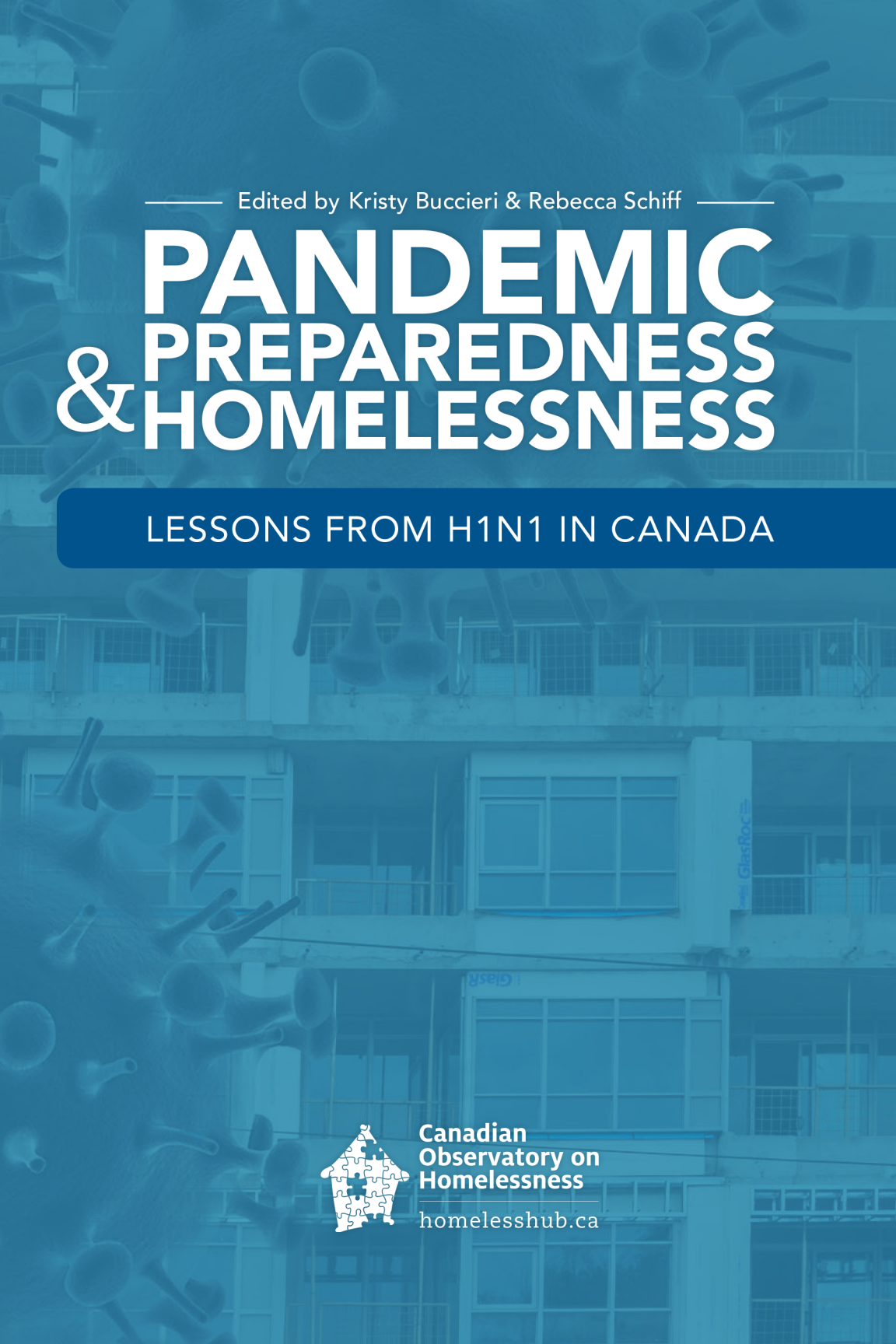

Edited by Kristy Buccieri & Rebecca Schiff

PANDEMIC PREPAREDNESS & HOMELESSNESS

LESSONS FROM H1N1 IN CANADA

Canadian Observatory on Homelessness
homelesshub.ca

PANDEMIC & PREPAREDNESS & HOMELESSNESS

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Canada

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INTRODUCTION

Kristy Buccieri

Natural and human-induced disasters have become increasingly common in modern society. “Factors such as increased urbanization, critical infrastructure dependencies and interdependencies, terrorism, climate change, environmental change, animal and human diseases and the heightened movement of people and goods around the world have increased the potential for various types of catastrophes” (Public Safety Canada, 2011, p. 3). While some emergencies are relatively localized events, others spread rapidly. Within the past two decades alone, viruses such as SARS and H1N1 have threatened the health and security of people around the world, largely due to technological advances that facilitate travel between global cities (Ali & Keil, 2008). The result is not only an increase in the number of disasters, but also in the potential for damage and loss of life. Large-scale emergencies, such as global pandemics, have become a reality of daily life, but while everyone is affected, not everyone is affected equally (Blickstead & Shapcott, 2009). Vulnerability is increased with inadequate structural and systemic protections, and is also grounded in the greater human, social, economic, physical and environmental capital accorded to some people over others (Canadian Red Cross, 2007). This book brings together findings from a multi-year, multi-site study that examined homelessness as a particular socio-structural vulnerability posing unique challenges to pandemic planning, preparedness and response across Canada.

Pandemic Planning and High-Risk Populations

Historically, influenza pandemics have occurred three or four times a century, with the most recent outbreak, prior to H1N1, being in 1968 (Toronto Public Health, 2009). The World Health Organization (WHO, 2009a) strongly advocates for pandemic influenza planning, warning that pandemics can create many varied challenges, both locally and globally. When we talk

about emergency situations, it is critical to keep in mind the magnitude, scope and duration of impact (Pleet, 2009). Recent emergencies and disasters have highlighted the need to reduce, as much as possible, undue suffering and loss (Canadian Red Cross, 2007). As Kass, Otto, O'Brien and Minson (2008) note of pandemics: "One must recognize that if citizens have limited or diminishing access to usual supplies of food, water, sewage systems, fuel and communication, the secondary consequences of a pandemic may cause greater sickness, death and social breakdown than influenza itself (p. 229)." Thoughtful and informed planning that includes sustained engagement by all stakeholders, even when there is no current emergency, is essential preparation for a pandemic response.

Pandemic preparedness is a collective responsibility. It depends on the government's ability to protect its citizens and critical infrastructure, including the processes, systems, facilities, technologies, networks, assets and services that are essential to the health, safety, security and economic well-being of Canadians (Public Safety Canada, 2009). However, while most plans are organized through government and community agencies, sound pandemic planning must also empower citizens to feel equipped to help themselves, as well as others, when faced with an emergency situation (Ng, 2009). Discussions about health care planning always contain a moral dimension, so that planning presupposes certain ethical values, principles, norms, interests and preferences (Kotalik, 2005). In pandemic outbreaks, health needs often overwhelm available human and material resources, requiring difficult decisions about how, where and to whom resources should be allocated (Thompson, Faith, Gibson, & Upshur, 2006).

Common ethical questions that arise include who will get priority access to medications and vaccines, what obligations health care workers have to care for the ill, despite risks to themselves and their families, how surveillance, isolation and quarantine measures can be undertaken while respecting ethical norms, and the obligations of countries to aid one another (WHO, 2007). As a general guiding principle, measures that limit individual rights and civil liberties must be necessary, reasonable, proportional, equitable, non-discriminatory and in full compliance with national and international laws (WHO, 2007). Decision makers need to recognize that within any

society some members experience vulnerabilities that increase their risk during emergencies. Pandemic plans must identify the barriers that produce such vulnerabilities, and ensure measures are in place to assist those at greater risk (Blumenshine et al., 2008).

All citizens "deserve equal attention when it comes to pandemic planning and pandemic resources, but not all [citizens] are equal when it comes to health status, nor are they equally able to take necessary steps to protect themselves or their families" (Blickstead & Shapcott, 2009, p. 2). The sources of risk may be medical or social, or both. Those who are medically at risk will experience poorer health outcomes following infection; those who are socially at risk are more susceptible to infection because of their life circumstances, but do not necessarily have poorer health outcomes than the general population (International Centre for Infectious Diseases [ICID], 2010). Risk can sometimes be attributed to health conditions, but poor health outcomes are also frequently a reflection of broader social conditions produced by inequities in social, economic, legal and political processes that fail to distribute resources and support equally among citizens (Canadian Red Cross, 2007).

According to leading health researchers Mikkonen and Raphael (2010): "The primary factors that shape the health of Canadians are not medical treatments or lifestyle choices, but rather the living conditions they experience. These conditions have come to be known as the social determinants of health" (p. 7). People who are medically and/or socially at risk because of the determinants identified by Mikkonen and Raphael (2010) and the Public Health Agency of Canada (2003) will not experience a public health crisis in the same way as those who are not considered to be high-risk individuals or part of a high-risk group (Ng, 2009). Being high risk reduces the ability of people to prepare before a pandemic, and cope or adapt once an outbreak has begun. At its worst, the potential for a pandemic to exacerbate existing social and economic inequalities underscores the importance of considering a pandemic, not only as a pressing public health issue, but also as an urgent matter of social justice (Uscher-Pines, Duggan, Garron, Karron, & Faden, 2007).

Who is at risk often depends on the type of emergency and the degree of preparedness (Chen, Wilkinson, Richardson, & Waruszynski, 2009). Researchers have identified a number of high-risk populations: people with disabilities (Campbell, Gilyard, Sinclair, Sternberg, & Kailes, 2009; Martin & the Medical Needs Task Force of the Emergency Preparedness for People with Disabilities Committee, 2009); the elderly (Hutton, 2008); prisoners (Hoff, Fedosejeva, & Mihailescu, 2009; Maruschak, Sabol, Potter, Reid, Cramer, 2009); low-income individuals and families (Blumenshine et al., 2008; Blickstead & Shapcott, 2009); tribal communities (Groom et al., 2009); and Aboriginal populations (Appleyard, 2009; Herring & Sattenspiel, 2007; Ministry of Health and Long-Term Care, 2009; Ng, 2009). Additionally, race/ethnicity, language and culture can be barriers to adequate health care and pandemic readiness (Ng & Bray, 2009). These are not mutually exclusive categories, but represent real people whose lives are shaped by a multiplicity of identities, relationships and living conditions (Canadian Red Cross, 2007). It should also be recognized that people may experience multiple risk factors simultaneously or at different times in their lives (ICID, 2010).

The need to focus on high-risk populations in emergency and pandemic planning is well documented, and policy-makers are continually reminded to identify groups that are socially disadvantaged and create plans with health equity in mind (Hutchins, Truman, Merlin, & Redd, 2009; ICID, 2010; WHO, 2007, 2009a, 2009b). Ng (2009) notes the planning process must also include those who themselves are at increased risk:

> *We can say that without unambiguous inclusion of the knowledge, experience and needs of the vulnerable and those who work closely with them, such planning will be essentially for the benefit of healthy, able-bodied, English-speaking, Christian, white, literate, middle-aged men with reasonable income and housing. In short…emergency planning for a minority (p. 23).*

Emergencies have become a common part of modern life. Planning, preparing and responding to them is a collective responsibility requiring that thoughtful and sustained consideration be given to those who may face

an increased burden as a result of medical or social risks, or both. While pandemic planning may serve as an opportunity to identify sources of risk and think about how to address them, efforts to eliminate social and structural inequalities must continue long after a crisis has passed.

Researching Pandemics in the Context of Canadian Homelessness

The negative health outcomes associated with living on the street or without stable housing are well documented in Canada (Daiski, 2007; Frankish, Hwang, & Quantz, 2005; Guirguis-Younger, McNeil, & Hwang, 2014; Hwang, 2001; Kelly & Caputo, 2007). Yet only a few published studies have focused on homelessness as an issue that poses challenges to pandemic planning efforts (Badiaga, Raoult, & Brouqui, 2008; Brouqui et al., 2010). There are certainly many lessons to be learned from the previously noted literature on high-risk populations that can be applied to planning in the context of homelessness. However, there are many challenges unique to those experiencing homelessness and to the agencies and providers that work with them, and also to the sectors that emerge to coordinate the provision of services to them. To give just a few examples, homeless shelters are often congregate settings, homeless people may be skeptical of health care providers, based on previous negative experiences, and the transience of many homeless people makes sustained contact and medical monitoring difficult.

At the same time that H1N1 emerged as a global influenza pandemic in 2009 and 2010, our team of interdisciplinary Canadian researchers undertook a multi-city study of how the planning and response for this pandemic unfolded within the context of homelessness. A primary research question guided the study: “In what ways does our current emergency response to homelessness impact on the vulnerability of homeless populations in the event of a pandemic, and present challenges to effective pandemic planning?” Supporting this were three sub-questions:

1. What risks does a potential influenza pandemic pose to people who are homeless in Canada?

2. How do the design and structure of emergency homelessness services impact (in both positive and negative ways) the spread of infectious diseases?

3. How adequately prepared are the interdependent infrastructures that work with vulnerable populations, such as the homeless, in the event of a pandemic?

While homelessness exists across Canada, it is not experienced or addressed in a uniform way, as evident in the Canadian definition of homelessness that utilizes a typology approach.[1] To reflect this reality, the research sites selected were diverse in geographic location, size, and demographics. These sites included (from west to east): Victoria, British Columbia (led by Dr. Bernadette Pauly); Calgary, Alberta (led by Dr. Jeannette Waegemakers Schiff); Regina, Saskatchewan (led by Dr. Rebecca Schiff); and Toronto, Ontario (led by Dr. Stephen Gaetz[2]). A common set of survey and interview questions was asked of homeless participants in all four cities (n=351), and semi-structured interviews were conducted with social service providers and/or key stakeholders in each city as well.[3] Although each research site used the same research instruments to guide data collection, the number of participants varied at each site. The specific details are outlined in each city chapter in this book. Research ethics approval was provided by the Research Ethics Board of each lead researcher's respective institution prior to data collection.

[1] Refer to Appendix A for the Canadian Definition of Homelessness document.
[2] Assisted by Dr. Kristy Buccieri.
[3] For research guides, please refer to Appendix B (homeless participant survey), Appendix C (homeless participant interview), and Appendix D (service provider interview).

	N (%)		N (%)
City		*Sex*	
Calgary	118 (33.6%)	Male	238 (67.8%)
Regina	40 (11.4%)	Female	105 (29.9%)
Toronto	149 (42.5%)	Transgendered	4 (1.1%)
Victoria	44 (12.5%)		
Age		*Age First Homeless*	
Mean (SD)	38.51 (13.18%)	Mean (SD)	28.17 (13.77%)
Youth (16–24)	85 (24.2%)	Range	4–66
Adult (25+)	259 (73.8%)		
Aboriginal/First Nations		*Visible Minority*	
Yes	110 (31.3%)	Yes	103 (29.3%)
No	214 (61.0%)	No	218 (62.1%)
Sexual Orientation		*Immigration Status*	
Straight	293 (83.5%)	Canadian Citizen	317 (90.3%)
LGBTQ	42 (12.0%)	Landed Immigrant	16 (4.6%)
		Refugee	5 (1.4%)

Table 1: Overview of Homeless Participants Combined (n=351)

Structure of the Book

This collected volume features chapters that take a broad look at issues involved in pandemic planning for homeless populations, detail city-specific responses to the H1N1 outbreak and provide a collective comparative look at the self-reported health and wellness of homeless individuals in the four cities. Each chapter offers unique insights into the issues of pandemic planning, preparedness and response in relation to homelessness in Canada.

The volume begins with a chapter entitled, "The Worst of Times: The Challenges of Pandemic Planning in the Context of Homelessness," in which Gaetz and Buccieri consider how the current emergency-based Canadian response to homelessness poses challenges to the health and well-being of homeless people, through an unsustainable system that will become further strained in the event of a serious, deadly pandemic outbreak. The authors propose six considerations for governments and

service providers, including support for planning, infection control, system capacity, inter-sectoral collaboration, communications and training, and unpredictability. In the chapter that follows, "Accessing Justice Amid Threats of Contagion,"[4] Mosher discusses the common perspective of pandemics as global threats to national security, and proposes an alternative framing that incorporates a social justice lens and a focus on the social determinants of health. These chapters appear at the beginning of the book to offer context and a theoretical structure for the research findings.

The chapters that follow offer individual case studies of how four diverse Canadian cities planned for and responded to the H1N1 outbreak in relation to homeless citizens. These chapters outline, respectively, the experiences of Victoria, British Columbia (authored by Pauly); Calgary, Alberta (authored by Waegemakers Schiff and Lane); Regina, Saskatchewan (authored by Schiff); and Toronto, Ontario (authored by Buccieri). These chapters discuss the experiences of the four cities and outline key lessons learned in each. In the final chapter of the book, "Pandemic Preparedness in the Context of Homelessness: Health Needs and Analysis of Pandemic Planning in Four Canadian Cities," the researchers consider the data collectively to share findings on the health and wellness of homeless individuals across Canada.

The threat of a pandemic outbreak is always a serious one that challenges the already-strained sectors working with homeless individuals. This book offers insights from a multi-year, multi-site study on how pandemic planning unfolded in cities across Canada for the H1N1 outbreak. It is intended to serve as a resource, to share lessons and to learn from one another's strategies and strengths. The best response to a pandemic outbreak for people experiencing homelessness is to address the social and structural barriers that produce and reproduce their vulnerabilities in the first place.

[4] Reprinted with permission. Original citation: Mosher, J. E. (2014). Accessing justice amid threats of contagion. Osgoode Hall Law Journal, 51(3), 919-956.

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