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**ISSUES IN PANDEMIC
INFLUENZA RESPONSES
FOR MARGINALIZED
URBAN POPULATIONS:**

**Key Findings and Recommendations
from Consultation Meetings and Key
Informant Interviews**




ICID
International Centre
for Infectious Diseases

This is a collaborative project between the International Centre for Infectious Diseases, Centre for Global Public Health at the University of Manitoba, and government and voluntary sector agencies, with financial support from the Public Health Agency of Canada.

The views expressed herein do not necessarily represent the official policy of the Public Health Agency of Canada.

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EXECUTIVE SUMMARY

The International Centre for Infectious Diseases, with technical support from the Centre for Global Public Health at the University of Manitoba, conducted a project entitled Pandemic Influenza Responses for Marginalized Urban Populations. The purpose of this Public Health Agency of Canada-funded project was to evaluate and synthesize existing prevention and response plans and develop further resources to assist front-line workers respond to issues related to influenza among marginalized urban populations and thereby minimize the impact of pandemic influenza on these populations, particularly in the context of the pH1N1 epidemic of 2009.

Specific project objectives included:

1. Perform a national scan to determine the current status of pandemic influenza planning for marginalized populations.
2. Convene consultation meetings and interviews with public health planners and direct service providers in major Canadian cities to identify planning strategies, service gaps, and inform the development of a resource to assist in planning services to address influenza among marginalized populations.
3. Prepare a national pandemic influenza planning resource guide and tool kit for distribution to public health and civil society organizations.

A web-based survey was distributed nationally to 288 public health staff in the month of October 2009 to ascertain the current status of and gaps in pandemic influenza planning for marginalized populations. A total of 96 completed responses were collected, representing a diverse set of roles in service delivery to marginalized populations across the country. Some of the results included the distribution of client populations, the pandemic planning status, the groups addressed in the plans, and resource requirements. Of note, Aboriginal persons were the most common client population, followed by persons with mental illness, drug users, and street involved or homeless individuals. These groups were also identified as being addressed in the current pandemic plans. Other groups identified included immigrants and refugees, sex workers, and injection drug users.

Three quarters of respondents with plans noted they had plans that were being implemented or were fully implemented, while the remaining 25% noted the planning process was still underway. Sixteen percent reported they were not preparing a plan and 29% of these respondents noted they were using another organization's plan. The most common required resources were education resources on vaccination and influenza for clients and staff followed by infection prevention protocols for staff and service planning resources. The survey results provided a baseline for the consultation and interviews with key stakeholders in Canada and informed the preparation of a national resource guide and tool kit for front-line workers working with marginalized urban populations. The results of the national pandemic planning response survey are presented in Appendix E.

Two consultation meetings and a series of key informant interviews were held to discuss responses to pandemic influenza and pH1N1, specifically regarding the impact on marginalized urban populations. The consultation meetings were held in Vancouver and Toronto in January 2010, and the key informant interviews took place between January and March of 2010. Consultation meetings and interviews provided information from a wide range of government and non-government community service providers and planners from Calgary, Dartmouth, Edmonton, Gatineau, Halifax, Hamilton, Moncton, Montreal, Thunder Bay, Toronto, Vancouver, Victoria, and Winnipeg (See Appendix A). The consultation meetings brought together a cross section of individuals representing agencies that

have an interest in vulnerable urban populations and facilitated the free exchange of thoughts and ideas related to planning strategies and service gaps, and solicited recommendations on the development of a resource to assist in planning services to address influenza among marginalized populations.

Key recommendations from the consultation meetings and key informant interviews are as follows:

1. Define 'marginalized' or 'at-risk' groups in the context of a pandemic influenza.
2. Enhance collaboration by:
 - a. including stakeholder groups in the planning and evaluation processes at the earliest stages, including front-line service providers, community leaders and representatives from groups who experience various barriers;
 - b. establishing a network of front-line workers to create a forum for communication, knowledge sharing, and enhanced and rapid access to public health guidelines for vulnerable populations;
 - c. fostering partnership between public health agencies and front-line community service agencies to develop communication lines and to help understand the roles and responsibilities of each group.
3. Pandemic plans should:
 - a. be sufficiently generic that they can be readily adapted to specific communities;
 - b. include guidelines and recommendations, but they should not be a specific recipe for service delivery, but rather offer guidance on various options in various situations;
 - c. utilize existing services and agencies and not implement an entirely new system during the pandemic.
4. Facilitate knowledge sharing by making electronic resources (e.g. guidance and communications products) available to the stakeholders working with marginalized urban populations. Ensure this information is easily accessible from a central source and have the capacity to be updated as jurisdictions develop plans and processes.
5. Accessibility issues for the marginalized populations should be addressed now. This includes overcoming the "poverty industry," ensuring access to primary medical care, funding and developing transportation methods.
6. Establish adequate human resources and train retired or non-front line staff prior to a pandemic, particularly as capacity is already low in these communities and organizations. Other required training should include cultural competency, computer training, and how to plan for and manage large scale vaccination clinics.
7. Enhance vaccine programs by:
 - a. delivering the vaccine to the community directly;
 - b. providing vaccine through non-traditional approaches (e.g. mobilizing the clinics/staff to go to the client to vaccinate).
8. Address the need for more shelter space, resting places for respite care, separate washrooms and showers for symptomatic people, and hospital beds.
9. Enhance communications at all levels by:
 - a. sharing pandemic plans between agencies;
 - b. addressing how the various plans intersect between agencies to avoid duplication and ensure consistent messaging and approaches;
 - c. utilizing new communication methods (i.e. social marketing campaigns);
 - d. ensuring one message is delivered to the public by a single responsible individual or agency to reduce confusion and establish trust by the community.

In response to the needs of agencies serving marginalized urban populations identified through the national survey, consultations, and key informant interviews, a national pandemic influenza planning resource guide (Guide Book) and tool kit for use and adaptation across Canada will be developed. Access to these resources from a central web-based site, such as the Public Health Agency of Canada, was recommended.

OVERVIEW OF CONSULTATION PROCESS

Consultation Meetings

Consultation meetings were held in Vancouver and Toronto in January 2010 to provide an opportunity for individuals working directly with the marginalized population, health care providers, policy makers, and public health staff to discuss responses to pandemic influenza, particularly relating to its potential impact on marginalized urban populations. See Appendix B for Consultation Meeting Agenda. Large group discussions were held to identify any issues with the definition, identification, or terminology used to identify the marginalized urban populations and the impact this may have on any of the groups that the participants represented. In addition, resources needed to improve pandemic planning and responses were identified.

Three separate small group discussions were facilitated using a series of related questions (see Appendix C). These small group discussions identified:

- the experiences and activities related to planning for influenza pandemic prior to the onset of pandemic;
- the approaches, successes, and challenges associated with implementing plans for the pandemic during the recent pH1N1 pandemic;
- the lessons learned in fall 2009, including insights on how to improve the pandemic planning.

Key-Informant Interviews

A network of public health planners and civil society organizations working directly with marginalized populations was developed with support from the survey and consultation meeting participants. This network provided a list of contacts from which to identify contributors involved in front-line service planning and provision. The range of organizations and agencies that provided input included those serving street involved and/or homeless persons, persons with mental illness, drug users, sex workers, and immigrant/refugees across the country, Aboriginal persons, men who have sex with men, persons infected with HIV and/or HCV, persons receiving methadone, low income adults and the elderly.

A questionnaire (see Appendix D) was administered in-person, by telephone, or was self-administered to ascertain:

- the specific 'marginalized urban populations' pandemic plans were intended to address;
- processes used for fall 2009 pH1N1 response;
- components of plans and issues considered;
- challenges and successes associated with the planning process and the implementation of plans;
- recommendations for future pandemic planning and plan implementation;
- resource needs.

SUMMARY OF FINDINGS

The assumption that planning is an important aspect of pandemic preparedness was supported by the results of the consultation meetings and key informant interviews with those who work with marginalized populations. Many participants expressed that they experienced significant pressure in Fall 2009 (during the second wave of the pH1N1 pandemic) to implement a pandemic response when sufficient planning had not been done prior to the pandemic. The fears and panic of clients and staff were partially mitigated through the development of pandemic plans in the summer and fall of 2009. The need for government, particularly local and regional public health departments and Public Health Agency of Canada, to support frontline service delivery organizations in pandemic influenza planning and implementation was highlighted by most participants, as well as the importance of regular communication and collaboration between multidisciplinary service delivery agencies.

Definitions of 'Marginalized Urban Populations'

To frame and contextualize discussions about pandemic planning and service implementation for marginalized urban populations, the meaning and definitions of these populations were proposed to the participants for consideration. The concepts of medically at risk of severe outcomes versus socially and economically at risk of negative impact of a pandemic was also highlighted, noting that a pandemic response should not only include considerations for those most at risk of infection and/or severe illness, but also those at increased risk of severe consequences from the pandemic, including societal, economic, and health-related consequences.

During an influenza pandemic, everyone will be at risk of infection. However, based on the disease epidemiology (e.g. disease attack rates, morbidity/mortality rates), there are certain people that will be more at risk of developing serious illness if infected. During the H1N1

outbreak of 2009^{1,2}, these groups were identified in Canada as being:


- children under five years of age (especially those under two)
- pregnant women (especially those in 2nd and 3rd trimester)
- people with chronic medical conditions (asthma, diabetes, cardiac, liver disease, immunocompromised/immunosuppressed, blood disorders, neurologic issues, morbid obesity)

At the same time, there are those who are at risk because of other factors that increase a person's risk of negative outcomes on health, safety and wellbeing that are linked to social vulnerabilities³. Social vulnerabilities change over time and vary in different environmental, political, cultural and social contexts so should be identified by jurisdictions and organizations for a particular health emergency.

¹Public Health Agency of Canada (2009). Clinical Recommendations for Patients Presenting with Respiratory Symptoms during the 2009-2010 Influenza Season.

²People aged 65+ were added as an "at risk" group during second wave.

³ Social vulnerabilities are those vulnerabilities that are not inherent qualities of a person or group but typically arise through social processes of isolation or marginalization (Reference: Canadian Red Cross (2007). Integrating Emergency Management and High-Risk Populations: Survey Report and Action Recommendations).



The major groups in Canada that were identified during the consultation meetings as being perceived as at increased risk included street involved and/or homeless persons, persons with mental illness, drug users, sex workers, immigrant/refugees, and Aboriginal persons. Other groups identified included persons with chronic infections such as HIV and hepatitis C virus, and persons receiving methadone. It was recognized that individuals may experience marginalization due to a variety of factors, and that the range of vulnerabilities experienced by an individual are not static and may change over time.

The participants identified additional populations who may be more vulnerable than the general population during a pandemic, which include:

- individuals without health insurance, including those who have lost their documentation, and those who are not yet eligible for health insurance coverage;
- individuals without access to health care due to economic and social conditions, such as poor transportation and poverty;
- housebound elderly individuals who are unable to attend clinics;
- housed injection drug users who don't wish to reveal their arms for fear of discovery;
- individuals in halfway houses;
- clients of women's shelters;
- individuals with chronic disease and mobility issues, as they are unable to attend public clinics where queuing may be required;
- tourists;
- individuals who are not attached to specific health care providers.

The groups identified were not considered to be exclusive of each other and it was felt that individuals should not be categorized into a specific group. Rather, it was suggested that the associated barriers to accessing services during a pandemic should be considered and the fact that individuals may experience multiple barriers simultaneously, or at different points in time, should be

recognized. As a result, plans targeting a single 'marginalized population' may not address the full range of barriers and risks experienced by an individual, and therefore plans should offer solutions to a full range of barriers and vulnerabilities. Others emphasized the importance of focusing efforts specifically, with clear and feasible objectives related to the transmission of influenza.

Concern was expressed that many of the agencies involved with the project had mandates that extended beyond the urban population and limiting planning to the urban population would not serve their jurisdiction. Limiting the process to only urban populations may not be possible for these agencies and using definitions that excluded non-urban populations would be too exclusionary. Another concern was the need to ensure that the vulnerable populations addressed in plans were at-risk, or became vulnerable in the context of a pandemic influenza, rather than being socially isolated or vulnerable in general. Specific examples of this include those individuals who have well controlled HIV being made vulnerable by the requirement to release medical information, or homeless individuals being included as vulnerable when their infection rate was lower than the general population. It was also emphasized that vulnerable populations may differ in future outbreaks and should be assessed in those contexts.

Terminology has the potential to influence the public perception of risk groups, but it does not directly impact service delivery at the client level. The definition of vulnerability must consider medical vulnerability (those individuals who will experience poorer health outcomes following infection), as well as functional vulnerability (those individuals who are more susceptible to infection but don't necessarily have poorer health outcomes than the general populations). In general, the individuals in the vulnerable population are not directly labelled but are rather seen as individuals. However, all the participants suggested that the term marginalized is not the best, as the implications are that these are individuals on the edge of society who should be striving for a social norm. Other terms may be more accurate, including vulnerable, at-risk, under-served, or socially isolated. However, the concept of marginalization is useful for the planning process, where the majority of individuals in society fall

in the central region of a scale and the goal for targeted planning for this population is to reach those at either end, or at the 'margins'.

Pandemic Planning and Process

Planning processes varied widely by jurisdiction and organization, with some driven at the community or local level, and others following a top-down approach to planning. Format of the planning process ranged from no apparent planning, to regional or community based collaborations in the planning process, to plans originating from higher jurisdictional level agencies. A lack of planning specific resources was seen as a major impediment to the planning process. There were a number of contributors who noted they were not producing their own plan but rather were using plans developed by other agencies. Much of the planning was focused on the continuity of services during a pandemic. Various jurisdictions reported that a successful process included the recruitment of previously-established groups already engaged in service provision for the populations of interest, which facilitated communication between the groups.

Planning Partners

Most organizations developed plans for their own individual agency, often prompted by the initiative of a particular staff member. In some agencies, a staff member was involved in planning for the larger jurisdiction, and used that experience to inform planning within their own agency. In some agencies, a single individual was responsible for preparing an influenza plan, but in most, teams of agency staff and often staff from partner service delivery agencies were involved in plan development.

Some developed committees with representatives from the major service delivery agencies involved in their type of work. Several agencies met with executive directors of partner agencies for specific components of their plans, such as to ensure access to partner agency facilities for specific services, such as outreach vaccination.


A number of different groups were identified as participating with the planning processes. Depending on the jurisdiction and the specific planning process implemented, the groups involved and the mechanisms of their involvement were variable. Groups included:

- city and provincial public health departments;
- physicians, nurses, counsellors;
- hospitals;
- emergency medical services;
- fire services;
- schools;
- correctional facilities;
- front line agencies and other direct service providers;
- established groups for at-risk populations;
- support groups;
- regional committees (e.g. disaster relief, infection control).

Pre-existing positive relationships and open and frequent communication between agencies were considered to be very important facilitators of collaboration in planning.

Planning Methods

Planning methods varied from organization to organization. Some began with a medical director providing background information on influenza, while others began with site visits to all partner service delivery organizations to learn about infectious disease monitoring capacity and influenza service needs. Many used existing pandemic plans from other organizations as templates and others



used their own organization's seasonal influenza plan as a starting point. Existing infection control guidelines for respiratory diseases were also useful. One organization contacted a similar organization in Australia because it was felt that due to seasonal differences, Australians would have already experienced the second wave of the epidemic and could share their experiences. Some contacted similar agencies across Canada by email to determine what components they were including in their plans.

Planning processes often began with brainstorming sessions, either by the individual point person for pandemic influenza planning, or by committees. The presence and availability of an informed, credible, and timely decision maker was indicated to be of value, as some staff members felt uncomfortable making specific decisions. Some organizations divided different tasks, such as service planning and resource planning, among multiple staff members to increase efficiency. Generally, a coordinator was assigned the role of communicating with both public health departments providing information and supplies and direct service providers within agencies providing influenza prevention services during both the process of planning and implementation of plans.

Many organizations began their planning process in summer and early fall of 2009, depending on the scope of pandemic influenza services to be offered. Some organizations planned a vaccination day very rapidly, in one or a few days of planning. Some reported that very specific and comprehensive plans took longer than expected to develop.

Some indicated that planning was disjointed, and that there were disagreements over prevention service priorities, such as whether the children of clients should be provided vaccination. Several individuals mentioned a pandemic planning conference that Public Health Agency of Canada hosted in Winnipeg five years ago. This initiated some plan development at the level of provincial governments, but it was indicated that direct service providers providing services to marginalized urban populations were not consulted during the development of these plans, and plans were not tested and therefore not known to be effective or relevant. Similarly,

representatives from some agencies across Canada indicated that they had not been consulted by public health departments during the recent planning process. Communication with public health departments was also reported to be disjointed and siloed, and contradicting information was provided.

Structure of Plans

Most organizations had written plans, although a few had plans that were entirely verbal. Most plans were agency-specific. Some organizations produced lengthy multi-staged plans with gradual escalation, while others discussed needs related to pandemic influenza but did not have the resources and capacity to develop plans or find and modify existing plans for use within their agency. Some plans were structured as a basic list of what services to provide and infection control guidelines to implement given the number of symptomatic staff and/or clients.

Communication of Plans

Most respondents indicated pandemic plans were communicated to all staff, and some were shared with partner agencies. Some agencies also communicated components of their plan with clients at every appropriate opportunity available, to ensure that clients were informed and aware of their responsibilities related to preventing disease transmission. Some individuals and agencies provided guidelines to their city and provincial public health departments to provide advice about how to organize vaccination clinics in their province, including how to circumvent the need for HIV positive individuals to state their serostatus at the vaccination clinic in order to demonstrate eligibility. One strategy was to provide the HIV positive client with a coupon that would be recognized at the vaccination clinic as indicative of being part of a priority group.

Many agencies gave copies of the plan to all staff members, and also gave presentations about their plans, with opportunities for staff to ask questions. Also, internal point persons were identified within some organizations to communicate information disseminated through government committees to staff as needed.

SUMMARY OF FINDINGS

ICID Analysis and Recommendations

A number of challenges as well as successes associated with the development of pandemic plans were identified. The dedication of staff led to many successes. Having pre-existing knowledge about the populations served and pre-established trusting relationships with the community allowed for appropriate planning.

A specific issue that was identified was the failure to identify leadership for the planning process. There was a perceived lack of support from public health departments in terms of developing pandemic plans for marginalized urban populations. Some other challenges associated with planning included difficulty finding examples of plans and lack of timely planning support from the government. Making connections with other organizations, such as those serving Aboriginal persons, was cited as a challenge by the staff of some organizations.

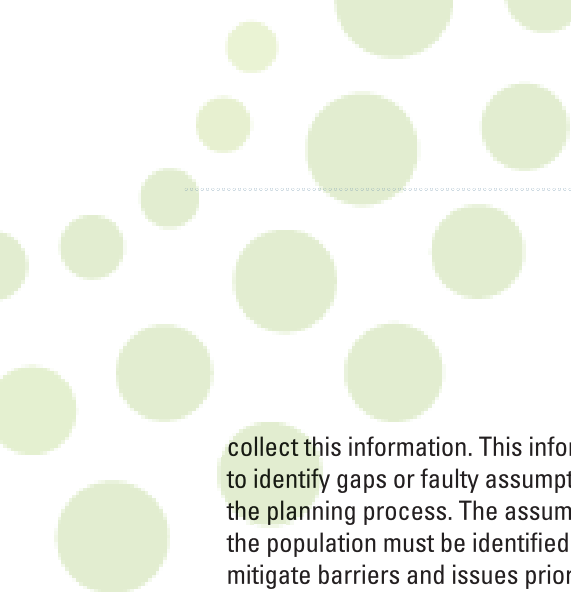
Challenges associated with pandemic planning included the following:

- Generally, community organizations were not engaged early enough to provide practical input for the development of public health department pandemic plans, which resulted in the inclusion of impractical and infeasible plan components. Basic resources were not sufficiently available for front line agencies (masks, gloves, etc).
- The plans were generic and did not include specifics for at-risk groups.
- Many resource-poor marginalized urban populations require a comprehensive network of health and social services, which were not always incorporated in pandemic plans. For example, persons who are homeless require respite care and community support following hospital discharge. Pandemic plans often did not incorporate these types of considerations.
- It was difficult to simultaneously develop the plan and implement the pandemic response without adequate testing of the plan.

- Lack of planning resources affected other programs.
- There was the perception of politicization of the planning process.
- The pH1N1 pandemic did not follow the predicted infection pattern in some groups, notably in the homeless population in some jurisdictions, which experienced lower infections rates. In light of this, the definition of the target vulnerable populations may have to be reconsidered. Also, it was noted that despite the fact that the 2009 pH1N1 pandemic was milder than anticipated, organizations should be prepared for potentially more severe future influenza outbreaks.
- Some agencies and social service departments were unwilling to take up the issue of pandemic planning. In some cases, front line staff were highly motivated, but not the directors. This may be due to lack of capacity.
- A number of participants noted difficulties associated with developing plans applicable to all of the diverse marginalized urban populations served by an organization.

Recommendations for planning include:

- Begin the planning process earlier. It was noted that the planning process cannot be a discrete activity, but must be ongoing. At this time, an effective debriefing and evaluation by the various health units to identify the lessons that were learned during the pH1N1 event and to implement these lessons into a new series of plans should be initiated. All stakeholders, from policy planners to community service agencies, should be brought together to improve communication, planning, and further pandemic planning.
- Use the information collected from the debriefing of health units and service providers with epidemiological data to understand how pandemic planning can be improved. Enhance surveillance to help



collect this information. This information can be used to identify gaps or faulty assumptions made during the planning process. The assumptions made about the population must be identified and understood to mitigate barriers and issues prior to a pandemic.

- A number of stakeholder groups must be included in the planning process at the earliest stages, including front line service providers, community leaders and representatives from groups who experience the various barriers.
- During the planning process, new communities or groups need to be identified (such as the Tibetans in Toronto) and their leadership identified to better understand potential barriers for these groups and to recruit champions.
- A plan should be sufficiently generic that it can be readily adapted to specific communities. Guidelines and recommendations should be available, but they should not be a specific recipe for service delivery, but rather offer guidance on various options in various situations. Specific details (e.g. supply requirements) should be included in the plans to allow agencies without experience to effectively offer services at short notice.
- Leadership of the planning process needs to be clarified to ensure accountability. This needs to occur at an intergovernmental level.
- It is important that the plan utilize existing services and agencies and not implement an entirely new system during the pandemic. As much as possible, existing resources and infrastructure should be utilized.
- Legislative changes may need to be considered to facilitate faster response to pandemic issues, including the delivery of medication to individuals. This includes giving control to those who are delivering the services.
- Facilitate electronic sharing of knowledge, communication and resources among and with the stakeholders working with marginalized urban populations. Ensure this information is easily accessible from a central source and has the capacity to be updated as jurisdictions develop plans and processes.

Components of Plans and Issues Considered

Some pandemic plan components included strategies for communication with public health departments, partner organizations, the media, staff, and clients; how to address staffing issues including vaccination of staff, replacement of sick staff, and relevant staff education requirements; the acquisition, management, and use of infection prevention and control resources; pandemic influenza prevention service provision; and how to maintain core service provision.

Staffing Issues

Staffing issues considered in plans included how to define and communicate the staff responsibilities in terms of continuation of core services and infection prevention and control for staff and clients. In some locations, staff were identified as health care workers, which facilitated priority access to vaccination, and they were encouraged to be vaccinated early to prevent staffing shortages due to illness. Vaccine acceptance amongst staff varied widely between organizations. The sick policy for staff was changed by some organizations to include an allowance for increased sick time as required and no requirement for a sick note from a physician, in part to reduce the burden at physician's offices. Plans were made for how to replace sick staff in order to continue to provide core services.

Core Service Provision

An important component included in plans was a mechanism to continue operations while addressing the needs of sick clients and preventing influenza transmission, particularly while short staffed. This included a service continuity plan for how to reduce and/or suspend non-essential service in stages, based on the number of clients and/or staff who were symptomatic, and the preparation of a list of casual staff members who could be on-call. Ways to provide core services to clients were identified, such as packaging and delivering food to a symptomatic client, or providing food services in a different venue or in shifts to smaller numbers of clients at a

time. Some organizations devised a plan for working with other organizations to enable the provision of these and other core services. A mechanism for staying in regular contact with sick clients was also developed by many organizations. Maintaining regular contact with clients who do not have a fixed address or experience paranoia related to providing their contact information is a challenge that was acknowledged by many.

ICID Analysis and Recommendations

Continuity of normal services was cited as a challenge due to the addition of influenza-related service provision, the implementation of infection prevention and control practices, and the potential for lack of capacity due to staff illness. Also noted as a challenge for many agencies was the ability to pay and train additional staff to replace sick staff. Structural issues (such as loss of pay or job security) were not addressed. The stress on public health workers and nurses was not anticipated; particularly those who were recruited back to the front line. Training for staff recruited back to the front line was not always considered.

There were a number of examples of community agencies sharing resources, notably human resources, with the willingness of individuals to cross over to assist other organizations. Human resources in general were considered extremely successful with staff willing to work hard to ensure success of the programs. Staff motivation was considered to be high and generally staff responded quickly to the challenges introduced by pH1N1. It is already known that many gaps exist in services designed for marginalized populations, many of which can lead to situations where disease transmission is difficult to prevent. The existing service gaps should be addressed to prevent future potential outbreaks among marginalized populations and the associated potential for significant morbidity and the possible transmission to the general population. Social and political will to address these gaps needs to be created and better infrastructure should be built now.

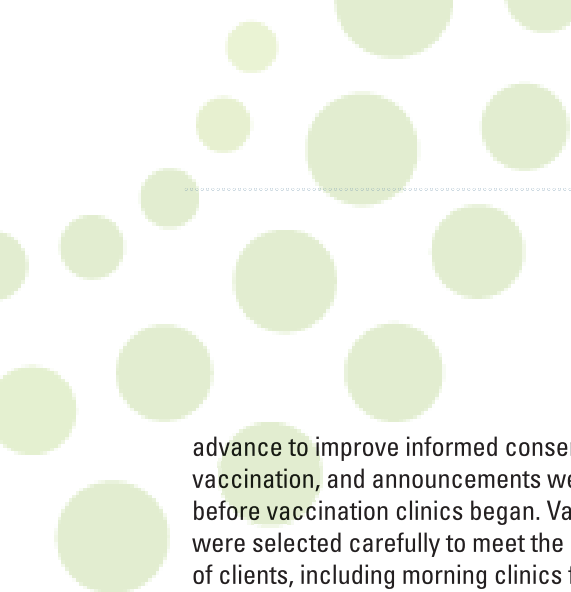
Recommendations include:

- Improve shelter buildings now to allow for adequate provision of isolation areas and increase medical care human resources to facilitate transitional care needs. Similarly, other systemic deficits should be addressed.
- Accessibility issues for the marginalized populations should be addressed now. This includes overcoming the “poverty industry,” ensuring access to primary medical care, funding and developing transportation methods.
- A number of stakeholder groups must be included in all phases of planning as the front line service providers, community leaders and representatives, and community service agencies are best suited to reflect issues and solutions for the populations who experience various functional and medical barriers.

Vaccination

There were a number of suggestions regarding key components of a pandemic plan specific to immunization. Generally these fall into the categories of location, communication, and logistics. Of note, the use of mobile clinics was observed to be a very successful intervention for the delivery of influenza vaccine to marginalized groups. Plans for vaccination on-site, or for facilitating vaccination at other sites, such as hotels, housing complexes, shelters, and drop-in centres where members of the population spend time and feel comfortable were included. Often a specific vaccination clinic was held on a specific day for the marginalized populations served, as the populations might experience significant barriers or discomfort associated with attending community vaccination clinics for the general public.

Communication included both advertising of vaccination services and the use of language interpretation at vaccination clinics. Posters were used to inform clients about vaccination clinics, information sessions were held in



advance to improve informed consent on the day of vaccination, and announcements were made right before vaccination clinics began. Vaccination times were selected carefully to meet the needs and routines of clients, including morning clinics for individuals who may be intoxicated later in the day and evening clinics for others.

Language interpretation, particularly for clinics designed for newcomers, was considered very important. Languages were listed on signs to allow clients to point to their language; the name of the language should have been written in the language itself. Interpreters could wear vests with the language they interpret written on the vest in that language. Some staff wore vests identifying their role, which was helpful to distinguish staff from clients.

In terms of logistics, pre-made labels indicating vaccine lot number, site of administration, and a spot for nurse signature were prepared in advance and increased vaccination and record keeping efficiency.

ICID Analysis and Recommendations

Challenges associated with vaccination included the following:

- Supply issues for delivery of the vaccine were not anticipated. The communications from the federal level often did not consider the lag in delivery time to get the vaccine to the client. Better coordination is required.
 - The packaging of the vaccine was also unanticipated. With multiple doses per vial and a short shelf life, if the entire contents of the vial were not used then the remaining doses had to be disposed of. This became a significant issue for providers due to a perceived shortage of the vaccine during the public campaign. This would not have been an issue had doses been packaged individually.

- The vaccine was not distributed at the agency level. Some agencies who work in the community providing health care services considered themselves a priority yet were not included as a vaccine clinic site.
- The effect of designating priority groups for vaccination was unanticipated. The narrow initial roll out of the vaccine to a small proportion of the population was seen, by the public, as a major concern that was inflamed by early negative stories about pH1N1 deaths. The supply issues with the vaccine further exacerbated the situation. Further, there was disagreement about the groups that should be considered priorities (such as the homeless).
 - In some areas, direct line workers were not in the initial priority group and could not be vaccinated in the first group. For some agencies, there was also an issue with isolation of infected individuals leading to increased concern about staff infection. This affected the planning for continuity of operations, which was not taken up as well as it could have been.
 - There was disagreement in terms of whether persons accompanying ‘marginalized’ populations, such as children, could be vaccinated at the same time as they were not listed as a priority group.
- There were a number of unanticipated issues with the use of vaccination clinics:
 - The requirement for public disclosure of medical conditions in vaccination clinics may have resulted in reluctance to be vaccinated in some groups that had greater need for the vaccine.
 - The selection of sites for vaccine clinics and the unwillingness to adapt to different clinic sites was an issue. Sites that should have been considered included schools, native friendship centres, cultural events, and community centres. The location of vaccination clinics intended for the general public were often inconvenient for the high risk populations.

SUMMARY OF FINDINGS

- There was a perception that vaccine distribution and roll out was not contemplated until immediately before delivery, exacerbating confusion among the public and professional providers of care.

A few specific gaps in vaccine uptake were noted:

- The rate of immunization was lower in inner city populations than in suburban areas in some cities.
- There was difficulty getting vaccine and antivirals quickly.
- There were issues about not knowing the correct course of action in unknown situations, specifically the cold chain delivery of vaccine.
- There was often the requirement to attend a clinic multiple times, with priority family members and then non-priority members, leading to decreased uptake in those individuals.

Some identified successes associated with vaccination included the following:

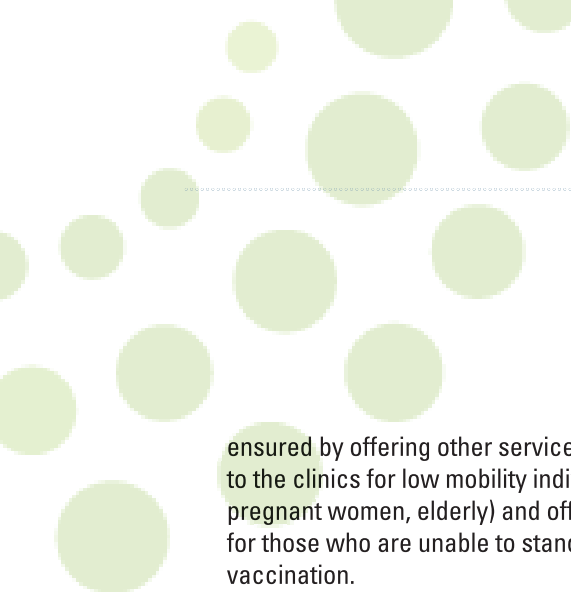
- The vaccination campaigns were considered successful, particularly the use of mobile vaccination clinics in some areas and the flu blitz. However, there were still issues noted with understanding the priority lists and inconsistent messaging about who was eligible for vaccination and when.
- It was generally noted that, even without adequate plans, the front line agencies were very effective in delivery of services simply by doing what they know will work. When plans were ineffective staff were able to deal with the inconsistencies and ensure efficient delivery of vaccine. This was reflected in the development of public and professional communications and resource sharing between various front line groups aiding in logistics and planning.
- The vaccination rate for the seasonal flu was seen to be increased over previous years, particularly in those areas that offered both seasonal and pandemic vaccines simultaneously.

- The use of flu assessment clinics helped to minimize the stress on other health care institutions. Flexibility in locating vaccination clinics in different or non-traditional settings was successful, allowing for delivery of the vaccine to areas that have the greatest need. Similarly, mobile clinics were successful.

- When vaccine access stabilized, the uptake of the vaccine and service delivery was high in the marginalized populations, with appropriate delivery locations. All the available vaccine was utilized.

Recommendations for vaccination include the following:

- Nursing and medical students should be utilized to simultaneously fill human resource gaps and gain experience in mass vaccination strategies. Human resources and training of retired or non-front line staff should be implemented prior to a pandemic, particularly as capacity is already low in a number of areas. Other required training should include cultural competency, computer training, and how to plan for and manage large scale vaccination clinics.
- Funding and implementation of a transportation plan is important to ensure that vulnerable individuals are able to access the vaccination services.
- Education and information documentation should be prepared early in languages that are appropriate for the target group, and should include images. Partnerships with community organizations need to be developed to ensure culturally relevant information is available.
- The vaccine must be delivered to the community directly. The clinics need to go to the community. Non-traditional approaches should be considered. Vaccination clinics should be localized with the groups that require the service and should be taken to places where the target population normally frequent. To achieve this, vaccines should be released to community nurses and community leaders should be engaged. Further, vaccine accessibility must be



ensured by offering other services, such as bussing to the clinics for low mobility individuals (such as pregnant women, elderly) and offering appointments for those who are unable to stand in line for a vaccination.

- Vaccines should be provided to family doctors to reduce the wait times at public health clinics.
- The vaccine delivery mechanisms must be prepared prior to a pandemic.

Public Health Measures

Some respondents mentioned that plans should identify what infection prevention equipment and supplies are required, how to acquire and pay for them, how and where to store them, and when to use them. Some agencies developed plans for how to share resources with partner agencies, particularly considering the shortage of some supplies. Some plans also included guidelines for how to determine when to use gowns, masks, and gloves, based on the specific service being provided and the extent of illness.

One organization implemented a daily health report system whereby the head office was informed daily of the status of pH1N1 infection within the organization. Checklists for environmental cleaning were prepared and implemented and extra supplies stocked. Hand sanitizers were installed as appropriate, depending on concerns about clients consuming the alcohol-based sanitizers. One organization reported installing a window at the front desk to protect staff from potential infection transmission. Exiting through doors at the back of the building was encouraged by one organization to prevent symptomatic individuals from re-entering the waiting area.

Some agency representatives felt some of the recommended disease transmission precautions were unrealistic. One example was the careful consideration needed prior to the use of gloves and masks, particularly among those with clients with whom trust and stigma are potential barriers to accessing services. Also, social distancing was considered difficult or unrealistic within

many organizations lacking a large physical space. The use of a single shelter as an isolation facility was suggested as a possible solution.

ICID Analysis and Recommendations

Challenges included the following:

- Costs of basic supplies (gloves, masks) were cited as a major issue for continuing care. A number of sites could not implement components of their plans because of the cost of supplies.
- It was difficult to obtain information about the distribution and purchasing of supplies, as well as the availability of mask fit-testing.
- The interactions between the regional health networks, the hospitals, and public health with other agencies was weak, resulting in poor planning for post discharge care.

A number of strengths were identified:

- Even with the identified communications issues, collaboration and consultation at local levels was cited as being effectively implemented. This included working within communities, informal information sharing, prevention messaging, and communications with business and unions to deal with disruptions in commerce.
- Some noted there were local successes in the organization of on-site respite care for men in shelters. This was not universally successful, however. Others confirmed very specific plans for vulnerable populations were available for use.
- The prevention of spread and the communication of the sleeve cough and hand-washing were highly effective.

Recommendations with respect to the implementation of public health measures include the following:

- more shelter space, resting places for respite care, separate washrooms and showers for symptomatic people, and hospital beds;

- new compensation models for community agencies to allow them to deliver the pandemic services without impacting their normal programs and operations;
- continued networking with direct line staff through a central source to facilitate communication, knowledge sharing, and access to public health measures available and developed for vulnerable populations.

Communications

Accurate, direct, and timely communication with public health departments, partner organizations, media, staff, and clients was considered to be a very important component of planning. Guidelines for whom to engage in specific situations were considered important, as was the development of a mechanism to facilitate this exchange of information. Some examples of communication strategies incorporated into plans included accurate and simple information for staff to allow them to clearly and consistently answer the questions of clients about pandemic influenza. Nursing students were also engaged to provide clear and simple information sessions for clients. Broadcast communications in various languages was also considered to be valuable.

ICID Analysis and Recommendations

Various communication utilized included intra- and internet (for agencies and public, respectively), as well as traditional media (radio, television, print). Certain jurisdictions noted haphazard and poorly organized communications strategies. Major issues included inappropriate language in the communications (not transferable to the agencies or to the public) which required extra time and resources to modify and revise for general staff use with the public. A major success was the health link (811) service in the west, which non-governmental organizations found a reliable and consistent information source, even though some clients without telephone services were unable to use this source.

A number of challenges were identified:

- The media response was seen as a particular challenge as they sensationalized bad news without

taking responsibility for their actions, which led to public confusion and trust issues.

- Compounding the media issues, poor formal communication lines led to poor delivery of relevant, consistent and usable information, particularly important to counter negative media stories or conspiracy theories.
- There was a lack of communications material for specific risk groups, such as materials for the hearing impaired.
- Specific communications issues were noted:
 - Government silos at all jurisdictional levels were cited as an issue in successful communication strategies.
 - Differences in language, terminology, and recommendations between health care departments and social services departments led to a lack of congruity between these two groups.
 - The media behaved irresponsibly, sensationalizing negative aspects and ignoring the positive messages.
 - Internet-based media was extremely fast and difficult to control and led to issues with accuracy of information.
 - It was not anticipated that so many clients would question the value and safety of the pH1N1 vaccine. Fear of the vaccine was perpetuated by a 'YouTube' video in which unproven side effects to the vaccine were portrayed. Combined with mixed media messages, there were concerns among some marginalized populations, including new immigrants and refugees, some of whom felt they were being used as guinea pigs for vaccine testing. Also, due to the early association with swines, some individuals who do not eat pork thought they were not vulnerable to pH1N1 infection, and so did not get vaccinated.

- In some cases, the language used to communicate with the public was inappropriate, unclear, and often inconsistent. The methods to communicate was mostly mass media, rather than face to face.
- Information for special groups (cultural groups, special physical needs groups) and special interventions were not available.
- The mild nature of the pandemic was not anticipated and impacted on the messaging, requiring on-the-fly changes to the messages delivered to the population.
- The fear and conspiracy theories around the vaccine, particularly in some vulnerable populations, was more prevalent and spread faster than anticipated, and required stronger response.

In communications, there were a number of successful activities that helped with the management of the pandemic. These included:

- the federal media presence through Public Health Agency of Canada advertising;
- the networks of community organizations that formed;
- the use of social media as a new information distribution method;
- information update calls with medical officers of health to get epidemiology and big picture information out to community agencies;
- informal support systems allowing for the connection (both locally and nationally) of isolated workers and nurses;
- communications with community leaders;
- the use of interpreters and other culturally sensitive activities;
- the use of youth videos to deliver vaccination messages;
- pictorial representations for those who are unable to read.

Recommendations in terms of communications include the following:

- Communication needs to be improved at all levels, with plan sharing between agencies, and particular emphasis on the intersections between the plans. New communication methods are required, including social marketing campaigns. Communication should be coordinated by a single responsible individual or agency to ensure a single message is delivered to the public to prevent confusion. Along with the actual pandemic plan, a distinct communication plan should be devised. Assumptions of this communication plan must be tested to ensure that information is being delivered to all groups, such as the hearing impaired or those who are illiterate. Feedback needs to be actively encouraged with recommendations from those groups being addressed.
- A collaboration between public health agencies and front-line community service agencies must be fostered to develop communication lines and to help understand the roles and responsibilities of each group.
- Prior to the pandemic, media outlets must be engaged to ensure they assume a more responsible role in the pandemic.

CONCLUSIONS AND NEXT STEPS

There was unanimous agreement on the need for pandemic planning for marginalized urban populations. The key areas identified for future work include defining the population and addressing barriers and vulnerabilities for this population in the context of a pandemic influenza. Comprehensive and inclusive pandemic plans should include input from direct service providers and include multiple mitigation strategies to address societal, cultural and linguistic differences. Additionally, it was felt that the opportunity to evaluate and improve plans and communication between influenza seasons should be leveraged.

In order to facilitate this planning, there is a need for improved inter-agency and inter-jurisdictional relationships and communication. Although pandemic preparedness and response activities are ultimately the responsibility of the provinces and territories, public health is a shared responsibility among federal and provincial/territorial governments. Ongoing collaboration among F/P/T governments, non-government organizations and key stakeholders is critical to address a pandemic outbreak. Therefore, it is recommended that the planning process in the inter-pandemic phase build on existing local links and partnerships beyond traditional health care providers (e.g. community-based organizations) who have established and trusting working relationships with at-risk clients. There is a demand for strong federal leadership in terms of clear, concise, and timely information and communication, planning tools, networking opportunities, and resources.

Next Steps

1. Dissemination of the Final Report

- International Centre for Infectious Diseases (ICID) will share this final report with each participant and with the Public Health Agency of Canada (PHAC).
- ICID and PHAC will identify a mechanism to ensure electronic public access to the report via ICID and PHAC websites and post the report in both official languages as soon as possible.

- Participants are encouraged to share this report within their organization and more broadly, as appropriate.

2. Advocacy

- PHAC will disseminate this report to key government officials in each province, via established F/P/T processes, to advocate building collaborative working relationships with organizations representing and working directly with at-risk populations.
- Participants are encouraged to use the findings and recommendations in this report to advocate for further engagement in planning and response activities.

3. Development of a Resource Guide for Organizations working with At-Risk Populations

- ICID, in consultation with PHAC, will prepare a guide book for influenza planning for use by organizations working with at-risk populations.
- The guide book will be disseminated to all participants and posted on the ICID and/or PHAC websites as part of a web-based clearinghouse of resources and information for organizations working with at-risk individuals.
- The guide book and clearinghouse will be reviewed and updated regularly (at least annually) for accuracy and completeness.

APPENDIX A

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APPENDIX B

Issues in Pandemic Influenza Responses for Marginalized Urban Populations Consultation Meeting Agenda

TIME	ITEM	PRESENTER
11:00	Opening Remarks & Welcome	Ms. Wendy Schettler Program Director, ICID
11:15	Project Objectives Survey Results	Ms. Brenna Shearer Project Manager, ICID
11:40	Fall 2009 Planning Experiences	Group Discussions and Presentations
12:20	Lunch	
13:00	Pandemic Planning Implementation Assessment & Reflections	Group Discussions and Presentations
14:05	Break	
14:15	What Did You Learn?	Group Discussions and Presentations
15:20	Next Steps	Ms. Brenna Shearer
16:00	Closing Remarks	Ms. Wendy Schettler

Consultation Discussion Questions

Population Definition

- Definition of Marginalized Urban Populations
- Quantification of target population and estimates of population reached

Fall 2009 Planning Experiences

Questions:

- What was the planning process?
- Who was involved in the planning process?
- How was the plan communicated?
- What interventions and outreach strategies were planned?
- In terms of pandemic planning for marginalized urban populations, what was done well and what were some of the challenges?

Presentation back to group

Pandemic Planning Implementation Assessment and Reflections

Questions:

- In terms of implementation of service delivery for marginalized urban populations, what was not anticipated? What was missed?
- What was included in plans but not implemented and why?
- Were there gaps in service uptake, where and why?
- What went particularly well in the implementation of service delivery?
- What creative solutions to barriers did you develop?

Presentation back to group

What Did You Learn?

Questions:

- What recommendations do you have for future pandemic planning for marginalized urban populations?
- What recommendations do you have for future pandemic services offered for marginalized urban populations?
- What issues need to be addressed to improve the process of planning and delivering influenza services for marginalized urban populations?
- What resources would support your planning and implementation processes?

Presentation back to group

Next Steps

- Contributions to Resource Guide.
- Review of major statements throughout the meeting.
- What should the Tool Kit include?
- What additional resources would the group like to see developed/made available nationally?

Key Informant Interview Questionnaire

Population Definition

- Definition of Marginalized Urban Populations
- Quantification of target population and estimates of population reached

Fall 2009 Planning Experiences

- What was the planning process?
- Who was involved in the planning process?
- How was the plan communicated?
- What interventions and outreach strategies were planned?
- In terms of pandemic planning for marginalized urban populations, what was done well and what were some of the challenges?

Pandemic Planning Response Assessment and Reflections

- In terms of implementation of service delivery for marginalized urban populations, what was not anticipated? What was missed?
- What was included in plans but not implemented and why?
- Were there gaps in service uptake, where and why?
- What went particularly well in the implementation of service delivery?
- What creative solutions to barriers did you develop?

What Did You Learn?

- What recommendations do you have for future pandemic planning for marginalized urban populations?
- What recommendations do you have for future pandemic services offered for marginalized urban populations?
- What issues need to be addressed to improve the process of planning and delivering influenza services for marginalized urban populations?
- What resources would support your planning and implementation processes?

Next Steps – Project Deliverables

- Contributions to Resource Guide
- What additional resources should be developed/ made available nationally?

Report of October 2009 Survey Results

Introduction

The International Centre for Infectious Diseases and the Centre for Global Public Health at the University of Manitoba, with financial support from the Public Health Agency of Canada, conducted a project entitled Pandemic Influenza Responses for Marginalized Urban Populations. The purpose of the project was to evaluate and synthesize existing prevention and response plans and develop further resources to assist health care providers respond to issues related to influenza among marginalized urban populations.

Specific project objectives included:

1. Perform a national scan to determine the current status of pandemic influenza planning for marginalized populations.
2. Convene consultation meetings and interviews with public health planners and direct service providers in major Canadian cities to identify planning strategies, service gaps, and inform the development of a resource to assist in planning services to address influenza among marginalized populations.
3. Prepare a national pandemic influenza planning resource guide and tool kit for distribution to public health and civil society organizations.

A web-based survey was distributed nationally to public health staff in October 2009 to ascertain the current status of and gaps in pandemic influenza planning for marginalized populations. The survey results provided a baseline for the consultation and interviews with key stakeholders in Canada and informed the preparation of a national resource guide and tool kit for health care providers working with marginalized urban populations. The results of the national pandemic planning response survey are presented in this report.

Method

A cross-sectional, anonymous, web-based survey was developed to collect current pandemic planning processes and issues from decision makers and pandemic planning managers providing services for marginalized urban populations across Canada. The survey was disseminated across Canada via email to 288 individuals with an invitation to participate and a web link to SurveyMonkey.com. A database of national and provincial stakeholders in pandemic planning was developed from existing administrative databases contained at the International Centre for Infectious Diseases and through internet searches for community agencies and government departments related to public health, health planning, marginalized service providers, and feedback from individual survey respondents.

Between October 9, 2009 and October 25, 2009, 96 responses were collected (94 in English; 2 in French).

The survey consisted of 20 questions, including 17 multiple choice questions with opportunities to specify “other” responses and three open-ended questions. The survey questions were pre-tested by representative government and non-government professionals involved in pandemic planning in Manitoba.

Results

Respondent Characteristics

The majority of responses were from Ontario (38%), Manitoba (15%), Nova Scotia (13%), British Columbia (10%), Saskatchewan (9%), and Alberta (6%), with some responses from New Brunswick, Quebec, Newfoundland and Labrador, Yukon, and Northwest Territories.

The majority of respondents work for organizations that provide health services (18%), non-profit organizations (17%), regional health authorities (16%), shelter/drop-in centres (13%), and provincial health departments (12%).

Number of Respondents Reporting Serving Specific Populations

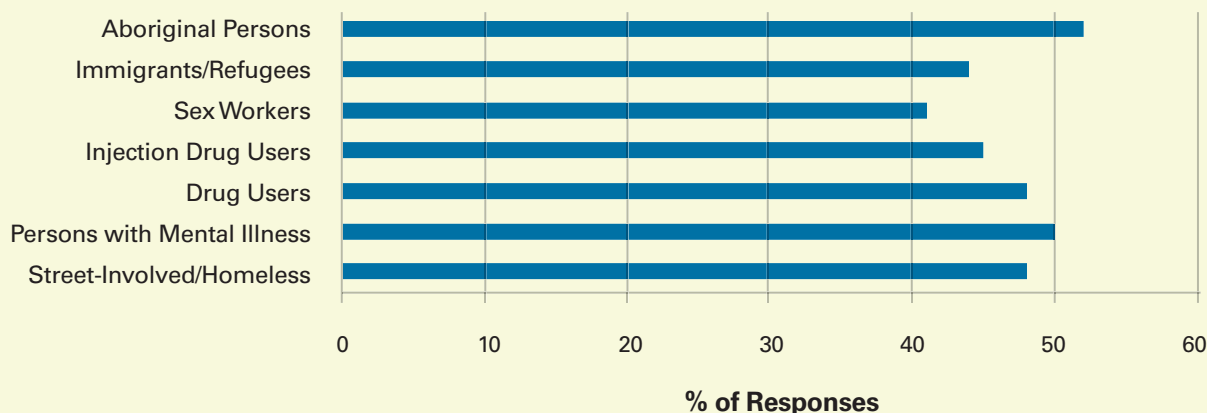


Figure 1. Marginalized urban populations served

Health care providers, other front line service providers, directors and managers of community organizations, researchers, medical officers of health, and directors and managers of government departments completed the survey.

The majority work for organizations that serve between 100 and 499 clients (15%), 1,000 and 9,999 clients (20%) or more than 10,000 clients (41%).

Approximately half the respondents reported serving each of seven categories of marginalized groups: street-involved/homeless persons, persons with mental illness, drug users, injection drug users, sex workers, immigrants/refugees, and Aboriginal persons (Figure 1). Some also reported serving persons with disabilities, persons with low income, gay, lesbian, bisexual, transgendered and transsexual persons (GLBTT), and women.

Status of Planning

Seventy percent of respondents indicated their organization has prepared a pandemic influenza plan or is currently preparing a plan while 16% indicated their organization has not.

Among those who indicated their organization is not preparing a plan, the most common reason was that a

plan from another organization would be used (29%). Other reasons included the implementation of a pandemic plan is not within the mandate of the organization (18%), other infection control plans developed by their organization would be sufficient (11%), or they lacked resources to address influenza issues (11%). Twenty-five percent of respondents were not sure why their organization wasn't developing a plan.

Among those who indicated their organization has prepared a plan, 25% were still being developed, 45% were in the process of being implemented, and 29% were fully or close to fully implemented.

As illustrated in Figure 2, between 45% and 70% of the marginalized risk groups are addressed in plans. Injection drug users is the group that is least frequently specifically addressed in plans, and street-involved persons and Aboriginal persons are the most frequently specifically addressed risk groups. A few respondents also included persons with low incomes, disabilities, pregnant women, seniors, and all persons within a specific "core" area.

Proportion of Plans that Include Each Risk Group

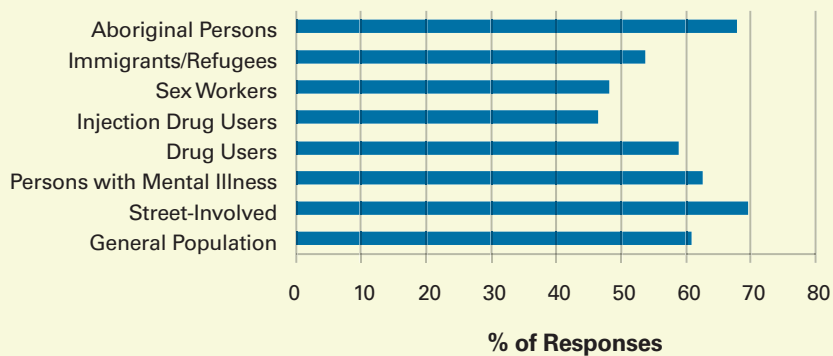


Figure 2. Proportion of plans that include each risk group

Respondents were also asked what types of interventions should be included in pandemic influenza plans. Eighty-nine percent selected public education, 86% selected staff restructuring/support, 83% selected vaccination, 79% selected initiatives to reduce contact with other people, 76% selected provision of clinical care for influenza, and 68% selected antiviral drug distribution. Additional responses and comments included:

- the need for practical and specific tactics;
- plans/services specific to pandemic stage;
- a shelter system for ill homeless individuals, including day shelters and sick rooms;
- pneumococcal vaccination;
- distribution of food in the case of disruption of food banks, community kitchens, and school food programs;
- infection control education and disinfection supplies;
- consideration of service venue accessibility from the perspective of marginalized populations;
- decision making structures, clear identification of agency roles and responsibilities, and a clear inter-agency communication process.

Respondents were asked to state their biggest concerns related to pandemic influenza within the context of the population served by their organization. Open-ended responses included:

- need to incorporate culturally-appropriate services and messaging;
- barriers to accessing vaccine clinics, including transportation, unfamiliar venues;
- challenge of reaching marginalized populations with traditional communications strategies;
- vulnerability and poor health status of marginalized populations, which increases their risk of severe disease;
- lack of consistent and accurate messages and the need to market the importance of immunization;
- closure of important services; how to continue programs; staffing shortages;
- potential for rapid transmission among marginalized populations;
- impact of illness on marginalized persons: unable to work, therefore unable to pay bills, etc.;
- failure to include shelter workers on priority vaccination list;

- lack of a physical space to be ill, and lack of health care providers to staff designated isolation shelter;
- unclear expectations as to what influenza-related services community organizations should provide;
- inappropriately high level of attention paid to pandemic influenza while numerous other health issues are being neglected.

Resources and Tools

Respondents were asked to identify what supports, resources, or tools they need for pandemic influenza planning. Thirteen percent indicated that nothing is needed. Figure 3 illustrates the proportion who indicated a need for specific resources.

The resources needed most often were identified as prevention protocols for staff, education resources on vaccination, education resources on influenza, service

planning resources, and networking with colleagues about issues and solutions. In addition to these resources, some respondents also indicated a need for:

- inclusion of equity impact assessments;
- plans for those living in institutional settings, in poverty, and immigrant families;
- information in other languages;
- consistent and accessible sources of information and updates for staff, the media, and the public, with visuals and targeted marketing;
- a way of knowing when there are enough resources and planning.

Respondents were asked to indicate what they think the potential impact of the above resources would be on pandemic planning processes. Twenty-seven percent indicated the result would be better service provision,

Proportion of Respondents Who Indicated a Need for Specific Resources

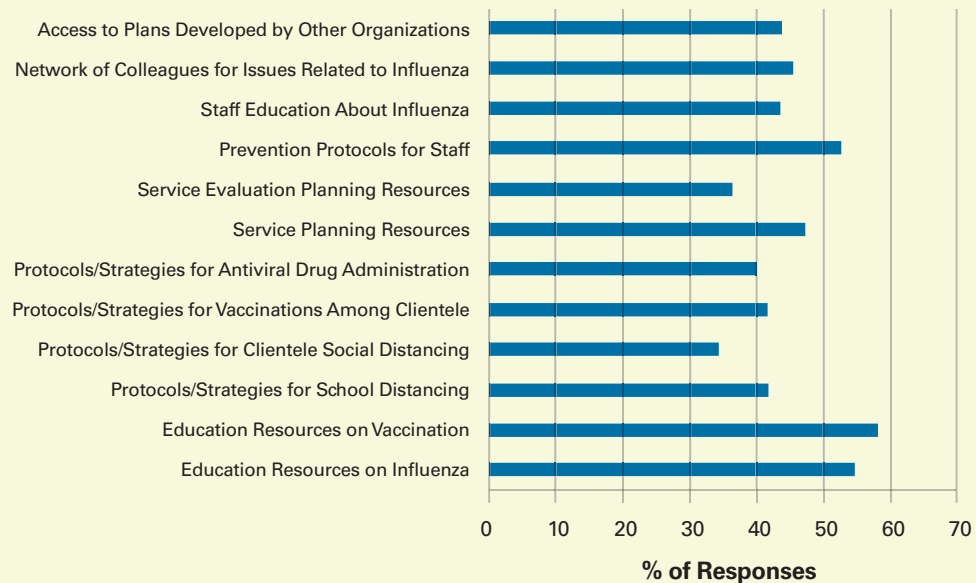


Figure 3. Resources required for pandemic influenza planning

resulting in a lower incidence of disease and severity of disease. Twenty percent indicated the result would be an improved knowledge base and better information dissemination. Seventeen percent indicated that collaboration and sharing of plans would result in improved efficiency and consistency, and that there is a need for a standardized or comprehensive national plan for local implementation. Fifteen percent indicated the result would be increased agency empowerment to address issues related to pandemic influenza. Seven percent indicated that stress and fear would be alleviated. Twelve percent indicated the impact is unknown and two percent indicated the potential impact would be minimal.

Final open ended comments made by some respondents included:

- the importance of proactive planning;
- the importance of communicating with other organizations, and the need for resources to do this;
- the need to target populations that are both most vulnerable and most likely to expose others;
- the need to address underlying social inequities;
- the need to involve and communicate with marginalized populations during the planning process.

Discussion

Survey responses were collected from a variety of health care decision makers, planners, and service providers across Canada and provided valuable information about the current status of pandemic influenza planning in Canada during a time frame just prior to and at the onset of the H1N1 public vaccination strategy.

Marginalized urban populations were identified by respondents as street-involved and homeless persons, persons with mental illness, drug users, injection drug users, sex workers, immigrants and refugees, Aboriginal persons, persons with disabilities, persons with low incomes, women, and GLBTT persons.

Service providers for marginalized urban populations in Canada identified a high level of preparedness in terms of development and implementation of prevention and control plans. While most agencies servicing marginalized urban populations were in the process of developing or implementing pandemic planning responses (70%), a

small percentage were not preparing a plan but utilizing a plan developed by another agency.

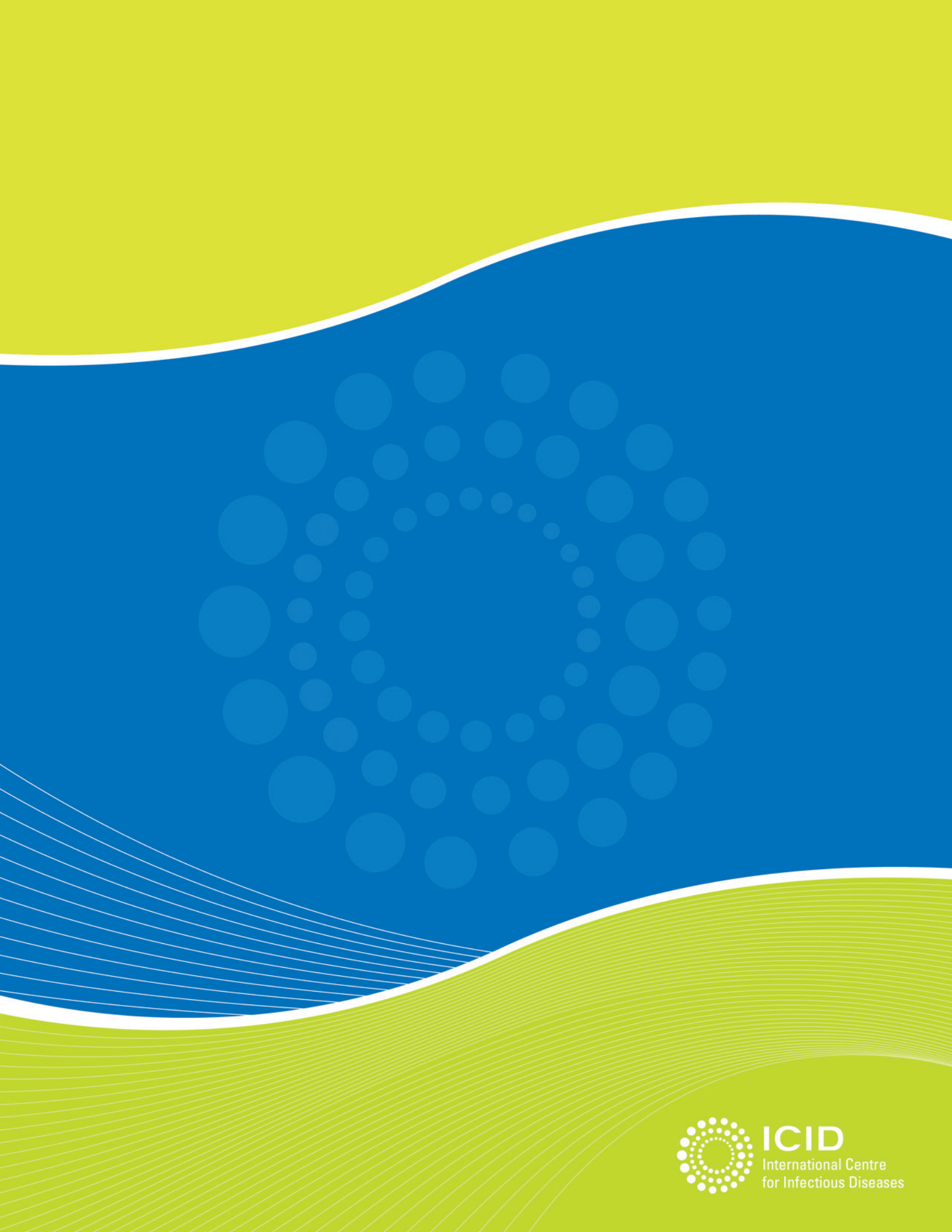
Public education, initiatives to reduce contact, support for staff and staff restructuring, vaccination, and provision of clinical care during pandemic planning were consistently reported as required components and components included in pandemic planning responses.

Issues and concerns remaining in the communities servicing marginalized urban populations were varied and focused around the similar themes of effective, consistent, and targeted public communication, rapid transmission potential, and barriers to vaccine access. These themes are consistent with the components identified as critical to pandemic planning responses.

Resources needed by those providing pandemic planning services to marginalized urban populations included prevention protocols for staff, vaccination education resources, service planning resources, and networking with colleagues about issues and concerns. Better service provision with a reduction in incidence and severity of disease were identified as the strongest benefit from provision of these resources and opportunities.

The survey responses may not be representative of all marginalized urban population service providers regarding pandemic planning. However, the consistency of responses across Canada, along with consistency between responses, suggests that responses may be generalized. While web based survey responses may have been negatively affected by the timing of the survey given pandemic planning implementation and responses from those most interested in the survey topic, responses were collected from most cities in the country and most respondents identified varied professional and organizational backgrounds.

Survey results reinforce the timeliness and need to address the project objectives. This environmental scan reinforces the need to continue to understand the current status of pandemic planning while conducting an immediate retrospective review of strengths, weaknesses, strategies developed, and areas for improvement within the window of pandemic planning implementation.



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