MSF COVID-19 OPERATIONS IN CANADA 2020

Photography note: While MSF publications normally feature images of medical action undertaken in our field operations, the COVID-19 operations in Canada were unusual as the work was primarily consultation and communication rather than direct patient care. Stock photos were selected to provide imagery indicative of each of the four targeted population groups.

Guided by principles of medical ethics, impartiality, neutrality and independence, Doctors Without Borders/Médecins Sans Frontières (MSF) responds to international humanitarian emergencies, assisting people affected by conflict, persecution, disasters and disease outbreaks. Working largely in countries unable to provide the necessary medical response, MSF regularly responds to cholera and measles and has been at the forefront in addressing outbreaks of Ebola.

The COVID-19 pandemic is an unprecedented threat to the lives and well-being of people around the world. As a result, MSF was compelled to respond globally, expanding operations to include countries that normally have high-functioning healthcare systems. In March 2020, MSF Canada took the exceptional decision to launch an operational response in Canada, targeting communities most vulnerable to the spread of COVID-19 and its impacts. Operations concluded on July 15, 2020.

INITIATING OPERATIONS

In Canada, COVID-19 cases began increasing in March 2020, just as the World Health Organization declared a pandemic. European countries were already starting to see the devastating consequences of the virus. Anticipating the Canadian healthcare system might become overstretched, and that practical support by experienced field workers would be needed, the MSF Canada board took the extraordinary decision to approve operations related to the COVID-19 pandemic in Canada. A small team was assembled. At the same time, appeals were coming in from across the country requesting MSF's expertise and support in scaling up COVID-19 interventions.

Given MSF does not have the operational infrastructure in Canada to run medical projects, we knew our COVID-19 operations in Canada would be modest, or in support of other organizations' activities. However, MSF's capacity in managing emergencies, and experience in rapidly scaling up access to lifesaving medical care and infection prevention and control (IPC) systems in an outbreak could fill a crucial gap.

Experienced field workers in Canada were eager to get involved. MSF connected Canadian field workers, unable to go on international field assignments due to travel restrictions, with organizations looking to benefit from their experience and expertise.

The justification for an MSF intervention was based on analysis of needs, response gap, MSF's unique added value and feasibility.

Regional coordinators in British Columbia, Northwest Territories and Quebec were identified to make local connections and determine if an MSF operational presence was needed. In Montreal, a team completed assessments of four long-term care facilities. In Toronto, a partnership with a medical association working with people experiencing homelessness was established.

BALANCING CANADIAN OPERATIONS WITH GLOBAL PRIORITIES

The intervention was approached with careful consideration to balance our resource inputs here in Canada with the usual flow of people and financial resources to crisis zones around the world. Generally, the team participating in the Canada response included people who would not otherwise have been sent out internationally during this period of time. Financially, the Canadian operations team was given an initial exploratory budget of $100,000. This limited envelope ensured we would not use significant funds that would otherwise go overseas, without further justification based on needs assessed here in Canada. Ultimately MSF Canada's intervention cost $104,200. This amount allowed us to fully maintain our targeted support to global field operations at approximately $60 million for 2020.

INTEGRATING EQUITY, DIVERSITY, INCLUSION INTO MSF'S RESPONSE

In keeping with MSF's social mission, any undertaking in Canada was designed to prevent the furthering of global, institutional or social inequities.

With the assistance of MSF Canada's Equity, Diversity and Inclusion (EDI) Officer, all COVID-19 interventions or partnerships considered health inequities, access to healthcare, and the impacts of socio-historical context and socio-cultural norms on health-seeking behaviour, adherence to treatment and agency of the target population. The EDI Officer developed guidelines to help define target populations, and assessment tools that acknowledged the realities and challenges that individuals and groups exposed to COVID-19 already faced. All operations team members received an EDI briefing and the regional Emergency Coordinators (Emcos) included EDI tools as part of the assessment framework.

UNDERSTANDING THE NEEDS AND REFINING MSF'S ROLE

By the beginning of April, MSF placed Emcos in Montreal, Toronto and Vancouver, where the three most significant outbreaks were occurring. MSF also placed an Emco in Yellowknife, presuming there would be outbreaks in Canada's northern Indigenous communities. In almost all locations our engagement took the form of real-time advisory support.

By May 1, 2020, trying to identify COVID-19-related gaps and needs across Canada, all teams came to the same conclusions:

- Canada's provincial public healthcare systems generally seemed to cope well with the caseloads.
- Local COVID-19 efforts needed better coordination of existing resources and actors rather than an increase in the number of actors intervening.
- Pre-existing issues such as food and housing insecurity and lack of access to health services were resulting in increased COVID-19 risk for many communities. These social and health inequities will need long-term, systemic solutions.

In a traditional MSF emergency response, the first priority is completion of a comprehensive needs assessment to guide decision making and program design. Undertaking a full COVID-19 needs assessment of Canada was not possible given the size of the country and need for a timely pandemic response. Given that MSF had never been operational in Canada before and was looking for partnerships, we relied on the local organizations approaching us and expressing their concerns and needs.

Through a number of requests and conversations we quickly decided to narrow our focus in three ways (subsequently adding a fourth), by exploring the needs of:

01. people experiencing homelessness

02. people living in remote and rural Indigenous communities

03. people living in long-term care facilities, and

04. healthcare and front-line workers.

01

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PEOPLE EXPERIENCING HOMELESSNESS

- Face higher risk of exposure to COVID-19 due to congregate and often overcrowded conditions.
- Often suffer from chronic health conditions that heighten their risk of developing severe complications from COVID-19.
- Saw a reduction or suspension of services during lockdown efforts to stop the spread of the virus: food kitchens had to serve meals at the door, and access to showers and toilets was lost.
- Food and housing insecurity, lack of access to health services, and social exclusion are significant factors affecting the mental health of numerous people in this community.

Out of fear of contracting COVID-19, many people left shelters and slept outdoors, especially in the early stages of the pandemic, when there were few alternatives. In cities such as Montreal, Ottawa, Toronto, Vancouver and Victoria, cities decided to open additional facilities and hotel rooms to decongest existing shelters. Some of these initiatives followed months of pressure from advocacy groups, after active community transmission of the virus was already established.

*In **Toronto**, a partnership between MSF and Inner City Health Associates (ICHA), the only medical association providing care for people experiencing homelessness in Toronto, was initiated to support the technical logistics and layout of a 400-bed COVID-19 isolation site. Due to community concerns, this site never came to fruition. The team pivoted, carrying out IPC visits at shelters and organizations supporting people experiencing homelessness. In **Vancouver**, MSF entered discussions on ways to support people experiencing homelessness in Vancouver's Downtown Eastside. In both Toronto and Vancouver, local organizations and advocates pressured municipalities early on to mobilize and respond – action was too slow at times but thankfully the number of positive cases remained much lower than initial projections.*

*An early response in **Montreal** had seemingly good results with outdoor day centres and extra shelters being opened, and protective equipment and testing made available for people experiencing homelessness. In March 2020, even before a local state of emergency was declared, Montreal's old Royal Victoria Hospital was converted into a COVID-19 isolation site for people experiencing homelessness who were awaiting testing or were infected, while Toronto's emergency departments were forced to deal with surges of the city's homeless population needing testing and isolation and having nowhere else to go. Unfortunately, Canada-wide data to better understand the situation across the country was not available and even local data was not representative.*

02

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PEOPLE LIVING IN REMOTE AND RURAL INDIGENOUS COMMUNITIES

- Suffer higher rates of chronic health conditions associated with severe illness or poorer outcomes from COVID-19, including diabetes and tuberculosis.
- Often live in multigenerational homes, with higher numbers of people living per household, making social distancing very difficult.
- May lack access to clean water, making handwashing a challenge.
- Face shortages of primary healthcare staff and difficulties accessing specialist care in many communities, amid a sub-standard level of social services delivery.
- Lack sufficient infrastructure, staffing and access to supplies needed for pandemic planning, compounding the many challenges these communities already face.

MSF connected with several Indigenous communities, mainly sharing resources designed to help health and other authorities to prepare and manage COVID-19. Online briefings were created on general IPC measures, with specific considerations for COVID-19, and on repurposing infrastructure for COVID-19. MSF supported Indigenous Services Canada (ISC) to develop guidance on emergency surge health infrastructure and provided technical guidance to Indigenous communities on preparation of COVID-19 isolation sites and pandemic preparedness plans.

Some of the challenges MSF helped address in remote Indigenous communities were similar to those MSF witnesses in developing countries where resources are limited, for example setting up hand washing facilities without running water, and using the natural wind direction against a building to direct air flow.

03

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PEOPLE LIVING IN LONG-TERM CARE FACILITIES

Seniors in long-term care (LTC) facilities, especially in Quebec and Ontario, have suffered disproportionally high mortality rates: 81 per cent of the coronavirus-related deaths in Canada – about twice the average rate of other developed nations. MSF assessments in four LTC facilities (known as CHSLD in Quebec) in Montreal highlighted the issues that impacted people in this setting:

- A lack of proper personal protective equipment (PPE)
- Widespread failure to organize IPC measures
- Staff challenges
- De-prioritization of mental health needs of residents, families and staff

Insufficient IPC measures were exposing staff and residents to infection, resulting in staff absences due to illness and work refusals. Programs and family visits were cancelled. All of these changes inadvertently culminated in deficient patient care and increased isolation, contributing to a rapid physical and psychological decline for some residents.

The bureaucracy to implement changes and share information proved challenging. At the same time, the Canadian military and Canadian Red Cross were given the access, authority and funding to implement IPC measures inside Montreal's LTC facilities. Consequently, MSF decided to refer MSF's staff directly to the Canadian Red Cross, bolstering their LTC response in Montreal, rather than pursue our own activities. In Ontario, the MSF COVID-19 operations team connected with a network of LTC facilities and supported them through advisory sessions and webinars, sharing personal experiences of dealing with feelings of fear and anxiety experienced when responding to outbreaks such as Ebola and cholera.

04

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HEALTHCARE AND FRONT-LINE WORKERS

- Face greater exposure to COVID-19 and risk of transmission, further heightened when proper infection control and PPE are lacking.
- Have to cope with a range of feelings including overwhelm, helplessness and potential impact of the loss of many patients during the outbreak.
- Engage in sustained, high-stress work with the potential for burnout.

While several mental health resources were available or emerging and there was no immediate need for an emergency intervention, MSF responded to ad hoc requests for support from the healthcare community. The MSF team lead participated in a webinar for National Nurses Week, providing peer support by sharing lessons learned from working in epidemic settings, and answering questions. Aiming to ensure longer-term support, the team decided to channel such requests through MSF's speaker request forum. As a result, MSF presented a keynote to front-line workers and others working in LTC at the Ontario Long Term Care Association's annual event, held virtually in 2020.

Toronto shelter visited by MSF for IPC recommendations

EVOLUTION OF THE OPERATIONAL MODEL

As the intervention progressed, MSF's operational model was honed into a consultative support model. The MSF team provided virtual technical support to various organizations and communities. Support included emergency preparation, pandemic planning, IPC advice, site planning and setting up emergency medical infrastructure.

MSF Canada conducted webinars focused on two target audiences: Canada's Indigenous communities and MSF's East African Association. Team members also spoke with a network of LTC facilities and a nationwide coalition of organizations working to end homelessness.

Responding to a lack of human resources with proven outbreak experience and IPC expertise, MSF Canada proactively facilitated the hiring of MSF-experienced staff in Canada for front-line organizations including the Canadian Red Cross, McGill University Health Network, ICHA, Nunavik Health Services, and Sioux Lookout First Nations Health Authority.

MSF also conducted many assessments in Toronto's shelter system and Montreal's LTCs, providing reports and recommendations.

SELECTIONS FROM MSF'S OPERATIONAL TIMELINE

MARCH

MARCH 25
MSF Canada's board approves COVID-19 operations in Canada

MARCH 30
MSF submits designs for 400-bed COVID-19 shelter in Toronto's Better Living Centre and provides Emergency Preparedness guidance to SeeChange and partners in Nunavut

APRIL

APRIL 13
MSF provides technical support to Sioux Lookout First Nations Health Authority

APRIL 14
MSF consults with Fort Hope on IPC & technical guidance

APRIL 15
MSF facilitates human resources to ICHA, Nunavik Health Services & Red Cross

APRIL 16
MSF provides technical guidance & floor plans for ISC's Blue Med Tent program

APRIL 17
MSF provides technical support to the Independent First Nations Alliance

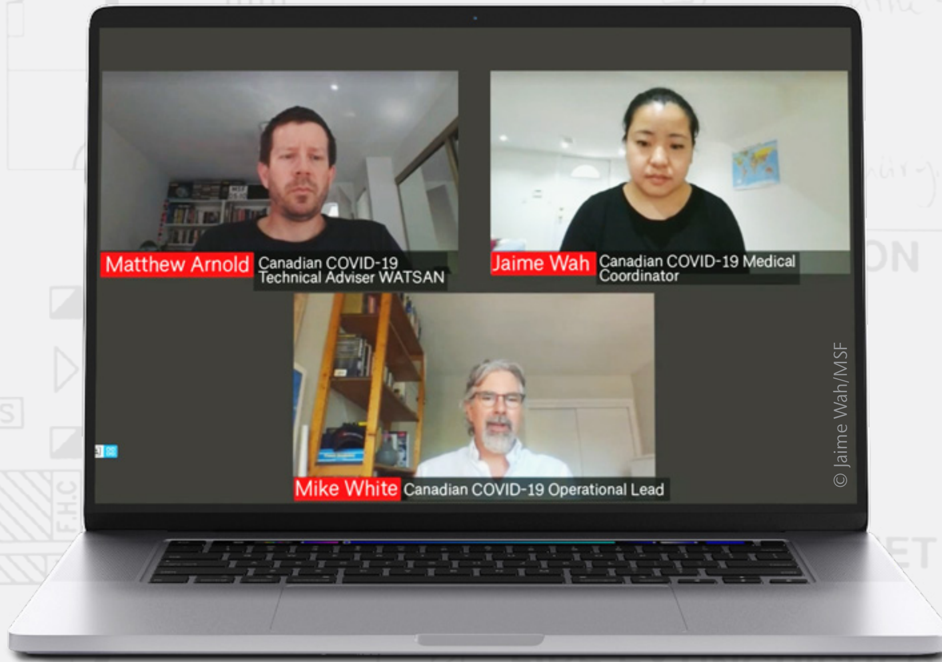
APRIL 21
BLC activities put on hold because community groups & City of Toronto prefer hotel options

APRIL 22
MSF does an IPC assessment at the Four Points by Sheraton COVID-19 recovery site in Toronto

APRIL 24
MSF provides technical support for peopleCare Communities LTC facility

APRIL 26-28
MSF's Montreal team assesses four CHLSDs. Recommendations sent to the Centre Intégré Universitaire de Santé et de Services Sociaux

APRIL 28-30
MSF assesses three Toronto shelters. Reports and recommendations provided.



Members of the MSF COVID-19 operations team meet online.

MAY

MAY 5
MSF supports ISC, producing COVID-19 *Guidance on Site Planning, Layout and Equipment and Supplies for Surge Health Infrastructure* and facilitates human resources to Red Cross in Quebec

MAY 15
Toronto project closes and Quebec Emco contract ends

MAY 22
Seven MSF Canada field workers (logistics and admin) hired by the McGill University Health Network

MAY 27
IPC eBriefing (English) completed

JUNE

JUNE 4
MSF provides pandemic planning to the Wabigoon Lake Ojibway Nation and completes the Medical Infrastructure eBriefing (English)

JUNE 9
IPC conference call with Health Directors from the Grand Treaty #3

JUNE 16
Medical Infrastructure conference call with Health Directors from the Grand Treaty #3

MAY 29-JUNE 22
MSF assesses four Toronto shelters. Reports and recommendations provided.

JULY

JULY 7
Resources shared with Migrant Workers Alliance & Migrant Rights Network

JULY 8
COVID-19 landing page finished

JULY 15
MSF's operations in Canada conclude

PHASING OUT

After three months of exploring COVID-19 support work in Canada, and keeping in mind the needs in our international projects, MSF decided to scale down and phase out operations in Canada.

The Canadian COVID-19 emergency highlighted systemic health inequalities in Canada that existed before the pandemic. Those living in remote locations continue to experience challenges in accessing adequate specialist healthcare. Many communities still face challenges accessing primary healthcare and necessities, such as clean water. Canadians facing difficulties accessing medical care because of insecure, inadequate or nonexistent housing conditions or geographic isolation remain vulnerable.

Despite existing and exacerbated disparities in Canada, there is little need for MSF's specific expertise currently. There is and likely will be a need for experienced human resources (especially IPC expertise) for the foreseeable future, which can be funnelled to other front-line Canadian organizations.

Accessible shower and toilet set up at the Better Living Centre, Toronto.

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LESSONS LEARNED FROM MSF'S CANADIAN OPERATIONS

LACK OF DATA

MSF uses epidemiological data to follow outbreak trends and identify at-risk groups and areas. This helps us target outbreak responses, tailored to people's needs. Each of Canada's 13 provincial and territorial health systems operates independently and collects information differently, including some Indigenous communities having their own health authority. Collected data is not systematically shared between provinces and communities. This siloed data collection means that data on higher risk groups is not readily available. For example, countries like the U.K. and the U.S. have provided data showing certain racial groups are disproportionately more likely to become infected with, hospitalized for, and die from COVID-19. This type of disaggregated data that includes racial or ethnic identity was not available during MSF's intervention. Canada-wide COVID-19 data related to known at-risk groups such as people experiencing homelessness, migrant workers, refugee claimants and asylum seekers was also not available. Without this type of information, it is hard to identify needs and design targeted programming.

Often what is publicly available is the total aggregate data province-wide and not detailed trends, especially at the community level.

LESSON
Collected data should be shared. If citizens are aware of the location where recent clusters of cases of the virus is circulating, they could take further measures to protect themselves, especially in the areas where they work and live. Community-level data is especially useful towards the end of the outbreak, where small clusters of cases will appear from time to time, as well as for remote communities in their efforts to scale responses up or down based on their proximity to the risk.

LACK OF COORDINATION AND EXPERIENCED LEADERSHIP

In MSF's experience, as soon as an outbreak is declared it is a race against time. Immediate, coordinated response efforts can prevent the spread of disease and spare countless lives.

Since the SARS outbreak in 2003, Canada has been preparing and developing pandemic preparedness plans. These plans were designed to outline how jurisdictions would work together to ensure a coordinated and consistent health-sector approach to pandemic response. Although these documents exist, it has become clear these plans were untested or outdated. A national mental health emergency response model is also needed to support responders and communities affected by all types of emergencies.

A single coordinated effort across Canada is intrinsically challenging because healthcare is administered at the provincial, territorial and federal levels. There were differences in the way the COVID-19 pandemic was managed in British Columbia when compared with Ontario and Quebec, such as advising against travel during March break, close coordination between health authorities and LTC management, broader testing criteria and independently sourced and supplied PPE separate from the federal procurement program.

LESSON
Coordinators should be testing and rewriting their pandemic plans in preparation for the next wave(s) and investing in the mental wellbeing of front-line staff. A national mental health emergency response model should also be developed and in place to support responders and communities affected by all types of emergencies.

During the IPC site visits in Toronto, it was clear there were not enough IPC specialists in the public health sector. Many IPC teams from hospitals were mobilized to support local-area LTC facilities and shelters, stretching their capacity. The Public Health department's input was not sought for designs of an isolation shelter – instead, Shelter, Support and Housing Administration funded it, making the final decisions on a public health matter.

LESSON
During a pandemic, all sectors must work and communicate together on initiatives so everyone is aligned and efforts are not duplicated. Coordination is needed at every level – national, provincial, territorial, regional and municipal – not just to make policy decisions but to help guide and shape the response.

DISRUPTED ACCESS TO HEALTHCARE

During MSF's response to Ebola outbreaks in West Africa and in Democratic Republic of Congo, we witnessed a significant increase in deaths from preventable and treatable illnesses simply because the population was unable to access their usual health centres. In Canada, the COVID-19 pandemic has resulted in access to elective surgeries being reduced or cut off, causing adverse health outcomes, especially for cancer patients.

LESSON
Maintaining health service provision is vital because months of delay could lead to negative outcomes. In MSF's response to outbreaks of cholera and measles, safe access to healthcare services is preserved by the identification and use of dedicated assessment and treatment sites outside of the regular health services. This avoids potential contamination of other health structures and their staff and ensures existing health services are not overwhelmed and can continue functioning. Investments in alternative, decentralized modalities of health delivery should be explored, such as telemedicine, home visits and mobile clinics, if disruptions to the health systems are unavoidable.

INCREASED RISKS OF WORKERS IN HEALTH SETTINGS

Inappropriate donning, wearing and removal of PPE poses the largest risk to workers and their colleagues in health settings.

LESSON
Training and reinforcement of the virus' mode of transmission and IPC measures is critical not only for medical staff. Cleaners, drivers, maintenance staff, delivery workers and office staff should understand their role in protecting themselves and others from the virus. If staff are required to wear PPE a good theoretical understanding of why and when to wear each piece is necessary. Knowing how to safely put it on and remove it is essential.

Protecting the psychological wellbeing of staff is just as important as protecting their physical health. Healthcare workers must work through the challenges of COVID-19 in the workplace, supporting fearful patients in the absence of visitors, while managing their own fear and anxiety of exposing their own family to the virus. Mental resilience is tested everyday. Over time this can be too much for some to bear.

LESSON
Psychological first aid and mental health supports should be made available to health workers responding to the COVID-19 pandemic, as they are for other mass casualty incidents.

Right: Sleeping area set up at the Better Living Centre, Toronto.

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The COVID-19 pandemic has challenged even the best resourced health systems, including here in Canada. As a humanitarian organization that normally operates in under-resourced settings, MSF's intervention in Canada was atypical. In retrospect, our intervention was warranted on the basis of MSF's extensive experience in global outbreak response combined with the extra severity of risks to certain groups within Canada. Our added value has been largely advisory and we are proud we were able to contribute in some modest way to Canada's pandemic response.

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