New Nouveau Brunswick
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Summary Report

2009 Pandemic H1N1 Mass Immunization in New Brunswick First Nations Communities

Office of the Chief Medical Officer of Health

Department of Health

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Acknowledgements

Thank you to everyone who was involved in the NB H1N1 FN mass immunization program and the development of this report.

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Introduction

Public Health (PH) is both an art and a science that focuses on preventing disease, prolonging life and promoting health of the entire population at both the individual and the community levels through the organized efforts of society (Last, 2001). The practice of PH encompasses a range of activities performed by different levels of government in collaboration with a wide variety of stakeholders and communities. The focus of public health interventions is to prevent rather than treat a disease through the surveillance of cases and the promotion of healthy behaviors i.e. immunization.

The role of the New Brunswick Office of the Chief Medical Officer of Health (OCMOH) is to plan, fund, and monitor mandated public health programs, which includes immunization, as well as to provide selected public health service delivery. In the province public health is divided into four regions each having a Regional Medical Officer of Health (RMOH). Regional Medical Officers of Health practice on behalf of the OCMOH to provide regional support to ensure that policies, and in this case, immunization, are implemented. They act as community medicine specialists for the regional teams.

The New Brunswick Immunization program is delivered by a variety of immunizers; one of the main groups being the RHA's public health staff. In the province there are two Regional Health Authorities ; RHA A and Horizon Health Network (formerly known as RHA B) which are responsible to ensure OCMOH policy decisions are implemented in each of their regions however they deem most efficient and effective, given the nature of their population and resources.[1]

Registered nurses in the province may immunize clients however he/she must be competent in the practice of immunization and be in possession of a medical directive that allows him/her to administer epinephrine, as per the New Brunswick anaphylaxis management protocol. The training and competency of the nurse is a shared responsibility between the nurse and the employer. Typically, nurses receive the necessary training upon being hired by their employer and then his/her practice determines the level of competency. RHA public health nurses receive training from the RHA upon employment as an immunizer. The medical directive for RHA public health nurses is provided by the RMOH in that region. The RHA's provide immunization services through a variety of settings such as public health clinics, school clinics and physician offices. Vaccine is acquired from central serum depot and the RHA's are responsible for storage,

[1] Taken from **New Brunswick Department of Health Provincial Pandemic Plan; Public Health Annex** Version 1 - September 10, 2009

handling and distribution of the vaccine as well as providing necessary supplies for immunization such as needles and syringes.

First Nations in the province also receive routine publicly funded immunization services through a variety of settings: physician's office, First Nation community health centers, Public Health Offices and public schools. When immunization is delivered by a Community Health Nurse (CHN) in a First Nation Health Centre, the same practice protocol is required i.e. the nurse must be competent to implement and manage a community based immunization program and have a medical directive. The necessary medical directives for the CHN's to immunize are acquired by the Bands through a variety of models that differ from community to community. Resources that may support the CHN's immunization practice include the NB Immunization Handbook, other CHN'S, the First Nations and Inuit Health, Atlantic Branch, (FNIH) immunization coordinator and professional relationships with RHA immunization teams. Vaccine for the community immunization program is obtained from the provincial serum depot and managed by the nurse. Needles and syringes are provided by Band's health program. FN community immunization programs are not currently integrated with the RHA's. For example they do not report immunization directly into the central data base immunization registry, Client Service Data System (CSDS).

Mass Immunization

The ultimate goal of mass immunization is to facilitate an efficient and effective response to control an outbreak of an infectious disease through immunization of at-risk groups by mobilizing required resources (regionally and, if needed, provincially) in an efficient manner; providing immunizations safely and as quickly as possible; and monitoring the safety and effectiveness of the immunization program. During mass immunization the provincial public health responsibilities are to:

- procure and distribute the vaccine to the RHA's
- determine vaccine sequencing
- recruit clinic staff and physicians
- develop a medical directive
- develop public and professional education materials
- communicate to the public
- collect, analyze and report immunization data

The RHA's role is to implement such policies set by the OCMOH and to administer the immunization program.

Methods

On April 28, 2009, the first lab confirmed case of pandemic H1N1 occurred in the province of New Brunswick (NB). During the summer months, as the first wave of the pandemic waned, planning for both the arrival of the second wave and the H1N1 immunization program began. As a result of the severe impact that was seen in Aboriginal people living on reserve in other parts of Canada, it was felt important to ensure that immunization of Aboriginal people was priority in the New Brunswick planning. On August 18, a meeting was held with First Nation Chiefs, Community Health Directors, the Minister and Deputy Minister of Health, the Chief Medical Officer of Health, Assistant Deputy Ministers, RHA A and Horizon Health Network (HHN) and employees from the Policy and OCMOH divisions of the Department of Health (DOH. The goal of this meeting was to discuss the path forward for H1N1 mass immunization for First Nations. During the meeting the DOH communicated to FN Chiefs that the H1N1 immunization program for First Nations communities was a departmental priority. A draft framework [2]for H1N1 communications between the DOH, OCMOH, and RHA public health with First Nation community leaders and staff (see appendix) was presented and discussed. This communications framework described the roles and responsibilities of the DOH and the Regional Health Authorities for communicating with First Nations communities in New Brunswick on Pandemic (H1N1) 2009 planning and response, to ensure that there was a specific communication link established with each First Nation. Consensus was reached that it was an appropriate model for communicating during the second wave of the pandemic. Participants left this meeting with an agreement that RHA PH staff would connect with First Nation communities in their areas for further planning. The following outlines both the provincial and regional processes that were put in place for H1N1 mass immunization in First Nations communities.

A. Provincial process

To ensure a safe and equitable process for H1N1 immunization there was a need to streamline processes across the province; hence the development of a H1N1 immunization program plan for First Nation community based clinics. A model was developed that supported the RHA Public Health immunization teams to implement the H1N1 mass immunization program in each First Nation community.

[2] prepared by the Department of Health Emergency Operations Center (EOC)

Ongoing dialogue occurred between the DOH and the RHAs throughout this time frame. This provided the opportunity for open discussion, question and answer periods and assurance that consistent provincial communication and planning was occurring.
As each First Nations community, their geographical location and the local public health program delivery varies across the province, the operational components of each plan needed to be individualized for each community.

B. ***Regional process***

Meetings occurred within each RHA geographical area between the RHA First Nation public health representatives and the individual First Nations community planning teams. The RHA First Nation representatives made visits to each community to discuss the individual plans and resources. The RMOH and Regional Public Health Directors also visited the communities to provide community wide information sessions to help alleviate any fear and/ or anxiety around the H1N1 vaccine.

For H1N1, the RHA's public health immunization teams were responsible to manage the vaccine distribution, storage and handling as well as, provide supplies and manage records. RHA immunization teams went to each FN community with immunization supplies, vaccine and immunizers and the community provided assistance by determining an appropriate location, recruiting volunteers, setting up, providing lists of people to be immunized, managing traffic communications to the band and community members, and supplying items such as stickers for children, refreshments for those feeling unwell or special services for elders. Leadership for the FN component of the plan varied in each community but ranged from Health Director, Chief, CHN and many community staff and volunteer members. The RHA immunization teams were responsible for immunization training and provided this to the nurses working in FN communities.

With the location of the Fredericton campus of University of New Brunswick (UNB) Faculty of Nursing being located within the geographical area of Horizon Health Network and three First Nation communities, the UNB community health nursing program had ongoing partnerships with these three communities. This helped immensely during the H1N1 Mass Immunization program as this collaboration continued. UNB faculty and students were familiar with the communities so they were able to offer suggestions for planning in each community, what would be needed for the clinics, and how to collaborate with the community. UNB nursing clinical groups were also incorporated into RHA training sessions.

Outcome

On January 28, 2010, the OCMOH held a debrief session for First Nation Chiefs, Health Directors and CHN's. The purpose of this gathering was to provide an opportunity for the Chiefs and their health teams to give feedback on their individual First Nation community H1N1 immunization programs. The meeting began with a traditional opening and closing ceremony given by an elder. Representatives from First Nation communities attended the meeting and the Chiefs joined the meeting by teleconference to provide their feedback. Others in attendance included the Deputy Minister, Chief Medical officer of Health, Deputy Chief Medical Officer of Health, Regional Medical Officers of Health, staff from Policy and Planning and the OCMOH divisions of the DOH, the FNIH Atlantic team and RHA Public Health directors. Also in attendance were the Health Technicians from MAWIW and UNBI and representation from the Atlantic Policy Congress. The Deputy Chief Medical Officer of Health presented an overview of the H1N1 immunization data and the impact of the vaccine on the health of NB's First Nations population. The meeting then continued forward with a series of presentations given by the Chiefs and each individual community. The summary of their feedback is provided below.

A. Chief's collective comments [3]

Successes

The Chiefs expressed a few challenges with the clinics held within their respective communities however; overall they were pleased to see that the program was delivered on-reserve with little difficulty.

Challenges:

- Each community planned for a variety of different populations : some communities planned for their full on reserve population only (including non –native/ non – status);others planned for all their membership regardless of where they resided (on /off) in addition to those residents with no status yet reside on reserve; and some planned to immunize all who came to their community clinics
- Information on the Government of New Brunswick (GNB) website did not clearly identify the target group for the community clinics
- A shortage of vaccine as the First Nation clinics were rolling out created a problem and some communities were forced to create priority groups. Given that the vaccine amounts were based on the registered population only for each community, some were forced to turn people away

B. First Nations communities' collective feedback[4]

Below is a summary list of the successes reported from the debrief meeting, written reports, emails and phone conversations.

Successes

- August planning meeting with the DOH and the RHA's
- Continual communications with the FN Advisory group[5]
- Coverage rates for community members that attended community clinics ranged from 82-100 %[6]. First Nation's being identified as a priority group for vaccine in NB was a factor in the success
- Establishment of partnerships between the RHA and FN community health staff. RHA identified key communication leads for the FN: this provided a means for consistent messaging and regular updates. Regional Medical Officers of Health, RHA Public Health Directors and RHA FN liaisons visited the communities prior to the clinics to have sessions to answer questions and provide information
- Community clinics created a level of trust and comfort. The community members reported to be treated professionally and respectfully. By having the clinics in the communities clients were able to be greeted by familiar people which included community volunteers, UNB staff and students, and health centre and other band employed staff
- Created interest from public health staff to learn more about the FN communities within their catchment areas
- Staff from the DOH being present in the community during clinics was a great support
- Communities were creative and took the lead in what processes would work in their respective communities. Some examples were: communication to their members through community forums and personal phone calls to parents; development of pandemic emergency kits and H1N1 information kits for each household; and implementing a variety of mass immunization models such as children's second dose clinics
- High level of community involvement. Examples consist of: ensured special waiting areas available for seniors or those who needed a quiet place ; arranged for band office staff to assist with the clinics ; had community security staff on site; supplied stickers and prizes

[3] NB Chiefs meeting teleconference with debrief participants Jan. 28, 2010
[4] Feedback was received from community health nurses, community health representatives, health directors, UNB Students and faculty, and RHA public health staff
[5] NB FN Advisory group is a forum that can effectively address First Nations Strategic Health Policy and Planning in NB
[6] Data obtained from FNIH Atlantic Epidemiology team; NB FN Coverage rates for H1N1 December 2009

for the children; provided beverages for those feeling faint; and provided suppers and snacks for staff working long hours

- UNB Students delivered immunizations (along with instructor) to a number of homebound people,developed community notices and information sheets related to seasonal influenza, and HINI pandemic influenza
- UNB Nursing faculty acted as liaisons between the health centre staff , public health , and community leadership
- In some communities the uptake of seasonal influenza vaccinations was greatly increased from previous years as UNB students administered the seasonal influenza vaccines

Challenges

- Community health nurses practicing in First Nations communities had difficulty in determining community and band members that were immunized as they did not have access to the provincial database and some communities did not receive paper copies of consents and or data form line lists
- Communications was a challenge. There was a fear that if many people came from a neighbouring FN community then it may cause a shortage of vaccine for the community that was holding the clinic. This caused a dilemma for the community leadership as it is very difficult to turn people away however clinics were held for band and community members only. Confusion also existed among community planning teams as to who exactly was eligible
- Lack of clarity concerning the application of the medical directive for community health nurses as they are not RHA staff and as a result, some CHN's were told they were unable to immunize
- New community health staff hired and required immediate training
- All communities did not hold their clinics during the same timeframe. As a result there was confusion among community members as to why they didn't have a clinic in their community at the same time as others. For example, one community held their clinic 3 weeks after the other FN communities held theirs
- Finding large and appropriate space to hold clinics in the community was sometimes a challenge
- Difficult for FN health teams to understand and navigate through the DOH and RHA networks
- Some community health teams were not involved in the initial regional planning for the clinics

The overall responses from the RHA public health teams was very positive and reflects the comments of First Nation communities in that the RHA staff were "welcomed" into the communities and were part of the community team with a common goal.

Summary of Key Findings and Suggested Actions

The points below have been brought forth by First Nation Chiefs and their health teams. They are both suggested actions and key findings relating to mass immunization in their communities.

A. Records and data management

- Community Health nurses do not currently have access to the provincial client service delivery system (CSDS) i.e. immunization registry. Copies or originals of such records of H1N1 immunization information was available to some of the CHN's working in First Nation communities however this practice was not consistent, leaving these communities with a need to photocopy many consent forms. Community health nurses require access to, and or copies of, immunization records and community data during mass immunization programs

B. Communications and PH Messaging

- Communication around First Nation community mass immunization clinics needs to clearly identify the specific target group
- First Nation communities need to have access to consistent, current information especially around priority status of FN vaccine groups
- First Nation communities need to have access to provincial communication tools and resources
- Mass immunization clinics for First Nations are successful when held in their communities.

Relationship building

- RHA First Nation liaison representatives and FN community health teams continue to build on the relationships established during H1N1 Mass immunization.
- The level of trust was increased by having Regional Medical Officers of Health and RHA Public Health Directors and their teams visit the communities when disseminating H1N1 information.

- Having the support of the Minister of Health, Deputy Minister and Chief Medical Officer of Health in attending First Nation community mass immunization planning and debrief meetings was important.
- RHA public health staff exhibited an interest in learning more about the community's culture.

Conclusions

Overall the H1N1 mass immunization program for First Nations in New Brunswick was very successful. Data collected from First Nation communities, compiled by FNIH, showed that, on average, there was 90% coverage from the community based clinics. [7]This reflects the creative planning by First Nations and the collaboration that took place with the Regional Health Authorities.

One of the key findings throughout this process was reflected by First Nation leadership and community health teams. The ability to mobilize their communities, incorporate their individual cultural practices , establish linkages with the RHA's and have such high coverage rates, demonstrated a community mass immunization model that was a success. These H1N1 immunization clinics supported the First Nations culture of community, family and friends as each community planned along with the RHA's. In moving forward this practice could be considered when planning future mass immunization programs.

First Nations communities were part of the planning, implementation and evaluation of this program. The entire process was not without challenges and frustrations however, RHA public health and First Nation immunization teams have set the stage for a future model to provide quality, safe and equitable mass immunization in First Nation communities in New Brunswick.

[7] Data obtained from the FNIH Atlantic Epidemiology group, Coverage rates for FN communities in NB Dec 2009

References

First Nations Communications Protocol; Approved September 23, 2009; Department of Health, Emergency Operations Centre

Last, John M. A Dictionary of Epidemiology; fourth edition 2001. Oxford University press, New York, NY

APPENDIX

First Nations Communications Protocol

Approved September 23, 2009

Department of Health

Emergency Operations Centre

This protocol describes the roles and responsibilities of the Department of Health, Regional Health Authority A and Regional Health Authority B for communicating with First Nations communities in New Brunswick on Pandemic (H1N1) 2009 planning and response.

This protocol will be incorporated into a more comprehensive document outlining roles and responsibilities of all levels of government with respect to First Nations and Pandemic planning and response.

The New Brunswick Department of Health (NBDH) will ensure that there is a specific communication link established with each First Nation. Information targeted to health care workers and the general public will be channeled through Regional Health Authority A (RHAA) and Regional Health Authority B (RHAB) lead contacts. Attachment 1 identifies the RHA lead contacts and alternates. These individuals have responsibility for the overall communications process. The attachment also contains names and contact information for Regional Medical Health Officers, other Public Health staff and First Nations contacts. The names, titles and contact information are correct at the time of writing. It will be the responsibility of each First Nation and each RHA lead contact to keep the lists current into the future.

Information not normally communicated through the health sector such as information to schools (communicated by the Department of Education) and day cares (communicated by the Department of Social Development) will be sent from the Department of Health to the Aboriginal Affairs Secretariat for distribution to applicable First Nations Chiefs in New Brunswick. It is expected that the Chiefs will forward the information to those in their communities with a need to know.

The Department of Health will copy all communication that it expects to be received in First Nations communities to the designated contacts within FNHIB.

First Nations Communication Framework

- **Department of Health**
- **Types of Information:** There are two types of information that can flow from the Department of Health:
- 1. that which is received from federal sources such as the Public Health Agency of Canada and the First Nation Inuit Health Branch;
- 2. information generated within the Department of Health from sources such as the Office of the Chief Medical Officer of Health and the Emergency Operations Centre.
- **Action:** Once information is reviewed it is distributed to the Regional Health Authority A and B for their appropriate dissemination.
- **Regional Health Authority A and B**
- **Types of Information:** Information received from the Department of Health, as well as, generated directly within the RHA. The information would be related to prevention, control and treatment for pandemic H1N1.
- **Action:** Receive information from sources such as the Department of Health and disseminate, via a specified RHA contact, to the First Nations Communities (including Chiefs, Health Directors, and Community Health Nurses).
- **First Nations Communities**
- **Types of Information:** Information is received from the Regional Health Authority and/or the Regional Medical Officers of Health for the use within the First Nation community.
- **Action:** Inquiries should be made to the specified Regional Health Authority contact for the community.
- **Regional Medical Officers of Health**
- **Types of Information:** Localized advisories and direct orders affecting a specific individual or community.
- **Action:** Regional Medical Officers of Health issues an advisory or order under the authority of the Health Act.

August 13, 2009

First Nations Communications Framework