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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Ladies and gentlemen, I call the meeting to order.

Thank you to our guests, the Public Health Agency of Canada and Canadian Blood Services. In this 42nd Parliament, you're the very first witnesses we've had at this standing committee; we waited for you.

Voices: Oh, oh!

The Chair: At any rate, we're very pleased you came.

The issue we are to talk about today is the Zika virus. All of us are members of Parliament, and all of us are hearing from our constituents. We need to have the right answers and we're hoping you can provide us with the right answers.

We'll try to go for an hour and a half. Then, if we've completed all of the questions and everybody's happy, we'll get into our steering committee report at about five o'clock.

I guess we'll start with the Public Health Agency, and then we'll go to Canadian Blood Services. Both presentations should generally go for 10 minutes. Then we'll ask questions.

Is that okay? Great.

Dr. Gregory Taylor (Chief Public Health Officer, Public Health Agency of Canada): Thank you very much, Mr. Chair.

Certainly, it's a privilege to be the very first witness, a double privilege. I have a very short deck. I'm going to go through the deck very quickly. I'm going to ask Dr. Matthew Gilmour, who is the head of our laboratory, NML in Winnipeg, to add to that. Those are basically the messages I have.

I'd like to start by conveying three key messages to you. The first key message is that our knowledge is rapidly evolving when it comes to the Zika virus. Many of the recommendations and activities that we're doing currently will likely change as the knowledge increases. The second key message is that the risk to Canadians living in Canada is low at this point in time. The third key message is that based on some of the science we have, we are certainly taking, and I think the globe is taking, a precautionary approach in terms of how we deal with the Zika virus.

Page 2 of the deck talks a bit about the virus, a bit about how it's transmitted. One of the key messages there is that only 20% to 25% of the people who are infected with the virus actually get symptoms. This virus has been around for a long time. It has been around in Africa and Asia since 1947 or 1950, but despite that, we don't know a lot about it, mostly because very few people actually got sick and very few people were hospitalized. It was one of those things that just happened and we didn't even look for it.

The current outbreak of the virus in the Americas is a little bit different, but the vast majority of the genome is the same. It's in a family of viruses, which I'm sure you've heard of, like dengue, yellow fever, and West Nile virus. West Nile virus is the virus that is in Canada, which makes some of the diagnostics a little bit difficult to do.

As I mentioned, there's very limited knowledge. We're learning more and more. You've seen reports of microcephaly and Guillain-Barré syndrome and that knowledge is gradually building. The diagnostics, and Dr. Gilmour will talk to those in a second, are extremely important. A key point here, though, is that there is no treatment. There is no vaccine for this virus and much research is needed.

The next slide is on the risk to Canadians. You've seen in the media that since the huge outbreak in the last several years, over 50 countries worldwide currently have a local circulation or outbreak of this virus and over 30 countries in the Americas at this time.

What's key to us, given that the risk to Canadians, as I mentioned, who live in Canada is very low, is the travelling public. You'll note from the slide that over three million Canadians travel every year to the countries currently affected in the Americas. As of March 7 there have been 20 confirmed cases of Zika in Canada. These are laboratory confirmed and these are all people who have acquired their infection outside the country. The key population that we're worried about is pregnant women and most of the remarks I'll make in the next little while are focused on them.

The next slide is Zika and pregnancy. Brazil, as you're aware, is reporting a serious spike in birth defects known as microcephaly, which is an abnormal head size associated with incomplete brain development. Along with microcephaly, there are other neurodevelopment changes that have been noted as well. This has not been proven yet and that's some of the difficulty.

There is an association of this virus. You've probably seen in the media reports of 5,000 or 6,000 new cases or reported cases of microcephaly. There's some evidence to suggest that those started before the Zika virus was actually in Brazil and there are only a few hundred that have been linked to the Zika virus. I emphasize linked. We will never have proof of this. You can't give a pregnant woman the virus just to see what's going on. They will always be observational studies, but that evidence is gradually building.

We do have evidence of the virus present in fetuses, in placentas. But does it cause the defect or does it just happen to be there? That's what is unknown.

We have special precautions with pregnant women specifically targeted. As you've seen in our travel health notices, we're advising pregnant women who are considering travelling to those countries to reconsider their travel and defer their travel at this time until the outbreak is over. If they must go, they should practice very careful mosquito avoidance techniques.

The other thing that's also new is sexual transmission. Prior to this outbreak, it was exceedingly rare, one or two cases reported globally. You've probably seen in the media a few more cases of sexual transmission. The virus seems to exist in semen. Our knowledge so far is up to about two weeks and there have been a few cases of men who have gone to these countries, become infected with the virus, and given it to women through sexual contact when they come back.

On slide 5 I'm going to talk a bit about our domestic response. Key to us is surveillance. We're monitoring the outbreak, compiling a national picture to find out what's going on, and we're certainly meeting our obligations under international health regulations.

● (1535)

We're a signatory to the International Health Regulations with the WHO. We're not obligated to the IHR to report on all cases of Zika that are acquired outside the country, but we are obligated if anyone acquires Zika inside Canada, or if it's associated with a birth defect.

We've been producing a lot of guidance, such as travel health notices, which I've alluded to. We have a public health notice going to the general public. We have CATMAT, the Committee to Advise on Tropical Medicine and Travel, a group of experts we've put together. They've been in existence for many years. They have produced a series of travel guides and put them on our website.

We also have laboratory testing and recommendations for Zika virus, which Dr. Gilmour will talk about in a second. You're probably aware that there's a 21-day deferral period in place for blood, cell tissue, and organ donations. My colleagues from Canadian Blood Services will speak to that in a minute.

Slide 6 talks about the diagnostic testing support, and I wanted to let you know that we have had the virus in Canada since 2013. It was isolated from a traveller who acquired it in Thailand in 2013. We kept a sample of it in our laboratory, which gave us a jump-start on the diagnostic tests for the virus. The virus was 99% identical.

Matt, do you want to add a few comments about our diagnostic support?

Mr. Matthew Gilmour (Scientific Director General, National Microbiology Laboratory, Infectious Disease Prevention and Control Branch, Public Health Agency of Canada): Yes, I'd be glad to, Dr. Taylor.

First, thank you for having me in from Winnipeg. It is certainly a busy time at the National Microbiology Lab right now, because we're offering first and foremost all the diagnostic testing services for Zika virus within the country.

We're offering two different types of tests. One is a molecular test. It's a rapid test. As Canadians return from endemic areas or areas where Zika is transmitting, if they've recently come back and they're recently symptomatic, we have a test that very quickly and definitively confirms if they do have the virus. It's detecting if they still have the virus circulating within their blood or within other tissues. It's an easy test.

The other test we have is called serology, and that's a test to see if someone has been exposed to the virus in the past. It's testing someone's own immune system to see if they have produced antibodies to the virus. Unfortunately, that test is not as rapid as the molecular suites, because we're trying to detect a past infection. It could take weeks to confirm a case.

Right now, we're lucky to have both of those within our menu of testing. It's coming through collaboration with our colleagues in the States at the CDC, through having had this 2013 isolate that came through a traveller who went to Thailand.

As you expect for the NML, one of the reasons we're there is that cases of infectious disease occur in Canada and there's not a chance to diagnose them locally within a hospital or provincial public health lab, as was the case with this return traveller from Thailand who had returned with symptoms of dengue. It wasn't dengue. It was something else, so they called on the NML. The specimens came to us in 2013, and we confirmed that this was the first travel-associated case of Zika. As Dr. Taylor said, it gave us that leg-up to start doing the work and to start offering and developing some of those diagnostics.

Right now, we're offering the diagnostic testing for all the provincial public health labs. In the background we've started to do research. Some is applied research on developing new tests. Some is evaluating commercial assays. If we can get those put into place, then we can disseminate the testing capacity into provincial labs so it's not all coming into Winnipeg.

We're also beginning other research studies, such as small animal models, because if one wanted to test antivirals or candidate vaccines, you'd want to start in small animals. Other models...such as in mosquitoes. We have an entomology lab where we can start doing testing to see if the mosquitoes that are in Canada can carry this virus. We have math modellers, tele-epidemiologists, and mathematical geographers who can model if the mosquitoes that are present in Brazil and Central America have a possibility of coming to Canada and also bringing the disease to Canada.

Again, we have a variety of research means to interrogate the likelihood, which is low, of this coming to Canada and sustaining in Canada. We have research on the go to develop these animal models, which will lead to possible therapeutics, whether an antiviral or a vaccine.

That's some of the work at the NML right now.

● (1540)

Dr. Gregory Taylor: Thanks, Matt. That's great. Also within the federal family we're coordinating across several departments, we're working with the provinces and territories, and we're also engaging with the international community.

We're communicating—and this is engaging the provinces—regularly with all of our colleagues across the country, consulting experts, providing the latest information, and assembling the guidance, as I mentioned. I'm talking to the chief medical officers of health almost daily. There's a lot of angst across the land in terms of how best to report, what happens, etc. We're going on an ongoing basis. We've connected with front-line practitioners, specifically the Society of Obstetricians and Gynaecologists, the college of family practice, the pediatric society, etc.

As you can imagine, pregnant women who may be infected or are concerned they're infected have a very difficult decision to make. The CEO of the Society of Obstetricians and Gynaecologists of Canada—I've talked to her several times—says she thinks that lot of women will be deciding to terminate their pregnancies, and whether they have a positive lab or not, a lot of women are having a very difficult decision. If they aren't symptomatic and it is based on serology or antibodies, it's a very difficult test to interpret, so we're working very closely with front-line practitioners to assist them with that.

I've mentioned several federal departments. We're also connecting with Sport Canada; the Canadian Olympic Committee, specifically Dr. Bob McCormack, who is the chief medical officer of the Olympic Committee; and the Canadian Paralympic Committee to assist them in terms of making their decisions for their athletes.

Internationally, we're working with WHO, and also PAHO. Since this is in the Americas, PAHO is our main contact. We've been working very closely with them. As I mentioned earlier we're reporting cases to the International Health Regulations, to WHO, so they're aware of what's going on in Canada. The WHO has been looking for $56 million across the federal departments. We're looking at how we can best meet some of those needs.

In terms of how we can assist, some of the work the laboratory is doing.... We're considering assisting CARPHA, the Caribbean Public Health Agency. We've worked closely with CARPHA for many years now. In essence, it's several Caribbean countries that have come together to form one overarching organization to support them. We're looking at how best to support them.

I will stop there and pass it on to my colleagues.

The Chair: Thank you very much, and thanks for the deck. It's very clear and it gives us a lot of information.

Dr. Sher.

Dr. Graham Sher (Chief Executive Officer, Canadian Blood Services): Thank you very much to committee members. At Canadian Blood Services we welcome this opportunity.

I'll very briefly tell you about Canadian Blood Services to give you some context on the issue of the Zika virus. As members of the committee know, we're an arm's-length organization within the larger health care system, supporting transfusion and transplantation medicine across the country. We are regulated by Health Canada under the Food and Drugs Act, but we are funded by the provinces and territories and the ministers of health across the country, who serve as the corporate members of Canadian Blood Services.

Our mandate is to manage the national supply of blood, blood products, stem cells, and related services for all the provinces and territories except Quebec, which has its own agency, Héma-Québec. We also manage for Canadians the national public umbilical cord blood bank. We're involved in the procurement of a variety of plasma-derived drugs for the country. We also lead an integrated interprovincial and national system for organ donation and transplantation. We look forward to talking to the committee about that at another opportunity.

We are dedicated as an organization to providing value to Canadians by improving the health outcomes of patients who depend on transfusion and transplantation by enhancing health system performance and by optimizing costs of the health system. We are an integrated pan-Canadian service delivery model, national in scope, with an infrastructure and governance model that makes us a unique part of the health fabric in this country.

I won't go into any detail with respect to Zika virus—for background, you've heard from colleagues at the Public Health Agency—other than to say that we do have a responsibility for mitigating risks to the blood supply for all viruses. Certainly Dr. Taylor referred to West Nile virus as a similar virus that emerged quite a number of years ago. At that time, we took very rapid and proactive steps to protect the blood supply against West Nile virus. Here we now face the same situation with respect to Zika virus.

What do we know about Zika virus and risks to the blood supply globally, and in particular in Canada? The transmission of Zika virus through blood transfusion was not entirely clear in the early evolution of this. More recently, there have been a couple of cases in Brazil that have strongly suggested that transfusion of blood products is indeed a route through which the virus can be spread.

One important point—certainly Dr. Devine can expand on this should committee members have questions—is that there is no licenced screening test we can put into the blood system today for Zika virus. Unlike the tests we have for West Nile, HIV, hepatitis B, and hepatitis C, there is no screening test that we can routinely do on blood donors. Blood system operators like Canadian Blood Services, in countries where Zika virus is not widely present, have had to resort to the policy of deferring as blood donors the people who have travelled to areas where Zika virus is present.

As the situation emerged, we began to see cases in Brazil in the middle of 2015; subsequently in Colombia, Mexico, Guatemala, El Salvador, Venezuela, and Paraguay by November; and in Puerto Rico by December. By January it was emerging in other parts of the Carribean.

At Canadian Blood Services, we immediately determined, given the frequency of travel of Canadians to this part of the world, that we needed to take some rapid and precautionary measures to protect the blood supply. We consulted with our international scientific and research advisory committee, a group of experts in the field of transfusion-transmitted diseases. We consulted with colleagues at Héma-Québec. We've been in regular conversation with both the Public Health Agency and Health Canada.

I echo what Dr. Taylor said, that we all recognized that the risk was small. Even if we didn't put anything in the way of a deferral policy in place, the likelihood of a transmission through blood transfusion in Canada was very low.

Nonetheless, and in keeping with the precautionary principle that underscores decision-making at Canadian Blood Services, on January 28 of this year we announced our intention to implement a formal risk-based decision-making policy with respect to Zika virus for the blood supply no later than one week after that announcement on February 5. At the time, on January 28, we publicly asked Canadians who had recently travelled to Zika-risk areas to postpone donating blood for a month until we had time to complete a comprehensive risk assessment and determine an appropriate deferral policy for the country.

Dr. Devine and her team of experts immediately began a rigorous risk-based decision-making process. It was primarily focused on ensuring the safety of the blood supply balanced with the security of the blood supply—meaning ensuring that we had enough blood to meet the needs of patients across the country.

● (1545)

We used all available scientific information to understand the nature of the risk and the data on travel behaviour of our donors. We developed a sophisticated risk model based on assumptions, predictions, and experience both with Zika virus as a known pathogen and similar viruses such as dengue virus.

On February 5 of this year we implemented a deferral policy of 21 days following exposure to Zika-risk areas. Héma-Québec introduced the same deferral policy. That 21-day deferral policy is based on several important criteria: an estimated risk of infection through a unit of blood in the Canadian blood system; available information on the duration of illness and residency of time of virus in the blood stream; the need for a deferral time period that aligned with our computer system so that we could implement it rapidly and effectively; the need for a simple approach that did not require changing every time another country reported Zika virus presence; a calculated impact on sufficiency of supply so we wouldn't lose more donors than could meet the needs of Canadian patients; and most importantly, the introduction of proportionate risk so as to have the right balance of safety and security of supply.

It was known to us at the time that the U.S. Food and Drug Administration was contemplating a 28-day deferral policy, as were several other countries where Zika virus may have been of concern. This concept of a 28-day deferral policy was based on calculations done by an organization in the United States known as the AABB, or the American Association of Blood Banks. Dr. Devine and I have served on the board of that organization. Their committee did two risk assessments: one for 14 days and one for 28 days. They did not do a risk calculation for 21 days. Those two time frames, 14 days and 28 days, were selected because they had been used for deferral policies for other viruses.

Their data showed that a 14-day deferral policy is likely too short from a risk mitigation point of view, so they ended up recommending a 28-day deferral policy. FDA followed this advice from the AABB, and that has become the policy in the United States.

Our risk modelling included a detailed calculation, including the 21-day deferral policy. Our data will show, as does Héma-Québec's, that the risk of a unit of blood being infected with Zika virus and entering the blood supply in Canada with our 21-day deferral policy in place is one in 38 million. The risk using a 28-day deferral policy would be one in 380 million. As context for committee members, the combined risk of HIV, or hepatitis B, or hepatitis C entering the blood supply in Canada today in the face of sophisticated screening tests is about one in 3.8 million. We're confident that our 21-day deferral policy significantly reduces the risk of Zika virus proportionate to other risks we manage.

The region of travel that we have chosen is intentionally very wide. In other words donors who have travelled outside of North America and Europe will be deferred for their 21-day period.

As was mentioned, there are also considerations with respect to donors for cells, tissues, and organs. As I mentioned in my opening remarks, in addition to managing the blood system we are also responsible for managing the stem cell network for Canada and the public umbilical cord blood bank. We are also involved in supporting organ donation and transplantation across the country. We are confident that the risk calculations applied to blood donors will be equally applicable to adult stem cell donors.

Health Canada has indeed provided guidance for cells, tissues, and organ organizations that aligns with our 21-day deferral policy that Canadian Blood Services and Héma-Québec now have in place. While we don't screen organ donors directly—that is done by other provincial organizations—we do believe the advice related to organ donor management provided by Health Canada and the Canadian Transplant Society is appropriate.

● (1550)

Like the Public Health Agency of Canada, we're involved in active monitoring of this evolving situation. We remain in contact with numerous partner organizations, including blood system operators around the globe, provincial and federal public health agencies, and many other organizations managing this entity.

As a closing point, I would like to leave committee members with an understanding of one other technology that, while not available imminently in Canada, is a technology that we at Canadian Blood Services believe is incredibly important from a risk management and risk mitigation point of view. It is a technology known as pathogen inactivation technology. Sitting beside me is one of the world's leading experts in that. She will be happy to answer committee questions.

It is a technology whereby we don't rely on testing for agents in the blood supply but actually depend on technologies to kill or inactivate the pathogens prior to transmission. That technology is not yet licensed and available in Canada, but Canadian Blood Services is on record and working with a clinical trial and the regulator to get licensing of the technology to further enhance the safety of the blood system.

In closing, Mr. Chair, Canadian Blood Services can assure Canadians that we have taken swift and decisive action to mitigate the risk of Zika virus from entering the blood supply in Canada. Canadian patients can continue to depend on us to manage a safe and secure system. We are confident that our rigorous, risk-based decision-making processes have resulted in an appropriate policy for Canada, given what we know about Zika virus today.

Thank you very much.

● (1555)

The Chair: Thank you very much. You've certainly raised a lot of thoughts and a lot of questions.

We're going to start with questions from Mr. Kang for seven minutes. Then we'll go back and forth.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair.

Good afternoon. I'd like to thank everybody. I'd like to thank the Public Health Agency and Canadian Blood Services for appearing before the committee. I think a lot of light has been shed on the Zika virus.

My question is about the risk. Are there any demographic groups or residents of the country in particular that are at risk in Canada?

Dr. Gregory Taylor: Do you mean people living in Canada? Is that what you're asking?

Mr. Darshan Singh Kang: Yes. Is there any particular group or any particular region of the country—

Dr. Gregory Taylor: Right.

Mr. Darshan Singh Kang: —that may be infected with the virus?

Dr. Gregory Taylor: Currently, the virus is not transmitted in Canada. The mosquitoes that transmit the virus can't live in our cold weather. As Matt said, there's research going on to see if Canadian mosquitoes could transmit the virus. Currently, there's a very low risk of that happening in Canada.

The risk is for Canadians who travel outside the country to countries where it's being circulated. Currently, we're not aware of any risk for anyone specifically, other than pregnant women. The association or the risk for a pregnant woman who gets infected with the Zika virus is the neurodevelopmental problems in the fetus, be it microcephaly, small brain, or other developmental disorders. There's even some new evidence suggesting that it can affect outside the neurological system, but those are all just associations so far.

Mr. Darshan Singh Kang: That may lead to a further question. We are now in winter. Are we prepared for the spring and the summer when the mosquito season is here? Do we have any plans in place to deal with it if that is the case?

Dr. Gregory Taylor: For the mosquitoes in Canada, the closest one that they transmit is West Nile virus. That is in Canada. It's typically a very mild infection. We recommend the typical routines to avoid mosquito bites: tuck your clothes in, wear Off!, etc. But that does not apply to Zika, because Zika is not able to live in.... The mosquitoes can't transmit it. I'm not an entomologist, but it has something to do with the salivary glands in our mosquitoes versus the two mosquitoes that it is transmitted in, and they can't reproduce.

That's some of the research we're doing with other folks to see if it's possible. At this point in time, there's no evidence of that. When the season comes to protect yourself from mosquito bites, it's the typical things, but it's more worrisome about things like West Nile virus, not Zika.

Mr. Darshan Singh Kang: Do you have any public education plan to put in place to educate people on this?

Dr. Gregory Taylor: We educate people with our travel health notices for people leaving the country. We've been doing that for several weeks now and we will continue to do that. We're tweeting. It's on Facebook, etc.

Every spring we educate people about mosquito bites in general, so those messages will reinforce and support each other.

For the people who are travelling, such as the pregnant women I alluded to, and who must travel, we have very—rigid is a bad word—different sorts of things. We advise a bed net, for example—and we don't advise that for anybody else—where at night, be it at a resort or not and whether or not they have screens on their window, they sleep under a bed net. Those are only for people who have to go.

We have those messages and our messages typically will support each other.

Mr. Darshan Singh Kang: Thank you, sir.

Considering Brazil as the epicentre of the current outbreak, do you foresee any potential travel ban in the future, or at any time did you consider a travel ban to Brazil?

Dr. Gregory Taylor: At this point in time, no.

This is different from Ebola, for example, where with Ebola there was a person-to-person transmission. With this particular disease it's transmitted through a vector and that is the virus. The vast majority, 80% of people who are infected, have no symptoms whatsoever. For most of the other 20% who are infected, there are very mild symptoms and a very small number are hospitalized with serious infections.

For the vast majority of people it's a very mild infection. We always recommend...for people who travel to countries with mosquitoes, because there are other diseases like malaria and dengue that are carried by the same sorts of mosquitoes, so that will continue. But we see no need for a travel ban, other than advising women who are pregnant that they should reconsider their travel until the outbreak has decreased.

● (1600)

Mr. Darshan Singh Kang: Is there a possibility that the virus may go dormant after maybe a month? How are we sure that after three or four weeks the person is clear of the virus? Is there any chance that after a month's time the virus may go dormant in the body and later on it may trigger again?

Dr. Gregory Taylor: That's a very good question. I alluded to this earlier, that the presence in semen, for example, is new knowledge. Prior to this outbreak there were only very rare cases of sexual transmission.

I think the U.S. now has identified six, if not more, potential cases of sexual transmission, where men have gone to a Zika-infected country and brought it back and infected a woman through sexual transmission. The knowledge base so far is that it stays in semen about two weeks, as far as we know. That science will change, and as I said in the opening, our recommendations will change if the science changes.

We're not aware of any other evidence of it staying anyplace else in the body at this time. There's no evidence of that, but we're watching very carefully and watching the science and would change, as I mentioned, recommendations if it does.

Mr. Darshan Singh Kang: Thank you, sir.

You shed a little bit of light here on how the Public Health Agency of Canada is going to reach out and coordinate with the provinces and health care providers. On a scale of one to 10 what work has been done on trying to reach out to the provinces and the territories?

Dr. Gregory Taylor: When you work for the federal government it always feel like a 10 when moving with the provinces.

We've had very good relations. It's becoming almost routine, if I may say, so we had the pandemic and then we had Ebola, and then we've had disease after disease, which is really quite interesting.

We have standing committees. There's the public health network, which I co-chair with Nova Scotia, which is a formal committee. We have the chief medical officers as well. We do that on a regular basis and an ongoing basis, so it has been routine business.

With the front-line practitioners it has been the same. We connected with them for the same issues as well. For the Syrian refugees, we connected with them as well, and that would be the nurses and the doctors and some of the other front-line practitioners. We're doing that on a routine basis. It is really becoming business as normal with this.

Mr. Darshan Singh Kang: Thank you, sir.

The Chair: Now we'll have a Conservative, Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair, and thank you to the panel. I appreciate your information.

Way back in February of this year, when I first heard about the Zika virus, it was almost like panic struck the media when the World Health Organization declared the Zika virus outbreak a public health emergency of international concern. Of course, I compared it to Ebola, or something that's very concerning. However, you say that the risk to Canadians is low.

I look at the symptoms, which are things like skin rashes, fever, muscle and joint pain, and headaches. The symptoms are mild and they last for about two to seven days. Most people recover from the infection without complications. The hospitalization rates are low. I'm pleased to hear that, and the fact that it's not comparable to Ebola or hepatitis, or whatever.

You mentioned there are about three million Canadians who travel to these infected countries, and we have 20 confirmed cases now. Are any of these confirmed cases pregnant women? That's the big risk right there. These pregnant women have the issue of deformation of their child.

Is it contagious other than through mosquitoes and through blood? Can you sneeze and give it to somebody else?

I have a question for our Canadian Blood Services doctors. Because of the symptoms and the fact that people fully recover from this, do you feel it's excessive that you're deferring blood, organs, and tissues? People are dying on tables waiting for these organs and tissues, and you're going to turn away a potential organ from someone who may have travelled to that area.

Is there a way for you to test these organs and tissues first, before deferring them? Have you had any cases of deferral of organs and tissues?

There's a whole pile of questions I've asked you

Just on procedure, Mr. Chair, if I don't use up my seven minutes, can I pass them on to my colleagues?

● (1605)

The Chair: Yes.

Mr. Len Webber: All right. I would like to do that, then.

The Chair: You have four minutes and 17 seconds left.

Mr. Len Webber: Thank you. Do my colleagues have any questions?

The Chair: Let's look at the answers first. You've loaded them up quite well.

Dr. Gregory Taylor: I hear three questions and they're all excellent.

In terms of pregnant women, as Matt said, we're doing all of the testing in Canada right now, both for the presence of the active virus in the blood and for antibodies towards the virus. The latter test is tough to interpret. It's very difficult to interpret, and we're suggesting that the doctor be aware of that and that they have a good conversation with their patient, either before or after that test.

Oftentimes, we don't know whether the sample is coming from a pregnant woman or not. We're aware of one in Canada at this time. There may be more, but we're not aware of them. Obviously, for confidentiality reasons, we're not indicating where this person is. It would be much too easy to identify them. But that's all we're aware of.

We expect the numbers will increase. Given the three million travellers, we expect we'll see a lot more people who are positive for that, hopefully not pregnant women but we'll see a lot more.

Regarding your question about whether it's contagious, no, you can't sneeze and that. The methods of transmission are limited to—and this is our scientific knowledge now—those two mosquito types.... The virus is in the mosquitoes, and they'd have to bite a person who is uninfected and inject that into them. There's also sexual transmission through semen. The virus is in the semen of a man who's been infected, and it lasts for up to two weeks after the infection onset. Rarely, as my colleagues were saying, there are a couple of cases involving blood transfusion in Brazil.

I'll pass that over to you.

Dr. Dana Devine (Chief Medical and Scientific Officer, Canadian Blood Services): Thank you.

I'll take your question about deferral, whether the deferral period of 21 days is too long and whether we are having a greater impact on the other side, which is the availability of tissues, organs, and blood products for Canadians.

We have put the 21-day deferral in place as a precautionary measure. As we learn more about the Zika virus and understand more about how it behaves in infected people and what the risk really is, we will keep looking at the deferral period to understand whether it's too much. What we feel right now is that it is the appropriate place for us to start, because we are lacking a lot of detail.

In terms of the availability of organs, we are not aware of any case of an organ donor travelling in a Zika-risk area and then becoming a problem for deferral potential.

The other thing that comes in with organ donation is that there is always physician choice. Because of the rarity of organs and the length of the wait list in the country, there is more latitude for being an organ donor than there is for being a blood donor.

On the stem cell front, we are aware of one case in which we had a stem cell donor who was lined up for a recipient, and the donor had a Mexican holiday planned and was not prepared to reschedule. Fortunately, the transplant centre had multiple match donors who could have donated to the patient, so the patient is getting the transplant anyway, even though the donor has elected not to change the Mexican holiday plans.

Mr. Len Webber: Thank you. I appreciate that.

Sorry, you have four more minutes, so go ahead.

The Chair: You have 50 seconds.

Mr. Colin Carrie (Oshawa, CPC): Fifty seconds? Wow, I could never talk for just 50 seconds.

First of all, Dr. Taylor, these handouts you have are excellent. I have not seen these before from the Public Health Agency of Canada. Are these readily available?

Dr. Gregory Taylor: Yes.

Mr. Colin Carrie: Where would people get these? Are they on the Internet? Where are they coming from?

To pick up on what my colleague Mr. Kang was saying, I think a lot of it is about communication. The media is really picking up on this microcephaly issue. It's a lot of stress.

When I asked the question in the House, the minister pointed me to a website and I couldn't find any of this material. How long have you had this out on the Internet?

● (1610)

Dr. Gregory Taylor: It's been for a while. We are also tweeting them with attachments. Those are infographics you're looking at, which we've been designing and trying to communicate. I think they are in our tweets and on Facebook. I'll have to get back to you in terms of how long they've been up, but they've been up for a bit, a few weeks.

Mr. Colin Carrie: I am curious to know whether you are disseminating them actively to different agencies, such as travel agencies. People get their information from different sources. I think the best treatment is prevention, if we can get that information out. What are you doing to get the information out to stakeholders and to people who could disseminate it to average Canadians who are travelling?

Dr. Gregory Taylor: We typically put the information through our travel health notices. That is something we put out on an ongoing basis, routinely. We thought that was the best way.

It's actually picked up by the app. We have a travel app now where our information is hidden within the typical advisories about what's happening. People can get that through their app.

Those are the normal routes we've been taking, as well as the tweets, Facebook, our website, etc. We don't typically go directly to travel agents. A lot of people just do their own travel. We find it more effective to do it through the normal channels where it gets disseminated.

Mr. Colin Carrie: Is there evidence to suggest that it is effective?

As I said, it's all about the communication part of it. Some Canadians aren't getting the information. There is a little bit.... I won't call it hysteria, but when you see a baby with microcephaly, this is a significant deformity, even though there may not be any direct evidence of a causal nature between the two. Is there a way you could measure it, to make sure this information is getting out to Canadians?

Dr. Gregory Taylor: Yes. We sometimes do that. That's where we do surveys, contact people, and look at whether the information is going out. We have not done that yet. That might be something to consider in the future.

Mr. Colin Carrie: That would be great.

Is that my 50 seconds?

The Chair: Yes. You did well.

Mr. Colin Carrie: Thanks.

The Chair: Mr. Davies had raised this issue.

You have the floor.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chairman.

Thank you to all of the panel members for being here.

I had the benefit of attending a talk on Friday at UBC. It was led by an OB/GYN specialist in disease prevention, Dr. Deborah Money. She led us through a state-of-the-art description of where we're at with the Zika virus. I realize and appreciate that we are in a real state of development; probably we're learning data every month.

What I took away from the talk on Friday was that the link between the Zika virus and grave outcomes in pregnant women and fetal damage is fairly strong at this point. Would that be fair to say?

Dr. Gregory Taylor: It depends on what you mean by “strong”. It's getting stronger every day, and more and more evidence comes out in little bits and pieces virtually daily. There was a report last week that came out in terms of infected stem cells with a precursor to neurological tissue. It is changing. It's a tough one to say “strong”, but it's looking more and more like that.

Mr. Don Davies: Would a better word be “increase”? Increasing data that is—

Dr. Gregory Taylor: Yes.

Mr. Don Davies: —at least tending towards showing a link with Zika.

Dr. Gregory Taylor: Yes, definitely.

Mr. Don Davies: I have in my hand a *The New England Journal of Medicine* paper from Friday, March 4 that just came out. It's pretty hot off the presses. The conclusion says that, “Despite mild clinical symptoms, ZIKV infection during pregnancy appears to be associated with grave outcomes, including fetal death, placental insufficiency, fetal growth restriction, and CNS injury.” In fact they found that 29% of the Zika-positive women had fetal abnormalities as revealed by ultrasonography and there were none in the control group. It seems to me that there's starting to be some compelling evidence in there.

Dr. Gregory Taylor: Yes, it is moving in that direction. As well there was evidence that it is affecting outside the neurological system, other parts, small fetus, etc. It's looking more and more causal, but we're not quite there yet. Is it there, did it cause that problem, or did it just happen to be there? That's something that is the hard part.

Mr. Don Davies: I was told that there are four causes of microcephaly: genetics, which is rare; intoxication or a chemical exposure during pregnancy—we've seen a little bit of a conspiracy theory about that already—malnutrition; and viral bacterial infection. One of the take-aways I took from our meeting on Friday is that the evidence is trending toward showing that there is an association. That's why I ask.

It also appears that the evidence is starting to show that first trimester exposure is particularly damaging to the fetus. Is that something that you're...?

● (1615)

Dr. Gregory Taylor: You would expect that. Typically the first trimester is when the fetus is most susceptible. It happens with other viral infections, exposure to chemicals, exposure to alcohol, or exposure to any sort of thing. That's what you expect, though there is also evidence to suggest it can have an effect in the last trimester as well. We'll see where that one goes.

On your comment about malnutrition, this may be multifactorial, which means you need several things to come together. What's still interesting is that this is from one area of Brazil only and there tends to be a lower socio-economic status in that area, so it may be that the combination is what causes this, and that's what we'll find out.

Mr. Don Davies: My colleagues have already commented that it's a bit of a paradox. The actual expression of Zika tends to be fairly asymptomatic 80% of the time, you testified, and it's actually mild expression in most cases. The people who talked to me told me that's actually more concerning from a public health point of view because it's not obvious when it's being transmitted. Is that a fair concern?

Dr. Gregory Taylor: It's a concern only in pregnant women or only in men who then have sex with someone or get someone pregnant. That's when it's a concern because, you're right; 80% majority don't know they're infected, and if they don't know, why would they think about it? Part of what we've had in terms of the testing is that if a pregnant woman has been travelling to the area and they come back, whether they've had symptoms or not, we advise them to talk to their doctor. If they want to be tested, we do the serology test and we're delighted to do that.

With men, we advise that they use a condom for at least two weeks following, and if they're having sex with a pregnant woman, to avoid it for at least the entire pregnancy. As well, if they're having sex with someone who could get pregnant, they should avoid it for a couple of months. Those are very conservative and they're being extra cautious, but it's for the very reason that they could transmit it and not know it.

Mr. Don Davies: I tried to fire off an email while you were talking because it may have been my mistake. I wrote down in my notes from this talk that the longest presence of Zika virus in semen has now been found to be 62 days. Is that an error on my part?

Dr. Gregory Taylor: I'm not aware of that. The research I've seen is two weeks. If it's 62 days, I'd like to see that.

Mr. Don Davies: Okay, I'll pass that on if I see it.

We know that Zika could be transmitted by blood transfusion, albeit rare. We know that it could be transmitted sexually. I also understand that the cases are all male to female. So far there are no cases of female to male. Is that correct?

Dr. Gregory Taylor: That's correct.

Mr. Don Davies: We know it crosses the placenta, so it's in utero and can be passed mother to child. I know that the Zika virus has been found in breast milk, but so far, apparently, there's no transmission through breastfeeding.

Dr. Gregory Taylor: We have no record of that.

Mr. Don Davies: What's the state of detection technology? I know that in pregnant women it's not present in blood or urine. It's in amniotic fluid, but the detection method is invasive. Is there any progress on better detection methods, particularly in pregnant women?

Dr. Gregory Taylor: I'll let Dr. Gilmour answer that, but on the surface of it, what we do for microcephaly in particular is serial ultrasounds. The Society of Obstetricians and Gynaecologists tells me that's not particularly good, and it doesn't work until later on, so it doesn't help early. We do serology in pregnant women. Those are the two tests so far.

Matt, did you want to comment?

Mr. Matthew Gilmour: You're right. With the amniotic fluid it's collected through amniocentesis. That's obviously a bit of an invasive procedure, so that's not a specimen that we've been receiving commonly at the NML. Odds on, the vast majority have been blood specimens, so it's people who are interrogating soon after their return from these countries to see if they are viremic, to see if the virus is still circulating within their body, or again, there's the alternative test with the serologic approach.

We actually have a two-pronged approach where we can fairly rapidly see if someone has a particular class of antibody that would be raised against a viral infection. The problem with that test is that it could equally be detecting something like dengue fever, or West Nile virus, or yellow fever. For these other viruses that are in the same class and are transmitted by the same mosquito, this initial test is really just saying, “You've had a past viral infection.” That's where we have to move on to a second round of serologic testing, a confirmatory test, where we're directly interrogating patients' blood to see if they have the antibodies to Zika. That's where the timelines come into play a bit. That, again, is why, very early on, we put the message out about being transparent about some of the test limitations that we have. There's not really a test limitation on Zika. It's just a test limitation for detecting some of these types of viral infections, including dengue, etc.

If someone is worried that they had Zika, but they're well, if they want the test, we can offer it. But again, it may not be an answer that comes quickly, within the same week. It may come weeks down the line because of the multitude of testing approaches that may be required. We're extremely cognizant of the decisions that patients might be making based upon these test results, again to possibly terminate their pregnancy or not. That's why we've been trying to be as transparent as we can with the limitations and the state of the art of the tests that we have right now, so that people can make this informed decision for themselves.

● (1620)

Mr. Don Davies: Thank you.

The Chair: Thank you. I just have one little question here before we go on.

Is it safe to say, for a Canadian woman who is considering getting pregnant, or who is pregnant, the only way they can get Zika virus is through a blood transfusion or through sexual relations with somebody who has Zika virus?

Dr. Gregory Taylor: Or by travelling to the country....

The Chair: If they're in Canada, then the only way a woman can get it is in those two ways?

Dr. Gregory Taylor: Yes, but that's our knowledge currently. That's correct.

The Chair: Okay, Liberals, who's up? Bryan?

Welcome to the committee.

Mr. Bryan May (Cambridge, Lib.): Thank you, Mr. Chair.

I am hopefully going to play the role of Mr. Oliver quite well and not embarrass myself.

First of all, thank you all for coming and speaking today. I had a number of questions that have been asked and answered, so thank you for that. The presentation was very thorough. There were a couple of things that we went through fairly quickly just to clarify, so I may be asking questions you may have answered already. I want to echo Mr. Webber's comments. I was relieved to hear some of the things today already about the severity and the risk level for Canadians. There is a bit of a sensational component sometimes with the media, and I was pleased to hear what I've heard so far with regard to the level of threat.

That's actually my first question. From PHAC's perspective, you've identified the level of threat to Canadians as very low. I'm just curious. How do you measure threats like this, and is it different each time? Is there a particular standard that's applied? What defines “very low”, versus “low” to “medium”, “high”, and so on?

Dr. Gregory Taylor: That's an excellent question.

Whenever one of these events happens, we do a risk assessment, so we look at the organism, look at transmission models, look at the outcomes, look at if there are ways to prevent it, if there is a vaccine. We look at all of those things and do a risk assessment and come up with what the risk is to Canadians. Granted, the definition of “low” versus “very low” is relatively subjective with that one, but in this case we don't have the virus in Canada. The mosquito vector doesn't exist in Canada. The only way they could infect, which we've just learned, is through sexual transmission. That's relatively new. Initially we didn't know that. Initially we didn't know about blood, because that is relatively new as well, so the estimate was that the risk to Canadians in Canada is very low.

Those risk assessments are updated on a ongoing basis, so we're looking at constantly updating. If new information comes in, research results come in, our scientists look at it again and look at our assessment and say, “Do we need to change that? Has the risk changed or not?” This is exactly the same thing we did throughout the Ebola outbreak, which is why we saw different measures for Ebola. When our assessment came it was still low, but we were watching this and acting.

It's an excellent question that gets into the core of what the agency does on an ongoing basis—constantly doing risk assessments and constantly monitoring that.

Mr. Bryan May: Thank you.

Again, I believe you've touched on this, but I wonder if you can go into a bit greater detail on Canada's contribution to the World Health Organization, specifically with this situation.

Dr. Gregory Taylor: We've been working directly with WHO. Dr. Theresa Tam, who is the deputy chief public health officer, is in Geneva as we speak discussing what's going to happen from a scientific perspective, so our contributions at this point in time to WHO in particular have been expertise, etc.

We're working closely with PAHO, and as I alluded to earlier, we're planning on assisting CARPHA in the Caribbean as a potential area with some laboratory assistance. That will happen in the next little while.

At this point in time it's typically expertise. Matt may be sending some folks to CARPHA, for example.

● (1625)

Mr. Bryan May: Excellent, thank you.

With regard to the testing that is available, there was mention that there is no screening for blood at this point. My question is twofold. Is there a hope that this is coming or is there development in that area, and is it something we're even seeking right now? Second, what is the sensitivity and the specificity of the tests that we are trying to use right now?

Dr. Dana Devine: I'll address that.

We do know that the companies that make the nucleic acid or NAT-based tests that we use for blood donor screening are actively looking at the possibility of developing a Zika test.

The application of that test is going to be of greatest value in countries where there already is Zika virus, because they have a real problem in needing to ensure that their blood supply.... If you're in Brazil, for example, you want to know that your blood is safe if you're going to transfuse it to other people.

For Canada, unless the situation changes dramatically, because we can't transmit the virus here—we're not a country that has endemic virus—doing blood donor screening doesn't make much sense. If we can get that safety factor by just asking people to delay coming in to donate by three weeks, we wouldn't want to stand up all the ongoing expense of a screening test.

Mr. Bryan May: Do I have much more time?

The Chair: You have one minute and 31 seconds.

Mr. Bryan May: I'm going to share that time.

Mr. Singh, do you have a...?

Mr. Darshan Singh Kang: I just want to take this a step further.

Are we keeping any records, for example, on how many blood donors we suspect of having Zika virus who we have been turning away? Is there a record of how many people were turned away?

Dr. Dana Devine: Yes, we do. When we turn donors away, we record that event and why they were turned away, whatever the reason is.

When we first looked at establishing a deferral for Zika risk, we went back to data that we had collected from Canadian blood donors who travel. We had done an extensive survey in 2014, and we used that as the basis to estimate what our loss of blood donors would be for a 21-day deferral. We were estimating that the loss of blood donors would be just about 3%. From the data we've collected up to about 10 days ago, which is the most recent data I've seen, we are deferring at the rate of just under 3% of donors, who we're asking to please come back in another three weeks and to not donate blood that day.

Mr. Bryan May: Quickly, what is the turnaround time on the Zika testing?

Mr. Matthew Gilmour: With the molecular testing, as soon as we get it in our hands it can be two to three days to have the results. But for the serology, again, it could take weeks. Without getting too technical, you might be testing both acute blood specimens, so those collected soon after someone's illness, versus convalescence, well after their illness has resolved.

If it's the blood testing, it's multiple specimens, with multiple tests —a screening test, a confirmatory test—so it's quite a milieu of approaches that we have to throw at the problem to finally land on a confirmation. If it's the molecular testing, it can come very quickly.

Mr. Bryan May: Thank you, Chair.

The Chair: The next round is five minutes for the Conservatives.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

I want to get back to the communications, because as I said before, the best treatment is prevention. When I asked the question in the House a couple of weeks ago, the minister basically said that what we're doing is pointing Canadians to a website.

Frankly, March break is coming up. We have three million Canadians who are going to be travelling to the areas where Zika could be occurring, and on March break there could be a few university students going down there. Regarding your comments that one should avoid having sex with women who could get pregnant, there might be some sex happening when Canadian university students go down south.

You mentioned that you do put it out on Twitter. Is there any other social media you put it out on—Facebook, Instagram, anything along those lines—to get the message out to Canadians, especially young Canadians heading down?

Dr. Gregory Taylor: We do use Facebook consistently, yes.

Mr. Colin Carrie: Could you get that back to the committee, just to let us know how you're getting that message out?

Dr. Gregory Taylor: Absolutely.

Mr. Colin Carrie: Are we able to ask you if you could get a little feedback to see if the message is getting out?

● (1630)

Dr. Gregory Taylor: Okay.

Mr. Colin Carrie: Okay, thanks.

I have the same question for the Canadian Blood Services. Do you guys have the opportunity to help disseminate information? I don't know if the information's getting out there, and in the next couple of weeks, there's going to be...I don't know about the numbers, but a lot of Canadians will be heading down south.

Dr. Dana Devine: Yes, you can get all of the information you want on our website, which is what our donors use. We push information to blood donors through electronic means to make sure people are aware of this.

The other thing that has helped us immensely is the amount of media attention on the Zika virus. It's allowed Canadian Blood Services to spread the word that we're asking people to please donate before they go down south, or if they have been travelling there to please not come and donate for 21 days after they've returned.

We believe the message has gotten out there reasonably well.

Mr. Colin Carrie: That's great because I know you guys do a lot of work at universities, and anything that we can do to get the word out...because as my colleague, Mr. Davies, was saying, maybe things are rare, but there could significant sequelae if somebody gets the Zika virus.

I wanted to change topic a bit and talk to Dr. Gilmour about the National Microbiology Laboratory. I know that you do great work over there. I remember the work with Dr. Plummer on H1N1 in coming up with the research, and something that we could be so proud of with the H1N1 vaccine, and the work you did on that.

What is the urgency of vaccine research for Zika? Are you integrated with the WHO on that? Are you doing any work on it?

Mr. Matthew Gilmour: Yes, there's a multitude of companies and other institutes across the world that are pursuing a Zika vaccine right now. Part of our team that was responsible for the Ebola vaccine, which was of great assistance in west Africa for the outbreak there, is part of an American consortium that is pursuing a DNA-based Zika vaccine. At this point it's still a candidate. It's not something that's promised to be effective and safe, but they've moved it along the development pipeline quite a bit. They want to start phase one clinical trials as their next step. That would be to show elements of safety and efficacy.

There's a large global interest in developing a vaccine for Zika. It's unlike the Ebola vaccine, where we're personally and formally pursuing that kind of answer. With Zika we're just participating with our global partners where we can. Part of our contribution is the team that's been part of the consortium to develop one of the candidates for Zika that's now under consideration.

Mr. Colin Carrie: Excellent. Thank you very much.

Dr. Sher, you mentioned the pathogen inactivation technology. I think you made a comment that sitting right next to you, to your right, is one of the world leaders on that. For some reason it's not licensed for availability in Canada. Could you elaborate a bit on why it's not licensed? Do you have funds for it? What's going on? Is it that the regulatory approach is difficult to get through? Could you give us an update on that?

Dr. Dana Devine: Sure, I'd be happy to. There are two companies that are seeking licensure for their pathogen inactivation technologies in Canada. One of them is the first company that got into the business, and it has been selling products for treatment in blood mostly in Europe initially, but globally at this point. They have enough experience with their technology that they could put a request before Health Canada for approval to market in this country with the experience base they had previously.

The other company is the second one in that came to marketing approvals in Europe about seven years after the first company, so it has less experience. In discussions with Health Canada, this second company was asked to acquire additional clinical experience. Canadian Blood Services has been involved with that company by assisting in doing a clinical trial for the treatment of platelet products with these pathogen inactivation technologies, and we have a trial running in several hospitals in Ontario that should be completed in May.

We do anticipate that marketing approvals will be granted to these two companies some time within the next 24 months, and then we'll have the opportunity to look at implementation in Canada.

Mr. Colin Carrie: How would that help Canadians who are concerned about Zika?

Dr. Dana Devine: These two technologies are very good at killing the viruses that are all of the Zika first cousins. In the preliminary studies that have been done on laboratory strains of the Zika virus, including the Thai strain that my colleagues from PHAC have been talking about, these two technologies killed the Zika virus. We are anticipating that this is a way of sterilizing blood and blood products.

The challenge for us is that the technologies that have been developed can only be used on platelets and on plasma. We don't have a technology for red cells. There are two technologies that are in clinical trials. We think that they're coming, but they're not here yet.

If you were talking about giving a red blood cell transfusion to a pregnant woman, you would not be able to reduce the Zika risk by the pathogen inactivation technologies quite yet, but we do see that coming in the near future.

● (1635)

Dr. Graham Sher: If I may I'll add to that question because I think this is an important message for the committee, and I will reiterate what I said in my remarks that Canadian Blood Services has gone on the public record as saying that pathogen reduction technology is the next paradigm in blood safety and as soon as these technologies are appropriately licensed we will be developing the plans to implement them. Given the limitations Dr. Devine has described initially it will be there for platelets and not for red cells.

We do believe this is a paradigm shift because it allows us to deal not just with the agents that we know and are concerned about today —HIV, hepatitis B, hepatitis C—but it also allows us to deal with the next Zika as it emerges and we will already be in a defensive position because we will have had this technology in place.

You're not always chasing your tail from a testing point of view, which is precisely the challenge we face. Today it's Zika. Yesterday, it was chikungunya. The day before, it was dengue virus. These technologies take a much broader approach.

Mr. Colin Carrie: That's great technology. Thanks for introducing me to it. I've never heard of it before, but hopefully it's something the government can move forward on and help expedite. That would be great.

Thank you.

The Chair: Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

I would like to thank the witnesses for joining us today. I'm going to ask my questions in French, if you don't mind.

The witnesses have answered a number of questions. Dr. Taylor, I'd like you to elaborate on what you were saying earlier. You were talking about the incubation period and transmission of the virus. Returning travellers need to wait a certain amount of time before having sex, specifically a certain number of days.

What I'm particularly concerned about is sexual transmission of the virus. A pregnant woman could become infected by a man who has returned from a trip and is carrying the virus. I understood that, when coming back from a trip, a couple where the woman is pregnant should not have unprotected sex for the entire pregnancy. Is that correct? Is it for just 28 days, or is it really for the entire pregnancy?

[*English*]

Dr. Gregory Taylor: That's a very good question. Thanks for clarifying that if I wasn't clear.

The recommendations that came from CATMAT, the experts we brought together, were that men coming back should use condoms for a two-month period if they're having sex with somebody who could get pregnant. That's being very careful, and that's based on the fact that we think it's about two weeks, but there may be evidence that there's virus in the semen for longer than that. So that's being extra cautious.

The “entire pregnancy” targeted to men meant that if they were coming back and they were having sex with someone who was pregnant they should then wear a condom for the duration of the pregnancy. Again, this is being extra cautious because there is evidence suggesting that even in the third trimester it could have an effect.

Those will change as we know more information about how long the virus lives in the semen, but that was the basis of that.

Thank you for the clarity.

[*Translation*]

Mr. Ramez Ayoub: If I understand correctly, then, it is not known how long the virus stays in the semen. Is that right?

[*English*]

Dr. Gregory Taylor: No, we don't, not yet. We're learning.

As I said, science so far tells us two weeks, but it may be longer. We don't know.

[*Translation*]

Mr. Ramez Ayoub: Okay.

What are the origins of the Zika virus in Canada? From what I see in the information, the virus was discovered in Uganda in the 1950s.

Why are we talking about it now? How did Zika suddenly become so prevalent?

[*English*]

Dr. Gregory Taylor: That's another excellent question.

The Zika virus originated in Africa and in Asia. As you mentioned it was first detected there in 1947, but it was not in the Americas. This virus is a slightly different strain. I believe the genetic similarity is about 99% or 98%.

In the Americas you have people who have never been infected before so there is no immunity. In Africa and Asia people have been infected on an ongoing basis, don't know they're infected, and develop an immunity, but we have a naive—that's the technical term—population in the Americas who have never been infected.

The theory or some of the theories we have is that an infected individual—French Polynesia I think was one of the first places—came to the Americas, potentially Brazil, and got bitten by a mosquito and then infected somebody else and then it just blew up. Literally, millions and millions of people are infected in the Americas right now.

Why it blew up so quickly probably has to do with the slight variation. We don't know if there's an animal reservoir of some sort, a lot of viruses like Ebola have animal reservoirs. However, at this point the theories are that it's a naive population and there's no inherent immunity. That's why it's spreading so quickly.

● (1640)

[*Translation*]

Mr. Ramez Ayoub: Now I'd like to ask a more technical question.

How do you track the spread of the Zika virus in Canada? What method do you use to monitor that?

[*English*]

Dr. Gregory Taylor: That again is a good question. It's difficult. If you don't look for it, you don't know if a person has it. I would suspect the vast majority of people in Canada who are infected will come back from having travelled with no symptoms or with mild symptoms and they won't get tested. We won't know about them.

The only time we know if someone has Zika is when blood goes to Matt's lab and we find the virus present in the blood or there's a suggestion from their antibodies that someone has it. That's all. So far, as I mentioned, 20 people in Canada have tested positive. I'm confident and I'm sure the numbers are much higher than that, but the only way we can detect it is if we test people.

[*Translation*]

Mr. Ramez Ayoub: Very good. Thank you.

[*English*]

The Chair: Mr. Kmiec, you're up.

Mr. Tom Kmiec (Calgary Shepard, CPC): Thank you very much, all of you, for your presentations so far.

Actually, the question I was going to ask is on organ donation, mostly because it's an area of personal interest for me. You said that so far no one has been denied an organ donation because of this, but you did talk about the case of stem cells.

We've heard that there might be larger cases or other cases in which we don't know someone has Zika, and they don't know either. What is the risk? Is there a potential that somebody might be refused a donation in the future, whether of an organ or a product like a stem cell or a bone graft or something else that they would be asking for? When it would come to that moment, you said that physicians could say they were going to continue on. I'm guessing they would involve the patient when making that decision. Can you talk about that a little bit more?

Dr. Graham Sher: I'd like to. Thank you for that question.

I'm going to make a general comment, and then Dr. Devine can provide a little bit more of the specifics. I think it is important for committee members to appreciate that the clinical decision-making to support an organ donation or a stem cell transplant is very different from the clinical decision-making to give somebody a transfusion.

We collect close to a million units of blood a year. About 1.5 million transfusion events happen in Canada every year, and if a physician needs to choose a unit of blood, typically there's a large selection to choose from, so we can easily defer 3% of the blood donors and still meet the needs of all the transfusion patients.

For stem cell donors and patients, and certainly for organ transplant patients and donors, there's a very different relationship. Getting the organ is a life-saving event and often it's the only organ available, and if the patient doesn't get it, he or she might well die from the underlying disease. The whole notions of risk-based decision-making and clinical decision-making are very different.

I'll let Dr. Devine clarify again the situation with the stem cell donor, but if an organ donor who may have travelled to one of the Zika-risk countries comes back to Canada and is, unfortunately, killed in a motor vehicle accident within that 21-day window, the physician will make a clinical decision as to whether that organ is potentially going to save a life at the risk and very low likelihood of transmitting Zika, probably in the order of one in three million or four million.

The set of risk-based decisions for organs and stem cells is very different from that for blood, and it is based purely on the availability of the resource to match the patient's needs. Again, I think we'll clarify for the committee the specifics on that stem cell case.

● (1645)

Dr. Dana Devine: The other thing I'd like to add to this is that I think we need to remember that the one really at risk of Zika virus infection is the fetus. We know that for the walking adult, it's a very mild illness, and most people who get it don't even know they have it.

From the perspective of making a clinical decision about transplanting an organ that potentially came from a donor who might have had a holiday in Cancun before they ended up being an organ donor or someone in the stem cell arena, we're not giving stem cell transplants or organ transplants to pregnant ladies, so there's a completely different set of clinical decisions that are made in that framework.

In terms of the actual concern over stem cell donors, we had the case I referred to, which you may have heard of through other avenues. It came up during the time before we had put the deferral in place.

Now that we have that deferral, we are communicating with all of our donors who are in the evaluation phase for possibly becoming stem cell donors. They've been identified as first-level matches or preliminary matches, and we start right up front by telling them that if they have any travel plans, they shouldn't go to any of these risk areas because doing so will preclude them from being donors.

I don't see that that's actually going to be a particular problem for the Canadian transplant centres.

The Chair: You have just a little time.

Mr. Tom Kmiec: Maybe I'll change pace.

On the international reaction from the countries where there is Zika, could you talk a little more about whether any countries have been way more restrictive or have put more controls on both blood donations and organ donations, or on travel? Have any countries banned travel for people who are coming from affected regions?

Dr. Dana Devine: I can't speak to the travel ban, but I can speak to the blood donation ban.

Most other countries are using a 28-day deferral. This is based on the fact that the original risk calculation assessments were done by an American group, and they assessed only 14 days and 28 days. When you do the calculations for 14 days, you realize that it might not be long enough, so while we're trying to understand more about the Zika virus and really apply the precautionary principle, they said to go with the 28 days, that it looks like it's probably safer until we understand more.

Canada did something a bit different. We said that what the Americans have done is very nice, but we wanted to do a Canadian calculation that's relevant to where blood donors travel from Canada and to what our risks are in this country. We had the ability to look at 14 days, 21 days, and 28 days, because those are three marks we can put in our computer system that are already there. We don't have to redesign a computer system to bring in that deferral. When we did those calculations, we realized that the deferral of 21 days was adequately protective, and it was just as good as the 28-day deferral. We went with the shorter deferral because it was less impactful on the blood supply.

The Chair: Thank you.

Did the 14-, 21-, and 28-day deferral only depend on the person self-identifying that they'd been in an area? How confident are you that people self-identify?

Dr. Dana Devine: It's one of the critical questions in our screening process. We ask every donor if they've travelled outside of Canada. If they say yes to that question, then we ask them further questions about where they went.

The Chair: Thank you.

Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you. That was a very useful presentation. I think it should allay the fears of a lot of people. As we've said, there's been so much excitement in the media. It's nice to hear a scientific voice of reason saying, “Don't panic.”

I had a few questions. The vast majority have already been asked and answered here.

In regard to neurological symptoms, to things like Guillain–Barré and that sort of thing, have there been any identified cases in Canada to date with this association?

Dr. Gregory Taylor: Guillain–Barré is something that happens. It is rare, as you've mentioned, and it is associated with all kinds of different viral infections. There's a small number of cases of Guillain–Barré in Canada every year. We're watching that and looking to see if there has been any increase. You're probably aware from the media there has been Guillain–Barré associated with Zika, but you would expect that because viral infections can cause Guillain–Barré syndrome.

Mr. Doug Eyolfson: Thank you.

Further to the question on organ donation, as you said, it's a clinical decision anyway. Given that the only at-risk people are pregnant women and it's a risk to the fetus, and since we don't do organ transplants on pregnant women, is there any thought to simply leaving that restriction on organ donation aside and just saying that only in a very rare case you might be considering this on a pregnant woman?

● (1650)

Dr. Dana Devine: I think we've left this right now to the decision of the transplanter, so that thinking can go through that truly clinical decision-making path. As we learn more about Zika virus and its biology, it may in fact turn out that some of these restrictions get modified.

Mr. Doug Eyolfson: Thank you.

I don't have any more questions now.

The Chair: Ms. Sidhu, we have a minute. Would you like it?

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

Thank you, panel, for giving us information about the Zika virus. I appreciate that.

On the spread of the Zika virus, in regard to whether they're transmitting the virus, do we have any mandatory tests? For example, for a person who goes to affected countries and comes back, even though they don't show any symptoms, are there any mandatory tests that doctors or family doctors can prescribe?

Dr. Gregory Taylor: There's no mandatory testing at this point in time. There are just the two tests that Matt has described, both looking for the virus in the blood or looking for antibodies toward the virus.

Ms. Sonia Sidhu: On the PHAC website, they recommend a two-month waiting period before trying to conceive when there's a possible case of Zika virus.

Are there any diagnostic tests available at this point to establish the virus is no longer going to affect—I know it's 21 days—but is there any test now to determine if they can conceive?

Dr. Gregory Taylor: A test during the two-month period? The test could be done on the male. That's the concern, the male having that, and I assume semen could be tested. They'd have to submit that specimen and be tested, or serology in the male could be done.

Mr. Matthew Gilmour: There would be a risk too because we have the test. We could test semen and if we found Zika then we rule it in. You confirm that Zika is present, but are we in a position to confidently rule it out? That would be the challenge that we're in. That would be part of the discussion that a physician would have with a patient to understand and accept those risks if they wanted to pursue testing. Maybe it's not a confident rule-out test at this moment, but we can certainly rule in that Zika is present.

Ms. Sonia Sidhu: I know this is on the website, and is it in any other language besides English?

Dr. Graham Sher: In French.

Ms. Sonia Sidhu: It's in French. Thanks.

The Chair: Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chairman.

I have a couple of things. I appreciate that we need to be science-based and certainly any kind of sensationalizing of this is not helpful. I want to drill down a little bit into the three million Canadians who are travelling to Zika-infected areas. Am I correct in understanding that the phenomenon really has occurred in the last year, in 2015, after being dormant for decades, or not having this kind of impact?

Would it not be the case then that we're just in the early days? I understand the mosquito that transmits Zika is not currently present in Canada and may not be, but with three million Canadians travelling to Zika affected areas, say, in 2016, would it not be logical to think that we're going to have an increased number of Zika infections in Canada in 2016?

Dr. Gregory Taylor: Absolutely. You would expect that most of them, as I mentioned, either have no symptoms or very mild symptoms. We've detected 20, but we're not testing the vast majority of Canadians who go. I would suspect that a lot more than 20 Canadians have been infected with Zika, but either they have no symptoms, or it's self-limited and they're fine.

Mr. Don Davies: What resources or tools would be helpful to your organizations in getting in front of this, in preparing? We do have a little bit of a luxury of seeing this develop and hopefully not much comes of it. That tends to happen with these pandemic fears, but what kinds of resources from government would be helpful to your organizations?

● (1655)

Dr. Graham Sher: I'll certainly answer on behalf of Canadian Blood Services.

Our decision to act and act quickly was based purely on the precautionary principle and actually, you asked that question earlier, Mr. Davies. I want to reinforce that we decided to act even in the absence of evidence because the whole precautionary principle says the absence of evidence is not evidence of absence.

Even though we didn't know that it could be transmitted through blood transfusion, we felt that a broad-brush safety measure deferring anyone who may have travelled to those areas for a 21-day period was an appropriate thing to do.

In terms of what additional resources my organization would need to further enhance the safety of the blood supply, one thing I have to credit governments in Canada, particularly the provincial and territorial governments.... When Canadian Blood Services was established in 1998 on the heels of the tainted blood scandal and the failures of our predecessor organization, one of the most important risk-mitigating strategies governments gave us was the capacity to act in the name of safety without asking governments for additional money.

Canadian Blood Services has a contingency fund, meaning we could implement any test or any measure at any cost to protect the blood supply without asking government for permission to fund it. We have a prefunded contingency fund in the amount of $40 million that allows us to act in the name of safety.

That is perhaps the most powerful resource that this organization has. Unfortunately, we acquired it because of the lessons learned from the tainted blood scandal, but to the credit of governments, both federal and provincial governments, when Canadian Blood Services was established, we were given the resource and capacity to act in the name of safety without fiscal restraints or constraints. That's perhaps the single greatest assurance we can give Canadians, that we do that when necessary.

Mr. Don Davies: Thank you.

Mr. Gilmour or Dr. Taylor.

Dr. Gregory Taylor: Speaking from the agency's perspective, let me say that we don't have a contingency fund. I'm quite jealous. It would be nice to have that sort of fund.

We are looking. It's a hard question to answer, because we don't know what the future holds in the next little while. Right now our focus is on research and diagnostics at the laboratory and how we can assist with the potential vaccine. We're reallocating resources to take care of that need right now. But I think the question is best answered by a number of different departments: CIHR, who are doing some work involving research funding; and some of the aid agencies, in terms of how much we contribute to the WHO and how much we help other countries in the world. We're working on that exactly.

Currently, from a diagnostic perspective I think the agency is well resourced, but determining how best to deal with this organism really depends upon what the Government of Canada wants to do on the global scene.

The Chair: Congratulations. We did it right on time. We're right on schedule, we did a good job, and everybody got their questions in.

I'd like to give you, either one of your organizations, the opportunity to give any message to us that hasn't come up. Is there any message? Is there any challenge for us? Is there anything we should be doing?

Canadian Blood Services.

Dr. Graham Sher: Thank you very much, Mr. Chair. Again, thank you for the opportunity.

I would certainly reinforce what Dr. Eyolfson said; perhaps we all do need to stay calm in the face of uncertainty. My organization, as stewards of the national blood system, would certainly like to assure Canadians that we believe we have managed this risk appropriately. We will continue to work with experts around the world to ensure that the blood system in Canada is there to protect Canadians and to serve Canadians well.

This is not the last emerging virus we will face. There will always be the next one, after Zika. That's why I wanted to stress the emergence of other technologies, such as pathogen reduction technology.

But we have in place a very sophisticated surveillance and risk-based decision-making mechanism. We believe it has responded quickly and we will obviously continue to monitor this one as it emerges and changes its biology and its epidemiology. For now, I think we can confidently say that we are doing what we can to protect the blood supply and individuals who may receive transfusions in Canada from the likelihood of Zika transmission.

Thank you again for the opportunity to present.

The Chair: Dr. Taylor.

Dr. Gregory Taylor: I'd like to echo Dr. Sher's comments. This is a great opportunity to speak to you and to have media present to speak to Canadians and reassure them that for the vast majority of Canadians this is a very low risk.

The message I'd like to leave you with is, again, that this is not going to be the last one and wasn't the first. These are going to require a global response for a whole variety of reasons. Just as the agency cannot act alone but needs many government departments, Canada cannot act alone. We've been working very closely with all of our colleagues across the world.

I think Ebola illustrated that very well. We were lucky with the Ebola. We had a vaccine that we had developed and it was ready to go. We don't have that for Zika. If we had one for Zika, this would be a much different story. It's going to take a while. There are technologies, some in Canada, that can make rapid production of vaccines possible, but doing so requires huge resources, and it has to be on a global stage.

I think that's the last message I would leave: it requires a global response. In the next little while, as I mentioned at the outset, our advice is going to change, because the science will evolve almost on a daily basis, and the advice and recommendations will change.

Thank you again for the opportunity to be the first two witnesses at your—

● (1700)

The Chair: And the best so far, too.

Some hon. members: Oh, oh!

The Chair: Thanks very much.

We'll take a break for a couple of minutes. Then we're going to come back to talk about the report of the steering committee and see whether we can pass it and get some direction.

Thank you very much.

● _____ (Pause) _____

●

● (1710)

The Chair: I think everybody has a copy of the report from the steering committee. It lists in the priority order the issues we and the steering committee came up with.

I don't know if there is any discussion on this. Does anybody take exception to anything here? Would you rather see something different?

Mr. Len Webber: Thanks, Mr. Chair.

Reading through this I'm trying to determine the difference between undertaking a study and requesting a briefing. To me, obviously, requesting a briefing is basically a much shorter version whereas undertaking a study seems to be more intense.

Of course, I was part of that subcommittee and the meetings there, but with regard to undertaking a study, do we have days, meetings, planned for each of these?

The Chair: I think the analyst has a work plan.

Do you?

Ms. Karin Phillips (Committee Researcher): That actually would be a good thing for the committee to decide today, how much time they want to devote to each of these subjects.

The difference in terms of a study versus a briefing is that a study is usually longer and there's a report tied to it whereas briefings are usually listed as information sessions on our website. It's usually one or two days. It is a study as well, but there is usually not a report tied to it.

Sometimes a committee can decide to have a briefing, like say you had your briefing today, and then all of a sudden feel like you want a report.

The Chair: It's a good question. Are we going to have a report from the meeting today? From the conclusions we had today is it normal to file a report?

I think we should have a report because I think we all learned something, and I think we should have a report. Could we commission the analyst to develop a one-hundred page report?

Ms. Karin Phillips: Does the committee have recommendations?

The Chair: I think what we learned today—I don't mean to assume anything—is that the risk is low. I think we could emphasize that the two agencies said the risk is low to Canadians. It can only be transferred to women in Canada by two ways, which I think is important because people asked me about how it can be transmitted, and I didn't know until today.

That would give people confidence I think if they knew that it could only be transferred two ways.

Also, the people who really are going to be affected are women who are pregnant or are going to be pregnant. Apparently most others hardly even know they have it.

That's it for me.

Mr. Carrie.

Mr. Colin Carrie: Thank you, Mr. Chair.

If we were going to do a report, it would be great to have a couple of recommendations from it. I know I was talking to some of the witnesses, and I did request that they send some information on to us, because one of the things I was trying to focus on is prevention.

I know through the H1N1 when we did that there was a whole system where we were able to do public relations to get the information out because, as you said quite rightly, it's a rare occurrence that things would happen, but the evidence is showing that if something does occur, it can be quite serious, even the death of a fetus.

If we had an opportunity to do the report and put some recommendations in, that would be great.

The Chair: We could have a report that listed the risk and the ways it can be transmitted. What else should the report have in it?

● (1715)

Mr. Colin Carrie: I think it should have a review of what we actually heard today. It should talk about what the witnesses brought forward and what we learned. You were saying you learned quite a bit today. So did I.

Then recommendations would be based on what we can do as a committee to recommend to the government how they could better manage it, because one of the things I learned today with these new technologies is that the pathogen inactivation technology could be a game-changer.

We have the opportunity in Canada to facilitate that and maybe expedite it, because Zika is not the last virus we're going to have to deal with for sure. These always come up. I think we're all aware this is not something that's going to be a pandemic that's going to affect every Canadian out there or people around the world, but it's about how to go about managing it. Prevention would be the best way to manage these on an ongoing basis.

The Chair: I think another issue would be public awareness, because I wasn't aware of the things they're saying, and I wasn't aware of the documents they have that you pointed out.

I saw that public awareness is a job that they have, or we have, and perhaps it could be just a little better. We all learned a lot today, and perhaps we should have known some of that—I don't know.

Go ahead, Mr. Davies.

Mr. Don Davies: Thanks, Mr. Chairman.

Just to throw another angle on it, I think the committee is master of its own business. We can do whatever we want, so we can certainly issue a report if we want. Customarily, a briefing is very different from a study and a report. We received a briefing today. That was a briefing for us as members of this committee. I didn't anticipate a report would come out of it.

Generally, when we say we want a briefing, it's to receive a briefing. When we undertake a study, generally it's to study in depth, hear from a variety of perspectives, and issue a report. The reason I think that distinction might be helpful....

I have two concerns about issuing a report based on today. Number one is that we did not have a comprehensive series of witnesses. We had two government agencies. Typically, in a study that results in a report you have a wide variety of witnesses from a wide variety of perspectives. Maybe there are epidemiologists or people working in disease control that would take issue with what was heard today. I don't know, but maybe that's the case.

Second, I'm really concerned because much of what I heard today mirrors what I heard on Friday, which is that the information on this is changing—and we heard it here—daily, maybe even weekly. By the time we write our report and get our recommendations, for all I know the gestation period for the virus in semen could be found to be.... As I said, I heard 62 days, and 14 days here today, so I'd be very concerned about this committee putting out a report based on one day of testimony from two government agencies without testing information on something that we know is a highly labile, fast-changing subject.

Now, we could write a report with that in mind—

The Chair: I'd even say that, that it's fast changing.

Mr. Don Davies: Yes, we could keep it tight. If we do a report, I would suggest that it be very tight, that it be kept to what it is we're very confident of, and that we name what is not known.

Those are my thoughts.

The Chair: Are there any other comments?

Mr. Darshan Singh Kang: I will echo Mr. Davies' comments.

We have had three million Canadians travelling to the Zika-virus affected areas, and we know of only 20 cases. We don't know what could evolve in the near future. There should be some kind of volunteer, if not mandatory, testing done on those people who travel to the Zika-virus affected areas. I think there may be a lot more people who are infected with the Zika virus that we don't know of.

If you're doing a report, I think we should keep that in mind too, that those people should be tested.

The Chair: Are there any other comments?

Mr. Colin Carrie: I was wondering, if we're going to be doing a report.... The analysts did somewhat of a review of the literature that's out there. Maybe we could ask them to enhance that a little. I have no problem keeping the report tight. There's such little information out there, since it's a new thing. I think this committee could show leadership by putting what we know as of today out there. It may help policy decision-makers, even at lower levels of government, to better get the information out. As I was saying today, the best treatment for this is obviously prevention, and the only way to prevent it is to get that information out.

One of the witnesses was saying it's the sexual activity, so automatically, if you're down in those areas, wear a condom. But people don't know that. What's the likelihood of somebody getting bitten by a mosquito when they're on vacation down there? I'd say it's highly likely.

With the comment that we heard of 20, that's a huge underestimation of what's going on out there. I think it's an opportunity for us to show a leadership role, and to take into account what Don was saying, it should be pretty tight.

● (1720)

The Chair: I agree there is not a lot for us to put out a parliamentary report. How about we put out a summary of the testimony we heard today? I think we should. There should be some record that we spent the day here listening to a lot of knowledgeable people. Together we will draft a summary of the testimony. It's not a report that says this, this, and this. I think it was very useful and I agree that you have to hear all sides of the story, which we didn't. But we did hear some valuable testimony. We'll draft a summary based on what we heard and we'll bring it back for approval.

Is that okay with everybody? All in favour of a summary?

Great. Okay.

Mr. Ramez Ayoub: I have one quick question. Is this the only time we are going to see some witnesses for Zika, or are we going to bring in some other witnesses?

The Chair: As far as I know, we're done. Does that satisfy your motion?

That's it for Zika.

Mr. Don Davies: Yes, I think so. We could always call them back later if you want.

Mr. Ramez Ayoub: I was thinking of some other association.

Mr. Don Davies: We wanted a one-meeting briefing, and I think we got that.

Mr. Colin Carrie: Depending on what happens, we can always call them back for an update. They're pretty good about that.

The Chair: That solves that problem.

Now we'll turn to the steering committee report. It's interesting that we undertake a study and then request a briefing from the Canadian Blood Services on the "Call to Action" report. Did you want to comment on that? I suspect you want more than a briefing.

Mr. Len Webber: No, not necessarily, because I believe that many organ and tissue donation studies have occurred in the past. Is it necessary? Perhaps not. Maybe we bring in Canadian Blood Services and the ministry of health and listen to what they have to say, and if the committee decides we would like to get more information, perhaps from the Trillium Gift of Life in Ontario and some other groups, then we can make that call at the time, if that's okay with the committee.

The Chair: The analyst came up with some reports that have already been done. Could we copy them and send them to all the members? Okay, but that's just a start.

We have several different subjects and we can't just stop and do one. I think we're going to have to run them together somewhat. In general though, does everybody agree with the priority: pharmacare first, then the organ donation issue, home care and palliative care, aboriginal health, and the status of antibiotic resistance. Does everybody agree with that in principle?

All in favour of adopting the report as our schedule?

(Motion agreed to [See *Minutes of Proceedings*])

The Chair: We have an agenda now.

Mr. Tom Kmiec: Mr. Chair, this is more like a procedural question. I wanted to know the difference between a study and a briefing. During a briefing with these organizations can the committee still ask for others to come and comment on the "Call to Action" report as well, or just the organizations referred to in the wording here?

● (1725)

The Chair: My own thought would be that we will do whatever it takes on organ donation. We'll get a start on it and see where it goes. If you want to add more to it, I'd like to see that done and I think most members have a lot of interest in organ donation.

I just talked to Canadian Blood Services. They provide 600 million dollars' worth of pharmaceuticals in blood-related issues. They have a pharmacare program funded by the provinces. I didn't know about that, so there's a model for us on pharmacare.

Yes, Mr. Davies.

Mr. Don Davies: Mr. Chairman, it's good that we've adopted, and now I think we have to consider putting some shape into this and maybe some business for our next meeting. Typically it's helpful to allocate how many days of hearings we may want to choose and then, of course, you have a couple of days to discuss the report.

This is a very ambitious agenda. It certainly would carry us to the end of the year. Is that what you intend, that this will take us until the end of December? Because certainly until the end of June, we would do well to knock off two of these, if that.

The Chair: This is up to the committee. It's not up to me; it's up to the committee. It depends on how in depth we want to get into these things. The pharmacare one is a big one. I know there's a lot of interest in that. Nova Scotia just announced a pharmacare program, and it lasted two days before they had to reverse it because it wasn't well thought out. It met a lot of opposition and they're still apologizing for it. Pharmacare, I think, will be a welcome discussion right across the country.

Mr. Don Davies: Yes, because I'm thinking, just loosely speaking, that a pharmacare study would be somewhere between, say, four and six, or four and eight meetings of witnesses.

On the home care and palliative care, I would think something similar, four to six to eight meetings. Aboriginal health would take four to six meetings. Antibiotic resistance might be a bit fewer, maybe two to four meetings. Then you'd have the meetings to go through the reports on top of that. Then, of course, the organ donation could be two to four meetings, depending on how many witnesses there are.

I can't remember how many meetings we have before the end of June. I think we're around 15. Do we have 15?

The Chair: I have the schedule right here. How many do we have?

Let's start with the pharmacare. What I'm thinking is that we'll start with the pharmacare and we'll gather information on the others as we go so that, when we do get to them, we'll have more information and we can act in an efficient manner. That's my thought.

Mr. Colin Carrie: What is the timeline for submitting our witnesses for this? What's your thought process on that?

The Chair: They should be submitted by the 11th. Do we have the minister coming on the 21st? No, the minister is on the 23rd, and the department's coming on the 21st. Those will take up those two meetings, I would think. Those two meetings are gone.

Mr. Don Davies: The minister is on the 23rd?

The Chair: The 21st is the department; the 23rd is the minister. The minister is only here for an hour on the 23rd. The officials will be with her, and they'll stay as long as we want them to. There are also Department of Health officials here on the Monday.

Mr. Don Davies: We take those out of the schedule and it reduces the number of days we have.

Could I suggest that we start by saying six meeting days of witnesses?

A voice: Yes.

Mr. Don Davies: That's two and two. That's two organizations per hour, so that's four. That would give us 24 organizations or individuals to hear from, which would be probably lots.

● (1730)

The Chair: That gives everybody time to line up. We find witnesses don't come really fast. They don't respond quickly. If we knock off the 21st and the 23rd with officials and the minister, then you can start gearing up for the pharmacare witnesses after that. In the meantime, we can be gathering information on others. Does that work for everybody?

Mr. Darshan Singh Kang: Mr. Chair, with two appearances from any organization, do you think that would be enough? Will there be enough time to question them?

The Chair: Actually, yes. If we're concise in our questions and if we're pointed, I think we can get the information we need.

Mr. Bryan May: Mr. Davies brings up a really good point. We've gone through this exercise in HUMA, and it's amazing how quickly the sessions get gobbled up. We actually only have two studies and we figure that's going to take us right through the year.

The other thing to consider is that the estimates will also be coming after the budget, and that will take a couple of days as well. You said you had the minister coming. You will also probably want to have updates from different departments before you get witnesses. That will take up a session.

I was just saying, this is not just your first year. This is maybe your first two or three.

The Chair: That's okay.

Mr. Bryan May: No, it's very good. It's aggressive.

The Chair: We're probably also going to get something to do with marijuana eventually. We're probably also going to get something to do with assisted death. All we can do is what we can do.

Right now, we have this list developed and agreed to, so let's start on pharmacare. We'll have to work around all the other things that we have to do.

Mr. Webber.

Mr. Len Webber: I have a quick question. When we do have the minister here, are we going to focus specifically on pharmacare, the first topic?

The Chair: No. It's up to you.

Mr. Len Webber: Okay.

The Chair: Mr. Davies.

Mr. Don Davies: I am mindful that our analyst suggested getting —I was repelled at the deadline, but maybe it's not a bad idea—us to fire in as many witnesses as possible to her by the end of this week so that she can at least get started.

The Chair: Yes.

Mr. Don Davies: The other thing I was going to mention is that, as Bryan mentioned—he's right—you typically start off a study by hearing from the department. The departmental officials will brief you in your first meeting, and then you start your other meetings. I'm thinking of having six meetings of nothing but witnesses, because Darshan is correct; it goes quickly when you have just two organizations per hour.

Sometimes, Mr. Chairman, you may choose to schedule a two-hour meeting with just a couple of witnesses if you wanted to delve in for longer. That can happen as well, if you so choose.

I'm thinking of one meeting for the briefing from the department and six meetings of witnesses, which would be 24 witnesses. We can always cut that down, depending on the witnesses. Maybe we can just fire in to the analyst our witness list at least by Friday, as a first swath. I wouldn't limit anybody. I would suggest that—

An hon. member: You need at least one meeting for the report.

Mr. Don Davies: We need to have at least one meeting—usually two—for the report that comes afterward.

The Chair: On the 21st, we're going to have officials here for two hours. On the 23rd, we're going to have the minister for an hour and then officials for another hour. Those three hours with officials, will they be enough to hear from the department on pharmacare, or do you want to keep it open?

Mr. Len Webber: Just on pharmacare...?

Mr. Don Davies: What are the officials coming for? For their meeting, wasn't that specifically to come on an annual report?

The Chair: It's up to the committee. If we think if that's enough time to hear the report and also ask them where the department fits on pharmacare, that could be our introduction to pharmacare and meeting with the officials.

Mr. Don Davies: You could explore that with them, Mr. Chairman, but I think one of the concerns would be the personnel that they would send to the meeting.

The Chair: Yes, they'd have to know.

Mr. Don Davies: Yes. My suspicion is that it's quite a discrete area, pharmacare, and you'd probably want one briefing with people knowledgeable in the department on pharmacare and pharmaceuticals. You could certainly explore that.

The Chair: We'll ask them for an update, and we'll also be asking questions on pharmacare.

Mr. Don Davies: If you think that's sufficient...? It could be efficient to double up on that.

The Chair: Yes, I think it would work.

Are there any thoughts?

Let's do that. We'll invite the officials with a focus on the update, but we also want to hear about pharmacare. Okay?

Some hon. members: Okay.

The Chair: If that's not enough, we'll bring them back.

Mr. Carrie.

● (1735)

Mr. Colin Carrie: As well, was there a meeting with the estimates coming up? Were there any estimates? When the minister comes, will she basically be here to talk about estimates on that visit?

The Chair: It's the day after the budget, too, so....

Mr. Colin Carrie: I'm thinking that with all that going on, maybe we'd need the minister for two hours. It seems a lot....

The Chair: Yes.

I don't know. The word that we got back was that she's available for an hour, but we could ask her for two.

Mr. Colin Carrie: There's probably a lot to cover.

Mr. Don Davies: There sure is.

I'm pretty sure the motion we passed was to have the minister come to discuss her mandate letter. We're not calling her for the estimates.

We could call her for the estimates, but in fairness to her, that's what she was coming for.

The Chair: You're right.

Mr. Don Davies: I know how busy ministers are. Usually, they come for one hour. I've rarely seen a minister come for two hours. It's open for any of us to put in a motion to have her come for the estimates. I don't think anybody has done that yet, but we could.

An hon. member: That's right. It's always a good thing.

Mr. Don Davies: Yes.

The Chair: In addition to the mandate letter session?

Mr. Don Davies: Yes. It's a separate issue. It's a separate matter.

The Chair: Yes, it is.

Where do we go? Is it enough? Is three hours with the officials enough to deal with an introduction to pharmacare from the perspective of the Department of Health or not? Is that enough? We can always ask them to come back again.

An hon. member: We can ask for more of their time.

An hon. member: It's not enough.

The Chair: You don't think so?

Mr. Darshan Singh Kang: That's not going to be enough.

The Chair: Ms. Tiedemann.

Ms. Karin Phillips: I wanted to raise a couple of things because one of our meetings with the officials is on the Canada Health Act and the annual report, so they are focused on that.

It's a good idea within that realm to talk about pharmacare because pharmacare is one of those things that is excluded from the Canada Health Act. It might be a bit much to try to have another briefing on pharmacare on top of that.

The other thing I would raise is with regard to some of the agencies that are involved in the pharmacare question. There's the Canadian Agency for Drugs and Technologies in Health, which provides recommendations on formulary listings; the Patented Medicine Prices Review Board, which is responsible for regulating drug prices; and the Canadian Institute for Health Information.

There's a range of federal organizations outside of the department we would want to hear from probably in a separate meeting from this briefing we're having on the Canada Health Act.

If I were you, I would separate the pharmacare issue out from the meetings that are currently scheduled and I would just have a separate meeting.

The Chair: Works for me.

The meetings on March 21 and 23 will not be pharmacare. They will be Canada Health Act updates, mandate letters, and so on.

Then the first meeting we have after that will be with Department of Health officials on pharmacare.

Does everybody agree?

Mr. Davies

Mr. Don Davies: Mr. Chair, I have a quick announcement before we adjourn.

After the votes tonight, there is a gathering with hors d'oeuvres just outside the parliamentary restaurant with survivors of the tainted blood scandal.

With Canadian Blood Services being here and us talking a little bit about the blood system, I wanted to invite my colleagues.

It's just outside the parliamentary restaurant on the 6th floor of Centre Block right after the votes tonight. If you want to stop by for 15 minutes, there will be free food. I'm told it's quite good. As members of the health committee, it might be of interest to you.

● (1740)

The Chair: Thanks very much, everybody.

The meeting is adjourned.