SARS-CoV-2 Challenge in Rhesus Macaques	Completed and showed that BNT162b2 protects against SARS-CoV 2

The fact that mRNA technology was previously studied in animals prior to COVID-19 does not support the safety of this technology, which is used to produce the pathogenic Spike (Wang *et al.*, Suzuki *et al.*, Lei *et al.*, Biancatelli *et al.*, Solopov *et al.*) protein in humans. In fact, the small scale phase I study of the Moderna COVID-19 vaccine published in NEJM by Jackson *et al.* also highlighted previous animal studies with coronavirus vaccines that raised concerns regarding the "potential for development of vaccine-associated enhanced respiratory disease with vaccine antigens that induced antibodies with poor neutralizing activity and Th2-biased responses."

Moreover, the previous studies using the lipid nanoparticle delivery system were mainly for targeted chemotherapy to deliver toxins and drugs into cancer cells or liposomes coated with proteins from viruses, bacteria or fungi as vaccine formulations for update by immune cells. The delivery of genetic information with a lipid nanoparticle to generate the foreign proteins as antigens to elicit an immunoresponse against a vaccinated person's own body cells has never been regulatory agency-approved for human use before. Since the mechanism of action to generate adaptive immunity requires requires inflammatory attack of the cells expressing the foreign protein on their surface, there are strong hypothetical reasons why repeated booster injections of the RNA vaccines may result in breakage of tolerance leading to autoimmune disease from production of antibodies and activation of T lymphocytes against the proteins of

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the body's own cells. It is also feasible that repeated injections that result in high doses of the foreign protein on the surface of the body's cells may induce tolerance against the virus by favouring the destruction of T- and B-cells that target the viral proteins. This might account for the high rates of breakthrough COVID-19 cases in double vaccinated populations.

AFP 2: Safety of COVID-19 vaccine in pregnant and breastfeeding women. *"The video claims that because pregnant and breastfeeding women were excluded from Pfizer-BioNTech's clinical trial, there "has never been any data to make safety claims about those people and inoculations." This is false. Studies have followed pregnancy outcomes, particularly in health care workers who were among the first to receive the COVID-19 shots." … pregnant individuals are considered a high-risk population for COVID-19 complications and appeals to the Society of Obstetricians and Gynaecologists of Canada recommend vaccination against the disease "during pregnancy in any trimester and while breastfeeding."*

The precautionary principle is the standard that governs care of pregnant women and their unborn or breastfeeding children (45 CFR 46, Subpart B; FDA DPMH Guidance for Industry.) This means that all agents that have not been proven safe through rigorous testing of both short and long-term clinical and sub-clinical effects on both mother and child should be avoided. The only way to prove safety is through prolonged rigorous testing in a phase III clinical trial that lasts through to the second year of development of the vaccine-exposed neonate. Although drugs have been approved for use in pregnant women based on observational studies following full approval in the general population (FDA DPMT Guidance to Industry), there is no precedent for approval of a vaccine approved under emergency use authorization in the general population and lacking long-term safety data. As pregnant women were not included in the phase III trials, no claims regarding the safety of the inoculation in this population can be made. An absence of "safety signals" from observational studies or small inadequately powered studies looking at transfer of vaccine mRNA in breastmilk are wholly inadequate to support claims of safety. They may provide some insight into whether the vaccines are present in breast milk of vaccinated pregnant women, but do not establish whether the pathogenic spike protein product is in the milk. All of this is a moot point, since it is now being proposed to directly inoculate babies with the COVID-19 vaccines.

Although the AFP refers to pregnant women as a high-risk group, the real world retrospective cohort studies used to support this designation were conducted in either pregnant women who had symptomatic COVID-19 or pregnant women who were hospitalized due to COVID-19 (Zambrano *et al.*, Martinez-Portilla *et al.*, Knight et al., Pineles *et al.*). As association does not infer causation, severe outcomes cannot be definitely attributed to a women's pregnant status and statements regarding risk should be appropriately qualified. Additionally, while increased risk of adverse outcomes for pregnant women was observed in large registry studies with substantial proportions of missing data after adjusting for selected confounding factors (Zambrano *et al.*, Martinez-Portilla *et al.*), results from analyses of hospital network databases (Knight *et al.*, Pineles *et al.*) did not confirm the increased risk observed in the registry studies. Moreover, outcomes from these trials should be limited to the actual populations studied and should not be extrapolated to the 72% to 98% who have asymptomatic COVID-19 (Woods *et al.*, Sutton *et al.* and Maru *et al.*). What AFP should have said was that pregnant women with

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symptomatic COVID-19 **may** be at an increased risk of severe disease. And even if this were true, this would not warrant use of these agents for which the short and long-term safety has not been proven.

The evidence that the AFP provided for the safety of the COVID-19 vaccines to pregnant women was limited to a single study. In the safety assessment "COVID-19 Vaccination During Pregnancy in Ontario - Report #1: December 14,2020 to May 31, 2021 - of 30,670 women that were vaccinated 99.3% had only one dose and 0.7% had two doses, and 84.1% had not given birth yet. Moreover, about 38% of all of the vaccinations occurred in the last month (May) in the study. The first trimester vaccinations would be at greatest risk of developmental issues, but almost no data would be available about the kind of parameters that were assessed in this study, which focused on post-birth metrics, and very few at that. Since pregnancy takes 9 months, the data in Table 2 of this report cannot be compared at all the range of background rates in Ontario, which is based on full 9 month terms. Therefore, there was no way to make a valid comparison at the time the Ontario Vaccine and Pregnancy study was reported. Moreover, this kind of limited data cannot be used to address the safety of the vaccines to embryos and babies prior to birth.

AFP3: Death of Danish footballer Eriksen: *The video includes several clips of news broadcasts, including one from the Euro 2020 football tournament in which Danish footballer Eriksen collapsed on the pitch during a match against Finland on June 12, 2021. At the time, AFP investigated claims that Eriksen's collapse was related to a Covid-19 vaccine, but the Danish Football Association and the director of his club Inter Milan said he had not been vaccinated.*

We included the video montage of athletes collapsing on the field to highlight the fact that there have been an unusual number of athletes collapsing on the pitch. Our point was that such episodes were rare and no longer based on the number of such stories in the news. Although Eriksen was not vaccinated, many healthy young athletes at little to no risk of severe COVID-19 have been required to be vaccinated to continue to play or compete. Many had to undergo the procedure despite clear warnings on the COVID-19 Vaccine Product Monograph indicating an increased risk of myocarditis and pericarditis, a risk that is particularly acute among young men (PHO Myocarditis and Pericarditis Dec 4 to Sept 4 2021).

AFP 4: Pfizer Pharmacovigilance Safety Report. *"The video points to a document released by the US Food and Drug Administration to claim that it revealed more than 1,200 deaths related to Pfizer-BioNTech's Covid-19 vaccine in a 90-day period. This document has been misleadingly shared across social media, but does not contain evidence to indicate the vaccine was linked to deaths. The figure of 1,223 fatalities among 158,893 adverse effects reflect "spontaneous" reports from sources that include health officials in several countries, without any verification of the cause, Pfizer spokeswoman Dervila Keane told AFP for a previous fact-check…. A multinational, placebo-controlled, observer-blinded trial reported in the New England Journal of Medicine on December 31, 2020 showed no fatalities among vaccine or placebo recipients and stated: "The safety profile of (the shot) was characterized by short-term, mild-to-moderate pain at the injection site, fatigue, and headache. The incidence of serious adverse events was low and was similar in the vaccine and placebo groups."*

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The video does not claim that reported deaths were due to vaccination. It simply states that Pfizer's own worldwide pharmacovigilance safety report recorded 1,223 vaccine-suspected deaths in the first 90 days of worldwide vaccine roll-out. It is well recognized that the passive surveillance systems under-report safety signals (Lazarus AHRQ 2010). In this same report Pfizer indicated that they were behind on processing the overwhelming number of COVID-19 vaccine-suspected adverse events that they had received to date and that the report does not reflect the full number of reported events (Pfizer PAAE Report to FDA 2021). So, although we cannot ascribe causation to the vaccine, it is common medical practice to consider such serious adverse events as signals of vaccine safety and that similar reports have been used to shut down vaccine campaigns in the past (Sencer and Miller *et al.* 2006).

It is also curious that the AFP cites preliminary results from the phase III trial (Polack *et al.* 2021) that we are critiquing to refute more mature results of the same trial (Thomas *et al.* 2021).. The most up to date findings of the cited trial show one additional death overall (15 vs 14) of which there were four additional cardiovascular deaths (9 vs 4) where seen in the vaccine compared placebo in the blinded phase, and six additional deaths in vaccine recipients overall compared to the unvaccinated (20 vs 14) with crossover (Thomas *et al.* 2021).

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Dillon, Megan (HC/SC)

From: Minister Champagne / Ministre Champagne (IC) <ministerofisi-ministredeisi@ised-isde.gc.ca>
Sent: 2022-01-19 2:42 PM
To: governmentrelations@canadiancovidcarealliance.org
Cc: hcminister.ministresc
Subject: Innovation, Science and Economic Development Canada
Attachments: TR: Suspend the Authorization of COVID-19 Injectable Biological Products (attached letter)

Innovation, Science and Economic Development Canada | Innovation, Sciences et Développement économique Canada

Dear Dr. Chaufan and Co-signatories:

On behalf of the Honourable François-Philippe Champagne, Minister of Innovation, Science and Industry, thank you for your correspondence of December 15, 2021.

The issue you have raised falls under the purview of the Honourable Jean-Yves Duclos, Minister of Health. I have therefore taken the liberty of forwarding your correspondence to his office for consideration.

Please accept my best wishes.

Sincerely,

[redacted]

Kirwins Charles
Director, Executive Correspondence

c.c.: Office of the Honourable Jean-Yves Duclos, P.C., M.P.

Canada

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Dillon, Megan (HC/SC)

From: Grégoire, Pierre (Champagne, François-Philippe - Député) <pierre.gregoire.370@parl.gc.ca>
Sent: 2021-12-16 9:44 AM
To: ISI.minister-ministre.ISI@canada.ca
Subject: TR: Suspend the Authorization of COVID-19 Injectable Biological Products (attached letter)
Attachments: 2021-12-14 letter to ministers CMOHs children youth.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

CHAMBRE DES COMMUNES
HOUSE OF COMMONS
CANADA

Pierre Grégoire
Directeur de circonscription
Constituency Director
Courriel/email : pierre.gregoire.370@parl.gc.ca
Bureau de l'honorable François-Philippe Champagne
Député de Saint-Maurice–Champlain
Ministre de l'Innovation, des Sciences et de l'Industrie
MP for Saint-Maurice-Champlain
Minister of Innovation, Science and Industry
Bureau de circonscription : 819 538-5291
Constituency office : 819 538-5291

De : Champagne, François-Philippe - Député <Francois-Philippe.Champagne@parl.gc.ca>
Envoyé : 15 décembre 2021 14:40
À : Grégoire, Pierre (Champagne, François-Philippe - Député) <pierre.gregoire.370@parl.gc.ca>
Objet : TR: Suspend the Authorization of COVID-19 Injectable Biological Products (attached letter)

De : governmentrelations@canadiancovidcarealliance.org <governmentrelations@canadiancovidcarealliance.org>
Envoyé : 15 décembre 2021 14:29
À : Champagne, François-Philippe - Député <Francois-Philippe.Champagne@parl.gc.ca>
Objet : Suspend the Authorization of COVID-19 Injectable Biological Products (attached letter)

Members of Parliament, House of Commons

December 15, 2021

Dear Sir or Madam,

We are writing to plead that you oppose or suspend authorizing COVID-19 Injectable Biological Products for children. We represent scientists, health, and other professionals, and academics from various disciplines who have followed, evaluated, and reported on the handling of COVID-19 for more than a year. We implore you to read and carefully

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consider the scientific, peer-reviewed information in the attached letter to guide your present and future decision-making.

The attached letter has been sent to all Ministers of Health, Education, Justice, Attorneys General, Chief Medical Officers and various health advisors both by email and hard copy via registered mail.

Respectfully,

Claudia Chaufan, MD PhD

Signatories:

Steven Pelech, PhD

Olga Collins, BSc

Maximilian Forte, PhD

Daphene Francis PhD, RN

Jeffrey Graham, PhD

Anton de Ruiter, PhD

Denis Rancourt, PhD

Claus Rinner, PhD

Julie Ponesse, PhD

Jan Vrbik, PhD

Keren Epstein-Gilboa, PhD

Angela Durante, PhD

Heather Springer, PhD

Anthony J. Hall, PhD

Jens Zimmerman, PhD

Laurent Leduc, PhD

Kevin Cheung, PhD

Valentina Capurri, PhD

Michael C. Owen, PhD

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Laurie Manwell, PhD

This message is sent via the Canadian Covid Care Alliance.

https://www.canadiancovidcarealliance.org

Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid

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Follow Up Flag: Follow up
Flag Status: Flagged

CHAMBRE DES COMMUNES
HOUSE OF COMMONS
CANADA

Pierre Grégoire
Directeur de circonscription
Constituency Director
Courriel/email : pierre.gregoire.370@parl.gc.ca
Bureau de l'honorable François-Philippe Champagne
Député de Saint-Maurice–Champlain
Ministre de l'Innovation, des Sciences et de l'Industrie
MP for Saint-Maurice-Champlain
Minister of Innovation, Science and Industry
Bureau de circonscription : 819 538-5291
Constituency office : 819 538-5291

De : Champagne, François-Philippe - Député <Francois-Philippe.Champagne@parl.gc.ca>
Envoyé : 15 décembre 2021 14:40
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Respectfully,

Claudia Chaufan, MD PhD

Signatories:

Steven Pelech, PhD

Olga Collins, BSc

Maximilian Forte, PhD

Daphene Francis PhD, RN

Jeffrey Graham, PhD

Anton de Ruiter, PhD

Denis Rancourt, PhD

Claus Rinner, PhD

Julie Ponesse, PhD

Jan Vrbik, PhD

Keren Epstein-Gilboa, PhD

Angela Durante, PhD

Heather Springer, PhD

Anthony J. Hall, PhD

Jens Zimmerman, PhD

Laurent Leduc, PhD

Kevin Cheung, PhD

Valentina Capurri, PhD

Michael C. Owen, PhD

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Laurie Manwell, PhD

This message is sent via the Canadian Covid Care Alliance.

https://www.canadiancovidcarealliance.org

Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid

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Ministers and Deputy Ministers of Health
Ministers and Deputy Ministers of Education
Ministers and Deputy Ministers of Justice and Attorneys General
Provincial Public Health Officers and Chief Medical Officers of Health
Chief Science Advisors

December 14, 2021

Dear Sir or Madam,

We are writing to you to ***plead that you oppose or suspend authorizing COVID-19 Injectable Biological Products*** (hereafter "COVID products") ***for children.*** Such authorization is likely to result in a public health disaster lasting many years, and of a magnitude that is hard to anticipate.

We represent scientists, health, and other professionals, and academics from various disciplines who have followed, evaluated, and reported on the handling of COVID-19 for over a year.

We draw your attention to the safety risks revealed in Pfizer/BioNTech's BNT162b2 mRNA **Phase III trials**, published November 4, 2021 in the *New England Journal of Medicine* (footnote #23), in which:

> The risk of **adverse effects** for the vaccinated was **298%** greater than in the control group;
> The risk of **severe adverse** effects was **71%** greater for the vaccinated; and,
> The risk of **death** was found to be **36%** greater.

We cannot agree that these vaccines are "safe and effective" based on the clinical data provided by Pfizer itself.

We ask you to review the Pfizer data and study, and reconsider any authorization, pending authorization or roll-out of these vaccines, especially for children.

To set the record straight, allow us to present an overview of the science underlying COVID products, especially as they concern children:

1) Risk of death of COVID-19 for children is statistically zero.

The major risk factor for serious COVID-19 is age. For ages 0 to 19, the death rate is statistically zero.[3] COVID-19 is mostly mild in this age range and long-term sequelae are rare.[4] In Sweden, with a population of 10 million, no children died of COVID-19 even though there were no lockdowns, no masks, and hardly any school closures[5]. A recent, widely circulated New York Times article falsely claimed that over 900,000 children in the USA had been hospitalized

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due to COVID-19, overestimating the real number of 63,000 hospitalized children by a factor of 14.[6] Even the lower number of 63,000 has been questioned, with some estimates of 39% to 48% of children originally admitted to hospital for unrelated illness but acquiring COVID-19 in the hospital.[7] The roughly 300 deaths of children in the USA were among children *with multiple comorbidities who were not offered early treatment*. However, by the time the paper retracted its error the false information had already impacted public opinion.

2) Children pose no risk to adults

A peer reviewed article in the prestigious journal *Pediatrics* found that most studies indicate that children are very unlikely to transmit the infection to adults in the household or at school, and when they develop COVID-19 it is generally a very mild form,[8] one that elicits durable, comprehensive, and strong natural immunity.[9] These data, combined with the Swedish data showing that leaving schools open did not lead to higher rates of COVID-19 among teachers, should reassure policymakers that children pose no risk to adults – grandparents, parents, or teachers. Moreover, it would be unprecedented in a democratic society like Canada if children were used as a means to an end – subjected to an experimental medical treatment, as these COVID products are, to shield adults or the elderly. As Dr. Peter Doshi, Associate Editor of the British Medical Journal, has pointed out, "even if we were to assume [protection against COVID- 19 with vaccines], *the number of children who would need to be vaccinated to protect just one adult from a bout of severe COVID-19 [...] would be extraordinarily high [and] would compare unfavorably to the number of children that would be harmed, including for rare serious events*."[4]

3) Children who develop COVID-19 can be treated with safe and effective drugs

There exist multiple safe, effective, and inexpensive, generic drugs to treat COVID-19 – for the rare cases when treatment is necessary, i.e., among children with multiple comorbidities – that have been used in all age groups, even young children[10]. A systematic review of 15 clinical trials indicated that the Nobel Prize winning antiparasitic drug Ivermectin (IVM) can be successfully applied to the treatment of viral diseases, including COVID-19, and reduces infection by an average of 86%.[11] A more recent report of 64 clinical trials, 30 of them randomized and controlled, indicated 67% effectiveness in prophylaxis, 84% in early treatment, and 20% in late treatment using protocols that include IVM at different doses and for different periods of time.[12] Another meta-analysis of 18 Randomized Controlled Trials of IVM in COVID-19 found large, statistically and clinically significant, reductions in mortality, time to clinical recovery, and time to viral clearance.[13] Finally, many examples of IVM distribution campaigns – in Mexico City, several states in India, and several Argentinian provinces – leading to rapid population-wide decreases in morbidity and mortality among all age groups, indicate the safety and effectiveness of this oral medication in all phases of COVID-19.[14] In light of the wealth of data supporting treatment modalities that can help to overcome the current public health, social, and economic crisis in Canada, the suppression and gross misrepresentation – by leading regulatory agencies

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and mainstream media[15] – and the efforts of medical colleges to criminalize doctors who treat COVID-19 patients with IVM and other repurposed drugs, [16] is unjustified and nothing short of scandalous. It is also unjustifiable to risk the health of young Canadians by subjecting them to unnecessary medical experiments when safe and effective alternatives exist.

4) COVID-19 products are not like traditional vaccines

Traditional vaccines, involving inactivated or attenuated viral particles have decades of research supporting their safety and effectiveness, i.e., their ability to stop transmission in the real world and not only in randomized controlled trials, with no major adverse effects. Still, vaccination is not mandatory in Canada[17], so mandating COVID products in schools – as they currently are in post-secondary educational establishments – would be unprecedented in Canadian history. Such mandates are also a major violation of the right to informed consent, which by definition must be free from coercion.[18] In the case of the very young, it is also a major violation of the right of parents to decide on the medical procedures performed on their children.

5) COVID-19 vaccine products are not safe – for adults or children

Several countries have stopped using COVID products in the young. Finland, Sweden and Denmark no longer use them in the population under 30 years of age due to concerns about myocarditis.[19] A retrospective assessment of reports filed to the US Vaccine Adverse Event Reporting System (VAERS) between January 1, 2021, and June 18, 2021, among healthy adolescents ages 12-17 who received COVID products, identified that this age group was up to six times more likely to be diagnosed with myocarditis than to be hospitalized for COVID-19.[20]

In Canada, a recent SickKids report notes that heart disease among the young – myocarditis and pericarditis – have risen since the launch of the vaccination campaign, and instructs clinicians on treatment of adverse events post injection – abdominal pain, vomiting, encephalopathy, and in some severe cases, hypertension and shock among others.[21] Considering that only 16 of 1,129 participants in the control group of the Pfizer trial tested positive for COVID-19[22] – of note, a positive test is not necessarily illness – whereas in the treatment group 3 in 4 participants experienced fatigue and headaches, around half muscle pain, and 1 in 4 joint pain, the relative benefits of the COVID-19 products remain at best dubious.[4]

Additionally, phase III trials are the highest level of evidence and our best tool for ascertaining the risks and benefits of a treatment. Results from the phase III trial of the Pfizer/BioNTech BNT162b2 mRNA product through 6 months were recently reported by Thomas *et al.* in the New England Journal of Medicine. [23] The study, which compared the mRNA COVID-19 vaccine to placebo in healthy adults, showed an absolute risk reduction (ARR) in symptomatic and PCR- confirmed COVID-19 cases among fully vaccinated individuals of 3.7%, *but an absolute risk increase (ARI) of 17.9% in treatment-related adverse effects in that same group.* As well, the study reported an ARR in severe COVID-19 cases of 0.1% among the fully

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vaccinated, *but also an ARI in serious adverse events among vaccine recipients of 0.5%.* While deaths were relatively comparable across arms initially (15 vs 14 deaths, vaccine vs placebo, respectively), 5 additional deaths were reported in vaccine recipients after cross over, bringing the total death count after vaccination to 20. (Table 1). *Of note, there were nearly twice as many deaths due to cardiac events in the vaccine arm compared to the placebo arm (7 vs 4 deaths).* **Results of the BNT162b2 mRNA COVID-19 phase III clinical trial clearly demonstrate at the highest level of evidence that the risks associated with the BNT162b2 mRNA COVID-19 vaccine outweigh the risks of COVID-19 in healthy adults, and do not support claims about the safety of these products, in this or any other population, and regardless of antibody levels.**

Finally, vaccine safety reporting systems are revealing a record number of injuries. As of October 15, 2021, reported adverse events worldwide had surpassed 2,344,240 in the WHO reporting system Vigiaccess.[24] VAERS recorded 122,833 serious adverse events, 17,128 of which ended in death, post administration of COVID products. For context, the *combined* serious adverse events, including deaths upon administering *all* (around 70) vaccines, except for COVID products, that have been reported to VAERS since 1990 when the system was established, was 103,767 and 9,054, respectively.[25] *Put another way, about 50% of serious adverse events ever recorded in the over 30 years of the existence of VAERS were associated with three COVID products* (AstraZeneca's product was not approved in the USA) within *less than one year*. Even these staggering numbers *underreport* the true adverse events post COVID products by a factor of at least 10[26] and likely as high as 41.[27]

VAERS data from October 22, 2021, for 12- to 17-year-olds specifically revealed:

- 22,212 total adverse events,[1] including 1,348 rated as serious[2] and 25 reported deaths (2 were suicides).
- 58 reports of anaphylaxis among 12- to 17-year-olds where the reaction was life-threatening, required treatment, or resulted in death.[3]
- 539 reports of myocarditis and pericarditis (heart inflammation).[4]
- 125 reports of blood clotting disorders.[5]

A recent death involved a 12-year-old girl (VAERS I.D. 1784945) who died from a respiratory tract hemorrhage 22 days after receiving her first Pfizer product dose. Another recent death is the case of a 16-year-old girl (VAERS I.D. 1694568) who died of pulmonary embolism 9 days after a Pfizer product dose (whether it was the first or second is unknown). Yet another recent death was that of a 15-year-old boy who died six days after receiving his first dose of Pfizer product. The VAERS report (I.D. 1764974) states that the previously healthy teen "was in his usual state of good health. Five days after the vaccine, he complained of shoulder pain. He was playing with two friends at a community pond, swinging from a rope swing, flipping in the air, and landing in the water feet first. He surfaced, laughed, told his friends 'Wow, that hurt!', then swam toward shore, underwater as was his usual routine. The friends became worried when he

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did not re- emerge. His body was retrieved by local authorities more than an hour later." The autopsy revealed "small foci of myocardial inflammation", an adverse effect of these COVID products commonly found among children and youth, particularly young men.

Of note, *none of these reports include long-term adverse events*, critical to assessing the safety of any medical product. If the history of drug development – such as that of thalidomide, dengue vaccine, and swine flu vaccine – teaches us anything, it is that the harm caused by implementing "remedies" that have not been properly tested can be much greater than the harm caused by the "disease" that these remedies are designed to treat. [28–30]

In concluding, we thank you for taking the time to read our analysis, expect it will contribute to your efforts to keep Canadian children safe, and would appreciate the opportunity to engage and collaborate with you and members of your team towards that goal.

Respectfully,

Claudia Chaufan, MD PhD[1]

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[15] Professor Emeritus, Globalization Studies and Liberal Education, University of Lethbridge

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Table 1

Table 1. Differences in efficacy and safety events reported in the 6-month update of the BNT162b2 mRNA Covid-19 Vaccine

Event	BNT162b2 (n)	Placebo (n)	Absolute Difference (p-value)	Absolute Risk Change* (%)	Relative Risk Change* (%)
Total Randomized Adults and Adolescents (n)	23,219	23,210			
Fully Vaccinated Cases Adults and Adolescents[$] COVID-like symptoms + PCR	77	850	-773 (p<.00001)	-3.7	-90.9
Any Treatment-Related Adverse Event Adults[#]	5,241	1,311	+3,930 (p<.00001)	+17.9	+298.3
Any Severe Event Adults[/]	**278**	**187**	**+91 (p=.000022)**	**+0.4**	**+48.7**
Full Vaccinated Severe Cases Adults[&] COVID-like symptoms + PCR	1	23	-22 (p<.00001)	-0.1	-95.6
Severe Adverse Events Adults Prevents daily routine activity or requires intervention or worse	262	150	+112 (p<.00001)	+0.5	+71.4
Deaths during placebo-controlled period [additional deaths during open-label period in vaccine recipients or those that only received placebo][%]	15 [+5]	14 [NR]	+1 [+5] (p=.853117)	+0.005 [+0.022]	+7.1 [+35.7]
Deaths due to cardiac events^	7	4	+3		

* Significance figures (p-values) estimated using a chi-square calculator available at https://www.socscistatistics.com/tests/chisquare. P-values are without the Yates correction. This procedure was applied following the framework used by Classen (2021) in their analysis of "All Cause Severe Morbidity" based on data from the initial reports of the vaccine Phase III trials.[2]

* Absolute and relative risk change calculations were performed using the common statistical definition, ie. number of events relative to total number of eligible patients for each event analysis reported;[3] vaccine efficacy estimates reported at source used total surveillance time as denominator, however, this value is not available for all the events analyzed

$ ≥7 Days after dose 2 among participants without evidence of previous infection

Assessed by the investigator as related to investigational product

/ In calculations combining efficacy and safety events, the number of patients randomized that received any dose of vaccine or placebo was used as the study population in the statistical calculations, following the framework used by Classen (2021) in their analysis of "All Cause Severe Morbidity".[2] Differences in the total (event-incident) population (ITT vs efficacy vs safety) used as denominator are relatively small and are expected to have minimal impact on the relative differences between arms.

& ≥7 Days after dose 2

% During the open-label period, 3 participants in the BNT162b2 group and 2 in the original placebo group who received BNT162b2 after unblinding died

^Those with reported cause of death due to: cardiac arrest, cardiac failure congestive, cardiorespiratory arrest, chronic obstructive pulmonary disease, hypertensive heart disease, or myocardial infarction.

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1

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2

https://medalerts.org/vaersdb/findfield.php?TABLE=ON&GROUP1=AGE&EVENTS=ON&SYMPTOMS[]=Anaphylactic+reaction+%2810002198%29&SYMPTOMS[]=Anaphylactic+shock+%2810002199%29&SYMPTOMS[]= Anaphylactoid+reaction+%2810002216%29&SYMPTOMS[]=Anaphylactoid+shock+%28100

3

https://medalerts.org/vaersdb/findfield.php?TABLE=ON&GROUP1=AGE&EVENTS=ON&SYMPTOMS[]=Anaphylactic+reaction+%2810002198%29&SYMPTOMS[]=Anaphylactic+shock+%2810002199%29&SYMPTOMS[]=Anaphylactoid+reaction+%2810002216%29&SYMPTOMS[]=Anaphylactoid+shock+%2810063119%29&SYMPTOMS[]=Anaphylaxis+prophylaxis+%2810049090%29&SYMPTOMS[]=Anaphylaxis+treatment+%2810002222%29&VAX=COVID19&STATE=NOTFR&WhichAge=range&LOWAGE=12&HIGHAGE=18

4

https://medalerts.org/vaersdb/findfield.php?TABLE=ON&GROUP1=AGE&EVENTS=ON&SYMPTOMS[]=Myocarditis+%2810028606%29&SYMPTOMS[]=Pericarditis+%2810034484%29&VAX=COVID19&STATE=NOTFR&WhichAge=range&LOWAGE=12&HIGHAGE=18

5

https://medalerts.org/vaersdb/findfield.php?TABLE=ON&GROUP1=AGE&EVENTS=ON&SYMPTOMS[]=Cerebral+venous+sinus+thrombosis+%2810083037%29&SYMPTOMS[]=Cerebral+venous+thrombosis+%2810008138%29&SYMPTOMS[]=Coagulopathy+%2810009802%29&SYMPTOMS[]=Deep+vein+thrombosis+%2810051055%29&SYMPTOMS[]=Disseminated+intravascular+coagulation+%2810013442%29&SYMPTOMS[]=Embolism+%2810061169%29&SYMPTOMS[]=Idiopathic+thrombocytopenic+purpura+%2810021245%29&SYMPTOMS[]=Immune+thrombocytopenia+%2810083842%29&SYMPTOMS[]=Immune+thrombocytopenic+purpura+%2810074667%29&SYMPTOMS[]=Ischaemic+stroke+%2810061256%29&SYMPTOMS[]=Myocardial+infarction+%2810028596%29&SYMPTOMS[]=Petechiae+%2810034754%29&SYMPTOMS[]=Pulmonary+embolism+%2810037377%29&SYMPTOMS[]=Purpura+%2810037549%29&SYMPTOMS[]=Thrombocytopenia+%2810043554%29&SYMPTOMS[]=Thrombosis+%2810043607%29&SYMPTOMS[]=Vasculitis+%2810047115%29&VAX=COVID19&STATE=NOTFR&WhichAge=range&LOWAGE=12&HIGHAGE=18

https://medalerts.org/vaersdb/findfield.php?IDNUMBER=1784945

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Ghaly, Maggy (HC/SC)

From: Deputy Prime Minister / Vice-première ministre <DPM-VPM@dpmo-cvpm.gc.ca>
Sent: 2022-01-17 1:45 PM
To: governmentrelations@canadiancovidcarealliance.org
Cc: HCMinister.MinistreSC@canada.ca
Subject: Reply to your correspondence
Attachments: NR Pfizer Inoculations For COVID-19 More Harm Than Good 20220113.pdf; Fact Check Pfizer Inoculations For COVID-19 More Harm Than Good 20220113.pdf

Dear Mr. Ross:

I would like to acknowledge receipt of your correspondence sent to the Honourable Chrystia Freeland, Deputy Prime Minister and Minister of Finance.

Please be assured that your comments have been carefully reviewed. I have taken the liberty of forwarding your correspondence to the Honourable Jean-Yves Duclos, Minister of Health, for consideration.

Thank you for taking the time to write.

Sincerely,

R. Kabongo
Executive Correspondence Officer/Agente de correspondance
Executive Correspondence Services/
Services de la correspondance de la haute direction

From: Government Relations <governmentrelations@canadiancovidcarealliance.org>
Sent: Sunday, January 16, 2022 4:11 PM
To: Freeland, Honourable/Honorable Chrystia <Chrystia.Freeland@dpmo-cvpm.gc.ca>
Subject: Pfizer Inoculations For COVID-19 – More Harm Than Good

Dear Minister Freeland,

Attached, please find a news release and presentation prepared by the Canadian Covid Care Alliance (CCCA), concerning the recently released results of Pfizer's 6-month clinical trial for its COVID-19 vaccine.

Pfizer's own clinical trial data demonstrates that their biological products are **causing more harm than good** contrary to the repeated claims of public health officials that these products are "safe and effective."

In addition, the data shows that the Pfizer trials that were required to obtain interim approval for them to be used in Canada and elsewhere were inadequately designed to prove the safety and clinical efficacy of the COVID-19 vaccines, and suffered from poor trial execution and imbalanced reporting, which could have misled the government regulators including Health Canada, policymakers like yourself, and the general public.

We respectfully request that you carefully review and consider the presentation, seek out independent expert advice on the material we have presented and other supporting materials that we can provide, and work to revise your government's policies and mandates accordingly, and in particular:

- That you seek an immediate halt to the vaccination of children, who derive no benefit from the injections, but bear all the risks of serious injury and potentially even death;

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- That emphasis be placed on early treatment of the disease in accordance with existing, proven treatment protocols, and that the restrictions placed on doctors by their governing bodies limiting their treatment options be terminated immediately;
- And, that, just as the European Union and many other jurisdictions have done, your government's health policy be revised to fully incorporate recognition that many Canadians have developed effective and lasting natural immunity to the virus from natural exposure.

We invite you to review other evidence-based scientific articles on our website: www.CanadianCovidCareAlliance.org. We also welcome your questions. Note that an additional file addressing the recent AFP "fact check" of the presentation is also attached.

Sincerely,

David Ross, FCPA FCA
President, Canadian Covid Care Alliance

on behalf of Canadian Covid Care Alliance members

Presentation link with voiceover: https://www.canadiancovidcarealliance.org/media-resources/the-pfizer-inoculations-for-covid-19-more-harm-than-good-2/

PDF presentation slides only: https://www.canadiancovidcarealliance.org/media-resources/the-pfizer-inoculations-for-covid-19-more-harm-than-good/

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ATIA - 19(1)

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Esteves, Dina (HC/SC)

From: Minister Champagne / Ministre Champagne (IC) <ministerofisi-ministredeisi@ised-isde.gc.ca>
Sent: 2022-02-09 4:03 PM
To: governmentrelations@canadiancovidcarealliance.org
Cc: hcminister.ministresc@canada.ca
Subject: Innovation, Science and Economic Development Canada
Attachments: image002.jpg; TR: Pfizer Inoculations For COVID-19 – More Harm Than Good

Innovation, Science and Economic Development Canada | Innovation, Sciences et Développement économique Canada

Dear Mr. Ross:

On behalf of the Honourable François-Philippe Champagne, Minister of Innovation, Science and Industry, thank you for your email of January 15, 2022.

The issue you have raised falls under the purview of the Honourable Jean-Yves Duclos, Minister of Health. I have therefore taken the liberty of forwarding your correspondence to his office for consideration.

Please accept my best wishes.

Sincerely,

[redacted]

Kirwins Charles
Director, Executive Correspondence

c.c.: Office of the Honourable Jean-Yves Duclos, P.C., M.P.

Canada

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Esteves, Dina (HC/SC)

From: Champagne, François-Philippe - Député <Francois-Philippe.Champagne@parl.gc.ca>
Sent: 2022-01-17 9:26 AM
To: ISI.minister-ministre.ISI@canada.ca
Subject: TR: Pfizer Inoculations For COVID-19 – More Harm Than Good
Attachments: NR Pfizer Inoculations For COVID-19 More Harm Than Good 20220113.pdf; Fact Check Pfizer Inoculations For COVID-19 More Harm Than Good 20220113.pdf

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De : governmentrelations@canadiancovidcarealliance.org <governmentrelations@canadiancovidcarealliance.org>
Envoyé : 15 janvier 2022 13:56
À : Champagne, François-Philippe - Député <Francois-Philippe.Champagne@parl.gc.ca>
Objet : Pfizer Inoculations For COVID-19 – More Harm Than Good

Dear Minister Champagne,

Attached, please find a news release and presentation prepared by the Canadian Covid Care Alliance (CCCA), concerning the recently released results of Pfizer's 6-month clinical trial for its COVID-19 vaccine.

Pfizer's own clinical trial data demonstrates that their biological products are **causing more harm than good** contrary to the repeated claims of public health officials that these products are "safe and effective."

In addition, the data shows that the Pfizer trials that were required to obtain interim approval for them to be used in Canada and elsewhere were inadequately designed to prove the safety and clinical efficacy of the COVID-19 vaccines, and suffered from poor trial execution and imbalanced reporting, which could have misled the government regulators including Health Canada, policymakers like yourself, and the general public.

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A2022001224

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on behalf of Canadian Covid Care Alliance members

Presentation link with voiceover: https://www.canadiancovidcarealliance.org/media-resources/the-pfizer-inoculations-for-covid-19-more-harm-than-good-2/

PDF presentation slides only: https://www.canadiancovidcarealliance.org/media-resources/the-pfizer-inoculations-for-covid-19-more-harm-than-good/

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News Release

The Pfizer Inoculations For COVID-19 – More Harm Than Good

January 13, 2022

(MONCTON, NB) – The presentation "The Pfizer Inoculations For COVID-19 – More Harm Than Good" by the Canadian Covid Care Alliance explains how Pfizer's own data shows that their Covid-19 inoculation is causing greater harm than the public was informed about.

The Canadian Covid Care Alliance represents over 500 independent doctors, scientists, and health care practitioners committed to providing quality, balanced, evidence-based information to the Canadian public about Covid-19 so that hospitalizations can be reduced, lives saved and our country safely restored to normal as quickly as possible.

The most important premise in medicine is: first, do no harm. The federal, provincial and municipal governments in Canada have a responsibility to protect the health of Canadians as well as their Charter Rights and Freedoms. Any medical interventions approved by Health Canada must first be proven safe.

Due diligence in research, as well as adherence to established doctor/patient protocols, informed consent, and scientific inquiry are essential to carrying out that responsibility. Deviating from those practices, causing harm, and failing to disclose risks of harm is negligent at best.

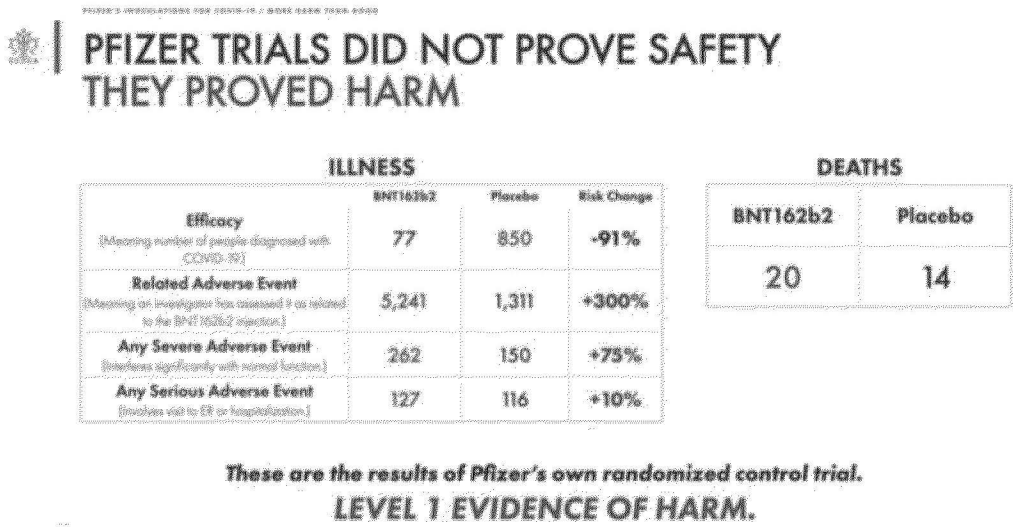
The highest form of scientific evidence – Level 1 evidence: data from Pfizer's own randomized controlled trial – showed that the reported benefit in COVID-19 case reductions came at the cost of increased sickness, and maybe even death.

The evidence shows the following increases in risk of illness:

- Related Adverse Events (as determined by an investigator) +300%
- Any Severe Adverse Event (significant interference with normal function) +75%
- Any Serious Adverse Event (ER visit or hospitalization) +10%

It also showed an increased number of deaths in inoculation recipients including those who had been in the placebo group who crossed over to receive the vaccine:

20 participants who took the inoculation vs.14 in the placebo group.



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Instead of proving these inoculations were safe, as they were supposed to do, the Level 1 evidence showed they caused harm and potentially increased death.

The public was led to believe that vaccines would protect them from disease and possible death, but the data that the regulators relied on did not show this. It not only showed an inability to improve survival but showed a numerical increase in death with crossover.

The trial also had some significant limitations. Among other things:

- the individuals in Pfizer's trial did not represent the population at greatest risk from Covid-19;
- it had an inadequate control group and used low-quality safety science;
- it focused on the wrong clinical endpoints (should have focused on reducing severe illness, stopping transmission, and all-cause mortality);
- it used a non-standard test to assess infection and did not consistently test all participants
- it was unblinded after only two months and the control group was offered the inoculation eliminating any chance of measuring long-term harm
- it was also rife with data integrity issues including loss of data and unblinding of patients

These products were inadequately and sub-optimally tested on the healthy and then given to the frailest members of society, with no way of evaluating the long-term harm.

While Pfizer's research has been used by health policy makers to justify mandating vaccination, the study did not include a lot of different types of people like pregnant women, those who are immunocompromised, and those who are naturally immune among others. More importantly there is no evidence that this product reduces disease transmission.

Even worse, adolescents and children who are at a near 0% risk of death from COVID-19 and at very low risk of severe illness are being mandated to receive this inoculation. The Pfizer studies in children and adolescents, which should have followed the highest possible safety science, had even more limitations. The studies were small, not placebo controlled, and not even designed to assess COVID-19. Even worse early safety data from the adolescent trial already show a 249% increase risk in severe adverse events and a 299% increase in serious adverse events in those receiving the inoculation. The company also admits the inoculations will cause myocarditis (irreversible damage to the heart with a mortality rate possibly as high as 20% at 6.5 years) in this group that has negligible risk from COVID-19.

How can we justify exposing any child to the risk of life altering severe events like those experienced by teenager Maddie de Garay – a 12-year-old participant who was hospitalized within 24 hours of her second dose and is now confined to a wheelchair and must eat from a feeding tube. In their report, Pfizer described her outcome as "functional abdominal pain."

How many Canadians would have chosen to take this product, or would have given it to their children, had they known it was not able to prevent transmission, was only able to confer a net benefit of 4% at six-months, could result in an increased risk of severe adverse events, and knowing that it was never tested on the most vulnerable members of society?

NOTE: Pfizer's claim of 95% efficacy is only a reference to Relative Risk Reduction (RRR) but the FDA notes that "patients are unduly influenced when risk information is presented using a relative risk approach [as] this can result in suboptimal decisions." The overall net benefit or Absolute Risk Reduction (ARR) (the FDA's recommended way of evaluating efficacy) observed in the trial was only 0.84%.

Contact: governmentrelations@canadiancovidcarealliance.org

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Fact Checking The Fact Checkers

In late December we were pleased to launch our video "More Harm than Good" which was inspired by our Critique of the Thomas *et al.* 2021 NEJM Publication which has recently been submitted for publication. Since then, we've received some great feedback, some requests for clarification and some critical reviews including a Fact Check by AFP. In the spirit of open scientific discourse and debate we present our responses to the AFP check in this below.

About AFP: *AFP is stated to be a for profit organization that seeks to give French and foreign users precise, impartial and trustworthy information in a regular, uninterrupted manner. It must, in no circumstances, fall under the control of an ideological, political or economic group. The AFP fact checked our video on January 4, 2021 and their full analysis can be found* HERE.

Despite their stated objectives, AFP's board of directors has five members with direct political ties, two members from government owned radio and television, and three government representatives: the minister of finance, the minister of foreign affairs and the Director General of Media and Cultural Industries who is appointed by the minister of culture (AFP, Board of Directors). It is difficult to imagine how the AFP can remain politically neutral while much of its funding comes from the French government (Allsop, Columbia Journalism Review) and a number of its ministers sit on the board of directors. Their one-sided, pro-narrative response lacks scientific rigour, and certainly does not reflect AFP's stated commitment to the dissemination of trustworthy and impartial information.

AFP 1: Animal testing was skipped. *"The video claims that animal testing was "skipped" during the vaccine's development, leading to compromised safety. That is false. Pfizer-BioNTech tested the mRNA shot on rhesus macaques and that data was reviewed by Health Canada prior to authorization of the vaccine. Although the COVID-19 shots are the first to use mRNA technology, research on it started in the early 1990s, and included promising tests on animals.'*

Preclinical testing is conducted to prove the short and long-term safety and efficacy of the vaccine in animal models before assessment in humans. Although some animal studies of BNT162b2 were conducted, to expedite development, these studies were done in tandem with the clinical trials and in some instances toxicology data from the lipid nanoparticle carrier components of the vaccine were accepted in lieu of BNT162b2 data (Pfizer/BioNTech FDA EUA Presentation.) The short and long-term safety results of the inoculation in humans was unknown at the time of clinical trial recruitment. In fact, at the time of FDA EUA approval in December 2020, only unpublished short term outcomes from two toxicology studies and one immunogenicity trial were available. Studies assessing reprotoxicity and teratogenicity were ongoing and no genotoxicity or oncotoxicity studies were underway. What this means is that the animal testing which is usually completed prior to assessment in humans to ensure both the short and long-term safety of the inoculation was skipped and some safety questions such as whether the inoculations could alter the human genome or cause cancer remained unanswered at the time of approval.

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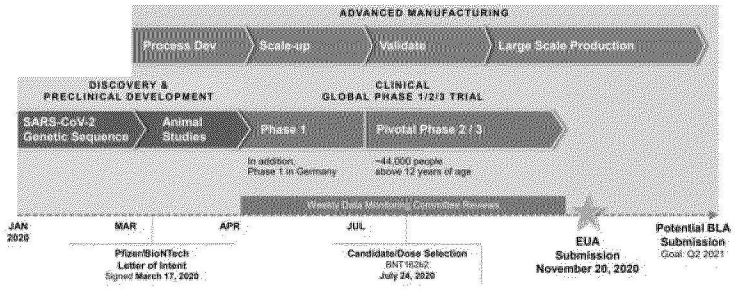

Key Nonclinical Studies with BNT162b2

Study No.	Study Description	Key Message
Toxicology Studies		
38166	17-Day, 2 or 3 Dose (1 Dose/Week) IM Toxicity in Rats With a 3 Week Recovery Period	Completed with no safety concerns
20GR142	17-Day IM Toxicity Study of BNT162b2 and BNT162b3c in Wistar Han Rats with a 3-Week Recovery	Completed with no safety concerns
20256434	A Combined Fertility and Developmental Study (Including Teratogenicity and Postnatal Investigations) of BNT162b1, BNT162b2 and BNT162b3 by the Intramuscular Route in the Wistar Rat	Ongoing with preliminary results mid-December 2020
Pharmacology Studies		
VR-VTR-10671	BNT162b2 Immunogenicity and Evaluation of Protection against SARS-CoV-2 Challenge in Rhesus Macaques	Completed and showed that BNT162b2 protects against SARS-CoV 2

The fact that mRNA technology was previously studied in animals prior to COVID-19 does not support the safety of this technology, which is used to produce the pathogenic Spike (Wang *et al.*, Suzuki *et al.*, Lei *et al.*, Biancatelli *et al.*, Solopov *et al.*) protein in humans. In fact, the small scale phase I study of the Moderna COVID-19 vaccine published in NEJM by Jackson *et al.* also highlighted previous animal studies with coronavirus vaccines that raised concerns regarding the "potential for development of vaccine-associated enhanced respiratory disease with vaccine antigens that induced antibodies with poor neutralizing activity and Th2-biased responses."

Moreover, the previous studies using the lipid nanoparticle delivery system were mainly for targeted chemotherapy to deliver toxins and drugs into cancer cells or liposomes coated with proteins from viruses, bacteria or fungi as vaccine formulations for update by immune cells. The delivery of genetic information with a lipid nanoparticle to generate the foreign proteins as antigens to elicit an immunoresponse against a vaccinated person's own body cells has never been regulatory agency-approved for human use before. Since the mechanism of action to generate adaptive immunity requires requires inflammatory attack of the cells expressing the foreign protein on their surface, there are strong hypothetical reasons why repeated booster injections of the RNA vaccines may result in breakage of tolerance leading to autoimmune disease from production of antibodies and activation of T lymphocytes against the proteins of

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the body's own cells. It is also feasible that repeated injections that result in high doses of the foreign protein on the surface of the body's cells may induce tolerance against the virus by favouring the destruction of T- and B-cells that target the viral proteins. This might account for the high rates of breakthrough COVID-19 cases in double vaccinated populations.

AFP 2: Safety of COVID-19 vaccine in pregnant and breastfeeding women. *"The video claims that because pregnant and breastfeeding women were excluded from Pfizer-BioNTech's clinical trial, there "has never been any data to make safety claims about those people and inoculations." This is false. Studies have followed pregnancy outcomes, particularly in health care workers who were among the first to receive the COVID-19 shots." … pregnant individuals are considered a high-risk population for COVID-19 complications and appeals to the Society of Obstetricians and Gynaecologists of Canada recommend vaccination against the disease "during pregnancy in any trimester and while breastfeeding."*

The precautionary principle is the standard that governs care of pregnant women and their unborn or breastfeeding children (45 CFR 46, Subpart B; FDA DPMH Guidance for Industry.) This means that all agents that have not been proven safe through rigorous testing of both short and long-term clinical and sub-clinical effects on both mother and child should be avoided. The only way to prove safety is through prolonged rigorous testing in a phase III clinical trial that lasts through to the second year of development of the vaccine-exposed neonate. Although drugs have been approved for use in pregnant women based on observational studies following full approval in the general population (FDA DPMT Guidance to Industry), there is no precedent for approval of a vaccine approved under emergency use authorization in the general population and lacking long-term safety data. As pregnant women were not included in the phase III trials, no claims regarding the safety of the inoculation in this population can be made. An absence of "safety signals" from observational studies or small inadequately powered studies looking at transfer of vaccine mRNA in breastmilk are wholly inadequate to support claims of safety. They may provide some insight into whether the vaccines are present in breast milk of vaccinated pregnant women, but do not establish whether the pathogenic spike protein product is in the milk. All of this is a moot point, since it is now being proposed to directly inoculate babies with the COVID-19 vaccines.

Although the AFP refers to pregnant women as a high-risk group, the real world retrospective cohort studies used to support this designation were conducted in either pregnant women who had symptomatic COVID-19 or pregnant women who were hospitalized due to COVID-19 (Zambrano *et al.*, Martinez-Portilla *et al.*, Knight et al., Pineles *et al.*). As association does not infer causation, severe outcomes cannot be definitely attributed to a women's pregnant status and statements regarding risk should be appropriately qualified. Additionally, while increased risk of adverse outcomes for pregnant women was observed in large registry studies with substantial proportions of missing data after adjusting for selected confounding factors (Zambrano *et al.*, Martinez-Portilla *et al.*), results from analyses of hospital network databases (Knight *et al.*, Pineles *et al.*) did not confirm the increased risk observed in the registry studies. Moreover, outcomes from these trials should be limited to the actual populations studied and should not be extrapolated to the 72% to 98% who have asymptomatic COVID-19 (Woods *et al.*, Sutton *et al.* and Maru *et al.*). What AFP should have said was that pregnant women with

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symptomatic COVID-19 **may** be at an increased risk of severe disease. And even if this were true, this would not warrant use of these agents for which the short and long-term safety has not been proven.

The evidence that the AFP provided for the safety of the COVID-19 vaccines to pregnant women was limited to a single study. In the safety assessment "COVID-19 Vaccination During Pregnancy in Ontario - Report #1: December 14,2020 to May 31, 2021 - of 30,670 women that were vaccinated 99.3% had only one dose and 0.7% had two doses, and 84.1% had not given birth yet. Moreover, about 38% of all of the vaccinations occurred in the last month (May) in the study. The first trimester vaccinations would be at greatest risk of developmental issues, but almost no data would be available about the kind of parameters that were assessed in this study, which focused on post-birth metrics, and very few at that. Since pregnancy takes 9 months, the data in Table 2 of this report cannot be compared at all the range of background rates in Ontario, which is based on full 9 month terms. Therefore, there was no way to make a valid comparison at the time the Ontario Vaccine and Pregnancy study was reported. Moreover, this kind of limited data cannot be used to address the safety of the vaccines to embryos and babies prior to birth.

AFP3: Death of Danish footballer Eriksen: *The video includes several clips of news broadcasts, including one from the Euro 2020 football tournament in which Danish footballer Eriksen collapsed on the pitch during a match against Finland on June 12, 2021. At the time, AFP investigated claims that Eriksen's collapse was related to a Covid-19 vaccine, but the Danish Football Association and the director of his club Inter Milan said he had not been vaccinated.*

We included the video montage of athletes collapsing on the field to highlight the fact that there have been an unusual number of athletes collapsing on the pitch. Our point was that such episodes were rare and no longer based on the number of such stories in the news. Although Eriksen was not vaccinated, many healthy young athletes at little to no risk of severe COVID-19 have been required to be vaccinated to continue to play or compete. Many had to undergo the procedure despite clear warnings on the COVID-19 Vaccine Product Monograph indicating an increased risk of myocarditis and pericarditis, a risk that is particularly acute among young men (PHO Myocarditis and Pericarditis Dec 4 to Sept 4 2021).

AFP 4: Pfizer Pharmacovigilance Safety Report. *"The video points to a document released by the US Food and Drug Administration to claim that it revealed more than 1,200 deaths related to Pfizer-BioNTech's Covid-19 vaccine in a 90-day period. This document has been misleadingly shared across social media, but does not contain evidence to indicate the vaccine was linked to deaths. The figure of 1,223 fatalities among 158,893 adverse effects reflect "spontaneous" reports from sources that include health officials in several countries, without any verification of the cause, Pfizer spokeswoman Dervila Keane told AFP for a previous fact-check…. A multinational, placebo-controlled, observer-blinded trial reported in the New England Journal of Medicine on December 31, 2020 showed no fatalities among vaccine or placebo recipients and stated: "The safety profile of (the shot) was characterized by short-term, mild-to-moderate pain at the injection site, fatigue, and headache. The incidence of serious adverse events was low and was similar in the vaccine and placebo groups."*

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The video does not claim that reported deaths were due to vaccination. It simply states that Pfizer's own worldwide pharmacovigilance safety report recorded 1,223 vaccine-suspected deaths in the first 90 days of worldwide vaccine roll-out. It is well recognized that the passive surveillance systems under-report safety signals (Lazarus AHRQ 2010). In this same report Pfizer indicated that they were behind on processing the overwhelming number of COVID-19 vaccine-suspected adverse events that they had received to date and that the report does not reflect the full number of reported events (Pfizer PAAE Report to FDA 2021). So, although we cannot ascribe causation to the vaccine, it is common medical practice to consider such serious adverse events as signals of vaccine safety and that similar reports have been used to shut down vaccine campaigns in the past (Sencer and Miller *et al.* 2006).

It is also curious that the AFP cites preliminary results from the phase III trial (Polack *et al.* 2021) that we are critiquing to refute more mature results of the same trial (Thomas *et al.* 2021).. The most up to date findings of the cited trial show one additional death overall (15 vs 14) of which there were four additional cardiovascular deaths (9 vs 4) where seen in the vaccine compared placebo in the blinded phase, and six additional deaths in vaccine recipients overall compared to the unvaccinated (20 vs 14) with crossover (Thomas *et al.* 2021).

ATIA - 19(1)

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2022-01-17 8:19 AM
To: hcminister.ministresc
Subject: TR: Letter from MLA Frey, Brooks Medicine Hat Alberta
Attachments: MLA Michaela L Frey Letter Concerning Trucker Vaccination Requirements.pdf

De : [redacted]@assembly.ab.ca>
Envoyé : 15 janvier 2022 12:29
À : Alghabra, Omar - M.P. <Omar.Alghabra@parl.gc.ca>; Freeland, Chrystia - M.P. <Chrystia.Freeland@parl.gc.ca>; Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>; O'Regan, Seamus - M.P. <Seamus.ORegan@parl.gc.ca>
Objet : Letter from MLA Frey, Brooks Medicine Hat Alberta

Honourable Ministers,

Please find attached a letter from MLA Michaela Frey detailing her concerns over the changes to truckers' vaccination requirements. We appreciate you considering the effects that these policies will have on the community she represents, Brooks-Medicine Hat, along with the rest of Canada, and look forward to you implementing some changes to reduce the effects of this decision.

Thank you for your consideration,

United Conservative caucus

[redacted]
Legislative Coordinator
MLA Frey / MLA Rosin
United Conservative Caucus
587.983.2476
6th Floor, Edmonton Federal Building
9820 107 St NW, Edmonton, AB T5K 1E7

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LEGISLATIVE ASSEMBLY
ALBERTA

Michaela L. Frey
MLA, Brooks-Medicine Hat

Jan. 15, 2022

Honourable Omar Alghabra, Minister of Transportation
Honourable Seamus O'Regan, Minister of Labour
Honourable Jean-Yves Duclos, Minister of Health
Honourable Chrystia Freeland, Minister of Finance

Ministers,

As the Member of the Alberta Legislative Assembly for Brooks-Medicine Hat, one of Canada's border communities, I'm contacting you regarding my concerns over the proposed changes to the cross-border vaccination requirement for truckers. With Canadians facing supply chain issues, coupled with a dangerous inflationary environment, disrupting supply chains by adding further uncertainty will only further serve to harm one of Canada's vital, job-creating industries. These crucial workers, truckers, deserve our support, not roadblocks and uncertainty in their employment.

Throughout the pandemic, our cross-border truckers have been a critical lifeline for Canadians. Despite early concerns among Canadians about food supply, stock concerns were largely mitigated thanks to the valuable, timely service provided by the transportation and trucking industry. Over the past two years, truckers have rightfully been accommodated within testing and isolation requirements due to the critical nature of their business. Premiers, politicians, and everyday Canadians alike have spoken in favour of the importance and value of the shipping industry. The federal Liberal government turning around and making their business more difficult to conduct is not only unfortunate but will have devastating impacts on supply chains across the country.

Every single day, I hear from constituents who are struggling to keep food on the table as inflation claims more of their monthly disposable income. Store shelves are already barren in some areas, or close to it. Supply chain issues are rampant in almost every industry. Freight rates have increased 20 to 30 per cent due to COVID-related challenges and some transportation firms anticipate having to lay off up to 20 per cent of their employees due to your government's unnecessary changes. Canadian families cannot afford to pick up the bill for this mismanagement and they should not have to.

Truck drivers and the transportation industry are, and have always been, essential to life in Canada. In the beginning of the pandemic, these very same people that you are now making life more difficult for were putting themselves at risk, travelling community to community while governments were trying to figure out appropriate safety measures. When the world shut down,

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they kept going, and they kept us fed. Their vaccination status should not be a pre-requisite for whether we thank them for their service. We should be celebrating them and thanking them, regardless.

On behalf of the hardworking constituents in Brooks-Medicine Hat who either work in the trucking industry or rely on them to keep us fed, I ask you to reconsider these changes and work with industry leaders to find a solution that keeps grocery shelves stocked and constituents like mine working.

Sincerely,

Michaela L. Frey
MLA, Brooks-Medicine Hat

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Esteves, Dina (HC/SC)

From: Champagne, Christine (HC/SC)
Sent: 2022-01-25 3:15 PM
To: HC.F ECD-Liaison / DCHG F.SC
Subject: Incoming VIP Correspondence (2022-01-25)
Attachments: 20220125112723576.pdf

Hello ECD,

Please find attached an incoming VIP correspondence from **MP Michael Chong, forwarded letter from constituents Butch Medemblik and Paul Broekema of Walinga Inc.** for profiling.

Thank you | Merci

Christine Champagne (She / Elle)
Correspondence Officer | Agente de correspondance
Deputy Minister's Office | Bureau du sous-ministre
Office of the Minister of Health | Cabinet du ministre de la santé
Health Canada | Santé Canada
Brooke Claxton Building
christine.champagne@canada.ca | 613-612-9509
Government of Canada / Gouvernement du Canada

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Hon. Michael Chong, M.P.
Wellington-Halton Hills

CANADA

L'hon. Michael Chong, député
Wellington-Halton Hills

January 5, 2022

The Honourable Jean-Yves Duclos P.C., M.P.
Minister of Health
70 Colombine Driveway, Tunney's Pasture
Postal Location: 0906C
Ottawa, ON K1A 0K9

Dear Minister Duclos,

I am forwarding a letter from Mr. Butch Medemblik and Mr. Paul Broekema of Walinga Inc. located in my riding. Their letter outlines their serious concerns about vaccine mandates and their impact on the Ontario agri-food sector. I trust that their concerns will be taken into careful consideration and that they will receive a response in due course. Please respond to the following address and copy me on your reply:

Mr. Butch Medemblik & Mr. Paul Broekema
Walinga Inc.
5656 Highway 6 North
Guelph, ON N1H 6J2

Thank you for your attention to this matter. Please do not hesitate to contact me if you have any questions.

Sincerely,

[redacted]

Michael Chong

cc: Mr. Butch Medemblik, CEO, Walinga Inc.
Mr. Paul Broekema, Chairman, Walinga Inc.

encl.

Fergus
A-190, rue David St, S/sud
Fergus, ON N1M 2L3
Telephone/Téléphone (519) 843 7344

Ottawa
House of Commons/Chambre des communes
Ottawa, ON K1A 0A6
Telephone/Téléphone (613) 992 4179

Georgetown
205-16, ch. Mountainview Rd. S/sud
Georgetown, ON L7G 4K1
Telephone/Téléphone (905) 702 2597

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Michael Chong
A-190 St. David Street South
Fergus, ON
N1M2L3

Greetings Michael Chong,

We wanted to reach out to you as our local Federal Member of Parliament about our concerns with the Government of Canada's proposed vaccine mandate for employees in federally regulated workplaces. Although we support vaccination and recognizes that vaccines are one of the ways to protect individuals against COVID-19, our company and overall industry cannot support the federal government mandating vaccination for federally regulated workplaces in the current environment.

Our company is a member of the Ontario Agri Business Association, a voluntary, not-for-profit trade association that represents the interests of over 500 members who operate country and terminal grain elevators, feed manufacturing facilities, crop input supply and affiliated businesses throughout the province of Ontario. OABA members generate in excess of $15.2 billion in annual sales and represent over 20,000 full and part time/seasonal jobs within the agri-food industry. Many OABA members are federally regulated under the Canada Labour Code Part II and as part of a joint statement issued earlier this week in collaboration with the Animal Nutrition Association of Canada have expressed our sector's concerns through recent correspondence to the Minister of Agriculture and Agri-Food Bibeau and several of her applicable Ministerial colleagues.

Our company (Walinga Inc.) is concerned with a vaccine mandate because there is still a significant portion of the Ontario agri business workforce that has not been vaccinated. As clearly outlined in the Minister of Agriculture and Agri-Food Mandate Letter dated December 16, 2021, it is recognized that the agri-food sector is deeply affected by persistent and chronic labour shortages. Our industries are highly dependent on employees to operate their facilities throughout the province and much of their staff has specific training that cannot be easily replaced. If the mandate is enacted, we are concerned that our customers will not be able to replace staff that are unable to work due to the proposed vaccine requirements. Losing staff may result in them having to shut down their operations or severely limit their production capacities. The impact would not only be devastating for their businesses, but would also cause a negative effect at the farm level.

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Our industry has had to adapt to a variety of challenges over the past year including supply chain disruptions related to product shortages due to COVID-19, a global shortage in shipping containers, floods and wildfires in British Columbia, and a lack of available labour. We have faced these challenges head on and adapted quickly however, we cannot support a restriction which has the potential to significantly decrease the existing workforce by losing employees to other non-federally regulated workplaces.

Throughout the course of the pandemic, our industries have implemented safeguards and additional measures to ensure employees are kept safe and to minimize the risk of COVID-19 transmission. Specifically for truck drivers, new measures have been implemented so that they have little to no face-to-face interaction with other employees, and in most cases delivery protocols have also been adapted to limit contact with others.

We ask that the proposed mandate for federally regulated workplaces be reconsidered or at a minimum that an exemption be given to the agri-food industries which fall under federal regulations. Instead, we ask for continued government support for businesses who are doing an exemplary job of keeping the agri-food value chain afloat while prioritizing employee health and safety.

I would be happy to provide further details on this issue or discuss further.

[redacted]
Butch Medemblik
CEO
Walinga Inc.
[redacted]@walinga.com

[redacted]
Paul Broekema
Chairman
Walinga Inc.
[redacted]@walinga.com

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El Jaouhari, Sidi-Adam (HC/SC)

From: MinFinance / FinanceMin (FIN) <minfinance-financemin@fin.gc.ca>
Sent: 2022-01-06 2:51 PM
To: governmentrelations@canadiancovidcarealliance.org
Cc: hcminister.ministresc
Subject: FW: 509693 - FW: Suspend the Authorization of COVID-19 Injectable Biological Products (attached letter)
Attachments: 2021-12-14 letter to ministers CMOHs children youth.pdf

Dear Dr. Chaufan and Co-signatories:

Thank you for your correspondence of December 15, 2021.

Since the matter you raise falls more directly within the jurisdiction of my colleague and the Minister of Health, the Honourable Jean-Yves Duclos, I have forwarded a copy of your correspondence to him.

Thank you for writing.

Sincerely,

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister and Minister of Finance

From: Freeland, Chrystia - M.P. <Chrystia.Freeland@parl.gc.ca>
Sent: Wednesday, December 15, 2021 2:50 PM
To: fin.minfinance-financemin.fin@canada.ca
Subject: 509693 - FW: Suspend the Authorization of COVID-19 Injectable Biological Products (attached letter)

From: governmentrelations@canadiancovidcarealliance.org <governmentrelations@canadiancovidcarealliance.org>
Sent: Wednesday, December 15, 2021 2:30 PM
To: Freeland, Chrystia - M.P. <Chrystia.Freeland@parl.gc.ca>
Subject: Suspend the Authorization of COVID-19 Injectable Biological Products (attached letter)

Members of Parliament, House of Commons

December 15, 2021

Dear Sir or Madam,

We are writing to plead that you oppose or suspend authorizing COVID-19 Injectable Biological Products for children. We represent scientists, health, and other professionals, and academics from various disciplines who have followed, evaluated, and reported on the handling of COVID-19 for more than a year. We implore you to read and carefully consider the scientific, peer-reviewed information in the attached letter to guide your present and future decision-making.

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The attached letter has been sent to all Ministers of Health, Education, Justice, Attorneys General, Chief Medical Officers and various health advisors both by email and hard copy via registered mail.

Respectfully,

Claudia Chaufan, MD PhD

Signatories:

Steven Pelech, PhD

Olga Collins, BSc

Maximilian Forte, PhD

Daphene Francis PhD, RN

Jeffrey Graham, PhD

Anton de Ruiter, PhD

Denis Rancourt, PhD

Claus Rinner, PhD

Julie Ponesse, PhD

Jan Vrbik, PhD

Keren Epstein-Gilboa, PhD

Angela Durante, PhD

Heather Springer, PhD

Anthony J. Hall, PhD

Jens Zimmerman, PhD

Laurent Leduc, PhD

Kevin Cheung, PhD

Valentina Capurri, PhD

Michael C. Owen, PhD

Laurie Manwell, PhD

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This message is sent via the Canadian Covid Care Alliance.

https://www.canadiancovidcarealliance.org

Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2022-02-01 11:41 AM
To: hcminister.ministresc
Subject: TR: CanAge Releases its Second Annual Adult Vaccinations Report - Read here
Attachments: VaccineReportCard-2021-22-FINAL-lowres.pdf

De : Diana Cable <[redacted]@canage.ca>
Envoyé : 31 janvier 2022 17:39
À : Prime Minister's Office <pm@pm.gc.ca>; Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>; phac.cpho-acsp.aspc@canada.ca; Khera, Kamal - M.P. <Kamal.Khera@parl.gc.ca>
Objet : CanAge Releases its Second Annual Adult Vaccinations Report - Read here

Dear Prime Minister Trudeau, Minister Khera, Minister Duclos and Dr. Tam,

As promised, please find attached the just-released 2022 Adult Vaccination in Canada Cross-Country Report Card. This report is also being sent to media today.
We are writing to request a meeting to discuss the report's findings, and we can be of assistance to support the uptake of adult vaccinations in your jurisdiction.
We look forward to hearing from you. Please feel free to email me at [redacted]@canage.ca or call me at 416 816 6624.

Respectfully,

Diana Cable

CanAge.
Canada's National Seniors' Advocacy Organization

Diana Cable (she/her)
Director, Policy and Research

M: +1 416.816.6624
E: [redacted]@canage.ca
www.canage.ca
www.canage.ca/voices
www.canage.ca/join

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CanAge

Adult Vaccination in Canada

Cross-Country Report Card 2022

CanAge.ca/VaccineReport

2021–2022

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Message from the CEO
The world has changed drastically. Why aren't adult vaccination efforts keeping pace?

Two years ago, no one could have predicted we'd be facing a global health crisis the likes of which hasn't been witnessed in nearly a century. When we released the first edition of this report card in Winter 2021 it was to create, for the first time, a clear and easily comparable snapshot of adult vaccinations in Canada; provincial and territorial governments needed to see a clear picture of the problems plaguing adult vaccination in Canada, and they needed to see it now.

Adult Canadians are under-vaccinated against preventable diseases like seasonal influenza, shingles and pneumonia (all of which can cause life-threatening and longstanding outcomes). The writing is on the wall: **improve the way we immunize older Canadians or they will continue to pay with their lives.**

Flash forward to 2022 and, as a country, we seem to be learning from our mistakes. In this year's report card, you'll see promising pockets of progress like new funding coverage for the best-in-class shingles vaccine (recommended by NACI). Pharmacies are being granted permission to administer more vaccines, emerging as integral community care partners and increasing healthcare capacity. Eligible age ranges for vaccines being opened up to include more older people who need them.

Yet, for every step forward, there seem to be several stumbles hampering our momentum. The NACI-recommended vaccines for older adults are still not funded across the country. Procurement of vaccines is still a bureaucratic slog that makes efficient immunization response impossible. Countless Canadians are forced to get the less-effective flu shot because they simply can't afford a seniors-specific formulation due to lack of coverage and the realities of living on a fixed income.

When a tragedy like a pandemic strikes, we have two options: sink into fear and doubt, or rise to the occasion. This report card is a call to action for provinces and territories to step up for their older populations and commit to invest in immunization. It saves money, it saves economies and, most importantly, it saves lives.

Which option will you choose?

Laura Tamblyn Watts
CEO, CanAge

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Executive Summary

This is the second edition of CanAge's annual Vaccine Report Card, covering 2021–22. The purpose of this report is to provide an objective snapshot of how each province and territory in Canada is currently performing in the priority area of adult vaccination. While the first edition (published January 2021) of this report served as a benchmark of performance, this edition compares performance across key indicators to capture and quantify any changes made in adult immunization programs and policy across Canada.

Each jurisdiction was graded using a comprehensive rubric of evaluation criteria, including whether they meet or exceed standards set by NACI (National Advisory Committee on Immunization). Provinces and territories were assigned an overall grade, as well as separate grades for vaccine Funding, Access, and Awareness (how easy it is for the general public to find relevant information).

Data show that, while Canada is effective at vaccinating children, vaccine uptake in adults is extremely low, putting the vast majority of older adults at risk of severe health outcomes caused by common preventable diseases including influenza, shingles and pneumonia. Vaccination is by far the most effective tool we have in reducing the burden on our healthcare system, keeping vulnerable seniors out of hospitals (where they are at high risk of lasting cognitive and physical decline) and saving countless lives annually in congregate care settings.

Using empirical evidence, this report shows that glaring gaps exist in provincial and territorial immunization programs in the areas of funding coverage, access, and availability of information to the public. Furthermore, while the federal government is taking strides to immunize older Indigenous populations through the Non-Insured Health Benefits (NIHB) program, our National Immunization Strategy is falling short of critical milestones needed to improve vaccine approval, procurement, and administration processes across the country.

Highlights

This year's findings paint a dismal picture. Despite improvements in some jurisdictions, older Canadians continue to be at-risk of being infected with vaccine-preventable illnesses. The national average score of D- hasn't changed since the 2020–2021 report, indicating a disappointing suspension of progress in protecting seniors.

1. The average overall score across provinces and territories was D-, unchanged from last year's inaugural report.
2. The highest performing provinces/territories were Prince Edward Island and Ontario.
3. The lowest performing provinces/territories were Newfoundland, Nunavut and Quebec.
4. The most improved province/territory is Yukon.
5. The Yukon Territory, Ontario and Prince Edward Island are the only provinces to fund the recommended shingles vaccine.

Corrections from last year's report:

BC - Last year we awarded a point for pertussis coverage as per NACI recommendations; upon further review we found that they only cover a shot if you have a) never had one in childhood or b) are pregnant. This results in the loss of 1 point for pertussis coverage.

QC - Last year we awarded points for Tdap coverage as per NACI recommendations; upon further review we found that QC does not follow NACI recommendations regarding Tdap administration and as a result, these points were lost.

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Cross Canada Comparison

NOTE: In last year's report, data around vaccine uptake was included here for each province/territory as additional context. At time of publishing, this updated data has not yet been made available by PHAC. (ETA March 2022)

Key Findings

In this year's report, small improvements were noted in many jurisdictions.

We continue to see glaring gaps in access to vaccination programs for older adults. The bad news belongs to BC and Quebec who are far behind where they should be in adult vaccinations, given their resources. BC finally instituted coverage for the basic, standard flu vaccine for people 18+ this year, leaving Quebec alone and dead last for influenza coverage. Newfoundland also continues to receive a failing score, which is disappointing in a province which has any number of easy-to-fix steps that would help raise its score. Nunavut and the Northwest Territories also struggled again this year, where lack of access to in-person medical care, a remote population, and a limited tax base can make adult vaccination a challenge – but one that was overcome with COVID-19 vaccines. That success makes it clear that progress in these territories is possible, where political will exists.

In the good news category, kudos go to Yukon for most improved jurisdiction. Yukon gained points thanks to implementing a high-dose flu seniors-specific vaccine coverage program, and providing the recommended shingles vaccines. Yukon also should be commended for its investment in improving its online resources on adult vaccinations.

Good news can also be found in our smallest jurisdiction, Prince Edward Island. This year, PEI joins Ontario and Yukon in funding the recommended shingles vaccine for any adult aged 65+. PEI, in fact, is the forerunner in this report, having the highest grade of all provinces and territories.

Overall, how does Canada do? So badly it is actually shameful given what we have been living through with COVID-19. Indeed, many of the excuses we have heard from governments about how hard it is to fund, provide access to, and current information about adult vaccinations has simply been proven false. We did it for COVID19 vaccines. We can, and must, do this for the rest of the NACI-recommended vaccines too. This report helps guide specific steps to improve pan-Canadian adult vaccinations.

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The Pandemic Effect: Where COVID-19 Vaccines Fit Into the Big Picture

While the scope of focus for this report does not cover COVID-19 vaccines, it is impossible to ignore the effect the pandemic has had on adult vaccination efforts across Canada. Due to the fact that COVID-19 vaccines are not yet included in the NACI vaccine schedule, and data surrounding the need for boosters and other variables are still in flux, this report focuses instead on well-established vaccines that are included in the schedule.

That said, given the newness of the COVID vaccines, the fact that approximately 94% of Canadians aged 60 or more received two doses, and that roughly only 70% (65+) received a flu vaccination in the 2020–2021 season (of which they are reminded year after year), it would appear that the COVID-19 vaccine rollout to older adults was not only successful, but shows what is possible with strong collaborations between the federal and provincial/territorial governments.

As a nation, we need to augment efforts to vaccinate older populations against the common vaccine-preventable diseases discussed in this report. This is not new information. It was evident in last year's Vaccine Report Card and we emphasize it again this year. Yet, the national average grade – a disappointing D- – hasn't changed. Has the pandemic taught us anything?

We think so. Based on the COVID immunization percentages across Canada outlined below, the rates for fully vaccinated older adults range from 88%–100% in less than one year of promotion and awareness. We can only dream of rates that high for annual flu shots. More needs to be done, and can be.

There are many lessons to be learned from the deployment of COVID-19 vaccines – lessons that could improve access to and uptake of flu, pneumonia, shingles and all other vaccines. Lessons that could keep older adults out of hospitals and living well for longer. Lessons that could reduce the burden on the healthcare system. Lessons that could save lives.

Key Learnings from the COVID-19 Pandemic

1. NACI-recommended vaccinations must be prioritized, fully funded, and seamlessly administered to all seniors in congregate care settings to avoid needless loss of life.
2. Vaccine procurement and roll outs must be coordinated and consistent across provinces and territories.
3. Processes for vaccine approval, procurement, and logistics must be streamlined to allow for quicker rollout to the public.
4. A greater emphasis should be placed on infection prevention and control in congregate care facilities immediately.
5. The pandemic had a disproportionate and disastrous impact on older adults, with those aged 65 and older accounting for 94% of COVID-19 deaths.

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Rates of COVID-19 Vaccination in Older Adults Across Canada

National Snapshot (as of January 8, 2022)

Age Group	Partially vaccinated	Fully vaccinated
60–69	94.03%	92.38%
70–79	≥95%	≥95%
80 and older	≥95%	≥95%

Provincial/Territorial Snapshot

(as of December 18, 2021 unless otherwise noted)

Alberta

Age Group	Partially vaccinated	Fully vaccinated
60–69	94.46%	92.80%
70–79	98.61%	96.66%
80 and older	95.51%	97.13%

British Columbia

Age Group	Partially vaccinated	Fully vaccinated
60–69	93.73%	91.90%
70–79	100%	98.75%
80 and older	100%	100%

Manitoba

Age Group	Partially vaccinated	Fully vaccinated
60–69	96.65%	95.37%
70–79	100%	100%
80 and older	100%	100%

New Brunswick

Age Group	Partially vaccinated	Fully vaccinated
60–69	93.43%	96.15%
70–79	98.72%	96.47%
80 and older	96.87%	92.82%

Newfoundland and Labrador

Age Group	Partially vaccinated	Fully vaccinated
60–69	99.62%	97.82%
70–79	100%	100%
80 and older	98.99%	95.62%

Northwest Territories

Age Group	Partially vaccinated	Fully vaccinated
60–69	89.95%	88.78%
70–79	100%	100%
80 and older	100%	100%

Nova Scotia

Age Group	Partially vaccinated	Fully vaccinated
60–69	98.26%	96.24%
70–79	100%	96.66%
80 and older	97.81%	100%

Nunavut

Age Group	Partially vaccinated	Fully vaccinated
60–69	100%	100%
70–79	100%	98.56%
80 and older	93.30%	89.39%

Ontario (as of December 31, 2021)

Age Group	Partially vaccinated	Fully vaccinated
60–69	94.89%	93.31%
70–79	97.63%	96.22%
80 and older	98.95%	96.63%

Prince Edward Island

Age Group	Partially vaccinated	Fully vaccinated
60–69	100%	100%
70–79	100%	100%
80 and older	100%	100%

Quebec (as of January 2, 2022)

Age Group	Partially vaccinated	Fully vaccinated
60–69	96.36%	95.10%
70–79	97.40%	97.62%
80 and older	97.62%	97.40%

Saskatchewan (as of December 31, 2021)

Age Group	Partially vaccinated	Fully vaccinated
60–69	96.64%	90.97%
70–79	98.48%	96.04%
80 and older	99.53%	96.59%

Yukon

Age Group	Partially vaccinated	Fully vaccinated
60–69	93.76%	91.53%
70–79	100%	100%
80 and older	100%	98.92%

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Canada's National Immunization Strategy: Underserves Older Populations and is Out of Date

Many may be surprised to learn that Canada actually does have a National Immunization Strategy (NIS). Very little has been made of it, even during COVID-19. It is rarely mentioned in vaccine documentation, media coverage or even in governments' own communications.

The NIS is meant to set key goals for immunization across the country. It has lofty objectives, which feel disconnected from the real urgency of the need for vaccine adoption and uptake.

These objectives include:

Objective #1: Canada has evidence-based goals for vaccine preventable disease rates and immunization coverage

Objective #2: Canada is better able to identify under and un-immunized populations and has an enhanced understanding of the determinants of vaccine acceptance and uptake

Objective #3: Canadians have timely and equitable access to immunization

Objective #4: Canada has the evidence needed to develop and implement evidence-based interventions, to improve immunization coverage rates

Objective #5: Canadians have the information and tools needed to make evidence-based decisions on immunization

Objective #6: Canada understands the key barriers to, and best practices in, improving immunization coverage and invests in addressing them

These objectives lack the push required to ensure Canadians have the best-in-class, modern vaccines to keep the population healthy. Preventive health falls squarely in the federal Health mandate, and yet even during COVID-19, PHAC or other government departments focussed on immunization did little to revitalize the NIS.

In fact, the NIS has languished. Last fully reviewed in 2016, the website indicates that it will be updated annually – however it appears not to have been updated since 2017. We note that it is promised to be reviewed in 2022. It is unclear if this is actually slated to happen, and if it does, will it be the robust review that a COVID-19 stricken country needs it to be?

The NIS does not meet the needs of an aging population, nor an increasingly diverse population.

For instance, of the NIS's 35 specific goals, only two of them are targeted towards seniors, the population most rapidly growing, and who also have much less effective immune systems. It is also so out of date that it does not even mention the effective shingles vaccine, which by 2021–2022 many jurisdictions are either covering or looking hard at public coverage. It is simply absent.

Additionally, in a profound, tone-deaf miss, the NIS does not discuss the many needs of diverse populations, particularly missing the needs of Indigenous populations.

Compared against other national standards, or global WHO vaccine recommendations, Canada's strategy was inadequate pre-COVID-19 pandemic. The reality that the NIS has not been updated in the past two years given the unprecedented toll that COVI19 has had, the rise of vaccine hesitancy and anti-vaccination sentiments, and disinformation, the strategy should have been strengthened, not ignored.

Given the context of COVID-19, the importance of newer vaccines entering the market, an aging population, challenges faced by Indigenous peoples, as well as rural and remote communities, the NIS needs a major reworking. We call on the federal government to focus on not just "reviewing" the NIS in 2022, but totally revising it to reflect changes in Canadian demographics, modern developments in vaccines, and the impact that COVID19 has had on the country. Every Canadian should know that the country has an NIS, and should be confident that the federal government should provide the equitable, and effective coverage for, and access to, the appropriate recommended vaccines.

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Will the National Immunization Strategy Goals Be Met By 2025? **It Seems Unlikely.**

The National Immunization Strategy has 35 specific goals which are to be met by 2025. Frankly achieving this target seems highly unlikely given the pace at which governments are moving on adult vaccinations.

Given this Report's focus on vaccines for older Canadians, there are only two of the 32 goals which specifically apply here:

a) Influenza
b) Pneumonia

As previously noted, the NIS is out-of-date and does not discuss the recommended shingles vaccine coverage.

Influenza: Goal is 80% of Seniors Vaccinated (Annually) by 2025 – Currently Sits at 70%

The NIS committed to having 80% of seniors receive flu shots by 2025, but that number has stagnated at an average of 70% for the past three years, reflective of the lack of progress seen again in this year's report. While a 10% difference may not seem as statistically significant at first glance, when you consider the implication of how damaging influenza is on this population, this undervaccination causes severe illness and even unnecessary death. This difference also has a high impact on stretched acute and chronic care health resources, and economic impacts as well. A 10% miss on this goal means profound illness, increased frailty, high healthcare costs and economic burden and unnecessary deaths.

For context, in the 2020/21 flu season we saw:

- Only four in 10 Canadian adults aged 18-64 years with chronic medical conditions (41%) received the flu shot.
- That vaccination coverage among seniors was ~70% however there was no improvement on this in the last three years despite increased demand.

Timing and place of vaccination

- Most Canadians were vaccinated against influenza in October (42%) or November (38%).
  - » Getting the flu shot early in the flu season (by the end of October) helps protect from infection before the flu begins to spread.
- Most respondents were vaccinated at pharmacies (49%), followed by doctor's offices (23%).

Reasons to get, or not get the flu shot

- The most common reason for getting the flu shot was to prevent infection or avoid getting sick (37%).
- The most common reason for not getting the flu shot was that Canadians felt that they were healthy and/or they "never got the flu" (29%).

Impact of COVID-19 on getting the flu shot

- Overall, 47% of Canadian adults stated that they had encountered difficulties in scheduling an appointment for the flu shot this year due to the preventive measures in place to reduce the spread of COVID-19. The difficulties encountered include:
  - » limited appointment availability (23%).
  - » concern about being exposed to COVID-19 (17%).
  - » lack of walk-in options (9%).

Co-Administration of COVID-19 and Flu Shots Was A Key Miss:

While healthcare providers and advocates consistently raised the importance of getting the COVID19 shot and flu shot co-administered for increased uptake and system ease, Canadians were not provided with adequate opportunities for co-administration. Public discussions of the possibility of "twindemics" of COVID-19 were robust, co-administration was approved, and yet little was done to execute this effective strategy.

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Pneumonia: Goal is 80% of Seniors Vaccinated by 2025 – Currently Sits at 55%

The strategy calls for 80% of adults aged 65+ to be vaccinated by 2025 for pneumonia, which is not an annual vaccine. For this age bracket, NACI recommends one dose of PNEU-P-23. In a recent report by the Government of Canada on vaccine uptake it found that:

- 55% of seniors reported having received a pneumococcal vaccine in adulthood.
- The number remains far below the national vaccination coverage goals for pneumococcal vaccine, which is 80% among this age group.
- Pneumococcal vaccination rate was higher for females (60%) compared to males (48%).
- The most common reason among seniors for not getting a pneumococcal vaccine was the perception that the vaccine is not necessary.

Among other adults:

- Only 26% of adults between 18-64 years of age with underlying medical conditions were vaccinated against pneumococci.
- The most common reason for non-vaccination among younger adults with underlying medical conditions was that they had never heard of the vaccine.

There is real opportunity to increase more awareness of, in particular, pneumonia vaccines, and for jurisdictions to create resources for primary care physicians. Canada needs to take a lifecourse approach to vaccines, and to treat the health and wellness of older adults with the same careful consideration we give to children and youth. To move forward, that will require more than two bullet points in a national strategy document.

A Leap Forward: Transformation is Possible

COVID-19 has fundamentally reshaped thinking about the critical role of adult vaccinations in daily life. It has also raised newfound pushback against adult vaccinations, with increased visibility and vaccine hesitancy.

We have witnessed provinces and territories truly struggle with vaccine purchasing – from the patchwork approach to seniors-specific flu vaccines to the 95% of seniors who live in the community, to sparse coverage of shingles.

The federal government should support the provinces and territories, take a leap forward in vaccine coverage, and provide a "leveling" of vaccine equity across the country.

3 Steps for Vaccine Equity in Canada

Step 1: A 3-Year Funding Pool for Vaccine Equity
The federal government should create a designated funding pool to support a three-year rolling program for vaccine purchasing to bring all provinces and territories up to date with NACI-recommended vaccines. This 3 year roll-in period will allow jurisdictions to create sustainability in their budgets, improve access sites and create information materials with this increased program.

Step 2: Assist the Territories
Provide Northwest Territories and Nunavut and the Yukon with increased supports for rural and remote vaccination programs.

Step 3: Tie a Revised NIS to Funding Needs
The NIS should be a tool of public health advancement and a key guidepost for strategic funding and supports. Connect a new, improved and up-to-date NIS with key investment from the federal government to vaccine supply, designed funding and supports for vaccine access infrastructure and public-centred information.

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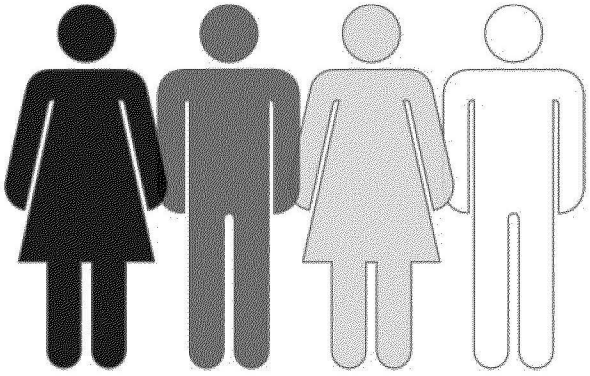
Vaccinating Older Indigenous Canadians



Older Indigenous people are less likely than other adults to be up-to-date with their routine vaccinations, further exacerbating low vaccine uptake within some already at-risk communities. One reason for this is that a vast minority of Indigenous seniors has no regular access to health care; another is that Indigenous peoples often face discrimination within the healthcare system, particularly for those who live off-reserve.

The federal government's Non-Insured Health Benefits (NIHB) program provides an ever-growing number of eligible First Nations and Inuit clients with coverage for a range of health benefits that are not covered through other means, such as provincial/territorial health insurance. With an exception of those who live in British Columbia, many Métis Canadians (who are not considered to be "treaty Indians"), are not eligible for the NIHB; the current government flows most of its health care funding for Métis through the Métis National Council.

Most vaccines are already covered through provincially and territorially funded insurance programs, and as such, are not provided through the NIHB. However, the best-in-class vaccine for shingles is covered, but only for clients between 65 and 70 years of age, and as of January 2021. This puts NIHB program recipients ahead of the game compared to other jurisdictions, although access remains an issue for those living in rural and remote areas. We are also concerned that adults under the age of 65, and those over the age of 70, are not eligible for the best-in-class vaccine for shingles. CanAge recommends that the shingles vaccine be made available to all adults aged 50+.

As we demonstrate in the following pages, just because a vaccine is available to an older Canadian, doesn't mean that it is easy to access, or that one is even aware of its existence. This is particularly true for those living in remote and rural communities, such as many Indigenous seniors.

These systemic issues, combined with a substantiated lack of trust in the system, add up to substantially increased health risks for Indigenous Canadians. This is not new information. "Distrust of the healthcare system is pervasive in a study that reviewed vaccination uptake during the 2009 influenza pandemic" amongst the Indigenous population.

We point again and again to the fact that more needs to be done when it comes to immunizing Canadians, and it is particularly true for our Indigenous older adults.

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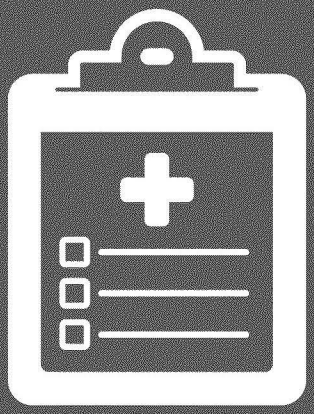
CanAge



Provincial and Territorial Report Cards

An objective, data-driven assessment of how each part of Canada performs on adult immunization.

Throughout this section, we're using these icons to indicate changes from last year's report:

- Grade increased
- Grade decreased
- No grade change

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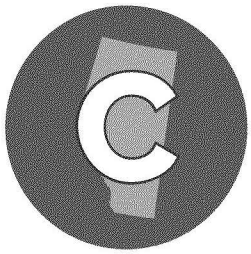
Alberta

LEADERSHIP	United Conservative Party (Majority)
PREMIER	Jason Kenney
MINISTER OF HEALTH	Jason Copping
MINISTER OF SENIORS	Not dedicated *Consolidated with Housing portfolio, Minister of Seniors and Housing: Josephine Pon*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Deena Hinshaw
SENIORS ADVOCATE	None



Change from last year D-

Population of Adults 50+	1,454,262
% of Total Population	32.70%

Overview Summary

The Government of Alberta's lack of innovation and data collection continue to undermine its immunization efforts, in spite of making some progress this year on improving vaccine funding and access. Since last year's report, adults 65+ are now able to get the high-dose flu shot, yet there has been a drop in the number of people who actually got those doses this year due to vaccine fatigue and supply issues. Many pharmacies were shortchanged on the number of high-dose flu shots they received, forcing them to turn away seniors who wanted the potentially life-saving vaccine. With shingles cases on the rise, older Albertans are still forced to pay approximately $300 out-of-pocket for the recommended vaccine, making it unaffordable for many, and totally out of reach for those on fixed incomes. Information about adult vaccinations is very difficult to find, unclear, and conflates publically-funded with out-of-pocket costs for coverage. If Alberta wants to leap-frog to the top vaccination bracket, funding the shingles vaccine and making it easily accessible would be a key change.

Key Findings

1. The high-dose flu shot is now available for seniors 65+, but there are supply chain and distribution issues that appear to have severely limited access this year.
2. The recommended shingles vaccine is not funded.
3. Adult vaccine information is difficult to find, and publicly-funded versus out-of-pocket costs for Albertans are unclear.

		Change from last year
Funding	B	C- ↑
Access	D-	F ↑
Awareness	D-	D- —

Action Needed

1. Ensure pharmacies and health care professionals receive the number of vaccine doses they request, and improve supply chain reliability in general.
2. Fully fund the recommended shingles vaccine and allow broad access via pharmacies.
3. Create an awareness campaign, including online and other sources to clarify which vaccines are recommended, where to get them, and which are publicly covered versus not.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Full list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Alberta**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	1 pt
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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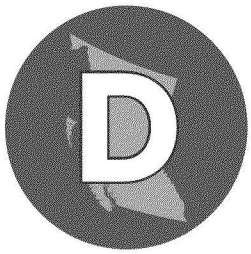
British Columbia

LEADERSHIP	New Democratic Party (Majority)
PREMIER	John Horgan
MINISTER OF HEALTH	Adrian Dix
MINISTER OF SENIORS	None *Parlimentary Secretary for Seniors and Long-Term Care: Mable Elmore*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Bonnie Henry
SENIORS ADVOCATE	Isobel Mackenzie



Change from last year D- ↑

Population of Adults 50+	2,109,056
% of Total Population	40.40%

Overview Summary

British Columbia prides itself on having some of the best health care coverage in Canada – and it does – but certainly not on immunization. The Government of BC's poor adult vaccination efforts are confounding when compared to its otherwise excellent standards in care and, unfortunately, not much has changed since last year's report. The province now finally funds the standard dose flu shot for adults 18+ – a move that was shockingly overdue – but has made no such move to fund a dose specifically formulated for those aged 65+ despite the compounded risks of COVID-19 and influenza overlapping for seniors.

BC provides incomplete coverage for pneumonia vaccines: PNEU-C-13 is only available for a partial list of well-established immunocompromised conditions, leaving those with organ transplants, sickle cell disease, splenic dysfunction, people undergoing immunocompromising therapy, malignant neoplasms (including leukemia and lymphoma) and nephrotic syndrome at risk. Also, the definition of "moderately to severely immunocompromised" is contradictory between the adult vaccine list and the COVID-19 definition.

The province does not provide any funding for the shingles vaccine, and this significant gap appears not to be on the government's radar, despite calls from opposition parties and public health advocates. At a time when health care capacity and spending in BC is near breaking point due to the ongoing pandemic, the government's under-prioritization of vaccinating older people is as baffling as it is worrying. Ironically, older British Columbians can easily learn about the vaccines that they cannot get and which the government does not fund. The bottom line is that the BC government must start to take leadership in bringing its funding levels up to NACI standards.

Key Findings

1. Only approximately 5% of seniors get the correct seniors-specific flu shot, and only because they live in long-term care. The rest of BC seniors are given the wrong NACI-recommended flu shot: the standard dose rather than a seniors-specific dose.
2. The recommended shingles vaccine is not funded at all and PNEU-C-13 vaccine is only available to a partial list of people who need it.
3. BC is one of only two provinces which restricts Tdap adult booster shots. Other provinces cover the Tdap every 10 years, but BC requires adults to prove that they haven't had the vaccine in later life in order to get this booster. This is cumbersome and puzzling as pertussis, commonly known as whooping cough, is making a comeback (especially in this province).

		Change from last year
Funding	D	F ↑
Access	F	F ---
Awareness	A	A ---

Action Needed

1. Don't just provide *information* about vaccines, provide actual funded coverage.
2. Bring immunization in line with other care standards in the province.
3. Simplify process for getting Tdap boosters.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "Vaccines for Seniors British Columbia" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	4 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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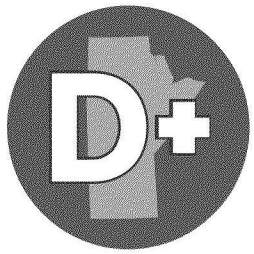
Manitoba

LEADERSHIP	Progressive Conservative (Majority)
PREMIER	Heather Stefanson
MINISTER OF HEALTH	Audrey Gordon
MINISTER OF SENIORS	Not dedicated *Consolidated with LTC: Scott Johnson*
MINSTER OF LTC	Not dedicated *Consolidated with Seniors: Scott Johnson*
CHIEF MEDICAL OFFICER	Dr. Brent Roussin
SENIORS ADVOCATE	None



Population of Adults 50+	480,115
% of Total Population	34.70%

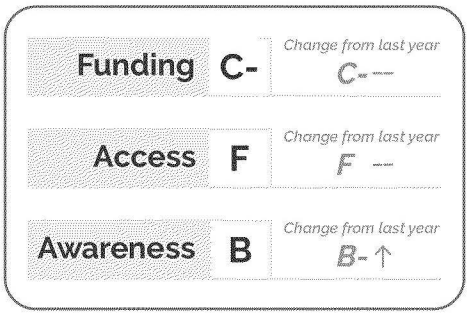
Overview Summary

Manitoba made improvements in public awareness this year, slightly increasing its score. The government also made strides in rural and Indigenous outreach, and launched a campaign to promote co-administration of seasonal flu with other vaccines. However, the overall picture of adult vaccination in the province is still quite grim. Manitoba failed to fund a seniors-specific dose for adults 65+ living outside of long-term care, and fares no better on shingles; the recommended vaccine is still completely unfunded. The harsh reality of living on a fixed income should never be a barrier to avoiding unnecessary pain and suffering.

Unfortunately, the Government of Manitoba has let its immunization program languish, even as hospitals in the province have been forced to close due to staffing shortages and overwhelming patient counts during the pandemic. If the province wants to keep its health care spending down, its economy moving, and seniors safe, the time to invest in vaccination is now. However, the recently announced appointment of Manitoba's first-ever Minister of Seniors kicks off 2022 on a very high note, as does an apparent increased focus on seniors' health.

Key Findings

1. While Manitoba expanded coverage for the specifically-formulated flu vaccine to include a number of specific groups of older adults, the province still leaves the vast majority of its seniors under-protected.
2. The recommended shingles vaccine is not covered for anyone.
3. PNEU-C-13 pneumonia vaccine is not covered for the full NACI-recommended list of conditions leaving people with sickle cell disease, immunocompromising therapy, malignant neoplasms, and nephrotic syndrome unprotected.



Action Needed

1. Continue vaccine outreach activities in rural, remote, Indigenous, and historically marginalized communities and improve access points and co-administration of vaccines.
2. Fund seniors-specific flu vaccines for all people 65+ and get them the NACI-recommended vaccine for their age group.
3. Fund the recommended shingles vaccine, and cover the complete list of immunocompromised people for pneumonia vaccines. Create an awareness campaign about the importance of getting all of your needed vaccines, not just some.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "Vaccines for Seniors Manitoba" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	4 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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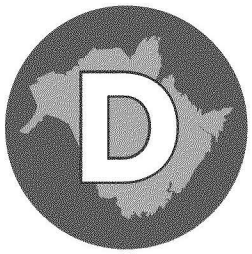
New Brunswick

LEADERSHIP	Progressive Conservative (Majority)
PREMIER	Blaine Higgs
MINISTER OF HEALTH	Dorothy Shephard
MINISTER OF SENIORS	Not dedicated *Consolidated under the Ministry of Social Development: Bruce Fitch*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Jennifer Russell
SENIORS ADVOCATE	Norman Bossé (Child, Youth and Seniors' Advocate)



Change from last year D- ↑

Population of Adults 50+	355,733
% of Total Population	45.07%

Overview Summary

The Government of New Brunswick has funded seniors-specific flu shots for seniors living in and outside of long-term care, increasing its overall score from last year. This welcome investment comes at a pivotal moment during the pandemic, and will help to lessen the burden on the province's healthcare system as COVID-19 variants continue to take their toll.

Sadly, New Brunswick has failed to translate this progress to shingles–there is still no coverage for the recommended vaccine in spite of immunologists in the province pleading for it to be made available free of charge to people 50+. New Brunswick also still has a long way to go in protecting immunocompromised adults, as the government only partially covers the recommended list of conditions for PNEU-C-13, leaving many with comorbidities unprotected. The province is among the worst in the country on access to vaccines and public education about immunization as a whole, creating profound barriers for older New Brunswickers trying to get their recommended routine vaccinations.

Key Findings

1. The high-dose flu shot is now funded for anyone 65+ in the province – a key improvement.
2. The recommended shingles vaccine is still not funded, despite expert advice to the contrary and the only partial pneumonia PNEU-C-13 coverage currently leaves many immunocompromised adults unprotected.
3. New Brunswick is one of only three provinces/territories to score an F on public awareness around adult vaccinations.

		Change from last year
Funding	C+	C- ↑
Access	F	F —
Awareness	F	F —

Action Needed

1. Significantly improve public information and knowledge mobilization about adult vaccinations, including redoing the website information, creating a public awareness campaign and putting this information in the Seniors' Guide.
2. Fund the recommended shingles vaccine for all adults 50+ and PNEU-C-13 vaccines for the full list of immunocompromised conditions.
3. Expand vaccination access to pharmacies for pneumonia and shingles vaccines, especially to support rural and remote communities.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "Vaccines for Seniors New Brunswick" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	0 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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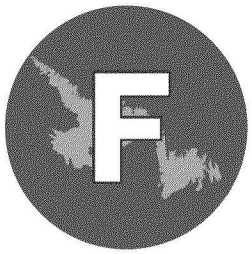
Newfoundland and Labrador



LEADERSHIP	Liberal (Majority)
PREMIER	Andrew Furey
MINISTER OF HEALTH	Dr. John Haggie, Minister of Health and Community Service
MINISTER OF SENIORS	Not dedicated *Consolidated with Children, Social Development, Housing and Persons with Disabilities: John Abbott*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Janice Fitzgerald (acting)
SENIORS ADVOCATE	None yet – accepting applications

Change from last year F —

Population of Adults 50+	244,659
% of Total Population	46.90%

Overview Summary

Newfoundland and Labrador was one of only three jurisdictions in Canada to score an overall failing grade in last year's report card. Sadly, the government has chosen inaction this year, maintaining a status quo in its subpar adult immunization program. The province has not expanded coverage for the recommended vaccines against flu, shingles or pneumonia and major gaps persist in how easily older people can find out about, and access, the shots they need to be safe.

The Government of Newfoundland and Labrador needs to prioritize immunization given the number of seniors living in rural areas in the province – especially as the pandemic situation continues to evolve. Older adults in Atlantic Canada deserve to live vibrant and connected lives free from the serious threat of preventable disease. The longer the province waits to act, the longer their lives will continue to be at risk.

Key Findings

1. Newfoundland and Labrador received an F overall, and is in the bottom three jurisdictions on efforts to vaccinate older adults.
2. The province does not meet NACI recommendations on any vaccines for older adults for the 'Big Three' common illnesses: flu, shingles, and pneumonia.
3. The Government of Newfoundland and Labrador did not implement any recommended policy changes from last year's report.

		Change from last year
Funding	C-	C- —
Access	F	F —
Awareness	F	F —

Action Needed

1. Create a government-supported stakeholder working group on adult vaccinations in the province to work on integrating lessons learned from COVID19 and applying them proactively to other adult vaccinations.
2. Together with input from the community and pharmacists, create a government public awareness campaign about adult vaccinations, which includes significant improvements on government websites, the Seniors' Guide and other channels on adult vaccinations.
3. Fund influenza vaccines for the 95% of seniors who live in the community, fund recommended shingles vaccines for everyone 50+ and fund PNEU-C-13 for the full list immunocompromised adults.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Newfoundland and Labrador**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts*"	0 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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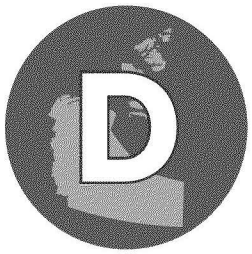
Northwest Territories

LEADERSHIP	Independent, Consensus Government
PREMIER	Caroline Cochrane
MINISTER OF HEALTH	Julie Green
MINISTER OF SENIORS	Not dedicated *Consolidated with Health and Social Service and Persons with Disabilities: Julie Green*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Kami Kandola
SENIORS ADVOCATE	None



Change from last year: D —

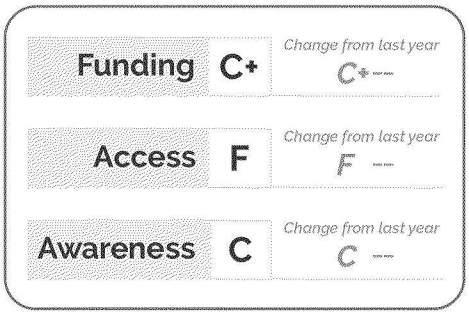
Population of Adults 50+	13,542
% of Total Population	29.76%

Overview Summary

Unfortunately, the Government of Northwest Territories has made no notable improvements to its adult immunization program since last year's report. While all territories face additional challenges with providing health care to rural and remote communities, this is all the more reason to start making moves to fund required vaccines and distribute them as widely as possible. Lessons learned during COVID-19 about the importance of vaccinating northern communities must not be lost. Preventive health through vaccines is more critically important than ever as limited resources make acute and chronic treatments scarce. The Northwest Territories should follow Yukon's lead, and must expand coverage to remove financial barriers to uptake, enhance access points, and better communicate the benefits of immunization for adults – all tangible actions we recommended in 2021. Evidently, this year, the Government of Northwest Territories has instead chosen inaction.

Key Findings

1. Northwest Territories failed to improve its overall score from last year.
2. The Government of Northwest Territories did not implement any recommended policy changes from last year's report.
3. Lack of access to vaccines continues to be a major problem within the territory, putting seniors living in rural and remote areas at risk.



Action Needed

1. Create a government and community working group to raise awareness of the need for adult vaccinations in the territory, including meaningful work with Indigenous, rural and remote communities to best serve their needs.
2. Work with pharmacies and community-based health supports to get the broadest possible access to vaccine uptake.
3. Fund NACI-recommended seniors specific flu vaccine for all adults 65+, improve pneumonia vaccination awareness and fund the recommended shingles vaccine for all adults 50+.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Full list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Northwest Territories**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts*"	2 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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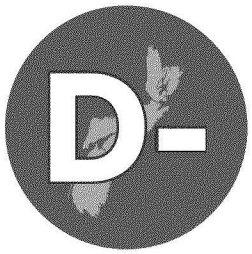
Nova Scotia

LEADERSHIP	Progressive Conservative (Majority)
PREMIER	Tim Houston
MINISTER OF HEALTH AND WELLNESS	Michelle Thompson
MINISTER OF SENIORS	Not dedicated *Consolidated with Ministry of LTC: Barbara Adams*
MINSTER OF LTC	Not dedicated *Consolidated with Ministry of Seniors: Barbara Adams*
CHIEF MEDICAL OFFICER	Dr. Robert Strang
SENIORS ADVOCATE	None



Change from last year D- ——

Population of Adults 50+	434,961
% of Total Population	43.80%

Overview Summary

The Government of Nova Scotia has stepped up its game this year in the way it promotes vaccines to older people in the province, but, despite this modest initiative, that's simply not enough to raise its overall score. The province has not improved funding coverage for the recommended vaccines for seniors, with the vast majority of people left to pay out-of-pocket. The province was smart to offer a seniors-specific flu vaccine to residents in long-term care alongside COVID-19 boosters this fall, but this leaves the approximately 95% of all Nova Scotia seniors unprotected. With demand for the flu shot at an all-time high this year, the government choice to still not fund a shot recommended for adults 65+ is a major missed opportunity – one that the Government of Nova Scotia can't afford to make if it wants to keep its healthcare system from sinking under the weight of unnecessary hospitalizations. However, with the recent change in provincial government, and its promises to prioritize health and seniors' care, there is new opportunity for improvement on vaccine coverage in 2022.

Key Findings

1. Nova Scotia failed to improve its overall score from last year. However, a new government has been elected with a mandate to increase seniors' and public health, creating a new opportunity for advancement in 2022.
2. The Government of Nova Scotia has started to promote adult vaccination alongside messaging around children, which shows promise.
3. The province made no improvements to vaccine funding or access for flu, pneumonia or shingles, in spite of increased demand for vaccines, strain on acute and chronic health care, and a serious rise of respiratory illnesses in the province.

		Change from last year
Funding	C-	C- ——
Access	F	F ——
Awareness	D+	D- ↑

Action Needed

1. Build upon COVID-19 learnings to ensure that access to vaccines is widely available via community-based hubs, pharmacies, and home care supports.
2. Promote adult vaccine information and vaccine uptake hubs targeting more marginalized groups including Acadian, Indigenous, African Nova Scotian, people with disabilities, and older residents of rural or remote communities.
3. Prioritize funding for a NACI-recommended seniors-specific flu vaccine, fully cover PNEU-C-13 for all immunocompromised adults, and fund the shingles vaccine for adults 50+.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Nova Scotia**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	0 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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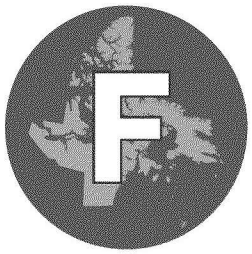
Nunavut

LEADERSHIP	Independent, Consensus Government
PREMIER	PJ Akeeagok
MINISTER OF HEALTH	John Main
MINISTER OF SENIORS	Not dedicated *Consolidated with Minister of Culture and Heritage, Minister responsible for Qulliq Energy Corporation, Minister responsible for Languages, Minister responsible for Seniors: Joanna Quassa*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Michael Patterson
SENIORS ADVOCATE	None



Change from last year F —

Population of Adults 50+	6,995
% of Total Population	17.75%

Overview Summary

The Government of Nunavut is the only jurisdiction in Canada to score a failing grade on all three performance indicator categories in this report, and has the lowest total score. However, this grade must be understood within Nunavut's very limited funding constraints, widespread rural and remote population and scarce health resources. In many ways, Nunavut's failure to move out of last place in this report is as much a failure of the federal government and its lack of targeted supports for the well-established needs of this unique territory: needs of which cannot be adequately sustained by the local tax base.

However, despite necessary contextual framing of the situation, Nunavut maintains inconclusive data about funding coverage and availability of seniors-specific flu shots for seniors, and does not cover the recommended shingles vaccine for people 50+. On top of that, Nunavut fails to fund the PNEU-C-13 pneumonia vaccine for any of the NACI-recommended list of conditions to provide additional protection to immunocompromised persons, setting the territory far behind the national standard.

Overall, the situation on adult vaccination in Nunavut is dire: the vast majority of people lack access to adult vaccinations and, of those seniors who do manage to visit a health care provider, many cannot afford to pay for the vaccines they need to stay safe. Unless the Government of Nunavut takes serious steps to improve adult vaccination, older people in the territory will continue to live their lives at significant risk.

Key Findings

1. Nunavut is the only part of Canada to score an F in all three scoring areas, and has the lowest overall score.
2. An abnormally large amount of data about vaccine funding and access for adults in the territory is inconclusive / incomplete.
3. The Government of Nunavut has not made any improvements to its adult immunization program since last year's report.

		Change from last year
Funding	F	F —
Access	F	F —
Awareness	F	F —

Action Needed

1. Nunavut needs to fund influenza, shingles, and pneumonia vaccines up to NACI levels. Nunavut should reach out to the federal government individually, or as part of a Territories Action Committee, to search for a dedicated pocket of funding to supplement needed vaccine purchasing.
2. Create a government and community working group to raise awareness of the need for adult vaccinations in Nunavut, including meaningful work with Inuit, Indigenous, rural, remote and fly-in communities to best serve their needs.
3. Work with pharmacies, community-hubs, and pop-up and mobile health supports to get the broadest possible access to vaccine uptake, learning from the COVID19 experiences.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	None

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Nunavut**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	0 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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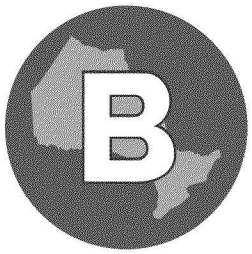
Ontario

LEADERSHIP	Progressive Conservative (Majority)
PREMIER	Doug Ford
MINISTER OF HEALTH	Christine Elliott
MINISTER OF SENIORS AND ACCESSIBILITY	Raymond Cho
MINSTER OF LTC	Paul Calandra (also Minister of Legislative Affairs and Government House Leader)
CHIEF MEDICAL OFFICER	Dr. Kieran Moore
SENIORS ADVOCATE	None



Change from last year B- ↑

Population of Adults 50+	5,688,896
% of Total Population	38.37%

Overview Summary

While Ontario has maintained its foothold as one of the two top performing jurisdictions in vaccinating seniors, the province has lost the top spot due to its inaction on several recommendations made in last year's report. The Government of Ontario funds seniors-specific flu shots, both high-dose and adjuvanted formulations, but this important differentiation has not been clearly communicated to the public. This lack of transparency has a negative impact on vaccine confidence and uptake, and needs to be addressed.

The Government of Ontario is a national leader in shingles prevention, and is one of only three jurisdictions to cover the recommended vaccine. However, the province is dragging its feet on allowing pharmacies to administer the shots, severely limiting access at a time when many seniors struggle to see their family doctor due to pandemic restrictions and healthcare capacity.

Ontario covers pneumonia vaccines for the full NACI-recommended list of conditions to provide additional protection to immunocompromised persons, which sets it above the national standard.

While it's clear that the Government of Ontario is committed to preventive health, its lack of momentum in critical areas of its adult immunization program could see the province left behind next year as other parts of Canada ramp up their efforts.

Key Findings

1. Ontario falls just short of the top score, due to an out of date Seniors' Guide which does not include information on adult vaccination, and lack of access to some vaccines at pharmacies.
2. The Government of Ontario is one of only three provinces / territories to fund the recommended shingles vaccine, but only covers adults aged 65–70 (not all adults aged 50+ as recommended).
3. Pharmacies are allowed to administer both flu shots and pneumonia vaccines, but not shingles vaccines.

		Change from last year
Funding	A-	A- —
Access	F	F —
Awareness	A-	A- —

Action Needed

1. Work with the existing Ontario Health Teams, community stakeholders, and vaccine expert groups to build upon the knowledge gained from COVID-19 vaccinations; including the importance of increasing access by way of mass vaccination sites, pop up and mobile sites and working with vaccine-hesitant communities.
2. Allow pharmacies to administer all pneumonia and shingles vaccines.
3. Expand the recommended shingles vaccine coverage to all adults 50+.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Full list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Ontario**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	4 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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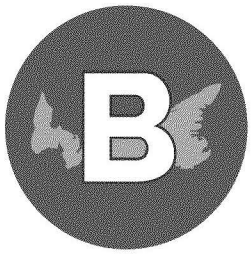
Prince Edward Island

LEADERSHIP	Progressive Conservative (Majority)
PREMIER	Dennis King
MINISTER OF HEALTH	Ernie Hudson, Minister of Health and Wellness
MINISTER OF SENIORS	None *The PEI Seniors' Secretariat is a body created to provide policy and program advice to government and other organziations to improve the quality of life for seniors under the Office of Seniors, which is located in the Ministry of Social Development and Housing. Several individuals make up the PEI Seniors' Secretariat.*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Heather G. Morrison
SENIORS ADVOCATE	None



Population of Adults 50+	66,987
% of Total Population	40.76%

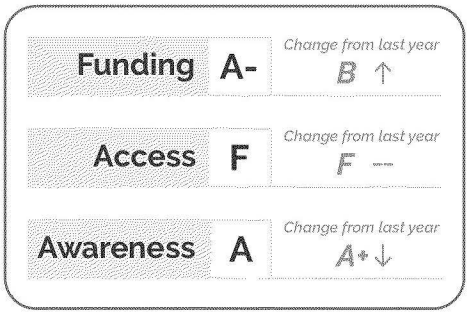
Overview Summary

It's incredibly impressive that PEI, Canada's smallest province, has emerged as the national leader in adult immunization. The Government of PEI scores the highest overall in this report, showcasing its commitment to protecting the health of seniors with top-tier vaccine funding and public education. Islanders 65+ can get a seniors-specific flu shot for free, even at pharmacies, and the province is one of only three to fund the recommended shingles vaccine.

However, the Government of PEI shouldn't rest on its laurels – expanding coverage for the new shingles vaccine to include everyone 50+ would further cement its excellent standing on preventive health.

Key Findings

1. Prince Edward Island scores the highest overall in this report.
2. The Government of PEI is one of only three to fund the recommended shingles vaccine.
3. Pharmacists can administer both flu shots and shingles vaccines.



Action Needed

1. Fully fund shingles vaccines for all adults 50+
2. Allow all doctors, nurses, pharmacies, and health care hubs to provide all vaccines.
3. Update the Seniors' Guide and ensure that information about vaccinations is clearly laid out in it.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Full list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Prince Edward Island**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	4 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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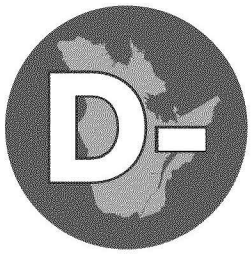
Quebec

LEADERSHIP	Coalition Avenir Québec (Majority)
PREMIER	François Legault
MINISTER OF HEALTH	Christian Dubé, Minister of Health and Social Services
MINISTER OF SENIORS	Not dedicated *Consolidated with Informal Caregivers: Marguerite Blais*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Luc Boileau
SENIORS ADVOCATE	None



Change from last year D- ——

Population of Adults 50+	3,537,640
% of Total Population	41.10%

Overview Summary

Quebec earned a shockingly low overall score in this report. The province has an almost bafflingly poor immunization program, utterly out-of-step with comparable jurisdictions or even compared to other aspects of Quebec's own quite good healthcare system.

As an example of how far-off Quebec is from the rest of the country, it is now the **only jurisdiction in Canada to not even publicly cover the standard dose flu shot for adults 18+ – a problematic and serious public health decision which leaves Quebec at influenza risk**. The only improvement in vaccine funding for Quebec in this year's report is that the seniors-specific flu vaccine program in long-term care (CHLSDs) was renewed. This years' report also scrutinized the province's Tdap eligibility even more closely: clarification of the government's Tdap coverage resulted in lost points. Additionally, Quebec still does not cover the recommended shingles vaccine, and just squeaks by in coverage for immunocompromised adults for PNEU-C-13.

Quebec has excellent public information about adult vaccines, at odds with its extremely poor public coverage. The province improved its public awareness activities, and earned points for a comprehensive seniors' guide. They also have very good information around influenza despite the fact that it has the worst vaccination coverage for influenza in the country.

However, the Government of Quebec hasn't done nearly enough to pull itself out of the worst-performing bracket in adult vaccination across Canada. With Quebec's very large and aging population, pressures on its health care system, and severe impacts during COVID-19, the government must commit itself to reforming its immunization coverage, strategy and focus.

Key Findings

1. The Government of Quebec has the worst flu vaccine coverage in the country, and does not fund even the standard flu shot for adults 18+.
2. Quebec has one of the worst overall scores of any province and is barely ahead of only Newfoundland and Nunavut for adult vaccinations.
3. The province does an excellent job on public information and education about adult vaccinations.

		Change from last year
Funding	F	D ↓
Access	F	F --
Awareness	A-	B- ↑

Action Needed

1. Quebec needs to reform its immunization systems to overcome the notable silos between the unelected vaccination policy-makers and the broader elected government health mandate.
2. Work with community and broader health stakeholders to reimagine a Quebec Immunization Policy which meets the needs of the population now and in the future, to bring vaccine funding and policies into the 21st century.
3. Bring funding of basic vaccines up to standard: a) Fund the standard flu vaccines for people 18-64; b) Fund the seniors-specific flu vaccine for people 65+ and c) Fund the shingles vaccine for people 50+.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Quebec**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	3 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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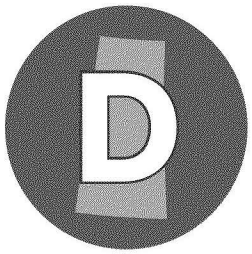
Saskatchewan

LEADERSHIP	Saskatchewan Party (Majority)
PREMIER	Scott Moe
MINISTER OF HEALTH	Paul Merriman
MINISTER OF SENIORS	Not dedicated *Consolidated with Mental Health and Addictions and Rural and Remote Health: Everett Hindley*
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Saqib Shahab
SENIORS ADVOCATE	None



Change from last year D+ ↓

Population of Adults 50+	411,427
% of Total Population	34.87%

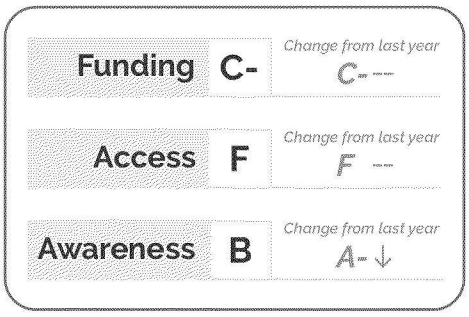
Overview Summary

The Government of Saskatchewan lost points this year on their reduced public education around non-COVID-19 adult vaccines, causing its overall score to drop slightly. The province is also still lagging far behind in funding coverage: it only funds a seniors-specific flu shot for residents in long-term care age 65+, leaving approximately 95% of all seniors unprotected.

The province also does not fund the recommended shingles vaccine at all. The Government of Saskatechewan simply can't afford to move backwards at a time when preventive health has never been more critical. The province must move forward to bring their score up to protect its older population.

Key Findings

1. The Government of Saskatchewan is still not funding seniors-specific flu vaccines for those living outside of long-term care, leaving approximately 95% of the provinces' seniors unprotected.
2. The province's public education efforts in the Seniors' Guide and vaccine information worsened. This should have been a core focus during the COVID-19 pandemic, particularly considering the need to keep vulnerable people safe and well.
3. None of the publicly funded vaccines recommended for seniors are available at pharmacies.



Action Needed

1. Fund seniors' specific flu vaccines for all seniors, not just the approximately 5% of seniors in long-term care.
2. Fund the recommended shingles vaccine.
3. Improve vaccine communications, including updating the Seniors' Guide, and work with rural and remote communities and historically marginalized groups to increase access and vaccine confidence.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING

Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*

Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING

Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●

ACCESS

*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*

Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts

Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Saskatchewan**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	4 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●

Communication Efforts to Seniors

A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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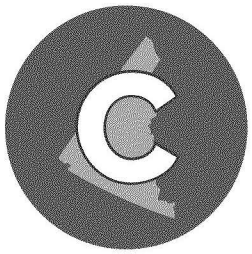
Yukon

LEADERSHIP	Liberal (Majority)
PREMIER	Sandy Silver
MINISTER OF HEALTH	Not dedicated *Consolidated with Social Services, and Minister of Justice: Tracy-Anne McPhee*
MINISTER OF SENIORS	None
MINSTER OF LTC	None
CHIEF MEDICAL OFFICER	Dr. Catherine Elliott (acting)
SENIORS ADVOCATE	None



Population of Adults 50+	14,919
% of Total Population	34.70%

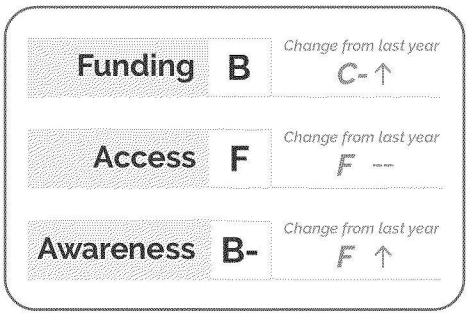
Overview Summary

The Government of Yukon has earned the most improved score in this year's report, due in large part to new funding for the recommended shingles vaccine and high-dose flu shot. The territory is signaling a strong commitment to improving vaccination uptake within its older population – especially as it is one of only three jurisdictions across Canada to make this move.

Yukon is also making considerable strides to improve the way information around vaccines is communicated to seniors, conducting an overhaul of its online information in this area. The territory's score is particularly impressive given the historical and geographic challenges faced in health care provision in the region. Yukon has provided rural leadership focused on creative engagement with the online community to improve vaccine uptake, which is a positive indicator for this government's commitment to preventive health.

Key Findings

1. The Government of Yukon earned the biggest improvement in overall score compared to last year's report.
2. Yukon now funds the recommended shingles vaccine.
3. The territory is redesigning and improving the way immunization information is communicated to the general public.



Action Needed

1. Work with pharmacies and community-based health supports to get the broadest possible access to vaccine uptake, which may also include creating mobile units, pop-up sites and clinics in rural or remote non-traditional community centres.
2. Continue creativity in raising awareness of adult vaccination importance and the ability to co-administer adult vaccines.
3. Allow pharmacies to give pneumonia vaccines.

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Scorecard

● YES ● INCONCLUSIVE ● NO

INFLUENZA • *Single dose • Annual*

FUNDING	
Standard influenza vaccines are publicly funded for all adults aged 18–64.	●
Standard influenza vaccines are publicly funded for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors are publicly funded by the province/territory for all adults 65+.	●
Influenza vaccines specifically-formulated for seniors were funded in LTC in the current calendar year (2021-2022).	●
ACCESS	
*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**:*	
Public health sites (includes seasonal clinics)	●
Doctors' offices	●
Pharmacies	●
*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors**:*	
Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

PNEUMOCOCCAL • *Doses vary • One-time, age 65+*

FUNDING	
PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for all adults 65+.	●
PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised.	Partial list
ACCESS	
*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)**:*	
Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●
*A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised:*	
Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

HERPES ZOSTER (SHINGLES) • *Two doses • One-time, age 50+*

FUNDING	
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+.	●
Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.	●
ACCESS	
*A policy or directive from the province/territory exists that directs its public health programs to provide and administer best-in-class **shingles vaccines (Recombinant zoster vaccine, RZV)**:*	
Long-term care (LTC)	●
Congregate care settings	●
Aging in place / at home with community health supports	●
Public health sites	●
Doctors' offices	●
Pharmacies	●

AWARENESS • Transparency • Patient Education Initiatives

Digital Communication Efforts	
Information is available that clearly outlines all NACI recommended adult vaccines	●
Information specifically identifies vaccination information specifically for seniors	●
Government provided information about immunizations is easily found using the search terms: "**Vaccines for Seniors Yukon**" *Information is found in under 3 mins = 4 pts* *Information is found in 3-5 mins = 3 pts* *Information is found in 5-7 mins = 2 pts* *Information is found in 7 minutes or more = 1 pt* *Information was not found on the website in less than 10 minutes = 0 pts"*	4 pts
Information is found regarding **annual/seasonal influenza vaccination**	●
Information is found regarding **shingles vaccination**	●
Information is found regarding **pneumococcal vaccination**	●
Information about vaccine coverage is found and is clear to the reader which vaccines are funded and which are not	●
A telephone number or website is provided to reach local public health authorities	●
Instructions are provided for accessing personal vaccination records	●
Information is available in both English and French	●
Communication Efforts to Seniors	
A Seniors' Guide is available	●
The Seniors' Guide is up to date (2021)	●
The Seniors' Guide is made available in a variety of formats, including printed copies upon request	●
The Seniors' Guide provides up to date information about the provision of vaccinations in the province/territory	●

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Methodology

The following rubric was used to calculate letter grades for each province/territory.

Scoring of each provincial/territorial government was broken down into three functional areas: Funding, Access and Awareness. These categories, as well as their weighting in calculating final grades, are explained in detail below.

Funding (Scoring Weight: 50%)

Each government was evaluated based on its investment in the health and wellness of its older adult populations by ensuring that best-in-class vaccines are publicly funded and distributed as broadly as possible. Beyond the act of funding a given vaccine, this category also acts as a dependency for the availability of the vaccines, as evaluated under Access.

For example, if a province funds an influenza vaccine that's seniors-specific, but fails to permit and fund pharmacists to administer the vaccine, they would not earn marks for that vaccine under Access at Pharmacies, in spite of scoring points under Funding.

FUNDING - COVERAGE - 13 POINTS TOTAL	
Influenza	Standard influenza vaccines are publicly funded for ALL adults aged 18-64.
Influenza	Standard influenza vaccines are publicly funded for ALL adults 65+.
Influenza	Vaccines *specifically-formulated* for seniors are publicly funded by the province/territory for ALL adults 65+.
Influenza	Vaccines *specifically-formulated* for seniors were funded in LTC in the previous calendar year (2021-2022) by this province/territory.
Herpes Zoster	Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ANY adults aged 50+ (any identified cohort).
Herpes Zoster	Shingles vaccine (Recombinant Zoster Vaccine, RZV) is publicly funded for ALL adults aged 50+.
Pneumococcal	PPV-23/PNEU-P-23 (Pneumococcal polysaccharide 23-valent) is publicly funded for ALL adults 65+.
Pneumococcal	PCV-13/PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for ALL adults 65+.
Pneumococcal	PCV-13/PNEU-C-13 (Pneumococcal conjugate 13-valent) is publicly funded for people who are immunocompromised. *Points were awarded as follows: 0 if no coverage, 1 point if the province/territory covered only a partial list of NACI's immunocompromised conditions, and 2 points if the province/territory covered the full list of NACI's immunocompromised conditions.*
Tetanus	Tdap Vaccine is publicly funded and should be received every 10 years. *NOTE: In the past, tetanus was administered as a standalone vaccine but is now included as a part of Td booster.*
Diphtheria	Tdap Vaccine is publicly funded and should be received every 10 years *NOTE: In the past, diphtheria was administered as a standalone vaccine but is now included as a part of Td booster.*
Pertussis	Tdap (Whooping Cough) Vaccine is publicly funded and should be received as an adult booster once in life over the age of 18. *NOTE: In the past, pertussis was administered as a standalone vaccine but is now included as a part of Td booster Tdap.*

Access (Scoring Weight: 30%)

Each government was evaluated based on its commitment to the health and wellness of its older adult populations by ensuring that vaccine availability and accessibility was as broad and consumer-friendly as possible. The six points of access used to score this category are:

- Long-term care settings – where LTC staff (or an authorized agent) can administer the vaccine to residents on site within this care setting, free of charge to the recipient.
- Congregate care settings (personal care homes, nursing homes, retirement homes, assisted living, etc.) – where on site staff (or an authorized agent) can administer the vaccine to residents within this setting, free of charge to the recipient.
- Directly to seniors aging in place with community/ home care health supports – where home care staff (or an authorized agent) can administer the vaccine to residents in their homes, free of charge to the recipient.
- Public health offices – without a prescription, free of charge to the recipient.
- Doctors' offices – in office – without having to visit a public health location or a pharmacy, free of charge to the recipient.
- Pharmacies – without a prescription from another health care provider, and administered on site, free of charge to the recipient.

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For standard dose influenza, only three points of access were evaluated for the adult population (18+) as the coverage provided by standard dose influenza vaccines is insufficient for seniors.

Points were awarded for each access point where the province or territory had a documented policy or evidence that an effort was made to make available a vaccine to seniors via that location. Worth noting: given the well-documented evidence that seniors lose their immunity over time, and may be subject to other factors that can limit their mobility, any practice that required two interactions to obtain a vaccine were not awarded points.

For example, if a doctor can write the prescription for a vaccine, but cannot administer it in office/on site, no points were awarded. If a pharmacist can administer the vaccine in a pharmacy, but not without a doctor's prescription, no points were awarded.

To qualify for a point, there must be 1) a policy/directive/written guidance by government, 2) a vaccine is actually administered at the setting specified and 3) no additional cost is borne by the recipient.

ACCESS - AVAILABILITY - 27 POINTS TOTAL	
Influenza	A policy or directive from the province/territory exists that directs its public health programs to provide and administer **standard dose influenza vaccines**: • At Public health sites – without a prescription • At Doctors' offices – without having to pick up the vaccine in pharmacy • At Pharmacies – without a prescription from a physician or other health care provider
Influenza	A policy or directive from the province/territory exist that directs its public health programs to provide and administer **influenza vaccines that are specifically-formulated for seniors** in any of 6 possible settings.
Herpes Zoster	A policy or directive from the province/territory exists that directs its public health programs to provide and administer **best-in-class shingles vaccines (Recombinant zoster vaccine, RZV)** in any of 6 possible settings.
Herpes Zoster	A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-P-23 (Pneumococcal polysaccharide 23-valent)** in any of 6 possible settings.
Pneumococcal	A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** to people who are immunocompromised in any of 6 possible settings.
Pneumococcal	*BONUS point: A policy or directive from the province/territory exists that directs its public health programs to provide and administer **PNEU-C-13 (Pneumococcal conjugate 13-valent)** in any of 6 possible settings.

Awareness (Scoring Weight: 20%)

Each government was evaluated based on efforts made to educate its older populations on vaccinations and provincial/territorial immunization programs.

In each case, the source was recorded for where the information was found. Where a source was not available, other sources to verify the information were utilized including direct phone calls to public health offices and to provincial/territorial health ministries.

Searches were conducted by individuals who had above average internet search ability, and who had at least one university degree.

For all categories under Funding, Access or Awareness, where information online was unclear and was not able to be successfully validated by another means, no points were awarded and the province/territory was recorded as "inconclusive" for that metric.

Letter grades where assigned for each category, as well as for the province/territory as a whole, based on the following percentage brackets:

Letter	Percent
A+	90%-100%
A	85%-89%
A-	80%-84%
B+	78%-79%
B	73%-77%
B-	70%-72%
C+	68%-69%
C	63%-67%

Letter	Percent
C-	60%-62%
D+	58%-59%
D	53-57%
D-	50-52%
F	0%-49%

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Glossary

Aging in Place Aging in place means having the health and social supports and services come to you in order to live safely and independently in your home for as long as you wish and are able. This may include government funded services provided by personal care/support workers.

Community Health Centre Community Health Centres are multi-sector health and health care organizations that deliver integrated, people-centred services and programs reflecting the needs and priorities of the communities they serve.

Congregate Care Settings A group living setting where a number of unrelated people reside in close proximity for either a limited or an extended period of time and receive care services in that location. *May be called: Nursing Homes, Assisted Living, Supportive Living*, etc.

COVID-19 COVID-19 (coronavirus disease 2019) is a disease caused by a virus named SARS-CoV-2 and was discovered in December 2019 in Wuhan, China. It is very contagious and has quickly spread around the world.

Diphtheria According to the Government of Canada (2018), diphtheria is a disease that is caused by the toxin-producing strains of the bacteria *Corynebacterium diphtheriae*. This bacterium is commonly spread through person-to-person contact and affects mucous membranes, specifically skin and upper respiratory tract.

Doctor's Office While here we say Doctors' offices, we are generally talking about licensed medical practices primarily engaged in the private or group practice of general or specialized medicine or surgery. Examples: private practices, walk-in clinics, health centres. This may also extend from physicians to nurse practitioners and other health care providers (HCPs).

Immunocompromised From NACI: asplenia; solid organ transplant; immunocompromising therapy including use of long-term corticosteroids (other than by inhalation, topical, or injection into a joint) e.g. oral prednisone for longer than two weeks, chemotherapy, radiation therapy, post-organ transplant therapy and certain anti-rheumatic drugs; Human Immunodeficiency Virus (HIV); hematopoietic stem cell transplant (HSCT); malignant neoplasms; nephrotic syndrome; sickle cell disease.

Influenza Influenza is a respiratory infection caused by influenza A and B viruses. Seasonal influenza epidemics occur annually in Canada, generally in the late fall and winter months. Typical symptoms include the suddent onset of fever, cough, and muscle aches and can cause serious health complications for those with comorbidities such as diabetes or heart conditions, leading to reduced functional ability in extreme cases.

Long-Term Care Facilities that provide living accommodations for senior residents who require on-site distribution of care and services 24 hours a day, seven days a week. Examples of provided services and care would be help getting out of bed, getting dressed, bathing, laundry, meals, health check ups, administering of medication, or housekeeping.

Each province/territory may use different names:

ON, NL, NU, NT, NB, YT, AB - Long-Term Care
BC - Long-term Care, Residential Care Facility
MB - Personal Care Home
QC - Residential and Long-term care Centre (CHSLD)
NS - Residential Care Facilities
SK - Special Care Homes, Long-term Care
PE - Long-Term Care or Nursing Homes

NACI National Advisory Committee on Immunization (NACI) makes recommendations for the use of vaccines currently or newly approved for use in humans in Canada. NACI provides the Public Health Agency of Canada with ongoing and timely medical, scientific, and public health advice relating to immunization.

Pandemic A disease prevalent over a whole country or the world.

Pertussis As stated by the Government of Canada (2020), pertussis is caused by *Bordetella pertussis* bacteria. Pertussis, also known as whooping cough, is a contagious infection targeting the lungs and airways.

Pharmacy Establishments, known as pharmacies and drug stores, primarily engaged in retailing prescription or non-prescription drugs and medicines.

PNEU-C-13 (Pneumococcal conjugate 13-valent) Vaccine The PNEU-C-13 vaccine is approved by Health Canada and provides protection against 13 types of *Streptococcus pneumoniae*, which causes pneumococcal disease and has been shown to provide additional protection for those who are immunocompromised or more susceptible to invasive pneumococcal disease (IPD).

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Glossary

PNEU-P-23 (Pneumococcal polysaccharide 23-valent) Vaccine The PNEU-P-23 vaccine prevents pneumonia and other infections caused by 23 types of the *streptococcus pneumoniae* bacteria.

Pneumoccocal (pneumonia) The bacterium *Streptococcus pneumoniae* is the cause of invasive pneumococcal disease (IPD) and a common cause of community acquired pneumonia (CAP).

Public Funding/Publicly Funded Paid for by the provincial/territorial government.

Public Health Site A Public Health Site is an official health location where vaccinations are administered. They also may offer healthy living programs and disease prevention information.

Senior For the purposes of this report, "senior" is defined through a health care delivery policy lens as it pertains to each identified vaccine in order to establish a metric for assessment: influenza: 65+; Pneumonia; 65+; all other illnesses: 65+, Shingles 50+. Where data has been collected by age cohort, we indicate that age marker in the report. Age demarcation used in this report is reflective of third party data sets. CanAge takes a LifeCourse Approach, and seeks age-inclusion, rather than using a specific age-number.

Seniors' Guide/Information Booklet Document that contains information pertaining to seniors produced by provinces and territories.

Seniors-specific Any course of prevention and/or treatment that is specific to older adults (seniors). While the Government of Canada generally considers the age of seniors to be 65+, it is important to note that those aged 50+ are at risk for a number of serious health conditions that can have serious impacts on quality and longevity of life, including heart disease, diabetes, obesity, and excessive use of alcohol or tobacco.

Shingles Herpes zoster (shingles) is a manifestation of reactivation of the chicken-pox virus that causes neuropathic pain and a dermatomal vesicular rash.

Shingles Vaccine Recombinant Zoster Vaccine (RZV) is a specifically-formulated vaccine recommended for adults 50+ used to prevent varicella-zoster virus (VZV).

Specifically-Formulated A vaccine that has been formulated and tested for an older adult (senior) population.

Tetanus Tetanus is a disease caused by the neurotoxin produced by the anaerobic bacterium called *Clostridium tetani*. This bacterium can be found in spore form among soil, dust and manure. There is no cure for tetanus, however it is a vaccine-preventable disease.

Vaccine A product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease. Vaccines are usually administered through needle injections, but can also be administered by mouth or sprayed into the nose.

Vaccine Schedule A government recommended series of vaccinations depending on age, health, and sometimes occupation in order to prevent certain diseases. The Federal Government body, NACI, recommends which vaccines for which populations and when, however each provincial/territorial government decides which they will publicly fund. If you would like to know which vaccines you should have as an older adult in Canada, you may download one here.

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References

When sourcing our material, we relied on considerable empirical evidence published by jurisdictional governments. We started with the most recent provincial/territorial information, the ministries of health, then public health authorities, in that order. Government publications are often available in multiple languages and easily accessible online.

All references listed are online and were verified and active as of January 28th, 2021.

Alberta

Alberta Health Services, "Adult Immunizations," n.d., https://myhealth.alberta.ca/health/Pages/conditions.aspx?hwid=immun&#hw254941

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About CanAge

CanAge is Canada's national seniors' advocacy organization, working to improve the lives of older adults through advocacy, policy, and community engagement. We are non-partisan and backed by a pan-Canadian membership base.

Since the onset of the COVID-19 pandemic, CanAge has been working collaboratively with all levels of government and stakeholders in aging, health care and related sectors to create policy reform that supports and promotes the rights of older Canadians.

Our CEO, Laura Tamblyn Watts, sits on numerous federal and provincial government task forces and expert panels working on a variety of issues including consumer protections, elder abuse and national standards of long-term care.

In addition to producing reports like this one, CanAge produces educational events and resources, supports research, consults with organizations on age-friendly practices and mobilizes community advocate groups across the country.

Impact Snapshot

150+	**Policy recommendations implemented**
111	**Policy recommendations included in the federal party platforms during the last election**
265%	**Growth in national reach**
40+	**Community, organizational and government collaborators nationally**
2000+	**Media mentions**

To find out more about our work, visit CanAge.ca/Impact.

Work with us

Visit **CanAge.ca/Partnerships**

Become a Member

Visit **CanAge.ca/Join**

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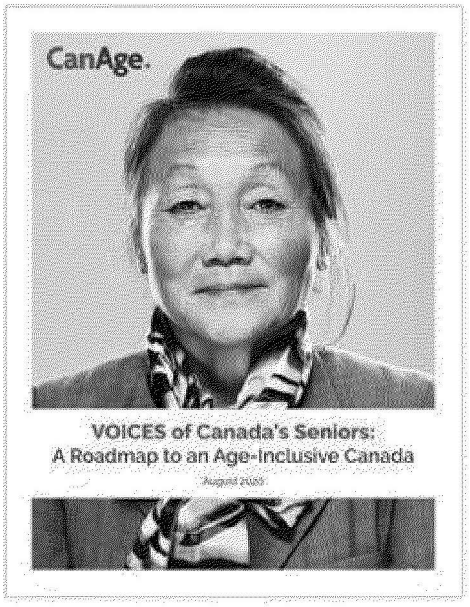
About our Policy Book



In October 2020, we launched '**VOICES: A Roadmap to an Age-Inclusive Canada**'; our inaugural policy book which makes 135 evidence-based recommendations to improve and protect the lives of older Canadians and caregivers. It takes into account the diverse lived experiences of older adults in Canada, giving special consideration to marginalized groups including Indigenous, LGBTQ2IA+, low income and seniors of colour, as well as those living with disabilities.

VOICES is the foundation for all of our work and is refreshed on a regular basis to address new and emerging issues.

This report springs from the I section in VOICES, which stands for Infection Prevention and Disaster Response. This section covers key policy issues, including:

- Issue #16: Vaccine Uptake and Reform
- Issue #17: Prioritize Adult Vaccination During COVID-19
- Issue #18: Adult Vaccine Schedule and Uptake Tracking

The 6 Compass Points of VOICES:

- **V** Violence and Abuse Prevention
- **O** Optimal Health and Wellness
- **I** Infection Prevention and Disaster Response
- **C** Caregiving, Long-Term Care, Home Care and Housing Resources
- **E** Economic Security
- **S** Social Inclusion

To explore our policy book, visit CanAge.ca/VOICES.

New updated edition coming Fall 2022

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CanAge

Authored by CanAge, January 2022.

This report has been wholly produced by CanAge, a national, not-for-profit organization. This undertaking would not be possible without the support of funders who have provided financial support at an arm's length to this project. The partners that funded this project, did not have any control over this report's findings, content or creative.

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   CanAge.ca

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Ghaly, Maggy (HC/SC)

From: Champagne, Christine (HC/SC)
Sent: 2022-02-08 12:32 PM
To: HC.F ECD-Liaison / DCHG F.SC
Cc: Browne, Robert (HC/SC)
Subject: Incoming VIP Correspondence (2022-02-08) - Minister Duclos
Attachments: 20220208115132707.pdf

Hello ECD,

Please find attached an incoming VIP correspondence for profiling from ***MP James Bezan, constituent Ms.*** [redacted] ***regarding Canada Vaccine Injury Support Program file number*** [redacted] for Minister Duclos 'office.

Thank you | Merci

Christine Champagne (She / Elle)
Correspondence Officer | Agente de correspondance
Deputy Minister's Office | Bureau du sous-ministre
Office of the Minister of Health | Cabinet du ministre de la santé
Health Canada | Santé Canada
Brooke Claxton Building
christine.champagne@canada.ca | 613-612-9509
Government of Canada / Gouvernement du Canada

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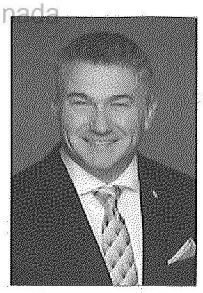
HOUSE OF COMMONS
CANADA



James Bezan
Member of Parliament
Selkirk-Interlake-Eastman

January 20th, 2022

Hon. Jean-Yves Duclos
Minister of Health
Health Canada
Address Locator 0900C2
Ottawa, ON K1A 0K9

Dear Minister:

I am writing on behalf of Ms. [redacted] regarding her Canada Vaccine Injury Support Program file number [redacted] You will find enclosed a copy of her Intake Form, supporting medical documentation and a MP authorization to disclose personal information.

[redacted]

[redacted]

The Canada Vaccine Injury Support Program needs to be more accessible for Canadians. I am requesting expeditious processing of Ms. [redacted]s Canada Vaccine Injury Support Program application.

Sincerely,

[redacted]

James Bezan, MP
Selkirk – Interlake – Eastman

Enclosure

c.c. [redacted]

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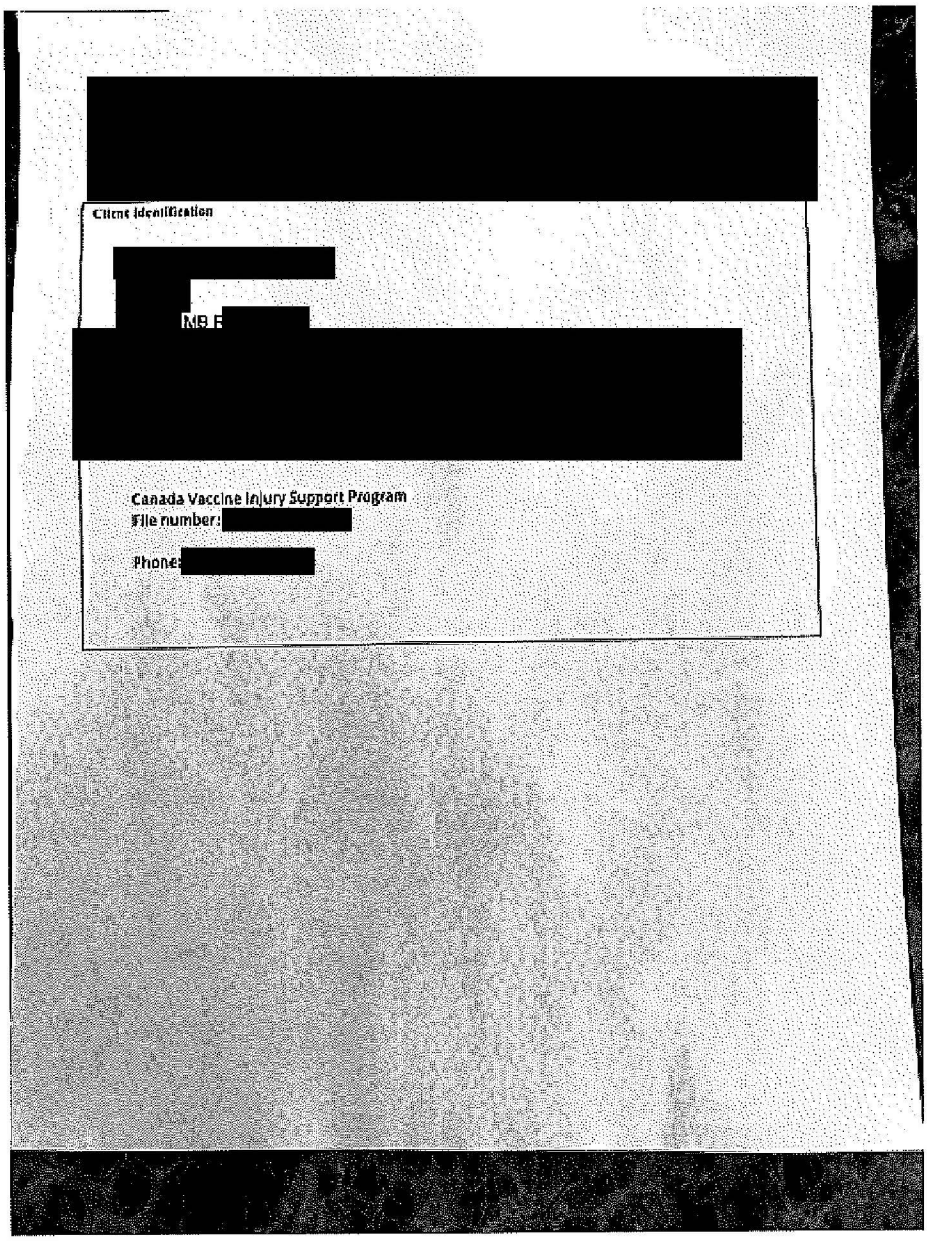

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Vaccine Injury Support Program

Form 1 – Intake Form

PROTECTED B (when completed)

Intake Form

Canada Vaccine Injury Support Program

(to be completed by the injured party or the injured party's authorized representative)

Please complete all fields of the following form for vaccinations administered in Canada on or after December 8, 2020. If you are representing an injured party, someone who is deceased, a minor or someone that cannot represent themselves, please complete Appendix A – Authorized Representative Form.

For vaccinations administered in Québec, please refer to Québec's Vaccine Injury Compensation Program. (https://www.quebec.ca/en/health/advice-and-prevention/vaccination/vaccine-injury-compensation-program)

1 IDENTIFICATION AND CONTACT INFORMATION OF THE INDIVIDUAL SUBMITTING THE CLAIM

Note: please select all options that apply.

Identity of the individual submitting the claim	☑ Injured Party	The individual who received a Health Canada authorized vaccine, administered in Canada, on or after December 8, 2020.
	☐ Beneficiary	The beneficiary is the individual who is determined to be eligible and would ultimately receive financial support. The beneficiary can be the injured party, or in the cases where the injured party is deceased; the beneficiary may be a family member of the injured party (ex. spouse, children, dependent, etc.).
	☐ Authorized Representative	The authorized representative is an individual authorized to complete the claim on behalf of either the beneficiary or injured party. (if applicable, please complete Appendix A).

Note: please complete the following information if you selected ONLY beneficiary.

Surname (last name) _____ Given name(s) _____

Relationship to injured party _____ (Spouse, Father, Mother, Child, Legal Guardian, etc.)

Preferred language ☐ English ☐ French

Mailing address

Number/Street (include apt # if applicable) _____ City _____ Prov/Terr. _____ Country _____ Postal Code _____

Email address _____ Primary telephone _____ Secondary telephone (if applicable) _____

2 IDENTIFICATION AND CONTACT INFORMATION OF THE INJURED PARTY

Note: all information is required to be completed, unless otherwise specified.

Surname (last name) [redacted] Given name(s) [redacted]

Residential address

[redacted] Number/Street (include apt # if applicable) _____ City MB Prov/Terr Canada Country R[redacted] Postal Code

Mailing address (if different from current residential address) ☐ Check if the same as above

[redacted] Number/Street (include apt # if applicable) _____ City MB Prov/Terr. Canada Country R[redacted] Postal Code

Email address [redacted] Primary telephone [redacted] Secondary telephone (if applicable) _____

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Vaccine Injury Support Program

Form 1 – Intake Form

PROTECTED B (when completed)

Place of birth		
[redacted]	MB	Canada
City	Prov./Terr. (if applicable)	Country

Date of birth	Sex	Preferred language
1976-[redacted]	Female	☒ English ☐ French
(YYYY-MM-DD)		

3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY

VACCINE ADMINISTRATION

Note: all information is required to be completed, unless otherwise specified.

[redacted]

Province or Territory where vaccination occurred: Manitoba

[redacted]

Name of medical professional 1	Primary telephone
Unknown	Unknown

ADDITIONAL MEDICAL CONSULTATION(S)

Note: all information is required to be completed, unless otherwise specified.

[redacted]

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Vaccine Injury Support Program

Form 1 – Intake Form

PROTECTED B (when completed)

4 IDENTIFICATION OF THE INJURED PARTY'S USUAL ATTENDING PHYSICIAN OR FAMILY PHYSICIAN

Note: If the Injured Party does not have a usual attending physician or family physician skip this section.

Name of physician: [redacted]

Hospital / clinic name [redacted]

[redacted] Wpg MB Canada

City Prov/Terr. Country Postal Code

Contact Information [redacted]

Secondary telephone (if applicable)

5 COMMENTS

Note: If no additional comments, skip this section.

[redacted]

Warning: Any false or misleading statement contained with respect to the submitted claim or any supporting [redacted] of any material fact, may result in the refusal to process the claim.

[redacted]

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St., Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca

The Vaccine Injury Support Program is funded by the Public Health Agency of Canada and administered by RCGT Consulting Inc.

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Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED B when completed

Medical Assessment Form

Canada Vaccine Injury Support Program

(to be completed by the licensed physician assessing the Injured Party)

This form must be completed by a licensed physician assessing the Injured Party. Please complete all of the following fields:

1 PHYSICIAN INFORMATION

Note: All information is required to be completed, unless otherwise specified.

Physician's surname (last name) [redacted] Physician's given name(s) [redacted]

[redacted] Ont MR Canada

Mailing address (if different from above) ☐ Check if the same as above

Number/Street (include unit # if applicable) City Prov./Terr. Country Postal Code

Email address [redacted] Primary telephone [redacted] Secondary telephone (if applicable)

Medical license number or licensed practice number [redacted] Preferred language ☑ English ☐ French

2 PATIENT (INJURED PARTY) INFORMATION

Note: All information is required to be completed, unless otherwise specified.

Patient's surname (last name) [redacted] Patient's given name(s) [redacted]

Date of birth

19[redacted]

yyyy-mm-dd

3 RELEVANT DETAILS PERTAINING TO THE VACCINE INJURY

Note: All information is required to be completed, unless otherwise specified.

[redacted]

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Vaccine Injury Support Program

Form 2 – Medical Assessment Form

PROTECTED B (when completed)

Patient status: [redacted]	If deceased, was an autopsy done? (complete if yes, or write future date if an autopsy is planned) (YYYY-MM-DD)

Description of adverse effects and/or injuries following vaccination (initial and persistent):
Instructions – Attach copies of ALL available documents (including imaging reports, Emergency Department and/or specialist consultations, injury assessment, discharge summary, clinical notes, laboratory reports and autopsy reports) and then complete additional information NOT AVAILABLE in existing documents, i.e. If patient has not received medical care – obtain history, examine

[redacted]

FIRST MEDICAL CONSULTATION
Note: all information is required to be completed, unless otherwise specified.

Date of first medical consultation [redacted]

Name of medical professional 1	Primary telephone

ADDITIONAL MEDICAL CONSULTATION(S)
Note: all information is required to be completed, unless otherwise specified.

Name of medical professional 2	Location	Primary telephone

[redacted]

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4 PATIENT MEDICAL HISTORY

[redacted]

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5 COMMENTS

Note: if no additional comments, skip this section.

Other Comments:

Warning: Any false or misleading statement contained with respect to the submitted claim and any supporting document, including the concealment of any material fact, may result in the refusal to process the claim.

By signing this form, I declare that all information provided above is true and completed to the best of my knowledge

Signature of the physician

[redacted]

Please return the completed, signed and dated forms to the Vaccine Injury Support Program administrator by mail:

Mail: Vaccine Injury Support Program
116 Albert St. Suite 1000
Ottawa, Ontario
K1P 5G3

For more information, please contact us by phone: 1-833-489-0839, email: info@vaccineinjurysupport.ca or visit our website: www.vaccineinjurysupport.ca.

WITHHELD / RETENUE

48 pages are exempted pursuant to section
48 pages sont exemptées en vertu de l'article

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

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Trojanovic, Julia (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-11-08 10:14 AM
To: hcminister.ministresc
Subject: TR: Ivermectin for the Clinical Management of Covid-19

-----Message d'origine-----
De : [redacted]@icloud.com> Envoyé : 8 novembre 2021 08:54 À [redacted] hcminister.ministresc@hc-sc.gc.ca; Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>; [redacted] sharon.tessier@rcmp-grc.gc.ca; [redacted] Faith.McIntyre@canada.ca; [redacted] Ivermectin for the Clinical Management of Covid-19

Dear Merck Canada,

I am writing directly to you to REQUEST that you send us some Ivermectin for the clinical management of Covid-19 in New Brunswick, Canada.

This email should have come long ago from Dr. Jennifer Russell, Chief Medical Officer of Health of New Brunswick and/or the Minister of Health of New Brunswick, Dorothy Shepard, or others. [redacted] and common sense,

Your reply will be most appreciated ASAP.

[redacted] President & CEO
[redacted] Inc.

Sent from my iPad, [redacted] NB, Canada

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Trojanovic, Julia (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-11-08 10:55 AM
To: hcminister.ministresc
Subject: TR: CADTH: Ivermectin for the Treatment and Prevention of Covid-19 - February 2021
Attachments: RC1336 - Ivermectin for COVID-19 v6.4.pdf

De : [redacted]@icloud.com>
Envoyé : 7 novembre 2021 11:22
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Cc : Faith.McIntyre@canada.ca; info@vcp-vdc.ca; stephen.lucas@hc-sc.gc.ca
Objet : Fwd: CADTH: Ivermectin for the Treatment and Prevention of Covid-19 - February 2021

Dear Minister of Health,

See email below. Your reply would be appreciated ASAP.

[redacted]

Sent from my iPad, [redacted] NB, Canada

Begin forwarded message:

> **From:** [redacted]@icloud.com>
> **Date:** November 3, 2021 at 10:50:48 AM ADT
> **To:** hcminister.ministresc@hc-sc.gc.ca
> **Subject: Fwd: CADTH: Ivermectin for the Treatment and Prevention of Covid-19 - February 2021**
>
> Dear Federal Minister of Health,
>
> See email below. In short, I am looking for Ivermectin for the clinical management of Covid.
>
> [redacted]
>
> Sent from my iPad, [redacted] NB, Canada
>
> Begin forwarded message:
>
> > **From:** [redacted]@icloud.com>
> > **Date:** November 3, 2021 at 9:15:27 AM ADT
> > **To:** [redacted]
> >
> > [redacted]
> >
> > [redacted]stephen.lucas@hc-sc.gc.ca,[redacted]

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[redacted]

Subject: CADTH: Ivermectin for the Treatment and Prevention of Covid-19 - February 2021

OPEN ACCESS EMAIL

https://cadth.ca/sites/default/files/covid-19/RC1336%20-%20Ivermectin%20for%20COVID-19%20v6.4.pdf

Dear CADTH stakeholders & Covid researchers,

Please be advised that the above-noted February 2021 document needs to be updated. We now have preliminary evidence by an Alberta doctor that he treated three patients successfully with Ivermectin.

Now we need a FULL BLOWN comprehensive clinical trial. [redacted] the CREDIBLE MEDS list to now include other drugs that prolong the QTc interval causing sudden cardiac death.

[redacted] who [redacted] Narcan Nasal Spray [redacted] Canada [redacted] I now have evidence of resuscitation success by fire department personnel, police, correctional officers who have resuscitated SUCCESSFULLY using Narcan Nasal Spray. [redacted] Dr. Jennifer Russell's Naloxone vial and syringe kit teaching video.

Any questions about my work, let me know. As some of you may know from my earlier emails, I have contacted Health Canada and/or Merck Canada to get us some Ivermectin. As you can see, without the drug, it is difficult to do a clinical trial.

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Thanks for reading.

[redacted] Inc.

ADVANCED ETHICAL SAFER than SAFE Medication prescribing and resuscitation using NEW evidence😀

Sent from my iPad, [redacted] NB, Canada

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CADTH COVID-19 PANDEMIC

COVID-19 CADTH Health Technology Review

Ivermectin for the Treatment and Prevention of COVID-19

This report was published on February 8, 2021.

To produce this report, CADTH used a modified approach to the selection, appraisal, and synthesis of the evidence to meet decision-making needs during the COVID-19 pandemic. Care has been taken to ensure the information is accurate and complete, but it should be noted that international scientific evidence about COVID-19 is changing and growing rapidly.

Version: 1.0
Publication Date: February 2021
Report Length: 29 Pages

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Authors: Khai Tran, Hannah Loshak

Cite As: *Ivermectin for the Treatment and Prevention of COVID-19*. Ottawa: CADTH; 2021 Feb. (CADTH Health Technology Review: Rapid Review).

ISSN: 1922-8147 (online)

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About CADTH: CADTH is an independent, not-for-profit organization responsible for providing Canada's health care decision-makers with objective evidence to help make informed decisions about the optimal use of drugs, medical devices, diagnostics, and procedures in our health care system.

Funding: CADTH receives funding from Canada's federal, provincial, and territorial governments, with the exception of Quebec.

Questions or requests for information about this report can be directed to **requests@cadth.ca**

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Abbreviations

AGREE II	Appraisal of Guidelines for Research & Evaluation II instrument
AMSTAR 2	A MeaSurement Tool to Assess systematic Reviews 2
CI	confidence interval
COVID-19	novel coronavirus disease 2019
C_{max}	maximum plasma concentration
GRADE	Grading of Recommendations Assessment, Development and Evaluation
IC_{50}	half-maximal inhibitory concentration
NCCET	National COVID-19 Clinical Evidence Taskforce
NIH	National Institutes of Health
PCT	prophylactic chemotherapy
RCT	randomized controlled trial
RNA	ribonucleic acid
ROBINS-I	risk of bias in non-randomized studies of interventions
RT-PCR	reverse transcription–polymerase chain reaction
SARS-CoV-2	severe acute respiratory syndrome coronavirus-2
SR	systematic review

Key Messages

- The primary studies identified in this report, including those within the systematic review, were found to have high risk of bias. Therefore, the very low quality of evidence from these studies preclude the ability to draw any strong conclusions as to whether ivermectin could reduce all-cause mortality, improve clinical symptoms, hospitalization, and viral clearance in patients with COVID-19.
- Evidence on the cost-effectiveness of ivermectin for the treatment and prevention of COVID-19 was not identified.
- With the current evidence, the included guidelines do not recommend the use of ivermectin for the treatment of COVID-19.

Context and Policy Issues

The novel coronavirus disease 2019 (COVID-19) is caused by a ribonucleic acid (RNA) virus called severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2).[1] In late 2019, the virus originally emerged from Wuhan in the central Chinese province of Hubei and quickly spread around the world creating the current pandemic that has threatened the health care system, devastated the economy, and disrupted people's normal lives in all countries.[1] Most people infected with SARS-CoV-2 are asymptomatic and have mild symptoms, which allows the virus to spread more readily.[1] Among the general population

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with a positive test for COVID-19, 20% to 75% were asymptomatic.[2] The disease is initially presented with flu-like symptoms such as fever, cough, sore throat, headache, fatigue, muscle pain, and chest pain.[1] Collective data from Wuhan, China, revealed that 80.9% of cases were mild, with flu-like symptoms; 13.8% were severe, with pneumonia; 4.7% required admission to the intensive care unit due to respiratory failure or organ failures.[1] To date, the COVID-19 pandemic has killed more than 2 million people worldwide, and more than 19,000 people in Canada.[3-5]

While vaccines are being rolled out, researchers around the world continue to search for the effective control and therapeutic treatment for COVID-19. In an effort to manage the pandemic, many older drugs that had been approved for other types of treatment have been repurposed as potential treatments for COVID-19, more than a dozen of which including ivermectin have been registered for clinical trials.[1]

Ivermectin is an antiparasitic drug and has been approved in Canada for the treatment of strongyloidiasis (a disease caused by infection with roundworm or nematode) and onchocerciasis (also known as river blindness, a disease caused by infection with a parasitic worm).[6] In addition to its antiparasitic properties, ivermectin has also been shown in in vitro studies to have an antiviral effect against a number of viruses including SARS-CoV-2.[7] A recent in vitro study has shown that a single dose of ivermectin given to the SARS-CoV-2 transfected cell line at 2 hours post-infection was able to inhibit by more than 90% viral RNA release and 99% cell-associated viral RNA at 24 hours post-infection.[8] By 48 hours post-infection, ivermectin was able to reduce viral RNA by about 5,000-fold compared with the control.[8] The half-maximal inhibitory concentration (IC_{50}) of ivermectin in this study was found to be between 2.2 and 2.8 μm.[8] Since then, there has been increasing interest in ivermectin for the treatment of COVID-19 and more than 50 clinical trials are ongoing to study the effect of ivermectin for SARS-CoV-2 infection in humans.[9]

The aim of this report is to review the clinical effectiveness and cost-effectiveness of ivermectin for the treatment and prevention of COVID-19. This report also aims to identify evidence-based guidelines regarding the use of ivermectin for the treatment and prevention of COVID-19.

Research Questions

1. What is the clinical effectiveness of ivermectin for the treatment and prevention of coronavirus disease (COVID-19)?
2. What is the cost-effectiveness of ivermectin for the treatment and prevention of COVID-19?
3. What are the evidence-based guidelines regarding the use of ivermectin for the treatment and prevention of COVID-19?

Methods

Literature Search Methods

A limited literature search was conducted by an information specialist on key resources including MEDLINE and Embase via OVID, the Cochrane Library, the University of York Centre for Reviews and Dissemination (CRD) databases, the websites of Canadian and major international health technology agencies, as well as a focused internet search. The search strategy comprised both controlled vocabulary, such as the National Library of

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Medicine's MeSH (Medical Subject Headings), and keywords. The main search concepts were ivermectin and COVID-19. No filters were applied to limit the retrieval by study type. Where possible, retrieval was limited to the human population. The search was also limited to English-language documents published between January 1, 2018 and January 5, 2021.

Selection Criteria and Methods

One reviewer screened citations and selected studies. In the first level of screening, titles and abstracts were reviewed and potentially relevant articles were retrieved and assessed for inclusion. The final selection of full-text articles was based on the inclusion criteria presented in Table 1.

Table 1: Selection Criteria

Criteria	Description
Population	Individuals with confirmed or suspected COVID-19 or those at risk of infection
Intervention	Ivermectin (used as a treatment or as a prophylactic, alone or in combination with other therapies)
Comparator	Q1 and Q2: No treatment, placebo, standard care, other active treatments (e.g., remdesivir, dexamethasone) Q3: Not applicable
Outcomes	Q1: Clinical effectiveness (e.g., mortality, length of hospital stay, clinical symptoms, viral load, safety [e.g., adverse events]) Q2: Cost-effectiveness (e.g., cost per quality-adjusted life-year gained) Q3: Recommendations regarding best practices (e.g., place in therapy, treatment protocols, appropriate patient populations and clinical settings, guidance related to which formulations are appropriate)
Study designs	HTAs, SRs, RCTs, non-randomized studies, economic evaluations, and evidence-based guidelines

COVID-19 = novel coronavirus disease 2019; HTA = heath technology review; RCT= randomized controlled trial; SR = systematic review.

Exclusion Criteria

Articles were excluded if they did not meet the selection criteria outlined in Table 1, they were duplicate publications, or were published prior to 2018. Systematic reviews (SR) in which all relevant studies were captured in other more recent or more comprehensive SRs were excluded. Primary studies retrieved by the search were excluded if they were captured in one or more included SRs. Guidelines with unclear methodology were also excluded.

Critical Appraisal of Individual Studies

The included publications were critically appraised by one reviewer using the following tools as a guide: A MeaSurement Tool to Assess systematic Reviews 2 (AMSTAR 2)[10] for SRs, the Downs and Black checklist[11] for randomized and non-randomized studies, and the Appraisal of Guidelines for Research & Evaluation (AGREE) II instrument[12] for guidelines. Summary scores were not calculated for the included studies; rather, the strengths and limitations of each included publication were described narratively.

Summary of Evidence

Quantity of Research Available

A total of 334 citations were identified in the literature search. Following the screening of titles and abstracts, 314 citations were excluded and 20 potentially relevant reports from the electronic search were retrieved for full-text review. Two potentially relevant

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publications were retrieved from the grey literature search for full-text review. Of these potentially relevant articles, 16 publications were excluded for various reasons and 6 publications met the inclusion criteria and were included in this report. These comprised 1 SR, 1 randomized controlled trial (RCT), 2 non-randomized studies, and 2 evidence-based guidelines. Appendix 1 presents the PRISMA[13] flow chart of the study selection.

A list of preliminary reports that have not been peer-reviewed and do not meet the inclusion criteria of this report are provided in Appendix 5.

Summary of Study Characteristics

The detailed characteristics of the included SR,[14] (Table 2) primary studies[15-17] (Table 3) and the National COVID-19 Clinical Evidence Taskforce (NCCET)[18] and the National Institutes of Health (NIH)[19] guidelines (Table 4), are presented in Appendix 2.

Study Design

The included SR[14] included 4 observational studies, 3 with a control arm and 1 without a control arm. The literature search was performed from 5 main databases from database inception to August 31, 2020. The risk of bias of the included studies was assessed using the risk of bias in non-randomized studies of interventions (ROBINS-I). The quality of the evidence for each outcome was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE). The random-effects model meta-analysis was used to provide the summary estimates.

The included primary studies comprised 1 RCT,[15] 1 retrospective chart review,[16] and 1 retrospective databases review.[17] The RCT[15] was a double-blind, parallel, 3-arm (1:1:1), placebo-controlled trial. One retrospective study[16] reviewed hospitalized patients charts between March 10th and 30th of 2020. Another retrospective study[17] conducted a database review of countries with routine mass drug administration of prophylactic chemotherapy (PCT). None of the studies reported sample size calculations to detect a clinically relevant treatment effect.

Both included guidelines[18,19] were developed by multidisciplinary guideline committees, which consisted of health care professionals who were experts in the areas of interest. The guidelines used systematic methods to search for, select, and synthesize evidence. The recommendations in both guidelines were evidence-based and consensus based, and were rated based on the certainty and the strength of the evidence. The NCCET guideline[18] used the GRADE approach to assess and rate the quality of evidence, and the strength of recommendations was rated as “Strong for” for highest, or “Consensus statement” for lowest, quality of evidence. Each recommendation in the NIH guideline[19] was rated with a letter A, B, or C for strong, moderate, or weak, respectively, based on the quality of evidence. As the clinical information is quickly evolving, both guidelines are kept at a living status so that the recommendations are frequently updated based on the latest published research findings.

Country of Origin

The included SR was conducted by authors in India.[14] The included primary studies were conducted by authors from Bangladesh,[15] Spain,[16] and the US.[17] The included guidelines were conducted by authors from Australia[18] and the US.[19]

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Patient Population

The included SR[14] included studies with adult hospitalized patients with mild (56%), moderate to severe (26%), symptomatic (14%), and asymptomatic (4%) cases of COVID-19. Patients in the included studies had a mean age of 53 years with about 60% being male. Most patients had 1 or more comorbidities like diabetes, hypertension, or bronchial asthma. A total number of 631 patients were included in the analysis.

The RCT[15] included 72 hospitalized adult patients with COVID-19. The COVID-19 severity status of included patients was not reported. The mean age of patients was 42 years and 46% were male. The mean duration of illness before assessment was 3.83 days. Patients with chronic illnesses, who were pregnant or lactating, were excluded from the study.

One retrospective study[16] reviewed the hospital charts of 26 patients diagnosed with COVID-19. The COVID-19 severity status of included patients was not reported. The mean age of patients was 49 years and 65% were male.

Another retrospective study[17] reviewed 2 publicly available databases of countries that routinely deployed mass drug administration of PCT including ivermectin to people. Information about PCT was obtained from the WHO data bank and the COVID-19 cases were obtained from Worldometer. Details of the patient populations was not reported in this study. Only cases among a subset of African countries were graphically reported.

The target populations in the NCCET[18] and the NIH[19] guidelines are people with diagnosed or suspected COVID-19. The intended users of both guidelines are health care workers responsible for the care of patients with COVID-19.

Interventions and Comparators

The SR[14] included studies comparing ivermectin as add-on therapy with usual care only (i.e., hydroxychloroquine and azithromycin, doxycycline, or N-acetylcysteine and atorvastatin). The dose of ivermectin varied between 150 and 200 mcg/kg body weight administered as a single dose. In one study, 13 patients received a second dose of ivermectin. The follow-up period was not reported.

The RCT[15] had 3 arms of comparison: ivermectin alone, ivermectin plus doxycycline, and placebo. In the ivermectin-alone group, patients were given 12 mg once daily for 5 days. In the ivermectin plus doxycycline group, patients were treated with 12 mg ivermectin single dose and 200 mg doxycycline on day 1, followed by 100 mg every 12 hours for the next 4 days. The treatment regimen in the placebo group was not reported. Patients were followed up until the test result was negative.

The retrospective hospital chart review[16] compared ivermectin as add-on therapy to immune-suppressant drugs (i.e., corticosteroids or tocilizumab) and standard of care versus control. A single dose of ivermectin was administered at 200 mcg/kg body weight. All patients received hydroxychloroquine, azithromycin, and lopinavir/ritonavir. Patients were followed up 8 to 10 days after treatment.

The retrospective study[17] that reviewed databases of countries that routinely deployed mass drug administration compared different types of PCT for parasitic infections including PCT using ivermectin, PCT using other drugs, and no PCT. Dosages of ivermectin or other treatments were not reported.

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The interventions considered in both guidelines[18,19] were corticosteroids, antiviral drugs, antimalarial drug, antiparasitic drug such as ivermectin, and many others.

Outcomes

The outcomes considered by the SR[14] were all-cause mortality, time to discharge from the hospital, time to viral clearance assessed by reverse transcription–polymerase chain reaction (RT-PCR), and clinical improvement assessed by the need for respiratory support.

The outcomes considered by the RCT[15] were time to viral clearance assessed by RT-PCR, clinical symptoms (i.e., fever, cough, and sore throat), duration of hospitalization, and all-cause mortality. Safety outcomes were adverse events and discontinuation of the study drug.

The post-treatment clinical and safety outcomes considered by retrospective chart review study[16] were viral clearance, symptom improvement, hospitalization, proportion of patients remaining in the intensive care unit, and serious adverse events.

The incidence of COVID-19, expressed as cases per 100,000 people, was the outcome of the retrospective databases review study.[17]

Both included guidelines[18,19] considered all the clinical and safety outcomes of the therapeutic management of patients with COVID-19.

Summary of Critical Appraisal

The detailed quality assessments of the included SR[14] (Table 5), primary studies[15-17] (Table 6), and guidelines[18,19] are presented in Appendix 3.

The included SR[14] was explicit in its research questions and inclusion criteria for the review, selection of study design for inclusion, and comprehensive literature search strategy. It was unclear if the study selection was performed in duplicate; however, 3 reviewers independently extracted and assessed the quality of data. The SR had a protocol published prior to the conducting of the review. The SR did not report the sources of funding of the studies included in their review and did not provide a list of excluded studies. The SR described the characteristics of the included studies in adequate detail, used appropriate techniques to assess the risk of bias of the included studies (i.e., ROBINS-I was used to assess the risk of bias in non-randomized studies), used appropriate methods to combine the results (i.e., random-effects model meta-analysis), accounted for the risk of bias in individual studies when interpreting or discussing the results, and reported conflicts of interest, as well as the source of funding received for conducting the review. Overall, the included SR was of high methodological quality.

The included RCT[15] clearly described the objective, the main outcomes, the intervention of interest, and the main findings. However, the study did not clearly describe the characteristics of the patients included in the study and it was unclear if the baseline characteristics were balanced between groups. Thus, residual confounding factors might not have been identified and controlled. Although the trial was a double-blind, controlled RCT, the lack of reporting about the method of random sequence generation and allocation concealment may introduce a high risk of selection bias. Performance and detection biases were minimized by the double-blind design of the trial. With a small sample size of patients (N = 72; 24 patients per group) enrolled from one hospital, it was unlikely that the participants were representative of the entire population from which they were recruited.

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The study did not clearly describe statistical methods used in data analysis and did not perform sample size calculation to determine the number of participants needed to detect a clinically relevant effect. Overall, the methodological quality of the included RCT was very low.

The included retrospective chart review study[16] had several limitations regarding reporting, internal validity, external validity, and retrospective design. The study did not clearly describe the main outcomes in the method section, did not identify and adjust for confounders, and did not provide estimates of the random variability in the data (e.g., 95% confidence interval [CI]) for the main outcomes. The study sample size was small (N = 26; 13 patients per group), suggesting that the participants were likely not representative of the entire population from which they were recruited. Additionally, a sample size calculation was not performed and it remains unclear if the study was adequately powered to detect clinically meaningful differences. The study may have a high risk of selection bias, detection bias, and reporting bias. Overall, the methodological quality of this study was very low.

The included retrospective database review study[17] also had several limitations regarding reporting, internal validity, external validity, and retrospective design. The study did not provide the characteristics of the populations or countries investigated and the dosages or treatment durations of ivermectin. Confounding factors were not identified and adjusted as the comparisons were made between different countries. The study did not report the sample sizes and the authors acknowledged that sizes of the 3 samples varied greatly. No actual numerical values and the random variability in the data for the main outcome were reported. The study may have a high risk of selection bias and detection bias. Overall, the methodological quality of this study was very low.

Both included guidelines[18,19] were explicit scope and purpose (i.e., objectives, health questions, and populations), and had clear presentation (i.e., specific and unambiguous recommendations, different options for management of the condition or health issue, and easy to find key recommendations). Regarding stakeholder involvement, the guidelines clearly defined target users and the development groups included individuals from all relevant professional groups; however, it was unclear if the views and preferences of the target populations were sought in the NIH guideline.[19] For rigour of development, both guidelines explicitly reported details of systematic searches for evidence, criteria for selecting evidence, strengths and limitations of the body of evidence, methods of formulating the recommendations, and health benefits, side effects, and risks in formulating the recommendations. Both guidelines were posted on its website and were regularly updated based on the latest published research findings and evolving clinical information. For applicability, the guidelines were explicit in terms of facilitators and barriers to application, advice and/or tools on how the recommendations can be put into practice, and monitoring and/or auditing criteria. It was unclear if the resource (cost) implications of applying the recommendations have been considered. For editorial independence, the guidelines reported that the funding bodies had no influence on the content of the guidelines. The competing interests of the guideline development group members were reported. Overall, both included guidelines were of high methodological quality.

Summary of Findings

The main findings and authors' conclusions of the SR[14] (Table 8), primary studies[15-17] (Table 9), and guidelines[18,19] are presented in Appendix 4.

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Clinical Effectiveness of Ivermectin

All-Cause Mortality

The meta-analysis of data from 3 observational studies in the SR[14] showed a significant reduction in all-cause mortality with ivermectin (200 mcg/kg, single dose) as add-on treatment compared to usual care only, such as hydroxychloroquine and azithromycin, doxycycline, or N-acetylcysteine and atorvastatin. The overall pooled odds ratio was 0.53 (95% CI 0.29 to 0.96); P = 0.04. It was estimated that ivermectin was associated with 54 fewer deaths per 1,000 (95% CI, 3 fewer to 85 fewer). The quality of the evidence was very low, as judged by authors of the SR.

The RCT[15] found no deaths during the course of the study in any of the ivermectin alone, ivermectin plus doxycycline, and placebo groups.

Clinical Improvement

The meta-analysis of data from 3 observational studies in the SR[14] showed that adding ivermectin (200 mcg/kg, single dose) resulted in a significant clinical improvement assessed by the need for respiratory support compared to usual care only, such as hydroxychloroquine and azithromycin, doxycycline, or N-acetylcysteine and atorvastatin. The overall pooled odds ratio was 1.95 (95% CI, 1.09 to 3.49); P = 0.02. It was estimated that ivermectin was associated with 61 more patients improved per 1,000 (95% CI, 12 more to 91 more). The quality of the evidence was very low, as judged by authors of the SR.

The results from the RCT[15] showed no significant differences between a 5-day course of ivermectin alone (12 mg once daily for 5 days) and placebo or between ivermectin plus doxycycline (12 mg ivermectin single dose and 200 mg doxycycline on day 1, followed by 100 mg every 12 hours for the next 4 days) and placebo in the proportion of patients who had improvement in fever (P = 0.09; P = 0.35), cough (P = 0.23; P = 0.18), and sore throat (P = 0.09; P = 0.35) from the day of enrolment to 5-day post-treatment.

The retrospective chart review study[16] found no significant difference between add-on ivermectin therapy (200 mcg/kg) group and the control group in clinical improvement 8 to 11 days after treatment (69.2% versus 76.9%; P > 0.999). Clinical improvement was not defined in this study.

Hospitalization

The SR[14] included 3 studies comparing ivermectin add-on therapy (200 mcg/kg, single dose) to non-ivermectin groups for hospitalization. Meta-analysis was not possible because of the different data reported. One study found that the ivermectin group had a significantly lower mean time of hospital stay than the non-ivermectin groups (7.62 ± 2.75 days versus 13.22 ± 5.90 days; P = 0.00005). The other 2 studies found no significant difference in time to discharge from hospital between groups.

The RCT[15] found no significant differences in the mean duration of hospitalization between a 5-day course of ivermectin alone (12 mg once daily for 5 days) and placebo (9.6 days versus 9.7 days; P = 0.93) or between ivermectin plus doxycycline (12 mg ivermectin single dose and 200 mg doxycycline on day 1, followed by 100 mg every 12 hours for the next 4 days) and placebo (10.1 days versus 9.7 days; P = 0.93).

The retrospective chart review study[16] found no significant differences between the add-on ivermectin therapy (200 mcg/kg) group and the control group in the proportion of patients

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discharged from the hospital (53.8% versus 46.1%; P = 1.000), no significant differences in the proportion of patients who remained in hospital (30.8% versus 30.8%; P = 1.000), or stayed in the intensive care unit (15.4% versus 23.1%; P = 1.000) after 8 to 11 days of treatment.

Time to Viral Clearance

The SR[14] included 2 studies having time to viral clearance as an outcome. In one study, the median time to viral clearance was significantly lower in the ivermectin group compared to the non-ivermectin group (7 days versus 12 days; P = 0.001). The other study did not find any significant difference between the 2 groups.

The findings of the RCT[15] showed that the mean duration for viral clearance (i.e., negative test) was significantly shorter for the 5-day ivermectin group (9.7 days; 95% CI, 7.8 to 11.8 days) compared to placebo (12.7 days; 95% CI, 11.3 to 14.2 days); P = 0.02. Similarly, the proportion of patients at risk for COVID-19 (i.e., remaining positive test) was significantly reduced in the 5-day ivermectin group on day 7 (P = 0.03) and day 14 (P = 0.02) compared to placebo. There was no significant difference for viral clearance between a single dose of ivermectin plus doxycycline and placebo (P = 0.27).

The retrospective chart review study[16] found no significant difference between ivermectin and the control groups in the proportion of patients remaining positive in the COVID-19 test performed between 3 and 5 days after treatment (38.5% versus 30.8%; P = 1.000).

Incidence of COVID-19

The retrospective databases review study[17] found that countries that deployed mass drug administration of PCT with ivermectin had a significantly lower incidence of COVID-19 compared to countries with no PCT (P < 0.01). Similarly, a subset of African countries that routinely used ivermectin in their PCT against parasitic infections had significantly lower incidences of COVID-19 compared to countries with no PCT (P ≤ 0.05). There was a statistically significant correlation between PCT with ivermectin and a lower incidence of COVID-19 (P = 0.017) among African countries.

Adverse Events

The RCT[15] reported no serious drug-related adverse events in all patients. The retrospective chart review study[16] found no significant difference in the proportion of patients having severe adverse events between groups.

Cost-Effectiveness of Ivermectin

No studies regarding the cost-effectiveness of ivermectin for the treatment and prevention of COVID-19 were identified; therefore, no summary can be provided.

Guidelines Regarding the Use of Ivermectin for the Treatment and Prevention of COVID-19

The NCCET guideline[18] does not recommend ivermectin for the treatment of COVID-19 ("Not recommended") based on very low-quality evidence.

The NIH guideline[19] also recommends against the use of ivermectin for the treatment of COVID-19 (A, strong recommendation) based on level III evidence (i.e., expert opinion).

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Limitations

Although the included SR[14] was well-conducted, the included primary studies provided very low-quality evidence. They were primarily small observational in design, with potential confounders. Of the included primary studies in the SR, 3 have not been peer-reviewed (i.e., preprints) and one study had no control arm. Meta-analysis was performed with 3 studies,2 of which were preprints. The RCT[15] and the retrospective chart review study[16] had small sample sizes to draw any solid conclusions and potential confounders were not identified and adjusted in the analysis, thus providing low-quality evidence. The retrospective database review study[17] was poorly conducted, with potential confounders and imbalanced sample sizes among groups. The period of investigation was short (i.e., a few months in 2020) to accurately determine an association between the incidence of COVID-19 and prophylactic chemotherapy. The evidence provided from this study was also of very low quality. The collected limitations of the included studies in this report preclude any definitive conclusions regarding the use of ivermectin for the treatment and prevention of COVID-19. The findings are therefore not generalizable to the Canadian context. Likewise, the included guidelines[18,19] currently do not recommend ivermectin for the treatment of COVID-19 because of the lack of strong evidence. Of note, the dose of ivermectin used in the included studies, which was the approved dose for parasitic infections, may not provide sufficient bioavailability against SARS-CoV-2 as shown in the in vitro study;[8,20] that may be one of the reasons that the effectiveness of ivermectin for COVID-19 treatment was not consistently observed in the included studies. The IC_{50} of ivermectin in the in vitro study was 2.2 to 2.8 μM, which is more than 35 times the maximum plasma concentration (C_{max}) after a fasted oral administration of an approved dose of ivermectin for the treatment of parasitic infections (i.e., 150 to 200 mcg/kg), reaching a C_{max} of 0.033 μM in the plasma and 0.087 μM in the lung.[20] Even with 10 times higher than the approved dose, the predicted Cmax in the lung was 0.820 μM, which is much lower than the in vitro IC_{50}.[20] Doses of ivermectin used in the included studies in this report were between 150 to 200 mcg/kg or 12 mg single dose; thus, the bioavailability of ivermectin may be far less compared to that observed in vitro against SARS-CoV-2 and the likelihood of a positive result of ivermectin in a trial is low with the approved dose. Novel formulations using microtechnology- and nanotechnology-based systems have been proposed to optimize ivermectin's bioavailability and to effectively inhibit SARS-CoV-2 in vivo.[21]

Conclusions and Implications for Decision- or Policy-Making

One SR[14] and 3 primary studies (one RCT[15] and two observational studies[16,17]) were included to address the clinical effectiveness of ivermectin for the treatment and prevention of COVID-19. No studies regarding the cost-effectiveness of ivermectin for the treatment and prevention of COVID-19 were identified. Two well-conducted guidelines — one from Australia[18] and one from US[19] — were identified. The primary studies identified in this report including those within the SR were found to have high risk of bias, thus producing a very low quality of evidence that preclude the ability to draw any strong conclusions as whether ivermectin could reduce all-cause mortality, improve clinical symptoms and hospitalization, and enhance viral clearance in patients with COVID-19. The decision for the use of ivermectin to treat COVID-19 is currently discouraged by the included guidelines due to lack of strong evidence. It is possible that the inconsistency in the observed efficacy of ivermectin in recent human studies was in part due to insufficient concentration of the drug reached in the plasma of patients when the approved dose for parasitic infections was

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used to treat COVID-19. Well-conducted, dose-response trials are needed to provide reliable conclusions regarding the benefit and harms of ivermectin for the treatment and prevention of COVID-19. Until then, interpretations of existing evidence in this report should be taken with caution.

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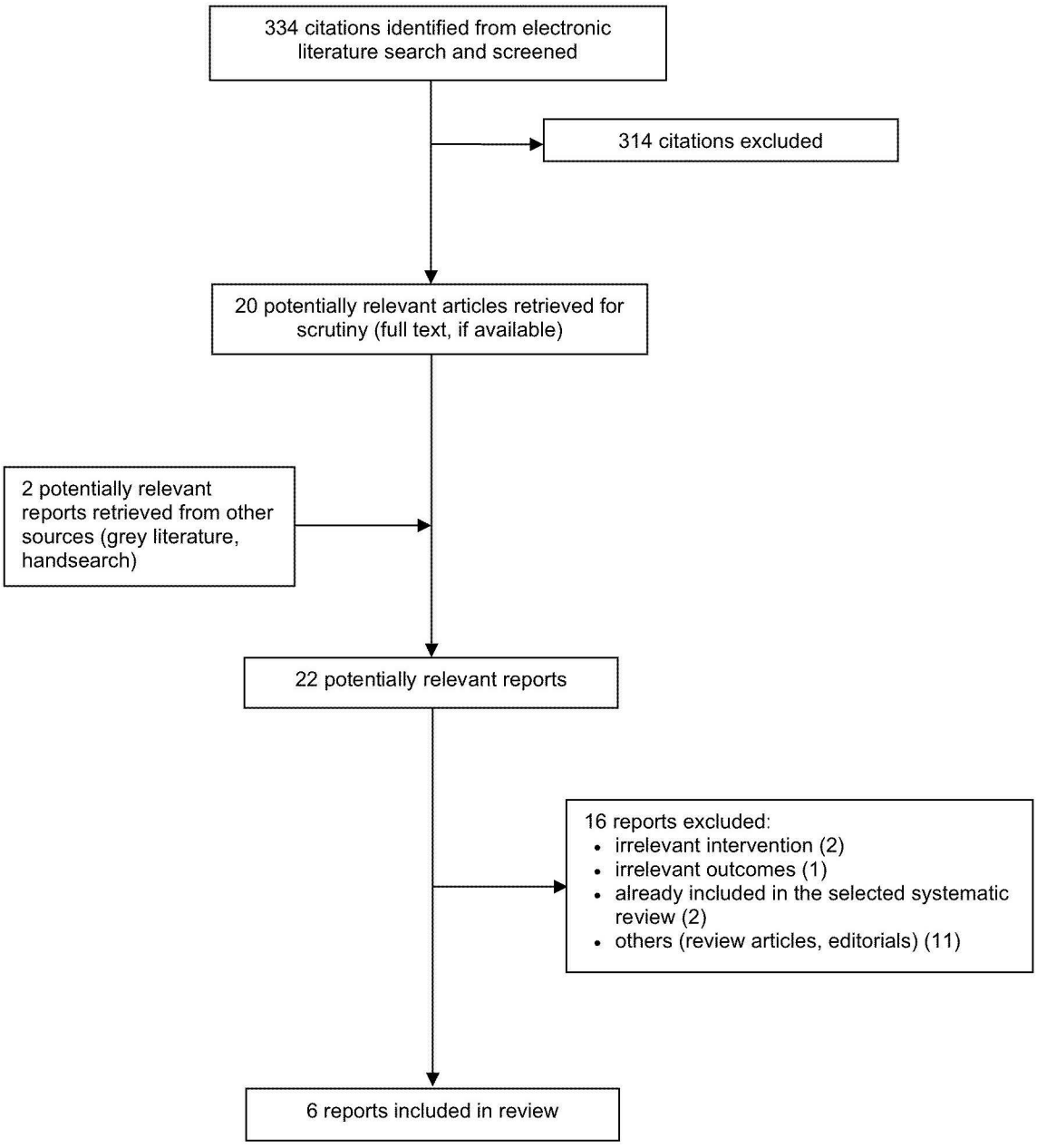
Appendix 1: Selection of Included Studies



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Appendix 2: Characteristics of Included Publications

Table 2: Characteristics of Included Systematic Review

First author, publication year, country, funding	Objectives, types and numbers of primary studies included quality assessment tool, databases and search date	Patient characteristics	Interventions and comparators	Outcomes and follow-up
Padhy et al. (2020)[14] India Funding: Not reported	Objective: To determine the therapeutic potential of ivermectin for the treatment of COVID-19 as add-on therapy Total 4 observational studies (N = 631 patients); 3 with control arm and 1 without control arm Quality assessment tool: ROBINS-I Grade of evidence: GRADE was used to assess the quality of the evidence Databases: PubMed, Embase, the Cochrane Library, SCOPUS, and Web of Science from their dates of inception to August 31, 2020 Data analysis: Random-effects meta-analysis	Adult patients with mild and moderate-to-severe cases of COVID-19 Comorbidities: Most patients had one or more comorbidities such as diabetes, hypertension, or bronchial asthma COVID-19 severity status: Mild, moderate-to-severe, asymptomatic, symptomatic Mean age: 53.3 years % Male: 59.5	Ivermectin (n = 397) • 233 mild cases • 104 moderate-to-severe cases • 11 asymptomatic • 49 symptomatic No ivermectin (n = 234) • 121 mild cases • 57 moderate-to-severe cases • 14 asymptomatic • 42 symptomatic Ivermectin dose: 200 mcg/kg, single dose. In one study, 13 patients received second dose of ivermectin Other therapies: hydroxychloroquine and azithromycin, doxycycline, or N-acetylcysteine and atorvastatin	Primary outcome: • Mortality Secondary outcomes: • Time to discharge • Clinical improvement (assessed by the need for respiratory support) • Viral clearance (assessed by RT-PCR) Follow-up: NR

COVID-19 = novel coronavirus disease 2019; GRADE = Grading of Recommendations Assessment, Development and Evaluation; NR = not reported; ROBINS-I = risk of bias in non-randomized studies of interventions; RT-PCR = reverse transcription–polymerase chain reaction.

Table 3: Characteristics of Included Primary Clinical Studies

First author, publication year, country, funding	Study design and analysis	Population characteristics	Intervention and comparator(s)	Clinical outcomes and follow-up
Ahmed et al. (2020)[15] Bangladesh Funding: Beximco Pharmaceutical Ltd., Bangladesh	Double-blind, parallel, 3 arms (1:1:1), placebo-controlled RCT Statistical analysis: Reported 95% CI and P values Sample size calculation: NR	Hospitalized adult patients diagnosed positive for COVID-19 (N = 72) COVID-19 severity status: NR Exclusion: Patients with chronic illnesses, were pregnant, or lactating	• Ivermectin alone (n = 24; 12 mg once daily for 5 days) • Ivermectin + doxycycline (n = 24; 12 mg ivermectin single dose and 200 mg doxycycline on day 1, followed by 100 mg every 12 hours for the next 4 days)	Primary outcomes: • Time required for viral clearance (assessed by RT-PCR) • Remission of fever (≥ 37.5oC) and cough within 7 days Secondary outcomes: • Failure to maintain an SpO2 > 93%

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First author, publication year, country, funding	Study design and analysis	Population characteristics	Intervention and comparator(s)	Clinical outcomes and follow-up
		Mean age: 42 years % Male: 46 Mean duration of illness before assessment: 3.83 days	• Placebo (n = 24; treatment not reported)	• Duration of hospitalization • All-cause mortality Safety: • AEs • Discontinuation of the study drug Follow-up: Until test-negative
Camprubi et al. (2020)[16] Spain Funding: The authors declared that they did not receive any specific funding	Retrospective chart review between March 10th and 30th 2020 in a hospital clinic in Barcelona, Spain Statistical analysis: Categorical variables were compared using chi-square test or Fisher's exact test; continuous variables were compared using Mann-Whitney-Wilcoxon test Sample size calculation: NR	Hospitalized patients diagnosed positive for COVID-19 (N = 26) COVID-19 severity status: NR Mean age: 43 years (41 to 49 years) in ivermectin group; 54 years (48 to 58 years) in control group % Male: 69.2% in ivermectin group; 61.5% in the control group	• Ivermectin (n = 13; 200 mcg/kg, single dose, plus immune-suppressant drugs such as corticosteroids or tocilizumab, and standard or care) • Control n = 13; (immune-suppressant drugs, and standard or care All patients received hydroxychloroquine, azithromycin, lopinavir/ritonavir	• Severe AEs • Positive test after 3 to 5 days of treatments • Improvement after 8 to 11 days of treatments • Discharged after 8 to 11 days of treatments • Remained in hospital after 8 to 11 days of treatments • Remained in ICU after 8 to 11 days of treatments
Hellwig and Maia (2020)[17] US Funding: NR	Retrospective databases review of data from countries that routinely deploy PCT using drugs including ivermectin From 2 publicly available databases, countries were grouped into 3 categories: those had ivermectin in their PCT, PCT treatment without ivermectin, and no PCT Statistical analysis: significance was adjusted using the Bonferroni method Sample size calculation: NR	NR	• Ivermectin in PCT • Other PCT • No PCT	Incidence of COVID-19

AE = adverse event; COVID-19 = novel coronavirus disease 2019; ICU = intensive care unit; NR = not reported; PCT = prophylactic chemotherapy; RCT = randomized controlled trial; RT-PCR = reverse transcription–polymerase chain reaction; SpO_2 = oxygen saturation.

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Table 4: Characteristics of Included Guidelines

Intended users, target population	Intervention and practice considered	Major outcomes considered	Evidence collection, selection, and synthesis	Evidence quality assessment	Recommendations development and evaluation	Guideline validation
NCCET (2020)[18]						
Intended users: Individuals responsible for the care of people with COVID-19 Target population: People with diagnosed or suspected COVID-19	Clinical management and care of people with suspected or confirmed COVID-19	Clinical efficacy and safety outcomes related to treatments, chemoprophylaxis, and care of patients with COVID-19	Key clinical questions in the management and care of people with COVID-19 were identified. Systematic methods were used to search for evidence, selection, and synthesis.	The risk of bias was assessed using the Cochrane Risk of Bias 2.0 assessment tool for RCTs, and the ROBINS-I risk of bias assessment tool for non-RCTs. The GRADE approach was used for assessing and rating the quality of evidence. The strength of the recommendation was rated based on the level of certainty of the evidence.[a]	The Evidence Review Team drafted the initial recommendations, which were then discussed, revised, and agreed on by the relevant guideline panels, approved by the Guideline Leadership Group, and endorsed by the Steering Committee. The guideline panels consisted of clinicians with clinical expertise relevant to the specific aspect(s) of care.	The guideline recommendations were reviewed and approved by a Steering Committee that was comprised of a representative from each of the member organizations the Chair of the National Guidelines Leadership Group and a representative of Cochrane Australia (Taskforce Secretariat).
NIH (2020)[19]						
Intended users: Health care workers who care for patients with COVID-19 Target population: Patients with COVID-19	Therapeutic management and care of patients with COVID-19	All clinical outcomes and safety related to the treatment and care of patients with COVID-19	Systematic methods were used to search for evidence and selection. Available data were critically reviewed and synthesized to develop recommendations.	Evidence was assessed based on the source of data, the study design, the quality and suitability of the methods, the number of participants, and the effect sizes. Each recommendation was rated with 2 letters: a letter (A, B, or C) indicates the strength of the recommendation[b] and a Roman numeral (I, II, or	Recommendations were developed by working groups of panel members with expertise in the area of each section. The working groups were responsible for reviewing and synthesized the available data. Recommendations were made based on	The panel members include representatives from federal agencies, health care and academic organizations, and professional societies. The guidelines are continuously updated based on the latest published research findings and evolving clinical information.

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Intended users, target population	Intervention and practice considered	Major outcomes considered	Evidence collection, selection, and synthesis	Evidence quality assessment	Recommendations development and evaluation	Guideline validation
				III) indicates the quality of the evidence[c]	scientific evidence and expert opinion.	

COVID-19 = novel coronavirus disease 2019; GRADE = The Grading of Recommendations Assessment, Development and Evaluation; NCCET = National COVID-19 Clinical Evidence Taskforce; NIH = National Institutes of Health; RCT = randomized controlled trial; ROBINS -I = risk of bias in non-randomized studies of interventions.

[a] Strength of Recommendation:

Strong for: Moderate- to high-certainty evidence suggests that benefits in critical outcomes clearly outweigh the reported harms.

Strong against: Moderate- to high-certainty evidence suggests harms outweigh benefits.

Conditional for: Moderate- to high-certainty evidence suggests equivalent benefits and harms, patients would mostly want to receive the practice, and there is no significant resources implication in doing so.

Conditional against: Moderate- to high-certainty evidence suggests equivalent benefits and harms, but there is expected large variation in patients' preference to receive this practice or important resource implications.

Consensus statement: Evidence is absent or of insufficient certainty.

[b] Strength of Recommendation:

A: Strong recommendation for the statement.

B: Moderate recommendation for the statement.

C: Optional recommendation for the statement.

[c] Quality of Evidence for the Recommendation:

I: One or more randomized trials with clinical outcomes and/or validated laboratory end points.

II: One or more well-designed, non-randomized trials or observational cohort studies.

III: Expert opinion.

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Appendix 3: Critical Appraisal of Included Publications

Table 5: Quality Assessment of Systematic Review Using AMSTAR 2 Checklist[10]

Item	Padhy et al. (2020)[14]
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Yes
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	Yes (A protocol was written according to PRISMA-P guidelines and registered in PROSPERO)
3. Did the review authors explain their selection of the study designs for inclusion in the review?	Yes (RCTs and observational studies reporting the use of ivermectin as add-on therapy in COVID-19 patients in the English language)
4. Did the review authors use a comprehensive literature search strategy?	Yes (5 databases were used)
5. Did the review authors perform study selection in duplicate?	Unclear (Not reported)
6. Did the review authors perform data extraction in duplicate?	Yes (3 reviewed authors independently and extracted and assessed the quality of the data)
7. Did the review authors provide a list of excluded studies and justify the exclusions?	No
8. Did the review authors describe the included studies in adequate detail?	Yes (Patient characteristics and dosages of treatment were described in adequate detail)
9. Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?	Yes (ROBINS-I was used to assess the risk of bias in non-randomized studies)
10. Did the review authors report on the sources of funding for the studies included in the review?	No
11. If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results?	Yes (Cochrane Program Review Manager 5.3 software was used for the meta-analysis. Random-effects modelling was used for data synthesis)
12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	No (This was due to the limited number of included studies whose quality was very low)
13. Did the review authors account for RoB in individual studies when interpreting/ discussing the results of the review?	Yes
14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?	Yes (I^2 values were provided for statistical heterogeneity)
15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?	Not applicable (Only 3 studies were included in the meta-analysis)

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Item	Padhy et al. (2020)[14]
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Yes (The authors declared that there was no conflict of interest)

AMSTAR 2 = A MeaSurement Tool to Assess systematic Reviews 2; COVID-19 = novel coronavirus disease 2019; PICO = Population, Intervention, Comparator, Outcomes; PRISMA-P = Preferred Reporting Items for Systematic review and Meta-Analysis Protocols; RCT = randomized controlled trial; ROBINS-I = risk of bias in non-randomized studies of interventions.

Table 6: Quality Assessment of Clinical Studies Using the Downs and Black Checklist[11]

Item	Ahmed et al. (2020)[15]	Camprubi et al. (2020)[16]	Hellwig and Maia (2020)[17]
Reporting			
1. Is the hypothesis/aim/objective of the study clearly described?	Yes (Determined the rapidity of viral clearance and safety of ivermectin among adult hospitalized patients with COVID-19)	Yes (Evaluated the efficacy of standard doses of ivermectin in severe COVID-19 patients)	Yes (Compared the incidence of COVID-19 between countries with routine mass drug administration of prophylactic chemotherapy with and without ivermectin)
2. Are the main outcomes to be measured clearly described in the Introduction or Methods section?	Yes (Outcomes were well described in the Methods section)	No (Outcomes were only reported in the Results section)	Yes (Main outcome was incidence of COVID-19)
3. Are the characteristics of the patients included in the study clearly described?	No (Only mean age, gender, and duration of illness before assessment were provided)	Yes	No (Only incidence was searched from databases)
4. Are the interventions of interest clearly described?	Yes (Dosage and duration of treatment of ivermectin were provided)	Yes (Dosage of treatment of ivermectin were provided)	No (No description on treatment dosage or duration of ivermectin)
5. Are the distributions of principal confounders in each group of subjects to be compared clearly described?	No (Details of patient characteristic were not clearly described)	No (List of principal confounders was not provided)	No
6. Are the main findings of the study clearly described?	Yes	Yes	Yes
7. Does the study provide estimates of the random variability in the data for the main outcomes?	Yes (95% CI was provided)	No (No standard error, standard deviation, or CI was reported)	No (No standard error, standard deviation, or CI was reported)
8. Have all important adverse events that may be a consequence of the intervention being reported?	No (Only mentioned that none of the patients had serious adverse events)	No (Only reported severe adverse events)	No
9. Have the characteristics of patients lost to follow-up been described?	NA (No patients lost to follow-up)	NA (Retrospective study)	NA (Retrospective study)

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Item	Ahmed et al. (2020)[15]	Camprubi et al. (2020)[16]	Hellwig and Maia (2020)[17]
10. Have actual probability values been reported (e.g. 0.035 rather than < 0.05) for the main outcomes except where the probability value is less than 0.001?	Yes (Actual P values were reported)	Yes (Actual P values were reported)	Yes (Actual P values were reported)
External validity			
11. Were the subjects asked to participate in the study representative of the entire population from which they were recruited?	Unclear (Only 72 hospitalized patients were enrolled)	Unclear (Only 26 hospitalized patients were enrolled)	Unclear (Not reported)
12. Were the subjects who were prepared to participate representative of the entire population from which they were recruited?	Unclear	Unclear	Unclear (Not reported)
13. Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of the patients receive?	Yes (Treatment was conducted in hospital)	Yes (Treatment was conducted in hospital)	NA (Database search for incidence)
Internal validity – bias			
14. Was an attempt made to blind study subjects to the intervention they have received?	Yes (Double-blind)	NA (Retrospective study)	NA (Retrospective study)
15. Was an attempt made to blind those measuring the main outcomes of the intervention?	Yes (Double-blind)	NA (Retrospective study)	NA (Retrospective study)
16. If any of the results of the study were based on "data dredging", was this made clear?	Yes (No retrospective unplanned subgroup analyses were reported)	NA (Retrospective study)	NA (Retrospective study)
17. In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?	Yes (Follow-up was carried out until test-negative)	NA (Retrospective study)	NA (Retrospective study)
18. Were the statistical tests used to assess the main outcomes appropriate?	Yes	Yes	Yes
19. Was compliance with the intervention/s reliable?	NA (Treatment was carried out in hospital)	NA (Treatment was carried out in hospital)	NA (Retrospective study)
20. Were the main outcome measures used accurate (valid and reliable)?	Yes	Yes	Yes
Internal validity – confounding (selection bias)			
21. Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?	Yes (Both groups were recruited from the same hospital)	Yes (Both groups were from the same hospital)	No (Comparison between different countries)
22. Were study subjects in different intervention groups (trial and cohort studies) or were the cases and controls	Yes (During the pandemic)	Yes (Between March 10th and 30th 2020)	Yes (During the pandemic)

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Item	Ahmed et al. (2020)[15]	Camprubi et al. (2020)[16]	Hellwig and Maia (2020)[17]
(case-controls studies) recruited over the same period of time?			
23. Were study subjects randomized to intervention groups?	Yes (RCT)	No	No
24. Was the randomized intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?	Unclear (There was no report on concealment allocation)	NA (Retrospective study)	NA (Retrospective study)
25. Was the adequate adjustment for confounding in the analyses from which the main findings were drawn?	Probably no (Patient characteristics were not clearly described)	No (No adjustment for confounding factors in the analyses)	No (No adjustment for confounding factors in the analyses)
26. Were losses of patients to follow-up taken into account?	NA (No loss to follow-up)	NA (Retrospective study)	NA (Retrospective study)
27. Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?	Unclear (Sample size calculation was not provided)	Unclear (Sample size calculation was not provided)	Unclear (Sample size calculation was not provided)

CI = confidence interval; COVID-19 = novel coronavirus disease 2019; NA = not applicable; RCT = randomized controlled trial.

Table 7: Quality Assessment of Guidelines Using AGREE II[12]

Item	NCCET (2020)[18]	NIH (2020)[19]
Domain 1: Scope and Purpose		
1. The overall objective(s) of the guideline is (are) specifically described.	Yes	Yes
2. The health question(s) covered by the guideline is (are) specifically described.	Yes	Yes
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.	Yes	Yes
Domain 2: Stakeholder Involvement		
4. The guideline development group includes individuals from all relevant professional groups.	Yes	Yes
5. The views and preferences of the target population (patients, public, etc.) have been sought.	Yes	Unclear
6. The target users of the guideline are clearly defined.	Yes	Yes
Domain 3: Rigour of Development		
7. Systematic methods were used to search for evidence.	Yes	Yes
8. The criteria for selecting the evidence are clearly described.	Yes	Yes
9. The strengths and limitations of the body of evidence are clearly described.	Yes	Yes
10. The methods for formulating the recommendations are clearly described.	Yes	Yes
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.	Yes	Yes
12. There is an explicit link between the recommendations and the supporting evidence.	Yes	Yes
13. The guideline has been externally reviewed by experts prior to its publication.	Unclear (The guideline was posted on its website)	Unclear (The guideline was posted on its website)

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Item	NCCET (2020)[18]	NIH (2020)[19]
14. A procedure for updating the guideline is provided.	Yes	Yes
Domain 4: Clarity of Presentation		
15. The recommendations are specific and unambiguous.	Yes	Yes
16. The different options for management of the condition or health issue are clearly presented.	Yes	Yes
17. Key recommendations are easily identifiable.	Yes	Yes
Domain 5: Applicability		
18. The guideline describes facilitators and barriers to its application.	Yes	Yes
19. The guideline provides advice and/or tools on how the recommendations can be put into practice.	Yes	Yes
20. The potential resource (cost) implications of applying the recommendations have been considered.	Unclear	Unclear
21. The guideline presents monitoring and/or auditing criteria.	Yes	Yes
Domain 6: Editorial Independence		
22. The views of the funding body have not influenced the content of the guideline.	Yes	Yes
23. Competing interests of guideline development group members have been recorded and addressed.	Yes	Yes

AGREE II = Appraisal of Guidelines for Research & Evaluation II.

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Appendix 4: Main Study Findings and Authors' Conclusions

Table 8: Summary of Findings in Included Systematic Review

Main Study Findings	Authors' Conclusions
Padhy et al. (2020)[14]	
Ivermectin (20 mcg/kg, single dose) versus non-ivermectin All-cause mortality (3 studies): • OR (95% CI) = 0.53 (0.29 to 0.96); I^2 = 0%; P = 0.04 • RD (95% CI) = 54 fewer per 1,000 (3 fewer to 85 fewer) • Quality of evidence: very low Clinical improvement (3 studies): • OR (95% CI) = 1.95 (1.09 to 3.49); I^2 = 0%; P = 0.02 • RD (95 % CI) = 61 more per 1,000 (from 12 more to 91 more) • Quality of evidence: very low Time to discharge from the hospital (3 studies; no MA due to different data reported): • 1 study: 7.62 ± 2.75 days in ivermectin group versus 13.22 ± 5.90 days in non-ivermectin group; P = 0.00005 • Other 2 studies: No significant difference in time to discharge between groups Time to viral clearance (2 studies): • 1 study: 7 days in ivermectin group versus 12 days in ivermectin group; P = 0.001 • Another study: No significant difference between groups	*"Ivermectin is an established drug with a long history of clinical use and with minimal safety concern. Recent observational studies have reported the effectiveness of this drug as add-on therapy in patients with COVID-19. Our meta-analysis also supports this finding and suggests the modest utility of ivermectin in reducing all-cause mortality and improving clinical outcomes. Currently, many clinical trials are ongoing, and definitive evidence for repurposing this drug for COVID-19 patients will emerge only in the future."*[14] (p. 468)

CI = confidence interval; COVID-19 = novel coronavirus disease 2019; MA = meta-analysis; OR = odd's ratio; RD = risk difference.

Table 9: Summary of Findings of Included Primary Clinical Studies

Main Study Findings	Authors' Conclusions
Ahmed et al. (2020)[15]	

Ivermectin alone (12 mg once daily for 5 days) versus ivermectin + doxycycline versus placebo
 	
Time required for virological clearance:
• Ivermectin alone: 9.7 days (95% CI, 7.8 to 11.8 days); P = 0.02 compared with placebo
• Ivermectin + doxycycline: 11.5 days (95% CI, 9.8 to 13.2 days); P = 0.27 compared with placebo
• Placebo: 12.7 days (95% CI, 11.3 to 14.2 days)
• Ivermectin alone versus placebo:
  ○ On day 7: HR (95% CI) = 4.1 (1.1 to 14.7); P = 0.03
  ○ On day 14: HR (95% CI) = 2.7 (1.2 to 6.0); P = 0.02
• Ivermectin + doxycycline versus placebo:
  ○ On day 7: HR (95% CI) = 2.3 (0.6 to 9.0); P = 0.22
  ○ On day 14: HR (95% CI) = 1.7 (0.8 to 4.0); P = 0.19
 	
Fever:
• At enrolment, proportion of patients had fever:
  ○ Ivermectin alone: 77.3% (17/22)
  ○ Ivermectin + doxycycline: 73.9% (17/23)
  ○ Placebo: 82.6% (19/23)
	"Although the study sample was too small (n = 72) to draw any solid conclusions, the results provide evidence of the potential benefit of early intervention with the drug ivermectin for the treatment of adult patients diagnosed with mild COVID-19."[15] (p. 216)

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Main Study Findings	Authors' Conclusions

• At day 7, proportion of patients had no fever:
  ○ Ivermectin alone: 100% (17/17); P = 0.35 compared with placebo
  ○ Ivermectin + doxycycline: 94.1% (16/17); P = 0.09 compared with placebo
  ○ Placebo: 84.2% (16/19)
 	
Cough:
• At enrolment, proportion of patients who had cough:
  ○ Ivermectin alone: 81.8% (18/22)
  ○ Ivermectin + doxycycline: 82.6% (19/23)
  ○ Placebo: 65.2% (15/23)
• At day 7, proportion of patients whose coughing had subsided:
  ○ Ivermectin alone: 61.1% (7/18); P = 0.18 compared with placebo
  ○ Ivermectin + doxycycline: 63.2% (7/19); P = 0.23 compared with placebo
  ○ Placebo: 40% (9/15)
 	
Sore throat:
• At enrolment, proportion of patients with sore throat:
  ○ Ivermectin alone: 18.2% (4/22)
  ○ Ivermectin + doxycycline: 13% (3/23)
  ○ Placebo: 17.4% (4/23)
• At day 7, proportion of patients whose sore throats had subsided:
  ○ Ivermectin alone: 75% (3/4); P = 0.35 compared with placebo
  ○ Ivermectin + doxycycline: 33.3% (1/3); P= 0.09 compared with placebo
  ○ Placebo: 75% (3/4)
 	
Failure to maintain SpO_2:
• None of the enrolled patients required oxygen
 	
Mean duration of hospitalization:
• Ivermectin alone: 9.6 days (95% CI, 7.7 to 11.7 days); P = 0.93 compared to placebo
• Ivermectin + doxycycline: 10.1 days (95% CI, 8.5 to 11.8 days); P = 0.93 compared to placebo
• Placebo: 9.7 days (95% CI, 8.1 to 11.0 days)
 	
Safety
• No serious drug-related AEs
• No death	

Camprubi et al. (2020)[16]	

Ivermectin (20 mcg/kg, single dose) versus control:
 	
• Other severe AEs:
  ○ Ivermectin: 4 (30.8%); Control: 3 (23.1%); P = 1.000
• Positive test 3 to 5 days after treatment:
  ○ Ivermectin: 5 (38.5%); Control: 4 (30.8%); P = 1.000
• Improvement 8 to 11 days after treatment:
  ○ Ivermectin: 9 (69.2%); Control: 10 (76.9%); P = 1.000
• Discharged 8 to 11 days after treatment:
  ○ Ivermectin: 7 (53.8%); Control: 6 (46.1%); P = 1.000
• Hospitalized 8 to 11 days after treatment:
  ○ Ivermectin: 4 (30.8%); Control: 4 (30.8%); P = 1.000
	"No relevant differences in microbiological or clinical outcomes were observed between groups."[16] (p. 4)

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Main Study Findings	Authors' Conclusions
• ICU 8 to 11 days after treatment: ○ Ivermectin: 2 (15.4%); Control: 3 (23.1%); P = 1.000	
Hellwig and Maia (2020)[17]	

PCT with ivermectin versus other PCT versus no PCT
 	
• Countries around the world that had included ivermectin in their PCT had significantly lower incidences of COVID-19 (cases per 100,000) compared to countries with no PCT.
  ○ On 15 April 2020; adjusted P < 0.01
  ○ By 15 June 2020; adjusted P < 0.001
• Among African countries, those that routinely used ivermectin in their PCT against parasitic infections had significantly lower incidences of COVID-19 compared to countries with no PCT (P ≤ 0.05).
• There was a statistically significant correlation between PCT with ivermectin and lower incidence of COVID-19 (P = 0.017) among African countries.
• No statistical comparison was made between PCT with ivermectin and other PCT.
	"It is important to note that the hypothesis that ivermectin might have a prophylactic effect against SARS-CoV-2 is merely based on a rather strong correlation. On the other hand, this correlation has grown increasingly stronger in the worldwide data set earlier this year and then been independently replicated within the African dataset later in the summer. Both remain highly significant, suggesting that there may be a causal connection, which is also suggested by other recent findings reported in the literature."[17] (p. 4)

AEs = adverse events; CI = confidence interval; COVID-19 = novel coronavirus 2018; HR = hazard ratio; ICU = intensive care unit; PCT = prophylactic chemotherapy; SARS-CoV-2 = severe acute respiratory syndrome coronavirus-2; SpO_2 = oxygen saturation.

Table 10: Summary of Recommendations in Included Guidelines

Recommendations and supporting evidence	Quality of evidence and strength of recommendations
NCCET (2020)[18]	
"Do not use ivermectin for the treatment of COVID-19 outside of randomised trials with appropriate ethical approval."[18] Supporting evidence: • Evidence came from 3 randomized trials that compared ivermectin with standard care in 287 adults with COVID-19. Two studies are only available as preprints that have not been peer-reviewed. • The authors of the guidelines were uncertain regarding the clinical efficacy (mortality, rate of viral clearance, time to clinical recovery, and length of hospital stay) and safety (adverse or serious adverse events) of ivermectin.	Quality of evidence: very low Strength of recommendation: not recommended
NIH (2020)[19]	
"The COVID-19 Treatment Guidelines Panel ***recommends against*** *the use of* ***ivermectin*** *for the treatment of COVID-19, except in a clinical trial"*[19] (p. 95) Supporting evidence: • Ivermectin is not approved for the treatment of any viral infection, including COVID-19 infection. The FDA issued a warning in April 2020 that ivermectin intended for use in animals should not be used to treat COVID-19 in humans. • A retrospective study that has not been peer-reviewed analyzed the use of ivermectin in patients with COVID-19. Consecutively admitted patients who were admitted to 4 hospitals in Florida received at least 1 dose of ivermectin of 200 mcg/kg (n = 173) or received usual care (n = 103). Most patients in each group received hydroxychloroquine and azithromycin. The study found that patients in the ivermectin group had significantly lower all-cause mortality (OR = 0.27; P = 0.03) compared to the usual care group, without a significant difference in the hospital length of stay or the proportion of ventilated patients who were	Quality of evidence: III Strength of recommendation: A

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Recommendations and supporting evidence	Quality of evidence and strength of recommendations
successfully extubated between groups. The mortality benefit appeared to be limited to the subgroup of patients with severe disease.	

COVID-19 = novel coronavirus disease 2019; NCCET = National COVID-19 Clinical Evidence Taskforce; NIH = National Institutes of Health; OR = odd's ratio.

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Appendix 5: Preliminary Reports — Not Peer-Reviewed

1. Hashim HA, Maulood MF, Rasheed AM, et al. Controlled randomized clinical trial on using ivermectin with doxycycline for treating COVID-19 patients in Baghdad, Iraq **[non peer-reviewed preprint]**. medRxiv; 2020: doi: 10.1101/2020.10.26.20219345. https://www.medrxiv.org/content/10.1101/2020.10.26.20219345v1. Accessed 2021 Feb 1.
2. Behera P, Patro BK, Singh AK, et al. Role of ivermectin in the prevention of COVID-19 infection among healthcare workers in India: a matched case-control study **[non peer-reviewed preprint]**. medRxiv; 2020: doi: 10.1101/2020.10.29.20222661. https://www.medrxiv.org/content/10.1101/2020.10.29.20222661v1. Accessed 2021 Feb 1.
3. Carvallo HE, Hirsch RR, Farinella ME. Safety and efficacy of the combined use of ivermectin, dexamethasone, enoxaparin and aspirin against COVID-19 **[non peer-reviewed preprint]**. medRxiv; 2020:doi: 10.1101/2020.09.10.20191619. https://www.medrxiv.org/content/10.1101/2020.09.10.20191619v1. Accessed 2021 Feb 1.
4. Morgenstern J, Redondo JN, De Leon A, et al. The use of compassionate ivermectin in the management of symptomatic outpatients and hospitalized patients with clinical diagnosis of COVID-19 at the Medical Center Bournigal and the Medical Center Punta Cana, Rescue Group, Dominican Republic, from May 1 to August 10, 2020 **[non peer-reviewed preprint]**. medRxiv; 2020: doi: 10.1101/2020.10.29.20222505. https://www.medrxiv.org/content/10.1101/2020.10.29.20222505v1. Accessed 2021 Feb 1.
5. Cadeginani FA, Goren A, Wambier CG, McCoy J. Early COVID-19 therapy with azithromycin plus nitazoxanide, ivermectin or hydroxychloroquine in outpatient settings significantly reduced symptoms compared to known outcomes in untreated patients **[non peer-reviewed preprint]**. medRxiv; 2020: doi: 10.1101/2020.10.31.20223883. https://www.medrxiv.org/content/10.1101/2020.10.31.20223883v1. Accessed 2021 Feb 1.
6. Soto-Becerra P, Culquichicon C, Hurtado-Roca Y, Araujo-Castilo RV. Real-world effectiveness of hydroxychloroquine, azithromycin, and ivermectin among hospitalized COVID-19 patients: results of a target trial emulation using observational data from a nationwide healthcare system in Peru **[non peer-reviewed preprint]**. medRxiv; 2020: doi: 10.1101/2020.10.06.20208066. https://www.medrxiv.org/content/10.1101/2020.10.06.20208066v3. Accessed 2021 Feb 1.

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Trojanovic, Julia (HC/SC)

From: MinFinance / FinanceMin (FIN) <minfinance-financemin@fin.gc.ca>
Sent: 2021-12-06 11:54 AM
To: [redacted]icloud.com
Cc: HCMinister.MinistreSC@canada.ca
Subject: FW: Health Canada Special Access Program - Request for Ivermectin use forCovid using New Evidence Oct,8, 2021.pdf
Attachments: Health Canada Special Access Program - Request for Ivermectin use forCovid using New Evidence Oct,8, 2021.pdf

Dear Ms. [redacted]

Thank you for your correspondence of December 5, 2021, addressed to the Deputy Prime Minister and Minister of Finance, the Honourable Chrystia Freeland.

The matter you raise falls more directly within the jurisdiction of the Minister of Health, the Honourable Jean-Yves Duclos. Therefore, we have forwarded a copy of your correspondence to his office.

Thank you for writing.

Sincerely,

Nathalie Gauthier
Manager
Consultations and Communications Branch

From: [redacted]@icloud.com>
Sent: Sunday, December 5, 2021 8:06 AM
To: Freeland, Chrystia - M.P. <Chrystia.Freeland@parl.gc.ca>
Cc: Long, Wayne - Assistant 1 <Wayne.Long.A1@parl.gc.ca>; Long, Wayne - Assistant 2 <Wayne.Long.A2@parl.gc.ca>; Long, Wayne - M.P. <Wayne.Long@parl.gc.ca>; Moore, Rob - M.P. <Rob.Moore@parl.gc.ca>; Bennett, Carolyn - M.P. <carolyn.bennett@parl.gc.ca>; [redacted]Webber, Len - M.P. <Len.Webber@parl.gc.ca>
Subject: Health Canada Special Access Program - Request for Ivermectin use forCovid using New Evidence Oct,8, 2021.pdf

OPEN ACCESS email

Dear Chrystia Freeland,

I have requested Ivermectin from Health Canada and/or Merck Canada for the clinical management of Covid-19 (attached). The money from Bill C-2 will be needed to secure this drug and to support NEW Canadian research. DEAD people cannot vote. Perhaps you need to go back to cast a REVOTE. Rob Moore did has a NAY vote and he just needed clarification.

Any questions, feel free to contact me directly. I have requested HEALTH CANADA to STOP the vaccine nonsense secondary to premature and preventable DEATH and other adverse side effects.

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You reply will be most appreciated. This email should be coming from MP Wayne Long or MP Rob Moore but [redacted]

😀.

[redacted] President & CEO
[redacted] Inc.
Website: [redacted].com

Sent from my iPad, [redacted] NB, Canada

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Health Canada / Santé Canada

Protected B when completed

Special Access Program
Form A - Patient specific request - C08.010(1)

Section A: Practitioner information

Practitioner's r[redacted]

Hospital or clinic na[redacted]

City: [redacted] Province: New Brunswick Postal Code: E[redacted]

Telephone #: [redacted] Fax #: ____

Email: [redacted]c/bud.com

If alternate contact is available complete section below

Alternate contact name: (First Last)

Telephone #: Fax #:

Email:

Shipping information as above

Send drug c/o: Correctional Facility

- X In-patient hospital pharmacy
- O Blood bank
- X Practitioner's office
- O Government agency depot
- O Nuclear medicine
- X Community Pharmacy

Shipping address: Saint John Regional Hospital
P.O. Box 2100
Saint John, NB E2L 4L2

City: Saint John Province: NB Postal Code: E2L 4L2

Telephone #: 506.648.6000 Fax #:

Section B: Drug and manufacturer information

Manufacturer: (name and location) Merck Canada
514.428.7920

Trade name: Ivermectin

Other name(s):

PO#:

Route of administration: X Oral O I.V. O I.M. O Topical O S.C. O Other:

Dosage form: X Tab O Cap O Liquid O Powder O Cream O Oint. O Patch O Other:

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Section C: Transfer of supply

Note: Authorization by the SAP and the manufacturer is required prior to transfer of supply to another patient
Transfer to another patient must be for the same medical emergency

Do you have a supply of the drug on hand and would like to transfer it to another patient? O Yes X No
If no, please move to Section D.

1) Please specify the request number of the initial request and the original patient initials being transferred:
N/A

2) Please specify to where the supply is being transferred:
See Cover

3) Please specify the patient initials of the patient to whom the supply is being transferred:
breach of confidentiality.

4) Please specify the total quantity of stock being transferred: (e.g. #tabs, vials, bottles, etc.)
not a transfer request

Section D: Patient information

Note: To ensure the patient's confidentiality, please do not indicate the patient's full name

X Please check this box if your patient is critically or terminally ill.

Patient initials (First .Last) (e.g. J.S)	Unborn child?	Date of birth (mm/dd/yyyy)	Sex	Exact indication for use of drug	Dosage form	New or Repeat patient via the SAP for this drug	Dosage and duration (e.g. #mg bid x #days)	Strength (e.g. #mg)
	O Yes O No		O Male O Female O Other			O New O Repeat		
	O Yes O No		O Male O Female O Other			O New O Repeat		

Please specify the **exact amount** of drug requested (e.g. number of tabs, vials, units, etc.) for each patient.

The SUM of the quantities for all patients must also be specified. The SAP will not calculate quantity.
Total:
wt based ∴ unable to comply ☐ request

Please specify the date at which you plan to administer / dispense the drug: Symptomatic Covid Patients or asymptomatic but tested positive.
2020/11/06

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Section E: Clinical rationale

i.e. details concerning the medical emergency for which the new drug is required

1) For **new** patients:

a) Provide below any relevant clinical information on the patient's current condition, medical history and co-morbidities. What specifically about this drug (e.g. mechanism of action, drug class, dosage form) makes it the best choice for your patient(s)?

Not available yet

- CALL For Electronic medical record in a Pandemic!!

2020/11/06

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b) Specify all treatments tried and/or failed, including details on dosage, duration and clinical response. For treatment options that have been ruled out on clinical grounds, please specify and explain.

see attached
- steroids used but not helpful.

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☐ I, the practitioner, have verified that the drug & indication that I am requesting is authorized by the European Medicines Agency or the United States Food and Drug Administration.

In the case of other drugs

c) Please provide recent and relevant data, references, and/or resources in your possession with respect to the use, safety, and efficacy of the drug. The supporting evidence must be directly relevant to the medical emergency specified, be from credible medical/scientific information sources. For citations, please include author(s), title, journal, volume, issue, date, and page information.

☐ Check if reference(s) is/are attached

World Health Organization (2019) Essential Medicines List

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2) For **repeat** patients:

a) Describe your patient(s)'s response to the drug relative to the initial treatment goal(s);

N/A

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b) Provide a rationale for requesting continued access.

See attached

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Section F: Practitioner attestation & signature

I, the practitioner, attest that I am accessing this non-marketed drug for use in the emergency treatment of a patient under my care in accordance with the *Food and Drug Regulations* C.08.010 and I attest that the patient's condition is considered to be serious or life-threatening.

I, the practitioner, attest that other therapies have been tried and failed or are considered medically inappropriate or are unavailable on the Canadian market at this time.

I, the practitioner, am aware that by accessing this drug through the SAP, the sale of the drug is exempt from all aspects of the *Food and Drugs Regulations* including those respecting the safety, efficacy and quality.

I, the practitioner, agree to provide a report on the results of the use of the drug including information on Adverse Drug Reactions and, on request, to account for quantities of the drug received.

I, the practitioner, attest that the drug supply will be administered to identified patients and will maintain records of those patients including the indication, quantity released, and the date the drug was administered and will provide them to Health Canada upon request.

By signing below, I certify that all information is true and correct to the best of my knowledge.

[redacted]

Practitioner licence # or College licence #: None → does c/licence should have ordered.

Date: Oct 8/2021

Special Access Program, Therapeutic Products Directorate
c/o Health Canada, AL 3105 A, Tunney's Pasture, Ottawa, ON K1A 0K9

Regular business hours are weekdays from 8:30 am to 4:30 pm Eastern Standard Time (EST) **Fax** all requests to **(613) 941-3194**

For after hours and urgent requests requiring immediate attention please follow up with a call to the SAP at: (613) 941-2108

Website: www.healthcanada.gc.ca/sap | **Email:** hc.sapd-pasm.sc@canada.ca

Privacy notice

The personal information you provide to Health Canada is governed in accordance with the *Privacy Act* and is collected pursuant to section C.08.010 (1) of the Food and Drug Regulations. The information is used for the purpose of assessing requests for access to drugs under the Sale of New Drug for Emergency Treatment provisions of the *Food and Drug Regulations*.

Pursuant to subsection C.08.010 (1)(b) of the *Food and Drug Regulations*, the practitioner agrees to report to Health Canada and the manufacturer results of the use of the drug in the medical emergency, including information respecting any adverse reactions encountered. This information is used for the processing of requests and may contribute to the detection of potential product-related safety issues as well as to the benefit-risk assessments of these products.

In limited and specific situations, your personal information may be disclosed without your consent in accordance with subsection 8(2) of the Privacy Act. This personal information collection is described in InfoSource, available online at www.infosource.gc.ca. Refer to Personal Information Bank Special Access Programme - Pharmaceuticals, Biologic and Radio-Pharmaceuticals [HC PPU 414].

In addition to protecting your personal information, the *Privacy Act* gives you the right to request access to and correction of your personal information. For more information about these rights, or about our privacy practices, please contact Health Canada's Privacy Coordinator at 613-946-3179 or privacy-vie.privee@hc-sc.gc.ca. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

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Tragedy In Rural Alberta, A Courageous Doctor Speaks Out .

OCTOBER 3, 2021OCTOBER 5, 2021 / BRIANPECKFORD

On the Steps of the Vancouver Art Gallery on Friday evening past , celebrating the 75 Anniversary of the Nuremberg Code, Dr. Nagase gave this Powerful Speech .

Mater of Ceremonies : Joseph Roberts , Publisher and Founder of Common Ground Magazine

Dr. Daniel Nagase has been a doctor for over 15 years, he graduated from Dalhousie Medical School in 2004.
He has been an emergency doctor for 10 years and has been working in rural underserviced communities throughout Alberta since 2015.
He has a story he'd like to share with you about what happened after he gave Covid patients Ivermectin in a small hospital west of Red Deer.

Thank you Joseph,

It is wonderful to see all of you here remembering Nuremburg.

And that's the key here, remembering.
Not just the nurses and doctors that are helping by speaking the Truth, people like Dr. Charles Hoffe in Lytton,

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But also to remember the doctors in hospital administration, the doctors at the college of physicians and surgeons, the doctors you see on TV that are standing in the way of life saving medicaitons,

Let me tell you what happened in Rimbey Alberta, a small town couple hours west of Red Deer. It shocked me.
I started on Saturday morning in the ER, and when it came time to round on the ward patients, the charge nurse informed me that 3 of the patients on the COVID wing had deteriorated overnight.

All the patients were on Oxygen and extremely short of breath. The only medication these patients were on were steroids.

A Medication that will decrease inflammation but increase the chances of a bacterial infection by suppressing the immune system.

That's right, the only medication the covid patients at this hospital were on were immune suppressants.

One woman said it felt like we just put her in a corner to die. We weren't doing anything for her.

I told her, I can't speak for the usual doctors during the week, but it's the weekend, and I'll do everything I can to help.

I offered Ivermectin. She wanted to try it because she heard nothing but good things about it. All 3 patients wanted to try ivermectin.

The hospital didn't have any, so we had to ask Red Deer Hospital's Central Pharmacy for the medication.

They refused to send Ivermectin. Red Deer's central pharmacist said Ivermectin was useless for COVID.

He even had the Pharmacy Director for All of Alberta contact me to tell me Ivermectin didn't work.
The Pharmacy Director for Alberta Health services is Dr. Gerald Lazarenko. Remember that name.
He is both a Pharmacist and a Doctor. And he insisted that Ivermectin had no place in the treatment of COVID. Really?

So we checked the local pharmacies. And God bless that charge nurse, although both pharmacies in town did not have ivermectin, there was one pharmacist who would do everything he could to get some even if it took all day.

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We didn't have all day, my patients were sick. So I started everyone on the next best thing, Hydroxychloroquine which the hospital did have.

I also started Vitamin C, Vitamin D, and Zinc.

And because the patients were coughing and short of breath I gave them inhalers… Salbutamol and Flovent, the same inhalers that have been used for asthma for over 50 years.

I also gave them Azithromycin.

Surprisingly by late afternoon, the town pharmacist finally found some ivermectin.

He couldn't get it from his usual chemical supply, because it was a Saturday. He had to get it from an agricultural supply.
He checked to make sure that it was the exact same Ivermectin a pharmacist would give to a person, brought it back to his pharmacy and checked it again.
He then called me with the good news.

I handed Ivermectin to each of my 3 patients with their exact dose of according to their weight.

And you'll never guess what happened next.

Within hours of getting Ivermectin, I got a call from the Central Zone medical director. Dr Jennifer Bestard.

She called me to tell me I was forbidden from giving Ivermectin to patients. Really!!

I told her she's never met the patients, she's not their doctor, and had no right to be changing the care of my patients without the patient's permission.

She said Ivermectin was forbidden from the hospital. Even if the patients had their own Ivermectin. (Which I would have happily given to a relative so they could to hand it over to them), Patients would not be allowed to take their own ivermectin.
She said it was a violation of Alberta Health Services Policy to give Ivermectin for COVID.

But that wasn't good enough. The next day she called the hospital and gave me 15 minutes notice that I would be relieved of my duties.

I told her that it was unreasonable. I had an emergency department full of patients who can't be sorted out in 15 minutes.

An hour later another local doctor came to replace me.

They didn't even want me to check up on the patients who I gave Ivermectin to.

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Not even 24 hours after getting Ivermectin, 2 out of my 3 patients were almost completely better. They were out of bed walking around and all the crackles I heard in their lungs from the day before were gone.

All it took was about 18 hours and 1 dose of Ivermectin.

The third patient who was 95 years old, stayed the same. She didn't get any worse like she had done the night previous.

I found out later that no sooner had I left Rimbey hospital, the next doctor who came to replace me stopped the antibiotics, stopped all the vitamins, she even stopped the patients inhalers.

Within hours of my leaving the hospital this doctor even took away the patient's inhalers, to help her breathe.

The patients were not even allowed vitamins.

Thankfully, both my 70 year old patients who had immediate recoveries after a single dose of ivermectin left the hospital that week.

(I'd like to speak briefly to the healthcare professionals in the crowd)
No doctor would take away antibiotics and inhalers for ANY viral pneumonia, never mind COVID. No doctor would do that to ANY patient with a pneumonia. Unless they were… Well I'll let you think about that. We are remembering Nuremburg after all.
And for healthcare professionals, I want us all to think very deeply about that.

But it gets worse, In my brief day and a half in the small town of Rimbey, I saw 2 patients who had recently been discharged from Red Deer Hospital after being on the COVID ward.
They were sent home with NOTHING. Not even an inhaler.

These patients ended up in ER at a small hospital wanting help. Just days after being sent home from a tertiary care hospital with nothing.

There is something malicious going on. I hope you can all see the bigger picture.

This is more than me having all my assignments to take care of small communities cancelled for the rest of the year.

This is more than the medical director, Dr. Fraincois Belanger banning me from hospital practice throughout all of Alberta.

Just a week after giving ivermectin and then filing a complaint against the Alberta Pharmacy Director,
a complaint sent to the College of Physicians and Surgeons, about the Pharmacy director for an

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entire province denying 11 pages of studies showing 0% mortality for patients given Ivermectin.

In study after study after study, 0% mortality, 0% mortality, 0% mortality… with Ivermectin.

And in "Severe" COVID? A 50% reduction in mortality with Ivermectin.

This is all in Albertat Health Services own Ivermectin report.

Just a week after I filed a complaint that Dr. Gerald Lazarenko was withholding a life saving medication from an entire province, the Alberta college of physicians and Surgeons forbade doctors and pharmacists from giving patients ivermectin.

We must remember.
We are here to remember.
Not just the people who died from medical experimentation.

We are here to remember the people today.
We are here to remember every single doctor, lawyer, and medical ethicist that sits on the board of the BC college who is investigating Dr. Charles Hoffe for speakng the truth.

We are here to remember every doctor who stopped patients from having a live saving medication.

And what for? To boost mortality? To create an ICU "crisis"? To create a state of emergency?

All to push a vaccine?

We must remember, the people of the past. And the people of today.

History repeats itself.
Nuremburg will happen again.
We must remember.

P.S. Because of the hundreds of thousands who have visited this article and though I have added additional information in subsequent articles on this blog perhaps I should post some of that info right here given that a very small minority have expressed doubt about the veracity of the article , the existence of the doctor and my credentials.

A. Dr. Negase exists . A couple of clicks on the computer and you will find him registered with the Alberta College Of Physicians and Surgeons, his name, address and phone number.

B. The Alberta Health Services this am confirmed his locum status in that Province. That is he fills in for doctors who will be absent from their position for a few days or weeks.

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Fax
Cover sheet

Date Oct 8, 2021

Number of pages (including cover sheet) 14

To
Health Canada
Special Access
Program

Phone ( )

Fax (613) 941 3194

CC

From
[redacted] Inc

Phone [redacted]

Fax ( )

[redacted]@icloud.com

Remarks ☑ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

As per your request – Form A
Please provide Merck Canada
with the most recent
Canadian Evidence
Attached

[redacted]

For store use only
Local transmission – SKU: 381623
Long distance transmission – SKU: 475809
International transmission – SKU: 381672
Incoming fax – SKU: 381663

staples
work. learn. grow.

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TRANSMISSION VERIFICATION REPORT

TIME : 10/08/2021 13:10
NAME : STAPLES
FAX :
TEL :
SER.# : U63274C4J647003

DATE,TIME	10/08 13:08
FAX NO./NAME	16139413194
DURATION	00:01:54
PAGE(S)	14
RESULT	OK
MODE	STANDARD ECM

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Health Canada / Santé Canada

Mail Stop: 3106B
Ottawa, Ontario K1A 0K9

February 11, 2022 22-001410 - 448

[redacted]@icloud.com

Dear [redacted]

Thank you for your letters dated November 3, 7, and 8, 2021, regarding ivermectin as a potential treatment for Covid-19 in Canada. Your correspondence was forwarded to my organization for response.

Health Canada is closely tracking all potential therapeutic treatments, vaccines, diagnostic tests, medical devices, and disinfectants currently available and in development in Canada and abroad. Every day, we are adding to our knowledge of COVID-19, keeping pace with the rapid growth of new scientific evidence as it emerges.

Ivermectin (brand name STROMECTOL) is an antiparasitic drug authorized by Health Canada for the treatment of parasitic worm infections, specifically intestinal strongyloidiasis and onchocerciasis. STROMECTOL has been marketed in Canada since 2018.

However, at this time, no ivermectin manufacturer has made an application for this drug to be authorized for the treatment or prevention of COVID-19. Therefore, the effectiveness of ivermectin as a therapeutic option for COVID-19 has not been evaluated by Health Canada.

While Health Canada issues market authorizations for drugs and approves the conditions for which the drugs are to be used, it does not issue treatment recommendations or guidelines. Heath Canada has no jurisdiction over how health care professionals prescribe drugs once they are authorized.

Healthcare practitioners may prescribe drugs, including ivermectin, outside of their authorized indications (this is referred to as “off-label use”), based on other sources of information such as medical literature. Off-label use falls under the practice of medicine and is regulated at the provincial and territorial level.

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For drugs that have potential to be helpful in treating COVID-19, Health Canada encourages drug manufacturers to conduct clinical trials. This would provide an opportunity for the healthcare community to collect information on the effectiveness of the treatment and its associated risks. Evidence from well-designed studies is needed to determine whether ivermectin might be helpful in preventing or treating COVID-19; at this time, there is no evidence that ivermectin is safe or effective for those purposes.

Please note that Health Canada also released a public advisory warning against the use of ivermectin, in particular against using products intended for veterinary use: https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2021/76365a-eng.php.

A list of all clinical trials authorized for the prevention or treatment of COVID-19 can be found on Health Canada's website: https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-clinical-trials/list-authorized-trials.html. To date, Health Canada has not received any clinical trial application for studying the safety and efficacy of ivermectin for the prevention or treatment of COVID-19. However, Health Canada is aware that such clinical trials may be planned or underway internationally.

Clinical trials can be pursued by a range of sponsors, such as a drug manufacturer, an academic institution or research centre, or a physician. It should be noted that Health Canada does not actively conduct the research. For more information on how to submit a COVID-19 Clinical Trial, please refer to the following link: https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/interim-order-respecting-clinical-trials-medical-devices-drugs/drug-guidance.html.

I hope that this information is helpful, and I thank you for writing to share your views.

Thank you again for writing.

Sincerely,

[redacted]

For:

Dr. J. Patrick Stewart, MD, CCFP(EM)
Director General
Therapeutic Products Directorate
Health Products and Food Branch

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Trojanovic, Julia (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2021-11-02 2:18 PM
To: hcminister.ministresc
Subject: lettre reçu au BDC
Attachments: DOC021121.pdf

Bonjour,

Voici une lettre reçu au bureau de circonscription aujourd'hui.

Merci
Émélie

Émélie Soucy
Coordonnatrice du bureau de circonscription
Bureau de l'hon. Jean-Yves Duclos
Député de Québec
600, boul. Charest Est
Bureau 201, C.P. 30014
Québec (Québec) G1K 3J4
T. 418 523-6666
emelie.soucy.359@parl.gc.ca

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IRCM INSTITUT DE RECHERCHES CLINIQUES DE MONTRÉAL
AFFILIÉ À L'UNIVERSITÉ DE MONTRÉAL
50 ANS
1967-2017

[redacted]

Le 26 octobre 2021

L'honorable Jean-Yves Duclos
Ministre de la Santé
Chambre des Communes
Ottawa, ON
K1A 0A6

Sujet: ANTI-VIRAUX pour la COVID-19.

Monsieur le Ministre,

Permettez-moi e vous féliciter de votre nomination au titre de ministre de la Santé du Canada. Vos nouvelles responsabilités sont de prime importance pour l'avenir du pays en raison des énormes soubresauts provoqués par la COVID-19 sur le système canadien de santé. Quoiqu'énorme, la tragédie fut atténuée par l'arrivée rapide des vaccins ARN. Or ceux-ci furent développés grâce à des recherches de base des [redacted] et [redacted] datant des années 2000. Je vous convie donc à favoriser le subventionnement des Instituts de Recherche en Santé du Canada (IRSC/CIHR) qui relèvent de votre ministère.

Pour contrer la COVID-19, le Canada s'est procuré suffisamment de vaccins pour couvrir adéquatement ou presque sa population des Provinces et Territoires. Ce fut réalisé grâce à des budgets de plusieurs milliards de dollars que vous avez approuvés à titre de Président du Conseil du Trésor.

Par ailleurs, je ne crois pas que votre gouvernement en ait fait autant pour le développement des antiviraux qui sont jugés essentiels pour vaincre la COVID-19. Je vous cite l'exemple du projet que [redacted] Suite à nos recherches de base effectuées à l'IRCM, nous avons soumis un protocole clinique aux experts de Santé Canada qui l'ont approuvé en juillet 2020. Or votre ministère de l'Innovation, des Sciences et l'Industrie (MISI) refuse de nous accorder une subvention de 6,38 millions$ sur un budget total de 10,530 millions$, dont 4,150 millions$ viennent de dons du secteur privé.

[redacted] Nous sommes déçus d'autant plus que nous sommes prêts à débuter dès que la subvention sera approuvée. En effet les 4,150$ recueillis du privé ont permis de nous procurer les capsules d[redacted] d'une compagnie suisse et de rassembler une équipe pour monter le projet, laquelle est disponible pour l'exécuter dans les hôpitaux du pays.

Malgré la lourdeur de vos responsabilités, puis-je vous demander la faveur de porter une attention à notre projet, d'autant plus qu'il n'y a pas encore de thérapie valable contre la COVID-19. Je vous envoie en rubrique copie du protocole et le document officiel de l'approbation par les experts de Santé Canada.

Je vous remercie de votre bienveillante attention et veuillez accepter l'expression de mes sentiments distingués.

Bien à vous

[redacted]

INSTITUTE (IRCM) - 110 avenue des Pins Ouest, Montreal (Québec), Canada H2W 1R7
[redacted]@ircm.qc.ca | [redacted]

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Health Canada Santé Canada

NATURAL AND NON-PRESCRIPTION HEALTH PRODUCTS DIRECTORATE

NOTICE OF AUTHORIZATION

Company Code. 56623
File No. 250402
Submission No. 251825

October 15, 2020

[redacted]
Institut de Recherches Cliniques de Montreal (IRCM)
110 avenue des Pins Ouest
Montreal, QC
H2W 1R7

Dear Dr. [redacted]

Re: CLINICAL TRIAL APPLICATION for [redacted]
PROTOCOL NUMBER: [redacted] *Natural Health Products Regulations* Section: 67

The Natural and Non-prescription Health Products Directorate is pleased to inform you that the information and material provided to support the above Clinical Trial Application - *Amendment* have been assessed and we have no objection to your proposed study. Please consider this as your notice of authorization to sell or import this natural health product for the purposes of this clinical trial in Canada.

Please note that you are responsible for ensuring the appropriate considerations are taken into account in order to comply with the requirements set out in the *Natural Health Products Regulations* (NHPR) and its associated guidance documents. For more information on the expectations and approaches relating to quality requirements and Good Manufacturing Practices for natural health products, please consult the *Quality of Natural Health Products Guide* and the *Good Manufacturing Practices* guidance document (http://www.hc-sc.gc.ca/dhp-mps/prodnatur/legislation/docs/index-eng.php).

I would remind you of the necessity of complying with the *NHPR*, Part 4, in the sale of this product for clinical testing. In addition, the Regulations (Part 4) impose responsibilities, including commencement notice, record keeping and reaction reporting, on those conducting clinical trials. Please ensure that all systems are compliant in order to meet these responsibilities.

Please note that the mandatory reporting requirements of the NHPR for Serious Adverse Reaction (SARs) that have occurred in Canada will continue to be applied by the Therapeutic Products Directorate (TPD). However, we request that you submit all SAR case reports using the Council for International Organizations of Medical Sciences (CIOMS) I Form. This preferred form can be downloaded and printed

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at http://www.cioms.ch/index.php/cioms-form-i. The SAR report should be faxed to the following number: (613)941-2121.

You are also reminded that all clinical trials should be conducted in compliance with the Health Canada Guidance for Industry: Good Clinical Practice: Consolidated Guideline ICH Topic E6.

Should you have any questions concerning this letter, please contact the submission coordinator at nhpd-cta.dec-dpsn@hc-sc.gc.ca.

Yours sincerely,

[redacted]

Shiva Ghimire
Acting Director, Bureau of Product Review and Assessment
Natural and Non-prescription Health Products Directorate
250 Lanark Avenue (A.L. 2002C), Ottawa, ON K1A 0K9

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November 19, 2021

Dear Honorable Jean-Yves Duclos,

I am writing to you on the matter of Covid-19 policies. Please find enclosed a printed copy of the Declaration issued by Canadian Covid Care Alliance. You will find information about this organization on page 2.

Since the beginning of 2020, we Canadians have shared in our common experience of suffering from illness, death, and a wide range of social impact. But we didn't suffer in vain. Our doctors and researchers have learned a lot while the government agencies held the fort with various emergency measures. In the enclosed document, you will find evidence based expert opinions.

Doctors worldwide were exchanging data and robustly debating in order to find the best pandemic solutions. But the media suppressed much of them by labeling them as misinformation. Fortunately, censorship didn't stop them from their fight against Covid and sharing of their findings with the public. The enclosed document is a summary of their findings. While the media paints the pandemic with fear and division, the doctors paint hope of living with the sars-cov-2 virus in a post-pandemic stage.

You might find the views presented in this document to be refreshingly different from the familiar narratives. My hope is that you will set aside the labels such as anti-vaxx and pro-vaxx. Evidence and data are neutral; they are neither left nor right, neither pro- nor anti-.

The media reports told us that the current mandate was not necessarily about health or protection, but more about making people comply to get a jab. However, the government's mission to accomplish full compliance has caused unprecedented mass firing of skilled and essential workers across the country. If "public health" mandate isn't solving the health problem but causing much social chaos and loss of value asset, then it seems rational to step back and reassess it.

In order to properly review the policy, it takes three things from people that are involved in the decision-making process: willingness to observe and listen with an open mind, courage to broaden understanding beyond familiar narratives, and fearless dedication to monitor and revise policies based on the available evidence. I hope that you will have the willingness, courage and dedication to do the right thing for the good of those who you serve.

Thank you for your time. Your feedback would be appreciated. If you would like to engage in a meaningful dialogue with the experts behind this document, please contact Canadian Covid Care Alliance via their website (https://www.canadiancovidcarealliance.org/).

Sincerely,

[redacted]

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Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid

COVID-19
Canadian Covid Care Alliance Declaration

September 24, 2021

Formatting updated December 16, 2021

The most up to date version of this document can be found at:

www.CanadianCovidCareAlliance.org

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CCCA

THE COVID-19 CANADIAN COVID CARE ALLIANCE (CCCA) DECLARATION

September 24, 2021

To the Canadian Federal, Provincial and Municipal Governments, Public Health Agency of Canada (PHAC), Health Canada and the Media

Executive Summary

1. Revoke the Declarations of Emergency e.g., Emergency Management & Civil Protection Act, Emergency Programs Act (or similar Act).

2. Develop effective national outpatient treatment guidelines based on the most-up-to-date evidence. Instruct PHAC to inform and educate physicians and the general public about the importance of prophylaxis and early treatment of COVID-19. The government should ensure the necessary supply of repurposed medications and prophylaxis agents.

3. Pause the current COVID-19 vaccination program pending full evaluation of impacts and benefits.

4. Halt the Vaccination Passport ("Vax Pass") program and do not permit any company, agency, or organization to unlawfully mandate COVID-19 vaccinations.

5. Do not permit any infringement on medical privacy by governments and businesses and end all coercive measures limiting freedom of individual medical choice.

6. Do not permit any infringement on the ability to move freely, both within and between provinces as well as internationally (leaving/entering Canada).

7. Do not impose any future lockdowns or quarantines of healthy individuals in view of the enormous destabilizing impacts on the economy, mental health and society at large. The government should instead focus their attention and funding to help those who feel vulnerable, if they so choose to accept the government's assistance.

8. Recognize physicians and researchers of diverse opinions (from the CCCA and other affiliations) as **essential stakeholders** to: 1) engage in an open and public forum to discuss early treatment options, COVID-19 vaccine program, the proposed vaccine mandates, Vaccine Passports, lockdowns and masking; and 2) to participate in the COVID-19 Planning and Implementation Team(s), the COVID-19 Immunity Task Force, the National Advisory Committee on Immunization (NACI) and the provincial Science Tables to address the evidence-based science supporting nonpharmaceutical interventions (NPIs).

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THE COVID-19 CANADIAN COVID CARE ALLIANCE (CCCA) DECLARATION

Introduction

We represent over 500 members, comprised of physicians, research scientists (including virologists, vaccinologists, and immunologists), and others; including highly accomplished professors from top Canadian universities, allied healthcare professionals, and lawyers from across Canada, who have serious concerns with respect to the management of the COVID-19 pandemic in this country. We are offering our assistance and have prepared this document to provide government, policy makers and other relevant stakeholders with a resource summarizing the most up-to-date scientific data, as well as legal and bioethical considerations that should be at the forefront of decision-making going forward.

Mortality data from Statistics Canada[1] demonstrates that we are no longer in a pandemic. Early modelling warned of an alarmingly high rate of deaths across the country as a result of SARS-CoV-2 infection, but eighteen months later, this has not come to pass. It has since been shown, by real world data, that the model presented by Neil Ferguson at Imperial College London was fundamentally flawed from the outset and has been proven wildly inaccurate across the world,[2] despite its projections acting as the basis for the reactionary lockstep response from most governments.[3]

In Canada, as of September 20, 2021, 79% of eligible Canadians aged 12 and over are fully vaccinated with the advised two-dose regimen of mRNA and DNA injections.[4] Today, virtually all Canadians intending to receive vaccination have already done so,[5] making the continued nationwide vaccination campaign redundant and overbearing with no reasonable expectation of benefit to public health. This is in addition to compelling evidence demonstrating waning efficacy of the vaccine products,[6, 7] especially when compared to protection offered by natural immunity, which we now know to be robust and long-lasting.[8, 9] This is the ideal time to reassess the Government's, Public Health Agency of Canada's and Health Canada's recommendations for

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[1] *Provisional death counts and excess mortality, January 2020 to May 2021.* (2021, August 9) Government of Canada, S. C. The Daily. https://www150.statcan.gc.ca/n1/daily-quotidien/210809/dq210809a-eng.htm

[2] Magness, P. W. (2021, April 22) *The failure of Imperial College modeling is far worse than we knew.* American Institute for Economic Research. https://www.aier.org/article/the-failure-of-imperial-college-modeling-is-farworse-than-we-knew/

[3] Ferguson, N. M., Laydon, D., Nedjati-Gilani, G. et al. (2020) *Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand.* South Kensington, London: Imperial College. Report 9:1-20. https://doi.org/10.25561/77482

[4] Little, N. (2021, August 28) *COVID-19 Vaccination Tracker.* COVID-19 Tracker Canada. https://covid19tracker.ca/vaccinationtracker.html

[5] *COVID-19 vaccine willingness among Canadian population groups.* (2021, August 20) Government of Canada, Statistics Canada. https://www150.statcan.gc.ca/n1/pub/45-28-0001/2021001/article/00011-eng.htm

[6] Chemaitelly, H., Tang, P., Hasan, M. R. et al. (2021) *Waning of BNT 162b2 vaccine protection against SARS-CoV-2 infection in Qatar.* medRxiv preprint. https://doi.org/10.1101/2021.08.25.21262584

[7] Mizrahi, B., Lotan, R., Kalkstein, N. et al. (2021) *Correlation of SARS-CoV-2 breakthrough infections to time-from-vaccine; Preliminary study.* medRxiv preprint. https://doi.org/10.1101/2021.07.29.21261317

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[9] Israel, A., Shenhar, Y., Green, I. et al. (2021) *Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection.* medRxiv preprint. https://doi.org/10.1101/2021.08.19.21262111

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protecting public health and moving out of the pandemic response, as is being done by many other countries around the world.

Countries such as Sweden,[10] Denmark,[11] and the UK[12] are almost fully open. As of September 8, 2021, Denmark's and the UK's vaccination rates for those individuals who are eligible and have received two doses were 73.6% and 64%, respectively, according to https://ourworldindata.org/covidvaccinations. As of September 3, 2021, Sweden's double vaccination rate was 57.9%.[13, 14] The UK is able to cope with current delta infections and its hospitalizations have been consistently much lower than in previous waves.[15] In comparison, as of September 20, 2021, Canada's fully vaccinated rate is 79%, a double vaccination rate which is on par with these countries. Further reduction in Canada's hospitalizations can be readily achieved by greater utilization and awareness of the early treatment protocols (see below). We, therefore, strongly object to the unfounded fear-based messaging that the Canadian public is being targeted by.

Denmark's Health Minister, Magnus Heunicke, recently announced:[16] "The epidemic is under control. We have record-high vaccination rates." He also stated that, starting on September 10, "we can drop some of the special rules we had to introduce in the fight against COVID-19". In fact, all restrictions for COVID-19, including the CORONAPASS were dropped on that date in Denmark, and the UK has similarly followed suit. Meanwhile, the Swedish government has kept society relatively open and has only maintained limited but rather fixed NPIs (non-pharmaceutical interventions) throughout the pandemic. Experts opine that,[17] "pre-immunity on a population level, could in fact be a consequence of large variability in individual-level susceptibility. Furthermore, this susceptibility may depend on innate immunity and cross-reactive protective immunity initiated by another virus or other factors."

Eighteen months into this pandemic and nine months into the vaccine program, there has been a tremendous amount of research completed around the world relating to SARS-CoV-2 virus, COVID-19 disease, its treatments and the vaccines. As a result of this research and growing bodies of evidence, we believe it is critical that the Canadian government and public health agencies take immediate action to engage stakeholders and re-examine public health measures with regards to the pandemic. As highly informed and educated health practitioners, researchers and professionals, members of the Canadian Covid Care Alliance (CCCA) are offering their assistance in this process. We offer this wealth of expertise with evidence-based knowledge to find viable, implementable solutions to end the pandemic restrictions to the benefit of all Canadians. It is time for Canada to

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[10] The Local. (2021, May 27) *KEY POINTS: Sweden's five-step plan for ditching pandemic restrictions.* https://www.thelocal.se/20210527/key-points-swedens-five-step-plan-for-lifting-coronavirus-restrictions/

[11] Ganz, J., & New York Daily News. (2021, September 10). *Denmark lifts all of its domestic COVID restrictions.* MSN; Microsoft News. https://www.msn.com/en-us/news/world/denmark-lifts-all-of-its-domestic-covid-restrictions/ar-AAOiT1I

[12] Kirka, D., & Hui, S. (2021, June 28). *UK Confident About July Reopening Despite Soaring Cases.* Courthouse News Service; Associated Press. https://www.courthousenews.com/uk-confident-about-july-reopening-despite-soaring-cases/

[13] *Sweden Coronavirus Full Vaccination Rate.* YCharts. Retrieved September 3, 2021, from https://ycharts.com/indicators/sweden_coronavirus_full_vaccination_rate

[14] Carlsson, M. and Soderber-Naucler, C. (2021) *Indications that Stockholm has reached herd immunity, given limited restrictions, against several variants of SARS-CoV-2.* mexRxiv preprint. https://www.medrxiv.org/content/10.1101/2021.07.07.21260167v1.full.pdf

[15] Government of UK. (2021) *Healthcare in United Kingdom.* Public Health England. https://coronavirus.data.gov.uk/details/healthcare

[16] Ganz, J. (2021) *Denmark declares epidemic 'under control' as it downgrades COVID-19.* NY Daily News. https://www.cityam.com/denmark-declares-epidemic-under-control-as-it-downgrades-covid-19/

[17] Roberston, S. (2021, July 14) *"Herd immunity" not responsible for Sweden's control of COVID-10, say researchers.* News Medical Life Sciences. https://www.news-medical.net/news/20210714/e2809cHerd-immunitye2809d-notresponsible-for-Swedene28099s-control-of-COVID-19-say-researchers.aspx

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set the stage for the return to a healthcare system based on evidence-based solutions, patient-provider trust and ethical regulation in government and industry.

Independent voices have always played an important role in the development of society, just as debate and critical thinking have been instrumental in the advancement of scientific research and knowledge. Based on the most current and verifiable scientific and medical data, it is now possible for the Canadian government to stand up as an international role model, acknowledge that COVID-19 is becoming endemic and move ahead with practical actions and solutions to finally end this extended crisis.

In this Declaration, we provide information and evidence regarding the following issues:

I. Early Treatment and Prophylaxis
II. Vaccine Safety and Surveillance
III. Immune Escape, Variants and Herd Immunity
IV. Informed Consent
V. Vaccine Passports ("Vax Pass") and Vaccine Mandates
VI. Censorship

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I. Early Treatment and Prophylaxis

COVID-19 is the disease that develops in some people infected with the SARS-CoV-2 virus. While these two terms are often incorrectly interchanged by the public, it is crucial to understand their difference. SARS-CoV-2 is the virus that spreads via aerosols (very small droplets)[18, 19] and enters the body primarily via the upper respiratory tract. Infection with this virus can lead to the development of the COVID-19 disease. To understand how to prevent or treat any disease, it is crucial to understand the pathophysiology of the disease.[20] Over the last 18 months, scientists and clinicians have described the cellular mechanisms of the SARS-CoV-2 infection.[21, 22] **Practitioners tailor the disease management and treatment by targeting the distinct pathophysiological phases of the disease.**

With the current wealth of information and experience, the medical community has established that **COVID-19 is a treatable disease**. It is difficult to understand why so many of the expert panels advising governments have practically no personal experience with COVID-19 treatment, especially in its early stage when it is most amenable to therapeutic intervention and provides most impact to a patient's health and healthcare system in general. Countless doctors around the world, including some Canadian doctors, have been successfully treating the disease in its early stages on an outpatient basis using well-known, accessible and inexpensive anti-inflammatory and anti-coagulation medications, among others. These doctors and their extensive networks are at your disposal to help inform effective national treatment guidelines based on the most-up-to-date evidence and their own personal front line experience. **Leading outpatient doctors should be the backbone of the government's advisory teams.**

PROPHYLAXIS (i.e., PREVENTION)

There are a growing number of studies showing the benefits of supplements in reducing viral replication and, therefore, the duration and severity of COVID-19. Readily available supplements such as Vitamin C,[23]

[18] Monroe, R. (2021, August 26) *It's not just SARS-CoV-2: Most respiratory viruses spread by aerosols.* Scripps Institution of Oceanography. https://scripps.ucsd.edu/news/its-not-just-sars-cov-2-most-respiratory-virusesspread-aerosols

[19] Scheuch, G. (2020) *Breathing is enough: For the spread of influenza virus and SARS-CoV-2 by breathing only.* J Aerosol Med Pulm Drug Deliv. 33(4):230-234. https://doi.org/10.1089/jamp.2020.1616

[20] McCullough, P. A., Kelly, R. J., Ruocco, G. et al. (2021) *Pathophysiological basis and rationale for early outpatient treatment of SARS-CoV-2 (COVID-19) infection.* Am J Med Sci. 134(1):16-22. https://doi.org/10.1016/j.amjmed.2020.07.003

[21] Shang, J., Wan, Y., Luo, C. et al. (2020) *Cell entry mechanisms of SARS-CoV-2.* PNAS. 117(21):11727–11734. https://doi.org/10.1073/pnas.2003138117

[22] Bodnar, B., Patel, K., Ho, W. et al. (2021) *Cellular mechanisms underlying neurological/neuropsychiatric manifestations of COVID-19.* J Med Virol. 93(4):1983–1998. https://doi.org/10.1002/jmv.26720

[23] Chiscano-Camón, L., Ruiz-Rodriguez, J. C., Ruiz-Sanmartin, A. et al. (2020) *Vitamin C levels in patients with SARSCoV-2-associated acute respiratory distress syndrome.* Crit Care. 24:522. https://doi.org/10.1186/s13054-020-03249-y

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Vitamin D,[24, 25] Zinc,[26] Quercetin,[27] Selenium,[28, 29] and Omega-3 fatty acids[30] have been shown to assist the immune system in the fight against COVID-19.[31, 32, 33, 34] It has been shown in multiple studies that low levels of Vitamin D lead to more severe disease.[35, 36] It is widely recognized that Canadians are typically vitamin D deficient,[37] which may contribute to increased susceptibility to respiratory infections, especially during winter months. Ireland has recently recognized the importance of vitamin D supplementation in their national public health guidelines.[38] Nasal and throat hygiene was also shown to substantially decrease viral replication and severity of disease.[39, 40] Several repurposed drugs with known antiviral effects have shown potent protection against infection (summarized here and here).

EARLY TREATMENT

As is now well accepted, both vaccinated and unvaccinated individuals are at risk to become infected with and transmit SARS-CoV-2, as well as become ill and even die from COVID-19.[41, 42] As such, **it is imperative to implement early and effective treatments regardless of vaccination status.** Since March 2020, numerous studies relating to early treatment of COVID-19 have demonstrated the effectiveness and safety of using several

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[25] Aranow, C. (2011) *Vitamin D and the immune system.* JIM. 59(6):881–886. https://doi.org/10.2310/JIM.0b013e31821b8755

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[31] Marik, P. (2021) *An overview of the MATH+, I-MASK+ and I-RECOVER Protocols: A Guide to the Management of COVID-19.* https://covid19criticalcare.com/wp-content/uploads/2020/12/FLCCC-Protocols-%E2%80%93-A-Guide-to-the-Management-of-COVID-19.pdf

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[36] CovidAnalysis. (2021) *COVID-19 treatment studies for Vitamin D: A Database of all vitamin D COVID-19 studies.* https://c19vitamind.com/

[37] Naugler, C., Zhang, J., Henne, D. et al. (2013) *Association of vitamin D status with socio-demographic factors in Calgary, Alberta: an ecological study using Census Canada data.* BMC Public Health. 13:316. https://link.springer.com/article/10.1186/1471-2458-13-316

[38] Joint Committee on Health. (2021, April) *Report on addressing Vitamin D deficiency as a public health measure in Ireland.* https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_health/reports/2021/2021-04-07_report-on-addressing-vitamin-d-deficiency-as-a-public-health-measure-in-ireland_en.pdf

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[42] Jeffay, N. (2021, July 25) *HMO: Early vaccinees are twice as likely to catch COVID as later recipients.* The Times of Israel. https://www.timesofisrael.com/hmo-those-who-inoculated-early-twice-as-likely-to-catch-covid-as-lateradopters/

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repurposed drugs with well-established safety profiles. For example, the inhaled steroid budesonide, has already been included in several Canadian and international treatment guidelines.[43, 44] However, for unknown reasons, this information has not reached many in the medical community, or the wider public. Information about early treatment has not even been adequately covered by the media, which is the primary source of pandemic-related information for most Canadians. Moreover, the biggest outpatient trial performed to date has been the Canadian COLCORONA trial, which showed a clear trend to benefit from a well-known drug, colchicine, on substantially decreasing hospitalizations and deaths.[45] Similar positive results have been also reported in top journals with another well-known drug - fluvoxamine.[46, 47, 48]

Some jurisdictions, such as Mexico City and El Salvador, have even deployed very successful public campaigns using treatment packs consisting of several medications and nutraceuticals.[49, 50]

A randomized, placebo-controlled, double-blind trial conducted in Israel from May 15, 2020, through to the end of January 2021 to evaluate the effectiveness of ivermectin in reducing viral shedding among non-hospitalized patients with mild to moderate COVID-19 concluded, "There were significantly lower viral loads and viable cultures in the Ivermectin group, which could lead to shortening isolation time in these patients."[51] Calls to adopt the drug have been made, among others by its discoverer, Nobel Laureate Satoshi Omura, as well as Haruo Ozaki (chairman of the Tokyo Medical Association) and U.S. and British frontline experts.

These are just some amongst hundreds of studies that support the early and efficacious treatment of COVID-19 with repurposed drugs. Well-known medications can be utilized much more easily than expensive monoclonal antibodies with limited availability and challenging administration. **Drug repurposing is the fastest, safest, and most readily deployable way to treat a pandemic disease.** Prophylaxis and early treatment protocols being used worldwide can be found at: The Association of American Physicians and Surgeons site: "Physician List & Guide to Home-Based COVID Treatment"; and the Front Line COVID-19 Critical Care Alliance (FLCCC) site.

Scientific studies have shown that multidrug early treatment with combinations of repurposed drugs and nutraceuticals is highly successful in preventing escalation of the disease. Physicians around the world are

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[43] Ramakrishnan, S., Nivolau, D. V., Langford, B. et al. (2021) *Inhaled budesonide in the treatment of early COVID-19 (STOIC): A phase 2, open-label, randomised controlled trial.* Lancet Respir Med. 9(7):763–722. https://doi.org/10.1016/s2213-2600(21)00160-0

[44] Yu, L-M., Bafadhel, M., Dorward, J. et al. (2021) *Inhaled budesonide for COVID-19 in people at high risk of complications in the community in the UK (PRINCIPLE): a randomised, controlled, open-label, adaptive platform trial.* Lancet. 398(10303):843–855. https://doi.org/10.1016/s0140-6736(21)01744-x

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[50] La Página Newsroom. (2021, January 2) *Delivery of drug kits to treat Covid-19 continues.* La Página. https://lapagina.com.sv/nacionales/continua-entrega-de-kits-de-medicamentos-para-tratar-covid-19/

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successfully managing COVID-19 in the outpatient setting using a variety of treatment and preventative protocols. The common message amongst them all is that treatment is most successful when initiated early.

It is the CCCA's strong recommendation that the government and PHAC re-focus their efforts to educate physicians and the general public about the importance of prophylaxis and early treatment in combating COVID-19.

II. Vaccine Safety and Surveillance

Safe and effective vaccines can be an important tool in addressing a pandemic. Unfortunately, since the government's vaccination program was implemented, we have observed, first-hand, the warning signs regarding vaccine safety, including many of the potential adverse events presented during the VRBPAC meeting on October 22, 2020[52] (Slide #16 in Appendix A) before the vaccine rollout, including significant signs of micro-clotting and even deaths.[53, 54]

In early 2021, Dr. Charles Hoffe of Lytton, British Columbia, discovered that several of his patients had experienced adverse events after receiving the Moderna vaccine. He wrote an open letter to Provincial Health Officer Dr. Bonnie Henry sharing his findings and to seek guidance,[55] but was dismissed, silenced and even sanctioned for his attempts to protect Canadians.[56, 57] More recently, Dr. Hoffe discovered that the majority of his vaccinated patients tested for the D-dimer marker showed elevated D-dimer levels pointing to signs of micro-clotting, a potentially very serious condition whose long-term effects are yet to be determined. Our colleague Dr. Byram Bridle, Associate Professor of Viral Immunology at the University of Guelph, also sounded the alarm when he realized that the SARS-CoV-2 spike protein itself is almost entirely responsible for the adverse cardiovascular effects from both COVID-19 and the vaccine product.[58] He too was aggressively silenced and criticized for sharing his findings,[59] which have been replicated and reasserted by numerous other experts. Increasing number of scientific studies show that the spike protein by itself is bioactive and can be toxic to

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tissues.[60, 61, 62, 63, 64, 65] The S1 subunit of the spike protein is sufficient to cause tissue damage.[66, 67, 68, 69] These findings are concerning because COVID-19 vaccines also induce production of the spike protein by our own human cells. Moreover, we now know that contents of the mRNA vaccine vials can leave the site of the injection and travel throughout the body.[70, 71] The spike protein and its S1 subunit have also been found to circulate in some vaccinated individuals.[72] While damage is expected in an untreated COVID-19 patient, vaccines are administered to healthy individuals. It is therefore paramount to use immunization strategies that use benign viral components. This, however, does not seem to be fulfilled with currently deployed COVID-19 vaccines.

Many other scientists, both in Canada and around the world, have expressed concerns regarding the potential development of antibody-dependent enhancement (ADE) in vaccinated individuals.[73, 74] ADE typically results in serious illness and even death by allowing the virus to more easily replicate in a person who has produced non-sterilizing antibodies (antibodies that do not destroy the virus). A study published on August 9, 2021, in the Journal of Infection confirmed ADE with the delta variant and the presence of infection-enhancing antibodies in symptomatic COVID-19 patients.[75] ADE is a well-known phenomenon that has been previously reported with several different viruses, including coronaviruses and has hindered vaccine development in the

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past.[76, 77] While we are seeing the acute and sub-acute adverse events of COVID-19 vaccination, the long term effects of these still largely experimental genetic vaccines will not be known for some time to come. It is however already known that the spike protein can cause hyper-inflammation.[78, 79, 80] Numerous biological activities of the spike protein, the biodistribution and the mechanism of COVID-19 vaccines suggest that possible future increase in autoimmune diseases and cancers cannot be ruled out. For example, the relationship between the Pandemrix vaccine deployed in 2009 against influenza and narcolepsy in children was uncovered by Swedish and Finnish authorities only after its wide commercial deployment to over 30 million people.[81] It has been a well-established practice that any new medical product must be closely monitored at both the formal clinical trial and deployment stages. However, the presently used vaccines have been deployed on the general public with little systematic reporting of vaccine injury and highly biased analyses of those reports that have been filed. Based on our experience, there is vast under-reporting of adverse events. Vaccine injuries are frequently downplayed or dismissed as mere coincidences, resulting in low reporting to the Canadian Immunization Surveillance Program (CAEFISS), rendering its reports unreliable.

Reports that do get submitted are frequently rejected despite sound clinical judgement from the primary care provider. This is clearly evident upon inspection of the Health Canada website (https://health-infobase.canada.ca/covid-19/vaccine-safety/) where the weekly reports of adverse reactions from May 1, 2021, onward surprisingly declined, despite increased rates of vaccine administration. Moreover, as the vaccination program has continued in recent months, the ratio of reports of serious adverse reactions (i.e., requiring hospitalization or deaths) versus mild reactions increased from ~15% to well over 40%. Finally, three-quarters of all the vaccine injury reports are for females, whereas a more equitable distribution between males and females would have been expected.

During the Emergency Use Authorization (EUA) process in the USA, the COVID-19 vaccines were considered for EUA pending reliance on the safety surveillance system called the Vaccine Adverse Events Reporting System (VAERS). As of September 10, 2021, VAERS has recorded 14,925 deaths, 60,741 hospitalizations, 19,210 permanent disabilities, 5,765 cases of myocarditis, 6,637 heart attacks, 1,862 miscarriages and more. These events are understood to be correlated and have been explored in clinical and research settings as they have emerged, such as with thrombocytopenia.[82] AstraZeneca vaccines were paused and then phased out in Canada in response to adverse events, though this has been an odd exception when

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compared to the multitude of similar and worse events reported in VAERS and other systems in relation to the mRNA vaccines.

Moreover, based on a 2009 Centers for Disease Control and Prevention (CDC) commissioned Harvard study, it is known that there is vast under-reporting of adverse events to the VAERS in general (less than 2% of valid adverse events get reported) and doctors are now finding that some of their reports to VAERS are either missing, or have been unjustifiably rejected. Over the last 30 years up to August 13, 2021, more than a third of all VAERS reports of vaccine injuries (1.4 million) have been linked to COVID19 vaccines (595,622). As of August 13, 2021, there were a total of 184,886 Serious Adverse Events (SAE) for ALL vaccines, 80,850 of which were entirely for COVID-19 vaccines.[83]

A Canadian researcher, Jessica Rose, PhD, MSc, BSc, recently authored a report entitled, "A Report on the U.S. Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 Messenger Ribonucleic Acid (mRNA) Biologicals."[84] Her results are found in Appendix C. Summarizing her findings,[85] Rose made the following conclusions:

- "[COVID mRNA] Vaccines are the likely cause of reported deaths, spontaneous abortions, anaphylactic reactions, in addition to cardiovascular, neurological, and immunological Adverse Events.
- There is a strong signal from the VAERS data that the risk of suffering Serious Adverse Events (SAE) shortly after injection is significant and the overall risk signal is high.
- Autopsies should be required in cases of deaths temporally associated with the COVID-19 injections.
- Investigation and focus on immunological issues must be a priority in future studies.
- The efficacy of the experimental vaccines needs to be assessed by immunological assays and long-term studies must be required.
- Extreme care should be taken when making a decision to participate in this mass vaccination experiment."

In the European Union, as of September 11 , 2021, EudraVigilance - which gathers adverse event reports from 27 EU member states out of a total of 50 countries in Europe - has recorded 24,526 deaths and 2.317 million vaccine injuries, of which almost 50% are considered serious in nature.[86, 87]

As a comparison, the 1976 swine flu vaccination program in the U.S., which was rushed to market based on incomplete knowledge, was halted within months once a temporal association was made with Guillian-Barre

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Syndrome.[88] In hindsight, that particular swine flu was not dangerous, and it did not result in a pandemic.[89] Over 40 million people in the U.S. had been vaccinated before the program was abandoned. A rushed vaccination campaign can ultimately result in more harm than benefit. In comparison, approved vaccines normally take 7-12 years to develop and properly test. It is, therefore, very worrying that COVID-19 vaccines have no predefined stoppage condition (i.e., number of severe adverse events that would trigger a halt and review of the vaccination program) and their safety is not monitored properly.

The Respiratory Syncytial Virus (RSV) vaccine candidate developed in the 1960s was not efficacious and actually enhanced disease when participants were subsequently exposed to RSV consistent with ADE. Hospitalizations were far more prevalent in the vaccinated group than among controls and there were two fatalities attributed to the vaccine.[90] The recent use of the Dengvaxia vaccine against Dengue Virus in the Philippines showed that vaccinated children without previous infection were at higher risk of severe disease upon reinfection compared to unvaccinated controls.[91, 92] Due to this severe vaccine limitation, it has since been approved only for a specific group of people at high risk.

These cases further illustrate the need for thorough testing of vaccines before their population-wide deployment. As outlined above, numerous safety signals and red flags are also emerging today with respect to the COVID-19 vaccines. Therefore, it is imperative that the Canadian government must act swiftly and responsibly to pause the COVID-19 vaccine program, especially when vaccination of young children and additional boosters to the general public are being considered.

The CCCA opines that the number of deaths and serious adverse events caused by the vaccines both in Canada and worldwide, has significantly and devastatingly surpassed any reasonable measure that would keep a population-wide vaccine program in place. It is the opinion of the CCCA that the Canadian government's current COVID-19 vaccine program should be paused immediately for the safety of all Canadians, especially considering that those most at risk of the disease are already largely vaccinated. Additional vaccinations will produce more harm than benefit.

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III. Immune Escape, Variants and Herd Immunity

Prior to initiating the vaccine program, scientists warned the World Health Organization (WHO) against vaccinating amidst a pandemic, particularly with a "leaky," or non-sterilizing vaccine. The basis for this warning is the well-known paradigm that the use of a leaky vaccine can create ideal conditions for the proliferation of potentially dangerous variants within vaccinated individuals. In the poultry industry, use of leaky vaccines has allowed survival and spread of deadly strains of Marek's disease virus to the point that none of the farmed chickens can survive nowadays without vaccination. Prior to vaccine use, mortality of chickens infected with Marek's disease was rather low.[93, 94, 95, 96]

This is in stark contrast to sterilizing vaccines, such as the ones used for smallpox or polio, which prevent individuals from contracting, transmitting, falling ill and dying from the diseases against which they have been inoculated.

In March 2021, Dr. Geert Vanden Bossche, a Belgian virologist and vaccinologist who formerly worked with the Bill & Melinda Gates Foundation and GAVI, wrote an open letter to the WHO about the consequences of vaccinating in the heat of a pandemic.[97] In his August 12, 2021, document entitled *C-19 Pandemia: Quo vadis, homo sapiens?*[98] he explains, "As of the early days of the mass vaccination campaigns, at least a few experts have been warning against the catastrophic impact such a program could have on global and individual health. Mass vaccination in the middle of a pandemic is prone to promoting selection and adaptation of immune escape variants that are featured by increasing infectiousness and resistance to spike protein (S)-directed antibodies (Abs), thereby diminishing protection in vaccinees and threatening the unvaccinated. This already explains why the WHO's mass vaccination program is not only unable to generate herd immunity (HI) but even leads to substantial erosion of the population's immune protective capacity. As the ongoing universal mass vaccination program will soon promote dominant propagation of highly infectious, neutralization escape mutants (i.e., so-called 'S Ab-resistant variants'), naturally acquired, or vaccinal neutralizing Abs, will, indeed, no longer offer any protection to immunized individuals whereas high infectious pressure will continue to suppress the innate immune defense system of the non-vaccinated. This is to say that every further increase in vaccine coverage rates will further contribute to forcing the virus into resistance to neutralizing, S-specific Abs. Increased viral infectivity, combined with evasion from antiviral immunity, will inevitably result in an additional toll taken on human health and human lives. Immediate action needs, therefore, to be taken in order to dramatically reduce viral infectivity rates and to prevent selected immune escape variants from rapidly spreading through the entire population, whether vaccinated or not. This first critical step can only be achieved by calling an immediate halt

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to the mass vaccination program and replacing it by widespread use of antiviral chemoprophylactics while dedicating massive public health resources to scaling early multidrug treatments of COVID-19 disease."

Less than 6 months later, his predictions are coming true. We are now faced with variants that circumvent the first generation of these genetic vaccines - which were modelled off the now extinct SARS-CoV-2 Wuhan strain provided by China. These vaccines have become relatively ineffective in combating the transmission of the newer delta variant and are expected to be even less effective with the emerging mu variant.[99] According to CDC Director Rochelle Walensky, "…we are seeing concerning evidence of waning vaccine effectiveness over time, and against the delta variant." That in addition to the CDC's August 19, 2021 admission that "those who were vaccinated early are at increased risk of severe disease as vaccine effectiveness is waning."

Currently, the scenario playing out around the world is seeing fully vaccinated individuals producing variants, as well as catching, transmitting, falling ill and dying from the virus.[100, 101, 102, 103] We are seeing surges of COVID-19 in highly vaccinated places such as Israel, Gibraltar and Iceland.[104] Israel had 72.5% of its eligible population double vaccinated,[105] yet it could not achieve herd immunity through vaccination. Consequently, they are now performing additional vaccinations with a third booster shot, without prior efficacy and safety studies, because long-lasting immune memory was not achieved with the first two injections of the Pfizer mRNA vaccine.

With an understanding that mass vaccination is likely significantly contributing to the development of concerning variants, and that the virus is fully circulating amongst and affecting even the fully vaccinated, it is scientifically inaccurate, divisive and vilifying to suggest that this is a 'pandemic of the unvaccinated'. This makes the language in Dr. Bonnie Henry's recent Public Health Orders deeply concerning, as she unfoundedly describes the mere presence of "unvaccinated persons" as posing "risk of harm to residents of B.C.", while also conceding that vaccinated individuals are also at risk of spreading the virus and falling ill with COVID-19.[106]

It is evident that no country, anywhere in the world, can eradicate the virus by indiscriminate vaccination and attempting to do so may in fact be dangerous as we create more resistant strains of SARS-CoV-2. Vaccination will not achieve herd immunity. We must instead move in the direction of natural immunity for those at minor risk, which is the vast majority of the population, with the added protections of prophylaxis and early treatment.[107] If we do otherwise, and continue with the current vaccination programs, we

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will face a waterfall of variants that will continue to pose a threat to the most vulnerable in our country, including those who are vaccinated. Also, since many diverse domestic as well as wild animals have been shown to be susceptible to SARS-CoV-2, containment of this virus by vaccination alone to prevent future infections of humans will be highly unlikely.[108, 109]

IV. Informed Consent

According to the Ontario Health Care Consent Act of 1996:

No treatment without consent: 10 (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless, (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

11 (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

In this case, the "treatment" is the COVID-19 vaccine.

As health care providers managing the care of thousands of patients who have experienced adverse reactions to the vaccines (the "vaccine injured"), **it has become apparent that our patients have not been properly informed regarding their individual risks and benefits of the COVID-19 vaccine products nor the nature of the underlying technology**.[110] Moreover, when it comes to children over 12 providing consent to an investigational product/injection without parental guidance, we are even more so alarmed.[111] By the manufacturers' own definitions, these are investigational gene therapy products.[112] They were initially

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broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells. Cell Reports Medicine, 2(7), 100354. https://doi.org/10.1016/j.xcrm.2021.100354

[108] Konner Cool, Natasha N. Gaudreault, Igor Morozov, Jessie D. Trujillo, David A. Meekins, Chester McDowell, Mariano Carossino, Dashzeveg Bold, Dana Mitzel, Taeyong Kwon, Velmurugan Balaraman, Daniel W. Madden, Bianca Libanori Artiaga, Roman M. Pogranichniy, Gleyder Roman Sosa, Jamie Henningson, William C. Wilson, Udeni B. R. Balasuriya, Adolfo García-Sastre & Juergen A. Richt (2021) *Infection and transmission of ancestral SARS-CoV-2 and its alpha variant in pregnant white-tailed deer*. Emerging Microbes & Infections. https://doi.org/10.1080/22221751.2021.2012528

[109] Griffin, B. D., Chan, M., Tailor, N. et al. *SARS-CoV-2 infection and transmission in the North American deer mouse.* Nat Comm. 12:3612. https://www.nature.com/articles/s41467-021-23848-9

[110] Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council (2019) *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.* Government of Canada. https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactivefinal.pdf

[111] Bowden, O. (2021, May 21) *Do Ontario children 12-15 need parental consent to get COVID-19 vaccines? It depends where you live.* Toronto Star. https://www.thestar.com/news/gta/2021/05/21/do-ontario-children-12-15-need-parental-consent-to-get-covid-19-vaccines-it-depends-where-you-live.html

[112] *"Moderna, Inc. Form 10-Q for the quarterly period ended June 30, 2020."* EDGAR. Securities and Exchange Commission, 2020, https://www.sec.gov/Archives/edgar/data/1682852/000168285220000017/mrna20200630.htm

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authorized by Health Canada under Interim Order and have recently been transition to an authorization under Division 8 (New Drugs) of the Food and Drug Regulations.[113] The regulatory decision itself states: "An important limitation of the data is the lack of information on the long-term safety and effectiveness of the vaccine".[114, 115] It is, therefore, entirely reasonable for individuals to take a cautious approach to a novel, not-fully-tested medical product that could present with short term, long term or potentially even transgenerational adverse events.

One of the concerns specifically related to the mRNA and adenoviral COVID-19 vaccines is their requirement for healthy cells to produce the spike protein of this virus, which sets them up for inflammatory responses to elicit antibody production. However, repeated inflammation of tissues is a well-known mechanism for breaking immune tolerance and induction of autoimmune diseases. Repeated immunizations, including with other vaccines that use the same technology but for other pathogenic viruses or bacteria, could be expected to cause new autoimmune disease or exacerbate pre-existing autoimmune disease.

Examples of some of the information with which Canadians should be provided prior to vaccination in order to give full informed consent include but are not limited to the following:

- **Adverse Events** - During the October 22, 2020, COVID-19 vaccine presentation to the American Food and Drug Administration (FDA), a list of potential adverse events was presented (Appendix A).[116] This list of potential adverse events was not exhaustive and was never presented to the Canadian public.
- **Risk/Benefit Calculations and Absolute Risk Reduction (ARR)** - PHAC has never provided a risk/benefit calculation based on health profile, age or gender for Canadians to consider, nor has it provided a true assessment of one's benefit from taking the vaccine. The high efficacy rate reported in the vaccine studies is a comparison of the ratio of illness prevalence in the treatment and placebo groups. It is called Relative Risk Reduction (RRR). This is a statistical comparison. However, to understand whether the vaccines reduce the risk of contracting COVID-19 one must examine the absolute risk reduction (ARR) value. According to the Pfizer trials, their vaccine afforded the individual less than a 1% reduction in the risk of contracting the disease compared to not receiving the vaccine at all. It is for this reason that the FDA clearly states in its *Communicating Risks and Benefits* guidelines:[117] "***Provide absolute risks, not just relative risks. Patients are unduly influenced when risk information is presented using a relative risk approach; this can result in suboptimal decisions. Thus, an absolute risk format should be used***." However, this information has not been communicated to Canadians.
- **Survivability** - In October 2020 prior to any COVID-19 vaccination campaign, the infection fatality rate (IFR) for COVID-19 was estimated by the WHO at 0.27%; with a **survivability rate of 99.73%**. The extent of actual infection of the Canadian public with SARS-CoV-2 is unknown as many asymptomatic cases would have been missed.[118] The American CDC estimates that only 1 in 4 infected have been identified

[113] Food and Drug Regulations (CRC, c.870) *New Drugs: C.08.001.* https://lawslois.justice.gc.ca/eng/regulations/c.r.c.,_c._870/page-141.html#h-578215
[114] Government of Canada. (2021) *Regulatory Decision Summary – COMIRNATY – Health Canada.* https://covidvaccine.canada.ca/info/regulatory-decision-summary-detail.html?linkID=RDS00856
[115] Government of Canada. (2021) *Regulatory Decision Summary – SPIKEVAX – Health Canada.* https://covidvaccine.canada.ca/info/regulatory-decision-summary-detail.html?linkID=RDS00855
[116] Anderson, S. (2020, Oct 22) *CBER plans for monitoring COVID-19 vaccine safety and effectiveness.* US FDA. VRBPAC Meeting. https://www.fda.gov/media/143557/download
[117] 7 Fischhoff, B., Brewer, N. T. and Downs, J. S. (2011) *Communicating risks and benefits: An evidence-based users' guide.* US FDA. https://www.fda.gov/about-fda/reports/communicating-risks-and-benefits-evidence-based-usersguide
[118] 8 Since the extent of actual infection of the Canadian public with SARS-CoV-2 was not properly established, this is

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by testing, putting true IFR at a much lower value than what is assumed from positive PCR numbers only.[119] CDC further estimates these age stratified IFRs: 0-17 years: 0.002% (survivability 99.998%), 18-49 years: 0.05% (survivability 99.95%), 50-64 years: 0.6% (survivability 99.4%), 65+ years: 9% (survivability 91%).[120] For a healthy person under age 70, IFR is 0.05% - this is the same daily risk as driving 23 km per day in Canada.[121]

- **Susceptibility** - Prior to instituting the vaccine program, PHAC was aware that it was mainly institutionalized elderly individuals with comorbidities who were at greatest risk. COVID-19 poses increased risk only to a small subset of the population - frail, elderly people with comorbidities - these are the same people who are also at risk from other common infections. By contrast, for children, COVID-19 is less deadly than the flu.[122]

  Consider:

  - 96.8% of COVID-19 deaths in Alberta had 1 or more comorbidities.[123]
  - 95% of deaths in the US had 1 or more comorbidities (on average 4 comorbidities).[124]
  - The vast majority of all Canadian COVID-19 deaths have been in long term care homes.[125]
  - According to Statistics Canada, the average age at death in Canada in 2019 was 76.5 years. However, the average age of those who died of COVID-19 in Canada last year was higher at 83.8 and is still around 76 years when more recent data are included.[126, 127]

- **Childhood Risk** - It is known that children have not been contributing significantly to the transmission of the virus.[128, 129, 130] The overall survival rate of minors (under the age of 19 years) with COVID-19 is 99.997%.[131, 132] With several serious adverse events being recognized only postauthorization (e.g. myocarditis and pericarditis), and potential yet unrecognized adverse events, it is possible that healthy

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likely to be a substantial overestimate of the IFR.

[119] CDC. (2021, Jul 27). *Estimated COVID-19 Burden.* https://www.cdc.gov/coronavirus/2019-ncov/casesupdates/burden.html

[120] CDC. (2021, Mar 19) *COVID-19 Pandemic Planning Scenarios.* https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

[121] Joffe, A. R. (2021, Feb 26) *COVID-19: Rethinking the lockdown groupthink.* Front Public Health. https://doi.org/10.3389/fpubh.2021.625778

[122] Shekerdemian LS, Mahmood NR, Wolfe KK, et al. (2020) *Characteristics and Outcomes of Children With Coronavirus Disease 2019 (COVID-19) Infection Admitted to US and Canadian Pediatric Intensive Care Units*. JAMA Pediatr. 2020;174(9):868–873. https://doi.org/10.1001/jamapediatrics.2020.1948

[123] Government of Alberta. (2021) *COVID-19 Alberta statistics.* https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#comorbidities

[124] CDC (2021) *COVID-19 Provisional Counts - Weekly Updates by Select Demographic and Geographic Characteristics.* https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#Comorbidities

[125] National Institute on Ageing. (2021) *NIA LONG TERM CARE COVID-19 TRACKER*. https://ltc-covid19-tracker.ca/

[126] Jackson, H. (2021, June 2). *COVID-19 deaths lowered Canadians' average life expectancy to 2013 levels: StatsCan.* Global News. https://globalnews.ca/news/7915634/covid-life-expectancy-stats-canada/

[127] *The Daily — Provisional death counts and excess mortality, January 2020 - May 2021.* (2021, August 9). Wayback Machine; Statistics Canada. https://archive.ph/P2f3y#selection-1381.0-1381.71

[128] Rajmil, L. (2020). *Role of children in the transmission of the COVID-19 pandemic: a rapid scoping review.* BMJ Paediatrics Open, 4(1), e000722. https://doi.org/10.1136/bmjpo-2020-000722

[129] Somekh, I., Boker, L. K., Shohat, R. et al. *Comparison of COVID-19 incidence rates before and after school reopening in Israel.* JAMA Netw Open. 4(4):e217105. https://doi.org/10.1001/jamanetworkopen.2021.7105

[130] Eberhardt, C. S. and Siegrist, C-A. (2021) *Is there a role for childhood vaccination against COVID-19?* Pediatr Allergy Immunol. 32(1):9-16. https://doi.org/10.1111/pai.13401

[131] Bhopal, S. S., Bagaria, J., Olabi, B., and Bhopal, R. (2021) *Children and young people remain at low risk of COVID19 mortality.* Lancet Child Adolesc Health. 5(5):E12–E13. https://doi.org/10.1016/s2352-4642(21)00066-3

[132] Smith, C., Odd, D., and Harwood, R. (2021) *Deaths in children and young people in England following SARS-CoV2 infection during the First pandemic year: A national study using linked mandatory child death reporting data.* Res Sq. https://doi.org/10.21203/rs.3.rs-689684/v1

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children face similar or higher risks from vaccination than from the disease itself. As of September 17, 2021, only 2% of all hospitalized in Canada that tested positive for SARS-CoV-2 have been under the age of 20 and only 15 Canadians in this age group infected with the virus died.[133] For comparison, about 110 kids die annually in Canada from cancer.[134] Furthermore, a 13-year-old girl that participated in a Pfizer trial for 12-15 year olds, Maddie de Garay, has been permanently disabled, yet this information has not been reported in trial results. This points to possible trial irregularities.[135] (Further information regarding youth vaccination in Appendix B).

From December 13, 2020 to August 7, 2021, there have been 314 reports of myocarditis or pericarditis following receipt of COVID-19 mRNA vaccines in Ontario.[136] The highest reporting rate of myocarditis/pericarditis was observed in males aged 18-24 years following the second dose. The UK government's advisory body on vaccination has decided not to recommend universal COVID vaccination for 12–15-year-olds, because of the "very low risk, considerations on the potential harms and benefits of vaccination are very finely balanced."[137]

It is clear our patients were not provided with this information prior to inoculation, and they were not given the opportunity to discuss their risk/benefit ratio and/or alternative prophylaxis or treatment options (discussed above) with their primary care practitioners or those administering the injections. Those who experience a vaccine injury, some of which are debilitating and life-altering, are scared, confused and angry about the lack of information essential for informed consent. As there are no standards of care for these vaccine injuries, many patients feel abandoned by their own practitioners and are left to seek treatment guidance on their own.

We are seeing unnecessary harm come to patients who were not fully informed about the potential adverse events nor their risk-to-benefit ratio. Consequently, they were unable to give full informed consent. Many of these patients would most likely have fully recovered naturally from COVID-19, particularly if provided with early treatment (as discussed above). This has been a flagrant abuse by the government in pressing a vaccination agenda, while robbing individuals of the freedom to make informed decisions about their own health. Without full transparency and informed consent, and without a full appreciation and proper evaluation of the safety of these novel vaccines (both short and long term) the current COVID-19 vaccination programs should be paused immediately. We greatly support classical vaccine programs as developed over past decades and are therefore deeply concerned that this blatant disregard for medical ethics and most recent scientific data during COVID-19 vaccinations will irreparably damage Canadians' trust in the traditional vaccine programs.

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[133] Government of Canada. (2021, September 20) *COVID-19 daily epidemiology update.* https://healthinfobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html

[134] Ellison, L. F., Xie, L. and Sung, L. (2021, February 17) *Trends in paediatric cancer survival in Canada, 1992 to 2017.* Statistics Canada. https://www150.statcan.gc.ca/n1/pub/82-003-x/2021002/article/00001-eng.htm

[135] Giang-Paunon, S. (2021, July 2) *Mom details 12-year-old daughter's extreme reactions to COVID vaccine, says she's now in wheelchair.* Fox News. https://www.foxnews.com/media/ohio-woman-daughter-covid-vaccinereaction-wheelchair

[136] Public Health Ontario. (2021) *Myocarditis and pericarditis following vaccination with COVID-19 mRNA vaccines in Ontario: December 13, 2020 to August 7, 2021.* Government of Ontario. https://www.publichealthontario.ca/-/media/documents/ncov/epi/covid-19-myocarditis-pericarditis-vaccines-epi.pdf

[137] Zhou, L. (2021, September 3) *UK Advisory Body not recommending CCP virus vaccines to healthy children under 16.* The Epoch Times. https://www.theepochtimes.com/mkt_app/uk-vaccines-advisory-body-not-recommending-ccpvirus-vaccines-to-healthy-children-under-16_3980285.html?v=ul

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V. Vaccine Passports ("Vax Pass") and Vaccine Mandates

On August 18, 2021, Prime Minister Justin Trudeau stated, "The bottom line is, if anyone who doesn't have a legitimate medical reason for not getting fully vaccinated chooses to not get vaccinated, there will be consequences".[138] NDP Leader Jagmeet Singh issued a statement saying public servants who refuse a shot could be punished under collective agreements between unions and the federal government.[139] **This is totalitarianism, plain and simple.**

The implementation of vaccine passports and vaccine mandates in order to maintain employment, travel or avail oneself of an education has implications with issues of informed consent, medical privacy, the Canadian Charter of Rights and Freedoms and the (Ontario) Human Rights Code.

The CCCA strenuously objects to Vaccine Passports ("Vax Passes") and vaccine mandates of any kind for the following reasons:

THE LAW

1. I**nformed consent:** We must examine the rights of a patient with respect to consenting to a medical treatment such as novel genetic vaccines. This fundamental principle is at the core of a person's bodily autonomy, integrity and dignity. Consent must be **informed** as set out in case law including the Supreme Court decisions of Parmley & Parmley v Yule,[140] and Hopp v Lepp.[141] The patient must be 'sufficiently informed to enable him to make an informed choice' otherwise medical treatment is tantamount to assault or force. Is it truly "consent" to receive a vaccine when the individual's ability to work to feed one's family, educate him/herself or to travel is being threatened?

   The Supreme Court decision of Her Majesty the Queen v Steven Brian Ewanchuk states that consent must be "**freely given**".[142] Consequently, if a person is fearful of losing his/her job, education or ability to travel, and is, therefore, being coerced to be vaccinated, consent is not freely given. The decision states: "As enumerated in s. 265(3) [**of the Criminal Code**], these include submission by reason of force, fear, threats, fraud or the exercise of authority, and codify the longstanding common law rule that **consent given under fear or duress is ineffective.**" [Author's emphasis]. "Authority" in this case could be someone's employer or the government (i.e., not permitting travel or access to funerals, weddings or restaurants).

2. Section 15 of the **Canadian Charter of Rights and Freedoms – Equality Rights** which states: "15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race,

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[138] Tasker, J. P. (2021, August 17) *Trudeau warns of 'consequences' for public servants who duck COVID-19 shots.* CBC News. https://www.cbc.ca/news/politics/trudeau-consequences-public-servants-vaccines-1.6143735

[139] Gray, M. (2021, August 17) *President of the largest public sector union 'will not stand' for termination of unvaccinated civil servants.* CTV News. https://www.ctvnews.ca/politics/federal-election-2021/president-oflargest-public-sector-union-will-not-stand-for-termination-of-unvaccinated-civil-servants-1.5550820

[140] *Parmley & Parmley v Yule*, 1945 CanLII 13(SCC), [1945] SCR 635. https://canlii.ca/t/21v4g

[141] *Hopp v. Lepp,* 1980 CanLII 14 (SCC), [1980] 2 SCR 192. https://canlii.ca/t/1mjv6

[142] *R. v. Ewanchuk,* 1999 CanLII 711 (SCC), [1991] 1 SCR 330. https://canlii.ca/t/1fqpm

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national or ethnic origin, colour, religion, sex, age or mental or physical disability." Persons in society being discriminated against—such as being unable to go into a theatre, concert or use public transportation - based on medical choice would be a violation of our human rights as per the Charter.

3. **Nuremberg Code** - Being coerced or forced into a mandated medical intervention is in violation of the Nuremberg Code principles. Article 6, Section 1 states: "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be expressed and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice". Article 6, Section 3 states: "In no case should a collective community agreement, or the consent of a community leader or other authority, substitute for an individual's informed consent".

4. Section 6 of the **Canadian Charter of Rights and Freedoms – Mobility** "6. (1) Every citizen of Canada has the right to enter, remain in and leave Canada" without impediment. It is a violation of our Charter rights to prevent passage between provinces, at the Canadian/US border, at train stations or in airports.

5. Vax passes violate our medical privacy laws as per the Personal Information Protection and Electronic Documents Act (PIPEDA) and Personal Health Information Protection Act (PHIPA).

6. While the government suggests repeat PCR testing for those employees who refuse an injection and, therefore, cannot show proof of "vaccination", according to Bill S-201 or the Genetic Non-Discrimination Act, "federally regulated employers cannot use a person's genetic test results in decisions about hiring, firing, job assignments, or promotions; or request or require genetic test results of an employee." PCR tests are a form of genetic testing. PCR tests that require probing deep within the nasal cavities on a repeated basis can inflict discomfort and injury, and could be viewed as a form of abuse.

THE SCIENCE, MEDICINE AND LOGISTICS

7. SARS-CoV-2 is neither a particularly deadly nor exotic virus and may be considered similar to a bad flu with over 99% survivability rate for the majority of the population. There are readily available early treatments to lessen the duration and severity of the illness. There is no valid reason for either a vaccine passport or vaccine mandate to protect oneself or others with respect to the present measured threat to society. Only a small portion of society is at higher risk of developing severe disease (elderly, frail, people with comorbidities), particularly when untreated. These are the same people that are at higher risk with respect to other diseases for which we do not isolate the healthy general public. If vaccine passports are accepted for such a low level of threat demonstrated by this virus, it may follow suit that such requirements be enacted for other viruses such as HIV, hepatitis, papilloma virus, influenza, or bacteria such as Mycobacterium tuberculosis.

8. Vaccine passports will not stop the spread of the virus. It is now abundantly clear based on emerging studies and clinical observations that both the vaccinated and the unvaccinated can contract, carry and

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transmit COVID-19 and carry similar viral loads.[143] This fact alone entirely negates the purpose of a Vax Pass or vaccine mandates. According to CDC Director Rochelle Walensky, "The increased viral load associated with the delta variant appears to make vaccinated people equal spreaders of the virus." A study by Chau *et al*. showed that vaccinated health care workers with breakthrough infections of the delta strain carried 251 times the viral load in their nostrils compared to those infected with older strains detected between March-April 2020 (when no vaccines were available).[144] This would explain the recent reports of fully vaccinated individuals infecting each other and demonstrates the futility in vaccinating groups at low risks of COVID19.[145, 146, 147, 148] Therefore, vaccine passports would give some a false sense of security.

9. As previously mentioned, apart from mounting evidence of waning efficacy of the COVID-19 vaccines approved for use in Canada, there is also increasing evidence of a relatively high rate of injury from these particular vaccines.[149]

10. As of December 2020, there were over 200 vaccine candidates for COVID-19 being developed and 52 were in human trials.[150] It will become logistically impossible for any one Vax Pass to keep up with the make, model and number of jabs required to stay current with respect to a vaccine schedule particularly when each product may require differing numbers of injections.

11. Newcomers or travelers will be forced to take more than one vaccine product to satisfy the country in which they wish to travel or live. Take for example the Canadian woman in China who has taken the Sinovac vaccine but wishes to return to Canada, a country which does not recognize that particular vaccine product. Consequently, she is forced to take a different vaccine product to satisfy Canada's requirements. The scientific community is unaware of the effects of combining these medical products. Furthermore, different countries have applied different standards in their acceptability of what constitutes proper vaccination protocols. For instance, the UK had required Canadians who have been fully vaccinated to undergo quarantine restrictions for entry, but not travelers from the European Union or the United States.

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[143] Riemersma, K. K., Grogan, B. E., Kita-Yarbro, A et al. (2021) *Shedding of infectious SARS-CoV-2 despite vaccination.* medRxiv preprint. https://doi.org/10.1101/2021.07.31.21261387

[144] Chau, N. V., and Gnoc, N. M. (2021) *Transmission of SARS-CoV-2 delta variant among vaccinated healthcare workers, Vietnam.* Lancet preprint. http://dx.doi.org/10.2139/ssrn.3897733

[145] Beale, J. and Shearing, H. (2021, July 14) *HMS Queen Elizabeth: Covid outbreak on Navy flagship.* BBC News. https://www.bbc.com/news/uk-57830617

[146] Massi, A. (2021, August 23) *I went to a party with 14 other vaccinated people; 11 of us got COVID: COMMENTARY.* The Baltimore Sun. https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0804-breakthrough-covid-20210803-t32trfpiwzdf5okfar45f64whi-story.html

[147] The Gateway Pundit. (2021, July 25) *UPDATE FROM SYDNEY: Reporter apologizes for unclear numbers on vaccinated individuals.* NSW News 9 (Rumble). https://rumble.com/vkba8x-update-from-sydney-all-new-covidhospitalizations-involve-vaccinated-indivi.html

[148] Markos, M. (2021, June 17) *Nearly 4,000 breakthrough COVID infections have now been reported in mass.* NBC Boston. https://www.nbcboston.com/news/local/nearly-4000-breakthrough-covid-infections-have-now-beenreported-in-mass/2408052/

[149] Lovelace, B. Jr. (2021, July 23) *Israel says Pfizer Covid vaccine is just 39% effective as delta spreads, but still prevents severe illness.* CNBC news. https://www.cnbc.com/2021/07/23/delta-variant-pfizer-covid-vaccine39percent-effective-in-israel-prevents-severe-illness.htm

[150] *The race for a COVID-19 vaccine, explained.* (2021, January 12). World Health Organization. https://www.who.int/news-room/feature-stories/detail/the-race-for-a-covid-19-vaccine-explained

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12. Vaccine passports will have a greater negative impact on the poor, the homeless and those with mental illness or developmental delays as they may not have a mobile device or a printer to demonstrate their documentation. For those who choose to remain unvaccinated, vaccine passports may prevent them from accessing fitness facilities that help to prevent obesity, one of the co-morbidities of COVID-19.

13. Many people already have immune protection to SARS-CoV-2 virus or are healthy with no symptoms. This includes 1) those who can show a negative rapid COVID-19 test; 2) those who are COVID-19-recovered as confirmed with a PCR test for the virus during their illness; and 3) those who can demonstrate antibodies and/or T-cells reactive to SARS-CoV-2. After at least 18 months of exposure of our population to SARS-CoV-2, the percentage of Canadians that is estimated to have naturally acquired immunity is up to 90%, with broader testing needed to establish the country-wide level and how it may affect safety and efficacy of the vaccine product.[151] Moreover, immunity acquired by infection is more robust, broader and more durable than the temporary immunity acquired by vaccination, yet a vaccine passport would exclude these individuals from participating in society.[152]

14. Vaccine passports and vaccine mandates discriminate against those who cannot be vaccinated either due to medical, religious or philosophical reasons.

15. Vaccine passports and vaccine mandates discriminate against those individuals who have had a "bad" reaction (as determined by the individual's experience) from a vaccine injection, and cannot or prefer not to take another injection, and cannot obtain a medical exemption. These individuals may never again be able to work or get onto a plane or participate fully in society. This may force many Canadians into poverty, depression and suicide. Moreover, more than 50% of double vaccinated individuals experience adverse reactions that provide symptoms equivalent to actual infection with the SARS-CoV-2 virus.[153]

16. Vaccine passports will impose an additional tax burden on Canadians and will be an ongoing implementation burden for businesses. Moreover, in the government's haste to develop Vaccine Passports, they have not provided the public with any evidence of its efficacy, and therefore, no means of pulling back the program if or when it achieves its desired goal.

17. We cannot discriminate against our American neighbours and other international visitors who have not been vaccinated by barring their entry into Canada since those who are vaccinated also carry a substantial risk of carrying and transmitting the SARS-CoV-2 infection. We must consider, for instance, those Americans who own recreational property in Canada who would be unable to tend to their own real estate.

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[151] Majdoubi, A., Michalski, C., O'Connell, S. E. et al. (2021) *A majority of uninfected adults show pre-existing antibody reactivity against SARS-CoV-2.* JCI insight. 6(8):e146316. https://doi.org/10.1172/jci.insight.146316

[152] Cohen, K. W., Linderman, S. L., Moodie, Z. et al. (2021) *Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells.* Cell Rep. 2:100354. https://doi.org/10.1016/j.xcrm.2021.100354

[153] *Local Reactions, Systemic Reactions, Adverse Events, and Serious Adverse Events: Pfizer-BioNTech COVID-19 Vaccine.* (2020, December 14). U.S. Centres for Disease Control and Prevention (CDC). https://www.cdc.gov/vaccines/covid-19/info-by-product/pfizer/reactogenicity.html

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Every Canadian is entitled to enjoy their basic freedoms without having to succumb to a mandatory medical intervention, one which is a novel experimental technology. Medical decisions are made through consultation with one's primary physician based on the individual's existing medical condition(s) and history. Some Canadians wish to prudently wait for more safety and efficacy data before taking this specially authorized injection. Our government is ignoring this fact as it continues to strenuously promote mass vaccination while simultaneously fostering behaviours of discrimination, bullying, and intimidation in the workplace and in society at large. Under duress, Canadians are being forced into making impossible decisions between an invasive medical intervention with poorly understood shortand long-term safety and their job/education/leisure/travel. Of note, on September 12, 2021, the UK decided to abandon the idea of Vaccine Passports.[154]

Canada has long stood as a beacon to other countries as a place of freedom from oppression. Let us not now shatter this pillar of Canadian democracy. Vaccine passports are reminiscent of the Nazi Reisepass, which permitted only certain Germans to freely travel inside and outside of Germany. The implementation of vaccine passports and vaccine mandates creates a polarized country and only serves to divide society into an apartheid of "haves" and "have nots." Vaccine passports and mandates for SARS-CoV-2 are not scientifically supported for need or effectiveness, and they are antidemocratic, anti-human rights and freedoms and anti-choice. Vaccine mandates against those Canadians who simply wish to make their own personal choices around their bodies are completely unconstitutional. The Canadian government must immediately halt all vaccine passports and mandates relating to these still largely unapproved, investigational genetic technologies, and ultimately choice must be preserved.

[154] Jackson, M. (2021, September 12) *England vaccine passport plans ditched, Sajid Javid says.* BBC News. https://www.bbc.com/news/uk-58535258

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VI. Censorship

The CCCA is calling out the government, mainstream media and social media platforms (including the "Trusted News Initiative") for their support of and collusion in the obvious censorship and suppression of valid and critical viewpoints regarding the COVID-19 pandemic and vaccination programs. Highly credentialed and well-respected physicians, scientists and academics are being purposely maligned, muzzled, threatened, sanctioned, smeared, de-platformed and canceled for simply advising their patients on well-researched treatments or for publicizing new research on vaccine safety whenever these views are contrary to the government narrative. **No democracy can survive such censorship**. If a democracy somehow exists amongst censorship, "then democracy will inevitably be snuffed-out there, and dictatorship will inevitably be the result" as "censorship blocks some essential truths from reaching the public".[155] We must stop the censoring of opposing viewpoints as, not only will Canadian democracy be put in jeopardy, but the public will also lose confidence in the government, science, medicine and, in this case, future vaccines.

As an essential stakeholder, the CCCA is requesting an open public forum to discuss the early treatment, COVID-19 vaccine programs, the proposed mandatory vaccines and vaccine passes. The CCCA is requesting to participate as a valued stakeholder and member of the COVID-19 Planning and Implementation Team(s), the COVID-19 Immunity Task Force, and the provincial Science Tables to discuss repurposed pharmaceutical treatments and to address non-pharmaceutical interventions (NPIs).

[155] Zuesse, E. (2020, February 15) *Censorship is the way that any dictatorship—and NO democracy—functions.* Strategic Culture Foundation. https://www.strategic-culture.org/news/2020/02/15/censorship-is-way-that-anydictatorship-no-democracy-functions/

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APPENDIX A

Slide #16 - FDA Safety Surveillance of COVID-19 Vaccines October 22, 2020 before EUA (Emergency Use Authorization): [156]

- Guillain-Barré syndrome
- Acute disseminated encephalomyelitis
- Encephalitis / myelitis / encephalomyelitis / meningoencephalitis / meningitis / encephalopathy
- Convulsions / seizures
- Stroke
- Narcolepsy and cataplexy
- Acute myocardial infarction
- Myocarditis / pericarditis
- Autoimmune disease
- Deaths
- Pregnancy and birth outcomes
- Transverse myelitis
- Other acute demyelinating diseases
- Anaphylaxis and non-anaphylactic allergic reactions
- Thrombocytopenia
- Disseminated intravascular coagulation
- Venous thromboembolism
- Arthritis and arthralgia/joint pain
- Kawasaki disease
- Multi-system Inflammatory Syndrome in Children
- Vaccine enhanced disease

All of these syndromes and more have been reported to the VAERS reporting system in the USA.

[156] Anderson, S. (2020, October 22) *CBER plans for monitoring COVID-19 vaccine safety and effectiveness.* US FDA. VRBPAC Meeting. https://www.fda.gov/media/143557/download

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APPENDIX B

Vaccination of Youth

According to the WHO, careful consideration must be given to make sure there is informed consent in the vaccination of children.[157]

In Canada and most countries in the world, privileges and responsibilities are given to individuals in stages, as they develop and mature. This graded introduction to adulthood is logical, as MRI evidence shows that the human brain is not fully mature until, on average, age 24. In regards to COVID-19, the vast majority of teens under age 17 are unlikely to have the intellectual or educational capacity to make decisions about their medical health (in particular regarding experimental treatments), as well as often having little or no knowledge about their own medical profile or that of their familial health history. Moreover, as stated above, the public in general has not even been presented with transparent information comparing risks and benefits of these novel vaccines.

Allowing children as young as 12 to make significant decisions regarding potentially life-changing medical procedures involving experimental treatments could have serious long term medical implications. This policy removes parent's rights to protect their children and puts those rights into the hands of the government, essentially making children temporary wards of the state. These are decisions and rights that should rest with the parents and for which children are, in most instances, incapable of making informed decisions about and are incapable of giving informed consent for.[158, 159]

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[157] *Considerations regarding consent in vaccinating children and adolescents between 6 and 17 years old.* (2014, May 12). World Health Organization (WHO). https://www.who.int/publications/i/item/considerations-regarding-consent-in-vaccinating-children-and-adolescents-between-6-and-17-years-old

[158] *Content: Brain Maturation is Complete at About 24 Years of Age – The Alcohol Pharmacology Education Partnership.* Duke University. Retrieved December 17, 2021, from https://sites.duke.edu/apep/module-3-alcohol-cell-suicide-and-the-adolescent-brain/content-brain-maturation-is-complete-at-about-24-years-of-age/

[159] Zimmer, C. (2016, December 21). *You're an Adult. Your Brain, Not So Much.* The New York Times. https://www.nytimes.com/2016/12/21/science/youre-an-adult-your-brain-not-so-much.html

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APPENDIX C

Recently published in the journal Science, Public Health Policy and the Law, Canadian Jessica Rose, PhD, MSc, BSc, authored a report titled, "A Report on the U.S. Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 Messenger Ribonucleic Acid (mRNA) Biologicals."[160]

This article entitled New study: Vaccines are the likely cause of adverse effects and deaths following vaccination summarizes the results:[161]

- 57% of reported deaths following vaccination occurred within 48 hours of inoculation.
- 66% of emergency room (ER) visits following vaccination occurred within 48 hours of inoculation.
- 63% of hospitalizations following vaccination occurred within 48 hours of inoculation.
- 70% of individuals developed symptoms within 48 hours following first or second doses.
- 79% of all VAERS reports were made after recipients received the first dose.
- 18% of all Adverse Events (AE) reports were cardiovascular, 12% were neurological, and 35% were immunological.
- Immunological AEs continue to rise with time even as other AEs have remained stable.
- Those aged 30 to 40 years old comprise the largest subset of reports overall.
- Higher absolute numbers of VAERS deaths and hospitalization are associated with the elderly aged 65 and above. 84% of deaths following vaccination belonged to those aged 70 to 90 years old.
- The highest frequency of cardiovascular AEs was by individuals aged 20 to 30 years of age.
- Spontaneous abortions recorded among women aged 20 to 40 years. 65% of these miscarriages happened after the first dose.

[160] Covid Strategies. (2021, July 2) *Canadian researcher analyzes CDC VAERS data for COVID-19 vaccine safety POV – But is the other side of risk calculated.* https://www.covidstrategies.org/canadian-researcher-analyzes-cdcvaers-data-for-covid-19-vaccine-safety-pov-but-is-the-other-side-of-risk-calculated/

[161] Covid Call to Humanity. (2021, May 24) *New study: Vaccines are the likely cause of adverse effects and deaths following vaccination.* https://covidcalltohumanity.org/2021/05/24/new-study-vaccines-are-thelikely-cause-of-adverse-effects-and-deaths-following-vaccination/

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El Jaouhari, Sidi-Adam (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2022-02-04 12:46 PM
To: hcminister.ministresc
Subject: TR: Letter on Covaxin Availability in Canada
Attachments: Covaxin Availability in Canada.pdf

De : Epp, Dave - M.P. <Dave.Epp@parl.gc.ca>
Envoyé : 4 février 2022 11:10
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : Letter on Covaxin Availability in Canada

Dear Minister,

Please find attached a letter regarding the availability of the Covaxin vaccine in Canada.

Thank you for your attention and consideration.

Sincerely,
Dave

Dave Epp

Member of Parliament
Chatham-Kent—Leamington

Tel: 888 326 9655

Email: dave.epp@parl.gc.ca

Website: www.DaveEppMP.ca

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February 4, 2022

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Hon. Jean-Yves Duclos, Minister of Health
House of Commons
Ottawa, ON
K1A 0A6

Dear Minister,

I am writing to you today regarding correspondence I have received from my constituents inquiring about the availability of additional vaccines in Canada.

There are constituents in my riding that do not feel comfortable taking the currently available vaccines in Canada due to their faith. There is at least one vaccine called Covaxin or BBV152, which has already been accepted as a valid COVID vaccine by Health Canada, that these constituents would freely take.

Minister, is this vaccine going to be made available in Canada for those who are not comfortable receiving the current vaccines but do wish to become vaccinated against COVID-19?

I have included one of the letters below from a constituent on this matter which fully outlines their reasoning and request.

Thank you for your consideration, and I look forward to your response that I can then share with these concerned constituents.

Sincerely,

[redacted]

Dave Epp, MP
Chatham-Kent—Leamington

ATIA - 19(1)

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20 January 2022,

Mr. Dave Epp

MP Chatham-Kent-Leamington

100-75 Erie Street South,

Leamington, N8H 3B2

Dear Mr. Epp,

[redacted] Bharat Biotech in India has produced a COVID vaccine which is free from fetal cell lines. BBV152 Covaxin has been given the green light by WHO and is being used in at least 13 countries. Also it has been recognized by Health Canada as a legitimate vaccine for people who are flying into Canada from countries that use it.

An American company called Ocugen has bought the rights to distribute Covaxin in Canada and in the US. [redacted] so far neither the FDA nor Health Canada have as yet given approval for the importation and use of Covaxin. [redacted] I am writing this letter in hopes that you will make this information available to your colleagues and encourage them to come together to put pressure on the Liberal Government regarding this matter.

For more information please visit https://www.lifenews.com/2022/01/17/covaxin-the-first-covid-vaccine-made-without-any-connection-to-abortion/

Sincerely,

[redacted]

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Trojanovic, Julia (HC/SC)

From: Prime Minister | Premier Ministre <PM@pm.gc.ca>
Sent: 2022-01-26 9:37 AM
To: [redacted]
Cc: Jean-Yves Duclos, P.C.,M.P.
Subject: Office of the Prime Minister / Cabinet du Premier ministre
Attachments: Mandatory_accination_CHP.pdf

Dear Mr. Taylor:

I would like to acknowledge receipt of your correspondence sent to Prime Minister Justin Trudeau.

Please be assured that your comments, offered on behalf of the Christian Heritage Party of Canada, have been carefully reviewed. In your correspondence, you raise an issue that falls within the portfolio of the Honourable Jean-Yves Duclos, Minister of Health. I have therefore taken the liberty of forwarding your email to Minister Duclos so that he may be made aware of your correspondence.

Thank you for taking the time to write.

M. Ibrahim
Executive Correspondence Officer/Agent de correspondance

Executive Correspondence Services/
Services de la correspondance de la haute direction

>>> From : [redacted]@hotmail.com Received : 15 Jan 2022 04:10:27 PM >>>

>>> Subject : Mandatory Vaccination - CHP >>>>

Please read our Open Letter against your mandate and desist in harming Canada.
https://www.chp.ca/news/open-letter-to-the-prime-minister

[redacted]AB

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CHP CANADA

PRESS RELEASE

January 12, 2022

Open Letter to the Prime Minister

Rod Taylor
National Leader, CHP Canada
PO Box 724 Telkwa, BC V0J 2X0
leader@chp.ca
250-877-8426

Rt. Hon. Justin Trudeau
Prime Minister of Canada
Ottawa, ON

Dear Prime Minister:

Recent statements by the Hon. Jean-Yves Duclos, Minister of Health—regarding the possible imposition of mandatory vaccinations—have heightened tensions and added to the concerns felt by many Canadians about the erosion of our rights and freedoms guaranteed under the Charter.

As national leader of the Christian Heritage Party of Canada (CHP Canada), I must express, in the strongest possible terms, my opposition to any mandated injection with the experimental mRNA products.

I understand that the Health Minister was proposing that the provinces institute these vaccine mandates but with the full support of the federal government. This overt pressure on the provinces to implement further unconstitutional and coercive measures is a shameful and cowardly act by your government and should be withdrawn immediately. Canadians have already endured far too much intrusion into their lives, far too much intimidation, far too much violation of their personal choices and their entitlement to medical freedom.

Our opposition to the threat of a vaccination mandate—whether provincial or federal—rests on several pillars of common sense, scientific evidence and moral justice:

- The mRNA injections neither prevent infection with nor transmission of COVID-19. The original purpose of promoting vaccination was to create immunity to this disease. They have failed to do that. In some areas, vaccinated persons are being infected in even greater numbers than the vaccine-free. This is especially true in regard to the Omicron variant.
- The vaccines are causing harm to a statistically-significant percentage of those receiving the injections. The number of vaccine-induced adverse events—including deaths—has already exceeded, in one year, the number of adverse events and deaths from ALL previous vaccines over the past 30 years.
- The injection of children—who are at virtually-zero risk of dying from COVID—with an experimental product known to cause harm to some is completely irresponsible.
- Forcing or compelling any Canadian citizen to participate in a medical experiment is unconscionable. Every Canadian must have a free choice AND must be given ALL the information—including risk factors and the fact that the mRNA vaccines do not eliminate the possibility of infection or transmission. That is the only way they can give "informed consent".
- Since the mRNA vaccines do not provide complete immunization, and since "fully-vaccinated" individuals are equally capable of transmitting the disease to others, there is NO logical reason to segregate, separate or create unfair barriers and obstacles for the vaccine-free.

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- Any coercion, mandate, threat, punishment or discrimination against a Canadian citizen based on his or her vaccine status is a violation of the Charter of Rights and Freedoms. Section 1 of the Charter does not nullify our rights, particularly because the limits imposed are not "reasonable", have not been "prescribed by law", and the need for them has not been "demonstrably justified".

- Neither the federal Health Minister nor any provincial health minister has done the due diligence to properly investigate alternative therapies that could alleviate or prevent severe symptoms and death. Studies from many local jurisdictions have shown that early treatment with several well-known, safe and inexpensive, repurposed drugs has reduced hospitalizations and deaths. Failure to at least properly investigate these claims may have resulted in many unnecessary deaths in 2020-2021.

- Those who have already contracted and survived COVID-19 are likely to have a much better and longer-lasting natural immunity than the temporary protection achieved by the mRNA vaccinations. To demand that COVID survivors subject themselves to dangerous experimental vaccination for little or no benefit and some possible harm does not make sense.

Every one of us mourns the death of any of our fellow-Canadians for any reason, whether due to COVID-19 or to a vaccine injury. However, the collateral damage caused by lockdowns, layoffs, bankruptcies, mortgage foreclosures, business closures, supply chain disruptions, missed education days, missed and postponed medical appointments and procedures and other unforeseen impacts far outweighs any benefit gained by brutal and unfair restrictions. In fact, when impacts on mental illness, drug abuse, suicides and the socialization of children are taken into account, it is obvious that the policies now in place have caused tremendous damage to our nation and to nations around the world.

Please reconsider your government's approach to these issues. I would be happy to introduce you to some of the brave and brilliant doctors and scientists who could help you chart a more effective course so we can turn the corner on this pandemic. There are thousands of good men and women ready and willing to return to their jobs in healthcare, aviation and law enforcement and other critical fields. They have unjustly suffered for their convictions and should be restored to their positions as soon as possible. We need them to help us rebuild our shattered economy, our groaning healthcare systems and crumbling social institutions. Mr. Prime Minister, you have an opportunity, if you act quickly, to mitigate some of the damage caused by the ill-conceived policies of the last year and a half.

Please instruct the Health Minister to withdraw his comments regarding "mandatory vaccinations" and personally assure Canadians that your government will no longer allow the rights and freedoms protected by the Charter to be violated.

Sincerely,

[redacted]

Rod Taylor
National Leader
CHP Canada
www.chp.ca

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Esteves, Dina (HC/SC)

From: Leong, Anthony [redacted]
Sent: 2022-05-05 3:49 PM
To: hcminister.ministresc@canada.ca
Cc: [redacted] Lucas, Stephen (HC/SC); Trombetti, Stefania (HC/SC); pierre.sabourin@hc-sc.gc.ca; Nadeau, Marika (HC/SC)
Subject: New McKesson Canada white paper "From Pandemic to Endemic: Lessons from COVID-19 on Improving Vaccination Campaigns in Canada"
Attachments: McKesson Canada White Paper - From Pandemic to Endemic 2022-05 FINAL.pdf

Hello Minister Duclos and team,

Hope you are keeping well.

It has been almost 18 months since COVID-19 vaccines have arrived, and McKesson Canada has been privileged to be part of the enormous effort to distribute doses across the country.

Building on our experience having distributed 17 million doses to community pharmacies, public immunization clinics, hospitals, long-term care homes, and other drop-off points in multiple provinces, attached is a 'sneak peek' at McKesson Canada's fourth COVID-19 related white paper, "From Pandemic to Endemic: Lessons from COVID-19 on Improving Vaccination Campaigns in Canada" (our previous white papers can be found at https://www.mckesson.ca/white-papers).

This white paper examines the lessons learned over the past year and a half of pharmacy-based COVID-19 immunizations, supported by pharmaceutical distributors. These lessons learned then inform a series of recommendations, including how community pharmacy can be the 'vaccination destination' for all public vaccines, whether they be COVID-19 boosters, routine immunizations, or to address other public health emergencies (e.g., measles outbreaks). In addition to leveraging a convenient immunization point for Canadians, having this year-round stand-up capacity would be of benefit during future surges arising from COVID-19 variants (as seen just before Christmas 2021) while allowing other healthcare professionals to focus on more critical needs, such as pandemic-induced backlogs in care.

We hope you find our new white paper helpful and timely as 4th dose eligibility continues to expand and new variants continue to threaten Canadians. We would be happy to answer any questions you may have and provide more detailed briefings if requested.

Cheers,

Anthony Leong, MBA, B.Sc.Phm, R.Ph

Vice President, Public Policy & Government Affairs | *t* [redacted]
Government Affairs

McKesson Canada | 2300 Meadowvale Road, Mississauga | www.mckesson.ca

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White Paper

From Pandemic to Endemic: Lessons from COVID-19 on Improving Vaccination Campaigns in Canada

May 2022

Key points at a glance

- McKesson Canada is proud to have played a significant role in Canada's COVID-19 immunization campaign, both as a pharmaceutical distributor delivering vaccines to pharmacies and public health sites, and as a pharmacy operator (via its six independent pharmacy banners and its Rexall chain), administering vaccines directly to patients. As of March 2022, Canadian pharmacists have administered more than 17 million doses across the country.
- The COVID-19 immunization campaign represents an inflection point in vaccination policymaking in Canada. Public health vaccines will play a more prominent role going forward. This presents an opportunity to optimize the way in which vaccines are delivered to Canadians, by making pharmacy the 'vaccination destination' – the primary source for all public health immunizations.
- By emphasizing the community pharmacy as the primary source for vaccines, governments would build upon a strong vaccine model (that has emerged in recent years via the seasonal flu shot campaign) while bringing relief elsewhere in the healthcare system, as well as year-round stand-up capacity for acute outbreaks, as seen with rapid rise of the Omicron variant.
- Pharmacists have the experience and expertise to oversee vaccine administration, and they are ideally suited to help vaccine-hesitant Canadians overcome the barriers to getting their dose.
- Pharmaceutical distributors have demonstrated that incorporating vaccines into the pharmacy distribution workflow creates efficiency for pharmacists, enabling smoother appointment processes for patients and minimizing vaccine waste. Four of the five provinces that had the largest share of vaccines administered in pharmacy used the existing seasonal flu vaccine distribution model to deliver doses to pharmacies.

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Introduction

Soon after the COVID-19 pandemic began in Canada in the Spring of 2020, it became clear that any return to 'normal' – perhaps not the status quo ante, but at least to some semblance of pre-pandemic life – would not occur until an overwhelming majority of Canadians have been vaccinated. At the time, a COVID-19 vaccine existed only in the designs of biomedical scientists; though the COVID-19 genetic sequence was published in early January 2020, most observers did not anticipate a mass-market vaccine arriving before at least 18 months had transpired. Beyond merely developing the vaccine, the pharmaceutical sector had to tackle the unprecedented challenge of manufacturing, transporting, storing, and administering billions of doses.

As the early spring phase of the pandemic turned to summer, policymakers began to grapple with the logistical challenges associated with mass immunization, particularly because the mRNA technology that underpinned some of the leading vaccine candidates required extreme temperature control. As the country's leader in pharmaceutical distribution, McKesson Canada began raising concerns and proposing solutions with federal and provincial governments on vaccine supply chain readiness in the summer of 2020, followed by a widely cited white paper in September of that year.

As fall arrived, and with it an increase in COVID-19 case counts, the prospects of one or several promising vaccine candidates improved considerably. On December 9, Health Canada issued an interim order authorizing Pfizer's COVID-19 vaccine for immediate use; similar authorizations followed for vaccines from Moderna, AstraZeneca, and Johnson & Johnson.

Following the authorizations, focus quickly shifted to mapping out how doses would be distributed and administered, requiring the focused collaboration of multiple levels of government, pharmaceutical manufacturers and distributors, public health agencies, and healthcare professionals. The first COVID-19 vaccine dose, manufactured by Pfizer, was administered to an 89-year-old long-term care resident in Quebec City on December 14, 2020.

In the ensuing months, the supply of COVID-19 doses increased considerably, though the arrival of doses was hardly straightforward. By summer 2021, all Canadians aged 12 and up who wanted a COVID-19 vaccine had access to one; by the end of the year, vaccines were available to those as young as five, and adults were encouraged to receive a booster dose. More than 80% of Canadians have received two doses of a COVID-19 vaccine, with more than 82 million total doses administered. Nearly half of Canadians have received a booster.

The emergence of the Omicron variant in late 2021 led to an explosion of case counts and placed Canada's healthcare system under extreme strain. While the initial Omicron data suggest that it is not as deadly as previous variants (particularly among those who have been vaccinated), many experts are adamant that the novel coronavirus will be with us for years to come. Its stubbornly high transmissibility means that our healthcare systems will remain vulnerable. Moreover, it is clear that the best tool policymakers have in their arsenal is vaccination.

The main question confronting policymakers is how to best establish a permanent vaccination campaign that is affordable, accessible, sustainable and that relieves pressure on our fragile healthcare system.

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This paper asserts that community pharmacy, supported by Canada's pharmaceutical distributors, is the logical and optimal destination for COVID-19 vaccination campaigns in Canada. As stated in our November 2020 white paper on *COVID-19 immunization readiness*, community pharmacies have the healthcare expertise and experience, the geographical footprint, and the established business practices to best serve Canada's public health vaccination needs going forward. Given that patient behaviour, including that related to immunization, is driven in large part by convenience, any successful vaccination strategy requires predictability of supply, efficient logistics and clear communications.

The paper outlines three broad recommendations:

- Canadian governments should engage community pharmacy as the principal 'vaccination destination' for Canadians, building on the efficiency, affordability, and convenience that Canada's pharmacies offer.
- The pharmaceutical distribution system should be considered the primary vehicle for managing the flow of vaccines and related supplies to pharmacies across the country.
- Canada's immunization system requires 'surge capacity' to quickly expand vaccination should the need arise, as occurred following the onset of the Omicron variant in late 2021.

Recommendation 1:
Make pharmacy the 'vaccination destination' for Canadians

The COVID-19 pandemic has surfaced the importance of comprehensive, timely, and affordable access to vaccines in Canada. The pandemic has also altered the way in which immunization policy is considered. Prior to the arrival of COVID-19, vaccines were often administered on a relatively routine basis, with most Canadians encountering immunization policy either through the routine vaccines administered to children or through the annual seasonal influenza campaigns.

The pandemic has demonstrated the importance of building immunization capacity to administer vaccines to a majority of the population in a very short timeframe, often with minimal advance warning. For policymakers, there are critical aspects of immunization policy that require considerable planning. For example, the development of vaccine manufacturing capacity has surfaced as an issue of national sovereignty. Public health officials similarly grapple with vaccine hesitancy in the population that can be pivotal in achieving herd immunity.

One takeaway from the pandemic is the valuable role that community pharmacy can play in ensuring immunization is accessible to all who need vaccines in a manner that is comprehensive, convenient, and affordable.

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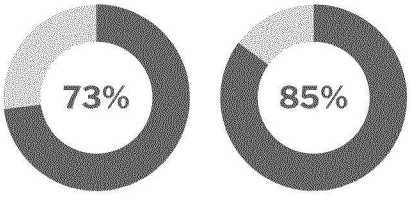
We encourage policymakers looking to establish strong and sustainable immunization capacity within the healthcare system to fully engage with the community pharmacy sector. McKesson Canada recommends that the federal and provincial governments engage the community pharmacy sector as the principal destination for public health immunizations in Canada.

By and large, Canadians agree that pharmacy is the ideal principal destination for vaccines. A June 2021 survey of Canadians conducted on behalf of the Neighbourhood Pharmacy Association of Canada by two professors from the University of Toronto found that convenience is the major factor driving patient preference for vaccine sites (respondents found only mass immunization clinics set up specifically for COVID-19 vaccines to be more convenient than pharmacies).[1]

While mass immunization clinics can handle huge volumes of patients in a relatively short amount of time, they are not sustainable. Adopting community pharmacy as the primary 'vaccination destination' would also enable pharmacists to engage with vaccine-hesitant populations; 73% of those who had received one dose and 85% of those who had received a second dose reported that they would accept a COVID-19 vaccine from a pharmacist if offered one on the spot. Unlike mass vaccination clinics, pharmacies benefit from access to patients who may not be planning to receive an immunization, but whose interaction with a healthcare professional can lead to a successful vaccination decision on the spot.



73% of those who had received one dose and 85% of those who had received a second dose reported that they would accept a COVID-19 vaccine from a pharmacist if offered one on the spot.

In addition to enabling more convenient access to vaccines for patients, engaging the pharmacy sector to be the main vaccine channel would alleviate stress and generate resource savings elsewhere in the healthcare system. By allowing pharmacists to perform the bulk of immunizations in Canada, governments would create opportunities for physicians and nurses to focus on other aspects of patient care, particularly given the backlogs created by the pandemic in screening of chronic diseases, surgical procedures, and regular medical checkups.

Enabling optimal pharmacy-based immunization would require governments at all levels to collaborate to build on the many lessons learned during the COVID-19 immunization campaign. McKesson Canada encourages immunization policymakers to consider the following observations:

- Community pharmacy requires infrastructure to handle larger volumes of vaccinations. Specifically, governments could benefit from leveraging existing investments pharmacists have made to ensure adequate temperature-controls within their pharmacy.
- Similarly, governments should consider creating more efficient data-management standards that are harmonized across jurisdictions and that better integrate pharmacy-level dose-tracking with provincial information technology systems (in many cases, pharmacists had to duplicate administrative work given the lack of IT integration).
- There is a need to better equip healthcare practitioners, including pharmacists, nurses, doctors, and public health officials, with tools to help combat vaccine hesitancy.
- Identifying pharmacy as the primary immunization channel requires clear objectives for pharmacy-based vaccinations, ensuring that pharmacists and governments have a shared understanding of expectations for vaccine administration. These objectives should be reflected in pharmacy funding frameworks
- In certain provinces, rules regarding pharmacist and pharmacy technician scope of practice require updating (namely what public vaccines can be administered to which age groups, as well as pharmacy technician

[1] https://neighbourhoodpharmacies.ca/sites/default/files/2021-07/NPAC%20Webinar%20Presentation%202021%2007%2015%20F.pdf

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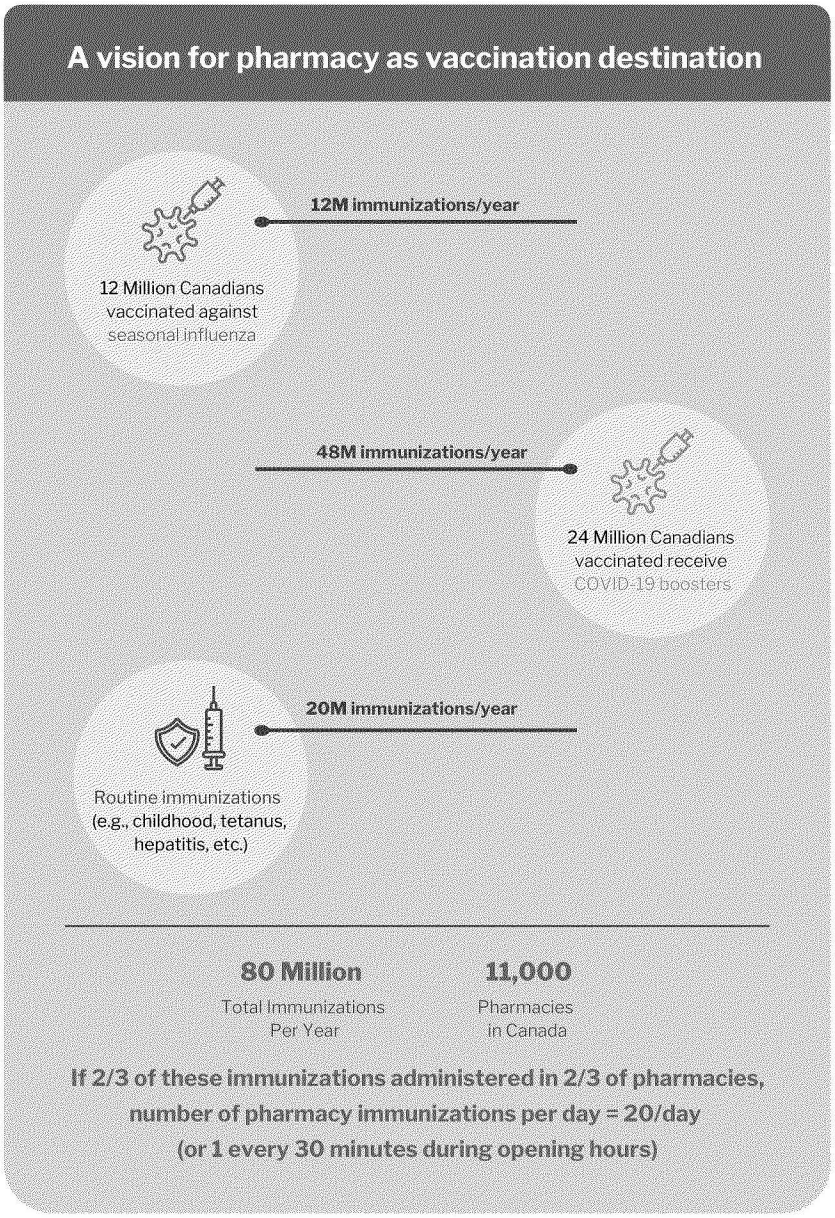
injection authority), such that pharmacy vaccination throughput can be maximized without compromising patient safety.

- Public health officials should work with pharmaceutical distributors and community pharmacists to establish a vaccination 'surge protocol' that would consist of a set of processes to quickly increase the number of vaccines administered in pharmacy. These could include timely pre-positioning of vaccines and related material with pharma distributors for quick distribution to community pharmacies, working with provincial pharmacy associations to pre-establish an allocation and vaccine pre-booking strategy, and reducing friction between government appointment and data entry systems and those used by pharmacies.



[2] https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009625

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Recommendation 2:
Leverage the pharmaceutical distribution system to make vaccine administration as efficient as possible

Canada's pharmaceutical distribution system is the ideal vehicle for managing the flow of vaccines. Pharmaceutical distributors have strong relationships with governments, pharmacies, hospitals, and clinics, as well as the industrial capacity and expertise to ensure the safe, secure, and speedy movement of vaccines and related supplies.

As of March 2022, McKesson Canada has delivered nearly 14 million COVID-19 vaccine doses to more than 5,000 pharmacies and public health units in six provinces that represent 92% of the Canadian population.[3] This amounts to 17% of all COVID-19 vaccine doses distributed across the entire country.

When the need to contribute to the distribution of COVID-19 vaccines emerged in December 2020, Canada's pharmaceutical distributors had an efficient model to build on, having been involved in seasonal influenza campaigns for several years. The public health flu distribution model was first developed by McKesson Canada in 2013 to ensure the efficient and equitable movement of flu shots from provincial depots to pharmacy clinics, built on a just-in-time model that ensured minimal waste and disincentivized hoarding practices.

The flu vaccine model is also built to service the preferred destination for immunization for Canadians: community pharmacy.[4] Currently, seven provinces work with pharmaceutical distributors to ensure the delivery of flu vaccines to pharmacies (in Alberta and Quebec, additional public health vaccines can be administered via pharmacy).

In addition to enabling Canadians to get their flu shots at their local pharmacies, the public flu distribution model has led to a 25% reduction flu vaccine waste, a 63% reduction in patients turned away because doses are out of stock, improved 'cold-chain' delivery integrity of doses, and better visibility and reporting of vaccine supply.[5]

In short, the public vaccine distribution model, initially developed for flu shots, provided a blueprint for ensuring COVID-19 vaccines could be stored, transported, and administered in the most efficient way possible.

Generally speaking, provinces that used the wholesale distribution system to ship vaccines to pharmacy had higher rates of pharmacy immunization than those that did not – four of the five provinces with the largest share of doses administered in pharmacy used the flu shot model for 'last mile' delivery.

McKesson Canada recommends that the federal and provincial governments engage Canada's pharmaceutical distributors as the primary system for delivering vaccines and supplies across the country. Doing so would ensure an efficient, cost-effective system of vaccine distribution that is already fully integrated with pharmacy workflows and requires little investment in transportation and storage capacity.

[3] B.C., Alberta, Saskatchewan, Ontario, Quebec, New Brunswick and P.E.I.
[4] Public opinion polling conducted by the Neighbourhood Pharmacy Association of Canada founds that seven in 10 Canadians favour having increased immunization options in pharmacy.
[5] Source: Canadian Association for Pharmacy Distribution Management.

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Achieving this objective would require adapting existing practices to address the challenges identified during the COVID-19 immunization campaign.

- As the immunization campaign matures, greater efficiencies will be realized by leveraging and augmenting the investments in vaccine infrastructure. While the public flu vaccine model provided a blueprint for distributing and administering vaccines to broad segments of the population in a limited timeframe, COVID-19 immunization effort required quickly ramping up infrastructure, staffing, business processes, and transportation networks that existed in limited ways or not at all (such as for frozen vaccines). Canada's new 'vaccine infrastructure' reflects the investment in large quantities of regular and ultra-low temperature freezers, as well as cold-chain and frozen pack outs to ensure the viability of the vaccine doses from end to end.
- The existing COVID-19 vaccine packs are best suited for surges in demand for vaccine. As we enter what will likely be a semi-permanent immunization campaign, pharmacies would benefit from the ability to order smaller quantities of vaccine. McKesson Canada encourages Health Canada to work with COVID-19 manufacturers to package their vaccines into smaller sizes, such as 1-vial and 5-vial packs, vs. 10-, 25-, or 195-vial packs, particularly as demand plateaus or patient populations become more targeted (e.g., pediatric vaccines).
- There are opportunities to improve the administrative processes related to immunization, such as by establishing organized coordination activities and communications among manufacturers, distributors, and governments to reduce resource-intensive data entry into provincial inventory tracking systems that were not designed for batch uploading of thousands of distribution transactions.
- A significant gap in the current immunization campaign relates to the liability indemnification and insurance coverage for pharmaceutical distributors for government-owned inventories, particularly for novel vaccines with unknown risk profiles. There is a need for a solution that limits the liability of the pharmaceutical distributors given they are not the product manufacturer and they do not own the products, aligned with the approach taken in the third-party logistics industry.

Recommendation 3:
Adapting the lessons of the Omicron wave to build 'surge capacity' into the immunization system

The onset of the Omicron wave in late 2021 fundamentally altered the way public health officials approached the COVID-19 pandemic. The rapid appearance of a COVID-19 variant that is considerably more transmissible than previous variants required that public health measures better suited to earlier waves of the pandemic be abandoned. In particular, Omicron's transmissibility demonstrated the limits of a 'test-and-trace' approach to containing the spread of the disease. Instead, officials focused on encouraging all eligible Canadians to acquire a booster dose as quickly as possible. As the figures below demonstrate, the swift increase in COVID-19 cases observed in December 2021 was matched by a spike in vaccine distribution, with the number of doses shipped in mid-December approaching five times the amount shipped in early November).

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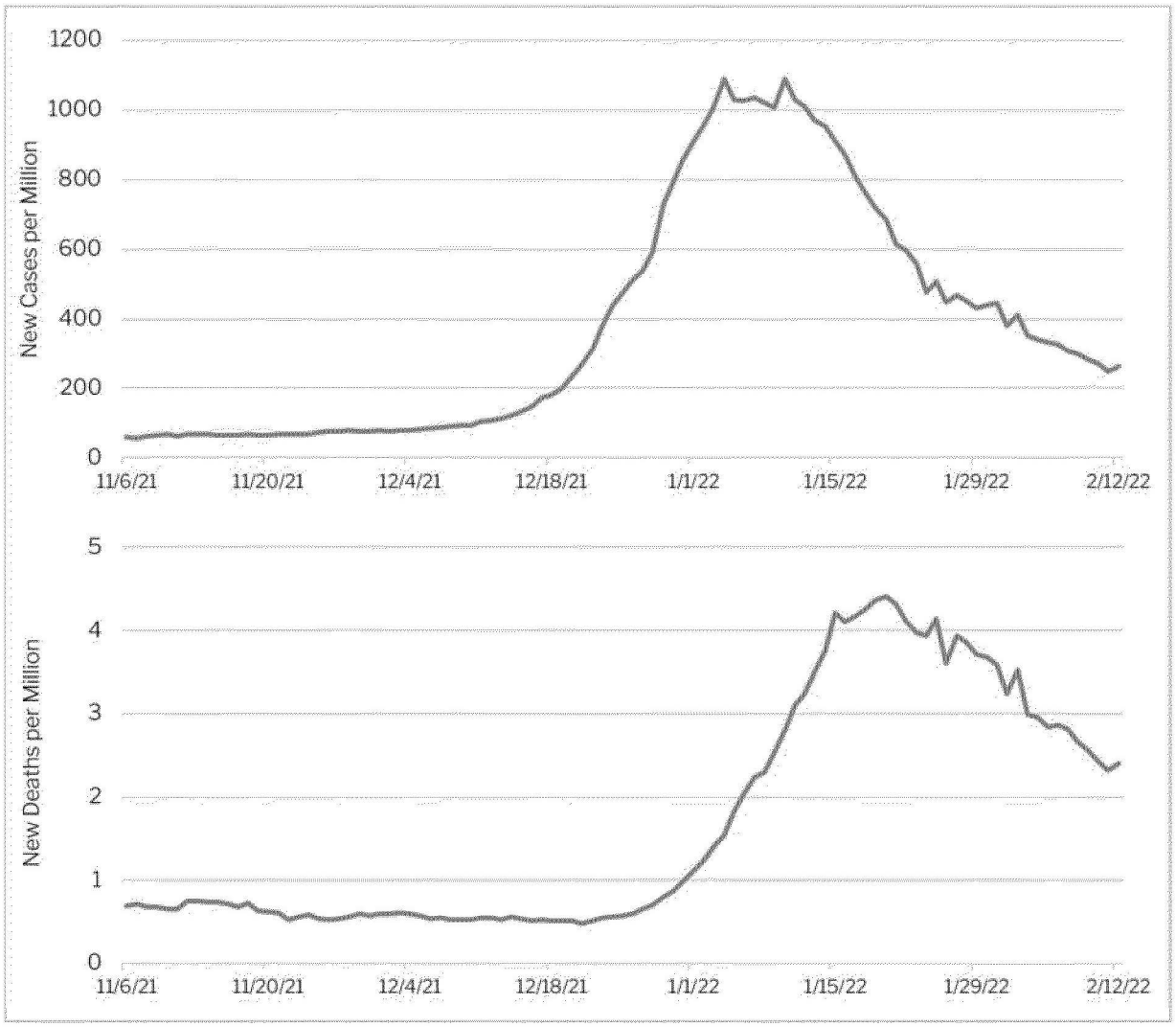
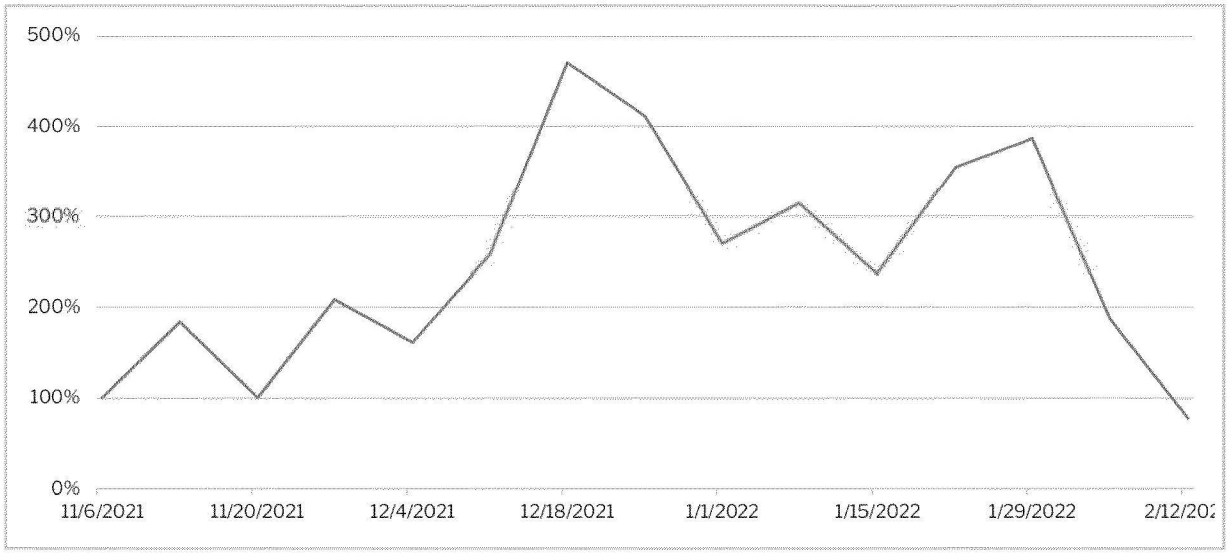
Figure 1: Daily new confirmed COVID-19 cases and deaths per million people (seven-day rolling average)



Source: Our World in Data: https://ourworldindata.org/covid-deaths

Figure 2: Weekly McKesson Canada Vaccine Distribution (November 6, 2021 = 100%)



Source: Internal McKesson Canada figures

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While one of the lessons of the Omicron wave is that future episodes of this pandemic are likely to be distinct from those that preceded them, the following recommendations can help prepare Canadians for a similar quick rise in cases:

- Work with pharmaceutical distributors and community pharmacists to establish a vaccination 'surge protocol' that would consist of a set of processes to quickly increase the number of vaccines administered in pharmacy. These could include pre-positioning a significant amount of vaccines and related material with pharma distributors for quick distribution to community pharmacies, working with provincial pharmacy associations to pre-establish an allocation and vaccine pre-booking strategy, and reducing friction between government appointment and data entry systems and those used by pharmacies.
- Provide provisional, if not permanent, vaccine administration authorization to pharmacy technicians to increase the potential pharmacy throughput.
- Develop and disseminate resources to support pharmacists working with vaccine-hesitant patients.
- Ensuring a short-term critical stockpile of COVID-19 related drugs (including the recently authorized antiviral Paxlovid), with particular attention paid to ICU drugs in the event that COVID-19 cases spike quickly

Conclusion

By any measure, Canada's immunization performance has been a success. As of this date, Canada leads the G7 with the highest share of its population having been vaccinated against COVID-19 (86%).

Community pharmacy has played a critical role in enabling access to vaccines across the country. Pharmacists have administered more than 17 million doses , limited only by decisions made by governments around vaccine dose allocation.

The rise of the Omicron variant accelerated plans for the administration of booster doses across the country and suggests that there will likely be further booster doses required, including possible co-administration of COVID-19 and seasonal flu vaccines in the fall.

McKesson Canada is proud to have participated in the country's fight against the coronavirus, marshalling its distribution and community pharmacy assets and networks to do as much as possible to get vaccines into arms. As we look forward to a future of increasingly common, regular and comprehensive vaccination campaigns, we encourage governments across Canada to enable the pharmacy sector to do its part. McKesson Canada recommends the federal and provincial governments use pharmaceutical distributors and community pharmacy as the main providers of all public health vaccines in the country.

In addition to drawing on the expertise and experience of pharmacists in administering vaccines, particularly around issues of vaccine hesitancy, optimizing the pharmacy channel's allocation of doses would relieve pressure elsewhere in the healthcare system. Using pharmaceutical distributors to ship vaccines would ensure an optimal and efficient integration of vaccine deliveries into pharmacy workflows, enhancing predictability and reducing waste. Our vision is one of improving health outcomes for all Canadians and, as such, we believe that making pharmacy the premier vaccination destination is a critical step in that direction.

About McKesson Canada

Our vision is to improve care in every setting — one product, one partner, one patient at a time.

We partner with hospitals, physicians, pharmacies, nurses, biopharmaceutical manufacturers and others across the spectrum of care to build healthier communities. By helping our partners be as successful as possible, we work together to improve patients' lives.

Contact Us

4705, Dobrin Street
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F. 514-745-2300

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Esteves, Dina (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2022-05-31 12:43 PM
To: hcminister.ministresc
Subject: TR : Letter to Minister Duclos RE: Supply of Evusheld
Attachments: 20220531_MinisterDuclos_Vecchio_SupplyofEvusheld.pdf

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De : Vecchio, Karen - M.P. <Karen.Vecchio@parl.gc.ca>
Envoyé : 31 mai 2022 12:07
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Cc : Vecchio, Karen - M.P. <Karen.Vecchio@parl.gc.ca>
Objet : Letter to Minister Duclos RE: Supply of Evusheld

Good Afternoon Minister Duclos,

Please find the attached letter from MP Karen Vecchio regarding the supply of Evusheld in Canada.

Thank you for your attention to this matter.

Sincerely,

Jillian Ferguson
Member's Assistant
Office of Karen Vecchio
Member of Parliament for Elgin-Middlesex-London
Shadow Minister for Women and Gender Equality and Youth
519-637-2255

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HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Karen Vecchio
Member of Parliament
Elgin—Middlesex—London

May 31, 2022

TO: The Honourable Jean-Yves Duclos, P.C.
Minister for Health
Sent via: Jean-Yves.Duclos@parl.gc.ca

RE: Supply of Evusheld for Immune Comprised Canadians

Dear Minister,

I am writing to you today regarding the recent announcement from Health Canada, which has authorized Evusheld (tixagevimab and cilgavimab) for use in individuals who are immunocompromised and unlikely to mount an adequate immune response to the COVID-19 vaccination, or for whom the COVID-19 vaccination is not recommended.

Following Health Canada's announcement on the authorized Evusheld, my office received a letter from a constituent who has indicated concerns with the supply of Evusheld and accessibility of the treatment for Canadians. This constituent is a kidney transplant recipient on immunosuppressive medication and believes that Evusheld would be revolutionary for her and all Canadians who have been isolating during the pandemic. I am writing to you today on behalf of these Canadians who are seeking an increase in supply of Evusheld.

I look forward to your response and providing my office an update on this pharmaceutical as well as restrictions that maybe placed on this drug for use. Thank you for your attention on this file.

Sincerely,

[redacted]

Karen Vecchio
Member of Parliament
Elgin-Middlesex-London

Ottawa
House of Commons
Room 449 Confederation Building
Ottawa, Ontario K1A 0A6
Tel: 613-990-7769
Fax: 613-996-0194
karen.vecchio@parl.gc.ca

Constituency
215-750 Talbot Street
St. Thomas, Ontario N5P 1E2
Tel: 519-637-2255
Fax: 519-637-3358
Toll Free: 866-404-0406
www.karenvecchiomp.ca

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Ghaly, Maggy (HC/SC)

From: hcminister.ministresc
Sent: 2022-12-14 2:11 PM
To: karen.vecchio@parl.gc.ca
Subject: In response to your correspondence / 22-004878 - 501

Ms. Karen Vecchio, M.P.
Elgin-Middlesex-London
karen.vecchio@parl.gc.ca

Dear Ms. Vecchio:

Thank you for your correspondence of May 31, 2022, concerning the availability of Evusheld for immunocompromised individuals in Canada. I regret the delay in responding.

I agree that the protection of people who are immunocompromised and who are unlikely to mount an adequate immune response to 2019 novel coronavirus (COVID-19) vaccination is a priority. For this reason, the Government of Canada has been working with the manufacturer and the provincial and territorial governments to ensure a sufficient supply of Evusheld for the Canadian population who would benefit from this COVID-19 prophylactic/treatment.

Evusheld is available for individuals 12 years of age and up who have a weaker immune system and are unlikely to be protected by a COVID-19 vaccine, as well as those for whom vaccination is not recommended. The product was also recently authorized by Health Canada to treat adults and adolescents (aged 12 years and older and weighing at least 40 kg) with confirmed mild to moderate COVID-19. Evusheld prophylactic was made available for provincial and territorial distribution in April 2022 and supply remains available for them to draw upon. Further deliveries are expected in the coming months to ensure a continued adequate supply.

Currently, eligible populations in Ontario, as outlined by Ontario Health, include:

- Solid organ transplant recipients;
- Stem cell transplant recipients;
- CAR-T cell therapy recipients;
- Other hematologic cancer patients undergoing treatment; and
- New as of October 2022
    - People receiving anti-B-cell therapy (e.g. rituximab); and
    - People with significant primary immunodeficiency.

There are various ways that patients can access Evusheld in Ontario:

- Access is offered through select hospital-based clinics, including cancer and transplant programs and some clinical assessment centres. Some clinics may accept referrals from providers in the community.
- Evusheld can also be dispensed through pharmacies as of October 3, 2022.

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Health Canada encourages individuals who are immunocompromised to consult with their physician about the use of Evusheld based on their individual circumstances. More information on the use of Evusheld can be found at **http://bit.ly/3O5ZxKm**.

Again, thank you again for writing. I hope this information is useful in addressing your concerns. Please accept my best wishes.

Yours sincerely,

The Honourable Jean-Yves Duclos, P.C., M.P.

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Christian Science Committee on Publication for Alberta

The Honourable Jean-Yves Duclos
Minister of Health
House of Commons
Ottawa, Ontario,
Canada
K1A 0A6

June 1, 2022

Re: *Minimizing the Risk of Exposure to COVID-19 in Canada Order (Prohibition of Entry into Canada)* (PC Number: 2022-0567, 2022-05-31)

VIA ELECTRONIC AND REGULAR MAIL

Dear Sir,

As Deputy Federal Representative for Christian Science in Canada,[1] I am writing to request a meeting with you or your officials. The purpose of the meeting would be to discuss whether options might be available to accommodate a non-citizen non-immigrant with sincerely held religious beliefs that are inconsistent with the COVID-19 vaccination requirement contained in the above order if the individual is entering the country solely to engage in a religious activity conducted by a religious organization.

At the outset, I would like to make clear that the Christian Science Church does not oppose COVID-19 vaccination and does not dictate the decisions of its members regarding health care or in any other respect.[2] In considering issues surrounding vaccination, Christian Scientists are acutely aware and mindful of the needs and expectations of their communities, as well as the challenges surrounding implementation of requirements for COVID-19 vaccination at the present time. Yet, many of our members do appreciate religious accommodations where possible.

It may be helpful to provide some context. Christian Science is a religion based on the Bible that has been practiced throughout Canada for more than a century. One of the core aspects of Christian Science is that gaining a deeper understanding of one's relationship with God through consecrated study and prayer results in healing of problems of all kinds. Generally speaking, Christian Scientists turn to prayer rather than conventional medical treatment when they experience health problems. Those decisions are not made out of opposition to medical treatment, but because these individuals have found reliance on Christian Science to be an effective way to maintain their health, in some cases over the course of their entire lives.

In my experience, church members' decisions about COVID-19 vaccination (and, indeed, vaccination in general) are highly individual and based on their religious practice and life experience. Based on this practice and experience, many of our members hold sincere religious beliefs that are inconsistent with COVID-19 vaccination. Under the terms of the above order, non-citizens holding such beliefs are not

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[1] I am one of five representatives of Christian Science (in the provinces of Alberta, Ontario, Quebec, Manitoba, and British Columbia) appointed by local branches of the First Church of Christ, Scientist to ensure that lawmakers and government officials have accurate information about our religion and its practice. I have been appointed to serve as the Deputy Federal Representative for Christian Science in Canada for the purpose of working with federal officials to address the issues described in this letter.

[2] Our church has published a public statement online that elaborates on these points in more detail.

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allowed to enter the country even if their visit relates to attendance at religious activity connected with a Christian Science organization in Canada. In many instances, these religious activities benefit Canadians, and sometimes there are no individuals in Canada available to perform these activities.

For example, there are organizations in Ontario and British Columbia that provide spiritual support and practical care to individuals who are experiencing health problems and have decided to rely on the teachings of Christian Science to address those problems. Because not many individuals in Canada are trained to provide this form of care, these organizations sometimes draw on resources from outside the country. The individuals receiving this form of care want and expect to receive care in accordance with the teachings of Christian Science. We are concerned that the current entry requirements could result in these organizations not having sufficient staff to provide needed care without some sort of accommodation.

In seeking to open a dialogue about religious accommodation to this vaccination requirement, we are not asking that exceptions be made to other applicable public health requirements, such as testing and quarantine. We also respect and appreciate the Government's prerogative to keep the population safe. We would simply like to explore with you or your officials whether some sort of narrow accommodation (which we believe would only be needed in a small number of instances) is possible.

Since the onset of the pandemic, I and my fellow representatives of Christian Science in Canada have had conversations about public health and vaccination with many individuals, some of whom are members of our church and others who are not. These conversations have given us insight into both the challenges involved with the processing of religious accommodation requests and ways in which that process can be done accurately. We would be happy to share what we have learned from these experiences if that would be at all helpful.

Thank you for your cooperation and consideration. Please feel free to contact me at (403) 651-6683 if you have questions or to schedule a meeting.

Respectfully Yours,

Jim McClimans

Deputy Federal Representative, Canada
Christian Science Committee on Publication for Alberta

347 Parkland Way SE. Calgary, Alberta T2J 4L1 (403) 651-6683 alberta@compub.org

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Dillon, Megan (HC/SC)

From: Falk, Ted - M.P. <Ted.Falk@parl.gc.ca>
Sent: 2022-07-11 11:32 AM
To: hcminister.ministresc
Subject: vaccine mandates

hcminister.ministresc@hc-sc.gc.ca

The Honourable Jean-Yves Duclos,

I write you regarding a constituent and federal public servant. [redacted]

Sincerely,

Ted Falk
Member of Parliament for Provencher
9A-90 Brandt St.
Steinbach, MB R5G 0T3
204-326-9889
Ted.Falk@parl.gc.ca

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Conlin, Marie (HC/SC)

From: Prime Minister | Premier Ministre <PM@pm.gc.ca>
Sent: 2022-07-11 11:26 AM
To: [redacted]@[redacted]
Cc: hcminister.ministresc
Subject: Office of the Prime Minister / Cabinet du Premier ministre

Dear Ms.[redacted]:

On behalf of Prime Minister Justin Trudeau, I would like to acknowledge receipt of your correspondence.

Please be assured that your comments have been carefully reviewed. In your correspondence, you raise an issue that falls within the portfolio of the Honourable Jean-Yves Duclos, Minister of Health. I have therefore taken the liberty of forwarding your email to Minister Duclos for information and consideration.

Thank you for taking the time to write.

J.P. Vachon
Manager/Gestionnaire
Executive Correspondence Services
Services de la correspondance
de la haute direction

>>> From : [redacted]@[redacted] Received : 08 Jul 2022 01:20:34 PM >>>

>>> Subject : PM Web Site Comments - Health >>>>

Subject/Sujet : Health
Date : 2022/07/08 5:20:11 PM
First Name/Prénom :[redacted]
Last Name/Nom :[redacted]
E-Mail/Adresse électronique :[redacted]@[redacted] Address/Adresse :[redacted] City/Ville : Langley Province : British Columbia Postal Code/Code postal : V[redacted] Telephone/Téléphone :[redacted] Comments/Commentaires : Hello Mr. Trudeau,

Recent articles on the CBC indicate strongly that Health Minister Tam and the Trudeau government will no longer consider 2 doses of the Covid vaccine as 'fully vaccinated' and instead are subtly laying the groundwork for mandatory boosters--possibly every 9 months. Please see article below. As someone who is currently fully vaccinated, in good health and not a senior, I strongly object to mandatory ongoing vaccines for Covid. Please convey my deepest concerns to your government. I currently serve as an [redacted] in the North Langley area of BC ([redacted], and serve many Canadian citizens in the Langley/Aldergrove area. Our [redacted] has complied with all government mandates regarding Covid, but a move to require further vaccines (or possibly be barred from travel or work) is completely unconstitutional and as Prime Minister, I ask you to do everything in your power to halt this action. Thank you for serving our country.

you.https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cbc.ca%2Fnews%2Fpolitics%2Fomicron-resurgence-booster-dose-1.6507089&data=05%7C01%7Chcminister.ministresc%40hc-sc.gc.ca%7C0ea7277d22b84c166a7108da6351b51f%7C42fd9015de4d4223a368baeacab48927%7C0%7C0%7C63793149

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9945388700%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C7000%7C%7C%7C&sdata=rZwEW01DSHTOq3kaEuOjDg7RpckWO2uXwFIY6qTTXIQ%3D&reserved=0

[redacted]

[redacted]

[redacted]

T: [redacted]

E: [redacted]@[redacted]

https://can01.safelinks.protection.outlook.com/?url=http%3A%2F%2F[redacted]%2F&data=05%7C01%7Chcminister.ministresc%40hc-sc.gc.ca%7C0ea7277d22b84c166a7108da6351b51f%7C42fd9015de4d4223a368baeacab48927%7C0%7C0%7C637931499945388700%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C7000%7C%7C%7C&sdata=%2BhMssUlEc9dNSsWZ%2FVtJ0ruK8DrA4bDT9tNh4MTJaNQ%3D&reserved=0

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Dillon, Megan (HC/SC)

From: Prime Minister | Premier Ministre <PM@pm.gc.ca>
Sent: 2022-07-15 3:37 PM
To: [redacted]
Cc: hcminister.ministresc
Subject: Office of the Prime Minister / Cabinet du Premier ministre

Monsieur,

Au nom du premier ministre Justin Trudeau, j'accuse réception de votre récente correspondance au sujet de l'approche du gouvernement fédéral concernant la vaccination contre la COVID-19.

Je puis vous assurer que nous avons soigneusement noté vos propos. J'ai pris la liberté de transmettre copie de votre courriel à l'honorable Jean-Yves Duclos, ministre de la Santé, à titre d'information et pour examen.

Je vous remercie d'avoir pris le temps d'écrire.

L. Morin
Agent de la correspondance
de la haute direction

>>> De : [redacted] Reçu : 07 juil 2022 11:27:03 AM >>>

>>> Sujet : RE: Office of the Prime Minister / Cabinet du Premier ministre >>>>

Bonjour L. Morin,

Dans ce cas-ci, ma grande inquiétude relève du fédéral et du Ministre Duclos. Voir l'article qui relate du propos.

https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.lapresse.ca%2Fcovid-19%2F2022-06-30%2Fpossible-obligation-vaccinale%2Fduclos-precise-ce-qu-est-une-vaccination-a-jour.php&data=05%7C01%7Chcminister.ministresc%40hc-sc.gc.ca%7C57cc1ac5bb5640d5f1c208da66997466%7C42fd9015de4d4223a368baeacab48927%7C0%7C0%7C637935106510180217%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C7000%7C%7C%7C&sdata=UzrS%2B7BXqgagKE6yItorkB4BK%2FwnB29dABsQ87ErmmE%3D&reserved=0

Je vous en conjure de ne pas faire l'erreur grave d'obliger les Canadiens à requérir à une 3e dose pour permettre de voyager au pays ou garder autres privilèges. Faites-en la promotion tant que vous voulez mais, laissez le libre choix aux Canadiens!

Merci

[redacted]

QUÉBEC | Salle de montre, siège social et usine
[redacted]

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ATIA - 19(1)

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MONTRÉAL | Salle de montre
[redacted]

-----Message d'origine-----
De : Prime Minister | Premier Ministre <PM@pm.gc.ca> Envoyé : 7 juillet 2022 11:13 À : [redacted]
<[redacted] Objet : Office of the Prime Minister / Cabinet du Premier ministre

Monsieur,

Au nom du premier ministre Justin Trudeau, j'accuse réception de votre récent courriel.

Nous vous remercions d'avoir écrit. Le premier ministre aime obtenir les commentaires des Canadiennes et des Canadiens sur les enjeux qui leur sont chers. Je puis vous assurer que nous avons pris bonne note de vos propos.

Comme certains enjeux concernant la vaccination relèvent de la compétence du gouvernement provincial, vous voudrez peut-être, si vous ne l'avez déjà fait, communiquer avec les autorités compétentes, notamment le ministère de la Santé et des Services sociaux du Québec. Vous trouverez les coordonnées du ministère à l'adresse suivante : https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.quebec.ca%2Fgouvernement%2Fministere%2Fsante-services-sociaux%2Fcoordonnees&data=05%7C01%7Chcminister.ministresc%40hc-sc.gc.ca%7C57cc1ac5bb5640d5f1c208da66997466%7C42fd9015de4d4223a368baeacab48927%7C0%7C0%7C637935106510180217%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C7000%7C%7C%7C&sdata=DLBZA3%2Bs0yLH4iA9eEGrZ16piV%2FdtnZ%2FzfeEaz9fnJM%3D&reserved=0.

Une fois de plus, nous vous remercions d'avoir pris la peine d'écrire.

L. Morin
Agent de la correspondance
de la haute direction

>>> De : [redacted]@[redacted] Reçu : 04 juil 2022 12:23:40 PM >>>

>>> Sujet : Covid-19 - SVP ne faites pas cette erreur >>>>

Bonjour M. le PM et ministres,

[redacted] J'ai aucune affiliation avec quelques groupes que ce soit.

Je vous écris aujourd'hui car, il semblerait qu'il y aurait une volonté d'imposer un 3e vaccin contre la Covid-19 dans les prochains mois. [redacted] Pour nous aider à repartir notre économie face à un ennemi méconnu qui a fait plusieurs ravages dans sa 1ère année. Heureusement depuis l'arrivée d'Omicron, ce variant nous permet de reprendre une vie plus normale avec une immunité collective qui est en train de se bâtir. Vous avez certainement comme moi, plusieurs personnes dans votre entourage qui ont été infectés sans complications sérieuses. Il y aura toujours des exceptions mais, dans l'ensemble, les choses se déroulent beaucoup mieux qu'avant et c'est ce qui comptent.

Aujourd'hui, nous réalisons que la guerre à tout prix contre la Covid-19 a fait des dommages collatéraux encore plus grave qu'anticipé. La santé mentale des Canadiens est à son plus bas malgré les centaines de milliards injectés dans

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l'économie du pays. Protéger à tout prix la population vulnérable contre la Covid-19 a eu de conséquences très graves. La pénurie de main d'œuvre, de matériaux, les problèmes de transport dans nos aéroports, la stigmatisation d'une partie de la population et j'en passe. Une période très basse de notre histoire et à preuve, le partie Libéral en paie le prix à l'heure actuelle!

Entretenir cette peur fonctionne très bien avec une partie de la population mais, le prix politique sera cher payé. Si vous désirez rallier le maximum de Canadiens, vous devez informer les canadiens en toute transparence, présenter les 2 côtés de la médaille et laisser le choix aux citoyens sur une vaccination de rappel ou pas. [redacted]

La pandémie a dévoilé au grand jour la faiblesse de notre système de santé. Il me semble que ça serait plus mobilisateur de proposer un beau projet de société et d'entretenir un message plus positif sur l'avenir de notre beau pays. La division, la peur et le populisme pratiqué par d'autres politiciens ne rallieront pas la majorité souhaitée pour gouverner avec solidité.

Ça prend un changement important de cap pour assurer votre avenir. Il n'en tient qu'à vous!

Sincèrement,

Merci

[cid:image001.png@01D88F9A.4CB53830]

[redacted]

MONTREAL | Salle de montre

[redacted]

[cid:image002.png@01D88F9A.4CB53830]

[redacted]

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[cid:image005.png@01D88F9A.4CB53830]

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Conlin, Marie (HC/SC)

From: CCCA Info <info@canadiancovidcarealliance.org>
Sent: 2022-07-19 11:34 PM
Subject: Request to Halt COVID-19 Vaccinations of Children
Attachments: CCCA-Halt-vaccination-of-children-Officials-Letter-Jul-14-22.pdf; thumbnail.jpeg

Dear Health Official,

We are a group of independent Canadian scientists consisting of pediatricians, immunologists, vaccinologists, health policy experts, and evidence-based methodologists from the Canadian Covid Care Alliance who have concerns regarding the use of the COVID-19 genetic vaccines in children. We understand the challenges inherent in ensuring that public health policy remains up-to-date in a field where science is rapidly evolving. We are reaching out today, to share with you, *the most up-to-date evidence on COVID-19 mRNA vaccines used in children (aged < 18 years).* It is our view that at this point in the COVID-19 crisis, the risks associated with COVID-19 mRNA vaccines far outweigh the benefits in children. Please consider the following:

1. **In the Omicron era, there is widespread naturally acquired immunity. Therefore, there is no medical need for children to receive COVID-19 mRNA vaccines**
   a. In the Omicron era when there is widespread naturally-acquired immunity and where the virus produces a milder form of COVID-19 than earlier strains, healthy children are even less at risk of severe disease or death from COVID-19.
   b. In the Omicron era, there is widespread immunity and where the vaccines cannot halt transmission (*i.e.,* non-sterilizing) and likely require perpetual updates, children pose no significant risk to adults.
   c. The vast majority of severe illness and deaths from COVID-19 have impacted frail and older persons having multiple co-morbidities who can better benefit from more targeted protection.

2. **COVID-19 mRNA vaccines do not work well relative to other forms of protection**
   a. Naturally acquired immunity is the gold standard for immunity – it is robust, comprehensive, durable, and provides appropriate protection against a respiratory infection.
   b. There is mounting evidence that the real-world effectiveness of the COVID-19 vaccines is extremely poor and short lived in children under 12 years of age.

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c. There are now potential treatments to prevent severe COVID-19 including new anti-virals, corticosteroids, antiseptic nasal/oral rinses and re-purposed drugs that can be used selectively unlike a global mass vaccination campaign where to be 'fully immunized' is not achievable.

3. The potential risks of COVID-19 mRNA vaccines outweigh their benefits in the Omicron era

a. Both non-inoculated and inoculated individuals with COVID-19 transmit SARS-CoV2 equally with little difference (less than a day) in sickness, eliminating the basis for the mass vaccination of children as a means of protecting society or ICU capacity.

b. In the Omicron era, where there is widespread naturally acquired immunity, current data shows that COVID-19 vaccines are neither particularly effective nor acceptably safe for children.

c. There is growing concern related to the adverse long-term impacts on immune function from repeated injections of now obsolete COVID-19 products that paradoxically increase susceptibility to infection and illness via antigenic imprinting, and antibody-dependent enhanced disease.

We are also attaching a fully referenced letter outlining our concerns. We thank you in advance for taking the time to review our findings and would be happy to meet you to discuss them in greater detail.

Respectfully,

The Canadian Covid Care Alliance

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Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid
CCCA

Website: www.canadiancovidcarealliance.org
E-mail: info.canadiancovidcarealliance.org

Request to Halt COVID-19 Vaccinations of Children

July 14, 2022

Dear Health Official,

The COVID-19 crisis has been filled with uncertainty since early 2020 that resulted in unprecedented measures adopted by the federal and provincial health agencies and officials to mitigate the impacts of a novel respiratory pathogen on vulnerable groups in our country. A key part of this national effort was Health Canada's approval of the first two-dose series of COVID-19 mRNA novel vaccines for use in children 12 to 15 years of age on May 5, 2021[1] followed by their approval for children 5 to 11 years of age on November 19, 2021,[2] and more recently recommendation of boosters by the National Advisory Committee on Immunization for use in high-risk children 12 to 17 years of age.[3] On June 15, 2022 the Food Drug Administration authorized these vaccines for children 6 months or older,[4] an indication that is currently under review by Health Canada and the National Advisory Committee on Immunization.[5,6]

We are a group of independent Canadian scientists consisting of pediatricians, immunologists, vaccinologists, health policy experts, and evidence-based methodologists from the Canadian Covid Care Alliance who share your concern for the well-being of Canadians. We understand the challenges inherent in ensuring that public health policy remains up-to-date in a field where the science is rapidly evolving. Given the decades of quality life years that our children have ahead of them,[7,8] we firmly believe it is our duty as adults to work together to ensure that our children are protected not only from sickness but also from unnecessary or harmful medical interventions. We are reaching out today, to share with you, *the most up-to-date evidence on COVID-19 mRNA vaccines used in children (aged < 18 years).* The data shows that, in the Omicron era, when population-based immunity is widespread, the risks associated with COVID-19 mRNA vaccines far outweigh the benefits in children. Please consider the following:

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1. **In the Omicron era, there is widespread naturally acquired immunity. Therefore, there is no medical need for children to receive COVID-19 mRNA vaccines**
   a. In the Omicron era when there is widespread naturally-acquired immunity and where the virus produces a milder form of COVID-19 than earlier strains, healthy children are even less at risk of severe disease or death from COVID-19.
   b. In the Omicron era, there is widespread immunity and where the vaccines cannot halt transmission (*i.e.,* non-sterilizing) and likely require perpetual updates, children pose no significant risk to adults.
   c. The vast majority of severe illness and deaths from COVID-19 have impacted frail and older persons having multiple co-morbidities who can better benefit from more targeted protection.

2. **COVID-19 mRNA vaccines do not work well relative to other forms of protection**
   a. Naturally acquired immunity is the gold standard for immunity – it is robust, comprehensive, durable, and provides appropriate protection against a respiratory infection.
   b. There is mounting evidence that the real-world effectiveness of the COVID-19 vaccines is extremely poor and short lived in children under 12 years of age.
   c. There are now potential treatments to prevent severe COVID-19 including new anti-virals, corticosteroids, antiseptic nasal/oral rinses and re-purposed drugs that can be used selectively unlike a global mass vaccination campaign where to be 'fully immunized' is not achievable.

3. **The potential risks of COVID-19 mRNA vaccines outweigh their benefits in the Omicron era**
   a. Both non-inoculated and inoculated individuals with COVID-19 transmit SARS-CoV2 equally with little difference (less than a day) in sickness, eliminating the basis for the mass vaccination of children as a means of protecting society or ICU capacity.
   b. In the Omicron era, where there is widespread naturally acquired immunity, current data shows that COVID-19 vaccines are neither particularly effective nor acceptably safe for children.
   c. There is growing concern related to the adverse long-term impacts on immune function from repeated injections of now obsolete COVID-19 products that paradoxically increase susceptibility to infection and illness via antigenic imprinting, and antibody-dependent enhanced disease.

Kindly allow us to expand on the extensive evidence supporting our claims.

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Children do not need COVID-19 mRNA vaccines

a. Healthy children are not at substantial risk of severe disease or death from COVID-19

A recent meta-analysis estimated that 60% of individuals <20 years-old with confirmed COVID-19 diagnosis are asymptomatic.[9] For healthy children ages 0 to 19, the risk of severe disease or death from COVID-19 is virtually zero.[10] This is likely due to fact that children have a lower concentration of the cell entry receptors for SARS-CoV-2 on the cells in their airways compared with adults[11] and that they have very robust natural innate immunity.[12–14] Although rare cases of multi-inflammatory syndrome (MSI, less than 1 out of 1,800 pediatric infections)[15,16] or long-COVID[17–21] in children were initially reported, these studies were not controlled and it is well established that severe COVID-19 outcomes are associated with known risk factors such as advanced age, obesity, and other comorbidities.[22–25] In Canada, the risk of death or hospitalization from identified cases of SARS-CoV-2 infection with the original strain in 0- to 19-years-old was 0.005% and 0.5%, respectively, by mid-May 2021, and given that most infections are not identified, the risk is likely considerably lower than reported.[26] Regardless of prior risk, with the advent of Omicron, the risk of COVID-19 hospitalization and death is considerably lower – by up to 65% relative to Delta according to Ontario data –[27,28] and cases of MSI as low as 1 in 26,000.[15] Even more, it has come to light that many jurisdictions including Ontario, have been over estimating the rate of COVID-19 pediatric hospitalizations and deaths by as much as 60%, which underscores that the true risk to children is substantially lower than originally estimated.[29] A recent seroprevalence study observed that about 75% of US children had infection-induced antibodies following Omicron, meaning that there is now widespread naturally-acquired immunity in this population (Figure 1).[30–32] Furthermore, in England, SARS-CoV-2 antibody testing of unvaccinated school pupils from January to February 2022, showed that 62.4% and 97% of primary and secondary students, respectively, were serologically positive for previous infection with the virus.[33] Similar high rates of SARS-CoV-2 specific antibodies have also been found in over 85% of tested Canadian children two and a half years into an ongoing clinical study led by Dr. Steven Pelech at Kinexus Bioinformatics (personal communication). Currently available data now clearly shows that the risk of severe disease due to COVID-19 in healthy children who are immune to COVID-19 is next to non-existent.

b. Children pose no significant risk to adults

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Early in the pandemic, there were concerns that children might be at increased risk of transmitting the virus to adults who were at risk of severe disease. However, it is now recognized that children are less likely to transmit the infection to adults in the household, and very unlikely to transmit the infection to adults in schools.[34] This is due to their low susceptibility to infection from lower levels of the ACE2 receptor to which SARS-CoV-2 binds in the upper airways of children as well as their robust innate immunity, which allows them to quickly clear infections, thus limit transmission.[35,36] Also, in early 2021, prior to the rise of widespread naturally acquired immunity, another nationwide Swedish study showed that leaving schools open did not lead to higher rates of COVID-19 among teachers.[37] Similar findings were recorded by researchers at the University of BC, and the BC Children's Hospital Research Centre in a 2021 study that found that approximately only 40 of the nearly 1,700 teachers tested contracted COVID-19 and that contact tracing showed that these were largely identified as acquired outside of the schools.[38,39] Well into the third year of the COVID-19 pandemic, with widespread immunity from either infection[40] or vaccination,[41] along with less aggressive variants in circulation,[42–44] the risk of severe COVID-19 posed to adults does not justify vaccination of children. Given that neither adults nor children remain at high risk of severe disease from COVID-19, there is no longer a compelling reason to continue with COVID-19 vaccinations in children.

Current vaccinations do not work well relative to other forms of protection

a. Naturally-acquired immunity is the gold standard of immunity – it is strong, comprehensive and durable, and is demonstrably superior to immunity conferred by the current vaccines

At the outset of the pandemic, there were concerns that a deficiency in population-wide immunity against SARS-CoV-2 would result in high rates of COVID-19 deaths. In the Omicron era, immunity is now widespread and, as of February 2022, approximately 75% of US children and adolescents had already demonstrated serologic evidence of a previous infection with SARS-CoV-2.[30] We also now know that young healthy immune systems produce rapid and robust serological and cellular responses to a broad spectrum of SARS-CoV-2 proteins[45,46] and that these responses confer protection throughout the entire respiratory tract.[46–48] Emerging evidence also shows that naturally acquired immunity is long-lasting, with immune responses to the highly related SARS-CoV-1 coronavirus still evident decades after the initial infection back in 2002-2004.[49,50] The Kinexus SARS-CoV-2 clinical study has similarly shown persistence of antibodies against this virus in their participants more than two years after their initial infection (Dr. Steven Pelech, personal communication) Figure 2 shows the high maintenance of SARS-CoV-2 antibodies from the first COVID-19 wave through to after the second COVID-19 wave in the Kinexus serological

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study). This durability of the natural immune response is in sharp contrast to vaccination-derived immunity, which is narrow, focusing exclusively on the spike protein,[51] short-lived, and according to the six-month results of the pivotal Pfizer phase III trial, peaking in less than two months after injection and diminishing by 6% every two months thereafter.[52] Additionally, vaccination against COVID-19 generates antibodies that are present at *low concentrations* in the upper airways, which is the primary site of infection.[48] In short, these vaccinations designed to target the original strain of SARS-CoV-2 offer waning and sometimes negative protective immunity against infection with variants such as Omicron, which have 32 or more mutations in the spike protein.[53] Importantly, naturally-acquired immunity bears *little to no risk in itself*, as healthy children usually experience infections that are either asymptomatic or develop into generally very mild forms of disease: with Omicron, no more than a common cold.[46] A randomized controlled trial comparing vaccination-derived immunity to naturally acquired immunity has yet to be conducted, thus claims regarding the superiority of vaccination-derived immunity relative to naturally-acquired immunity, especially in the *Omicron era and beyond are speculative at best*, unsupported by the evidence, and contrary to past experiences with viral and bacterial infections.[54–56] In sum, in contrast with vaccination-derived immunity, naturally-acquired immunity is strong, broad and durable with virtually no safety concerns,[55,57–62] and is therefore the best option for ensuring long-lasting protection for children from future SARS-CoV-2 infections.

b. <u>An increasing number of agents are available to treat those who continue to be at risk of severe COVID-19</u>

Nutraceutical and dietary supplement can aid an individual's immune system providing support against acute respiratory viral infections by assisting normal maintenance and function.[63,64] For the very few non-immune individuals who remain at risk of severe COVID-19 – for instance, those with comorbidities or immunosuppression[65] – Health Canada has approved a number of outpatient drugs for adults including anti-virals like nirmatrelvir/ritonavir (Paxlovid)[66] and remdesivir (Veklury),[67] and monoclonal antibodies.[68–71] Additionally, the Ontario Science Table has recommended fluvoxamine and budesonide for preventing severe disease in adults at low risk of hospitalization.[72] As more is now known about how to bolster the immune system and treat SARS-CoV-2 infections,[72] there is even less of a need for vaccinations that provide negligible incremental protection in a population that is already largely immune to a now treatable disease. Even vulnerable sub-groups of children, who are immunosuppressed, have poor respiratory function (i.e., cystic fibrosis) or are undergoing surgery may benefit from simple, safe and cost-effective

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prophylactic alternatives, such as virucidal povidone-iodine nasal rinses[73,74] than increasingly obsolete COVID-19 vaccine products.

The potential benefits of COVID-19 vaccinations do not outweigh their risks

a. COVID-19 vaccinations do not stop acquisition or transmission of SARS-CoV-2

The promise of mass vaccinations to achieve herd immunity and protect those at risk of severe COVID-19 has not come to pass: *abundant evidence confirms that COVID-19 vaccinations neither prevent infection nor stop viral transmission, and that both inoculated and non-inoculated individuals carry equal viral loads, i.e., can equally transmit SARS-CoV-2.*[75–78] Large studies of community transmission have found *equal secondary attack rates among the inoculated as among the non-inoculated*. A large study in the United Kingdom found that 25% of household contacts of fully inoculated individuals who had experienced breakthrough infections contracted COVID-19 vs. 23% of household contacts of unvaccinated individuals who had experienced COVID-19.[76] As shown by a landmark Israeli study, vaccinations have also failed to stop transmission *even in medical institutions with fully vaccinated staff and patients*.[79]

It has been suggested that vaccinated individuals recover from COVID-19 sooner than unvaccinated individuals, and so they are transmissible for a shorter period of time. However, a recent scientific study reported by the US CDC with post-marketing release of the Pfizer/BioNTech vaccine conducted primarily in Denver found that vaccinated participants with Omicron infection spent an average of one half day less sick in bed than did unvaccinated participants with Omicron infection.[80]

It is noteworthy that no gold standard, placebo-controlled disease endpoint trials, large enough (n=800,000) to categorically establish the clinical safety and long-term efficacy of the Pfizer COVID-19 mRNA vaccinations in children 12- to 15-years-old, 5- to 11-years-old, 2- to 4-years-old, and 6-months-old to 23-months-old have been undertaken. Instead, Pfizer vaccination approvals for these age groups were based on the preliminary results of four very small *immuno-bridging trials*, enrolling fewer than 3,000 participants each. They were *not designed to establish the superiority of vaccination compared to naturally acquired immunity,* but only the non-inferiority of "neutralizing" antibody concentrations in the blood of a small number of 12- to 15-years-old (n=190), 5- to 11-years-old (n=264) children, 2- to 4-years-old (n=143), and

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6-months-old to 23-months-old (n=82) compared to young adults.[4,81,82] Because antibody titers in the blood are not a clinically validated measure of efficacy for mucosal infections of the respiratory tract, *study claims regarding efficacy are speculative at best*. Moreover, in these studies, assessment of "neutralizing" antibodies only focused on those antibodies that block the binding of the original strain of SARS-CoV-2 to the ACE2 receptor and entry into test cells. Many of the mutations in Omicron occur within the receptor binding domain of the spike protein. Furthermore, over 95% of antibody responses to the SARS-CoV-2 spike protein in both vaccinated and SARS-CoV-2-infected individuals are directed toward other regions of the spike protein, and the vast majority of the immune protective response is not measured by "neutralizing" antibody tests.

Starting 7 days after the last dose and less than 3 months post-vaccination for those under 12 years, the aforementioned studies provided descriptive relative risk reductions (RRR) in symptomatic cases of COVID-19 of 100%, 91%, 82%, and 76% for children aged 12 to 15 years, 5 to 11 years, 2- to 4-years-old, and 6-months-old to 23-months-old, respectively. Moreover, when outcomes were analyzed to reflect the net benefit of the vaccinations in these groups, the absolute risk reduction (ARR) in mild symptomatic COVID-19 was a mere 2% or lower for all groups, results which lack clinical relevance for the 60% of children and adolescents (<20 years) who experienced asymptomatic infections.[9] In addition, the vaccines did not demonstrate an ability to reduce severe COVID-19 or halt transmission, rendering claims regarding protection in the vast majority of children speculative at best. Of great concern, however, were findings in the 2- to 4-years-old cohort that showed that following the first dose the vaccine was associated with a 199% relative risk increase in severe COVID-19 and a 149% relative risk increase in multiple COVID-19 infections compared to placebos.[4] Moreover, the 76% RRR noted for 6 to 23 month old infants was astonishingly based on just three participants in this age group (1 vaccinated and 2 placebo), and the 82% RRR on just seven participants in the older 2–4-year-olds (2 vaccinated and 5 placebo), and was only after triple vaccination of these children.

The pivotal child vaccination studies were too short to establish vaccinal efficacy and did not control for natural immunity. Natural immunity was only assessed by the detection of antibodies against the nucleocapsid protein of SARS-CoV-2, which often fails to be measurable in people that have recovered from COVID-19. The child vaccine trials were designed to test vaccines developed against the original strain of SARS-CoV-2, which is no longer in circulation. Not surprisingly, COVID-19 vaccinations have demonstrated a lack of effectiveness against Omicron, which has spread widely through mostly inoculated

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– even boosted – populations.[83] Real world studies conducted during the Omicron surge in New York State and Denver found that the effectiveness of COVID-19 mRNA vaccination ranged from 51% to 59% for children 12 to 17 years of age and from 12% to 31% for children aged 5 to 11 years.[80,84–85] In the New York State study, efficacy decreased to negative values by 5-6 weeks post second vaccine dose.

Following Omicron, and despite having a very high rate of vaccination (87%) for eligible Ontarians aged five years and older,[41] the Government of Ontario reported ***a negative dose-response effect for the COVID-19 vaccinations***. In other words, the proportion of cases of COVID-19 were highest among those who had been 'boosted', lower among the 'fully inoculated' and least among the 'not fully inoculated' (which includes the 'uninoculated' (Figure 3 panel A). A similar pattern was observed in the 12 to 17 years-old and the 5 to 11 years-old age groups (Figure 3 panel B &C). Additionally, a greater proportion of "boosted" Ontarians have died, revealing that the vaccinations may be associated with serious secondary effects (Figure 4). A concern has been expressed by researchers in Denmark who conducted a meta-analysis of all COVID-19 vaccine randomized controlled trials and found that the mRNA vaccinations were associated *with a significant increase in all-cause and cardiac-related mortality compared to the adenovirus-vector vaccines*.[86] These findings indicate the potential for vaccination-induced adverse effects, including vaccination-enhanced COVID-19 disease,[87,88] development of T-cell[89–91] and vaccine exhaustion[92] especially in the context of multiple and frequent boosters.[93] This alarming data supports epidemiological evidence from Nordic countries of an elevated risk for myocarditis and pericarditis that is dose and mRNA vaccine product dependent, particularly for young males (16-24 years).[94]
Similarly, another recent report has confirmed no significant increase in the incidence of myocarditis or pericarditis in patients recovering from COVID-19 infection.[95] Importantly, there is now documented autopsy analysis from young adult fatalities that support an autoimmunological response to the COVID-19 vaccination among susceptible individuals as reflected by SARS-CoV-2 spike protein expression within the heart with extensive CD4+ lymphocytic infiltration.[96] In sum, there is a lack of quality evidence supporting COVID-19 vaccination efficacy in an Omicron era and a concerning signal of harm with mechanistic evidence supporting a causal link to COVID-19 vaccination as compared to natural infection and recovery among otherwise healthy young adults/adolescents.

The mechanisms by which vaccination may cause negative efficacy in boosted individuals remains unclear, although several hypotheses have been advanced based on prior vaccine prototypes developed for SARS-CoV-1 and MERS, including antibody-dependent enhancement (ADE) and original antigenic sin (or

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antigenic imprinting).[97, 98] ADE occurs when antibodies may hasten the destruction of immune cells via the antibody-dependent binding of viruses to these cells and facilitates their entry. Original antigenic sin arises when an initial antibody response against an earlier version of the virus predominates over subsequent responses to mutated versions of the same virus. There is clear evidence that prior COVID-19 RNA vaccines apparently blunts the natural immune response following a COVID-19 infection. Moderna's 30,000-participant study of persons 18 years or older for its RNA vaccine has indicated that subsequent production of antibodies against the Nucleocapsid protein of SARS-CoV-2 was evident in only 40% of previously vaccinated individuals with COVID-19 compared to 93% of unvaccinated peoples that acquired COVID-19.[99] Even an unvaccinated person with a mild case of COVID-19 had a 71% chance of showing Nucleocapsid antibodies in their blood compared to a 15% chance with a vaccinated person that recovered from mild COVID-19.

b. <u>COVID-19 vaccinations demonstrate a concerning increase in all-cause morbidity and absence of established long-term safety</u>

The best available data for assessing the safety of the Pfizer COVID-19 vaccinations in children has come from the phase III trials. These trials provided *important preliminary descriptive data for the level of safety of COVID-19 vaccinations for children,* revealing *dramatic increases in dose-dependent all-cause morbidity.* While the trial demonstrated a 2% reduction in the absolute risk of acquiring a mild COVID-19 infection in both 12- to 15-year-old children and 5- to 11-year-old children, it was associated with a *dramatic net increase in all-cause morbidity relative to placebo which increased with each dose.*[81,82] In the older group, the vaccination was associated with net increases in injection site pain for the first and second dose (63% and 61%) as well as increases in fatigue (19% and 42%), headache (19% and 40%), chills (18% and 35%) and muscle pain (10% and 24%) despite a net increase in the use of anti-pyrectics (26% and 42%) compared to placebo (Figure 5).[81] As no cases of severe COVID-19 were reported in either study,[79,80] claims regarding protection against severe disease in children and adolescents *remain unsubstantiated*. In addition, the studies showed an *absolute risk increase for both severe* (0.4%) *and serious* (0.3%) *adverse events for the COVID-19 vaccinations* compared to placebo in adolescents. These findings were in line with the six-month results of the Pfizer COVID-19 mRNA vaccine trial in adults, which showed significantly more all-cause illness in the vaccinated compared with placebo arms (262 vs 150, $p<0.0001$, Table 1). The study, which has a protocol-specified plan to unblind the trial and offer crossover to the vaccine at six months, is unlikely to yield quality long-terms safety data.[81,82] Even more concerning were the rates of severe adverse

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events associated with booster administration. A real world study conducted by the US Centers for Disease Control showed that 25.8% of the 3,418 adolescent booster vaccination recipients aged 12 to 17 years were unable to perform daily activities; 20.0% were unable to attend school or work; and ~0.9% required medical care (Figure 5).[100] The vaccinations were associated with dramatic increases in dose-dependent short-term all-cause morbidity with no current evidence of long-term safety.

Additionally, the phase III trials were insufficiently powered to detect less common safety signals in the study population and were not designed to assess safety in the COVID-19-recovered, those with multiple co-morbidities, or the immunocompromised.[81,82] As a result health officials primarily relied upon passive pharmacovigilance systems, which notoriously underreport vaccination-suspected adverse outcomes.[101] Despite their lack of sensitivity of such passive surveillance systems, a wide range of vaccination-suspected adverse events of a cardiovascular, neurological and immunological nature have been reported.[102] The most concerning of these adverse events has been myocarditis/pericarditis, along with cardiac emergencies, which have been observed in multiple recent population-based studies particularly in male adolescent and young adults.[103-107] The risk of symptomatic myocarditis and pericarditis arising after the second dose of COVID-19 mRNA vaccination in 18- to 24-years-old men in Ontario was originally estimated at 1 in 17,000 for Pfizer and 1 in 3,000 for Moderna from June 1 to Sep 4, 2021,[108, 109] but is now approaching 1 in 5,000 (19.8 events per 100,000 vaccine doses) for mRNA vaccines overall following the second vaccination.[110] These rates likely under-estimate overall heart damage as they do not account for asymptomatic myocarditis, which can be three-times higher than symptomatic[111] myocarditis, and both of which have been linked to long-term cardiovascular disease and premature death.[112, 113]

In addition, a recent Pfizer pharmacovigilance report released from the FDA showed that within the first two months of the worldwide COVID-19 vaccination rollout, 42,086 cases of vaccination-suspected adverse events were processed by Pfizer, of which 1,223 were fatal.[114] A total of 1,077 immune-mediated adverse effects including nerve pain, swelling in the brain and myocarditis and pericarditis were reported, of which 780 were serious and 12 were fatal. Moreover, a total of 34 adverse event cases were reported in children less than 12 years of age of which 24 were serious. Both clinical trial and real world findings point to a concerning increase in dose-dependent all-cause morbidity and concerning immune-mediated safety signals, which increase with each vaccine dose.

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In conclusion, the COVID-19 vaccinations were developed to protect children from severe COVID-19 outcomes from the Wuhan strain of SARS-CoV-2 at a time when population-wide immunity was limited. Now that Omicron has displaced the original strain and that there is presently widespread naturally acquired immunity, it is abundantly clear that: children are at extremely low risk of severe COVID-19; further vaccinations do not stop transmission; vaccinations are demonstrating negative-effectiveness; each dose is associated with dramatic increases in all-cause illness including life-altering complications; and there is still no long-term safety data. Considering that children have decades of quality life years ahead of them and that the first principle in medicine is to "Do no harm," it is imperative that every public health official do whatever is in their power to immediately halt the vaccination of children until the long-term efficacy and safety of these vaccinations is either definitively established or disproved.

Finally, we note that the Children's Covid Vaccine Advisory Council of the Health Advisory and Recovery Team in the UK has recently made similar concerns to those provided here by the Canadian Covid Care Alliance regarding the vaccination of children in an open letter dated June 30, 2022 with over 60 Ph.D. and M.D. signatories.[115] Likewise, Søren Brostrom, the director of the Danish Health and Medicines Authority has concluded that it was a mistake to vaccinate children for COVID-19.[116] A safety report published in September 20, 2021 by the Federal Institute for Vaccines and Biomedicine at the Paul-Ehrlich-Institut in Germany already concluded that for children age from 12 to 17 years, the number of reported cases of mis-understood COVID-19 vaccine side effects exceeded the total number of COVID-19-related hospitalizations in this age group.[117]

Thank you for taking the time to review our findings. We trust that our research has provided you with evidence needed to adjust Canadian health policy to protect our children from undue harm. We would be happy to meet you to discuss findings documented in this letter in greater detail.

Respectfully,

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Dr. Robert Rennebohm, MD, MSc, Pediatric Rheumatologist, Cleveland Clinic (OH, U.S.)

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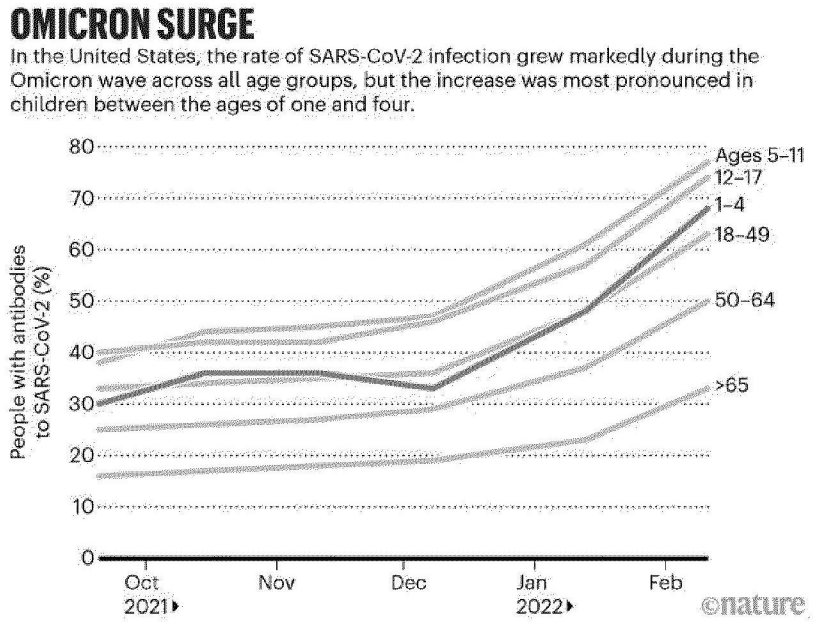
Figure 1: Seroprevalence of infection-induced SARS-CoV-2 antibodies, by age group — United States, September 2021–February 2022



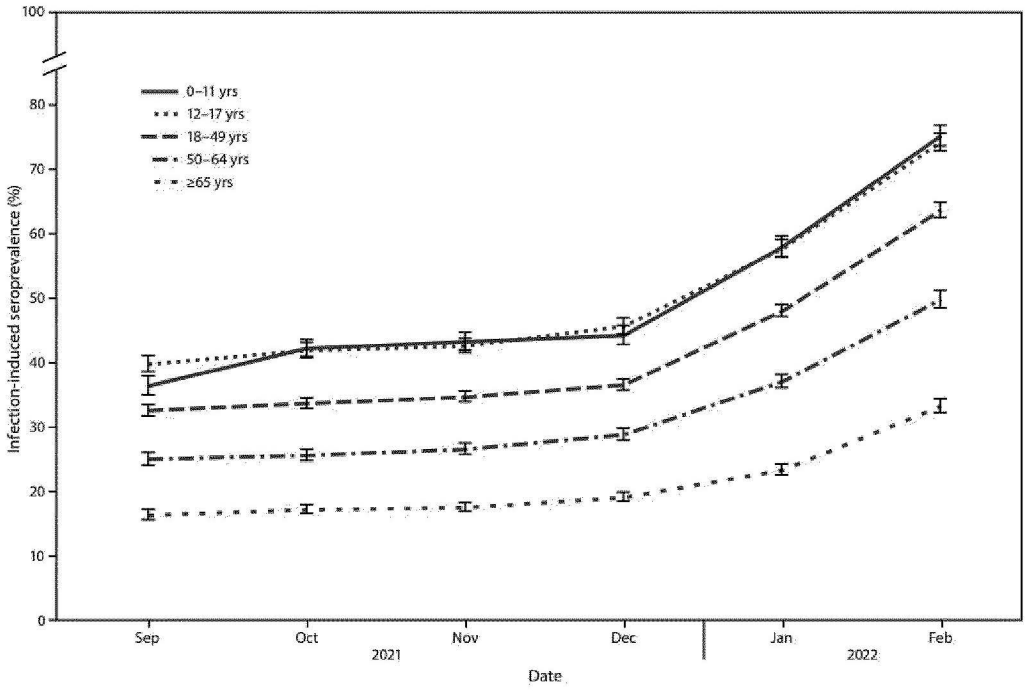


Figure 2: Stability of SARS-CoV-2 antibody patterns in serum samples of twelve COVID-19 recovered individuals tested with the Kinexus 110 marker SARS-CoV-2 antibody screen. The locations of peptides within the various SARS-CoV-2 proteins are indicated in the map shown immediately below. A detectable spot corresponds to the presence of antibodies in the serum that specifically recognize a portion of the target

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SARS-CoV-2 proteins. Spot D26 corresponds to a positive control to ensure that the test was working properly. The same participant was tested approximately 10 months later with the results shown in the right panel as compared to when originally tested as shown in the corresponding left panel, and the columns of panels are from the different participants that were tested.

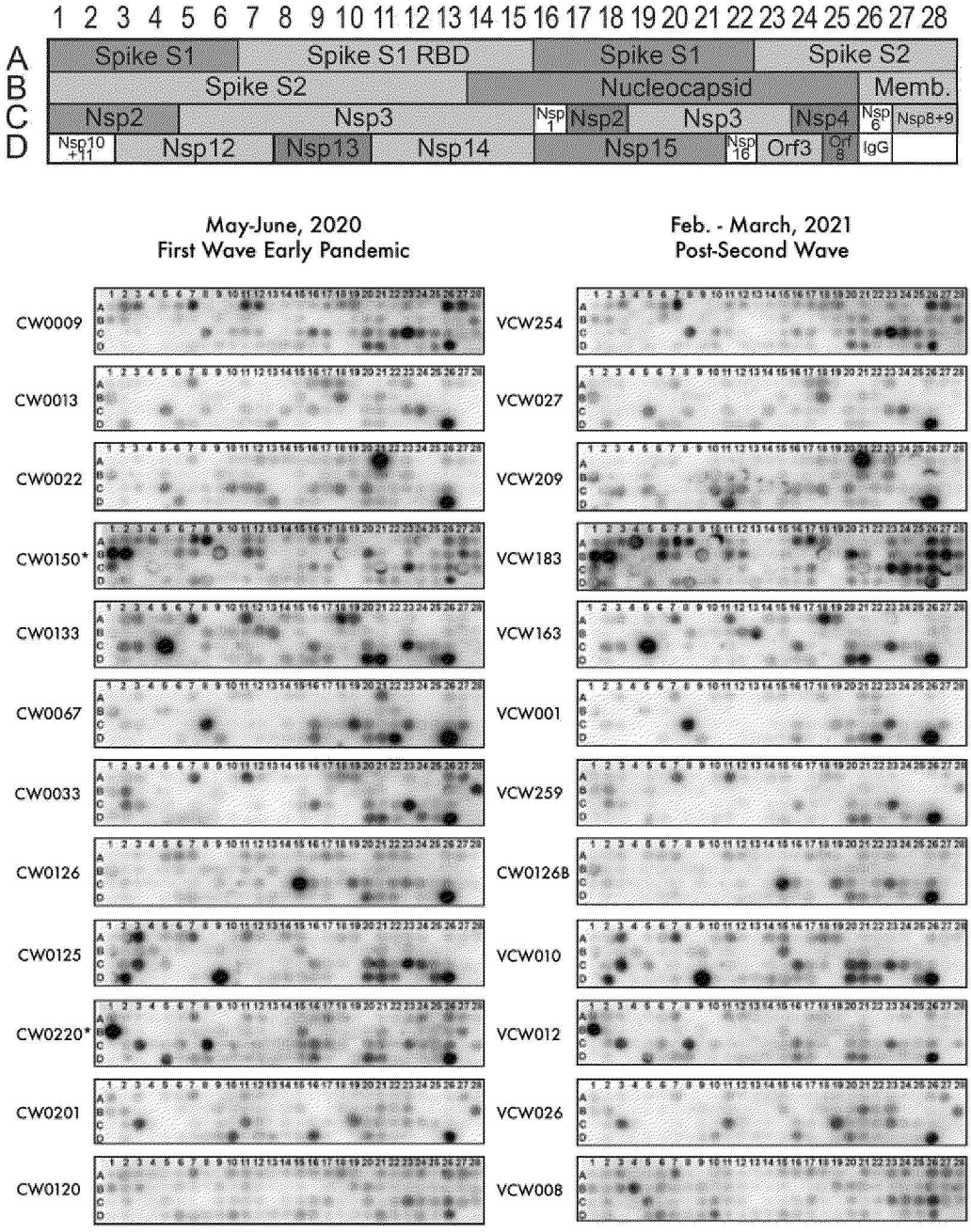

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Figure 3: Proportional of daily cases of COVID-19 occurring among A) Ontarians of all ages B) those 12 to 17 years and C) those 5 to 11 years who were 'not fully vaccinated' (i.e., unvaccinated or a single dose; purple line), 'fully vaccinated' (i.e., two doses; pink line), or 'vaccinated with booster dose' (i.e. three or more doses; green line). This graph was copied from Public Health Ontario website on April 30, 2022 (https://covid-19.ontario.ca/data). No data for this graph are available prior to March 17, 2022.

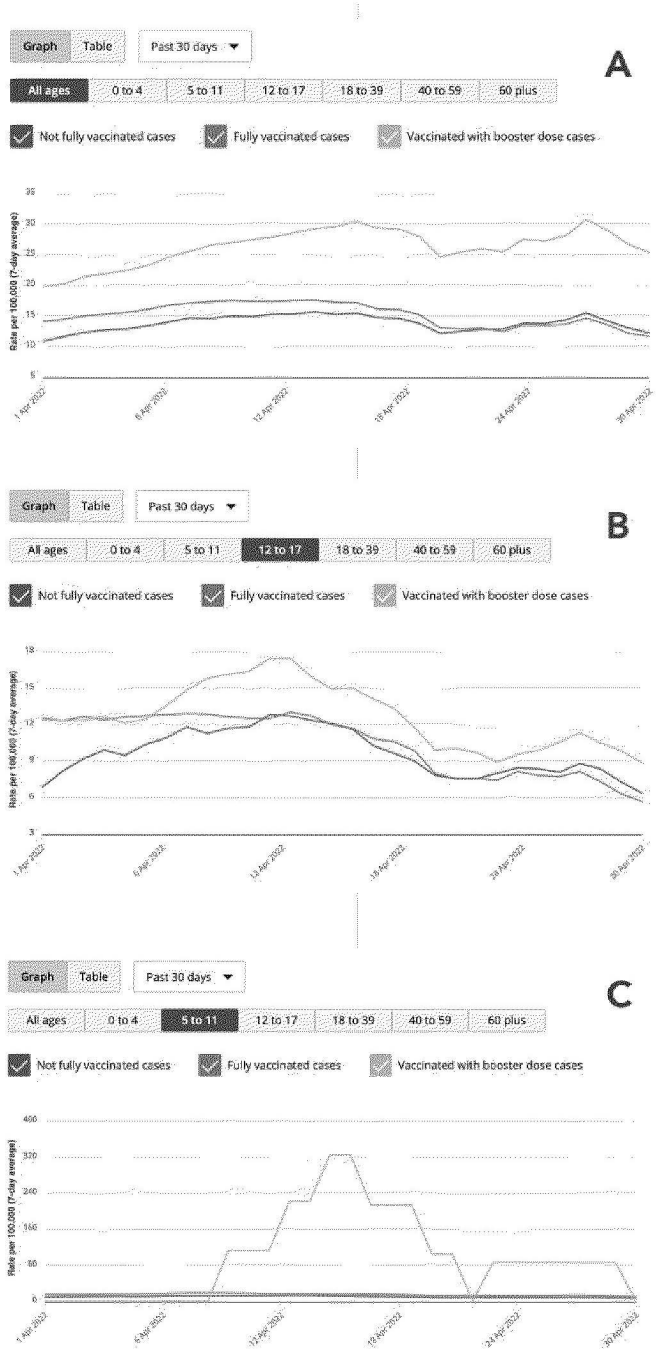

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Figure 4: Proportional of daily COVID-19 deaths occurring among Ontarians of all ages who were 'not fully vaccinated' (i.e., unvaccinated or a single dose; green line), 'fully vaccinated' (i.e., two doses; blue line), or 'vaccinated with booster dose' (i.e. three or more doses; pink line). This graph was copied from Public Health Ontario website on April 30, 2022 (https://covid-19.ontario.ca/data). No data for this graph are available prior to March 17, 2022.

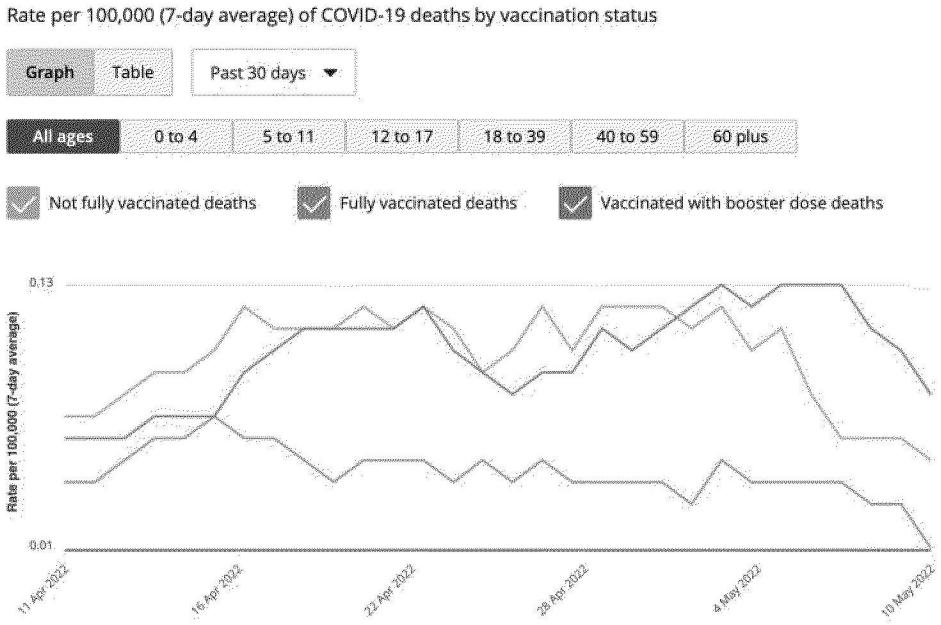

Figure 5 - Local reactions and systemic events reported in 12-to-15-year-olds

within 7 days after administration of dose 2 of BNT162b2 or placebo all participants[78] **Symptom severity:** Mild-green, Moderate-blue, Severe-orange.

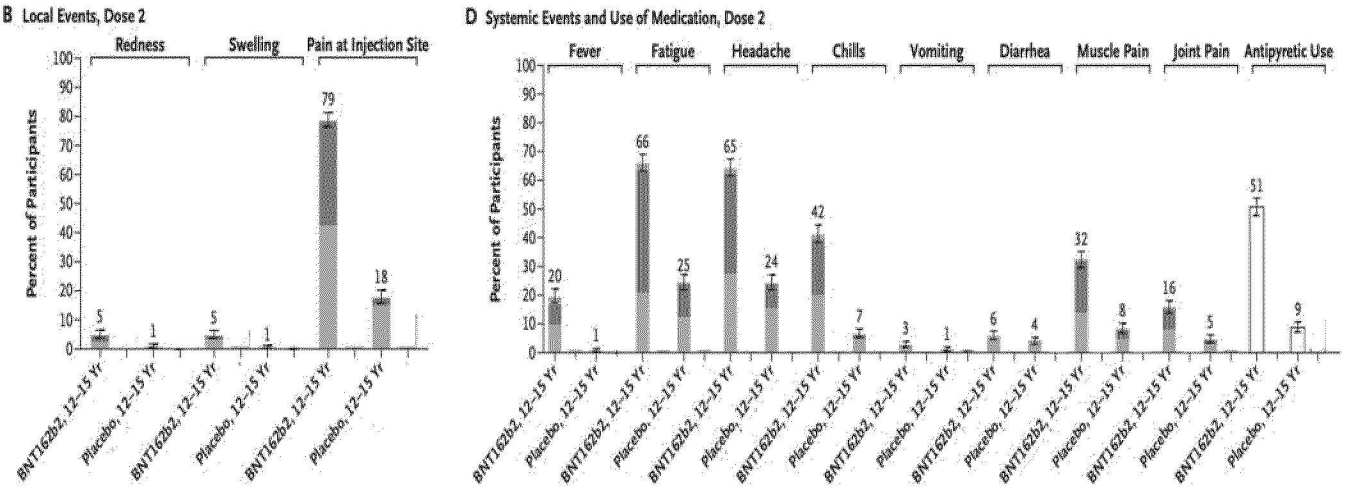

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Figure 6 - Adverse reactions and health impacts reported* among persons aged 12–17 years (N = 3,274) who received a homologous Pfizer-BioNTech COVID-19 vaccine booster, by vaccine dose — United States, December 9, 2021–February 20, 2022.

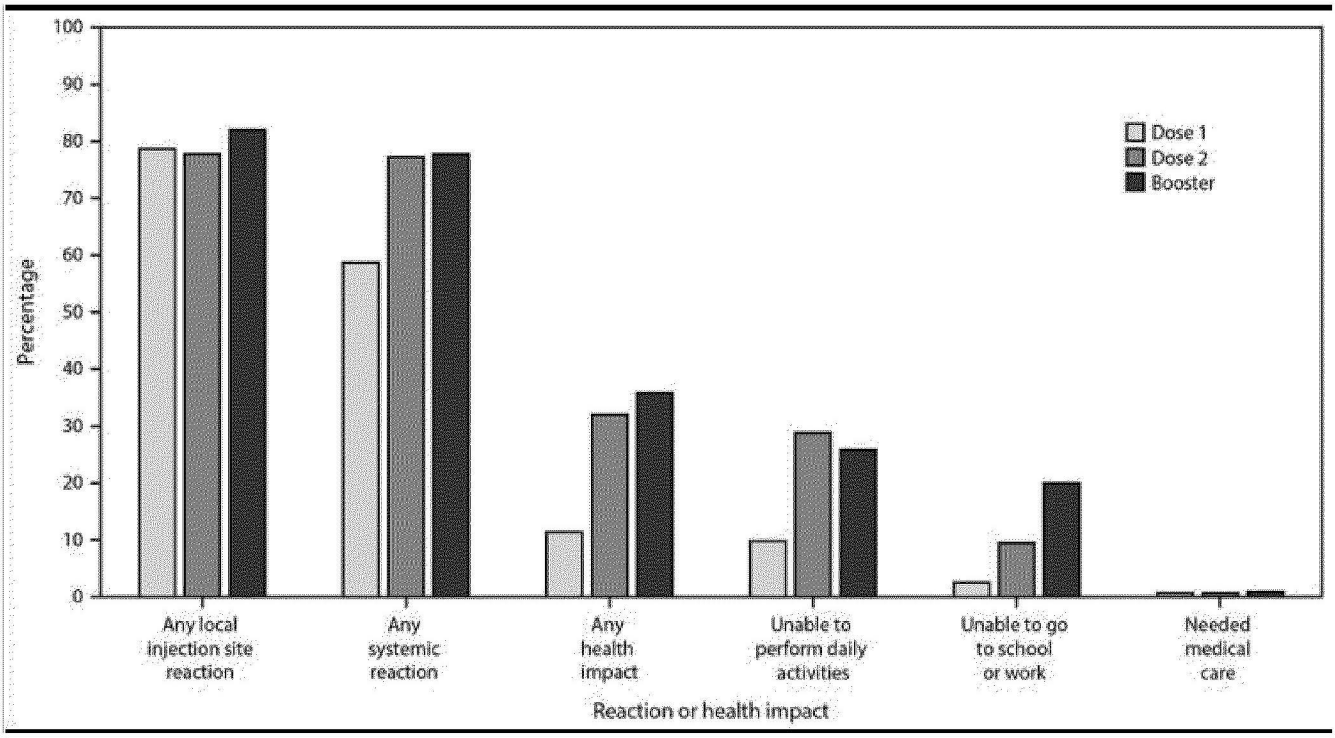

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Table 1 - Differences in efficacy and safety events reported in the six-month update of the BNT162b2 mRNA COVID-19 vaccine.[52]

Table 1. Differences in the number of efficacy and safety events in eligible populations¥ reported in the 6-month update of the BNT162b2 mRNA Covid-19 vaccine

Event	BNT162b2 (n)	Placebo (n)	Absolute Difference (p-value)?	Absolute Risk Change* (%)	Relative Risk Change* (%)
Cases Adults and Adolescents 7 days after 2nd dose$	77	850	-773 (p<0.00001)	-3.7	-90.9
Any Unsolicited Treatment-Related Adverse Event Adults#	5,241	1,311	+3,930 (p<0.00001)	+17.9	+299.7
Any Severe Event Adults/	390	289	+101 (p=0.0001)	+0.5	+34.9
Severe Cases in Adults 7 days after 2nd dose&	1	23	-22 (p<0.00001)	-0.1	-95.7
Unsolicited Severe Adverse Events~ Adults Prevents daily routine activity or requires intervention or worse	262	150	+112 (p<0.00001)	+0.5	+74.6
Serious Adverse Event Adults§ Requires hospitalization or results in permanent injury or death	127	116	+11 (p=0.5)	+0.05	+9.5
Deaths during placebo-controlled period [additional deaths during open-label period in vaccine recipients or placebo-only]%	15 [+5]	14 [NR]	+1 [+5] (p=0.9)	+0.005	+7.1
Deaths due to cardiovascular events^	9	5	+4		

¥ For the purpose of this table and in accordance with the terminology used in the study report, adult and adolescent populations are defined as ≥16 years old and 12-15 years old, respectively;

? Significance figures (p-values) estimated using chi-square calculator available at https://www.socscistatistics.com/tests/chisquare. P values are without the Yates correction. This procedure was applied following the framework used by Classen in his analysis of "All Cause Severe Morbidity" based on data from the initial reports of the vaccine Phase III trials;[107]

** Authors estimated vaccine efficacy using total surveillance time as denominator, however, as this value was unavailable for all the events analyzed, our calculations used the common statistical definition, i.e., number of events relative to total number of eligible patients for each event analysis reported[108] similar to previous analyses of this nature;[107,109]*

$ ≥7 Days after dose 2 among participants without evidence of previous infection;

 # Adverse events reported outside of the reactogenicity subgroup and assessed by the investigator as related to investigational product / In calculations combining efficacy and safety events, the number of patients randomized that received any dose of vaccine or placebo was used as the study population in the statistical calculations, following the framework used by Classen in his analysis of "All Cause Severe Morbidity".[107] Differences in the total (event-incident) population (randomized vs efficacy vs safety) used as denominator are relatively small and are expected to have minimal impact on the relative differences between groups. Without access to individual patient data, these calculations were performed under the assumption that efficacy and safety events were non-overlapping;

& ≥7 Days after dose 2; confirmed severe COVID-19 defined as PCR-positivity and "presence of at least one of the following: • Clinical signs at rest indicative of severe systemic illness (RR ≥30 breaths per minute, HR ≥125 beats per minute, SpO2 ≤93% on room air at sea level, or PaO2/FiO2 <300 mm Hg); • Respiratory failure (defined as needing high-flow oxygen, noninvasive ventilation, mechanical ventilation, or ECMO); • Evidence of shock (SBP <90 mm Hg, DBP <60 mm Hg, or requiring vasopressors); • Significant acute renal, hepatic, or neurologic dysfunction;• Admission to an ICU; • Death";

~ Severe (grade ≥3) adverse events were generally defined as those that interfere significantly with participant's usual function, those that affect daily living or require medical care; grade 4 events were generally defined as those that required emergency room visit or hospitalization;

§ Serious adverse events were defined as any untoward medical occurrence that, at any dose: a. Results in death; b. Is life-threatening; c. Requires inpatient hospitalization or prolongation of existing hospitalization; d. Results in persistent disability/incapacity;

% Deaths during the open-label period were reported only in vaccine recipients, 3 participants in the BNT162b2 group and 2 in the original placebo group who received BNT162b2 after unblinding;

^Those with reported cause of death due to: aortic rupture, arteriosclerosis, cardiac arrest, cardiac failure congestive, cardiorespiratory arrest, hypertensive heart disease, or myocardial infarction

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Dillon, Megan (HC/SC)

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Le 29 juin 2022

Position officielle du bureau du Premier Ministre

Bureau du Premier Ministre du Canada
A/s Le Très Honorable Justin Trudeau
80 Wellington st,
Ottawa, ON
K1A 0A2

Monsieur le Premier Ministre,
C'est à titre d'ambassadeur de [redacted] au Canada[1], que je vous achemine cette communication officielle. Notre organisation est accréditée par les Nations Unies et un de nos mandats est la protection des droits de l'homme.

Après la seconde guerre mondiale, un procès a eu lieu afin de faire la lumière sur les crimes contre l'humanité qui ont eu lieu pendant cette sombre période. Le procès de Nuremberg a mené à la rédaction du code de Nuremberg que vous connaissez sans doute.

Bien que certains semble l'ignorer, le code de Nuremberg est toujours d'actualité et un de nos mandats est de nous assurer que celui-ci soit bien compris par tous et respecté.

État de la situation concernant les vaccins ARN Messager.

En date d'aujourd'hui, la science précise que les ''vaccins'' offerts sont dans les faits des traitements génique expérimentaux, toujours en cours d'évaluation et qui n'ont toujours pas fait preuve de leur efficacité et de leur innocuité. Ces traitements n'empêchent ni l'infection, ni la transmission, ce qui fait qu'il n'y a aucun fondement épidémiologique ou éthique pour un mandat vaccinal de quelque nature que ce soit. Sans compter que le ''vaccin'' n'est pas sans risques comme le démontrent les nombreux effets indésirables, dont certains sont majeurs, dans les différentes bases de données qui les compilent, bien que partiellement.

Comme biens des pays, le Canada est gouverné par des lois qui sont basées sur l'éthique. Les femmes et les hommes ont le droit de disposer de leur corps et de refuser des traitements médicaux.

Le fondement éthique du code de Nuremberg[1] stipule qu'on ne permettra plus jamais de procéder à des interventions médicales sans consentement informé, même pour le bien de l'individu ni même pour le bien de la collectivité.

Par définition le mandat vaccinal avec ses mesures de coercition comme l'exclusion de la vie sociale et économique, la perte d'emploi, l'interdiction de voyager même à l'intérieur du pays, constitue une forme de coercition pour forcer les citoyens à accepter une intervention médicale sans consentement libre et éclairé, en violation directe avec du code de Nuremberg et la charte des droits et libertés.

Pendant les 2 dernières années, il y a eu une évolution dans nos connaissances relative aux traitements et les victimes du SRAS COV 2.
Pendant les premiers mois, nous croyons que les gouvernements avaient l'obligation de se montrer prudent et imposer des mesures afin d'assurer une protection pour l'ensemble de la communauté. Plus le

[redacted]

ATIA - 19(1) ATIA - 20(1)(c)

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temps passe et il devient nécessaire d'ajuster les mesures afin de protéger les plus vulnérables et limiter les contraintes pour tous les autres citoyens.

Selon nos standards, la pandémie de la COVID-19 ne rencontre pas le seuil de menace qui pourrait justifierait le maintien de telles mesures d'exception.

Les faits

1) La COVID-19 présente des incidences de mortalité de 0.15-0.2%, soit de moins de 1% des conséquences léthales de la variole. De plus, il a été démontré que la Covid 19 était pratiquement inoffensive pour les enfants.[ii]
2) Il y a plusieurs traitements pour mitiger son impact[iii].
3) Les vaccins géniques expérimentaux ont fait l'objet de plus d'effets indésirables en un an que l'ensemble de tous les vaccins au cours de 30 dernières années. (VAERS [iv])

Questions à votre attention

1- Compte tenu que le niveau de léthalité de la Covid 19 est nettement trop bas pour décréter une urgence sanitaire.
   a. Selon vous, quels sont les conditions nécessaires pour justifier la mise en place d'une gouvernance sous décret d'urgence sanitaire.
   b. Selon vous, quelles sont les conditions qui vont permettre de lever l'urgence sanitaire et la gouvernance par décret?
2- Nous aimerions savoir si vous compter toujours appliquer le code de Nuremberg dans votre paradigme de protection des droits de l'homme?
3- Quelles sont les conditions pour le retrait du Pass sanitaire et empêcher que celui-ci devienne un genre de contrôle de la population via une forme de crédit social et voir ainsi la transformation des droits en privilèges.
4- Avez-vous émis des communications concernant votre position officielle sur le traitement de la pandémie par les gouvernements des provinces et du Canada. Si oui nous en envoyer copie.
5- Nous avons eu vent, que certaines personnes avaient été emprisonnées lors de manifestations pacifiques. Pouvez-vous nous informer des actions que vous avez prises pour vous assurer que ces arrestations ne soient pas des emprisonnements politiques et que le droit de manifester soient protégés.

[redacted]

[redacted]

[redacted]

ATIA-2019-[illegible]

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[redacted]

2207020058
3879 H4T

Bureau du Premier Ministre du Canada
A/s Très Honorable Justin Trudeau
80 Wellington st,
Ottawa, ON
K1A 0A2

MHU / UTC
2022 -07- 04
LP

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Le 20 juillet 2022

Monsieur [redacted]
[redacted]

Monsieur,

Au nom du premier ministre Justin Trudeau, j'accuse réception de votre lettre du 29 juin.

Je puis vous assurer que nous avons pris bonne note de vos propos. J'ai pris la liberté de transmettre copie de votre correspondance à l'honorable Jean-Yves Duclos, ministre de la Santé, à titre d'information et pour examen.

Je vous prie d'agréer, Monsieur, l'expression de mes sentiments les meilleurs.

COPY / COPIE

L. Morin
Agent de la correspondance de la haute direction

ATIA - 19(1)

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Executive Correspondence Services / Services de la correspondance de la haute direction (PCO/B

From: Marion, Jean-Luc
Sent: Wednesday, July 6, 2022 5:53 PM
To: Executive Correspondence Services / Services de la correspondance de la haute direction (PCO/BCP)
Subject: letter
Attachments: 21850182F - [redacted]pdf

LPM

Please forward as appropriate.

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Ghaly, Maggy (HC/SC)

From: Laurent, Alex (Duclos, Jean-Yves - Député) <alex.laurent.359@parl.gc.ca>
Sent: 2022-08-01 2:42 PM
To: hcminister.ministresc
Subject: TR: Données envoyées depuis MFP13688591 01/08/2022 14:33
Attachments: DOC010822.pdf

Hi,

Here is a correspondence that we received at the office of MP Duclos.

Regards,

House of Commons
Chambre des communes
Canada

Alex Laurent (il/he)

Adjoint de circonscription | Constituency Assistant
Bureau de *l'hon. Jean-Yves Duclos* | Office of *The Hon. Jean-Yves Duclos*

Député | Member of Parliament – Québec

Ministre de la Santé | Minister of Health

600, boul. Charest Est
Bureau 201, C.P. 30014
Québec (Québec) G1K 3J4

(418) 523-6666

-----Message d'origine-----
De : LaureA.359 <alex.laurent.359@parl.gc.ca>
Envoyé : 1 août 2022 14:33
À : Laurent, Alex (Duclos, Jean-Yves - Député) <alex.laurent.359@parl.gc.ca>
Objet : Données envoyées depuis MFP13688591 01/08/2022 14:33

Numérisé depuis MFP13688591
Utilisateur:
Date :01/08/2022 14:33
Pages :5
Résolution :200x200 DPI

Do not Reply - This is an automated process

Ne pas répondre - Ceci est un processus automatisé.

Page: 482 of/de 538
A2022001224

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[redacted]

Honorable JEAN-YVES DUCLOS, député
Ministre de la Santé du Canada
Chambre des communes
Ottawa (Ontario) K1A 0A6

le 19 Juillet 2022, Montréal

Monsieur le ministre,

Je m'appelle [redacted] et je suis vice-présidente de l'organisation humanitaire [redacted]. Notre organisation s'engage à protéger les libertés et les droits des enfants non seulement au Canada, mais partout dans le monde.

Cette lettre est la suite directe de nos fonctions immédiates. Nous recevons actuellement un très grand nombre de demandes de parents anxieux avec des questions sur la sécurité et la légalité des vaccinations contre le coronavirus pour les enfants de plus de 6 mois.

En raison de la forte inquiétude du public, nous vous demandons de bien vouloir nous fournir la composition chimique, les formules moléculaires et l'analyse structurelle du vaccin Corona Virus Covid-19. Nous pourrons mener notre propre analyse et par conséquent nous serons heureux de rassurer l'opinion publique sur l'innocuité et l'utilité complètes du vaccin !
Compte tenu de l'extrême urgence d'action de notre part, nous vous prions de bien vouloir fournir les informations ci-dessus dans les meilleurs délais de 10 (dix) jours ouvrables.

Merci beaucoup et bonne journée,

[redacted] Vice-Présidente
[redacted]
[redacted]
[redacted]

ATIA - 20(1)(c)

ATIA - 19(1)

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Innovation, Science and Economic Development Canada
Corporations Canada

Innovation, Sciences et Développement économique Canada
Corporations Canada

Certificate of Incorporation

Canada Not-for-profit Corporations Act

Certificat de constitution

Loi canadienne sur les organisations à but non lucratif

[redacted]

Corporate name / Dénomination de l'organisation

[redacted]

Corporation number / Numéro de l'organisation

I HEREBY CERTIFY that the above-named corporation, the articles of incorporation of which are attached, is incorporated under the *Canada Not-for-profit Corporations Act*.

JE CERTIFIE que l'organisation susmentionnée, dont les statuts constitutifs sont joints, est constituée en vertu de la *Loi canadienne sur les organisations à but non lucratif*.

[redacted]

Hantz Prosper

Director / Directeur

2022-05-09

Date of Incorporation (YYYY-MM-DD)
Date de constitution (AAAA-MM-JJ)

Canada

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Innovation, Science and Economic Development Canada
Corporations Canada

Innovation, Sciences et Développement économique Canada
Corporations Canada

Form 4001
Articles of Incorporation
Canada Not-for-profit Corporations Act (NFP Act)

Formulaire 4001
Statuts constitutifs
Loi canadienne sur les organisations à but non lucratif (Loi BNL)

1 Corporate name
Dénomination de l'organisation
[redacted]

2 The province or territory in Canada where the registered office is situated
La province ou le territoire au Canada où est maintenu le siège
QC

3 Minimum and maximum number of directors
Nombres minimal et maximal d'administrateurs
Min. 1 Max. 10

4 Statement of the purpose of the corporation
Déclaration d'intention de l'organisation
Is to ensure the future, Freedom, well being and the liberty of our children.

5 Restrictions on the activities that the corporation may carry on, if any
Limites imposées aux activités de l'organisation, le cas échéant
None

6 The classes, or regional or other groups, of members that the corporation is authorized to establish
Les catégories, groupes régionaux ou autres groupes de membres que l'organisation est autorisée à éta
See attached schedule / Voir l'annexe ci-jointe

7 Statement regarding the distribution of property remaining on liquidation
Déclaration relative à la répartition du reliquat des biens lors de la liquidation
See attached schedule / Voir l'annexe ci-jointe

8 Additional provisions, if any
Dispositions supplémentaires, le cas échéant
None

9 **Declaration:** I hereby certify that I am an incorporator of the corporation.
Déclaration : J'atteste que je suis un fondateur de l'organisation.

Name(s) - Nom(s) Original Signed by - Original signé par

[redacted]

A person who makes, or assists in making, a false or misleading statement is guilty of an offence and
term of not more than six months or to both (subsection 262(2) of the NFP Act).

La personne qui fait une déclaration fausse ou trompeuse, ou qui aide une personne à faire une telle d
sommaire, une amende maximale de 5 000 $ et un emprisonnement maximal de six mois ou l'une de ces pei

You are providing information required by the NFP Act. Note that both the NFP Act and the *Privacy Act* allow this information to be disclosed to the public. It will be stored in personal information bank number IC/PPU-049.

Vous fournissez des renseignements exigés par la Loi BNL. Il est à noter que la Loi BNL et la *Loi sur les renseignements personnels* permettent que de tels renseignements soient divulgués au public. Ils seront stockés dans la banque de renseignements personnels numéro IC/PPU-049.

Canada

IC 3419 (2008/04)

A2022004224

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Innovation, Science and Economic Development Canada
Corporations Canada

Innovation, Sciences et Développement économique Canada
Corporations Canada

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Form 4002
Initial Registered Office Address and First Board of Directors
Canada Not-for-profit Corporations Act (NFP Act)

Formulaire 4002
Adresse initiale du siège et premier conseil d'administration
Loi canadienne sur les organisations à but non lucratif (Loi BNL)

1 Corporate name
Dénomination de l'organisation

[redacted]

2 Complete address of the registered office
Adresse complète du siège

[redacted]

3 Additional address
Autre adresse

4 Directors of the corporation
Administrateurs de l'organisation

[redacted]

5 Declaration: I hereby certify that I am an incorporator of the new corporation or that I am a director or an authorized officer of the corporation continuing into or amalgamating under the NFP Act.
Déclaration : J'atteste que je suis un fondateur de la nouvelle organisation ou que je suis un administrateur ou un dirigeant autorisé de l'organisation se prorogeant ou se fusionnant en vertu de la Loi BNL.

Original signed by / Original signé par

[redacted]

[redacted]

A person who makes, or assists in making, a false or misleading statement is guilty of an offence and liable on summary conviction to a fine of not more than $5,000 or to imprisonment for a term of not more than six months or to both (subsection 262(2) of the NFP Act).

La personne qui fait une déclaration fausse ou trompeuse, ou qui aide une personne à faire une telle déclaration, commet une infraction et encourt, sur déclaration de culpabilité par procédure sommaire, une amende maximale de 5 000 $ et un emprisonnement maximal de six mois ou l'une de ces peines (paragraphe 262(2) de la Loi BNL).

You are providing information required by the NFP Act. Note that both the NFP Act and the *Privacy Act* allow this information to be disclosed to the public. It will be stored in personal information bank number IC/PPU-049.

Vous fournissez des renseignements exigés par la Loi BNL. Il est à noter que la Loi BNL et la *Loi sur les renseignements personnels* permettent que de tels renseignements soient divulgués au public. Ils seront stockés dans la banque de renseignements personnels numéro IC/PPU-049.

Canada

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Innovation, Science and Economic Development Canada
Corporations Canada

Innovation, Sciences et Développement économique Canada
Corporations Canada

Canada Not-for-profit Corporations Act (NFP Act)

Change of Registered Office Address

Form 4003

Loi canadienne sur les organisations à but non lucratif (Loi BNL)

Changement d'adresse du siège

Formulaire 4003

Received Date (YYYY-MM-DD): 2022-05-10
Date de réception (AAAA-MM-JJ):

1 Corporate name
Dénomination de l'organisation
[redacted]

2 Corporation number
Numéro d'organisation
[redacted]

3 Complete address of the registered office
Adresse complète du siège
[redacted]

4 Additional address
Autre adresse

5 Declaration: I certify that I have relevant knowledge of the corporation and that I am authorized to sign this form.
Déclaration : J'atteste que je possède une connaissance suffisante de l'organisation et que je suis autorisé à signer ce formulaire.

Original signed by / Original signé par
[redacted]

A person who makes, or assists in making, a false or misleading statement is guilty of an offence and liable on summary conviction to a fine of not more than $5,000 or to imprisonment for a term of not more than six months or to both (subsection 262(2) of the NFP Act).

La personne qui fait une déclaration fausse ou trompeuse, ou qui aide une personne à faire une telle déclaration, commet une infraction et encourt, sur déclaration de culpabilité par procédure sommaire, une amende maximale de 5 000 $ et un emprisonnement maximal de six mois ou l'une de ces peines (paragraphe 262(2) de la Loi BNL).

You are providing information required by the NFP Act. Note that both the NFP Act and the *Privacy Act* allow this information to be disclosed to the public. It will be stored in personal information bank number IC/PPU-049.

Vous fournissez des renseignements exigés par la Loi BNL. Il est à noter que la Loi BNL et la *Loi sur les renseignements personnels* permettent que de tels renseignements soient divulgués au public. Ils seront stockés dans la banque de renseignements personnels numéro IC/PPU-049.

Canada

IC 3420 (2008/04)

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VaxFacts

For members of Black Communities

Our VaxFacts Clinic is partnering with the Black Physicians' Association of Ontario to provide a dedicated service for members of Black communities who would like to discuss vaccines with a trusted healthcare provider also from the Black community. **Our doctors are ready to talk, listen and help you get the facts.**

REQUEST A PHONE CONSULTATION
with a Black Physician at the VaxFacts Clinic

shn.ca/VaxFacts | 416-438-2911 ext. 5738

SHN
SCARBOROUGH HEALTH NETWORK

VaxFacts CLINIC

BPAO
Black Physicians' Association of Ontario

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VaxFacts for Parents

COVID-19 vaccines are now available for kids aged 6 months and up — and our VaxFacts Clinic is here to connect you with qualified doctors who understand that you may have questions or concerns, or just want to learn more.

They are ready to talk, listen and help you get the facts.

Schedule a one-to-one phone conversation so you can make an informed decision.

BOOK AN APPOINTMENT ONLINE

shn.ca/VaxFacts

CALL TO MAKE AN APPOINTMENT

416-438-2911 ext. 5738

SHN
SCARBOROUGH HEALTH NETWORK

VaxFacts CLINIC

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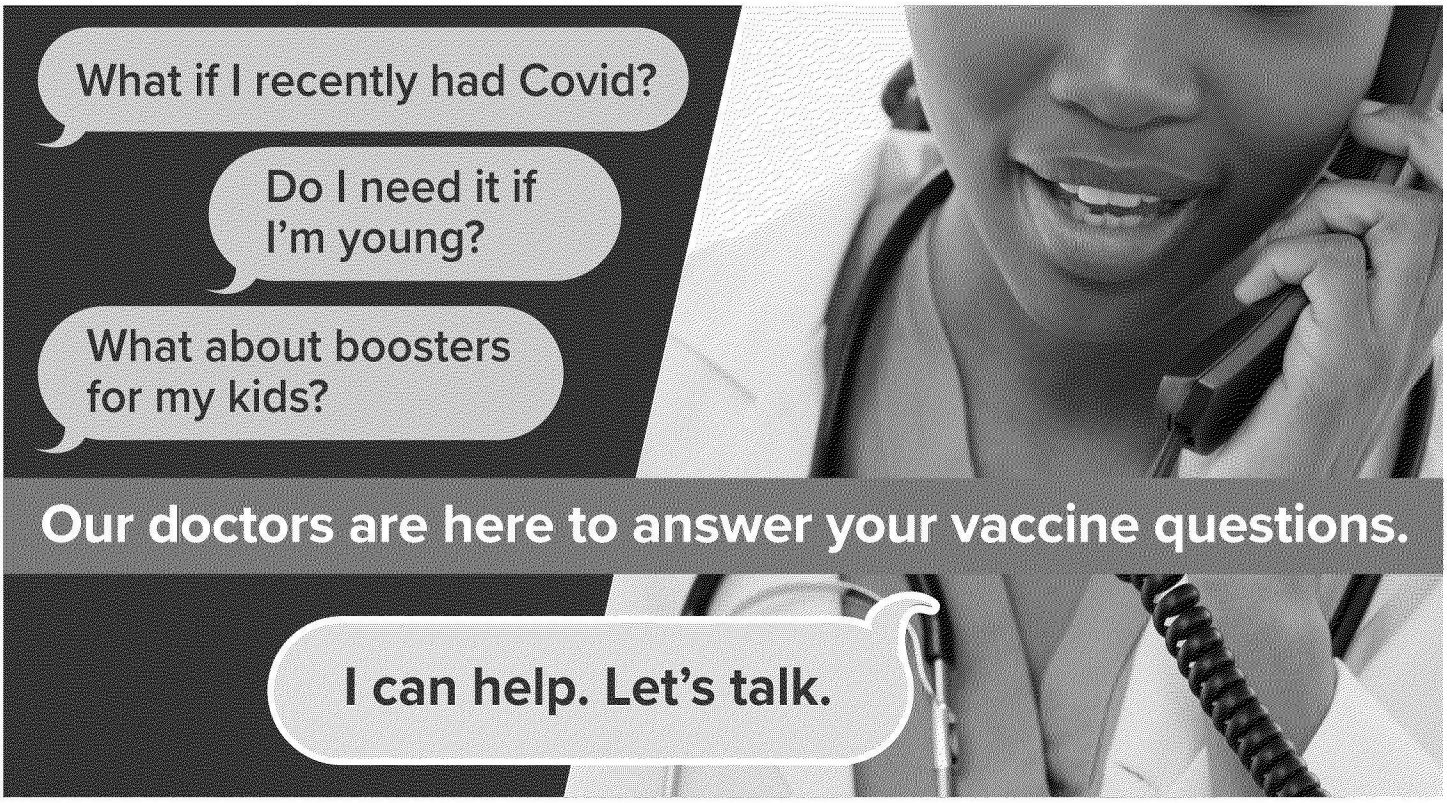
Wondering if you should get boosted this summer?



Our VaxFacts Clinic will connect you with qualified doctors who understand that you may have questions or are looking for more information about COVID-19 vaccines. They are ready to talk, listen and help you get the facts.

Schedule a one-to-one phone conversation.
BOOK ONLINE OR GIVE US A CALL.

shn.ca/VaxFacts | 416-438-2911 ext. 5738

SHN
SCARBOROUGH HEALTH NETWORK

VaxFacts CLINIC

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Plouffe, Sandra-Ann (HC/SC)

From: Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Sent: 2022-08-17 2:34 PM
To: High Call Volume / Volume d'appels élevés; hcminister.ministresc
Subject: TR: VaxFacts Clinic for Black Communities | Telephone Service | Request For Support
Attachments: Min. Jean-Yves Duclos - VaxFacts Clinic for Black Communities _ Telephone Service .docx.pdf; Fr-vaxfacts-black-communities-poster-FEB2022_FRENCH.pdf; Vaxfacts-Black-communities-poster.pdf; Vaxfacts-for-parents-poster.pdf; vaxfacts-plus-poster-AUG2022_v1.pdf; Vaxfacts-poster.pdf

De : [redacted] <communications@bpao.org>
Envoyé : 17 août 2022 13:36
À : Duclos, Jean-Yves - Député <Jean-Yves.Duclos@parl.gc.ca>
Objet : VaxFacts Clinic for Black Communities | Telephone Service | Request For Support

Good Afternoon Honourable Jean-Yves Duclos and team,

I hope this message finds you well and taking care.

I am reaching out to you today on behalf of the Black Physicians' Association of Ontario.

We see that your work at Health of Canada compliments efforts of reaching greater health equity within our communities, so we are hoping for your support on our current initiative.

We are asking for in-kind support from Health of Canada in the form of online promotions on your social media platforms and website news blog, of our joint service *VaxFacts for Black communities*, as well as the general *VaxFacts* Clinic telephone service, which is available to all Canadians.

Attached you can find the full letter with more details about the Vaxfacts service that aims to bring vaccination information directly to communities from physicians.

You can also find promotions material should you be willing and able to share.

We hope to hear from your team about willingness to support, and can be reached directly at the contact listed below.

Take great care,

[redacted]

Communications, Lead (she/her)
Black Physicians' Association of Ontario
E-mail: communications@bpao.org
Phone: [redacted]

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VaxFacts+

Speak with a VaxFacts Clinic physician about more topics!

In addition to any questions about the COVID-19 vaccine, our trusted doctors are here to speak with you about:

OTHER VACCINES

For different infectious diseases, such as Monkeypox

RELATED COVID-19 SERVICES

Such as drug therapies (Evusheld, Paxlovid and remdesivir)

HOW TO STAY SAFE

In the community and during new waves of COVID-19

Schedule a one-to-one phone conversation.
BOOK ONLINE OR GIVE US A CALL.

shn.ca/VaxFacts | 416-438-2911 ext. 5738

SHN
SCARBOROUGH HEALTH NETWORK

VaxFacts CLINIC

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BPAO
Black Physicians' Association of Ontario

Date: August 17, 2022

Attention: The Honourable Jean-Yves Duclos, MP

Re: VaxFacts Clinic for Black Communities | Telephone Service

Dear Mr. Duclos

As you know, the Black population has been one of the groups hardest hit by the COVID-19 pandemic. They are also one of the groups with the highest rate of vaccine hesitancy. Decreasing vaccine hesitancy in Black populations will increase equity and will also improve the overall effectiveness of our pandemic efforts.

The Black Physicians' Association of Ontario is a not-for-profit organization that aims to increase the number of Black physicians and improve health equity in the province. During the pandemic, we have been successfully providing culturally safe vaccine clinics for Black communities.

Much like you and your team, we have been working hard to improve equity throughout the pandemic. This year, our efforts have taken on a national scope. Through a project called *VaxFacts for Black communities,* which we are offering in partnership with the Scarborough Health Network, we are providing information by telephone about vaccines, anti-virals and other COVID-related matters directly to Black patients across the country.

We are reaching out to ask for in-kind support from Health Canada in the form of online promotions on your social media platforms and website news blog of our joint service *VaxFacts for Black communities*, as well as the general *VaxFacts* Clinic telephone service, which available to all Canadians.

The VaxFacts Clinic, designed as a telephone service, is an opportunity to speak with a physician one-to-one on a confidential, non-judgemental phone appointment. On the call, patients can address any questions or concerns they may have about the COVID-19 vaccines. The general

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VaxFacts Clinic has been operating since May 2021, having seen over 2000 patients across Canada. Approximately 85% of patients choose to get vaccinated after speaking with a VaxFacts physician.

In partnership with Scarborough Health Network, the BPAO organized a special stream called "*VaxFacts for Black Communities,*" which launched in February 2022. It connects Black patients with a Black physician, for more culturally rich conversations about the COVID-19 vaccines, anti-virals and other COVID-19 related matters.

Many Black people have experienced racial bias in Canadian healthcare and in other aspects of their lives, which has contributed to medical system distrust and vaccine hesitancy. We aim to combat this through facilitating safer spaces for community members to access information.

The VaxFacts Clinics were created with health equity in mind and this is seen throughout the design. Call-in hours are between 9am to 8pm to accommodate diverse working schedules, interpretation services are available in over 200 languages, and OHIP is not required to access the service to remove barriers. This means we are available to refugees, undocumented folks, international agricultural workers, and other marginalized groups across the country.

As COVID-19 evolves, there will be new variants, new vaccines, boosters, and messaging from health authorities. VaxFacts serves as the link for our community members to gain the information they need to make informed decisions about their health.

We hope we can depend on you and Health Canada to support this effort by informing Canadians of the general *VaxFacts Clinic* and the *VaxFacts Clinic for Black communities*.

Our VaxFacts posters in English and French are attached for your information.

With Many Thanks,

[redacted]

Dr. Onye Nnorom, MD, MPH, CCFP, FRCPC
Medical Advisor, Black Health Vaccine Initiative
Black Physicians' Association of Ontario

[redacted]

Dr. Latif Murji, MD, CCFP
Lead Physician, VaxFacts Clinic
Coordinator, Global Health, Diversity, Health Equity

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Scarborough Health Network

ATIA - 19(1)

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Bourke, Phil (HC/SC)

From: Champagne, Christine (HC/SC)
Sent: 2022-09-01 1:08 PM
To: HC.F ECD-Liaison / DCHG F.SC
Cc: Fontaine, Marie-Pier (HC/SC); Browne, Robert (HC/SC)
Subject: FW: mRNA-1273.214 (Spikevax Bivalent Original/Omicron) Approval

Hello ECD,

Just for information, .MinO will acknowledge receipt. No response needed.

Thank you | Merci
CC

Government of Canada / Gouvernement du Canada

From: [redacted]@hc-sc.gc.ca>
Sent: 2022-09-01 12:37 PM
To: Champagne, Christine (HC/SC) <christine.champagne@hc-sc.gc.ca>
Cc: [redacted]@hc-sc.gc.ca>; [redacted]@hc-sc.gc.ca>; [redacted]@hc-sc.gc.ca>; Fontaine, Marie-Pier (HC/SC) <marie-pier.fontaine@hc-sc.gc.ca>; Browne, Robert (HC/SC) <robert.browne@hc-sc.gc.ca>
Subject: FW: mRNA-1273.214 (Spikevax Bivalent Original/Omicron) Approval

Bonjour Chris,

Could you please share the below with the correspondence team as an incoming correspondence for the Minister? No need for a response a this time, MinO will acknowledge receipt.

Merci,
[redacted]

From: Patricia Gauthier [redacted]
Sent: 2022-09-01 12:09 PM
To: Duclos,x, Jean-Yves (HC/SC) <Jean-Yves.Duclos.x@hc-sc.gc.ca>
Cc: [redacted]@hc-sc.gc.ca>; [redacted]@hc-sc.gc.ca> [redacted]
Subject: mRNA-1273.214 (Spikevax Bivalent Original/Omicron) Approval

Cher Ministre Duclos,

J'espère que vous allez bien.

It is with great pride that I received the news about Health Canada's approval of our next generation bivalent vaccine for Canadians today. Our team at Moderna has worked in close collaboration with Health Canada, the Public Health Agency of Canada, and many other public stakeholders to make this happen. It illustrates the continued sense of urgency and ability to work with competing priorities that has made Canada a leader in dealing with the vaccination response for COVID-19 thus far.

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As you know, in order to stay ahead of another possible wave of COVID-19 infection as we move inside for fall, it's important to protect Canadians as best as possible for as long as possible. As discussed before, knowing that the virus continues to mutate, a booster that could provide broad protection against several different variants, even ones they weren't specifically designed to fight against, is critical to this aim.

The clinical data from mRNA-1273.214 (Spikevax Bivalent Original/Omicron), which was based on the BA.1 strain, shows a superior neutralizing antibody response against Omicron BA.1 and a potent response against subvariants BA.4 and BA.5. As the first Omicron-containing bivalent COVID-19 booster approved in Canada, mRNA-1273.214 provides Canadians with a critical public health tool to protect vulnerable populations against the dominant strains of COVID-19.

Our team is working diligently on the first shipment of the mRNA-1273.214 (Spikevax Bivalent Original/Omicron) which is coming from the United-States and is planned to reach Canada tomorrow should everything go according to plan.

Please reach out to me directly if you have any questions about this news, or additional updates you may be interested in as we continue to grow our pipeline and expand partnerships and footprint in Canada.

Merci beaucoup à vous et votre équipe pour votre collaboration continue.

Meilleures salutations,
Patricia

Patricia Gauthier

President, General Manager
Présidente, Directrice Générale
Moderna Canada

(416) 859-0079

modernatx.com

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A2022001224

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ECD Health Canada
DCHG Santé Canada
Rec'd Reçu OCT 1 1 2022
22-011973-679

HOUSE OF COMMONS
CANADA

September 9, 2022

Hon. Jean-Yves Duclos
Minister of Health
Health Canada
Address Locator 0900C2
Ottawa, ON K1A 0K9

James Bezan
Member of Parliament
Selkirk-Interlake-Eastman

Dear Minister:

[redacted]

Sincerely,

[redacted]

James Bezan MP
Selkirk-Interlake-Eastman

Ottawa
Room 500
Justice Building
Ottawa, Ontario
K1A 0A6
Tel.: 613-992-2032
Fax: 613-992-6224
ottawa@jamesbezan.com

Constituency
Unit 1 - 228 Manitoba Avenue
Selkirk, Manitoba
R1A 0Y5
Tel.: 204-785-6151
Toll Free: 888-247-9606
Fax: 204-785-6153
office@jamesbezan.com

www.jamesbezan.com

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This form authorizes Health Canada, and the Vaccine Injury Support Program to release confidential client information to the Office of James Bezan and his staff.

I, _____ hereby authorize Health Canada, and the Vaccine Injury Support Program to disclose to the Office of James Bezan, information relating to me as identified below

Client Identification

[redacted]

(City/Province) (Postal code)

[redacted]

Client signature

Case Number-

[redacted]

Case Manager [redacted]

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HOUSE OF COMMONS
CANADA

October 11, 2022

James Bezan
Member of Parliament
Selkirk-Interlake-Eastman

Hon. Jean-Yves Duclos
Minister of Health
Health Canada
Address Locator 0900C2
Ottawa, ON K1A 0K9

Dear Minister,

Please see letter from Ms. Ms. [redacted] Please respond directly to her regarding her case.

Sincerely,

[redacted]
James Bezan MP
Selkirk-Interlake-Eastman

Ottawa
Room 500
Justice Building
Ottawa, Ontario
K1A 0A6
Tel.: 613-992-2032
Fax: 613-992-6224
ottawa@jamesbezan.com

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Vaccine Injury Support Program
116 Albert Street
Ottawa, Ontario
K1P 5G3

vaccineinjurysupport.ca

[redacted]
[redacted] MB
R[redacted]
Case #[redacted]

Dear [redacted]

Thank you for placing a claim with the Vaccine Injury Support Program. Upon review of your claim, we regret to inform you that it has been declined based on the following reason(s):

[redacted]

Appeals:

If you disagree with this decision and would like to appeal, please contact your Case Manager, ***by no later than*** December 5th, 2022

Please note that if you do not request an appeal of the decision before the date listed above, the decision will be final and the opportunity to appeal will be revoked.

Our team wishes you the strength to sustain you during this difficult time, and we invite you to contact us with any questions you may have regarding the aforementioned.

Thank you again,

The Vaccine Injury Support Team

[redacted]@vaccineinjurysupport.ca

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Vaccine Injury Support Program
116 Albert Street
Ottawa, Ontario
K1P 5G3

vaccineinjurysupport.ca

APPENDIX

Vaccine Injury Support Program

Medical Review Board Final Report Confirmation

Medical Review Board Final Report

Protected (when completed)

The Vaccine Injury Support Program (VISP) Medical Review Board was comprised of specialists in Family Medicine, Internal Medicine, and Emergency Medicine. In order to be eligible for compensation within VISP, the Board must reach consensus that an injury is severe, permanent, and causally associated with vaccination.

[redacted]

The Board thanks the claimant for her submission.

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Esteves, Dina (HC/SC)

From: hcminister.ministresc
Sent: 2022-12-14 3:20 PM
To: james.bezan@parl.gc.ca
Subject: In response to your correspondence / 22-011973-679
Attachments: Appendix B – VISP Claimant Process Brochure.pdf; Appendix C – VISP Process Map Infographic.pdf; MP Information Kit.pdf; Appendix A – VISP Overview Brochure.pdf

Mr. James Bezan, M.P.
Selkirk–Interlake–Eastman
james.bezan@parl.gc.ca

Dear Mr. Bezan:

Thank you for your correspondence of September 9, 2022, on behalf of your constituent, Ms. [redacted] concerning her claim under the Vaccine Injury Support Program (VISP). I sincerely regret the delay in responding.

I am truly sorry to learn of Ms. [redacted]s health issues and the challenges she is experiencing.

As you may be aware, since its launch on June 1, 2021, the VISP is being administered independently by RCGT Consulting. Recipients of eligible claims can receive various supports from the VISP, including income replacement, payment for injuries and reimbursement of other eligible costs, such as uncovered medical expenses. The Public Health Agency of Canada (PHAC) is not involved in individual cases or the VISP program process in order to ensure independent medical review.

RCGT and its team of medical experts assess each claim individually. The timelines for determining eligibility and support depend on the nature and complexity of each claim.

To determine if there is a probable link between the injury and the vaccine, RCGT reviews all required and relevant medical documentation and the current medical evidence. If a probable link is identified, the medical experts will also assess the severity and duration of the injury. In order to do this, RCGT must request medical records directly from the individual's province or territory or from the medical institution where the individual received care, regardless of what medical documents are initially submitted with the claim. This process can take several months and may involve multiple health care institutions and health care providers, with potential to create delays outside of RCGT's control.

I understand that these delays can be frustrating. Please share with Ms. [redacted] that if the claim is deemed eligible, payments will be retroactive to the date of injury. In the meantime, individuals are encouraged to explore other federal or provincial benefits programs (**http://bit.ly/3X4wIIF**) that may be available to them.

Although PHAC cannot intervene on behalf of an individual claimant, our officials are monitoring the implementation of the VISP and share all related feedback received with RCGT. PHAC meets regularly with RCGT to discuss areas for improvement as the VISP matures as a program. This

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includes opportunities to ensure the VISP is as responsive as possible to the needs of those affected by potential vaccine injuries.

RCGT is continuously working to improve its processes, has hired additional staff to support claims management and processing, including additional medical resources, and is working to accelerate medical record retrieval. Currently, RCGT is moving the VISP case management system to an online platform to facilitate easier access. Case managers will continue to be in touch regularly to provide support and updates to individuals, and claimants will now also be able to track their cases online.

Please find attached several brochures about VISP, as well as the VISP Information Package for Members of Parliament. I hope that you find this information helpful as you support your constituents who have submitted, or are considering submitting a claim, to VISP.

Again, thank you for writing, and please extend my best wishes to Ms. [redacted]

Yours sincerely,

The Honourable Jean-Yves Duclos, P.C., M.P.

Attachments

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Ghaly, Maggy (HC/SC)

From: Hadi Malou, Fatima (Duclos, Jean-Yves - Député) <fatima.hadimalou.359@parl.gc.ca>
Sent: 2022-10-19 3:14 PM
To: hcminister.ministresc
Subject: Courrier reçu au BDC
Attachments: DOC191022.pdf

Fatima Hadi Malou
Adjointe exécutive
Bureau de l'hon. Jean-Yves Duclos
Député de Québec
600, boul. Charest Est
Bureau 201, C.P. 30014
Québec (Québec) G1K 3J4
T. 418 523-6666
fatima.hadimalou.359@parl.gc.ca

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Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise en charge de la covid
CCCA

Website: www.canadiancovidcarealliance.org

E-mail: info.canadiancovidcarealliance.org

To: The Honourable Jean-Yves Duclos, MP

Main office - Québec
600 Charest Blvd East, PO Box 30014
Suite 201
Québec, Quebec
G1K 3J4

Date: September 30, 2022

Re: OPEN LETTER – To the Health Minister regarding Health Canada's use of the mRNA vaccines

cc.: The International Criminal Court (The Hague) – Reference: OTP-CR-465/21

Dear Minister,

We ask that you, as Minister of Health overseeing the activities of Health Canada, seriously review and consider the contents of this letter. We are aware that medical and scientific issues are not your area of expertise, and therefore we expect that you will forward our letter to the appropriate persons. In short, we have analyzed several of Pfizer's COVID-19 vaccine reports, and noted several fundamental flaws that were not identified by Health Canada when the submissions were reviewed, and subsequently accepted for use in healthy Canadians. This correspondence concentrates on just one of these issues, which should have resulted in the rejection of Pfizer's submissions. Our objective in writing this letter is to have a face-to-face meeting between your scientists from Health Canada and our scientists. Only then will the Canadian people know the truth regarding the efficacy and safety of these COVID-19 genetic vaccines.

Respectfully submitted by:

Philip Britz-McKibbin, PhD, Professor, Dept. of Chemistry and Chemical Biology, McMaster University

Claudia Chaufan, MD, PhD, Associate Professor, Health Policy and Global Health, York University

L. Maria Gutschi BScPhm, PharmD, Pharmacy Consultant.

John Hardie, BDS, MSc, PhD, FRCDC Consultant Oral Pathologist (retired)

Bonnie Mallard, PhD, Professor of Immuno-Genetics, University of Guelph

Kanji Nakatsu, PhD, Professor Emeritus Pharmacology, Queen's University

Philip R. Oldfield, DPhil, CSci, CChem, FRSC (UK) Scientific and Regulatory Consultant (retired)

Steven Pelech, PhD, Professor, Dept. of Medicine, University of British Columbia

Christopher A. Shaw, PhD, Professor, Dept. of Ophthalmology, University of British Columbia

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Executive Summary

- The mRNA COVID-19 vaccines are using gene therapy technology in which the active product, the encoded spike protein, is not actually part of the formulation.
- Health Canada has used an inappropriate guidance document for the regulatory review, contrary to Good Scientific Practice, effectively compromising the safety of Canadians.
- Pharmacokinetics, and distribution studies of the encoded spike protein in various tissues were not performed in any of the Pfizer's studies. Therefore, off-target effects and the safety of the product were based purely upon assumptions.
- Genotoxicity studies were not performed.
- Carcinogenicity studies were not performed.
- An inappropriate rodent species (*i.e.,* Wistar Han rat) was used to generate nonclinical toxicology data; a species such as the Chinese Golden hamster, in which the ACE2 receptor behaves more like that of humans, would have been appropriate. This effectively compromised the safety toxicology, developmental and reproductive studies.
- Developmental and reproductive studies were inadequate. Concentrations of the encoded spike protein were not determined in the pups or in maternal milk. Therefore, it cannot be said that the mRNA COVID-19 vaccines are suitable to administer to pregnant women and mothers who are breast feeding.
- A second species (non-rodent) should have been used to generate nonclinical toxicology data, as per standard procedure. This was not done!
- Full histopathology investigations should have been performed plus immunostaining for the encoded spike protein to evaluate its biodistribution in tissue and organs. This was not done.
- An ascending dose Phase 1 clinical study should have been performed to include pharmacokinetics of the encoded spike protein, as well as synthetic cationic lipids. This was not done.
- Analysis of post-authorization adverse event report data showed high mortality following mRNA vaccine administration. This should have resulted in the immediate and full withdrawal of the product from the market. This did not happen.
- Health Canada must give an account for its actions with full transparency. The mRNA vaccines are known not to be as safe and effective, as the Canadian public have been led to believe. Furthermore, the long-term adverse effects of the mRNA vaccines are not known, since the studies required to ascertain this were never performed.
- From all the above, Health Canada and the Government of Canada are guilty of spreading misinformation among the Canadian public through heavy advertising in the media without a formal risk-benefit analysis, putting countless lives needlessly at risk.

All of the Pfizer data or lack thereof were provided by the United States FDA by court order. Although the FDA Biologic's Application License (BLA) is cited, note that Health Canada had reviewed, and accepted the same flawed data.

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Introduction

Traditional vaccines contain a known amount of the target antigens or proteins of the pathogen to create an immune response. They do not require a person's cells to manufacture and present them on their membrane surface at an uncontrolled rate and level. It is this very difference that has been overlooked when assessing the safety, dosage, and pharmacokinetics of BNT162b2 (Pfizer-BioNTech mRNA Vaccine) and its components/mRNA encoded product.

Therefore, BNT162b2 is not like any other vaccine that has ever been used successfully in the past as the innate immune response is initially targeted directly against one's own cells rather than against the invading pathogen.

Unlike traditional vaccines, in which the formulation contains a known concentration of viral antigen, BNT162b2 does not contain the viral antigen that triggers the immune response. Instead, the mRNA directs the body's cells to manufacture the viral spike protein *in vivo* at levels that may vary over 100-fold amongst vaccinees, and it is that very difference that has been overlooked when assessing the safety and pharmacokinetics of BNT162b2 and its components/mRNA encoded product. Individuals produce variable amounts of spike protein due to their genetics, age, hormonal, and nutritional status, batch of vaccine they receive, and so on. This problem was further exacerbated by the arbitrary decision to mix different vaccine products from various manufacturers (including adenoviral DNA biologics no longer permitted for use) assuming that they were simply interchangeable.

The concentration and exact composition of the encoded viral spike protein was never determined in any of the Pfizer's studies as required for other biologics. Therefore, the distribution of the encoded spike protein, and the safety of BNT162b2 was based upon assumptions. This product should never have gone into clinical trials, let alone on the market as COMIRNATY.

Flaws in Health Canada's review process

Nonclinical safety / Toxicology studies

By not performing pharmacokinetic studies of the encoded spike protein, which was already known to be toxic and bioactive, the regulatory submission is incomplete. From the very start, the nonclinical safety studies were designed in order to provide data that would put their product in a "good light." The critical flaw here, was that the guidance documents used by Health Canada were only applicable to traditional vaccines, and not vaccines using gene therapy technology.

Table 1. List of Toxicology Studies as Provided on Page 17 of Pfizer's Nonclinical Overview[a].

Toxicology – Studies with BNT162b2 variants					
38166	Repeat-dose toxicity	Wistar Han Rats	BNT162b2 (V8)	100 µg	Section 2.4.4.3
20GR142	Repeat-dose toxicity	Wistar Han Rats	BNT162b2 (V9)	30 µg	Section 2.4.4.3
20256434	Development and Reproductive Toxicity	Wistar Han Rats	BNT162b2 (V9)	30 µg	Section 2.4.4.6

(a) FDA. BLA (STN: BL 125742/0) Summary Basis for Regulatory Action. [Online] August 23, 2021. https://www.fda.gov/media/151733/download

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The first thing to notice from Table 1 is that all these studies are performed using Wistar Han rats. This approach is rather unusual on two accounts. Firstly, it is standard procedure to perform toxicology studies using two species (rodent and non-rodent species), in this case the second species would have been Macaques. Secondly, although not as obvious, was the selection of the species used for these studies, does not correlate with human physiology. Rats in the wild are associated with at least 55 different pathogens that they can pass onto humans, SARS-CoV-2 is not one of them. Therefore, we suspect that like mice to whom they are genetically closely related, their ACE2 receptor does not bind to the SARS-CoV-2 spike protein. So, although rats would be expected to produce antibodies against the encoded spike protein, they would not properly demonstrate adverse effects (toxicology), since the spike protein is not expected to bind its ACE2 target in this species. The most relevant rodent species would be the Chinese Golden Hamster. Therefore, this needs to be considered when interpreting the results from such studies. **In any case, two relevant species should have been used in toxicology studies.**

As these studies stand, the direct adverse effects of the encoded spike protein would never have been detected. During these past 19 years since the initial SARS outbreak, the toxic effects of the viral spike protein binding to the ACE2 receptor in humans have been elucidated. **The fact that the appropriate rodent species was not used, means that the results of the repeat dose, and reproductive toxicology studies would be misleading to say the least.**

Other toxicology studies

On page 29 of Pfizer's Nonclinical Overview document section 2.4.4.4. Genotoxicity, it states: "*No genotoxicity studies are planned for BNT162b2 as the components of the vaccine construct are lipids and RNA and are not expected to have genotoxic potential.*" And again, in section 2.4.4.5. Carcinogenicity, it states:

"*Carcinogenicity studies with BNT162b2 have not been conducted as the components of the vaccine construct are lipids and RNA and are not expected to have carcinogenic or tumorigenic potential. Carcinogenicity testing is generally not considered necessary to support the development and licensure of vaccine products for infectious diseases.*"

Although BNT162b2 might not be expected to have genotoxic or carcinogenic potential, the encoded spike protein that is produced does. Therefore, these studies should have been performed. Also, in section 2.4.4.6. Reproductive and Developmental Toxicity, it should be noted that these studies were performed using Wistar Han rats, a rodent species that is totally inappropriate for toxicology studies as mentioned earlier. A more relevant species such as the Chinese golden hamster should be used to focus on the toxicity of the spike protein and how it affects the offspring. In addition, the distribution of the spike protein in the tissues in both the mother and the pups would have provided much needed information as to whether BNT162b2 is suitable to administer to pregnant women and mothers who are breast feeding.

Clinical studies

On page 27 of Pfizer's Clinical Overview document [(b)] section 2.5.3. Overview of Clinical Pharmacology, it states: "*Pharmacokinetic studies are not usually required for vaccines. Measurement of the plasma concentration of the vaccine over time is not feasible.*" Drawing our

(b) Pfizer, Inc. BLA Submission for BNT162b2 Module 2.4. Clinical Overview. Public Health and Medical Professionals for Transparency Documents. [Online] April 30, 2021. https://phmpt.org/wp-content/uploads/2021/12/STN-125742_0_0-Section-2.5-Clinical-Overview.pdf

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attention to safety, Section 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports submitted by Pfizer, on Table 1 of their report, denoted here as Table 2 (see below) there were 1223 deaths over a 3-month period from December 1, 2020 until February 28, 2021. Such a high mortality rate following drug administration would have resulted in any other medicinal product being taken off the market immediately. Therefore, the question should be asked, why aren't the mRNA vaccines taken off the market? From Pfizer's own data, Health Canada must have already known that it is not safe.

Table 2. General Overview: Selected Characteristics of All Cases Received During the Reporting Interval

Characteristics		Relevant cases (N=42086)
Gender:	Female	25014
	Male	9152
	No Data	2990
Age range (years): 0.01 -107 years Mean = 50.9 years n = 34952	≤ 17	175[a]
	18-30	4953
	31-50	13886
	51-64	7884
	65-74	3098
	≥ 75	5214
	Unknown	6876
Case outcome:	Recovered/Recovering	19582
	Recovered with sequelae	520
	Not recovered at the time of report	11361
	Fatal	1223
	Unknown	9400

a. In 46 cases reported age was <16-year-old and in 34 cases <12-year-old.

In addition, what about the case outcomes of 9400 people classified as "unknown" along with 6876 people whose age could not be determined? Was that a result of poor documentation, or is there something else going on? Either way, such a flaw in the documentation of a regulated study should have been further investigated, and the findings documented.

Conclusion

The fundamental flaw was that Pfizer failed to determine the concentration and distribution of the encoded spike protein in their nonclinical and clinical studies. They had also failed to perform a Phase 1 ascending dose clinical study, which would have provided important information regarding the amount of encoded spike protein produced. With the knowledge that is already known regarding the spike protein's toxicity, any safety conclusions of the mRNA vaccines that have been offered are purely speculative and unsupported by the evidence, and are therefore invalid. In addition, genotoxicity and carcinogenicity studies were not performed. It can only be assumed that the incorrect guidance document (*i.e.,* that for a traditional vaccine) was used, instead of one more applicable to a gene therapy product. Good science should always supersede an inappropriate regulatory guidance document.

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Courville, Renee (HC/SC)

From: Jeffrey, Heather (HC/SC)
Sent: 2022-04-23 7:43 PM
To: Jean-Yves Duclos (parl.gc.ca) (cont)
Cc: [redacted] (HC/SC); [redacted] (HC/SC); [redacted] (HC/SC); Murseli, Lissa (HC/SC); Kochhar, Harpreet (PHAC/ASPC); Lucas, Stephen (HC/SC); MacKay, Jennifer (HC/SC)
Subject: Re: Weekly Reports

Categories: ATIP 001224

Hi Minister- Health Canada issues PS wide occupational health advice through the Public Service Occupational Health and Safety Program. PHAC also feeds into the advice. Departments then apply that overall advice individually based on their authorities and the specific operational requirements and context of their work. So it can look different in terms of its application in different settings based on different operational requirements. For example, if the advice speaks to the need for masks and respirators, you may be required to use an N95 if you are an ISC nurse, but a medical mask might be the requirement for an office worker in another department. The overall advice is continually reviewed and updated. We can provide additional briefing material on the program via your office.

Heather

Sent from my iPhone

> On Apr 23, 2022, at 6:28 PM, Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca> wrote:
>
> Merci Heather!
>
> By the way: who sets the public health rules for Service Canada and other agencies? Is it PHAC? Health Canada? Treasury Board? Or is it left to individual departments and agencies?
>
> Jean-Yves
>
> ---
>
> **De :** Jeffrey, Heather (HC/SC) <heather.jeffrey@hc-sc.gc.ca>
> **Envoyé :** Saturday, April 23, 2022 2:17:37 PM
> **À :** Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
> **Cc :** [redacted] (HC/SC) [redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; Murseli, Lissa (HC/SC) <lissa.murseli@hc-sc.gc.ca>; Kochhar, Harpreet (PHAC/ASPC) <harpreet.kochhar@phac-aspc.gc.ca>; Lucas, Stephen (HC/SC) <Stephen.Lucas@hc-sc.gc.ca>; MacKay, Jennifer (HC/SC) <jennifer.mackay@hc-sc.gc.ca>
> **Objet :** Weekly Reports
>
> Minister,
>
> Please find attached the following five weekly summary reports:

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- Surge Update
- International comparisons of vaccination rates for select countries
- international COVID-19 vaccine requirements
- Rapid testing report

All the best,

Heather

Heather Jeffrey
(she|her|elle)
Associate Deputy Minister / Sous-Ministre déléguée
Health Canada / Santé Canada
heather.jeffrey@hc-sc.gc.ca
Mobile - 613-355-5721

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Courville, Renee (HC/SC)

From: Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
Sent: 2022-01-10 9:45 PM
To: Lucas, Stephen (HC/SC); Kochhar, Harpreet (PHAC/ASPC); Tam, Dr.Theresa (PHAC/ASPC); [redacted](HC/SC); [redacted](HC/SC); [redacted](HC/SC); Provost, Marjolaine (HC/SC); [redacted](HC/SC) [redacted](HC/SC)
Subject: FYI

Categories: ATIP 001224

You probably have already seen, or understood, this.

https://ici.radio-canada.ca/nouvelle/1853038/vaccins-covid-brevets-oms?fromApp=appInfoIos&partageApp=appInfoiOS&accesVia=partage

Rachel: merci de m'imprimer stp.

Jean-Yves

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Vaccins COVID : la levée des brevets, un débat toujours pas tranché

INFO

Pas moins de 41 pays n'ont toujours pas été en mesure de vacciner 10 % de leur population.
PHOTO : RADIO-CANADA

Agence France-Presse
Publié le 10 janvier 2022

Face aux inégalités d'accès aux vaccins contre la COVID-19, la levée des brevets sur ces sérums est réclamée par de nombreuses organisations. Le point sur un débat qui, plus d'un an après la commercialisation des premières doses, n'a toujours pas été tranché.

Selon l'Organisation mondiale de la santé (OMS), 41 pays n'ont toujours pas été en mesure de vacciner 10 % de leur population, tandis que 98 pays n'ont pas atteint les 40 % de vaccinés, un fort contraste avec les pays occidentaux, où la couverture vaccinale atteint parfois les 80 %.

Des milliards de doses de vaccins ont pourtant été produites l'an dernier. Mais les différents mécanismes de redistribution, comme le dispositif COVAX (moins de 10 % des doses administrées

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dans le monde), mis en place par l'OMS pour assurer la vaccination des pays à bas revenus, n'ont guère fonctionné.

Or, a alerté en décembre le directeur de l'OMS, Tedros Adhanom Ghebreyesus, il en va de l'intérêt général. En détournant les doses loin des pays aux taux de vaccination très bas, « des programmes de rappel sans discernement ont toutes les chances de prolonger la pandémie, plutôt que d'y mettre fin », a-t-il prévenu.

Dès fin 2020, l'Afrique du Sud et l'Inde ont proposé à l'Organisation mondiale du commerce (OMC) de suspendre les droits de propriété intellectuelle pour les traitements et les vaccins contre la COVID-19.

Nombre d'ONG et d'Etats, et même les États-Unis, leur ont emboîté le pas. En France, le président Emmanuel Macron a d'abord appelé à faire du vaccin un « bien public mondial », avant de faire marche arrière.

Les partisans d'une levée des brevets plaident pour une dérogation aux accords sur les aspects des droits de propriété intellectuelle qui touchent au commerce (ou ADPIC) de l'OMC, permettant de suspendre les monopoles de 20 ans conférés par les brevets.

Si cette dérogation était appliquée, les producteurs seraient amenés à laisser d'autres fabricants produire des vaccins, sans que ces derniers aient à leur payer des droits.

Mais en plus d'un an, la discussion n'a guère avancé. Le sujet était de nouveau à l'ordre du jour de la conférence ministérielle de l'OMC en novembre, réunion reportée en raison du variant Omicron.

En général, développer un nouveau médicament, de son concept à la mise sur le marché, prend 10 ans et demande environ un milliard d'euros d'investissements. Traditionnellement, le brevet est donc le garant de l'intérêt pour une société de prendre des risques.

« L'idée centrale est d'encourager l'innovation : on investit car, au bout, on a la certitude d'avoir un brevet qui permette un retour sur investissement », relève Yann Basire, directeur général du CEIPI, le Centre d'études internationales de la propriété intellectuelle.

Les laboratoires font aussi valoir que les brevets ne sont pas le facteur le plus déterminant dans l'accès inégal aux vaccins. Matières premières en tension, difficultés technologiques sont les principaux points mentionnés.

Par ailleurs, chaque vaccin est le fruit non pas d'un seul brevet, mais de plusieurs, comme pour l'ARN messager, avec des technologies et techniques de production utilisées aussi dans d'autres domaines que la lutte contre la COVID, et qui sont détenus par d'autres organismes que Moderna ou Pfizer-BioNTech.

« Si on lève tous ces brevets, ça ne sera pas que pour les vaccins, mais cela concernera d'autres produits hors COVID », souligne Cyra Nargolwalla, conseil en propriété industrielle au cabinet

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Plasseraud IP, qui prédit une situation « chaotique ».

Enfin, se pose la question de la faisabilité. « Même en admettant qu'il y ait une dérogation sur les brevets, il faudrait aussi une levée des informations confidentielles pour le savoir-faire. Sans compter qu'on ne sait pas qui pourra produire l'ARN : en France, on n'a pas réussi à produire de vaccin », rappelle François Pochart, du cabinet August Debouzy, spécialiste des questions de brevets.

Il existe dans le cadre des accords de l'OMC une licence obligatoire rendant possible l'utilisation d'un brevet par les pouvoirs publics sans l'autorisation de son titulaire. Un système qui prévoit d'indemniser le groupe à son origine. « Dans ce cadre, ce n'est pas une expropriation, mais une location forcée », explique Yann Basire.

Ce système complexe, jamais utilisé en France, a permis à des pays à bas revenus d'accéder à des antirétroviraux dans la lutte contre l'épidémie de VIH.

Reste aussi le mécanisme des licences volontaires. Pour les vaccins COVID, certains laboratoires comme Novavax ont ainsi accordé des licences au COVAX pour que leur vaccin soit produit par d'autres. « Il y a même eu des accords entre sociétés concurrentes. Et cela été fait en dehors de tout mécanisme de contrainte », rappelle Cyra Nargolwalla. Des licences qui reposent toutefois sur la bonne volonté des producteurs.

Enfin, remarque François Pochart, au sein de l'Union européenne, il existe également un mécanisme de licence pour des exportations de médicaments à destination des pays qui en ont besoin. Un mécanisme « qui a été utilisé, et prévoit une rémunération du détenteur de brevet de 4 % du prix total. C'est une option envisageable, mais que personne n'a activée », souligne-t-il.

À lire aussi :

- COVID-19 : tout sur la pandémie

ATIA - 19(1)

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Courville, Renee (HC/SC)

From: Lucas, Stephen (HC/SC)
Subject: FW: Vaccination data

From: Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
Sent: 2022-01-11 9:14 PM
To: Kochhar, Harpreet (PHAC/ASPC) <harpreet.kochhar@phac-aspc.gc.ca>; Lucas, Stephen (HC/SC) <Stephen.Lucas@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; Provost, Marjolaine (HC/SC) <Marjolaine.Provost@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>
Subject: Vaccination data

Bonjour Harpreet,

Voici un exemple d'une tendance de la vaccination à travers le temps que je trouve utile. Particulièrement utile puisqu'elle porte sur l'augmentation des premières doses chez les adultes, ce qui est une question que je ne peux pas bien étudier à partir du rapport dans sa forme actuelle. En espérant que cela peut aider! Et merci pour tout le travail de l'équipe.

Jean-Yves

ATIA - 19(1)

Courville, Renee (HC/SC)

From: Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
Sent: 2022-03-09 9:50 PM
To: Kochhar, Harpreet (PHAC/ASPC); Lucas, Stephen (HC/SC)
Cc: [redacted] (HC/SC); [redacted] (HC/SC); [redacted] (HC/SC); [redacted] (HC/SC); Murseli, Lissa (HC/SC)
Subject: Re: Global Public Health Announcement

Categories: ATIP 001224

Very interesting!

Jean-Yves

De : Kochhar, Harpreet (PHAC/ASPC) <harpreet.kochhar@phac-aspc.gc.ca>
Envoyé : Tuesday, March 8, 2022 8:32:43 PM
À : Lucas, Stephen (HC/SC) <Stephen.Lucas@hc-sc.gc.ca>
Cc : Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; Murseli, Lissa (HC/SC) <lissa.murseli@hc-sc.gc.ca>
Objet : Re: Global Public Health Announcement

Good evening Ministér
Just to add that I met with the Canadian rep of Moderna as well as country medical officer of Moderna global from Boston US. I can also debrief you on that interaction.
Kind regards

Harpreet

Dr. Harpreet S. Kochhar
President
Public Health Agency of Canada

On Mar 8, 2022, at 7:19 PM, Lucas, Stephen (HC/SC) <Stephen.Lucas@hc-sc.gc.ca> wrote:

Ministér - I will debrief after my meeting with the Moderna Canadian CEO this week.

Steve

Begin forwarded message:

From: Patricia Gauthier [redacted]
Date: March 8, 2022 at 6:09:24 PM EST
To: "Lucas, Stephen (HC/SC)" <Stephen.Lucas@hc-sc.gc.ca>
Subject: Global Public Health Announcement

Canada Health Act
A2022001224

ATIA - 19(1)

Good afternoon Steve,

I hope you are well and I look forward to connecting on Thursday.

I wanted to share a global announcement about ground-breaking mRNA research more specifically as it pertains to pandemic preparedness, global public health and R&D that are much aligned to the work we have been doing with your team in the past months. We believe that there are significant opportunities for Canadian researchers to creatively partner with Moderna on such initiatives.

Among today's announcements are the following:

1. **A commitment to advance vaccines targeting 15 pathogens identified as biggest public health risk by WHO and CEPI into clinical studies by 2025.** This portfolio of 15 vaccine programs will target emerging or neglected infectious diseases, which may include a potential "Disease X"(WHO's term for a pathogen currently unknown to cause human disease). This is the centerpiece of Moderna's commitment to be ready for the "next pandemic". One of the reasons that Moderna was able to roll out a COVID vaccine so quickly was because we had already done research into the MERS virus, which belongs to the same "family of virus". This initiative will do the same kind of prep research for other viruses. (A list of the 15 target viruses is attached).

2. **The launch of "mRNA Access", a new collaborative enabling researchers around the world to utilize Moderna's mRNA technology platform to pursue research in their own labs on emerging and neglected infectious diseases.** This program will leverage Moderna's preclinical manufacturing capabilities and research and development expertise and also allow scientists around the world to explore novel vaccine designs. There will be an opportunity for some Canadian Researchers to be involved in this initiative.

3. **Moderna is also updating its patent pledge and expanding its commitment to global health equity by pledging to never enforce our COVID-19 patents in the Gavi COVAX AMC for 92 low- and middle-income countries,** provided that these vaccines are manufactured solely for use in these countries.

4. **Africa manufacturing capabilities.** Additionally, Moderna has announced the establishment of an MOU to construct a manufacturing facility in Kenya, which will support vaccine access for Africa.

I look forward to discussing further on Thursday.

Many thanks in advance and best regards,

Patricia

Patricia Gauthier
President & General Manager, Moderna Canada
Présidente & Directrice Générale, Moderna Canada
416-859-0079 | [redacted]

Page 523 of/de 528
A2022001224

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ATIA - 19(1)

Courville, Renee (HC/SC)

From: Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
Sent: 2022-03-21 12:20 PM
To: Kochhar, Harpreet (PHAC/ASPC); Lucas, Stephen (HC/SC); [redacted] (HC/SC); [redacted] (HC/SC); [redacted] (HC/SC)
Cc: Uppal, Sunny (PHAC/ASPC)
Subject: Re: COVID-19 Daily Report – March 21, 2022 // Bulletin quotidien COVID-19 – 21 mars 2022

Categories: ATIP 001224

Merci!

Jean-Yves

De : Kochhar, Harpreet (PHAC/ASPC) <harpreet.kochhar@phac-aspc.gc.ca>
Envoyé : Monday, March 21, 2022 10:56:49 AM
À : Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>; Lucas, Stephen (HC/SC) <Stephen.Lucas@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>
Cc : Uppal, Sunny (PHAC/ASPC) <sunny.uppal@phac-aspc.gc.ca>
Objet : RE: COVID-19 Daily Report – March 21, 2022 // Bulletin quotidien COVID-19 – 21 mars 2022

Minister,

In response to your question - there seems to be a mistake in the PCO report. The information presented there is not consistent with standardized and validated information that we receive directly from BC. The issue seems to be in the numerator that was used to calculate the percentage (91.0%).

Based on the latest data that we have received from BC, 190 395 children aged 5-11 have received one dose of the pediatric vaccine. This works out to 55% of the children in BC having received a first dose of the pediatric vaccine.
This is aligned with the data found on the BC-CDC website: http://www.bccdc.ca/health-professionals/data-reports/covid-19-surveillance-dashboard

We have cross-checked with the references contained in the PCO report. It is possible that one of the sources that they are using seems to have incorrect data for the number of doses administered and they have used this as the numerator to get the 91.0% coverage in the report.

This has been flagged to PCO.

Please let me know if you have any questions,

ATIA - 19(1)

Kind regards

Harpreet

Dr. Harpreet S. Kochhar
(he | il)

President
Public Health Agency of Canada / Government of Canada
harpreet.kochhar@phac-aspc.gc.ca / Tel: 613-946-3498

Président
Agence de la santé publique du Canada / Gouvernement du Canada
harpreet.kochhar@phac-aspc.gc.ca / Tél. : 613-946-3498

** Please note the new email address*

From: Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
Sent: 2022-03-21 8:43 AM
To: Kochhar, Harpreet (PHAC/ASPC) <harpreet.kochhar@phac-aspc.gc.ca>; Lucas, Stephen (HC/SC) <Stephen.Lucas@hc-sc.gc.ca>; [redacted] (HC/SC) [redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted] (HC/SC) <[redacted]@hc-sc.gc.ca>
Subject: Fwd: COVID-19 Daily Report – March 21, 2022 // Bulletin quotidien COVID-19 – 21 mars 2022

Harpreet,

I see in this report that the rate of first-dose pediatric vaccination in BC would be 91%? Can we check that please?

Jean-Yves

De : PCO Daily Report / Bulletin quotidien du BCP (PCO-BCP) <covidreport-bulletincovid@pco-bcp.gc.ca>
Envoyé : Monday, March 21, 2022 7:55:20 AM
Objet : COVID-19 Daily Report – March 21, 2022 // Bulletin quotidien COVID-19 – 21 mars 2022

Good morning,

Please see attached today's COVID-19 Daily Report.

In order to ensure the continued safeguarding of documents, distribution of documents is restricted to this e-mail list.
Should additional recipients be identified within your organization, they should be directed to send an e-mail to this account. Decisions regarding additional distribution will be made on a case-by-case basis.

Bonjour,

Veuillez trouver ci-joint le Bulletin quotidien COVID-19.

Afin de maintenir la protection des documents, la distribution des documents est strictement limitée.
Si d'autres destinataires devaient être désignés au sein de votre organisation, il faudra les inviter à écrire un courriel à cette boîte générique. Des décisions concernant la distribution supplémentaire seront prises au cas par cas.

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Government of Canada | Gouvernement du Canada

Courville, Renee (HC/SC)

From: Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
Sent: 2022-03-23 1:25 PM
To: Tam, Dr.Theresa (PHAC/ASPC); Kochhar, Harpreet (PHAC/ASPC); Lucas, Stephen (HC/SC)
Subject: Vaccination

Categories: ATIP 001224, PRINTED FOR DM

Hello Theresa, Harpreet and Steven,

Dr. Muhajarine summarizes well the point of view I was trying to express yesterday:

https://www.cbc.ca/news/business/unvaccinated-travel-canada-1.6393668

Take good care!

Jean-Yves

Page: 528 of/de 538
A2022001224

Business

COVID-19 restrictions are lifting, but unvaccinated Canadians still can't board planes or trains

Some unvaccinated Canadians question why federal government still maintains mandate

Sophia Harris · CBC News · Posted: Mar 23, 2022 4:00 AM EDT | Last Updated: March 23, 2022

Canada's vaccine mandate prevents unvaccinated Canadians from boarding a commercial plane or train in Canada to both domestic and international destinations. (Evan Mitsui/CBC)

comments

Because she's unvaccinated against COVID-19, Tamika McIntosh of Brampton, Ont., wasn't allowed to board a plane to fly to Jamaica last month to attend her grandfather's funeral.

Now, McIntosh combs the news daily for any indication when Canada might lift its vaccine mandate for travellers so she can finally go to Jamaica and pay her last respects.

"You don't get the closure when you don't get to physically be there to say goodbye," said McIntosh. "Until I physically get to go to his grave site and spend some time there, that void will always be open."

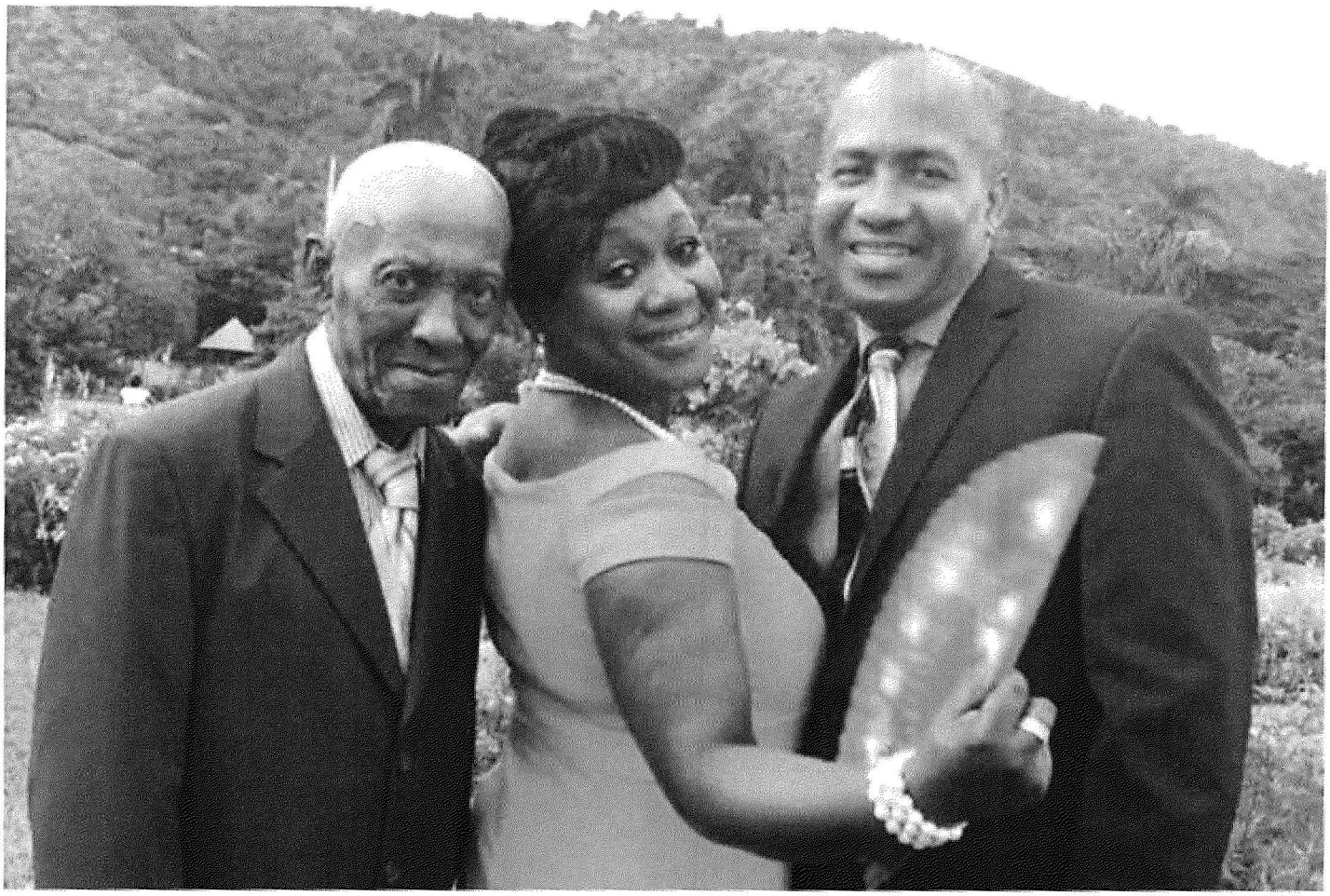
Canada's vaccine mandate — which took effect in November 2021 to boost vaccination rates — prevents unvaccinated Canadians from boarding a commercial plane or train in Canada to both domestic and international destinations. Now that COVID-19 restrictions are fast disappearing, some unvaccinated Canadians question why the federal government still maintains the mandate.

- SECOND OPINION **COVID-19 vaccine mandates have worked in Canada — but they're harder than ever to justify**
- **Federal government to end pre-arrival COVID testing for travellers entering Canada**

"I don't think it's fair," said McIntosh. "I don't have mobility rights. I'm still stuck in a country and I can't leave."

Although COVID-19 vaccines available in Canada have been deemed safe and effective by Health Canada and other regulators, McIntosh still has reservations about getting the shot.

"I just feel like I have the right to choose," she said.



Tamika McIntosh of Brampton, Ont., with her late grandfather, Melsome Lee, left, and uncle, Andrew Lee, right, in 2017. Melsome Lee died earlier this year, but McIntosh, who has chosen not get vaccinated, can't fly to Jamaica to visit his grave until Canada lifts its vaccine mandate. (Submitted by Tamika McIntosh)

Provinces dropping most vaccine mandates

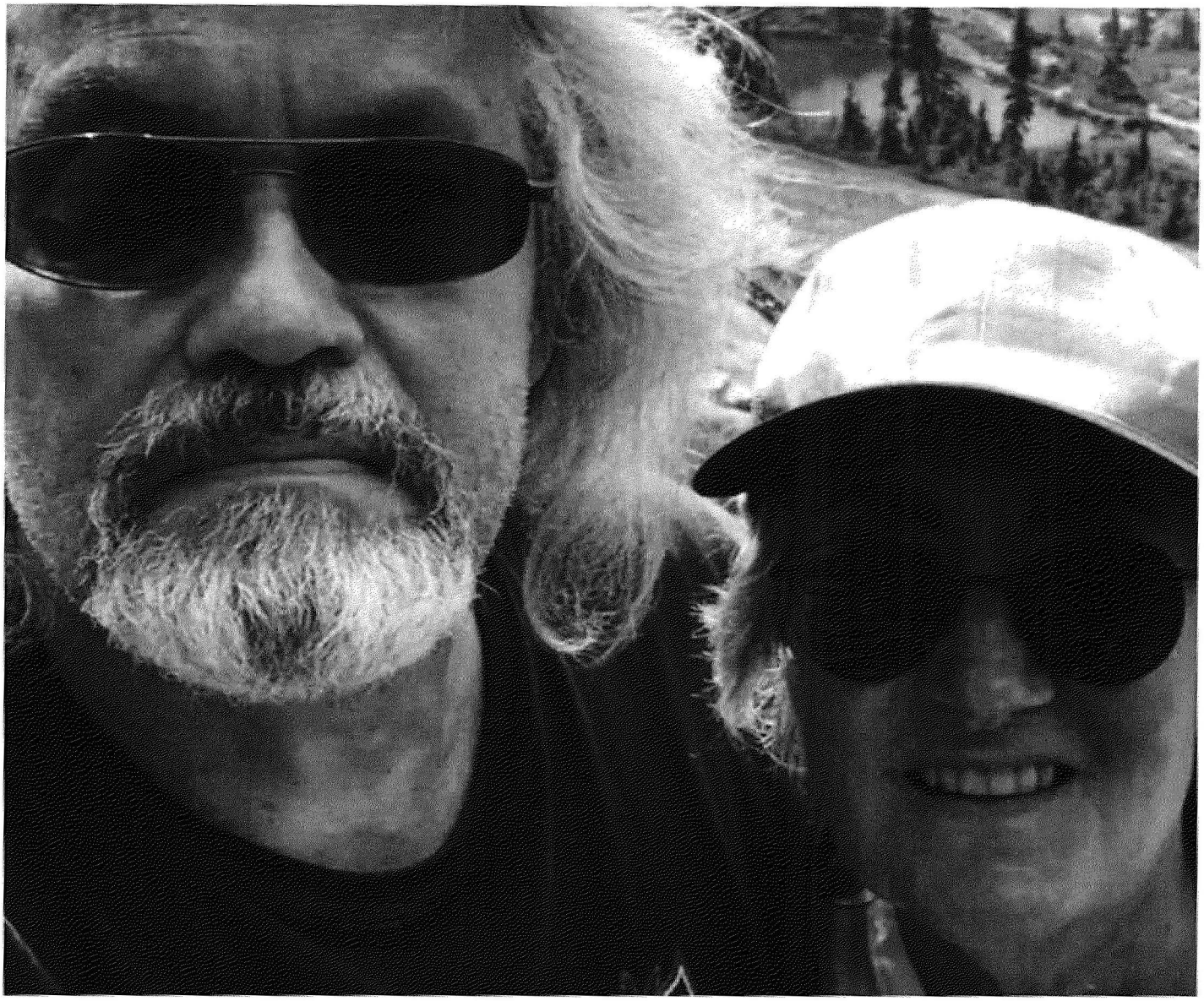
More than 85 per cent of Canadians aged five and older are now fully vaccinated.

Meanwhile, following a decline in COVID-19 cases after the Omicron wave, Canada's provinces are dropping most or all of their vaccine mandates. That means unvaccinated people can return to venues such as restaurants, gyms and hockey games.

They are also welcome in many countries such as England, Ireland, Iceland and Norway, which have dropped all their COVID-19 travel restrictions. Other countries, such as Greece and Jamaica allow unvaccinated travellers to enter with a negative COVID-19 test.

The Canadian government isn't "paying attention to the things that are going on in other countries," said Kathy Neudorf of Langley, B.C., who is also unvaccinated and eager to travel.

"I don't have the freedom to come and go as I choose ... I can't even go across to Quebec or something, because I can't get on a plane."



Kathy Neudorf of Langley, B.C., and her American partner, David Johnson, are both unvaccinated. (Submitted by Kathy Neudorf)

Global COVID-19 resurgence could delay plan

Canada's Chief Public Health officer, Dr. Teresa Tam, said Ottawa is reviewing its vaccine mandates for both travellers and federal workers, with an eye to dropping them. But she suggested the current resurgence of COVID-19 cases globally could delay that plan.

"The potential for the Omicron resurgence, particularly the subtype BA.2 can still occur. So I think this is just waiting to see what happens with that situation," she said at a House of

Commons health committee meeting on Monday.

- **Why some unvaccinated Canadian travellers are still able to board a plane**
- **COVID-19 deaths strain South Korea's crematoriums, hospitals**

At the same meeting, Health Minister Jean-Yves Duclos offered no timeline for ending federal vaccine mandates, but said the decision will be based on a number of factors including COVID-19 case numbers, waning immunity and vaccination rates.

Although Canada's vaccination rate is high, Duclos noted that less than 60 per cent of Canadian adults have got their booster shot.

"We need more than that to protect against Omicron and future variants," he said.

Currently, Canadians do not need a booster shot to qualify as fully vaccinated.

Many who are vaccinated still get COVID-19, expert notes

Some medical professionals say it's time for Canada to rethink its vaccine mandate for travellers.

Infectious disease physician Dr. Zain Chagla points out that many people who got vaccinated also got COVID-19.

"Knowing that two doses of vaccines likely doesn't prevent a lot of transmission, it really does start poking holes in the fact that this mandate is meant to [prevent] transmission," said Chagla, a physician at St. Joseph's Healthcare Hamilton.

He encourages people to get vaccinated, as data shows vaccines can help prevent serious illness and death from COVID-19.

Watch: Canada ending pre-arrival test for vaccinated travellers:

Canada to end pre-arrival COVID-19 testing for fully vaccinated travellers

11 months ago | 1:43

Fully vaccinated travellers will no longer be required to show proof of a negative COVID-19 test before arriving in Canada by plane or car as of April 1. There are concerns it's too soon for Ottawa to drop the rule, given rising case counts in Europe and Asia.

But Chagla said now that the provinces have dropped their vaccine mandates, it would make sense for the federal government to follow suit.

"Going on a domestic flight and sitting in the ... Scotiabank Centre for a Raptors game — the risks are not that far off," he said. "But one of those events requires a proof of vaccine mandate."

Unvaccinated pose a greater risk of infecting others: epidemiologist

Epidemiologist Nazeem Muhajarine takes a different stance. He argues the vaccine mandate for travellers should remain until the majority of the global population is fully vaccinated.

He said although vaccinated people can still get COVID-19, the unvaccinated pose a greater risk of infecting others, because they can carry the virus for longer.

"They will be shedding the virus, more of it for a longer time, which actually means that they will be more effective transmitters of the virus to others," said Muhajarine, a professor of community health and epidemiology at the University of Saskatchewan, and a member of the federal government's Coronavirus Variants Rapid Response Network.

Epidemiologist Nazeem Muhajarine says Canada shouldn't drop its vaccine mandate for travellers until the majority of the global population is fully vaccinated. (University of Saskatchewan)

Nazeem also said it could be problematic if Canada were to drop the vaccine mandate, and then reinstate it at another time, if the pandemic worsens.

"Trying to reintroduce it is awkward, and it is never good policy," he said. "People are confused."

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ATIA - 19(1)

From: Courville, Renee (HC/SC)
Sent: 2023-05-18 2:10 PM
To: Littleton, Sonia (HC/SC)
Subject: FW: Vaccination data

Hi Sonia – this is the email you are looking for

From: Duclos, Jean-Yves - Personnel <Jean-Yves.Duclos.P9@parl.gc.ca>
Sent: Tuesday, January 11, 2022 9:14 PM
To: Kochhar, Harpreet (PHAC/ASPC) <harpreet.kochhar@phac-aspc.gc.ca>; Lucas, Stephen (HC/SC) <Stephen.Lucas@hc-sc.gc.ca>; [redacted](HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted](HC/SC) <[redacted]@hc-sc.gc.ca>; [redacted](HC/SC) <[redacted]@hc-sc.gc.ca>; Provost, Marjolaine (HC/SC) <Marjolaine.Provost@hc-sc.gc.ca>; [redacted](HC/SC) <[redacted]@hc-sc.gc.ca>
Subject: Vaccination data

Bonjour Harpreet,

Voici un exemple d'une tendance de la vaccination à travers le temps que je trouve utile. Particulièrement utile puisqu'elle porte sur l'augmentation des premières doses chez les adultes, ce qui est une question que je ne peux pas bien étudier à partir du rapport dans sa forme actuelle. En espérant que cela peut aider! Et merci pour tout le travail de l'équipe.

Jean-Yves

Progression du nombre de premières doses administrées quotidiennement au Québec chez les 18 ans et plus, selon une moyenne mobile sur sept jours
1 400
1 200
1 000
800
600
400
200
0
1er déc.
10 déc.
20 déc.
1er janv.