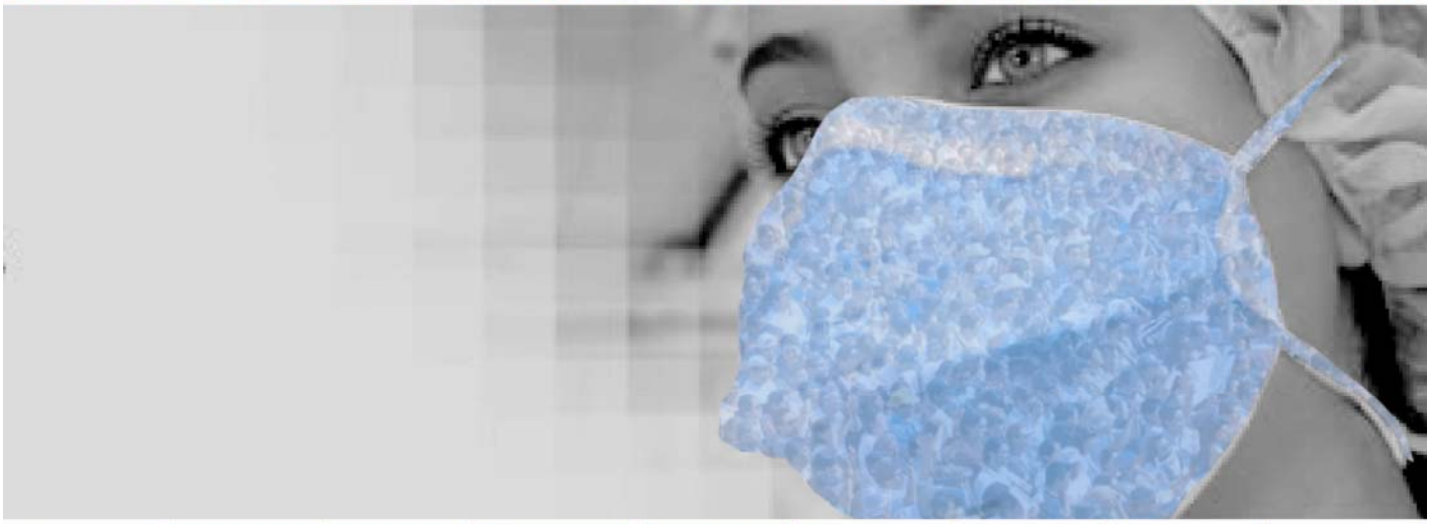
Evaluation of the Preparedness for an Apprehended Influenza Pandemic of The First Nations Communities of Quebec



First Nations of Quebec and Labrador
Health and Social Services Commission

CAUTION

This document does not replace legislation in effect; nor does it constitute a legal opinion.

ACKNOWLEDGEMENTS

The First Nations of Quebec and Labrador Health and Social Services Commission is proud to present the report on the state of Influenza Pandemic Preparations.

First of all, we are grateful to all the communities that participated in the evaluation and we would like to express our appreciation to the people who have work directly or indirectly in this project.

Last but not least, we wish to thank Health Canada for their financial contribution..

Coordination : Sophie Picard, Marjolaine Siouï
Research and Editing: Gestion SPL, under the leadership of the FNQLHSSC
Graphic Design: Chantal Cleary

This document was prepared by and for
First Nations of Quebec and Labrador
Health and Social Services Commission
250, Place Chef Michel Laveau, local 102
Wendake (Québec) G0A 4V0
Tel: 418 842-1540
Fax: 418 842-7045
Website: www.cssspnql.com

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LIST OF ABBREVIATIONS, INITIALISMS AND ACRONYMS

ADM	Assistant Deputy Minister
AFN	Assembly of First Nations
AFNQL	Assembly of First Nations of Quebec and Labrador
ASSS	Health and Social Services Agency
CSSS	Health and Social Services Centre
DM	Deputy Minister
DPAP	Departmental Pandemic Action Plan (MSSS)
EMP	All-Hazard Emergency Measures Plan
FN	First Nations
FNC	First Nations Communities
FNIHB	First Nations and Inuit Health Branch
FNQLHSSC:	First Nations of Quebec and Labrador Health and Social Services Commission
FOG	Federal Operations Group
GOC	Government Operations Centre (Ottawa)
HC	Health Centre
HC	Health Canada
INAC	Department of Indian Affairs and Northern Development
LPAP	Local Pandemic Action Plan
MSP	Department of Public Security (Quebec)
MSSS	Department of Health and Social Services (Quebec)
NERS	National Emergency Response System
NIHB	Non-Insured Health Benefits
NS	Nursing Station
ORSC	Regional Civil Protection Organization

OSCQ	Quebec Civil Protection Organization
PHAC	Public Health Agency of Canada
QCPC	Quebec Civil Protection Committee
QCPP	Quebec's Civil Protection Plan
QPIP	Quebec Pandemic Influenza Plan
QPIP- HM	Quebec Pandemic Influenza Plan – Health Mission
RCM	Regional County Municipality
RPAP	Regional Pandemic Action Plan
WHO	World Health Organization

INTRODUCTION

On August 22, 2006, Quebec's community health directors met for the first time to discuss the specific issue of a possible influenza pandemic. This meeting acted as a catalyst for subsequent initiatives taken by the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC): to assist communities in their efforts, the Commission decided to develop and implement a work plan to efficiently coordinate community preparedness in the event of such a pandemic.

The FNQLHSSC's mandate consists of three main tasks:

- Ensure that the communities have a pandemic action plan, and support their preparation and development activities
- Foster links between the various players in the Quebec health network and communities that want their support
- Ensure that all communities are consulted in the development of regional health and social services plans in Quebec

The Commission also took steps to obtain the funding needed to implement commitments made at the socio-economic forum held in Mashteuiatsh in October 2006.

Given the importance of this new initiative, which constitutes an addition to its existing daily health and social-service community responsibilities, the Commission felt it was essential to further consolidate its position within the First Nations and with its federal and Quebec government partners.

On January 16, 2007, to assist it in this process, the Commission asked consultants Gestion *SPL Inc.* to evaluate community influenza-pandemic action plans, with the findings to be compiled in a report containing useful recommendations on the measures to be taken by the Commission to ensure adequate community preparedness. The communities in question—32 in number—basically included the non-Agreement communities of southern Quebec, thus excluding those located within the boundaries of the Cree Regional Authority and the Kativik Regional Authority. The evaluation was conducted by means of a detailed questionnaire developed specifically for the purpose and completed by most of the communities contacted. The questionnaire was also designed to act as a pandemic-preparedness tool.

In addition, to be able to assess the measures to be taken by the Commission in its community-support efforts, we conducted documentary research into the role and responsibilities assumed by the Commission in relation to its Aboriginal institutional and federal and Quebec government partners. This study was oriented primarily toward the legal, administrative and organizational aspects of the influenza pandemic-action framework applying to the First Nations of Quebec. The analysis of the questionnaire findings, in addition to the deliberations that accompanied our documentary research, enabled us to identify a certain number of action items needed to provide the communities

with more assistance and to consolidate the Commission's role as a stakeholder among the First Nations in a pandemic context.

This report begins with a chapter summarizing the phenomenon of an apprehended pandemic and its foreseeable impact on the populace, together with the action framework provided for in Canada and Quebec to mobilize public organizations to offset the effects thereof. Chapter Two deals with the problem involved in incorporating First Nations communities and organizations into the pandemic action plans established by the two levels of government, starting with the structural obstacles faced by the communities and continuing with an analysis of their preparedness (based on responses to the survey questionnaire). This chapter also discusses the Commission and the AFNQL (Assembly of First Nations of Quebec and Labrador) Secretariat—more particularly, their legal status and respective responsibilities should a pandemic occur.

Chapter Three presents several recommendations intended to make the communities better able to combat an influenza pandemic, especially via the enhanced integration of government programs and emergency-measures plans, as well as the creation of new institutional relations with Quebec's health network. Other recommendations are aimed at consolidating the Commission's role by means of uninterrupted communications links and joint action with the federal and Quebec departments concerned. This chapter also underscores the importance the Commission and other agencies must accord to their own preparations, so as to be able to effectively assist the communities before and during an apprehended pandemic.

1.0 FEDERAL AND PROVINCIAL INFLUENZA PANDEMIC PREVISIONS FOR FN COMMUNITIES: A YET-TO-BE DEFINED DIVISION OF RESPONSIBILITIES

1.1 THE INFLUENZA PANDEMIC: A GLOBAL THREAT FOR ANY COMMUNITY

1.1.1 Current Situation

For some years now, the World Health Organization (WHO) has been tracking the development of the H5N1 strain of the influenza virus. The main natural reservoir for this genetically unstable virus is wild birds, especially migrating birds—for this reason, it has been dubbed the "bird flu". The first documented transmission of the virus occurred in 1997 in Hong Kong; of the 18 people infected, six died. Since that time, occasional transmissions have occurred in Asia, Europe and Africa. To date, the disease apparently has been transmitted only by contact between humans and birds. However, although no direct human-to-human transmission has been documented, it is thought that, in rare cases, it has occurred among members of the same family. [1] On May 16, 2007, the WHO recorded 306 cases of contamination, including 185 that were fatal.[2]

According to the WHO's health authorities, the Public Health Agency of Canada and Quebec's Department of Health and Social Services (MSSS), the risk of the virus mutating and becoming transmissible by direct human contact is very real. The propagation of the disease would then take on proportions similar to the great pandemics of the 20th century:

> "An influenza pandemic is an influenza epidemic that is limited in time but not in space, affecting populations over several continents. Phenomena of this kind can have devastating effects. Last century, there were three influenza pandemics, all of which originated in birds: the "Spanish flu" in 1918-1919, the "Asian flu" in 1957-1958 and the "Hong Kong flu" in 1968-1969. Historical data show that a new pandemic strain of the influenza virus emerges every few decades. Although it is impossible to accurately predict when a new strain will emerge, the probability of that happening increases when certain conditions arise at the same time. Experts agree that an influenza pandemic is becoming ever more likely, with three of the four conditions required for a pandemic virus to emerge already in place."[3]

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[1] Ministère de la Santé et des Services sociaux, *Québec Pandemic Action Plan – Health Mission* (Québec: 2006) 14, online: Ministère de la Santé et des Services sociaux du Québec, http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05-235-05a.pdf .

[2] WHO, *Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1) Reported to WHO*, online: WHO, http://www.who.int/csr/disease/avian_influenza/country/cases_table_2007_05_16/en/index.html (consulted most recently May 16, 2007).

[3] Ministère de la Santé et des Services sociaux, *Québec Pandemic Action Plan – Health Mission* (Québec: 2006) 13.

Those three conditions are: the appearance of a new strain, human vulnerability to that strain, and the virulence of the strain. The only condition lacking at present is effective human-to-human transmission. Once this, too, comes into play, we will have to be able to move quickly from the preparation phase to the response phase.

The scale established by the WHO to identify pandemic risk developments is composed of six phases. The first two correspond to the interpandemic period; phases three, four and five, to the pandemic alert period; and phase six, to the pandemic period itself. We are now at phase three of the scale; the disease can be transmitted to humans only by close, prolonged contact with fowl. However, once we arrive at phase four, human-to-human transmission will have begun, and health services will have to prepare for the possibility the disease will spread over the months that follow. Table 1 on the next page presents a description of each phase and the preparatory strategies related thereto.

Once the virus can be transmitted by direct human contact, the likely course taken by the pandemic would be as follows:

- First, the virus would arrive in Canada one to six months after emerging in another part of the world.
- The first peak of illness could occur within two to four months after the virus arrives.
- The first peak of deaths could be expected about one month later.

We would then have to anticipate two additional waves of illness, perhaps more. The second wave would occur three to nine months after the first, and would be just as devastating. Each wave would last six to eight weeks.

During the entire period, the pandemic would obviously have several different effects on the populace. Not only would people's health be threatened, but their physical well-being and society's overall functioning would be as well (see following).

TABLE 1. WHO Pandemic Phases and Corresponding Management Strategies

Phase	Description	Strategy
Interpandemic Period	Conditions: Normal	General preparedness
Pre-Pandemic Period		
Phase 1	No new influenza virus subtypes have been detected in humans. If the virus is present in animals, the risk of human infection or disease is considered to be low.	Strengthen influenza pandemic preparedness.
Phase 2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.	Minimize the risk of transmission to humans.
Pandemic Alert Period		
Phase 3(Current Phase)	Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.	Early detection, notification and response
Phase 4	Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.	Containment
Phase 5	Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).	Maximize efforts to gain time to implement pandemic-response measures.
Phase 6	Pandemic: increased and sustained transmission in general population.	Minimize the impact of the pandemic.
Post-Pandemic Continuity		

Source: Public Health Agency of Canada, 2005.

1.1.2 Foreseeable Impact

The *Canadian Pandemic Influenza Plan for the Health Sector* predicts that the number of people directly affected by the influenza virus during a pandemic will be from 15% to 35%, depending on the severity of the pandemic.[4] The guide issued by the Quebec Department of Health and Social Services (MSSP) describes the foreseeable direct impacts on the province's population as follows:

> "For planning purposes, the Ministère in Québec has adopted the hypothesis that the first wave of an influenza pandemic would affect 35% of the population, over a period of eight weeks. In this model:
> • 2.6 million people would be infected;
> • 1.4 million people would need to consult a healthcare professional;
> • 34,000 people would require hospitalization;
> • 8,500 people may die."[5]

Adjusting the percentages in question to a population consisting of communities of 500 to 5,000 residents, we see that the impact of the first wave of a pandemic would likely translate the figures appearing in Table 2.

Table 2: Impact of the First Wave of a Pandemic, in Accordance with Number of Community Residents

	Effect on Residents	Proportion of the Population[6]	Community Population 500	1,500	2,500	5,000
A	**Infected Individuals**	35%	175	525	875	1,750
B	**Outpatient Care**	50% of A	87	262	437	875
C	**Hospitalization**	1% of A	2	5	9	17
D	**Deaths**	0.4% of A	1	2	3	7

Health and Social Services

It is easy to predict the effects of a pandemic on workplace absenteeism: rates would increase in community health and social service directorates precisely when staff is needed most. Because of an influx of people seeking outpatient care and requiring hospitalization, the work overload on healthcare personnel would be considerable.

[4] Public Health Agency of Canada, *Canadian Pandemic Influenza Plan for the Health Sector*, Part 2 – Background (2006) 4, online: http://www.phac-aspc.gc.ca/cpip-pclcpi/hl-ps/pdf/CPIP-highlights-2006_e.pdf.
[5] Ministère de la Santé et des Services sociaux, *Quebec Pandemic Action Plan – Health Mission* (Québec: 2006) 15.
[6] Public Health Agency of Canada, Canadian Pandemic Influenza Plan for the Health Sector, Part 2 – Background (2006) 4.

In addition, regular absences, as well as an additional proportion of employees who would refuse to report to work for personal reasons (caring for a family member or child, reluctance to risk exposure, etc.), must be added to the absenteeism rate directly caused by the infection (which could reach 35%). The worst-case scenario would therefore involve staff reductions of between 35% and 50%.[7] Even in this difficult period, community health and social services would still have to provide the public with core care.

The Community in General

We must emphasize here that a pandemic differs from other major emergencies. When it strikes, it will run rampant through Canada's Aboriginal communities for several months. Health workers' and first responders' risk of exposure will be higher than that of the general public, thus compromising their ability to act.

Absenteeism due to the scope of the disease will affect several categories of stakeholders directly involved in emergency-measure implementation (police, fire and public-works departments; utilities companies in charge of maintaining essential infrastructures).

The Canadian Manufacturers and Exporters guide summarizes the economic impact of a pandemic as follows:

> "A pandemic may have other impacts on businesses, for example:
>
> • The provision of essential services like information, telecommunications, and financial services, energy supply, and logistics may be interrupted;
>
> • Customer orders may be cancelled or may not be able to be filled;
>
> • Supplies of materials needed for ongoing business activity may be disrupted. Further problems can be expected if goods are imported by air or land over the Canada-U.S. border;
>
> • The availability of services from sub-contractors may be affected (this may affect maintenance of key equipment, and is an area that merits close planning attention); and
>
> • Demand for business services may be affected—demand for some services may increase (internet access is a possible example); while demand for others may fall (e.g. certain types of travel activity)."[8]

[7] Canadian Manufacturers and Exporters, *Influenza Pandemic – Continuity Planning Guide for Canadian Business* (March 2006) 6 and 80, online: www.pandemiequebec.ca/en/news/news.aspx.
[8] Ibid., 6.

The guide continues, stressing the fact that Canada's trade status could be compromised and that "the tourist industry would be badly affected."[9] This last item is of particular concern, as the tourist industry represents an appreciable source of income for certain communities. Basic infrastructures would also be affected, and supplies of goods and services would be problematic for many FN communities. In some cases, economic survival itself would be at stake.

Under such circumstances, in which people's health is threatened and their material well-being, jeopardized, it is obvious that uncertainty and social tensions would ensue. Accordingly, it is vital that community leaders immediately start taking the appropriate measures to prepare all residents for a possible influenza pandemic.

Fortunately, the communities will not be alone in meeting the needs of residents. The governments of Canada and Quebec also have health and social-service responsibilities to Aboriginals that would continue throughout a pandemic. To provide a better understanding of this issue, the following section discusses how those responsibilities are divided between the federal and provincial governments.

1.2 THE LEGAL AND ADMINISTRATIVE FRAMEWORK APPLYING TO PANDEMIC PREPARATIONS FOR QUEBEC ABORIGINALS

Where an imminent or actual disaster is threatening the members of a community or seriously disturbs its activities, legislation exists to organize a collective response, determining the urgent action to be taken to efficiently combat the effects of the disaster and allow for a rapid return to normal, and identifying the organizations and individuals who are in charge of that action. Because of its severity and scope, a possible influenza pandemic meets all the conditions required for the implementation of legislative provisions on the establishment and management of such a response. In Canada, however, the legislative framework and division of responsibilities between federal and provincial government agencies must reflect the division of powers established by the Constitution. This aspect will be discussed in the following section.

1.2.1 Constitutional Division of Powers and the Pandemic

Sections 91 and 92 of the *Constitution Act, 1867*[10] basically define the areas of jurisdiction in which the Parliament of Canada and provincial legislatures are empowered to enact laws. In a pandemic context, we must distinguish between the division of emergency powers and the division of the respective responsibilities of the two levels of government in the area directly involved—i.e., health and social services. However, in the specific case of the First Nations, a third constitutional dimension must be added: the jurisdiction of the federal government over Aboriginal affairs. Given the scope and extreme complexity of the interrelationship between these three aspects of constitutional law, we will limit our

[9] Ibid., 7.
[10] *Constitution Act, 1867*, R.S.C. 1985, Appendix II, No. 5.

remarks here to the main factors likely to assist in the comprehension of the division of powers between the two levels of government with respect to a pandemic.[11]

1.2.1.1 Use of Emergency Powers in Exceptional Circumstances

The general powers contained in the introductory paragraph to section 91 of the *Constitution Act, 1867* empower Parliament to exercise its emergency powers in situations of exceptional threat such as a war or catastrophe, or where the economic context is deemed sufficient serious to constitute a threat to public welfare.[12] The emergency powers the federal government can exercise apply, depending on the circumstances, to a portion or all of Canada; they must be temporary and limited to the objective in question. In principle, therefore, the federal government will restrict the rights protected by the *Canadian Charter of Rights and Freedoms*,[13] and infringe upon the powers attributed exclusively to the provinces, only insofar as this is necessary to eliminate the threat in question. Other than in exceptional circumstances, the exercise of emergency power will respect the division of powers defined in the Constitution.

1.2.1.2 Division of Powers in the Health Field

The *Constitution Act, 1867* grants the provinces jurisdiction over the establishment and administration of hospitals, as well as matters of a local nature in the province.[14] Because these powers enable the provinces to organize medical practice and their own health and social-service networks, the Quebec government is responsible for those networks within its boundaries. The federal government, on the other hand, has very limited powers over healthcare, although it can declare quarantines,[15]especially as concerns visitors from abroad arriving at Canada's ports, airports and borders. Parliament can also organize health services on land under federal jurisdiction, such as Indian reserves, and coordinate interprovincial and territorial public health activities.[16]

[11] For a more in-depth analysis of these issues, readers may wish to consult the following: Abran, France et al., *Le cadre juridique de la gestion des sinistres au Québec* (study conducted for the scientific and technical commission assigned to examine the events of the ice storm of January 5 to 9, 1998) (Sainte-Foy, Quebec: C.R.D.P., Publications du Québec) April 1999, 13 - 29; Deschênes, Michel, "Les pouvoirs d'urgence et le partage des compétences au Canada" (1992) 33 *Les Cahiers de Droit*: 1181 - 1206.
[12] See *Anti-Inflation Act Reference*, [1976] 2 S.C.R. 373.
[13] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982* , R.S.C. 1985, Appendix II, No. 44.
[14] *Constitution Act, 1867*, ss. 92 (7) and 92 (16).
[15] *Constitution Act, 1867*, s. 91(11).
[16] We should add here that other constitutional sources have been cited in legal doctrine and case law to allow the federal government to intervene in certain aspects of the health field, especially its criminal-law jurisdiction (*Constitution Act*, 1867, s. 91(27) and power to spend (*Constitution Act, 1867*, ss. 91(1A) and 91(3)). See Abran, France et al., *Le cadre juridique de la gestion des sinistres au Québec*, op.cit. 26, and Deschênes, Michel, "Les pouvoirs d'urgence et le partage des compétences au Canada," loc. cit. 1197 - 1198.

1.2.1.3 Division of Powers and Aboriginals

The *Constitution Act, 1867* confers on Parliament exclusive jurisdiction over Indians and lands reserved for Indians.[17] Accordingly, the federal government is involved in First Nations communities in all spheres of activity, in particular the funding and maintenance of basic health and social services, complementing action taken by the Quebec network. Provincial laws of general application (driving, disease prevention, sanitation of premises, etc.) are valid within reserve boundaries until a federal law or regulation replaces them, or the band council adopts its own by-law. As regards a pandemic, therefore, a federal law or regulation, or a band council by-law, may be adopted and replace Quebec standards on health, sanitation, social services, etc., on the reserve.

Having provided this very brief overview of some of the rules governing the division of constitutional powers applicable to a pandemic, we will now examine the main laws that have been passed and the resulting administrative organization established, in order to examine more specifically how that division is exercised by the two levels of government in question.

1.2.2 Pandemic-Action Legislative Framework and Administrative Organization

To facilitate an understanding of the legislative and administrative framework applying to the pandemic action plan, this section will duplicate the order of presentation adopted previously for our discussion of the constitutional division of powers. Accordingly, it will start with a brief summary of the legislation and the administrative organization of federal pandemic emergency measures (1.2.2.1), then review the same aspects in a Quebec context (1.2.2.2).

1.2.2.1 Federal Government Pandemic-Response Framework

In Canada, the organization of federal-government emergency measures is based on two main laws: the *Emergencies Act*[18] and the *Emergency Preparedness Act*.[19] In truly exceptional circumstances—for example, a major earthquake or serious pandemic—the federal government could invoke the *Emergencies Act*, which lays out the broader scope of powers available to Parliament in case of a "national emergency" within the meaning of the Act. For a situation to qualify as a national emergency, it must "seriously endanger the lives, health or safety of Canadians and be of such proportions or nature as to exceed the capacity or authority of a province to deal with it, and not be able to be effectively dealt with under any other law of Canada".[20] To date, not even the Saguenay flood of the summer of 1996, the ice storm of 1998, or any other natural disaster has justified recourse to this legislation.

[17] *Constitution Act, 1867*, s. 91(24).
[18] R.S.C., c. E-4.5.
[19] R.S.C., c. E-4.6.
[20] *Emergencies Act*, s. 3(a).

The *Emergency Preparedness Act* obliges all federal departments and agencies to establish plans for dealing with emergencies in their respective fields, and to assist the provinces where the latter so request. The Minister of Public Safety and Emergency Preparedness is in charge of seeing the Act is implemented, and coordinates the activities of federal departments and their liaison with provincial authorities. The responsibilities imposed by the *Emergency Preparedness Act* on federal departments have resulted in the development of action plans such as the National Counter-Terrorism Plan, the Federal Nuclear Emergency Plan, and the Canadian Pandemic Influenza Plan.[21]

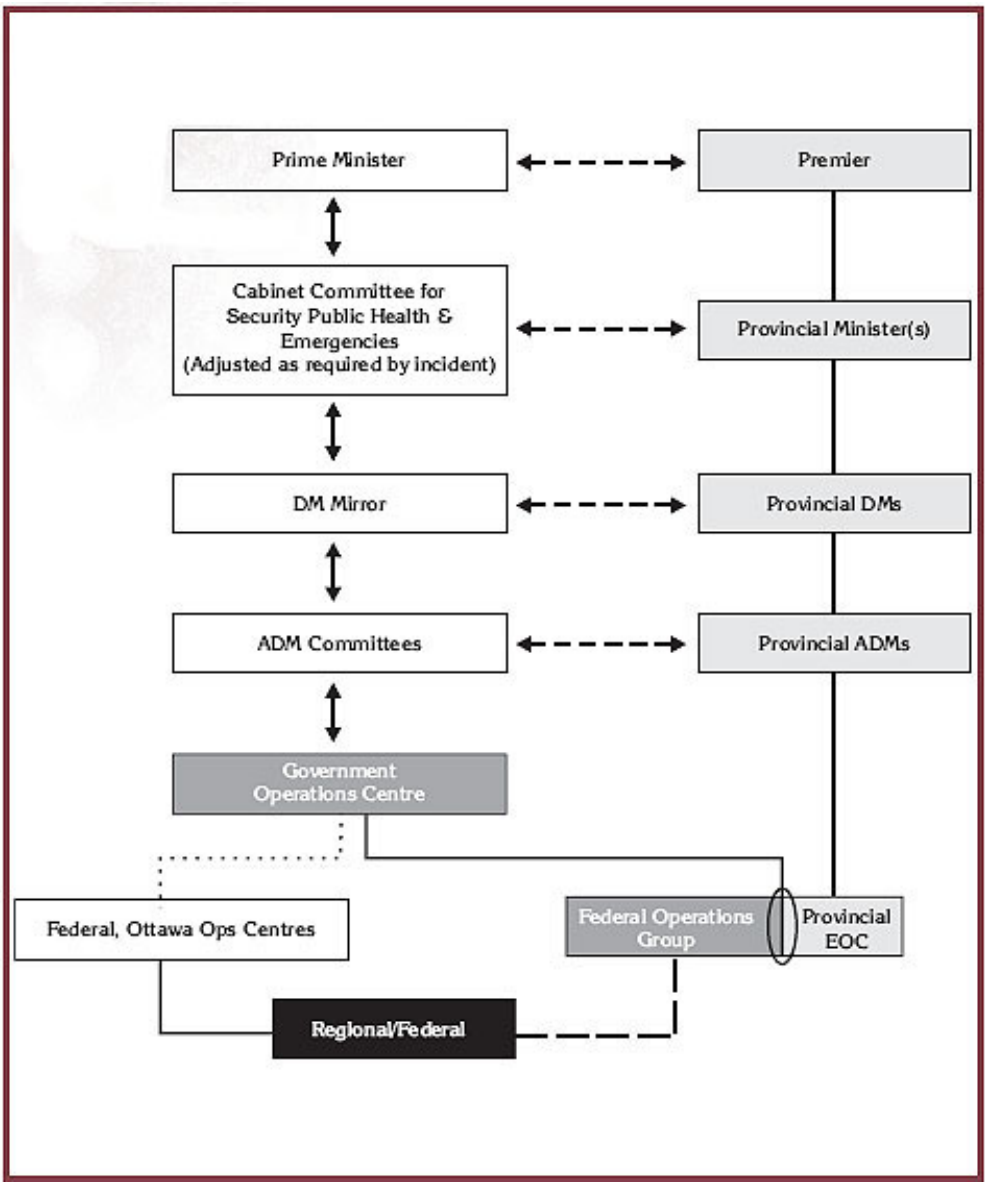
It should be noted that the *Emergency Preparedness Act* will soon be replaced by the *Emergency Management Act*,[22] which enhances the scope of the Minister of Public Safety and Emergency Preparedness' powers and responsibilities; it also specifies more clearly the latter's central role in federal interdepartmental emergency-management coordination.

With a view to organizing emergency action taken by federal departments and agencies to ensure it is consistent with their responsibilities under the *Emergency Preparedness Act*, the Canadian government is currently drawing up an administrative system called the National Emergency Response System (NERS).[23] The purpose of the new system is to ensure the strategic coordination of federal administration (Transport, Defence, Coast Guard, Environment, Health, Royal Canadian Mounted Police, etc.) whenever the government of Canada intervenes in an emergency in liaison with the provinces and territories. The NERS provides for the maintenance of links among the ministers and deputy ministers of the federal departments and their provincial counterparts via structures established at each reporting level. Figure 1 on page 12 shows a diagram of the relationships in question.

[21] Public Health Agency of Canada, *Canadian Pandemic Influenza Plan for the Health Sector*, Annex L: Federal Emergency Preparedness and Response System, 1.
[22] *Emergency Management Act*, Bill C-12 (passed December 11, 2006), First session, 39th Legislature (Can.). The effective date will be determined by order-in-council (s. 14).
[23] Public Health Agency of Canada, *Canadian Pandemic Influenza Plan for the Health Sector*, Appendix L: Federal Emergency Preparedness and Response System, p. 1.

Figure 1: Flowchart of Links Between Federal and Provincial Emergency Response Structures[24]

National Response Structure
National Emergency Response System (NERS)
Strategic and Federal, Provincial and Territorial Interface



[24] Public Health Agency of Canada, *Canadian Pandemic Influenza Plan for the Health Sector*, Appendix L: Federal Emergency Preparedness and Response System, 3.

A federal response coordinator has been appointed by the Department of Public Safety and Emergency Preparedness to head up Ottawa's Government Operations Centre (GOC), which brings together the federal departments and agencies concerned. In each of the country's regions, the GOC is in direct contact with an interdepartmental coordination centre known as the Federal Operations Group (FOG). Within the GOC, depending on the nature of the disaster in question, a deputy coordinator may also be appointed by another department to assist the federal coordinator. As concerns the Pandemic Influenza Plan, because of the nature of the threat, the federal deputy coordinator is appointed by the Public Health Agency of Canada (PHAC), the entity responsible for health action at the federal level.

Under its incorporating legislation[25], the Agency is to act on behalf of the federal government to take measures relating to disease and injury prevention, as well as public-health emergency preparedness and response. Reporting to the Minister of Health, it assists the latter in exercising or performing the Minister's public-health powers, duties and functions, and works with foreign entities, international health agencies—in particular, the World Health Organization (WHO)—and health authorities from Canada's provinces and territories. The Agency is also responsible for implementing the *Quarantine Act*,[26] the purpose of which is to protect public health via measures aimed at preventing the introduction and spread of communicable disease by travellers from outside the country. Owing to its domestic and international links, it is in an excellent position to monitor health and trigger a pandemic alarm. The Agency shares the health portfolio with Health Canada, which has been in charge of First Nations and Inuit health since 1945, when this responsibility was transferred from the Department of Indian Affairs.[27]

Within Health Canada, the First Nations and Inuit Health Branch (FNIHB) is charged with ensuring that First Nations communities are adequately prepared for an influenza pandemic. In communities that have concluded transfer agreements, the FNIHB provides only health-service funding; the communities are responsible for providing services. However, as concerns the Canadian Pandemic Influenza Plan, regional FNIHB offices must "develop FNIHB regional pandemic influenza plans, in consultation with FN communities and FN regional agencies, and integrate with provincial systems where possible…." They are also to conclude agreements with the provinces to clarify and co-ordinate mutual roles and responsibilities during public health emergencies for the purchase and eventual distribution of antivirals and vaccines intended for FN communities; for the supply and control of supplies and other useful medical products, etc.[28]

Moreover, the FNIHB must come to an understanding with the communities, regional organizations and the provincial authorities to obtain assistance from the provincial health network for assistance with public health/medical care services in overwhelming

[25] Public Health Agency of Canada, *Canadian Pandemic Influenza Plan for the Health Sector*, Appendix L: Federal Emergency Preparedness and Response System, 3.
[26] S.C. 2005 c. 20 [R.S.C. c. Q-1.1], s. 4. It should be noted that this legislation applies only to travellers from outside the country, and cannot be used to quarantine Aboriginal communities.
[27] Online, Health Canada: http://www.hc-sc.gc.ca/fnih-spni/index_e.html.
[28] Public Health Agency of Canada, *Canadian Pandemic Influenza Plan for the Health Sector* (Annex B: Pandemic Influenza Planning Considerations in On-Reserve First Nations Communities) 2.

situations.[29] In Quebec, the regional FNIHB offices have issued a policy paper[30] and, as part of the action plan for the First Nations Socioeconomic Forum,[31] undertaken to provide financial and technical support to enable FN communities to develop their own pandemic action plans.[32] The Canadian Plan also stipulates that the regional offices are to establish a partnership with their counterparts from Indian and Northern Affairs Canada (INAC) to integrate health emergencies into overall emergency preparedness planning.[33]

Charged with implementing the *Indian Act*,[34] INAC is responsible for assisting Aboriginal communities in emergencies, and has established a program on contributions for emergency-management assistance for activities on reserve. The objectives of this program are to:

> "- protect the health and safety of First Nations members when faced with natural disasters and damage or destruction of community infrastructure and houses by natural disaster or accident;
>
> - assist in the remediation of essential infrastructure and houses through timely assessment of emergency needs and facilitation of an appropriate emergency response from other areas within the department; and
>
> - support communities on a compassionate basis through continuation of search and recovery activities associated with lost persons."[35]

In the preparatory phase, INAC's role consists primarily in providing financial support to band councils, so they can develop or update their all-risk emergency measures plans and business-continuity plans and provide community stakeholders with adequate training.[36] In case of a

[29] Ibid., 5, sect. 2.1.1(c).
[30] Health Canada, *Framework for a Community Pandemic Influenza Plan — Health Mission* (FNIHB (Quebec Region)): November 2006.
[31] Action plan adopted at the Mashteuiatsh Socioeconomic Forum held October 25, 26 and 27, 2006, which was attended, notably, by the Premier of Quebec, representatives of the federal government, the AFNQL Regional Chief, and First Nations community representatives.
[32] AFNQL, *First Nations Socioeconomic Forum Report*, Forum held in Mashteuiatsh October 25, 26 and 27, 2006, Action 7.6.3, 2.5.0. A total of $20,000 was paid to each non-Agreement community to develop a pandemic action plan, and a regional FNIHB office representative visited several communities in the winter of 2007 to assist in that regard. A sum of $50,000 was also offered to the FNQLHSSC to fund a liaison/coordination officer.
[33] Public Health Agency of Canada, *Canadian Pandemic Influenza Plan for the Health Sector* (Annex B: Pandemic Influenza Planning Considerations in On-Reserve First Nations Communities) 5.
[34] R.S.C., c. I-5, s. 3.
[35] http://www.ainc-inac.gc.ca/pr/pub/rmaf/Anx9g_e.html.
[36] INAC has undertaken to fund emergency-plan updating, provide the training required by each community over the next few years, and assume the costs of an information kit on psychosocial intervention (*First Nations Socioeconomic Forum Report*, Forum held in Mashteuiatsh October 25, 26 and 27, 2006, Action 7.6.3, 2.5.1.

pandemic, INAC would respond to any local state of emergency [37] declared by the band council of the community concerned. INAC can then ask Public Safety and Emergency Preparedness Canada to mobilize federal resources or request assistance from the provincial government.

As mentioned above, the federal government's influenza pandemic-action framework is based on close cooperation with the provincial authorities. Health-service organization and delivery are the responsibility of the provinces, and Quebec FN communities have access to the province's health network to complete the first-line services available to their residents. We will now provide a brief summary of the legislative framework and administrative organization applying to influenza-pandemic emergency measures in Quebec.

1.2.2.2 Quebec's Pandemic-Action Framework

In Quebec, major-disaster management is provided for by the *Civil Protection Act*,[38] which aims at ensuring the protection of individuals and property. The Act divides responsibilities among the Quebec government, regional county municipalities (RCMs), local municipalities, businesses and individuals. The Department of Public Security (MSP), which is responsible for implementing the Act, coordinates the action of other Quebec government departments and agencies. The Act obliges the latter to reduce their vulnerability and establish prevention and protection measures for their respective spheres of activity. In addition, each must identify the resources that could be used to support the action taken by the government or local municipalities affected by a major disaster. The government resources in question are then incorporated into Quebec's Civil Protection Plan (QCPP),[39] and organized into 15 "missions". Preparations for and implementation of each mission are left to the government department in charge, in keeping with its usual responsibilities. One of these missions bears on health; here, the MSSS is in charge of organization and implementation.

The Act also specifies that local municipalities must cooperate with their RCM to develop a civil-protection plan that organizes municipal and private resources into a response system that can be integrated at the regional level. The Kativik Regional Authority is also to develop such a framework. Although this process has not yet begun, a similar though less wide-ranging system is presently being completed in most Quebec RCMs—as well as for the Kativik Regional Authority—under the *Fire Safety Act*.[40] This law obliges every RCM to draw up a fire safety cover plan to protect the public against fires and the most common risks (road accidents, accidents involving hazardous materials, etc.). Quebec municipalities thus have access to regional support that is better organized to deal with all sorts of disasters. In addition, since the *Civil Protection Act* was passed in December 2001, each local municipality has had to have an operational civil-protection plan.[41]

[37] http://www.ainc-inac.gc.ca/pr/pub/rmaf/Anx9g_e.html.
[38] R.S.Q., c. S-2.3.
[39] *Ibid.*, s. 61.
[40] R.S.Q., c. S-3.4.
[41] *Civil Protection Act*, s. 194.

Quebec's civil-protection system is designed to operate most often in keeping with a bottom-up decision-making process, with higher levels supporting the initiatives of lower levels. Accordingly, individuals, companies, and local municipalities—in that order—are responsible for preventing and dealing with disasters. Next, Quebec government departments and agencies intervene under the QCPP at the regional level to support municipal authorities; similarly, regional directorates receive assistance from central headquarters and ministers' offices. In most cases, the municipalities maintain a coordinating role throughout the operation.

At the regional level, government operations are coordinated by the Regional Civil Protection Organization (ORSC) and, at a higher level, by the Quebec Civil Protection Organization (OSCQ). Reporting to the government civil-protection coordinator (an associate deputy minister from the MSP), the OSCQ coordinates the action of government departments and agencies. It also works with Public Safety Canada in harmonizing the joint action of both government levels and coordinating requests for assistance from one government to another. At the top of the chain of command is Quebec's Civil Protection Committee (QCPP), made up of deputy ministers and officials from the main departments and agencies concerned with disaster management, as well as the government civil-protection coordinator. In case of a major disaster, the QCPP supervises the deployment of the QCPP.

With respect to influenza-pandemic action, the MSSS has decided to establish a top-down decision-making process. The latter starts at the Department's higher echelons and proceeds down from there to the regional level, occupied by health and social-service agencies (ASSS), and to the local level, represented by the health and social-service centres (CSSS), which are comprised of hospitals, local community health centres, and so on.[42] This model has the advantage of better complying with the legal framework imposed by the *Public Health Act*,[43] which sets forth the obligatory measures to be taken by the Minister of Health and the public health director in the event of a pandemic.[44] At the same time, it significantly modifies the relationship that must be established between the Health Mission and the other missions described in the QCPP. However, a specific influenza action plan for Quebec (the QPIP) has been developed.[45]

Where there is a serious threat to health, whether real or imminent, the *Public Health Act* provides that the Quebec government can declare a **public health emergency** for a period of ten days (renewable) for a given geographical area.[46] Notwithstanding any provision to

[42] The *Act Respecting Health Services and Social Services* (R.S.Q., c. S-4.2) divides responsibilities among the various organizations that compose Quebec's health and social-service network.
[43] R.S.Q., c. S-2.2.
[44] In particular, the director of public health can order the closing of premises, the evacuation of a building, the disinfection of premises, the cessation of an activity or the taking of special security measures, the isolation of a person at home or the latter's detention in a given location, etc. (s. 106).
[45] We should mention here that the *Québec Panemic Action Plan* stipulates, not only the responsibilities of Quebec government departments and agencies as part of their respective missions, but also the civil-protection organization coordination process in the event of a pandemic.
[46] R.S.Q., c. S-2.3, s. 118 and ff.

the contrary, while the public health emergency is in effect, the Government or the Minister, if he or she has been so empowered, may, without delay and without further formality, to protect the health of the population, order compulsory vaccination of the entire population or any part of it against any other contagious disease seriously threatening the health of the population. The Minister may also draw up a list of individuals or groups who require priority vaccination, and order the closure of educational institutions and any other place of assembly.

Furthermore, the Minister can prohibit entry into all or part of the area concerned, or allow access to an area only to certain persons and subject to certain conditions. He or she may order, where there is no other means of protection, the evacuation of people from all or any part of the area or their confinement—and, if the individuals in question have no other resources, provide for their lodging, feeding, clothing and security needs. The Minister can also order the construction of any work, the installation of sanitary facilities or the provision of health and social services.[47]

According to our analysis, within the QPIP, the Health Mission is especially important, with the action of departments and agencies responsible for implementing the other missions of the QCPP depending thereon.[48] Thus, in case of a pandemic, the QCPP, coordinated by the Department of Public Security, would assist health-network organizations in implementing the five dimensions of the Health Mission: public health, physical health, psychosocial response, communication, and continuity of services.

Should the situation deteriorate, municipal authorities would be ably to rely on assistance from the ORSC, which comprises representatives of Quebec government departments and agencies from their own administrative regions. Thanks to links with regional municipalities, the ORSC can mobilize government QCPP resources and coordinate federal aid to assist those municipalities in protecting people and property, maintaining municipal services, providing basic goods and services, and so on. The municipalities also coordinate their own action with the CSSS serving their area, to obtain the required information on health measures for personnel, a workplace vaccination clinic, psychosocial support for staff, etc. The CSSS can also request assistance from the municipalities to facilitate the safe transport of antivirals, vaccines, medical supplies and nursing staff to the premises where care is dispensed.

In each phase of a pandemic, Quebec's civil-protection system allows for coordinated action by various local, regional and central stakeholders. Local municipalities, which are to ensure the safety and well-being of their residents, can count on support from all government resources provided for in the QPIP. What is more, if necessary, they have access to assistance from federal agencies that cooperate with the ORSC at the regional level.

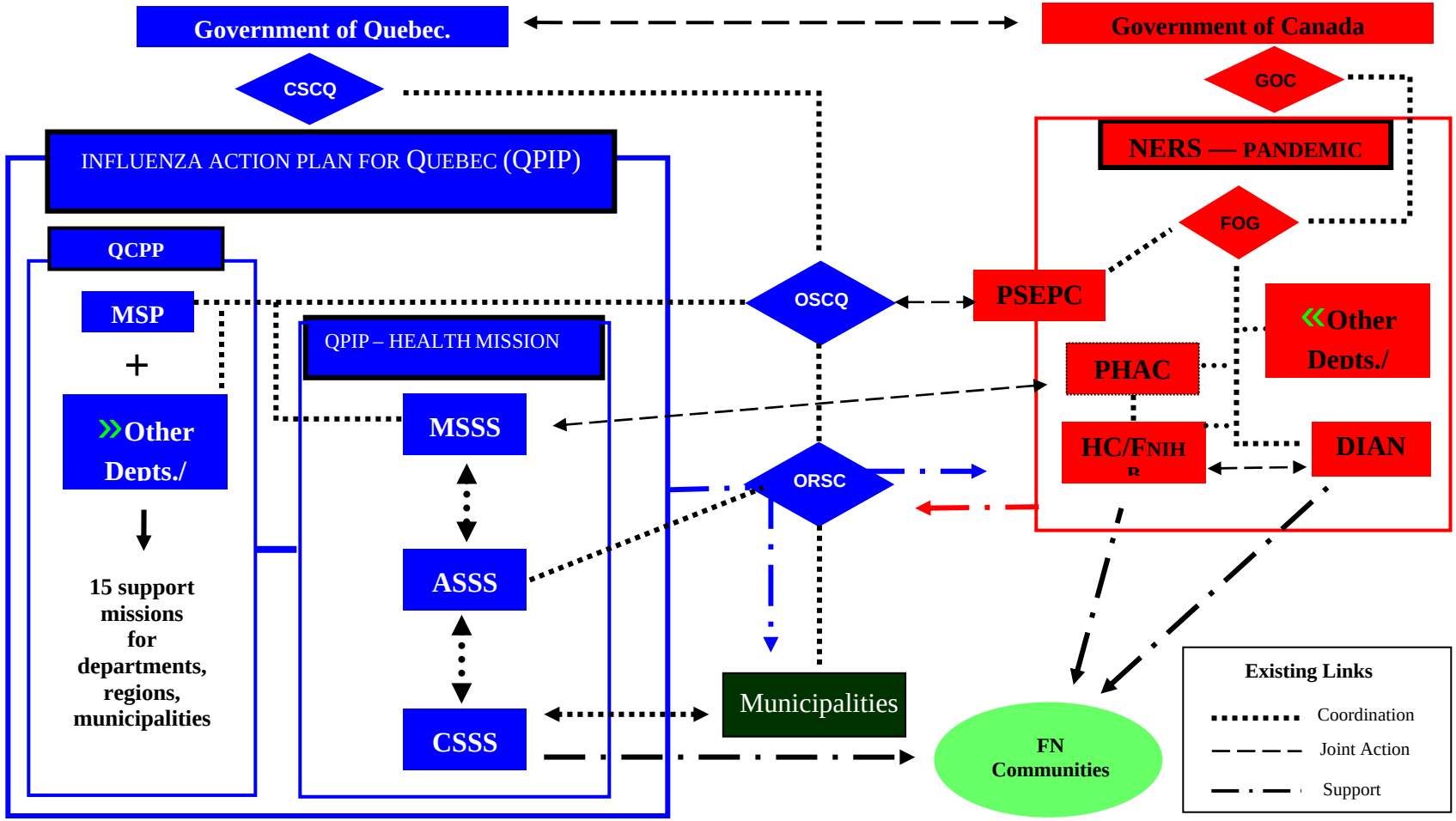
[47] Ibid., s. 123.

[48] The Food and Agriculture Mission, a responsibility of Quebec's Department of Agriculture, Fisheries and Food (MAPAQ), will also be important in detecting and rapidly eradicating sources of infection in poultry enterprises.

Figure 2 provides an excellent illustration of how Quebec municipalities benefit from integrated government-agency support. This contrasts significantly with the support provided for non-Agreement First Nations communities. With respect to the pandemic action plan, it would seem that, at present, only the complementary support provided to communities daily by the CSSS exists uniformly throughout the province. In other areas, Quebec government support varies considerably, and, most often, requires a response from the regional FNIHB offices or INAC, within the framework of an existing aid agreement accompanied by a federal funding accord.

The next chapter discusses the particular problem represented by the incorporation of non-Agreement First Nations into the provisions of the pandemic action plan established by the two levels of government.

Figure 2: Simplified Flowchart of the Links Between Quebec and Federal Pandemic Response Structures and the Local Authorities: Municipalities and First Nations Communities[49]



[49] This flowchart is a simplified synthesis designed solely for the purposes of this report. For a more in-depth, accurate picture of Quebec and federal pandemic structures, readers are invited to consult the official documentation issued by the governments of Canada and Quebec, available online at various department Web sites.

2.0 INTEGRATING FIRST NATIONS COMMUNITIES AND ORGANIZATIONS INTO CANADIAN AND QUEBEC INFLUENZA-PANDEMIC ACTION PLANS: A SPECIAL PROBLEM

An important dimension of managing major disasters—including an influenza pandemic—is the ability of local authorities to efficiently coordinate the measures needed to deal with the source of the threat, or to mitigate the harmful effects on the public. As representatives of the first level of government, local officials are responsible for taking those measures, in keeping with the resources available, in order to guarantee the safety and well-being of area residents.

This weighty responsibility, which falls to Quebec's municipal officials, is of particular importance where band council members are involved, as the latter must not only ensure the welfare of the community, but also maintain the economic, cultural and social survival of their own nation under difficult circumstances.

This chapter will provide a brief discussion of the legal and administrative framework applying to First Nations of Quebec communities and organizations as concerns pandemic action plans; with the help of the findings of a survey completed by some 20 such bodies, the preparedness of communities with respect to the five sections of Quebec's Civil Protection Plan - Health Mission will then be analyzed.

2.1 FIRST NATIONS OF QUEBEC NON-AGREEMENT COMMUNITIES AND THEIR DEGREE OF PREPAREDNESS IN THE FACE OF THE PANDEMIC THREAT

2.1.1 Powers and Responsibilities of the communities in the matter of health and social services in combating the flu pandemic.

Given the very nature of the pandemic threat, the responsibilities assumed by Aboriginal communities are greater than those generally falling to Quebec municipalities since, unlike the latter, Aboriginal communities are empowered to handle health and social services within their boundaries.

The source of these enhanced powers lies partly in the *Indian Act*, which confers on band councils the power to "provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases."In addition, as part of the movement toward self-determination and changes in Canada's legal context during the 1980s, pressure has been exerted on the federal government by Aboriginal organizations to gain significant control over programs with an impact on FN communities. As a result, in 1988, Ottawa approved the transfer of control over health-program resources for Aboriginals south of the 60th parallel to the communities themselves. For the latter, other than the wish to assert their political autonomy more strongly, one of the reasons justifying this transfer was to obtain access to culturally

adapted services—i.e., services reflecting the concept of "(…) conformity between the cultural characteristics of the patient and the provider, as well as the quality of the communication between the two." [Translation]

Health services in Quebec's non-Agreement communities take two forms: health centres (HC) and nursing stations (NS):

- Health Centres: These are usually located in non-isolated or semi-isolated communities, with personnel comprising one or more community-health nurses as well as support staff. Services are limited mainly to prevention and health-promotion activities; primary and emergency care is dispensed by local, regional or visiting physicians.

- Nursing Stations: These are most often located in isolated or remote communities, and employ at least two nurses as well as support staff organized to dispense primary health care. They provide 24/7 emergency services, short-term hospitalization, and public and community health services. The services of a visiting physician and dentist are also available.[50]

These front-line services offered by the communities are funded by Health Canada (regional FNIHB offices) in almost all non-Agreement communities in southern Quebec.[51] The offices also provide various public health, environmental, and community health programs.

The coverage available to community residents would be insufficient if not complemented by Quebec health institutions, which supply specialized services free of charge to all Quebec residents. For those services not insured by the province, in particular medical supplies and equipment and medical transport, the FNIHB offsets the costs via the Non-Insured Health Benefits Program (NIHB).[52]

While encouraging the First Nations to exercise greater independence in managing their affairs, the federal government's transfer policy also has had an impact on the relationships existing among the communities and the organizations that represent them: [Translation]

> "The approach adopted by the federal government with its transfer policy emphasizes the unit on which First Nations autonomy should be based—i.e., the community…. This policy, without excluding negotiations with other governance structures such as tribal councils and Aboriginal organizations, tends to set a premium on negotiations with the community."[53]

[50] *Ibid.*, p. 64.
[51] Health Canada continues to directly provide health services in only three of 32 non-Agreement communities.
[52] Roy, Nathalie, L'organization des soins de santé destinés aux autochtones du Canada — À la recherche d'un espace de partage, 65.
[53] Ibid., p. 69.

While at first glance advantageous, the primacy granted community officials also means they alone are responsible for solving the problems created by the lack of consistency among government programs for Aboriginals and by the lack of coordination between the two levels of government.[54] This situation has had a definite impact on health and social-service management: "For communities that manage their own health services, and for others as well, the fragmentation of services and funding sources among various government departments and levels still constitutes one of the main barriers to more integrated health-care organization and management."[55] [Translation]

Moreover, this fragmentation affects the very organization of public services, as reflected in the separate management of health and social services, which are the responsibility of different government bodies in many communities. This practice makes integrated management such as that existing in Quebec's health and social-service network impossible, and has even created a dichotomy between the health directorates that receive financial and technical support from Health Canada and social service directorates, which do not enjoy comparable assistance from Indian and Northern Affairs Canada (INAC), but must rather deal with several specialized programs sometimes administered by other federal agencies.

This problem also exists where preparations for a pandemic action plan are concerned. For example, with respect to the responsibilities assigned the communities in Annex B of the Canadian Pandemic Influenza Plan,[56] the latter are expected to develop their plans in cooperation with regional FNIHB offices and the local or regional health authorities.[57] The measures to be included in such plans deal primarily with preparations in the areas of public and physical health and, to a lesser extent, communication and continuity of services, as well as essential services (firefighting, policing, water, power, etc.); in addition, they are to "actively participate in local pandemic influenza planning (in neighbouring municipalities) to facilitate coordination of efforts and integration with provincial/regional systems in dealing with pandemic influenza."[58]

To reach these objectives, communities must deal with many different federal programs that were not developed jointly, and for which there is no common implementation schedule. For example, INAC has begun funding a number of programs, to be staggered over the 2006 to 2008 period, including the production of an all-hazard emergency measures planning software for communities, preparation or updating of all-risk emergency plants and operational continuity plans, and two training programs for community stakeholders—in addition to funding for a toolbox on psychosocial intervention (an aspect not covered by the regional FNIHB offices).[59]

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[54] Ibid., 70.
[55] Ibid., 71.
[56] Public Health Agency of Canada, Canadian Pandemic Influenza Plan for the Health Sector (op. cit., Annex B, note 4: Pandemic Influenza Planning Considerations in On-Reserve First Nations Communities).
[57] Ibid., 4 - 5, Table 1, section 1.
[58] Ibid., 5, section 1.1(t).
[59] Minutes of the inter-departmental meeting on influenza pandemic preparations held at 1:30 p.m. on January 16, 2007 in the Quebec City INAC offices; personal notes on the inter-departmental meeting held at

The latter did not anticipate providing the communities with assistance at the beginning of 2006, other than via a budget allocation for each community to develop a plan on the Health Mission of the pandemic action plan and the regional information sessions already begun.[60] They felt the communities should make their own preparations, with the regional FNIHB offices playing the role of facilitator for steps involving interaction between the communities and health-network agencies. In the wake of the action plan adopted at the First Nations Socioeconomic Forum held in Mashteuiatsh, however, the FNIHB in November made a complete about turn, issuing a policy paper, the *Framework for a Community Pandemic Influenza Plan — Health Mission*, which deals with preparations for the pandemic action plan's Health Mission. .It then pursued this initiative, providing technical support lasting one day on the average in several communities.

At present, while all communities are responsible for coordinating these programs and ensuring they are consistent, this does not mean they control contents or implementation schedules. Consequently, they will obviously have difficulty identifying their planning activities in advance, given that the related INAC and regional FNIHB office programs have not yet been firmed up. Furthermore, most communities feel they lack the human, technical and financial resources needed for adequate preparation.[61] This is perfectly understandable, given the low populations that often make it impossible to attain a critical mass capable of independently and permanently sustaining the resources required to maintain a suitable level of preparation.

It should be noted here that, although these programs will undoubtedly be useful in helping FN communities improve their overall preparedness, it is not certain that, in their present form, they will be sufficient. The contents of these various plans have yet to be harmonized, as does coordination at the local and regional levels with Quebec health-network agencies,[62] the local municipalities and government organizations, which are all already integrated into the province's civil-protection system.

2.1.2 Community Preparedness and the Five Sections of the Health Mission: A Summary

From the outset, we wanted to answer the following questions: Are the First Nations up to date in their efforts to prepare for an apprehended influenza pandemic? What are their strengths? What areas of improvement could result in specific action priorities for the

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1:30 p.m. on May 8, 2007 in the Quebec City INAC offices. The following were repesented: AFQNL, FNQLHSSC, MSSS, INAC, FNIHB.

[60] Memo dated August 3, 2006 re updates on the pandemic action plan (see Appendix :summary of telephone call of Thursday, April 13, 2006 to the FNIHB).

[61] FNQLHSSC, letter of September 27, 2006 to Health Canada and Quebec's Department of Health and Social Services re a request for funding for influenza-pandemic preparation coordination (See Appendix A, Observations 1, 2 and 6).

[62] Especially to ensure adequate coverage of the five sections comprising this mission.

FNQLHSSC and its partners? Does the model currently used by those partners ensure the degree of preparation anticipated at March 31, 2007?

Study Objectives

To answer these questions, we came to an agreement with the FNQLHSSC to conduct a study with having following objectives:

1- To identify existing preparedness (March 31, 2007) of non-Agreement communities with respect to the following types of plans:
   - Influenza pandemic action plan (IPAP);
   - All-hazard emergency measures plan (for coordination).

2- To take advantage of the study to provide those in charge of the First Nations Health Mission with a tool for use in preparing their IPAP.

Method

We wanted to compare First Nations preparedness with the criteria contained in the *Framework* developed by Health Canada's First Nations and Inuit Health Branch (FNIHB) and in the Quebec Pandemic Influenza Plan (QPIP).

First, we asked general-information questions on the community and the training and documentation received. We introduced various indicators selected from a list of documents sent out by the ASSS to the CSSS that the FN health centres should have received (in particular, the Regional Pandemic Influenza Plan's **Manager's Toolbox** and **Annual Program**).

We then chose 148 questions on an equal number of specific, measurable steps comprising the QPIP - Health Mission's five sections, which were to form a completed portion of the First Nations IPAP at March 31, March 2007 (see Appendix A).

These questions were taken from the QPIP and the *Framework*; the Ontario, Canadian and WHO plans were also consulted.

At the end of each section (public health, physical health, psychosocial response, communication and continuity of services), we added questions, developed by two experts on all-hazard emergency response measures, about the degree of coordination between the pandemic action plan and the band council's all-hazard emergency measures plan.

The questionnaire was developed for use as a checklist in the process of preparing for an apprehended pandemic.

Respondents were to enter Y (for "yes") or N (for "no") in the box corresponding to March 31, 2007 for each question. If the answer was "no", a choice of three answers was possible: June 30, September 30, and December 31, 2007.

Where the question did not apply to the organization concerned, respondents were asked to enter N/A (for "non-applicable").

Despite the deadlines involved, we were able to submit the French version of the questionnaire to five people—including two nursing-care managers working in a community and three FNQLHSSC professionals—for ratification.

The questionnaire was then sent to 32 non-Agreement communities, together with a letter signed by the FNQLHSSC's Operations Manager explaining the context, questionnaire objectives, and the importance of a rapid reply.

Realizing that the means of communication most commonly used is the fax, we took advantage of the opportunity to measure the efficiency of e-mail transmissions to FN health and social-service directors (using addresses provided by the FNQLHSSC).

The questionnaire was sent to French-speaking communities on March 26, for a reply by March 31. It was sent to English-speaking communities on April 3, for a reply by April 13. This was followed by telephone prompting within one to seven days, and a written reminder sent by fax on April 26. During that call, we checked transmission quality and the time required before management became aware of the documents sent.

An infrastructure was set up to ensure management of calls following receipt of the questionnaire, and an Excel database was established for use in entering and processing replies.

Findings

The findings reflect the situation at March 31, 2007.

General Information; Training and Documentation Received

As regards general information and training and documentation received, Tables 3 and 4 summarize the findings from 20 communities. In all communities, someone has been appointed to ensure general pandemic coordination, and all save one have someone in charge of the all-hazard emergency measures plan.

Table 3. Compilation of General Information (20 communities)

	Number	%
Individual in charge of pandemic general coordination	20	100
Individual in charge of all-hazard emergency response plan	19	95

Table 4. Training and Documentation Received (20 communities)		
	Number	**%**
Framework (Health Canada)	18	90
Initial training (HC/MSSS/ASSS/CSSS)	16	80
QPIP	18	90
RPIP (Regional Pandemic Influenza Plan)	14	70
LPIP (Local Pandemic Influenza Plan)	11	55
Indicators selected (20 communities)		
No. of communities that had received the Manager's Toolbox	**4**	**20**
No. of communities that had received the 2007-2008 program for their region	**6**	**30**

Two communities said they had not received the FNIHB's *Framework*; 16 out of 20 (80%) had attended the *Framework* preparation meeting. Of the 20 communities involved, 18 (90%) had the Quebec plan *(*QPIP) in hand; however, only 70% had the ASSS regional plan, and 55%, the CSSS plan.

Of the two indicators introduced to measure the quality of information between the CSSS and FN health centres, only four (20%) communities had received the Manager's Toolbox, and six (30%), the 2007-2008 program for their region.

Checklist

As regards the 148 questions on the Checklist, two communities were excluded from the process: one, because it had opted to deal with Ontario, the other because it already had a preparation process.

The compilations shown in figures 3 to 16 bear on the responses of the 20 communities that returned their questionnaire by May 21, 2007.

The results are expressed as a percentage of those communities that replied Y ("yes") or "N/A" at March 31, 2007 to the Checklist question.

During the process, we received a number of comments to the effect that the questionnaire was very useful as a preparation tool.

Figure 3

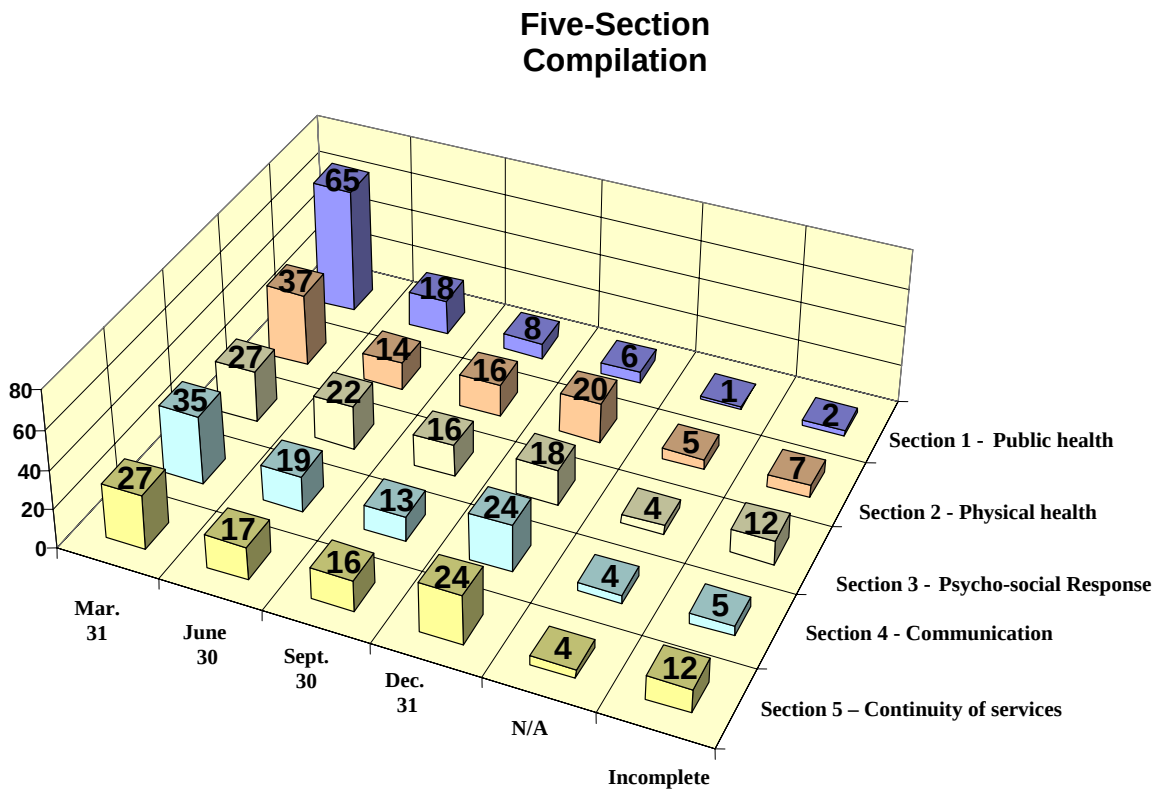


Figure 3 shows a comprehensive compilation of the Health Mission. Community preparedness in the area of public health (65%) is clearly higher than for the other sections, for which the figures vary between 27% and 37%. Rates for psychosocial response (27%) and continuity of services (27%) are very low. Physical health (37%) and communication (35%) figures, while significantly higher, still leave something to be desired.

Figure 4

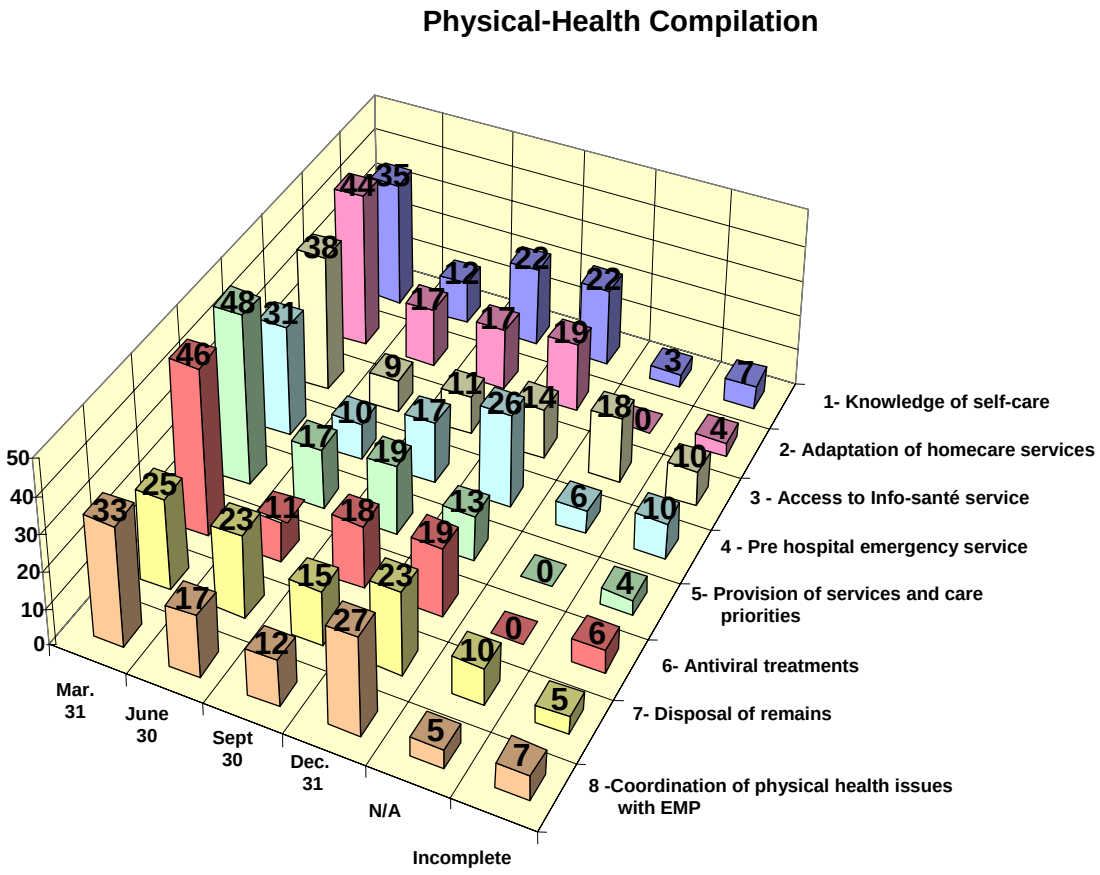
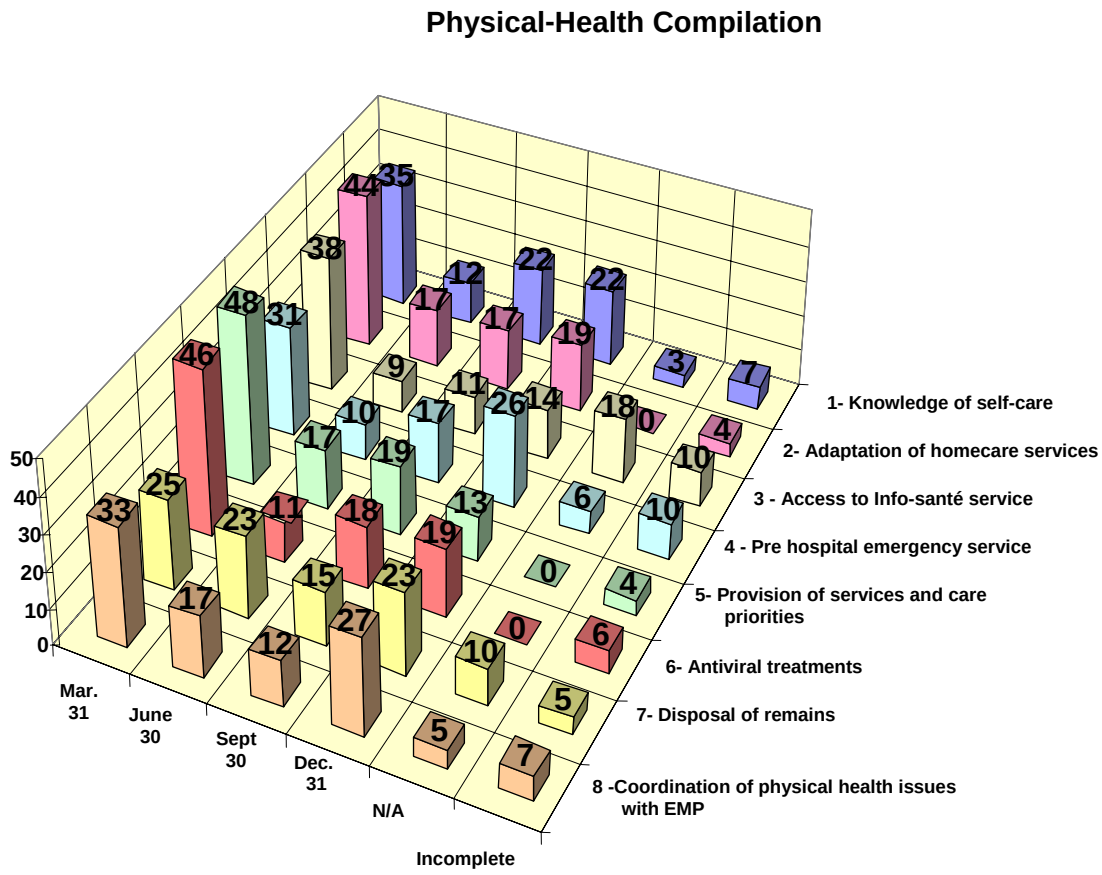


Figure 4 illustrates FN communities' level of preparedness in the four areas of public health: epidemiological-surveillance methods, adaptation of pandemic infection-prevention, administration of vaccination measures, and case and contact management. The findings vary only slightly from one area to the next (57% to 75%). The number of non-responses (boxes left empty) is low (0% to 4%), enhancing response validity. Coordination with the EMP is only 47%, which tends to demonstrate that, in this area as well as the others, much work remains to be done.

Figure 5



With respect to physical health (**Figure 5**), community preparedness at March 31, 2007 varies considerably from one area to another (25% to 48%). Provision of services and care priorities (48%) and antiviral treatments (46%) rank highest, with the disposal of remains (25%) and pre-hospital emergency services (31%) in last place; in between are knowledge of self-care (35%), adaptation of homecare services (44%), and access to Info-santé (38%). The N/A rate for the latter is 18%. The non-response rate varies from 4% to 10%, which seems high. Coordination with all-hazard emergency measures plans has been evaluated at 33%.

Figure 6

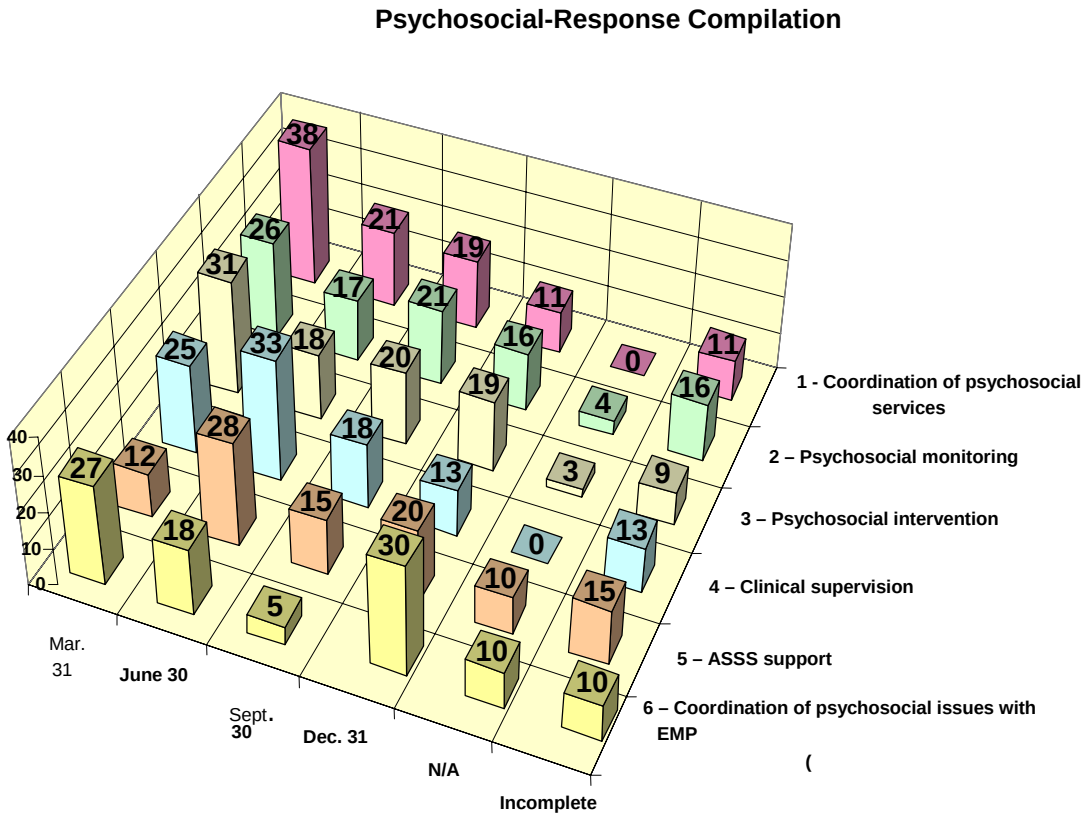
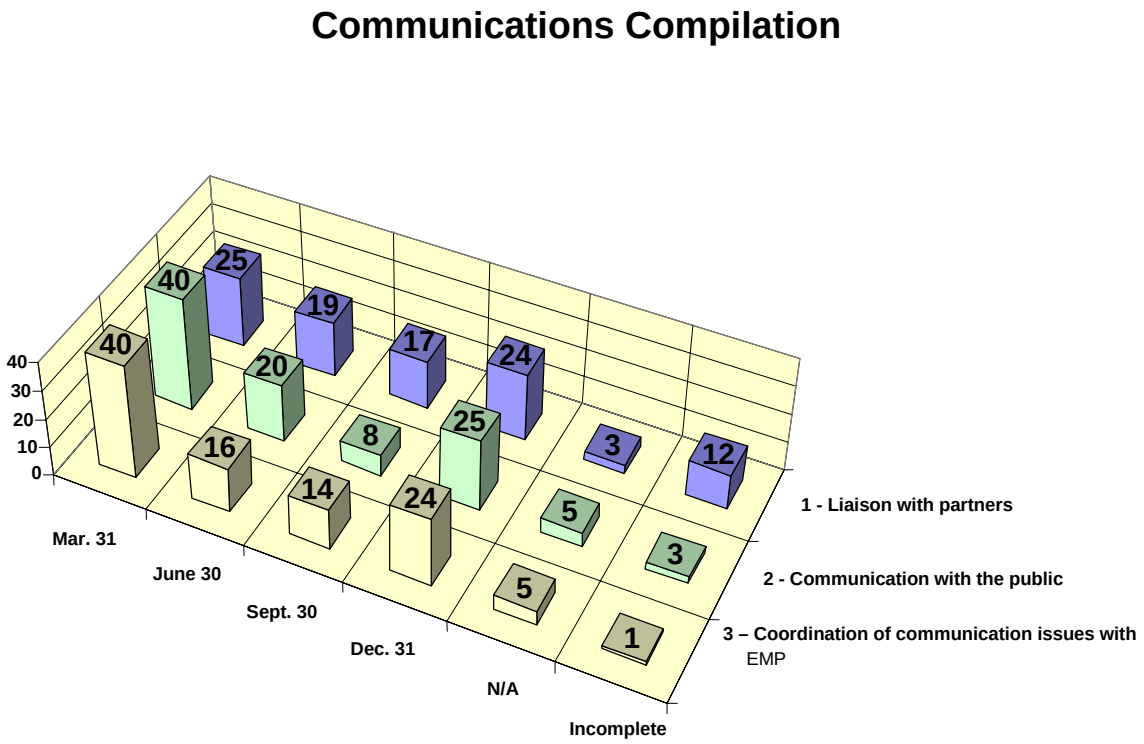


Figure 6 shows that, at March 31, community preparedness with respect to psychosocial response (coordination, monitoring, intervention, clinical supervision, and ASSS support) varies between 12% and 38%. Standing at 12% on March 31, ASSS support had made considerable gains by June 30. The non-response rate varied from 9% to 15%, a high figure that tends to emphasize the lack of preparation in this area. Coordination with the all-hazard emergency measures plan is 27%, which, as was true for the other sections, is low.

Figure 7



Four communities out of ten (40%) would apparently be prepared to manage community communication in cooperation with those in charge of the all-hazard emergency measures plan (**Figure 7**). However, a fairly large number (25%) indicate they will not be ready until December 31, which reduces their overall preparedness, as this date was the latest available choice. The remarkably low rate (25%) for liaison with partners (CSSS, ASSS, FNQLHSSC) should be noted here.

Figure 8

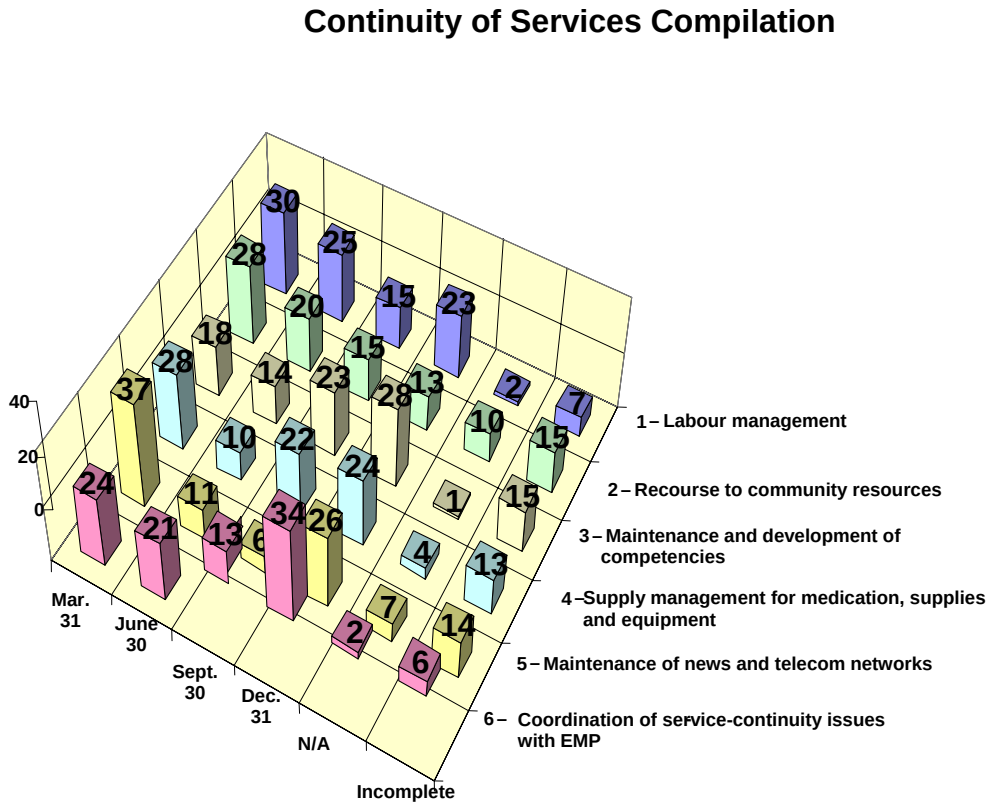


Figure 8 illustrates the five areas of the "continuity of services" section: labour management, recourse to community resources, maintenance and development of competencies, supply management of medication, supplies and equipment, and maintenance of news and telecommunication networks. The preparedness rate varies between 18% and 37%, depending on the area in question. At 18%, development and maintenance of competencies ranks worst, with the high rate of non-response (15%) further compromising matters. As was true for the other sections, coordination with the all-hazard emergency measures plan is low, standing at 24%.

We compiled the findings taking account of the "language of communication (English or French)" variable (**figures 9 and 10**); there was a significant difference between two aspects. In the public-health area, the English-speaking communities have a 48% preparedness rate; for their French-speaking counterparts, the figure is 66% (with a low non-response rate). Rates for psychosocial response are low in both cases, but even more so in Anglophone communities. However, it should be remembered that the number of these communities in the cohort was small.

Figure 9

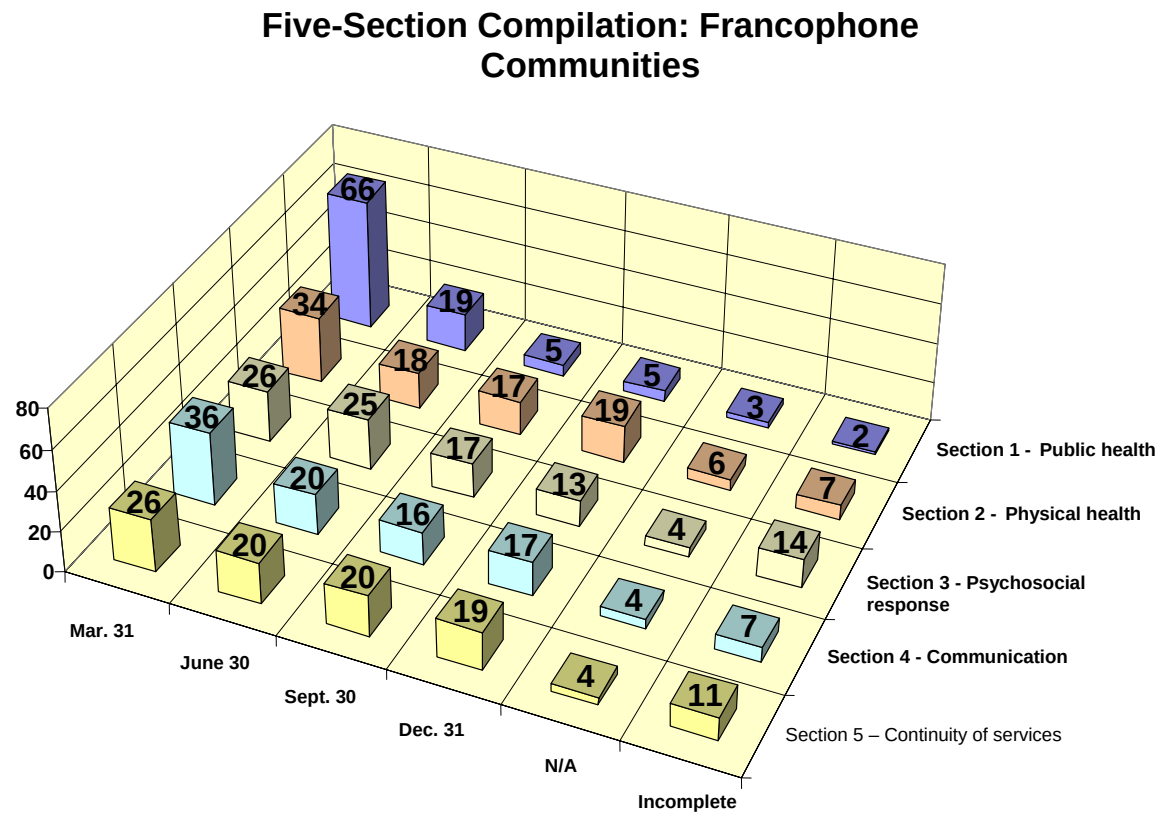


Figure 10

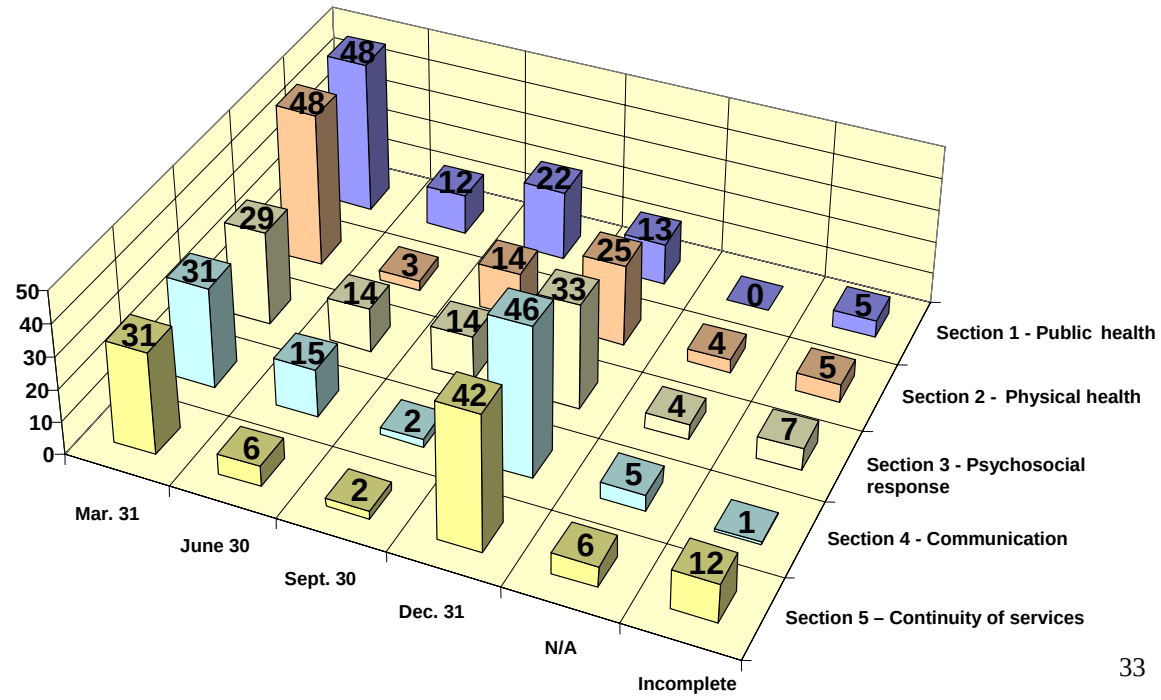


Figure 11

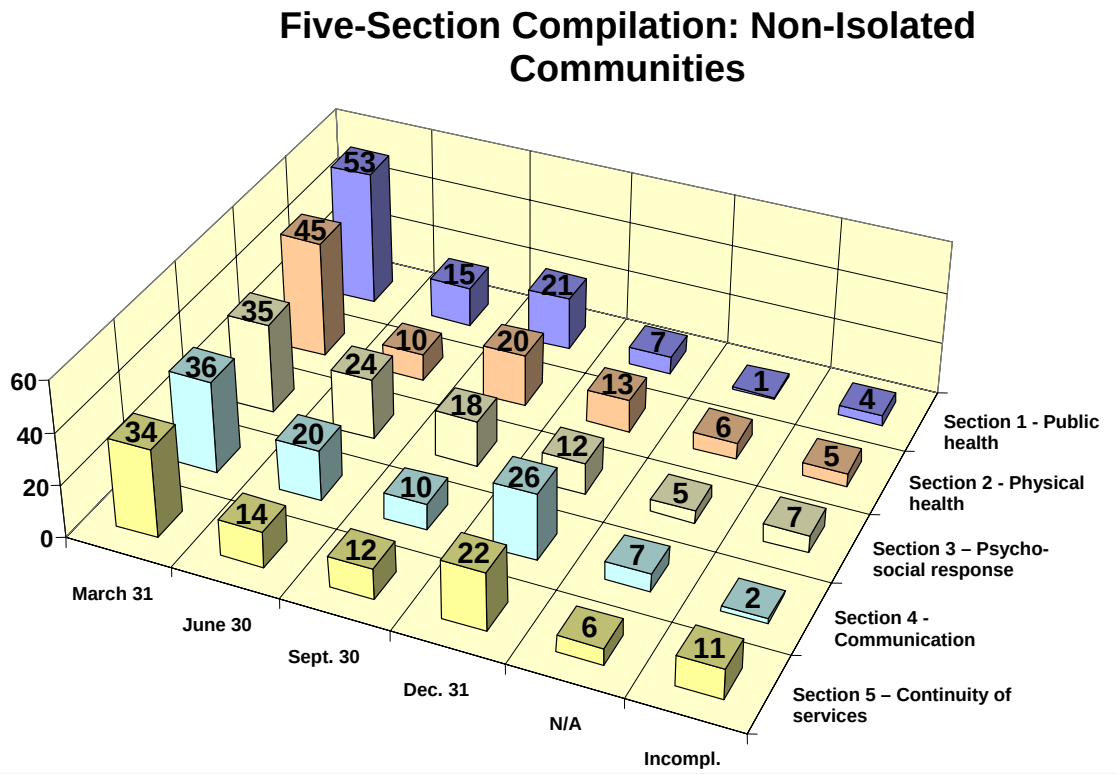


Figure 12

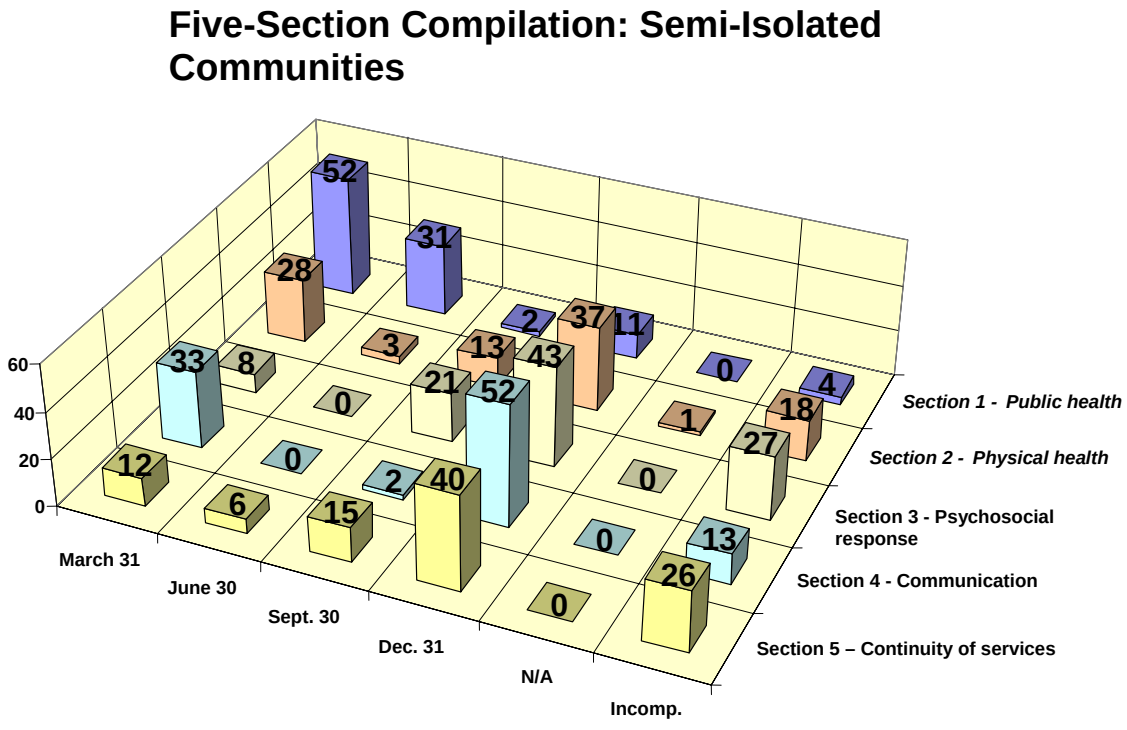
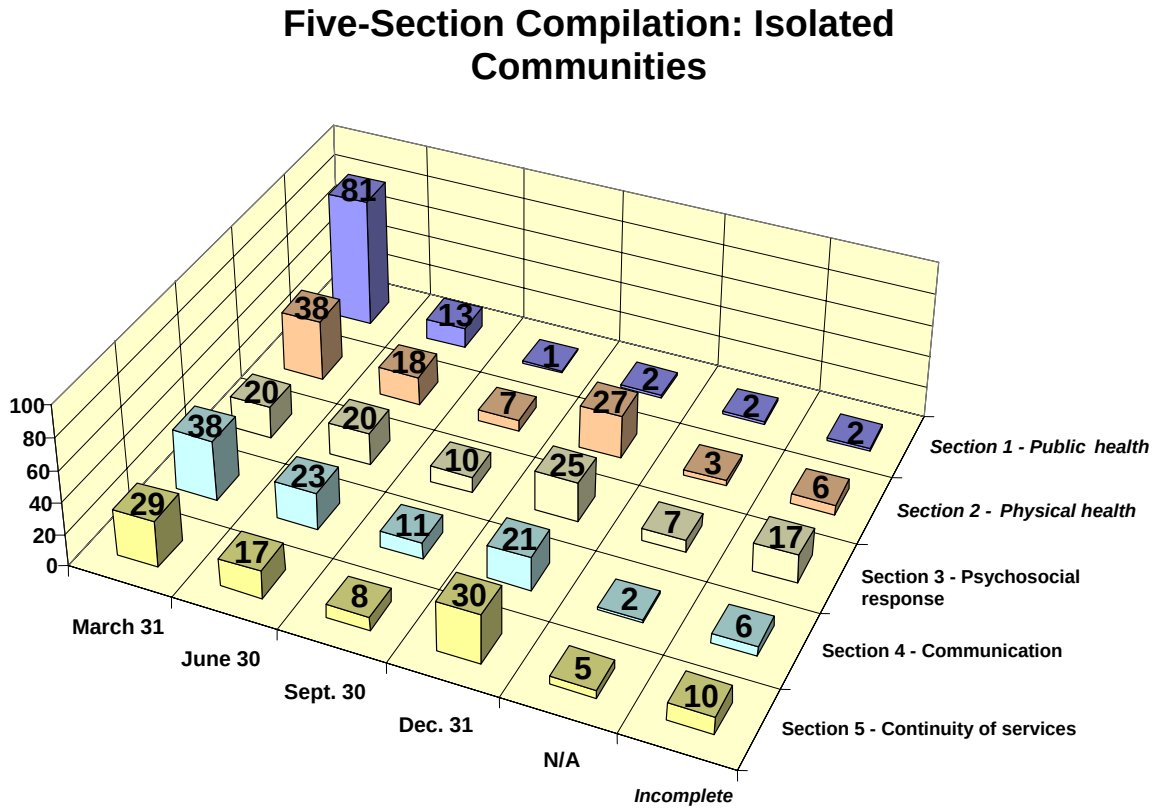


Figure 13



Figures 11, 12 and 13 illustrate the situation in non-isolated, semi-isolated and isolated communities. The latter seem to perform better than the rest in the area of public health. The semi-isolated communities are particularly weak in three areas: psychosocial response (8%), continuity of services (12%), and physical health (28%). Paradoxically, the isolated communities perform better than the rest overall, especially as regards public health (81%), with the semi-isolated communities seeming to be less well prepared.

Figure 14

Five-Section Compilation: Communities with Fewer than 500 Residents

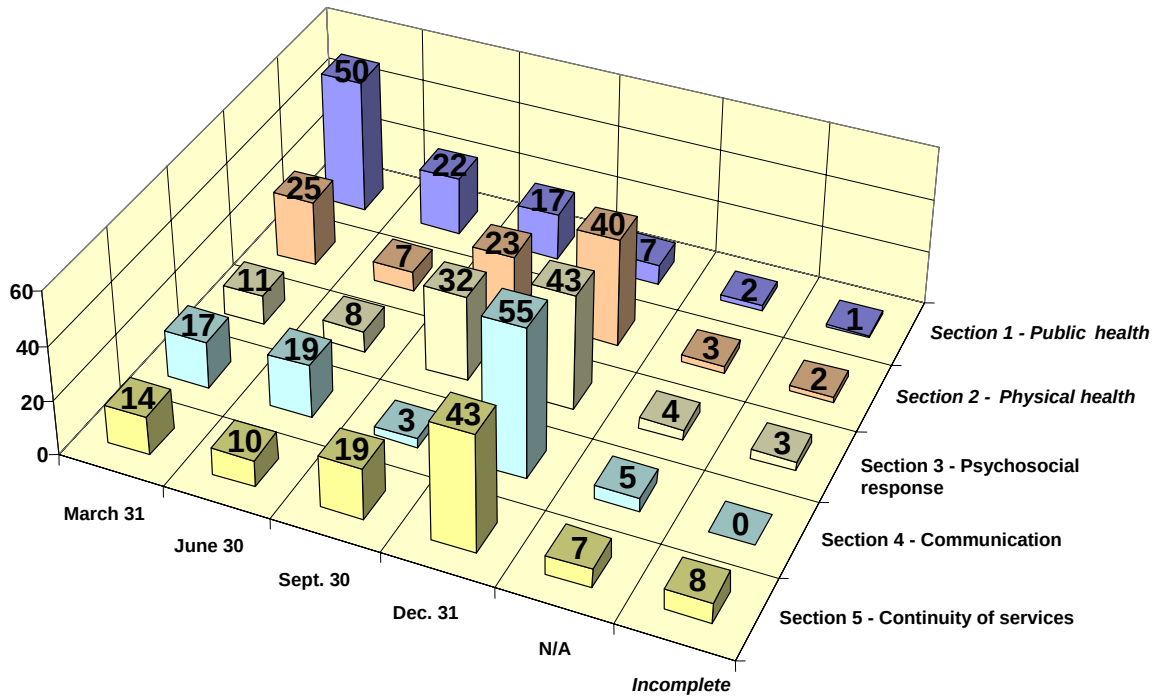


Figure 15

Five-Section Compilation: Communities with 501 to 1,000 Residents

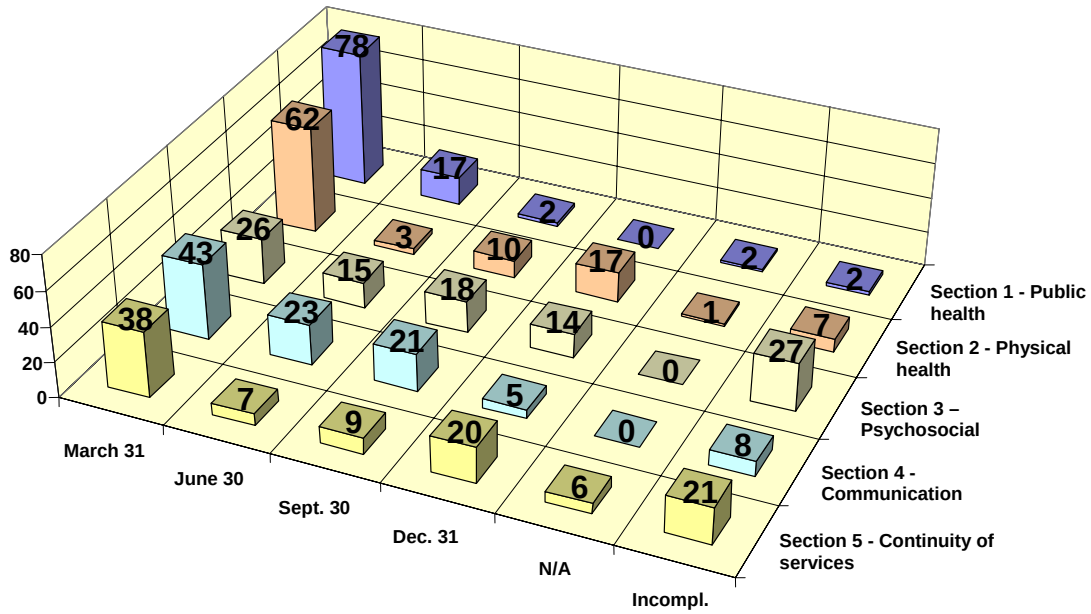
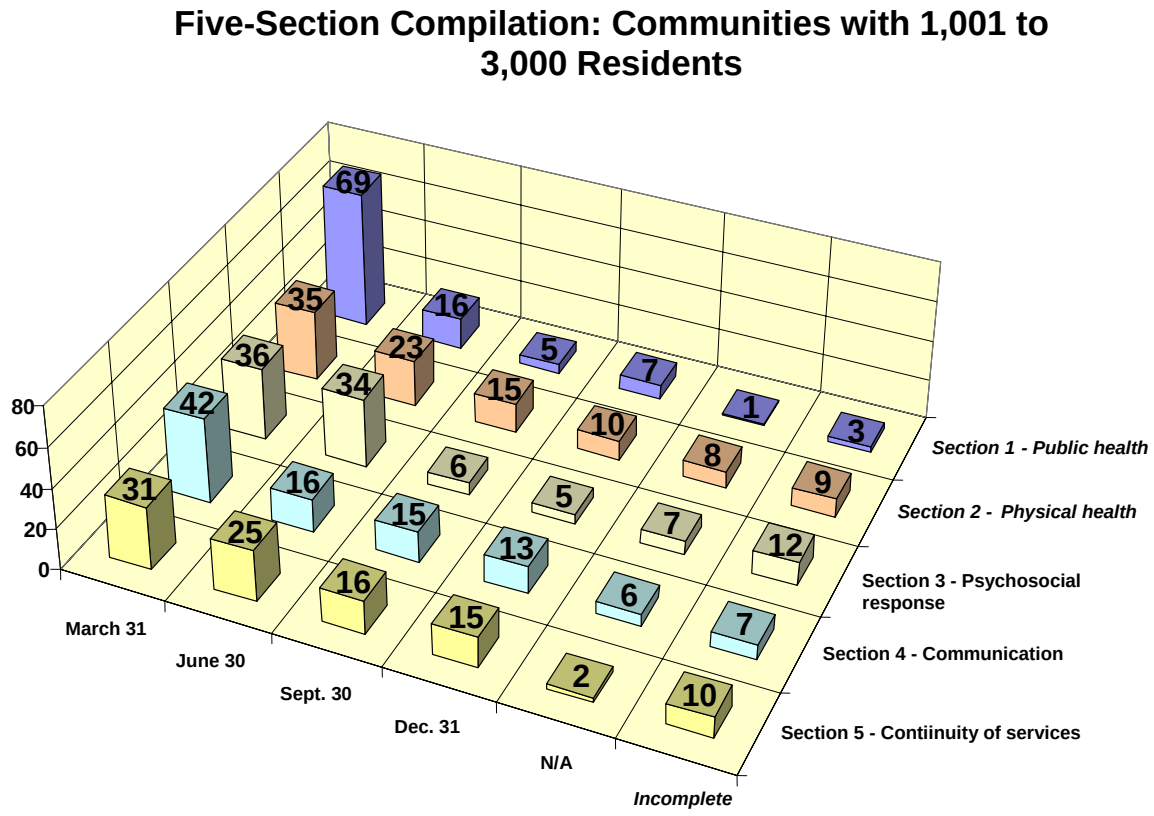


Figure 16



When comparing the data from figures 14, 15 and 16, we observe a significant difference in all sections for communities of fewer than 500 people; preparedness here is clearly lower than that for the other communities, especially as regards psychosocial response (11%).

2.1.3 Observations on Community Preparedness

Over the course of the study, we realized that the *Framework* fully covers the public health and physical health sections, partly covers communication and continuity of services, and does not really touch on psychosocial response. The division of responsibilities between Indian and Northern Affairs Canada and Health Canada is reflected in the FN preparedness process, and creates a dichotomy (public health and physical health on one hand, and psychosocial response and the all-hazard emergency measures plan on the other). This leaves communication and continuity of services, which seem to occupy a kind of a grey area.

As the return rate for completed questionnaires was 66% (2/3), this seems sufficient to identify a significant trend in the findings. At the time this report was being drafted (May 16, 2007) ten communities out of 30 had still not replied—a puzzling state of affairs possibly explained by the fact that, either no one has yet been appointed to coordinate pandemic preparations in these communities, or the latter are not prepared and preferred not to respond. Some of those that did reply mentioned they found the Checklist helpful, and will use it to monitor their preparation-process schedule. From an evaluation viewpoint, we must consider the non-responding communities either to lie within the average range or to be even less prepared than those that did reply.

We must also mention a few study biases. First, the fact that the latest possible response choice was December 31, 2007: A high level of responses for that date would seem to indicate problems with preparedness. Anther bias, inadvertently introduced in the cover letter, may also have influenced response time and rate, as the letter stated the questionnaire was intended for "non-transferred" rather than "non-Agreement" communities. However, we turned this bias into an opportunity to send out reminders (by fax).

For all aspects except public health, the results are poor to very poor. We compared the results from **Figure 3** with those of a qualitative evaluation via semi-structured telephone interview conducted by FNQLHSSC headquarters in August 2006. Of the 29 communities reached, nine had no plan, 11 had a plan pending or half-finalized, and nine had a plan that was ready or almost ready. Despite the disappointing findings for the four sections involved, therefore, we feel there still has been an improvement since August 2007.

Several of the results are significant:

- ⇨ All communities examined (i.e., 20 out of 20) have appointed someone to take charge of the pandemic action plan; of those same 20, 19 have designated someone to be responsible for the all-hazard emergency measures plan. Paradoxically, the nearer one gets to the local level (CSSS plan) in relation to the provincial (MSSS plan) and regional levels (ASSS plan), the less often communities have actually received the plan, thus giving rise to doubts about the quality of information to which FN communities have access at the local level.

- ⇨ Public-health preparations appear adequate, but Anglophone communities need to be monitored.

- ⇨ Preparations in the areas of psychosocial response, communication and continuity of services are lacking everywhere; this is not surprising, as these sections received little or no coverage by the FNIHB, given the division of responsibilities established between INAC and the regional FNIHB offices. ASSS psychosocial-response support should be re-examined in the future.

- ⇨ Coordination with the all-hazard emergency measures plan is poor for all sections; the AFNQL, the FNQLHSSC, INAC and the regional FNIHB offices should consider taking joint action in this regard.

- ⇨ The low rate of positive responses on the two indicators for information transmitted by the ASSS—i.e., the Manager's Toolbox and 2007 – 2008 Planning Program—tends to demonstrate the importance of sending out information directly from the ASSS to the First Nations local level, rather than via a third party such as the CSSS. The latter method prevents the FN from receiving information in real time and being taken on board at the same time as the CSSS.

- ⇨ Another factor that deserves serious thought is the development and maintenance of competencies (question 119), which forms part of the continuity of services section—here, positive results stood at only 16%!

- ⇨ Liaison with partners (ASSS, CSSS, FNQLHSSC, HC, INAC) should be re-examined (questions 87 – 92).

- ⇨ Surprisingly, if we look at the findings as at March 31, the isolated communities were better prepared than the semi-isolated ones, in all respects.

- ⇨ The semi-isolated communities appear the most vulnerable.

- ⇨ Obviously, those communities with a population of fewer than 500 are particularly vulnerable, and should be given priority.

In conclusion, while one can probably state matters had improved between August 2006 and March 31, 2007, it is impossible to quantify that improvement. Preparedness levels are satisfactory as concerns public health, lacking in the areas of physical health and communication, and extremely dissatisfactory with respect to psychosocial response and continuity of services.

Much work remains to be done as regards coordinating pandemic action plans with all-hazard emergency response plans.

Communities with fewer than 500 residents and semi-isolated communities should be given priority.

Lines of communication among the ASSS, CSSS and FN health and social services should also be reviewed, so as to respect the latter's autonomy and give them a chance to prepare at the same rate as the CSSS.

It seems clear that concerted action by INAC, the regional FNIHB offices, the FNQLHSSC and the AFNQL is needed to provide FN health and social services with integrated measures, so that program silos do not prevent their needs—and those of their clients—from being met.

2.2 RESPONSIBILITIES OF FIRST NATIONS ORGANIZATIONS IN A PANDEMIC CONTEXT

As we saw earlier, the *Indian Act* grants FN communities a certain number of powers to organize and implement political, social and economic activities within their geographical

boundaries. However, most such activities cannot be conducted without taking into account a much larger context. For example, as regards health and social services, the problems faced by a given FN community are often similar to those of other Aboriginal communities, given that their circumstances differ significantly from those of the rest of Quebec. This is also true with respect to economic development, employment, and environmental protection.

FN communities naturally hope to find common solutions that reflect Aboriginal realities and can be implemented accordingly. To that end, several non-profit organizations have been established over the years by member nations of the AFNQL. The community support provided by these agencies is indispensable. It might also be adapted to a pandemic context, as long as the communities are given the necessary resources and the federal and Quebec governments agree to work with them in this regard.

With respect to the pandemic action plan, the participation of two such organizations is vital: the AFNQL Secretariat and, more particularly, the First Nations of Quebec and Labrador Health and Social Services Commission.[63] After taking a brief look at the former, we will focus on the latter and its mission, which is directly related to the preparations and action involved in dealing with an apprehended influenza pandemic.

2.2.1 Assembly of First Nations of Quebec and Labrador

2.2.1.1 Legal Status, Powers and Responsibilities

The AFNQL Secretariat is a non-profit organization in charge of representing the interests of all Quebec and Labrador Aboriginal communities. It is a legal, unincorporated entity that exists tacitly as an administrative association for which representatives from the AFNQL's 42 communities act as voting members.[64]

The Secretariat administers the government consultation and operating funds provided to the AFNQL, and coordinates the activities of various boards. It should be noted here that this central coordinating role is not based in law, but exercised by the Secretariat for reasons of administrative efficiency and because of the considerable legitimacy it enjoys within FN communities and Aboriginal organizations.

The Secretariat is divided, on a fairly informal basis, into two branches: a policy bureau, represented by the Regional Chief, and an administrative bureau, which reports to the latter's political attaché.[65] The Regional Chief acts, in particular, as AFNQL spokesperson with Aboriginal and non-Aboriginal governments at the federal and international levels. He or she also plays same role with the AFN Executive Committee on the national scene, and

[63] Hereinafter referred to as the FNQLHSSC or the Commission.
[64] This type of association exists legally under paragraph 2, 2186 and articles 2267 and ff. of the *Civil Code of Québec*, S.Q. 91 c. 64. Source: Nadir, André, Legal opinion submitted to the AFQNL on February 22, 2005 (internal document) 4 - 5 and 10 - 11.
[65] Ibid., Nadir André, 4.

has a number of health-related responsibilities.[66] The political attaché assists the Chief and acts as the Secretariat's executive director,[67] supervising the work of a number of staff in charge of various issues (for example, public safety, which includes activities to support communities in preparing their all-hazard emergency measures plan).

2.2.1.2 Specific Pandemic-Threat Responsibilities: The All-Hazard Emergency Measures Plan

The AFNQL considers it paramount that every Aboriginal community have an effective, operational all-hazard emergency measures plan, as such a plan will make it possible to mitigate the harmful effects of an apprehended pandemic on community socio-economic activities while helping community health and social services implement the required measures.

Given its legitimate role as a coordinating body, the AFNQL Secretariat received a proposal from INAC in 2006 aimed at making it responsible for coordinating all activities involved in updating FN community all-hazard emergency measures plans.[68] The AFNQL agreed to assume this role, and put someone in charge of the matter in February 2007. In addition to ensuring coordination for their all-hazard emergency measures plan, the Secretariat will also be assisting the communities in establishing a business-continuity plan.[69]

2.2.2 First Nations of Quebec and Labrador Health and Social Services Commission

2.2.2.1 Legal Status, Powers and Responsibilities

Legally separate from the AFNQL, the FNQLHSSC is a tacit association created in 1994 by the Assembly of Chiefs of the First Nations of Quebec and Labrador.[70] Its mission is to "improve the physical, mental, emotional and spiritual well-being of First Nation and Inuit individuals, families and communities in respect of their local autonomy and culture by helping communities that wish to initiate, develop and promote comprehensive health and social programs and services as designed by First Nations and Inuit organizations recognized by the First Nations and Inuit".[71]

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[66] Online, http://www.affairesautochtones.com/contenu/gouvernements/gouvernements_AFQNL.html.
[67] Nadir, André, Legal opinion submitted to the AFQNL on February 22, 2005, 4.
[68] See FNQLHSSC, Summary of the Health Directors' Meeting of August 22, 2006: Pandemic (internal document) 1; also, internal memo of August 3, 2006 from the FNQLHSSC's health coordinator to three members of the FN health and social-service directors' pandemic task force.
[69] Minutes of the inter-departmental meeting on influenza pandemic preparations held at 1:30 p.m. on January 16, 2007 in the Quebec City INAC offices; personal notes on the inter-departmental meeting held at 1:30 p.m. on May 8, 2007 in the Quebec City INAC offices.
[70] Resolution 3-94. Like the AFQNL Secretariat, the FNQLHSSC is governed by article 2186(2) and articles 2267 and ff. of the *Civil Code of Quebec*. In addition, although not incorporated, it is entered in Quebec's business register.
[71] FNQLHSSC, Charter and By-Laws, June 1997 (hereinafter referred to as the Charter), article 3.

It also acts in an advisory capacity, consulting with FN communities and the Assembly of First Nations of Quebec and Labrador in matters of health and social services.[72]

The FNQLHSSC has several goals, including, in particular, to provide First Nations and Inuit organizations with technical support for health and social services, innovative and traditional practices, research, development and training, at the request of FN communities.[73] It also ensures that the government-service delivery system takes account of Aboriginal peoples' basic needs,[74] and promotes the exchange of information and ideas on all aspects of health and social-service development initiatives.[75]

The FNQLHSSC is headed up by a board of directors, with day-to-day management ensured by a management committee, a program-delivery manager, and administrative-support services. Its structure reflects the four main programs it administers: health services, early-childhood services, community social services, and the social-development office. Apart from its finance and development (research and information technology) departments, the FNQLHSSC also has an executive secretary and a communication expert. This well-structured organization, which boasts almost 40 employees, is funded mainly by INAC and Health Canada, and, to a much lesser extent, by the MSSS.

2.2.2.2 Special Pandemic-Threat Preparations and Response Responsibilities: The Health Mission

Established in 1994, the FNQLHSSC has been operative since March 1995, or more than 12 years. The arguments in favour of establishing the Commission mentioned at the founding meeting testify to the concerns of all member Aboriginal communities:

- The desire to <u>better identify and call attention to their health and social-service concerns</u>
- The determination to <u>adopt a consistent approach</u> in identifying, coordinating and defending community stances on health and social services
- The need to <u>eliminate the confusion surrounding initiatives of the two main levels of government</u>, which are often taken without consulting the communities beforehand
- The determination to <u>establish a dialogue capable of enhancing awareness</u> of First Nations problems and to implement the measures required to solve them
- The need to <u>deal with a growing government technological infrastructure that is increasingly demanding</u> in terms of accountability.[76]

These are the same reasons for which FN community health and social-service directors asked the FNQLHSSC to play an active role in supporting FN communities in their efforts to prepare for an apprehended influenza pandemic.

[72] Ibid., art. 5.
[73] Ibid., art. 4(2).
[74] Ibid., art. 4(3).
[75] Ibid., art. 4(4).
[76] See FNQLHSSC, *Plan d'action 2003-2008*, Annexe - Plan opérationnel (September 2002) 7.

At the directors' meeting of August 22, 2006—a meeting also attended by representatives of the AFN, the AFNQL, Health Canada (regional FNIHB offices), INAC and the MSSS—the FNQLHSSC submitted the findings of a telephone survey conducted a few days previous, which showed, as mentioned above, that, of the 29 communities involved, only nine had a plan that was ready or almost ready. The FNQLHSSC emphasized the need for greater preparedness, and the communities unanimously supported the FNQLHSSC's motion to find the required funding and take charge of coordinating related activities and clarifying stakeholder roles and responsibilities.[77]

That support motivated the FNQLHSSC's board of directors to create a coordination unit, and to specify its role as follows:

> "The coordination unit, which will be particularly active in the pre-pandemic (preparation) phase, shall:
>
> 1- ensure that all communities have a pandemic action plan;
>
> 2- ensure that all communities can update their emergency measures plan (by working closely with the AFNQL);
>
> 3- assist the communities in developing and verifying their emergency-measures and pandemic-action plans;
>
> 4- inform the communities on the pandemic, and help mobilize them accordingly;
>
> 5- ensure that healthcare personnel from all communities have access to training on the influenza pandemic;
>
> 6- ensure communication among stakeholders;
>
> 7- promote links between health agencies/health and social-service centres and any interested FN communities;
>
> 8- ensure that all communities are consulted in the process of developing regional plans (health agencies/health and social-service centres)." [78] [TR:]

In addition to support from the directors, the FNQLHSSC also receives financial assistance from regional FNIHB offices, INAC, and the MSSS in connection with the First Nations Socioeconomic Forum action plan.[79]

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[77] FNQLHSSC letter of September 27, 2006 to Health Canada and Quebec's Department of Health and Social Services re a request for funding for coordinating influenza pandemic preparations (see Appendix A). Also, FNQLHSSC, Summary of the Health Directors' Meeting of August 22, 2006: Pandemic (internal document) 4.

[78] FNQLHSSC, letter of September 27, 2006 to Health Canada and Quebec's Department of Health and Social Services re a request for funding for influenza-pandemic preparation coordination (see Section 2.3 above).

[79] See *supra*, notes 33 and 37. The MSSS has also earmarked $60,000 for the FNQLHSSC for coordination and liaison between FN communities and the Quebec health network.

To carry out this role as effectively as possible, the FNQLHSSC decided first to perform an in-depth evaluation of community preparedness; the results of that assessment appear in section 2.1.2 above. However, as concerns the FNQLHSSC's own pandemic action and business-continuity plans, most of the work still remains to be done. The same is true for the AFNQL Secretariat and other Quebec Aboriginal organizations. On the basis of the observations in this chapter, we will now discuss a certain number of useful recommendations and their underlying analyses.

3.0 PROVIDING FN-COMMUNITY MEMBERS WITH PROTECTION COMPARABLE TO THAT ENJOYED BY RESIDENTS OF QUEBEC LOCAL MUNICIPALITIES: RECOMMENDATIONS

3.1 MAKING THE COMMUNITIES CAPABLE OF DEALING EFFECTIVELY WITH A PANDEMIC

3.1.1 Developing an Integrated Action Plan to Implement Government Programs

Given the findings of the community survey, it would seem that, except for the area of public health, a major effort will be needed this year to satisfactorily improve preparedness. The challenge consists, not only in freeing up the human and financial resources needed to reach that objective, but also in using those resources with a view to optimizing outcomes in the field, within the communities. Given the paucity of their structure and means, the latter can hardly be expected to rectify government-partner administrative inconsistencies on their own.

While it must be recognized that the regional FNIHB and INAC offices are not responsible for decisions made by their respective central headquarters, those in charge of both departments should agree on the need to better plan program implementation via a Quebec-wide action plan. As community delegates, the FNQLHSSC and AFNQL Secretariat would help develop such a plan, notably by using the preparedness database discussed in the last chapter. This tool could prove useful in identifying communities that, considering their level of preparedness, require special support for program implementation. It would also make it possible to determine which communities are sufficiently prepared to take part in more advanced training programs (to be implemented gradually, in keeping with community levels of preparedness).

***Recommendation 1*: THAT the FNQLHSSC and the AFNQL Secretariat ensure that a Quebec-wide integrated action plan is developed to support the implementation of federal pandemic action programs. This plan would be established jointly by Health Canada (regional FNIHB offices), INAC, the MSSS, the FNQLHSSC, and the AFNQL Secretariat.**

3.1.2 Developing an Action Plan to Support FN Communities

Some of the observations in the last chapter imply the establishment of action priorities to offset certain shortcomings in community preparedness. Accordingly, the FNQLHSSC, in cooperation with the AFNQL Secretariat, should develop an action plan to identify which communities or categories thereof will require priority support over the next few months as regards the Health Mission, the all-hazard emergency measures plan, and the business-continuity plan. The survey database should be used to better target those communities that need pandemic-preparedness support. In order to establish a more accurate picture of the situation, the communities that did not complete the poll should be re-contacted; this would also provide an opportunity to verify if the omission was due to a lack of preparedness or some other reason. The communities in question should then be asked about the form support should take, on what aspects it would bear, and what FNQLHSSC and AFNQL resources would be required.

As concerns the Health Mission, the communities concerned and the regional FNIHB offices will still have to be consulted to determine the type of support the latter intend to provide, so as to prevent useless duplications of effort.

***Recommendation 2*: THAT the FNQLHSSC and the AFNQL Secretariat develop a joint action plan to identify the communities or categories thereof that should receive priority support over the next few month, for the Health Mission, the all-hazard emergency measures plan, and the business-continuity plan. That action plan would cover the period from 2007 to 2009.**

3.1.3 Emergency Plan Harmonization

As mentioned occasionally in the previous chapters, pandemic action requires the collaboration of various organizations, which must work together to be able to take efficient measures. Although they all have the same goal—i.e., the safety and well-being of the public, as well as the maintenance of institutional and socio-economic structures—the civil-protection systems of Quebec and Canada are organized differently, and require special coordination and cooperation mechanisms if they are to be effective.

In the case of FN communities, the need for close links with neighbouring municipalities and Quebec government organizations is even greater, as they must all act together to take specific measures. Since the communities will most often need help from those municipalities and organizations, and the latter are already operating within a well-established system, the communities will have to make a greater effort to tailor their action plans to those of their local and regional partners. Indeed, as regards such plans, local municipalities and government agencies do not enjoy the same degree of autonomy as the FN communities. The *Civil Protection Act*, the *Fire Safety Act* and other Quebec laws govern the objectives, structure, and planning and operating terms and conditions of these organizations. As a result, the FN communities will have to ensure their plans are better harmonized in order to be able to coordinate them properly with those of their Quebec partners.

Accordingly, the FNQLHSSC and the AFNQL Secretariat should exercise clear leadership by ensuring that existing and future INAC and regional FNIHB office programs on the development or updating of pandemic health-mission action plans, all-hazard emergency measures plans and business-continuity plans provide for the harmonization, not only of plan contents, but also of these plans with the Quebec civil-protection model (guidelines, terminology, organization, operating procedure, etc.). Such harmonization should also extend to stakeholder training and related documentation and information. Moreover, the budgets needed to ensure plan-content and stakeholder-training harmonization would have to be added to program allocations, and the proposed measures would naturally have to be custom-tailored to FN communities' distinctive cultural, social and administrative characteristics.

***Recommendation 3*: THAT the FNQLHSSC and the AFNQL Secretariat exercise clear leadership by ensuring that existing and future INAC and regional FNIHB office programs on the development or updating of pandemic health-mission action plans, all-hazard emergency measures plans and business-continuity plans provide for the harmonization, not only of the contents of such plans, but also of these plans with the Quebec civil-protection model. Such harmonization should also extend to stakeholder training and related documentation and information.**

***Recommendation 4*: THAT the additional budgets required by the FNQLHSSC and the AFNQL Secretariat to conduct harmonization activities be provided for in federal programs.**

3.1.4 Establishing New Regional Links Between Community Health and Social Services and the Quebec Health Network

Existing Situation

In connection with its action plan for an apprehended influenza pandemic, the MSSS is responsible for ensuring the protection of the entire Quebec populace, including First Nations and Inuit communities. This means that, in each region of Quebec containing an Aboriginal community, the latter's health and social services should be integrated into the local pandemic-action plan established by the CSSS. However, given FN communities' particular legal status and autonomy, this type of integration is not usually characteristic of the relations between the two entities.[80]

Although distinct healthcare institutions, nursing stations and health centres are similar to Quebec-network establishments should therefore be considered such. For this reason, community healthcare institutions and the CSSS maintain complementary links for the regular distribution of services at the local level. The former provide front-line care to community residents, while the latter supply the general and specialized services needed to complete those of First Nations institutions wherever necessary.

[80] In actual fact, HC/NS are simply considered agencies operating within CSSS boundaries, in the same capacity as a medical clinic, family medicine group, community agency or cultural community.

Under normal circumstances, this rather flexible model has the advantage of accommodating the autonomy of First Nations institutions and the unique identity of FN communities, while enabling residents to benefit from the general and specialized services available from the Quebec network. However, as regards the efficient implementation of Quebec's pandemic action plan in those communities, it is a less-than-optimal tool. Most First Nations healthcare institutions are located at the end of the service chain, and maintain few or no direct links with the agency serving their area. Several First Nations health-service directors would therefore not have access, at the same time as the CSSS, to the documentation and information they need to adequately prepare services (training programs, treatment protocols, ratification, etc.) for the five sections of Quebec's pandemic action plan. Any further setbacks occurring in the transmission of this information might result in even longer delays in readying stakeholders from community health and social-service bodies, especially since several of them must adapt and translate staff-training documentation and materials so the latter accommodate their unique cultural identity.

In this context, once phase four of the WHO[81] scale is reached, it will become extremely difficult for community health services to reach or even maintain a preparedness level comparable to that of the CSSS. However, this is essential if the residents of these communities are to enjoy a degree of protection that is at least equivalent to that provided by Quebec's health network. In order to rectify the shortcomings of the existing system, section 3.1.6 proposes various recommendations aimed at improving communication between and joint action by First Nations and Quebec health services.

With a view to truly integrating community healthcare institutions into local and regional influenza-pandemic action plans, it would appear vital to ensure their participation in the regional joint forums discussed above.

Participation in Regional Forums

Regional forums allow healthcare institutions from a given area to periodically meet with regional-agency representatives to take stock of progress made in implementing their activity programs with respect to a given section of the pandemic action plan. They also constitute an opportunity for discussing problems encountered or anticipated, making it possible to consider specific dimensions and examine appropriate solutions. It is paramount that all First Nations healthcare institutions be invited to attend on a regular basis, so as to establish and maintain closer ties with other area organizations. In so doing, they will be able to better monitor developments in regional and local pandemic action plans, while making representatives of the regional agency and area institutions aware of the impact certain measures could have on services for FN communities.

These forums would definitely promote a better understanding of the administrative structure of FN-community health and social services by those in charge of regional agencies and Quebec health-network institutions, as well as enabling network partners to better take account of the geographical, social and cultural constraints experienced by FN community healthcare institutions. The organization of regional pandemic influenza plans

[81] See *supra*, p. 5, Table 1.

(RPIPs) and local pandemic influenza plans (LPIPs) could then be better tailored to the needs of FN communities.

***Recommendation 5*: THAT the MSSS ensure that all First Nations healthcare institutions be invited to attend regional forums on a regular basis, in order to establish and maintain closer ties with other area organizations.**

Participation in Regional Pandemic-Preparedness Activities

The participation des First Nations healthcare institutions in regional forums would not in itself solve the former's communication and information problems with respect to the Quebec health network's pre-pandemic-preparedness activities. Indeed, to keep pace with CSSS member institutions and participate effectively in local and regional plans, FN community healthcare institutions must also be on the intranet distribution list used by the regional agency to transmit information to the CSSS. It should be noted here that, in case of a pandemic, the CSSS would intervene only to complement the services provided by First Nations institutions. Consequently, it is just as important that FN community nursing stations and health centres receive useful information at the same time as the CSSS, since they constitute healthcare institutions with the same responsibilities—i.e., serving a given community and area, as concerns all Health-Mission sections.

For the same reason, HCs and NSs must also be invited to take part in all regional pandemic action-plan training, ratification, protocol, and other activities organized by the agency in which other area institutions take part.

Furthermore, in case of a pandemic, the establishment of these new coordination and joint-action channels would enable the First Nations communities (FNC) to themselves tailor their all-hazard emergency measures plan to the needs of their healthcare institutions. Local and regional coordination between the communities and Quebec's Civil Protection Plan (QCPP) – Health Mission would thus be improved.

Figure 17 (see next page) illustrates the new communication links discussed previously, as well as those proposed to ensure better coordination between the First Nations and the Quebec plan.

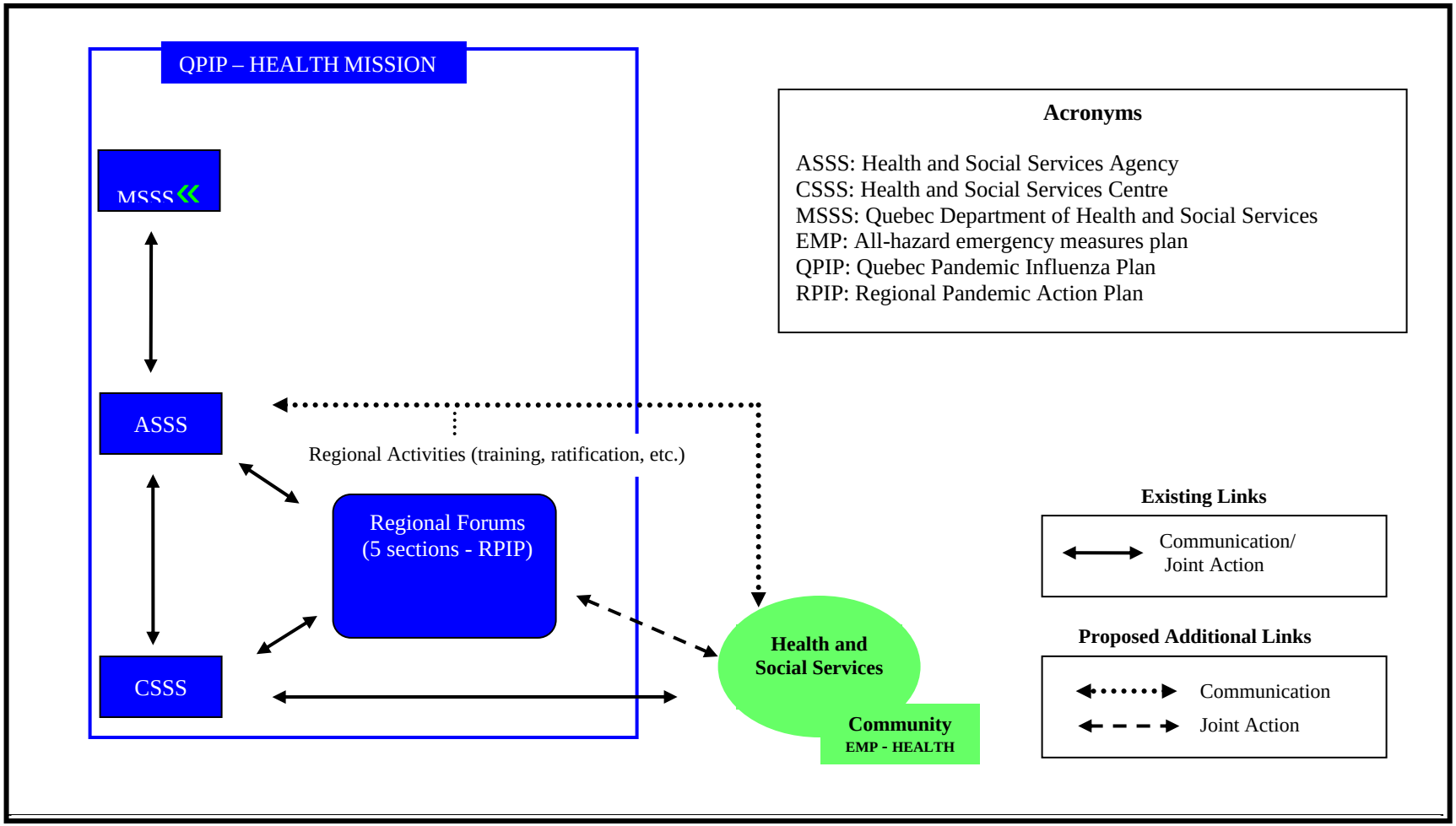
As regards everyday public-health regional directorate support for immunization programs, supply of vaccines, continuing professional development, epidemiological monitoring, etc., this First Nations HC/NS communication model already exists at the provincial level.

With respect to other sections of the Regional Civil Protection Plan – Health Mission, proof of the efficacy of the proposed model can be seen in the case of at least one community: Wendake.

***Recommendation 6*: THAT the MSSS ensure that FN community health and social-service institutions be put on the distribution list used by the regional agency to send information to the CSSS.**

<u>Recommendation 7</u>: THAT the MSSS ensure that FN community healthcare institutions are invited to take part in all regional pandemic action-plan training, ratification, protocol, and other activities organized by the regional agency in which other area institutions take part.

FIGURE 17: QUEBEC PANDEMIC-INFLUENZA ACTION PLAN: EXISTING AND PROPOSED LINKS BETWEEN FN-COMMUNITY HEALTH AND SOCIAL SERVICES AT THE REGIONAL AND LOCAL LEVELS



3.2 CONSOLIDATING THE FNQLHSSC'S PANDEMIC-ACTION PLAN ROLE WITHIN THE FIRST NATIONS AND VIS-À-VIS ITS GOVERNMENT PARTNERS

3.2.1 Recognizing the FNQLHSSC's Status as an Essential Stakeholder in Government Pandemic Action Plans

Several Quebec Aboriginal communities have experienced natural disasters, such as floods or forest fires, which have occasionally required the temporary evacuation of all residents. Faced with risks of this nature, which generally threaten only a small number of communities at a time, community officials and stakeholders are usually able to make the required decisions and organize response measures, if necessary, with the help of neighbouring municipalities and provincial and federal government authorities.

In the case of an apprehended influenza pandemic, however, the magnitude of the threat is such that the entire Native population of Quebec could be affected. Moreover, the complex nature of the phenomenon means that preventive and control measures necessitate the development of specific procedures that must be properly understood, not only by response personnel, but the general public as well. Finally, to limit the spread of the disease throughout Quebec and Canada, response management must be based on a top-down model,[82]as opposed to the usual bottom-up civil-protection model.

With the top-down model, FN community health and social services are the final links in the Quebec health-network's chain of decision, information transmission and service delivery. At the federal level, community health services receive financial and technical support from the regional FNIHB offices (Health Canada), with INAC providing financial assistance to social services. Support is thus based on a number of different programs, administered in parallel by these departments.

As mentioned previously, in the final analysis this situation duplicates the usual relations existing between FNC health and social services and organizations from both levels of government, obliging the communities to deal with several government players and to try to harmonize compartmentalized programs themselves. For example, we know that the Quebec pandemic action plan deals with five aspects of Health-Mission preparedness: public health, physical health, psychosocial response, communication and continuity of services. The financial and technical assistance provided by Health Canada up to March 2007 focused primarily on the first two areas,[83] whereas INAC has funded the development of psychosocial response training (via the FNQLHSSC). The communities have apparently not received any actual government support for the two other dimensions (communication and continuity of services); furthermore, they still do not know if they will obtain such support or, if it indeed is forthcoming, which government agency will provide the funding or what the terms and conditions will be.

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[82] Ministère de la Santé et des Services sociaux, *Quebec Pandemic Action Plan – Health Mission* (Québec: 2006) 19.

[83] It should be noted here that Health Canada's development of the *Framework* and a visit to the communities by a professional to explain the contents was not preceded by consultations with the FNQLHSSC to specifically identify the needs to be met relative to the Health Mission's five sections.

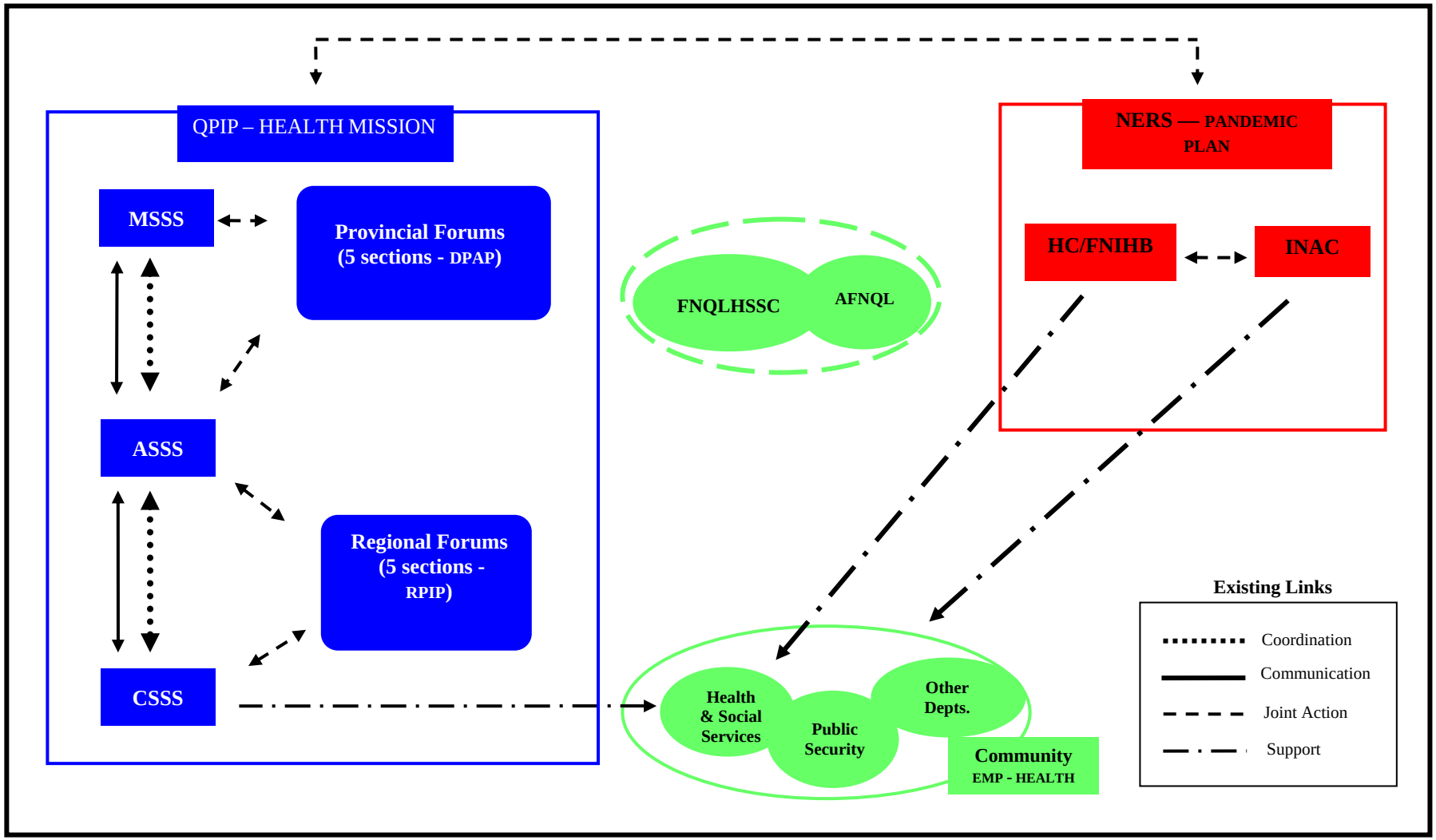
Under normal circumstances, the FNQLHSSC cooperates with interested communities to eliminate the confusion created by the existence of program silos, helping them tailor programs to their needs and specific cultural identity. The time involved in obtaining information and additional funding from departments and agencies does not usually prevent the FNQLHSSC and the communities from providing services designed to meet the specific requirements of First Nations peoples.

However, this procedure is completely ineffective in a pandemic context, as it is based on an exploded organizational structure incompatible with the requirements of the centralized coordination effort characteristic of major-disaster management. On one hand, there are the 32 (non-Agreement) communities that deal separately with the various government departments and agencies; on the other, the FNQLHSSC (and the AFNQL Secretariat), which lie outside the communication and coordination channels established by the federal and provincial governments in connection with their respective pandemic action plans. FNC health and social services do not benefit from such solid links; their relations with federal departments are distant and compartmentalized. For its part, the FNQLHSSC has not managed to establish truly supportive relationships with the communities in order to carry out its usual role, because it is not directly informed about government initiatives early enough on in the top-down pandemic decision-making process—i.e., before such initiatives are implemented in the communities.

Figure 18 (see next page) illustrates, not only the isolation experienced by the FNQLHSSC and the AFNQL Secretariat in relation to the federal and provincial governments, but also the lack of strong ties between FN communities and provincial and federal stakeholders (excluding the links with health agencies proposed previously). It also shows exactly why, at present, it is impossible for most First Nations communities to coordinate their own pandemic-preparedness activities.

While only the establishment of new communication links and forums will make it possible to attain the desired degree of coordination, before dealing with that dimension, we will now explore the pandemic-preparedness role played be the FNQLHSSC in greater detail.

FIGURE 18: LINKS BETWEEN THE FIRST NATIONS AND FEDERAL AND PROVINCIAL PARTNERS AT MARCH 31, 2007: PANDEMIC ACTION-PLAN PREPARATION PHASE



3.2.1.1 Coordination, Liaison, Support and Leadership

From the outset, we should emphasize that the FNQLHSSC's pandemic coordination role, as concerns both the preparation and response phases, can be played only in conjunction with the federal and provincial departments and concerned. However, there are certain dimensions the latter cannot cover, for a number of reasons: too many additional responsibilities of their own, action that is beyond the scope of their mission, unfamiliarity with the cultural and organizational circumstances of the FN communities, and the risk that such action would compromise the political autonomy of those communities.

One of the FNQLHSSC's main tasks would be **to ensure the monitoring of communication and joint-action channels at the local and regional levels**. The Commission would have to ensure that all Quebec health-network or federal-department information to be received by health and social services had actually been sent within established deadlines. If not, the FNQLHSSC would be responsible for pinpointing the reasons, and working with the government partners concerned to determine the appropriate solutions. Obviously, to effectively assume this role, the FNQLHSSC would have to be formally linked to federal and provincial departments and agencies, so as to obtain the necessary information. Proposals for the establishment of such links are discussed in Section 3.2.2.

Another FNQLHSSC task would be to provide community health and social services with **the support required to implement measures aimed at developing and implementing their pandemic action plans.** This support would consist in organizing services, developing operating procedures for the Health Mission's five sections, and implementing treatment protocols provided by the health agency. For interested communities, the FNQLHSSC could ensure compliance with recommended standards and practices; the establishment of rules and procedures; the organization of general services, physical plant and equipment; and the qualifications of staff assigned critical duties. It could also help assess progress made throughout the preparation process, and, to that end, help the FNC develop exercises and simulations with local and regional partners (community services, ASSS, CSSS, etc.).

Lastly, the FNQLHSSC could assume the role of catalyst and leader by **stimulating community participation** in pandemic-preparedness activities, via awareness-raising and information sessions, not only for health and social-service stakeholders, but also for all officials and other decision makers from the community in question. Obviously, public information sessions would also have to be held for area residents; such activities could be offered in cooperation with AFNQL representatives. In some cases, they could also be coordinated with regional representatives of provincial or federal government agencies.

Where applicable, the FNQLHSSC should monitor participation in regional forums and other such events by those in charge of community health and social services, making the individuals in question aware of the need to coordinate as closely as possible with the LPIP and RPIP, notably by taking part in regional health-agency activities and associated forums.

3.2.1.2 Gathering and Interpreting Information

As previously mentioned, pandemic-preparedness information received by the communities comes from a number of government sources, and is most often of a fragmented nature. Accordingly, if it is to be properly understood by community stakeholders with a view to planning future action, it must be organized coherently. **The FNQLHSSC could gather and interpret such information** provided it is able to rapidly obtain additional details on current or future measures taken by government agencies, and has access to useful scientific and technical data. The Commission would then submit that information to pandemic action-plan stakeholders from communities that so request, interpreting it in the appropriate context (i.e., taking account of the cultural specificity and unique political and administrative organization of the community in question).

Furthermore, FN health and social-service directors have already demonstrated their desire to share their respective experiences, so as to be able to implement original solutions from other communities.[84] The Commission could also gather and distribute such knowledge and practices among communities, thus promoting the gradual emergence of a civil-protection culture specific to the First Nations.

The FNQLHSSC would interpret information by taking measures to ensure that all documentation and information for FNC health and social-service agency stakeholders (and their alternates) is accessible in both official languages, and, where applicable, the ancestral language of the community. Il is essential that these stakeholders be able to properly understand the information sent them, and that language not constitute an obstacle in this regard.

The FNQLHSSC would be in an excellent position to carry out this mission, given that it can rely on qualified professionals whose main role is to ensure specific pandemic-action coordination and support until the threat is eliminated.

If the Commission is to play all these roles, certain links must be established among the various federal and provincial government organizations concerned; the purpose of such links would be to involve the FNQLHSSC and its partner, the AFNQL Secretariat, in Quebec and federal pandemic-action measures for FNC services.

3.2.2 Integrating FNQLHSSC Efforts into Interdepartmental Coordination Activities Affecting the First Nations

3.2.2.1 Proposed New Communication Links Between Quebec's Department of Health and Social Services and the FNQLHSSC

The implementation of recommendations 4 to 6 above on enhanced contact between Quebec health-network forums and lines of communication with First Nations healthcare institutions does not mean the latter will use them on a regular basis. To date, in fact, their

[84] See FNQLHSSC, Summary of the Health Directors' Meeting of August 22, 2006: Pandemic (internal document) 6.

autonomy has generally not favoured the maintenance of close links the Quebec network. Furthermore, the lack of management and professional staff in First Nations institutions has often resulted in human resources being "spread too thin", and could make their participation in additional activities problematic. Under these conditions, the existing scarcity of information may persist, adversely affecting preparedness. Accordingly, this would be an opportune time for the FNQLHSSC to get involved in the joint action and information-exchange process, with a view to supporting community healthcare institutions and establishing conditions favourable to improving pandemic action-plan preparations.

In order to complete the abovementioned local and regional liaison mechanisms, similar procedures should be established at the central level. More formal communication links between the Department and the FNQLHSSC should be created to give the latter rapid access to all information for use in its own preparations, as well as those of the communities it serves.

The FNQLHSSC's Participation in Provincial Forums

So it can keep apprised of proposed pandemic-action measures and action, determine the impact on FN communities and, where applicable, directly inform participants from the MSSS and regional agencies of any particular problems that could occur in implementing preparation measures, the FNQLHSSC should be invited to attend provincial forums. This would make Quebec's pandemic action plan more efficient.

If First Nations requirements are to be taken into account from the outset (i.e., at the same time as for most Quebec residents), it is vital that the FNQLHSSC be able to act as early on as possible in the decision-making process. The Commission could play a coordination and liaison role with MSSS staff concerning the situation of FN communities, passing on any of the latter's concerns. Its participation would facilitate relations between the Department and the regional agencies on one hand, and the First Nations on the other. It would also ensure the Department's decision-making process was more transparent. Figure 19 (page 59) illustrates the proposed relationship.

Furthermore, the FNQLHSSC could complete the information gathered by the AFNQL, making it possible to for the two bodies to establish a joint action strategy to support the communities regarding the five sections of the Health Mission and updates to their all-hazard emergency measures plans.

***Recommendation 8*: THAT the MSSS invite the FNQLHSSC to provincial forums attended by Department and regional agency-representatives, so as to keep the Commission apprised of proposed pandemic-action measures and action, determine the impact on the FNC, and, where applicable, directly inform participants from the MSSS and regional agencies of that impact.**

Establishing Formal Communication Links between the MSSS and the FNQLHSSC

To be capable of making its own pandemic preparations and maintaining its support activities with the communities, the FNQLHSSC must establish close ties with the MSSS. First, in order to rapidly obtain the latest pandemic-preparation data distributed to network institutions (and, eventually, those of the communities), it should have access to the electronic database of official MSSS documents available to the agencies. It should also directly obtain from the Department all documentation and information on regional pandemic-preparation activities sent to the regional agencies for subsequent distribution to the institutions.

The FNQLHSSC could monitor communication channels in the different regions, determining if community institutions were receiving the information and documents intended for them in a timely manner. Where problems inherent in the operation of the Quebec network occurred, the FNQLHSSC could report them to the Department and work with the latter on solutions. However, if the difficulties stemmed from the First Nations healthcare institutions themselves, the FNQLHSSC would have to assume a leadership role with community officials to make them aware of the requirements for preparing those institutions properly in the pre-pandemic phase and of the need to establish links with the Quebec network. The Commission could then take effective measures to coordinate pandemic action-plan preparation activities with the communities, while accommodating their political autonomy and the mission of government partners.

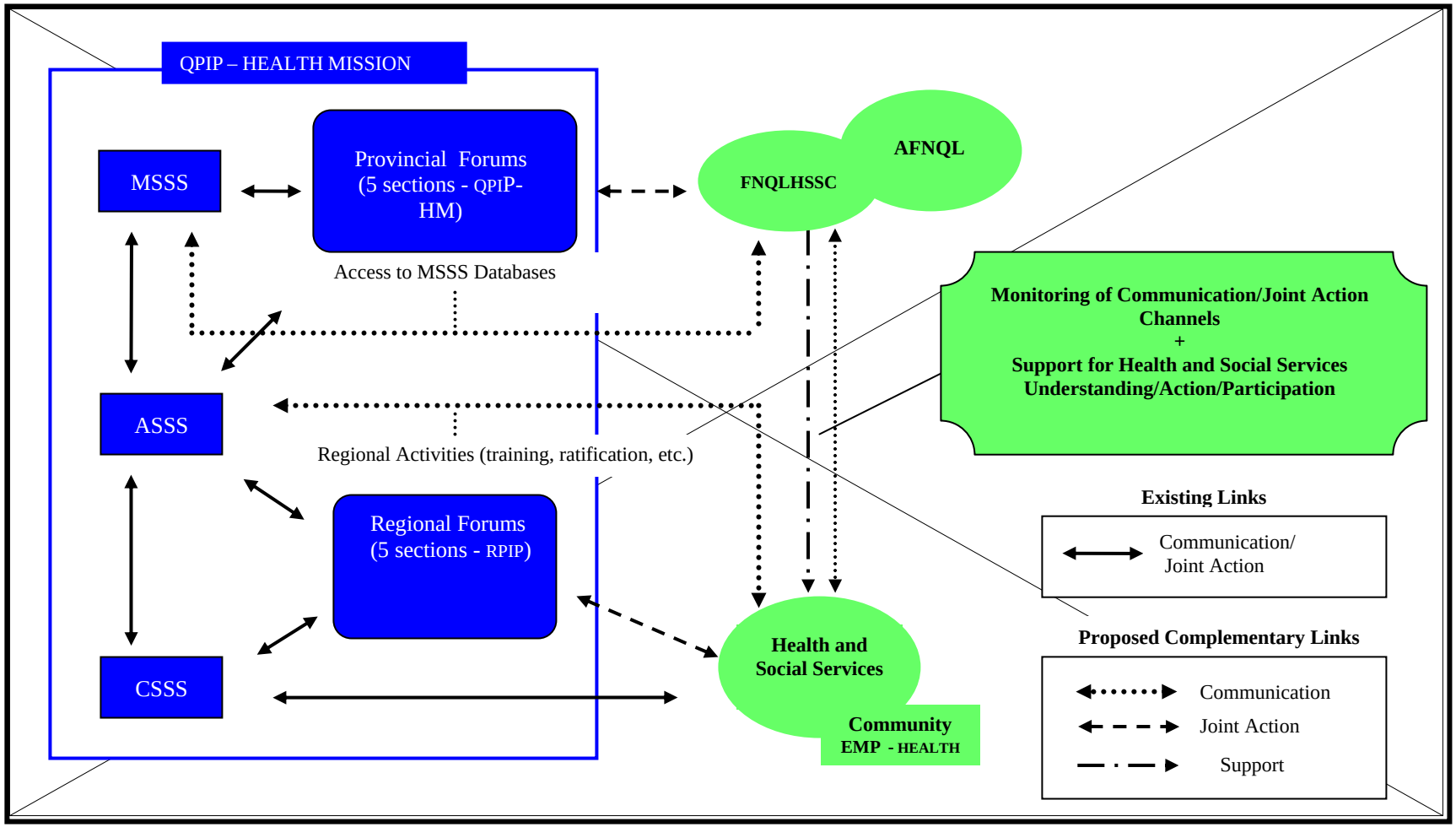
***Recommendation 9*: THAT the FNQLHSSC have access to the electronic database of official documents available to the agencies, or an equivalent solution, so as to be able to rapidly obtain the latest pandemic-preparation data distributed to network institutions.**

***Recommendation 10*: THAT the MSSS forward directly to the FNQLHSSC documentation and information on regional pandemic-preparation activities sent to the regional agencies for subsequent distribution to the institutions.**

3.2.2.2 Establishing Forums and Communication Links Early on in the Decision-Making Process

The links described previously between non-Agreement communities, the FNQLHSSC, and Quebec health-network agencies, if created, would establish an organizational framework conducive to a faster, more effective response from health and social services at the local level, enabling the FNQLHSSC to play its coordinating and support role with FNC. However, such a framework would not in itself allow the Commission to solve the problems created by program silos and the failure to take account of distinctive First Nations circumstances before decisions are made. There are two types of program silos: one corresponding to the gulf between the federal and Quebec governments, and the other, to disparities between the departments of a given level of government.

FIGURE 19: EXISTING AND PROPOSED LINKS BETWEEN THE FIRST NATIONS AND THE QUEBEC HEALTH AND SOCIAL-SERVICE NETWORK: PANDEMIC ACTION-PLAN PREPARATION PHASE



Creating an Intergovernmental Pandemic Action-Plan Forum

To mitigate the impact of the gulf between the federal and Quebec governments, an official pandemic-action plan forum composed of representatives of the MSSS, Health Canada (regional FNIHB offices), INAC, the FNQLHSSC and the AFNQL Secretariat could be created. This would, in actual fact, merely formalize the relationship that has existed among these organizations in the shape of *ad hoc* meetings.[85]

The role of this intergovernmental forum would be to enable the participating agencies to take stock of FN community preparedness and the steps taken by the Quebec government, the federal government, and Aboriginal organizations to ensure their support. It would constitute an auspicious arena for discussing the impact that new government pandemic-preparedness measures could have on Aboriginal communities and organizations themselves, and would allow the First Nations to be better informed on related Quebec government projects, action plans and implementation procedures.

Established for a proposed two-year period, this forum would make it possible to clarify and update the division of responsibilities among the stakeholders concerned as regards existing and future programs. At the same time, it could also act as a venue for discussion and the exchange of ideas, with a view to ensuring that all parties concerned share a common understanding of the measures or programs in question. This way, forum members could send out a unified message to the FN communities and their local and regional health-network partners.

Furthermore, given the extremely broad scope of the preparedness measures required, it would be more useful if the issues dealt with were not restricted solely to the Health Mission, but also included programs related to FNC all-hazard emergency response plans and business-continuity plans. Accordingly, it would be timely to invite a representative of Quebec's Department of Public Security Quebec (MSP) to discuss the procedures to be established in order to ensure optimal coordination of both types of plans with the province's civil-protection system, as concerns the RCMs and regional civil-protection organizations (ORSCs). To keep the process as efficient as possible, the MSSS and MSP could, in keeping with partner-identified priorities, participate on a rotating basis.

***Recommendation 11*: THAT the regional FNIHB offices and INAC take the necessary steps with the government of Quebec to formally establish an intergovernmental pandemic-action forum for 2007 to 2009. This forum would be composed of FNQLHSSC, AFNQL Secretariat, Health Canada (regional FNIHB offices), INA, MSSS and MSP representatives. Meetings would be held in Quebec City at least three times a year (winter, spring and fall).**

Creating a Pandemic Action Forum for the First Nations of Quebec and the Federal Government

As mentioned at the beginning of this section, there are also disparities between the departments of a given level of government. In the case at hand, the disparity that indubitably has the greatest

[85] At the instigation of Health Canada (regional FNIHB offices), two meetings on pandemic preparations, involving representatives of the regional FNIHB offices, INAC, the MSSS, the FNQLHSSC and the AFQNL Secretariat were held January 16 and May 8, 2007.

impact on FN communities lies at the federal level, and involves Health Canada (regional FNIHB offices) and INAC.

As stated earlier, funding for pandemic action in the non-Agreement communities is based essentially on programs administered by INAC and Health Canada. However, although these programs have complementary objectives and are implemented simultaneously, they are not the object of a truly joint approach.[86] In 2006, this situation was a source of confusion for the communities, with the result that the latter asked the FNQLHSSC to intervene to clarify the respective responsibilities of all partners, define action priorities, and make the necessary inquiries to obtain technical assistance and sufficient funding.[87]

Other pandemic-preparedness programs will soon be added. For example, in 2007-2008, INAC intends to focus on the updating of all-hazard emergency measures plans and initial basic training for community stakeholders. A second, more advanced training phase, as well as an annual emergency-plan updating mechanism, will then be put in place.[88] It is imperative that these initiatives be implemented in such a way as to be harmonized with Heath Canada's *Framework* and the five sections of the Health Mission; they must also take account of the regional organization of Quebec's civil-protection system, with a view to ensuring efficient coordination.

Given the significant influence of such federal programs on FNC preparedness, and as the FNQLHSSC and the AFNQL Secretariat have been mandated to assist the communities, a body formally bringing together these two organizations with their federal partners should be established. The creation of a special forum to that end would seem the best solution. Chaired by the FNQLHSSC, it would give members the opportunity to confer on federal pandemic programs and action plans, at least until the end of 2009. The contents of new programs would be explained, and the potential impact of any of these on other existing or planned programs would also be assessed and discussed, so that members could acquire a common understanding of the measures in question before they were implemented.

Gradually, the "First Nations of Quebec – Federal Government" pandemic forum would foster enhanced coordination of member action. It could become a venue where the First Nations and their federal partners jointly defined their respective responsibilities and identified their action priorities, providing the opportunity to establish a common action plan and timetable for the harmonized implementation of community technical-support measures, training, funding, etc.[89] This would make it possible to tailor Health Canada and INAC programs for all Aboriginal populations to the particular requirements of the FN communities of Quebec, taking account of the administrative organization of Quebec institutions. Additionally, if a joint communication strategy were to accompany the action plan, **the adverse affects on FN communities of federal-department program and responsibility silos would be reduced to a minimum**.

To maintain these cooperative ties between forum member organizations between meetings, uninterrupted communication links must be established among between the FNQLHSSC, INAC, and Health Canada (regional FNIHB offices), so the FNQLHSSC can obtain documents and

[86] See *supra*, section 2.1.1.
[87] See Summary of the Health Directors' Meeting of August 22, 2006: Pandemic (internal document).
[88] Meeting on pandemic preparations held on May 8, 2007, op. cit., note 63.
[89] The forum would thus constitute an ideal opportunity for implementing the measures suggested in the recommendations 1 and 3.

information on government pandemic-action initiatives as quickly as possible, thereby enabling the latter to assess, in a timely fashion, the impact on the five sections of the Health Mission and coordination with the all-hazard emergency measures plan. Similarly, the AFNQL Secretariat would have to be in constant contact with INAC, in order to evaluate the effects of government measures on preparations for community all-hazard emergency response plans (and business-continuity plans). Together, the two Aboriginal organizations could establish a common community-support strategy[90] and keep their federal partners apprised of their position via these same links. If need be, the FNQLHSSC could convene a meeting of the forum to allow First Nations representatives to state their views and attempt to establish a joint action plan with their federal partners.

Lastly, the proposed forum would constitute a venue conducive to eliminating differences of opinion, especially as regards relations between the communities and Quebec local and regional institutions.[91] During the work carried out by the intergovernmental forum, it would promote a common stance by the First Nations and their federal partners.

Recommendation 12: THAT the FNQLHSSC and the AFNQL Secretariat jointly propose to Health Canada and INAC that a pandemic action-plan forum, involving the First Nations of Quebec and the federal government, be formally established for the years 2007 through 2009. This forum would be chaired by a representative of the FNQLHSSC, and bring together AFNQL Secretariat, Health Canada (regional FNIHB offices) and INAC representatives. Meetings would be held in Quebec City at least three a year (winter, spring and fall).

Recommendation 13: THAT the regional FNIHB offices and INAC undertake to send to the FNQLHSSC and the AFNQL Secretariat all information on government programs and other initiatives related, to whatever extent, to pandemic action, before such information is sent to the communities.

Figure 20 (page 64) illustrates how the establishment of communication links and forums could eliminate the existing isolation (shown in Figure 18) of the FNQLHSSC and the AFNQL Secretariat. This model would allow these bodies to be part of an arrangement set up by the two levels of government to support FN communities. These measures would also give both Aboriginal organizations the opportunity to assist federal and Quebec departments prior to program implementation, as well as to complete the proposed links between FN communities and Quebec's regional health network. The First Nations would therefore benefit from a flexible structure that not only accommodated FNC political autonomy, but was also able to efficiently coordinate pandemic-preparation communication and support measures.

3.2.3 Implementing Pandemic-Preparation Measures within the FNQLHSSC and Other Quebec Aboriginal Organizations

The recommendations discussed so far in this chapter have borne on measures to be taken by the FNQLHSSC, the AFNQL Secretariat, and their government partners to create an organizational and functional framework that focuses more on community pandemic-preparation requirements. We will now complete that framework by identifying specific action to be taken by the

[90] Such as that proposed in Recommendation 2.

[91] For example, the Commission's determination to have communities establish direct links with regional health agencies and participate in regional forums (see recommendations 4 to 6, *supra*, section 3.1.4) is not yet truly shared by regional FNIHB office representatives.

FNQLHSSC to enable the latter to properly assist the communities, in particular the leadership role it assumes with other Aboriginal organizations.

3.2.3.1 The FNQLHSSC's Coordination Unit

In order to accomplish its mission (as described in Section 2.2.2.2),[92] in the fall of 2006,[93] the FNQLHSSC made to plans to create a coordination unit. Other than the development and implementation of a work plan for the Quebec region, this unit was to:

- act as liaison between the province, the federal government, and FN communities and agencies;
- clarify departmental roles and responsibilities, and ratify an agreement;
- work closely with the communities to update emergency measures and develop a pandemic action plan;
- give the communities the necessary technical support;
- develop a communication plan and the appropriate tools;
- provide health and other stakeholders with the required training;
- review and adjust materials;
- cooperate with other FNQLHSSC sectors.

While the creation of such an entity, as well as its respective duties, is still necessary, the evaluation of community FNQLHSSC preparedness shows just how broad such a mission would be. We believe the coordination unit should be composed, not only of a liaison officer, as initially suggested, but also at least one member from each of the following areas: health services, early-childhood services, social services, and the social-development office.

Working a few hours a month, these four individuals would be responsible, firstly, for forwarding information on each community concerned, so as to help the liaison officer identify the best strategies for use in all Health-Mission preparations. Also, in cooperation with the officer, they should determine which community-support role their particular sector would play in the event of a pandemic, and, at the same time, mobilize sector employees in that regard. They would also play a major role in developing and implementing the FNQLHSSC's business-continuity plan.

<u>Recommendation 14</u>: THAT the FNQLHSSC establish a pandemic-action coordination unit comprising <u>at least</u> one fulltime liaison officer and four part-time resources from the following sectors: health services, early-childhood services, social services, and the social-development office. The unit's main mission would be to help FN communities with their pandemic preparations and determine which services the FNQLHSSC would provide in the response phase.

Supporting FN Communities in the Preparation Phase

In keeping with Recommendation 2 above, the coordination unit's work plan would have to be harmonized with the proposed joint action plan for the FNQLHSSC and the AFNQL Secretariat.

[92] *Supra*, p. 43.
[93] FNQLHSSC, letter of September 27, 2006 to Health Canada and Quebec's Department of Health and Social Services re a request for funding for coordinating influenza-pandemic preparations (Section 2.4).

Subject to the priorities identified following an analysis of the survey findings entered in the database, the following items should form part of that plan:

- Additional steps must be taken to ensure that those communities that have not completed the questionnaire do so as quickly as possible.
- The most vulnerable communities, especially those with fewer than 500 residents, must be given priority for assistance.
- Beginning in the fall of 2007, in cooperation with the AFNQL, hold information and awareness-raising sessions for officials, service administrators, business executives and community organizations on the respective importance of the pandemic action plan - health mission, all-hazard emergency measures plan, and business-continuity plan
- Another assessment of community preparedness should be conducted in the fall of 2007.
- The FNQLHSSC must cooperate with the AFNQL to ensure that, as regards the communities, the pandemic action plan - health mission and the all-hazard emergency measures plan are properly coordinated. Accordingly, the FNQLHSSC should, together with the AFNQL, develop an exercise to help the communities furthest along determine their exact degree of preparedness, as well as the extent of consistency among existing emergency plans (including business-continuity plans).
- Given that all Health-Mission aspects have not, to date, been given equal support, the FNQLHSSC will have to put together a response kit, accompanied by training, for distribution to FN communities on psychosocial response.
- Work sessions should be held in the field specifically to help the FNC prepare adequately for the psychosocial-response, communication, and continuity of services sections of the Health Mission.
- In the areas of public health, physical health and psychosocial response, technical assistance such as clinical advice dispensed by health professionals will have to be provided to the communities.
- All useful preparedness information from government departments and agencies must be compiled and sent to the communities.

Clarifying Organizational Roles and Responsibilities

If many of the recommendations contained in this chapter are to be implemented, the coordination unit will have to:

- take steps with the federal and provincial departments concerned to establish the proposed forums and communication/information links;
- conclude formal agreements between the FNQLHSSC and the latter's government partners;
- assist FN communities in negotiating and concluding formal agreements with their local and regional partners;

- identify issues for discussion at provincial and regional sector-based interdepartmental meetings and by the aforementioned forums;
- prepare for, call a meeting of, and head up at least one forum three times a year;
- monitor the measures contained in local and provincial agreements to ensure they are properly implemented (especially those establishing channels at the local and regional levels to ensure the communities have access to information).

Supporting FN Communities in Case of a Pandemic

In a pandemic, the FNQLHSSC and AFNQL must assume responsibility for liaison and coordination with their government partners, so as to inform the latter of community requirements and ensure that the necessary measures are taken. Under such circumstances, the two organizations could:

- help develop a situation report (sitrep) that identifies information on FN communities;
- work with government partners to gather information on the status of those communities;
- direct community requests to the proper government agency, so as to simplify the coordination of aid and prevent duplications in the mobilization of resources;
- where applicable, ensure that a local resource (and an alternate) is available to translate or interpret, into English or the ancestral language in question, information for stakeholders received from the health network; if necessary, request assistance from the FNQLHSSC or a First Nations partner to provide this service.

Intervention by the FNQLHSSC in a pandemic situation implies the latter would be part of the community and government warning system. Accordingly, the Commission would have to be able to receive an alert from the MSSS or community concerned to activate its own deployment procedure.

Should a band council declare a local state of emergency, the FNQLHSSC would have to determine if the CSSS in question had been informed and was mobilizing the additional resources required; the AFNQL would do the same with the municipalities and government organizations taking part in local and regional pandemic action plans.

***Recommendation 15:* THAT the FNQLHSSC ensure it is incorporated into MSSS, regional FNIHB office, INAC and community warning procedures should a major emergency occur.**

Furthermore, in the event of such an emergency, in accordance with the type of disaster, FN communities are entitled to expect that INAC, the regional FNIHB offices, the FNQLHSSC and the AFNQL Secretariat would ensure an uninterrupted, 24/7 response service.[94] According to our data, INAC already provides this type of service, enabling community leaders to rapidly obtain support when it is required.

With a view to ensuring the implementation of efficient, better-integrated support in a major disaster, a response service involving the two organizations most concerned and most knowledgeable about the impact of this type of situation on FN communities (i.e., the FNQLHSSC and the AFNQL) should be created.

[94] Health directors of First Nations of Quebec communities demonstrated their desire to be able to rely such services at their meeting of June 12 and 13, 2007 held in Quebec City.

Recommendation 16: ***THAT the FNQLHSSC and AFNQL jointly establish an uninterrupted, 24/7 service for communities in case of a pandemic or other major emergency. This type of service would be in constant contact with INAC and the regional FNIHB offices. In the event of an influenza pandemic, this measure should be implemented as soon as phase four of the pandemic was declared.***

3.2.3.2 Training Stakeholders and Tailoring Services to the Special Social and Cultural Needs of FN Communities

The FNQLHSSC must be given all relevant information on health-network training activities conducted, even if they are not directly related to the pandemic, to be able to identify which could prove useful in improving existing qualifications and preparedness of community health and social-service agency stakeholders. Once the latter have been assessed, the FNQLHSSC could choose the most relevant and negotiate the agreements with the MSSS needed to tailor those activities. The additional budgets required for such adaptation, as well as their , would then be requested from INAC or Health Canada.

In Recommendation 3, we stated that the FNQLHSSC, in cooperation with the AFNQL Secretariat, should play a leadership role in harmonizing training and documentation on emergency plans intended for community stakeholders. Intervention by these organizations should not be limited solely to the training proposed by the federal government, but extend to that offered by various Quebec institutions—primarily those that have been certified by the Department of the Public Security. The advantage of these programs is they have been designed specifically to meet the needs of the province's civil-protection system, and would enable stakeholders to better understand that system, thus facilitating coordination with their municipal or governmental partners at the local and regional levels.

We believe it would be opportune to analyze these programs in order to determine if they would be useful to community stakeholders, and to establish which of those selected could be adapted to community needs. An adjustment and program could then be negotiated with suppliers, and, if conditions were reasonable, INAC could be asked to fund the project for two or three years.

This would enable FN communities to take advantage of the same training as that given to Quebec municipalities, and to reach, not only the objectives established for pandemic preparedness, but also those aimed at all risk categories. By facilitating coordination between the communities and their municipal and government partners, this Quebec-specific training would enable INAC to better comply with the principles of the *Emergency Preparedness Act* and the latter's successor, the *Emergency Management Act.*

3.2.3.3 The FNQLHSSC's Pandemic Risk-Management and Business-Continuity Plans

This report demonstrates the scope of the mission to be assumed by the FNQLHSSC, if the latter complies with the mandate assigned by its own board of directors. Accordingly, it will have to, not only create the abovementioned coordination unit, but also ready the entire organization to support the FN communities concerned, regardless of the phase of the pandemic in question. Obviously, as mentioned above, that unit would take on a large part of the work, in particular by

drawing up a pandemic risk-management plan for FNQLHSSC personnel and a business-continuity plan to ensure ongoing community support in a pandemic.
For the purposes of this document, we will not discuss plan contents further, but refer readers to the numerous guides that already exist, especially that published by Canadian Manufacturers and Exporters,[95] as well as those accessible on Quebec's influenza-pandemic site.[96] However, we would emphasize one particular dimension that should be part of any business-continuity plan: the organization of a communication network linking the FNQLHSSC to the province's 32 non-Agreement communities.

Furthermore, the FNQLHSSC and the AFNQL Secretariat should suggest that other Aboriginal organizations establish their own pandemic risk-management plans for personnel and a business-continuity plan to ensure ongoing community support in a pandemic.

Recommendation 17: ***THAT, in addition to helping the AFNQL, the boards, and regional Aboriginal organizations establish pandemic action plans, the FNQLHSSC develop its own pandemic action and business-continuity plans.***

Recommendation 18: ***THAT the FNQLHSSC obtain the additional funding required to establish its pandemic-action and business-continuity plans, and conduct the activities needed to prepare Aboriginal organizations and communities for a pandemic.***

Telecommunication Networks and Computer Systems

As a result of the written questionnaire and telephone prompting used in polling FN communities, we concluded it is often difficult to contact the individual in charge.

E-Mail

While e-mail doubtless constitutes the most efficient means for sending comprehensible information and voluminous documents over large distances, it is often compromised by the sole fact that some directors and other individuals in charge do not monitor their messages regularly, or that, in their absence, this task is not assigned to someone else (secretary, assistant, etc.). Occasionally, people prefer working with a "hotmail" address that differs from the one officially entered on the FNQLHSSC's list. **Accordingly, the use of e-mail must be better organized and integrated into the administrative practices of health and social-service directorates, to ensure this mode of transmission is more reliable in all circumstances.**
Furthermore, in at least one case, we faced a conversion problem that made it impossible to read a completed questionnaire, as the version sent had been converted to the latest Microsoft Office version. **Because of software developments, computer-system requirements could make themselves felt within two or three years; this in turn would necessitate additional investments for upgrades to equipment used by the FNQLHSSC, other Aboriginal organizations and—especially—community public services.**

Telephone Calls

[95] Canadian Manufacturers and Exporters, *Influenza Pandemic – Continuity Planning Guide for Canadian Business*, March 2006.
[96] Government of Quebec, online: www.pandemiequebec.ca/en/news/news.aspx.

Our call-back campaign showed that it can be problematic to contact health and social-service personnel in a timely fashion, as the latter are often travelling, in a meeting or on holidays, and few other staff members are well informed on the issues in question (especially the influenza pandemic) or able to provide any assistance whatsoever. In a few cases, the only numbers listed for health and social-service directors were for a voicemail box; we could not be transferred to any other staff member. Consequently, we had to make frequent calls, or wait up to two days before those calls were returned.

Faxes

The fax, which seems a more common tool in the communities, is an excellent way to reach stakeholders. However, it is not the best method for transmitting comprehensible information or large documents. While likely an ideal means of warning and mobilizing organizations in an emergency, it should be used in conjunction with e-mails or the telephone where information is copious or more particulars are required.

In a pandemic context, the intensive use of these three modes of communication would mean an additional overload on phone lines, which are, in most areas, the only means of ensuring support. Moreover, the possibility of such an overload would doubtless be higher in those regions most affected by the pandemic.

Videoconferencing

While involved in our support and evaluation activities with the communities, we did not use the videoconferencing system at AFNQL Secretariat headquarters in Wendake. However, given that most communities are now equipped with these systems, it would be more economical and practical to reduce travelling time by opting for this mode of communication. We believe that, in the medium and long term, videoconferencing will be used frequently to monitor preparation activities, especially as regards information and training sessions and simulations. **All FN communities should have videoconferencing capabilities in order to enhance the quality of communication between themselves and the Aboriginal organizations represented at Wendake.**

Telecommunication-Network and Computer-System Analysis

Given the importance of telecommunication and computers in a disaster, we feel a study should be conducted a soon as possible on the capacity of the networks and systems used by Aboriginal organizations and FN communities. This study should also focus on the ability of FNQLHSSC and AFNQL Secretariat telecommunication and computer infrastructures to service a dozen-odd communities—and two times that number, in a crisis—at the same time. And, of course, northern communities wishing assistance from their representative organizations might have to be added to the 32 non-Agreement communities in question. The analysis would not have to be limited solely to systems capacity, but could also cover compatibility and upgrading issues.

In accordance with the evaluation of these infrastructures, an external and internal communication plan could be developed for the FNQLHSSC and the AFNQL Secretariat, based both on actual systems capabilities and changes required in the future.

Recommendation 19: ***THAT a study be conducted to assess the technical capabilities of telecommunication networks and computer systems to efficiently support an integrated communication and data-processing system that would link FN communities to the FNQLHSSC, the AFNQL Secretariat and other Aboriginal organizations in the event of a pandemic.***

Furthermore, as several health and social-service directors have already suggested, the FNQLHSSC should use its Web site to compile and make accessible information on the pandemic, emergency plans, available training, etc. It could also create an electronic bulletin board allowing FN communities to share their experiences.

Recommendation 20: That the FNQLHSSC use its Web site to compile and make accessible information on the pandemic, and create an electronic bulletin board allowing FN communities to share their experiences.

Lastly, to be able to carry out their respective missions during a pandemic or other major disaster, the FNQLHSSC and the AFNQL Secretariat should jointly establish a coordination centre containing the communication equipment, office equipment, and premises needed to efficiently coordinate community support activities.

Recommendation 21: that the FNQLHSSC and the AFNQL Secretariat jointly establish a coordination centre to manage community-support activities in the event of a pandemic or other major emergency.

CONCLUSION

Any study on risk management for major disasters involves a certain degree of deliberation on the division of responsibilities between the numerous governmental, public-service agency, private-enterprise, local authority, and other stakeholders involved. This also holds true for preparations for an apprehended influenza pandemic, which necessitate a comprehensive approach. As regards the First Nations, the complex nature of organizational relationships in a crisis is of particular importance, as it forms part of an ill-defined political and legal context that is in constant flux.

The main objective of this report was to evaluate the preparedness of FN communities of Quebec as regards an action plan for an apprehended influenza pandemic, and to identify the steps to be taken by the First Nations of Quebec and Labrador Health and Social Services Commission to efficiently assist the communities in their preparations.

The March 31, 2007 results show that preparedness has likely improved since August 2006; as regards the public-health section, preparedness is considered satisfactory, but physical health and communication are less so. Much remains to be done in the areas of psychosocial response, continuity of services, and the coordination of pandemic plans with all-hazard emergency response plans. Lastly, communities with fewer than 500 residents, as well as semi-isolated communities, could benefit from special attention.

One dimension that stands out in this report is the clarification of roles and responsibilities shared by government partners and Aboriginal organizations. In this regard, our aim was mainly to present an overview of the arrangements that now exist, and identify the approaches to be taken to solve the problems caused by existing structural weaknesses in the civil-protection system.

The principles on which we based our recommendations can be summarized as follows:

- **First, conditions conducive to allowing FN communities to act with greater autonomy at the local and regional levels had to be established.**
- **Second, the means proposed had to contribute to a true partnership among the parties concerned at all levels, in order to help them find joint solutions to the structural problems in question.**
- **Third, the participation of the FNQLHSSC could not encumber system operation by adding additional steps.**

In our view, the recommendations contained in this report comply with these principles; thanks to the links established with Quebec partners at the local and regional levels, they would allow interested communities to improve their response capabilities and speed. In a pandemic, enhanced community autonomy would reduce demands on federal departments, the FNQLHSSC and the AFNQL Secretariat.

The participation of First Nations representatives in existing or new forums would allow them to cooperate with their federal and Quebec partners at various levels to find solutions that take account of the specific context of First Nations peoples.

The establishment of two new forums at the upper levels of the decision-making process would not slow that process, but enable FN community needs to be considered from the outset, rather than at the end, as is the case at present. The creation of such forums merely accords program-implementation consultation the importance it deserves, in keeping with common practice for the general public.

We invite readers to pursue their deliberations by consulting the list of recommendations on the following page.

LIST OF RECOMMENDATIONS

***Recommendation 1**: THAT the FNQLHSSC and the AFNQL Secretariat ensure that a Quebec-wide integrated action plan is developed to support the implementation of federal pandemic action programs. This plan would be established jointly by Health Canada (regional FNIHB offices), INAC, the MSSS, the FNQLHSSC, and the AFNQL Secretariat.* — **p. 46**

***Recommendation 2:** THAT the FNQLHSSC and the AFNQL Secretariat develop a joint action plan to identify the communities or categories thereof that should receive priority support over the next few month, for the Health Mission, the all-hazard emergency measures plan, and the business-continuity plan. That action plan would cover the period from 2007 to 2009.* — **p. 46**

***Recommendation 3**: THAT the FNQLHSSC and the AFNQL Secretariat exercise clear leadership by ensuring that existing and future INAC and regional FNIHB office programs on the development or updating of pandemic health-mission action plans, all-hazard emergency measures plans and business-continuity plans provide for the harmonization, not only of the contents of such plans, but also of these plans with the Quebec civil-protection model. Such harmonization should also extend to stakeholder training and related documentation and information.* — **p. 47**

***Recommendation 4:** THAT the additional budgets required by the FNQLHSSC and the AFNQL Secretariat to conduct harmonization activities be provided for in federal programs.* — **p. 47**

***Recommendation 5**: THAT the MSSS ensure that all First Nations healthcare institutions be invited to attend regional forums on a regular basis, in order to establish and maintain closer ties with other area organizations.* — **p. 49**

***Recommendation 6**: THAT the MSSS ensure that FN community health and social-service institutions be put on the distribution list used by the regional agency to send information to the CSSS.* — **p. 50**

***Recommendation 7**: THAT the MSSS ensure that FN community healthcare institutions are invited to take part in all regional pandemic action-plan training, ratification, protocol, and other activities organized by the regional agency in which other area institutions take part.* — **p. 50**

***Recommendation 8**: THAT the MSSS invite the FNQLHSSC to provincial forums attended by Department and regional agency-representatives, so as to keep the Commission apprised of proposed pandemic-action measures and action, determine the impact on the FNC and, where applicable, directly inform participants from the MSSS and regional agencies of that impact.* — **p. 57**

***Recommendation 9:** THAT the FNQLHSSC have access to the electronic database of official documents available to the agencies, or an equivalent solution, so as to be able to rapidly obtain the latest pandemic-preparation data distributed to network institutions.* — **p. 58**

Recommendation 10: ***THAT the MSSS forward directly to the FNQLHSSC documentation and information on regional pandemic-preparation activities sent to the regional agencies for subsequent distribution to the institutions. — p. 58***

Recommendation 11: THAT the regional FNIHB offices and INAC take the necessary steps with the government of Quebec to formally establish an intergovernmental pandemic-action forum for 2007 to 2009. This forum would be composed of FNQLHSSC, AFNQL Secretariat, Health Canada (regional FNIHB offices), INA, MSSS and MSP representatives. Meetings would be held in Quebec City at least three times a year (winter, spring and fall). — p. 60

Recommendation 12: THAT the FNQLHSSC and the AFNQL Secretariat jointly propose to Health Canada and INAC that a pandemic action-plan forum, involving the First Nations of Quebec and the federal government, be formally established for the years 2007 through 2009. This forum would be chaired by a representative of the FNQLHSSC, and bring together AFNQL Secretariat, Health Canada (regional FNIHB offices) and INAC representatives. Meetings would be held in Quebec City at least three a year (winter, spring and fall). — p. 62

Recommendation 13: THAT the regional FNIHB offices and INAC undertake to send to the FNQLHSSC and the AFNQL Secretariat all information on government programs and other initiatives related, to whatever extent, to pandemic action, before such information is sent to the communities. — p. 62

Recommendation 14: THAT the FNQLHSSC establish a pandemic-action coordination unit comprising at least one fulltime liaison officer and four part-time resources from the following sectors: health services, early-childhood services, social services, and the social-development office. The unit's main mission would be to help FN communities with their pandemic preparations and determine which services the FNQLHSSC would provide in the response phase. — p. 63

Recommendation 15: THAT the FNQLHSSC ensure it is incorporated into MSSS, regional FNIHB office, INAC and community warning procedures should a major emergency occur. — p. 65

Recommendation 16: THAT the FNQLHSSC and AFNQL jointly establish an uninterrupted, 24/7 service for communities in case of a pandemic or other major emergency. This type of service would be in constant contact with INAC and the regional FNIHB offices. In the event of an influenza pandemic, this measure should be implemented as soon as phase four of the pandemic was declared. — p. 65

Recommendation 17: THAT, in addition to helping the AFNQL, the boards, and regional Aboriginal organizations establish pandemic action plans, the FNQLHSSC develop its own pandemic action and business-continuity plans.— p. 67

Recommendation 18: THAT the FNQLHSSC obtain the additional funding required to establish its pandemic-action and business-continuity plans, and conduct the activities needed to prepare Aboriginal organizations and communities for a pandemic. — p. 67

***<u>Recommendation 19</u>: THAT a study be conducted to assess the technical capabilities of telecommunication networks and computer systems to efficiently support an integrated communication and data-processing system that would link FN communities to the FNQLHSSC, the AFNQL Secretariat and other Aboriginal organizations in the event of a pandemic.* — p. 69**

***<u>Recommendation 20:</u> THAT the FNQLHSSC use its Web site to compile and make accessible information on the pandemic, and create an electronic bulletin board allowing FN communities to share their experiences.* — p. 69**

***<u>Recommendation 21:</u> THAT the FNQLHSSC and the AFNQL Secretariat jointly establish a coordination centre to manage community-support activities in the event of a pandemic or other major emergency.* — p. 69**

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APPENDICES

APPENDICE

INFLUENZA PANDEMIC PREPAREDNESS QUESTIONAIRE FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES – 2006-2007 –

INFLUENZA PANDEMIC PREPARATIONS 2006 - 2007

1. Background

The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) has been mandated to develop and implement a work plan to effectively coordinate community preparation in response to the serious threat of a possible influenza pandemic.

This mandate can be summed up in three main functions:

- Ensure that communities have a pandemic action plan and support their preparation and implementation activities
- Foster links between the various players in the Quebec health network and the communities that want their support
- Ensure that all communities are consulted in the development of regional health and social services plans in Quebec

For the Commission to accomplish this mandate, we need to evaluate each community's preparedness in terms of the five sections of the Health Mission's pandemic influenza plan, as well as the level of coordination between these five sections and the communities' all-hazard emergency measures plans.

2. Evaluation documents to be completed

To this end, and with the support of Health Canada, the Commission is issuing a pandemic action plan tool that will also provide us with information about your state of preparedness. In the following pages you will find a short questionnaire that asks for certain general information, as well as a checklist in table form that will allow us to evaluate the state of preparedness of the health and social services in your community in relation to a certain number of planning elements that need to be carried out in each of five areas in preparation for a possible influenza pandemic (phases 1 to 5 on the World Health Organization scale).

We request that you complete these documents as indicated and return them to us by email or fax no later than March 31, 2007.

As explained above, the checklist was also designed to assist you in your preparations. Based on Health Canada's basic planning structure and the Ministère de la Santé et des services sociaux du Québec Pandemic Influenza Plan, this checklist can be used as a tracking tool to evaluate the progress of your preparations over the next three quarters of 2007. We suggest that you keep a copy to monitor your state of preparedness at the end of each of the three quarters indicated in the last three columns at the right of the table.

Abbreviations and acronyms

ASSS	**Health and social services agency (formerly Regional Board)**
CSSS	**Health and social services centre**
HC/NS	**Health centre / Nursing station (First Nations communities)**
FNQLHSSC	**First Nations of Quebec and Labrador Health and Social Services Commission**
FNIHB	**First Nations and Inuit Health Branch (Health Canada)**
INAC	**Indian and Northern Affairs Canada**
MSSS	**Quebec health and social services ministry**
EMP	**All-hazard emergency measures plan (First Nations communities)**

Influenza pandemic preparedness checklist for community health and social services directorates March 2007

Confidentiality: The information collected by the Commission in this document will remain confidential. It will only be communicated to third parties with the written authorization of the health and social services directorates of the communities involved. The Commission may, however, use this information to produce reports and statistics, ensuring that the results are presented in a general way and do not reveal the identity of the communities involved.

GENERAL INFORMATION

a) Community name:_____

b) Is there someone in charge of general coordination for the influenza pandemic action plan in your HC/NS?_____

c) If so, please provide the person's name and title:_____ _____Phone: _____

d) Name and position of the person in charge of the community's all-hazard emergency measures plan (EMP):_____ Phone: _____

e) When was the last time the health and social services section of the community's all-hazard emergency measures plan was updated?_____

f) How many permanent community members are there in your territory? _____

QUESTIONS g) to j): If you do not have the information you need to answer any of these questions, please enter "U" (for unavailable). We suggest that you ascertain this information within the next few months, in order to more accurately evaluate the scope of your community's real needs in the event that an influenza pandemic or other major disaster occurs.

g) How many permanent residents of other origins live in your territory?_____

h) Other than permanent residents, how many seasonal or temporary residents (workers,

tourists, etc.) do you estimate there may be in your territory?_____

i) During which month(s) of the year are these seasonal or temporary residents present?_____

j) What do you estimate to be the maximum number of people who may be present at any one time in your community territory? _____

TRAINING AND DOCUMENTATION RECEIVED

k) Does your health and social services directorate have a copy of the Pandemic Influenza Plan for the Health Sector Framework distributed by Health Canada?

l) Has at least one health and social services directorate representative attended the plan preparation meeting given by Health Canada representatives in Quebec communities?_____

m) Have you received a copy of the **Management Toolbox** (MSSS)? _____

n) Do you have a copy (paper or electronic) of the **Quebec Pandemic Influenza Plan – Health Mission** (MSSS)?_____

o) Do you have a copy (paper or electronic) of the **Regional Pandemic Influenza Plan** (ASSS)? _____

p) Do you have a copy (paper or electronic) of the **Local Pandemic Influenza Plan** (CSSS)? _____

q) Have you received the 2006-2007 pandemic influenza activity planning program from your regional ASSS?_____

Completed by: _____ Date:_____
Name and title

What is your responsibility in the pandemic preparation process?
_____

INSTRUCTIONS FOR COMPLETING THE TABLES

For each planning element listed in the following tables, please indicate "Y" in the March 31 column if this element has been achieved as of March 31, 2007. If this element has not been achieved by March 31, 2007, please enter "N" for No.

Wherever you enter "N" in the March 31 column, please put an X in one of the three adjacent columns to indicate when you expect to have completed this step (June 30, September 30 or December 31).

If you feel that a particular planning element does not apply to your community, please enter "N/A" (for not applicable) in the March 31 column and provide an explanation on the comments page at the end of each section.

INFLUENZA PANDEMIC PREPAREDNESS CHECKLIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
– 2006-2007 –

Instructions: Please indicate whether each planning element listed in the table will be achieved by March 31, 2007. Wherever you enter N for "no" in the March 31 column, please place an X in one of the three adjacent columns to indicate when you expect to have completed this step. If you feel that this planning element does not apply to your community, please enter N/A (not applicable) in the March 31 column and provide an explanation on the comments page at the end of the section.

No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 1 — PUBLIC HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
	1) Epidemiological surveillance methods				
1	A coordinator and alternate for public health issues in the event of a pandemic have been identified, approved by the directorate, and introduced to HC/NS workers.				
2	An epidemiological surveillance coordinator has been designated for the community and his or her name has been communicated to the ASSS and the CSSS.				
3	An epidemiological surveillance respondent has been designated for the community and his or her name has been communicated to the ASSS and the CSSS.				
4	Your service is included in the ASSS regional case distribution list.				
5	Your service is familiar with the data transmission rules for cases of infection.				
	2) Adaptation of pandemic infection prevention measures				
6	Respiratory etiquette has been implemented in all care centre waiting rooms.				
7	Isolation wards have been identified in the health centre and/or nursing station.				
8	All HC/NS staff has been informed of the specific prevention and personal protection measures for stages 3 to 5 of the pandemic.				
9	Home care workers outside of health services (e.g., private agencies) who are in daily contact with people receiving home care have been informed of the specific prevention and personal protection measures for stages 3 to 5 of the pandemic.				

Instructions: Please indicate whether each planning element listed in the table will be achieved by March 31, 2007. Wherever you enter N for "no" in the March 31 column, please place an X in one of the three adjacent columns to indicate when you expect to have completed this step. If you feel that this planning element does not apply to your community, please enter N/A (not applicable) in the March 31 column and provide an explanation on the comments page at the end of the section.

No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 1 — PUBLIC HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
	3) Administration of vaccination measures				
10	Measures have been implemented to promote seasonal flu vaccines among high-risk groups.				
11	Management plans have been completed to ensure the cold chain is maintained during the storage and distribution of antivirals and vaccines.				
12	The ASSS has been informed in writing of the vaccine distribution methods in the community (storage locations, order forms, etc.).				
13	A vaccine security plan has been completed to monitor people with direct access to vaccine reserves and to track vaccine transportation and storage.				
14	Affected workers have been informed of the vaccine administration procedures.				
15	Members of priority groups have been identified in a nominal roll.				
16	The estimated number of individuals in priority groups has been communicated to the ASSS or the CSSS.				
17	The list of staff required in vaccination clinics has been established and responsibilities have been defined.				
18	A list of supplemental staff for vaccination clinics has been established.				
	4) Case and contact management				
19	The staff who will make up the individual case and contact management teams have been identified.				

INFLUENZA PANDEMIC PREPAREDNESS CHECKLIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
– 2006-2007 –

Instructions: Please indicate whether each planning element listed in the table will be achieved by March 31, 2007. Wherever you enter N for "no" in the March 31 column, please place an X in one of the three adjacent columns to indicate when you expect to have completed this step. If you feel that this planning element does not apply to your community, please enter N/A (not applicable) in the March 31 column and provide an explanation on the comments page at the end of the section.

No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 1 — PUBLIC HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
	5) Coordination of public health issues with the all-hazard emergency measures plan (EMP)				
20	A person is identified in the EMP to be in charge of security and support for vaccine distribution and storage activities.				
21	EMP coordinators and workers have been designated as members of the priority group of service providers.				
22	If additional staff is expected to be needed in the vaccination clinics, accommodations for these people are identified in the EMP.				
23	The community health and social services directorate held an information and awareness session with the emergency measures coordinator and all community directorates concerning the scope of the problem, the consequences of a pandemic, and the importance of being prepared.				
24	The community health and social services directorate held an information and awareness session with the band council concerning the scope of the problem, the consequences of a pandemic, and the importance of preparing the entire community.				
25	The community health and social services directorate held an information and awareness session with the directors of businesses and other public or private organizations concerning the scope of the problem, the consequences of a pandemic, and the importance of preparing their respective organizations.				

SECTION 1 — PUBLIC HEALTH: QUESTIONS / COMMENTS / DETAILS

Completed by: _____ Date: _____
Name and title

What is your responsibility in the pandemic preparation process?

_____

INFLUENZA PANDEMIC PREPAREDNESS CHECKLIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES

– 2006-2007 –

Instructions: Please indicate whether each planning element listed in the table will be achieved by March 31, 2007. Wherever you enter N for "no" in the March 31 column, please place an X in one of the three adjacent columns to indicate when you expect to have completed this step. If you feel that this planning element does not apply to your community, please enter N/A (not applicable) in the March 31 column and provide an explanation on the comments page at the end of the section.

No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 2 — PHYSICAL HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
	1) Knowledge of self-care				
26	A coordinator and alternate for physical health issues in the event of a pandemic have been identified, approved by the directorate, and introduced to HC/NS workers.				
27	The executives and employees of public directorates and services in the community have been trained in the use of the self-care guide.				
28	Public service workers and their volunteer assistants are promoting the self-care guide.				
	2) Adaptation of home care services				
29	The regular service plan for home care and support has been adapted specifically for a pandemic situation.				
30	Additional home care needs for influenza patients have been evaluated and the possibility of seeking assistance from various organizations has been explored.				
31	Cooperation mechanisms have been established with these organizations.				
32	A home care coordinator and alternate have been identified and their names have been communicated to the CSSS and ASSS coordinators.				
33	Mechanisms for identifying and monitoring people with influenza have been defined.				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 2 — PHYSICAL HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
	3) Access to the Info-santé service				
34	Specific methods of access to the Info-santé service have been defined for the community.				
35	Methods for collaborating with the CSSS have been established and adapted to the needs of the community.				
36	In the absence of specific access to the Info-santé service, alternative strategies have been developed to ensure continuous telephone information service (24/7) for the community.				
37	If such a service has been established in the community, alternate nursing staff has been arranged to provide 24/7 telephone information service.				
38	A specific training program has been arranged for staff assigned to the community's telephone information service.				
	4) Pre-hospital emergency services				
39	The increased need for ambulance transportation and related planning (e.g., qualified additional or alternate drivers) has been estimated in collaboration with the ASSS.				
40	Call prioritization, transportation and intervention protocols have been projected for a pandemic situation, based on instructions from the MSSS.				
41	Other types of transportation have been evaluated to supplement ambulances in the event of overflow (or lack of transportation).				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 2 — PHYSICAL HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
42	Transfer/transportation rules have been established with partners who can offer supplemental transportation.				
43	Measures have been taken to ensure funding for the predicted 15% increase in subsidized transportation.				
	5) Provision of services and care priorities				
44	Essential services have been identified.				
45	The care and service hierarchy has been established based on the severity of the situation and the service location.				
46	Care trajectories, including locations for screening and evaluation, and necessary resources have been determined.				
47	Screening and infection prevention measures for the mass arrival of infected people have been established for nursing stations and health centres, based on the ASSS screening form.				
48	Direct telephone and computer access to the CSSS has been arranged so workers can obtain the scientific, technical or organizational information they need.				
49	A grid has been developed for the priority assignment (location/time) of human resources based on the most urgent needs in a pandemic situation, including volunteers and alternate staff.				
	6) Antiviral treatments				
50	Workers have been trained by the ASSS on care guides and antiviral treatment protocols.				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 2 — PHYSICAL HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
51	Secure sites for the storage of antivirals in the designated communities have been identified in compliance with the ministerial orders from the MSSS.				
52	The number of people in priority groups for receiving antivirals has been estimated in compliance with the instructions provided by the ASSS.				
53	A coordinator and alternate have been identified to keep track of the number of people in these priority groups.				
	7) Disposal of remains				
54	A management plan for human remains has been established in cooperation with the community's funeral services and in compliance with the ASSS regional plan.				
55	Medical or other staff able to certify deaths (e.g., police officers) have been identified in sufficient numbers.				
	8) Coordination of physical health issues with the all-hazard emergency measures plan (EMP)				
56	Community or external organizations have been identified in the EMP to support home care services.				
57	The EMP provides for material and technical support (e.g., additional telephone equipment) when alternative strategies have been created to provide continuous telephone information services (24/7) for the community.				
58	If a telephone information service established in the community requires additional staff, the EMP provides for support: e.g., accommodations and supplies for additional nursing staff from outside the community.				
59	Adjustments have been made to the EMP to meet the significant rise in the demand for ambulance transportation (clearing and maintenance of priority roads, vehicle maintenance, etc.).				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 2 — PHYSICAL HEALTH	March 31 Y / N	June 30	Sept. 30	Dec. 31
60	The availability of means of transportation in addition to the ambulance service has been established in collaboration with private and public organizations and INAC.				
61	The EMP provides priority technical support for telecommunications at the HC/NS.				
62	An EMP coordinator has been designated to provide security and support for the distribution and storage of antivirals and vaccines.				
63	Sites for the disposal of human remains are identified in the EMP and continuous access to these sites has been arranged.				
64	Measures have been planned to allow funeral services to be held without raising the risk of infection.				

SECTION 2 — PHYSICAL HEALTH: QUESTIONS / COMMENTS / DETAILS

Completed by: _____ Date: _____
Name and title

What is your responsibility in the pandemic preparation process?

_____

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 3 — PSYCHOSOCIAL RESPONSE	March 31 Y / N	June 30	Sept. 30	Dec. 31
	1) Coordination of psychosocial services				
65	A coordinator and alternate for psychosocial issues have been identified and their names have been communicated to the CSSS.				
66	The responsibilities of the coordinator have been defined and adapted to the specific needs of a pandemic situation.				
67	The psychosocial aspect of the local emergency measures plan has been adapted to the specific needs of a pandemic situation and an intervention procedure has been established.				
68	Procedures have been established for collaborating with specialty facilities and community organizations.				
	2) Psychosocial monitoring				
69	Clients known to be psychosocially vulnerable have been identified.				
70	The list of known vulnerable clients extends back 2 years.				
71	The list of known vulnerable clients is maintained in a computer data base.				
72	The reasons for psychosocial consultation have been tracked and procedures for data transmission to the CSSS identified.				
73	Methods have been established to identify unknown clients.				
74	Methods have been established to identify health and social services staff who need psychosocial invention because of the pandemic.				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 3 — PSYCHOSOCIAL RESPONSE	March 31 Y / N	June 30	Sept. 30	Dec. 31
	3) Psychosocial intervention				
75	A list has been established to identify alternate staff and workers who can be mobilized to provide intervention and crisis management services.				
76	The functional relationships and contributions of various community and external partners have been defined.				
77	Current activities other than those related to the pandemic have been identified and assigned a priority.				
78	A psychosocial telephone response system based on the MSSS pandemic intervention guide has been established.				
79	Individual, domestic, family and crisis intervention systems have been defined and are ready to be put into action.				
80	A psychosocial telephone response system for the community has been jointly planned with the Info-santé telephone information service (as a health/social-health information line).				
	4) Clinical supervision				
81	The clinical supervision coordinators for your HC/NS workers have been identified and their names have been submitted to the ASSS.				
82	Clinical supervision procedures for HC/NS workers have been established with the CSSS or the ASSS or private services.				

INFLUENZA PANDEMIC PREPAREDNESS CHECKLIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
–2006-2007 –

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 3 — PSYCHOSOCIAL RESPONSE	March 31 Y / N	June 30	Sept. 30	Dec. 31
	5) ASSS support				
83	Consultation methods have been established to allow psychosocial workers to access ASSS expert consultants in relation to the pandemic.				
	6) Coordination of psychosocial issues with the all-hazard emergency measures plan (EMP)				
84	The EMP identifies community organizations involved in psychosocial issues.				

SECTION 3 — PSYCHOSOCIAL: QUESTIONS / COMMENTS / DETAILS

SECTION 3 — PSYCHOSOCIAL : QUESTIONS / COMMENTS / DETAILS

Completed by: _____ Date: _____
Name and title

What is your responsibility in the pandemic preparation process?

_____

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 4 — COMMUNICATIONS	March 31 Y / N	June 30	Sept. 30	Dec. 31
	1) Liaison with partners				
85	A communications coordinator and alternate have been designated to manage communications for the community health and social services in the event of a pandemic.				
86	A communications plan for all health and social services communications needs has been specifically designed for the influenza pandemic.				
87	Continuous communications links (24/7) have been set up with the CSSS to allow for the timely exchange of information specifically related to the pandemic (information and feedback) with the HC/NS and psychosocial workers.				
88	Continuous communications links (24/7) have been set up with the ASSS to allow for the timely exchange of information specifically related to the pandemic (information and feedback) with the HC/NS and psychosocial workers.				
89	A strategy has been developed to ensure that information and documentation from the ASSS or the CSSS is understood by health and psychosocial workers and their alternates, as well as alternate staff and volunteers (adaptation, translation, information sessions, etc.).				
90	Continuous lines of communication have been set up with the community communications coordinator and the other public services in the community to allow for the timely exchange of information specifically related to the pandemic (information and feedback).				
91	Continuous lines of communication have been set up with community organizations to allow for the timely exchange of information specifically related to the pandemic (information and feedback).				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 4 — COMMUNICATIONS	March 31 Y / N	June 30	Sept. 30	Dec. 31
92	Continuous lines of communication have been set up with Health Canada and INAC to allow for the timely exchange of information specifically related to the pandemic (information and feedback).				
93	Continuous lines of communication have been set up with the FNQLHSSC to allow for the timely exchange of information specifically related to the pandemic (information and feedback).				
94	The health/social-health information line is in direct and continuous communication with the HC/NS to allow for the timely exchange of information specific to the pandemic (information and feedback).				
95	In the event that an alternative health/social-health telephone service (24/7) is established in the community by the HC/NS, it is in direct and continuous communication with the CSSS or the ASSS to allow for the timely exchange of information specific to the pandemic (information and feedback).				
	2) Communication with the public				
96	A coordinator and alternate have been designated to validate information that will be issued to the public and the media.				
97	In collaboration with the EMP communications coordinator, a strategy has been defined to determine which information should be issued to EMP coordinators before being issued to the public (because of its potential impact on public security and other EMP missions, such as the next delivery of the vaccine).				
98	The linguistic profiles of the public are known and a strategy has been developed to ensure that French and English instructions and information received from the MSSS for the public can be communicated in the ancestral language of the community when necessary (e.g., community radio).				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 4 — COMMUNICATIONS	March 31 Y / N	June 30	Sept. 30	Dec. 31
99	The various means chosen for communicating information to the public are adapted to public needs (radio, television, telephone, mobile loudspeakers, door-to-door, etc.) and will ensure that all residents of the territory are reached.				
	3) Coordination of communications issues with the all-hazard emergency measures plan (EMP)				
100	The EMP communications coordinator is known.				
101	The lines of communication between the HC/NS and the EMP coordination centre to use in the event of a pandemic have been established.				
102	The EMP coordinator responsible for receiving sensitive information is known to the health mission communications coordinator.				
103	The EMP communications coordinator has identified certain groups who only understand the ancestral language and has a designated interpreter who can provide health and psychosocial support for this clientele.				
104	The EMP communications coordinator has identified the most effective means of contacting the entire population in the territory and will makes these means available for health and psychosocial needs.				

SECTION 4 — COMMUNICATIONS: QUESTIONS / COMMENTS / DETAILS

Completed by: _____ Date: _____
Name and title

What is your responsibility in the pandemic preparation process?

_____

INFLUENZA PANDEMIC PREPAREDNESS CHECK LIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
– 2006-2007 –

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31
	1) Labour management				
105	A service continuity coordinator and alternate have been identified and introduced to the health and social services staff at the HC/NS.				
106	A mobilization plan for replacement workers (alternate staff and volunteers) has been established to provide services to the public during a pandemic.				
107	Essential tasks that may be compromised by a lack of staff have been identified.				
108	The possible consequences of high absenteeism (35%) have been evaluated.				
109	An emergency task reassignment plan for existing staff has been established, taking into consideration limits imposed by collective agreements and labour standards.				
110	Mechanisms have been defined to identify alternate staff to be mobilized and the availability of these people is periodically verified for the registry.				
111	The tasks to be accomplished by alternate staff have been defined.				
112	Action areas for volunteers and their tasks have been defined.				
113	The role of family and friends in helping service users has been defined and a mechanism for communicating with them has been established.				
114	A procedure for communicating requests and offers for alternate staff has been established with the ASSS.				

INFLUENZA PANDEMIC PREPAREDNESS CHECK LIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
– 2006-2007 –

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31
	2) Recourse to community resources				
115	A list of community organizations has been established, indicating the type of services they offer and the number of employees.				
116	The organizations on the list have been informed of needs they may be called upon to fill.				
	3) Maintenance and development of competencies				
117	Community groups that may be called upon to fill new health and social services roles have been identified specifically on a list.				
118	The MSSS training plan for alternate staff and community workers has been applied and it specifies learning materials to use, logistics, available information technology (computers, software, etc.) and a timetable.				
119	Consultations have been held with the CSSS, the ASSS, the FNQLHSSC, Health Canada and INAC to determine how training responsibilities will be shared by these organizations.				
	4) Supply management for medication, supplies and equipment				
120	A list of medical supplies needed in the community in the event of a pandemic has been established and validated by the FNIHB.				
121	The required quantity of each product on the list has been established based on the needs of the community.				
122	A secure storage site that complies with standards and recommendations has been identified for use as a medical supply reserve.				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31
123	Additional office space, office supplies, computer and telecommunications equipment needs (to handle additional phone calls to the HC/NS) have been identified.				
124	Suppliers of medical equipment and supplies have been identified and have confirmed that they have a contingency plan to ensure supplies in the event of pandemic.				
125	Businesses that transport medical supplies have all been identified and have confirmed that they have a contingency plan to ensure uninterrupted service to your community in the event of a pandemic.				
126	Reliable alternative solutions have been identified for situations in which a supplier or transporter cannot fulfil their commitment in the event of a pandemic.				
127	Locations that can be used to train pandemic workers have been chosen.				
128	Minor fit-ups have been planned to maximize the use of existing locations (partitions, screens…).				
129	Fit-ups ensure strict physical separation of places for flu patients and places for people with other conditions.				
130	The community's maximum patient capacity has been defined, and the CSSS and ASSS have both been informed.				
	5) Maintenance of news and telecommunications networks				
131	The offices and work stations of all community health and social services executives and employees workers are equipped with up-to-date computer equipment that allows for the rapid exchange of emails as well as data gathering and access to internet data bases.				
132	An intranet network effectively links all community administrative directorates and services.				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31
133	The additional computer equipment (computers, screens, printers, software, servers…) required to prepare for and take action in the event of a pandemic has been determined.				
134	Alternative measures have been identified in the event the server or computer link with external partners breaks down (fax, videoconferencing, etc.).				
135	The additional land lines, cell phones and fax machines required to effectively communicate in the event of a pandemic have been determined.				
136	The additional radio communication equipment required to effectively communication in the event of a pandemic has been determined.				
137	The additional videoconferencing equipment required to effectively communicate in the event of a pandemic has been determined.				
	6) Coordination of service continuity issues with the all-hazard emergency measures plan (EMP)				
138	Organizations likely to be called on by health services are identified in the EMP, along with the nature of their offering and the number of employees or volunteers involved.				
139	The EMP security coordinator has been informed of the location of the medical reserve and the related security needs.				
140	A coordinator for material, real estate and information resources is designated in the EMP.				
141	The EMP material resource coordinator has been consulted concerning additional needs for office space, office fit-ups and office supplies.				

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31
142	The EMP transportation coordinator has been consulted concerning possible alternative solutions for the transportation of medical supplies.				
143	The computer equipment needed to liaise with partners in the event of a pandemic has been determined jointly with the EMP material resource coordinator.				
144	The telephone equipment (landlines, cell phones, pagers and fax machines) needed to liaise with partners in the event of a pandemic has been determined jointly with the EMP material resource coordinator.				
145	The radio communications equipment needed to liaise with partners in the event of a pandemic has been determined jointly with the EMP material resource coordinator.				
146	The videoconferencing equipment needed to liaise with partners in the event of a pandemic has been determined jointly with the EMP material resource coordinator.				
147	In the event of a blackout, the EMP provides for a sufficient number of emergency generators to be assigned in priority to the refrigerated antiviral and vaccine storage locations, the HC/NS and other health care offices, the medical supply reserve and the computer, telecommunications and radio communications networks required for the effective operation of health services.				
148	All locations needed for health and social services are designated in the EMP as priorities for electrical reconnection in the event of a blackout.				

INFLUENZA PANDEMIC PREPAREDNESS CHECK LIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
– 2006-2007 –

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31

SECTION 5 — SERVICE MAINTENANCE: QUESTIONS / COMMENTS / DETAILS

INFLUENZA PANDEMIC PREPAREDNESS CHECK LIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
– 2006-2007 –

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31

Completed by: _____ Date: _____
Name and title

INFLUENZA PANDEMIC PREPAREDNESS CHECK LIST
FOR COMMUNITY HEALTH AND SOCIAL SERVICES DIRECTORATES
– 2006-2007 –

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No.	PLANNING ELEMENTS COMPLETED IN 2007 SECTION 5 — CONTINUITY OF SERVICES	March 31 Y / N	June 30	Sept. 30	Dec. 31

What is your responsibility in the pandemic preparation process?

_____

APPENDIX B

LETTER OF SEPTEMBER 27, 2006 FROM THE FNQLHSSC TO HEALTH CANADA AND QUEBEC'S DEPARTMENT OF HEALTH AND SOCIAL SERVICES RE A REQUEST FOR FUNDING FOR INFLUENZA-PANDEMIC PREPARATION COORDINATION

— REPRODUCTION OF TEXT FROM APPENDIX A —

"In connection with a profile established on First Nations community preparedness for a possible influenza pandemic, and given the concerns voiced by community health directors as to stakeholder roles and responsibilities in the pre-pandemic, pandemic and post-pandemic phases, the FNQLHSSC has the following observations:

Observation 1

Preparedness differs greatly from one community to the next. While a minority have developed a pandemic plan, most have not begun the process, or, if begun, the plan is still incomplete. The main obstacles mentioned by these communities are a lack of human, technical and financial resources needed for plan development; a lack of information and community awareness; and a lack of mobilization on the part of the community stakeholders in question.

Observation 2

Several communities require technical assistance, as well as adequate funding, to:

a) draft and ratify their pandemic action plan;
b) inform community stakeholders and the public;
c) train community healthcare providers;
d) obtain additional equipment and medical supplies;
e) update their emergency measures plan;
f) establish ties with regional health agencies/CSSS, etc.

Observation 3

There is an urgent need to clarify the pre-pandemic, pandemic and post-pandemic roles and responsibilities of the provincial health agencies, the CSSS, Health Canada, INAC, and the First Nations communities. Some links between stakeholders need still to be established or reinforced.

Observation 4

There is also a pressing need to make all stakeholders' roles and responsibilities official, so as to prevent any ambiguity now, during the development of community plans, or during a possible pandemic.

Observation 5

A number of communities do not have an up-to-date emergency measures plan. This is of particular concern because any pandemic action plan must be appended to a current, operative emergency measures plan. The possibility of a pandemic constitutes an unprecedented opportunity for updating those emergency-measures plans.

Observation 6

Several communities have mentioned they lack the technical knowledge required to develop and coordinate their pandemic-action plans. A considerable number did not attend the preparatory meetings organized by Health Canada and the health agencies, and did not avail themselves of the funding available to draw up such plans.

Observation 7

The great majority of First Nations communities were not consulted by the health agencies/CSSS during regional-plan development. Some links between stakeholders need still to be established or reinforced.

Observation 8:

Widespread confusion remains in the communities as to upcoming action and stakeholder roles and responsibilities. Lastly, communication and transparency issues will have to be dealt with to give communities access to the same information."

First Nations of Quebec and Labrador
Health and Social Services Commission
250, place Chef Michel Laveau (local 102)
Wendake (Quebec) G0A 4V0

Tel. : (418) 842-1540
Fax : (418) 842-7045