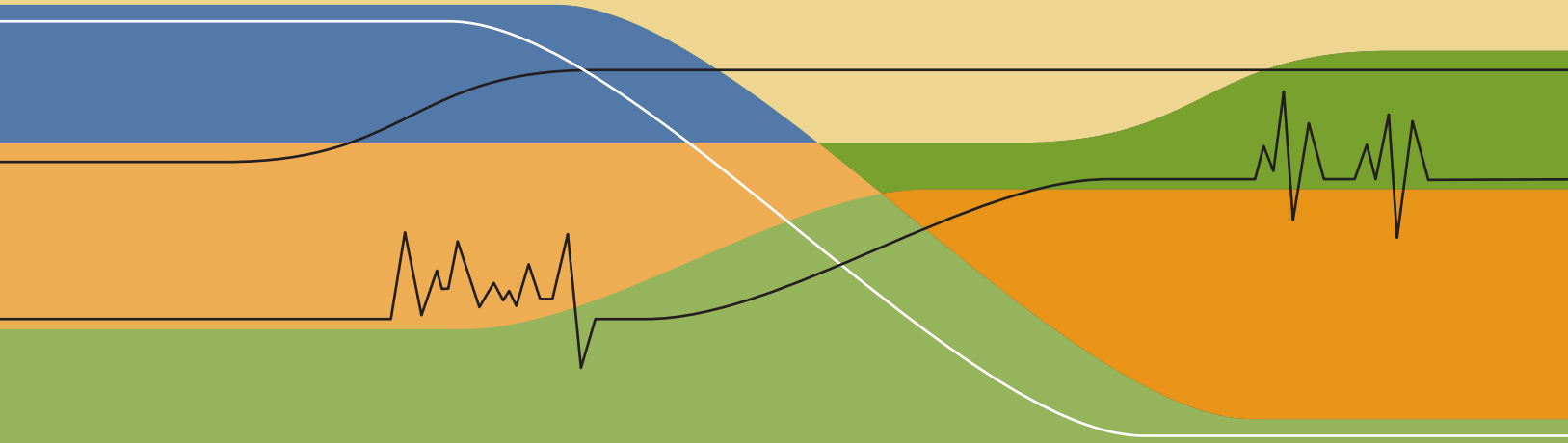
Voluntary Sector Framework for HEALTH EMERGENCIES



2nd Edition

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Thanks and Appreciation

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Supporting Organizations

Canadian Medical Association
Canadian Nurses Association
Canadian Psychological Association
Canadian Public Health Association
Centre for Voluntary Sector Research and Development, Carleton University
Community Foundations of Canada
Edmonton Chamber of Voluntary Organizations
Edmonton Multicultural Health Coalition
Focus Humanitarian Assistance Canada
Mennonite Disaster Service
Policy Link New Brunswick
Volunteer Canada

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TABLE OF CONTENTS

1 INTRODUCTION

Preamble

Mobilizing the Voluntary Sector in a Health Emergency

At present, governments depend heavily on the voluntary sector for emergency response expertise, specialized skills and resources, and an ability to quickly adapt and respond to emerging situations. The voluntary sector is therefore already an integral part of emergency response systems. It has capacities that the public authorities lack and may require in the event of a health emergency, including the ability to mobilize volunteers, access local contacts and networks, and utilize acquired knowledge about the community. The sector also offers practical experience in logistics, communications, and event management. In summary, the voluntary sector contributes not only its tangible human and physical resources but also special means of activating them. Involving the voluntary sector means involving the community in responding to a health emergency.

The voluntary sector also has an important – but currently underutilized – place in Canada's response to health emergencies in particular.

While some voluntary organizations have well-established roles in emergency response, a much broader range of organizations could make vital contributions before, during, and after a health emergency than is currently expected. For one, they can convey important information to their clients in the community regarding the emergency and preventive self-care procedures to limit the spread of infection. For another, they can build "surge capacity" to mobilize volunteers so that their contributions can be effectively applied. They can also take the necessary precautions and steps to ensure that their core services continue to be provided to their clients and the public.

While the emergency response mechanisms in place in most provinces and communities across the country now respond well to meet the needs of affected populations, health emergencies create additional and unique demands. For our purposes, a health emergency can be understood as an occurrence or imminent threat of a serious or life-threatening illness or health condition to a population that exceeds its capacity to cope. (See the *Glossary of Terms* for a more complete description) A health emergency can overwhelm the health care system when the number of affected people surpasses its normal capacity to respond. It can also be widespread, covering a number of provinces, territories and communities at the same time. Health emergencies may also take place rapidly in a specific timeframe. They differ from natural disasters, which, in Canada, tend to be localized (even when they cover a large area, such as a forest fire) or infrequent, even if potentially dangerous, such as earthquakes. In large-scale health emergencies, extraordinary measures are called for. A pandemic, in particular, would add significant international economic, political, and trade implications to the list of concerns.

The voluntary sector can help minimize the potential suffering and socio-economic dislocation that will occur in the event of a health emergency. Public authorities need to understand what the voluntary sector can offer, and how to access its complex array of knowledge, skills and resources. The challenge is therefore to identify and then involve voluntary agencies that can have a positive impact in the preparation for and response to health emergencies.

The Danger is Real and This Is Not a Theoretical Exercise

The risk of a large-scale health emergency in Canada is real and growing. Such emergencies have happened in the past and will happen again. The most recent was the SARS crisis in 2003 in Toronto. Currently the threat of the H5N1 avian flu mutating into a new human influenza strain is seen as the most likely to affect large numbers of Canadians, probably in every region of the country. The potential for an avian flu pandemic to spread rapidly across the globe is exacerbated by millions of people travelling by air around the world, acting as rapid vectors. Canada is also subject to the full array of natural disasters that have the potential to become health emergencies although these would be more localized than a pandemic. The conclusion is that Canadians will have to deal with and react to health emergencies in the future. However events evolve, there will be large numbers of people affected by disease, suffering, death and socio-economic dislocation.

Project Goals

- To recognize the contribution of the voluntary sector and to raise awareness about the risks of health emergencies to organizations within the sector and to the clients they serve.
- To encourage voluntary sector organizations to prepare for health emergencies and to provide resources to assist them in this.
- To encourage voluntary sector organizations to participate in the community responses to health emergencies.

2 SCOPE OF THE FRAMEWORK

Context

In 2001, the Federal, Provincial, and Territorial Ministers of Health recognized the necessity for a more integrated and coordinated strategic plan for emergency management in the health and social services sectors across Canada. The Deputy Ministers of Health then mandated the development of a pan-Canadian framework for health emergency management, resulting in the National Framework for Health Emergency Management, which provides a set of guiding principles for the development of an integrated and comprehensive health emergency management system in Canada.

Although the National Framework does not explicitly outline the role of the voluntary sector in health emergency management, it is recognized that both the government and non-government sectors, including the full range of voluntary organizations, are key to enhancing preparedness and response capacities in Canada. Indeed, the Canadian Pandemic Influenza Plan includes clear expectations of the voluntary sector in Annex J (Guidelines for Non-Traditional Sites and Workers), although further work is required to broaden and define its scope.

This Framework is intended to pursue the dialogue between the voluntary sector and the federal, provincial, and territorial governments about the present and potential roles of the sector in planning and policy formulation, as well as operational matters of health emergency preparedness and response. The process will reflect the commitments in the Accord between the Government of Canada and the Voluntary Sector[1] and the Code of Good Practice on Policy Dialogue.[2]

In very broad terms, overall community management of emergencies is generally a municipal responsibility. However, the regional, provincial/territorial, and federal governments have additional responsibilities depending on the nature and scale of the emergency.[3]

Who May Participate?

Regardless of whether an organization has ever previously participated in emergency response, is big or small, or is local or national in scope, it may play an important role in reducing the impact of health emergencies on Canadians. All organizations should seriously consider whether they could contribute to the community response to a health emergency. It is especially important for local and regional organizations (even if they are part of a provincial or national network) to look carefully at their capacities in a health emergency since the response to a health emergency occurs primarily at the local level.

This Framework is directed primarily at voluntary organizations in which volunteers play an important role in service delivery as well as governance. While umbrella or national organizations may not use volunteers in their activities, their ability to activate networks and mobilize their volunteer or other members may be a distinct and valued role. Where applicable, a role for such associations is expressly included. The roles of hospitals, colleges, and universities are beyond the scope of this Framework, although there can be continued dialogue to explore opportunities for participation.

[1] *Online at: http://www.vsi-isbc.ca/eng/relationship/the_accord_doc/index.cfm*

[2] *Online at: http://www.vsi-isbc.ca/eng/policy/policy_code.cfm*

[3] *F/P/T Network for Emergency Preparedness and Response (2004). National Framework for Health Emergency Management.*

For the purpose of this document, the following definitions apply:

- The "voluntary sector" consists of those entities that are neither for profit nor agencies of the state. It includes incorporated non-profit organizations as well as unincorporated volunteer community groups. It is also known as the community-based-sector, the non-profit sector, the third sector or the public benefit sector. The common feature is their reliance on volunteer boards of directors to govern their activities.[4] See Characteristics of the Voluntary Sector for further information.
- "Voluntary agency" is used interchangeably with "voluntary organization".
- "Volunteer" refers to someone who willingly gives help in the form of time, service or skills, through an organisation or group. Volunteers are generally unpaid, although circumstances exist where they may be compensated for expenses or receive honoraria.
- "Clients" are those who benefit from the services and programs of voluntary sector organizations. Notably, many of these client groups are among societies most vulnerable.[5]

For additional definitions of terms used in this document, please refer to the attached Glossary.

Organizational mandate

This document distinguishes between organizations that have an emergency response mandate from those that do not, recognizing their different needs, roles, and responsibilities. By "mandate", it is meant that an emergency response-related goal or activity is an official part of the organization's constitution or operating principles. In some cases, a mandate can be based on an historic practice and not necessarily be a part of the organization's written documents. Examples of large organizations that have an emergency mandate include the Canadian Red Cross, St John Ambulance and the Salvation Army.

Organizations without an emergency mandate may nonetheless have an important contribution to make in a health emergency, contributing skills and attributes not present in the traditional emergency response organizations. This document will help those organizations decide whether they are potentially interested in participating. Other agencies experienced in this field can provide practical guidance in their preparedness and delivery of emergency services.

Mandate? What Mandate?
During a major province wide blackout in 2004, the Kids Hotline in Ottawa received hundreds of calls from distressed people needing information and re-assurance. This service had virtually nothing to do with the mandate of the Kids Hotline. The agency and the volunteers rose to the challenge.

[4] *Adapted from definitions found at: www.voluntary-sector.ca/eng/about_us/glossary.cfm and en.wikipedia.org/wiki/Voluntary_sector*

[5] *Of Canadian registered voluntary organizations, 23% serve children and youth, 11% serve the elderly, and 8% serve people with disabilities. See Section 3.2 for further details.*

3 CHARACTERISTICS OF THE VOLUNTARY SECTOR

Quantitative Profile

The Canadian voluntary sector includes over 161,000 registered charities and other non-profit organizations. This figure is believed to be a small proportion of the actual number of volunteer groups active in our communities. The following statistics[6] reflect the realm of registered organizations only.[7]

The sector includes two distinct profiles. Large organizations (those with revenues > $1 million, including hospitals, universities and colleges) represent only 7% of the total number, but account for 84% of the revenues and 74% of all paid staff. In contrast, 63% of all registered organizations have annual revenues under $100,000 and only 10% of all paid staff. 54% of all organizations have no paid staff at all.

The sector represents a very large workforce of 1.5 million paid workers and 549,000 full-time equivalent volunteers, totalling over 12% of the economically active population.[8] It is difficult to calculate the number of individual volunteers, as the most active ones participate in a number of organizations. Available data indicate that over half of social service volunteers (including emergency response volunteers) also volunteer for at least one other type of organization.[9]

In the realm of the provision of emergency services, a 2005 survey of 44 Canadian health and emergency services agencies showed that 28% of these agencies had a specific mandate in emergency services. 61% of those agencies without a mandate would be willing to support a response to a health emergency. Therefore, while the agencies with a mandate in emergency services are limited, the number of agencies that could potentially be involved in a health emergency response could be quite large.

To add a cautionary note, two factors may significantly reduce the projected number of volunteers that organizations will be able to mobilize during health emergencies. First, volunteers may not step forward if they fear infection or another health consequence. Experience with SARS showed that fear of infection affected even paid health care professionals' willingness to participate. Second, organizations may discover that some volunteers do not step forward because they volunteer for several organizations and have chosen one of their other volunteer roles as a priority. This will be slightly different for community groups whose main contributions would most often be in the area of relationships, trust, communication and the mobilization of people to safe centers.

[6] *All statistics are based on various reports published before 2004. Updated information will be available on our future project website.*

[7] *All statistics in this section were drawn from the 2003 NSNVO, the 2000 NSGVP, and the 1997-1999 Satellite Account*

[8] *This total of over 2 million FTEs includes hospitals, universities, and colleges; if excluded the total is still over 1.5 million FTEs.*

[9] *See http://www.givingandvolunteering.ca/pdf/reports/Where_Canadians_Volunteer.pdf at page 14.*

Qualitative Profile

In Canada, the vast majority of organizations operate primarily on a community or regional level.[10] Networks and connections across broader geographic areas have evolved, but may vary greatly depending on the nature of the organizations' activities, populations served, jurisdiction, or other factors. No all-encompassing umbrella organization or communications system exists.[11]

73% of registered voluntary organizations serve people other than their own members: 46% serve the general public, 23% serve children and youth, 11% serve the elderly, and 8% serve people with disabilities. When classified by number of organizations by area of activity,[12] the top three categories are sports and recreation (21%), religious groups (19%), and social services (12%). Emergency preparedness organizations fall within the social services category. Health services comprise 3%, while associations (including professional health-related associations) account for a further 5%. Groups involved in law, advocacy and politics comprise 1% of the total.

[10] *64% serve their local community, while 19% serve a region within a province. Only 3% focus on service delivery Canada-wide.*

[11] *While the CRA has a central registry of charitable organizations based on tax returns, charities are only one component of registered organizations. [TBC]*

[12] *Categories refer to the International Classification of Nonprofit Organizations (ICNPO) that divides the sector into 12 major groups. See http://www.statcan.ca/english/freepub/13-015-XIE/2004000/icnpo.htm#group4*

4

ROLES, RESPONSIBILITIES AND FUNCTIONS OF THE VOLUNTARY SECTOR IN HEALTH EMERGENCIES

It is recognized that the extent and details of how the voluntary sector will participate in health emergencies will be determined in partnership with governments at all levels, and will be the community-based component of health emergency response plans.

Assumptions & Guiding Principles for Voluntary Sector Participation in Health Emergencies

- Voluntary agencies have a role to play in responding to health emergencies in support of the public authorities, depending on organizational capacities and the needs of the population affected.
- Participation in the response to health emergencies is motivated by the desire to assist Canadians in the event of such an emergency, this assistance being provided based on need and without profit or gain.
- The practical reality is that voluntary organizations are unlikely to extend beyond their usual activities during an emergency unless they are coping well with the impact of the emergency on their own organization. Internal planning and preparation are therefore critical steps in preparing an agency to consider going beyond its existing mandate and clientele to enable it to be actively engaged in responding to a health emergency. In addition, the question of how community organizations will internally prepare themselves for an emergency when their resources are already over extended remains an ongoing challenge.
- Services offered will be primarily non-medical, although they may include activities such as first aid and psychosocial support.
- Many voluntary organizations serve the needs of vulnerable populations such as elderly, disabled, economically disadvantaged, and youth. This natural connection to determinants of health is a valuable asset that should be recognized.
- Many emergency response organizations are already engaged in practical collaboration in planning and in service delivery in the event of a health emergency. These organizations have come to recognize the value of codes of behaviours and conduct for their organizations' staff and volunteers. The codes articulate principled guidelines for behaviour in emergencies. Other agencies should endorse these codes and put their principles into practical action. The essence of the codes is that human needs take precedence over all other considerations and those organizations involved will not use the emergency to promote their own interests.[13] Capabilities within organizations greatly differ, some organizations, which serve vulnerable populations, may have limited capacity to participate in a health emergency response, however these organizations may have vital connections to community members. These contributions need to be equally recognized.

Principles of collaboration with public authorities

The following points summarize the principles of collaboration with public authorities:

- The organization will provide services, expertise, and access to resources as part of a coordinated effort in concert with public authorities and consistent with their health emergency frameworks.
- Mandated and non-mandated organizations, regardless of size or scope, should where possible develop strategies and operating procedures that concentrate on cooperative-collaborative efforts with local authorities, closest to the need for services and support during a health emergency. Since most voluntary sector agencies are community-based, they will be communicating directly with municipal authorities that have the primary responsibility for emergency preparedness.

[13] *Specific examples of codes of conduct are:* The Code of Conduct of the Red Cross Movement and Non-government Organizations in Disaster Relief and the Guidelines for Cooperation, *endorsed by seven Canadian voluntary agencies applicable to emergencies in Canada. (both available from Red Cross)*

- This in no way precludes cooperation and integration at a provincial or national level.
- Where a voluntary organization expects or is expected to participate in health emergency response, that organization and its local authorities are each responsible to communicate their respective expectations at an early pre-event stage. Such organizations should expect to participate in all aspects including planning, mitigation and preparedness, service delivery during and after the emergency and post-emergency evaluations.
- Voluntary organizations participating in the response to health emergencies will in no way be compromised by their participation: they retain their identities, decision-making capacity, independence and full control of their workforce and programs, subject to the role, responsibilities and functions that they have accepted.

Specific Voluntary Sector Functions in a Health Emergency

The functions of the voluntary sector will be described according to the following phases of a health emergency.

Pre-Emergency Phase

- Risk, Hazard and Vulnerability Assessment
- Mitigation: Prevention
- Mitigation: Preparedness

Emergency Phase

- Response
- Recovery

It is important to note that the stages of an emergency frequently overlap, they flow into each other and occur simultaneously.

Elements of the Framework in the Pre-Emergency Phase

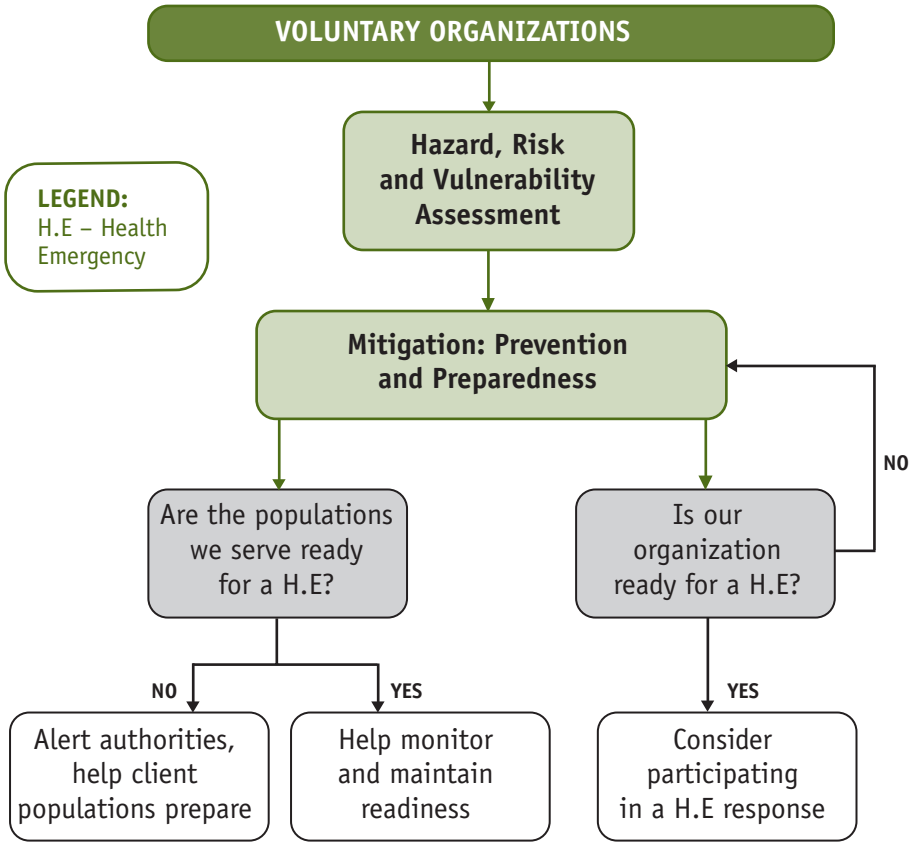
Risk, Hazard and Vulnerability Assessment

Before a health emergency occurs, all organizations need to take stock of their assets and resources as well as their weaknesses and vulnerabilities as part of business and service continuity planning. This includes an assessment of the hazards, risks, and vulnerabilities involved in a health emergency, and the impact it would have on:

- internal operations, including risks to volunteers and staff;
- demand for the organization's services, including how the emergency may affect client groups in the community that depend on the services offered by the organization; and
- other public, private and voluntary sector organizations on which the organization may depend for a range of products or services, or with which the organization has important relationships.

An organization must be able to determine whether, during a health emergency, the most appropriate action is to maintain, suspend, or re-prioritize its operations. During this process, organizations that have a mandate for emergency response should know how they will support and prioritize all emergency functions in accordance with their established roles and responsibilities.

Figure 1 – Framework Flowchart: Pre-Emergency Phase



Important Considerations

- During the hazard, risk and vulnerability assessment, organizations should consult with their key suppliers to ensure their capabilities as well as their client populations to identify their needs. Organizations should also contact emergency preparedness organizations for guidance.
- While undergoing the assessment, organizations must assess both the impact a health emergency would have on their internal operations and on the demand for their services.
- Emergency planning encompasses continuity planning, identifying the strengths and assessts of an organization and addressing any gaps and weaknesses that may exist.

Mitigation: Prevention

The assessment process will result in the identification of vulnerabilities and gaps in internal planning for coping with emergencies. The next step is to develop and implement strategies to mitigate (reduce or eliminate) risks to the organization's capacity to function appropriately during a health emergency. Organizations that have experience in emergency preparedness may be able to assist with resources, training, and advice in this regard. Emergency services organizations often focus on the provision of one or more of the "emergency social services": provision of water, shelter, food, clothing, family reunion/registration, medical or first aid, psycho-social support (counselling) and special services, for example.

If the assessment also identifies particular risks to the vulnerable populations served by the organizations (beyond their expected ability to cope), the organization should confer with its local health emergency authorities to bring those vulnerabilities to their attention, and help their client groups in self-help preparations.

In addition, specific guidelines on how to best serve vulnerable populations should be outlined for health emergency authorities including appropriate cultural and linguistic practices.

We're Having Guests for Dinner. 30,000 in fact

In the direct aftermath of the 9/11 attacks, all commercial flights in the US and Canada were ordered to land immediately at the nearest airport. This meant that hundreds of planes carrying approximately 30,000 passengers landed unexpectedly at airports all over Canada. Within an hour, voluntary agencies started to mobilize to provide shelter, food, and contact with families and support services to our guests, some of whom had to remain in Canada for more than a week. Airports and communities in Atlantic Canada were particularly involved given the large number of passengers that landed in Halifax, Gander and other airports on flights from Europe. Voluntary agencies and volunteers did extraordinary work that day.

Mitigation: Preparedness

Organizations that have a mandate for emergency response should have already clarified their own roles and responsibilities with local emergency response authorities. Therefore, if those understandings are in place, such organizations should be ready to respond immediately to health emergencies once internal preparations are complete.

In contrast, organizations that do not traditionally consider themselves a part of the emergency response system could theoretically limit their involvement to this stage, having prepared their own organization for health emergencies and mitigated the risks to themselves and the people they serve.

However, this framework invites such organizations to consider extending beyond their traditional roles and to directly participate in health emergency response activities.

Assessing Potential Involvement Beyond the Traditional Mandate

The essential question such organizations should ask at this step is whether, during a health emergency, they would have something that would be surplus to their own assessed needs that could be offered to the health emergency response. Such surpluses could include:

- **Human resources** – Paid and volunteer staff who might have special skills to offer during the emergency (particularly if the organization scales back on its own regular operations);
- **Physical resources** – This could take the form of premises, technical equipment, or other hard assets;
- **Capabilities and knowledge** – Organizations might have skills, capacities, knowledge, or relationships that have special value during an emergency. For example, organizations may have special knowledge of the demographics of a particular community.
- **Communications capacity** – Organizations may have unique reach, networks, or dissemination mechanisms that could facilitate the transmission of information from public authorities.

This asset mapping and inventory exercise needs to occur in consultation with the local health emergency response authorities to determine whether there is a match between what is needed and what the organization can offer. If these discussions result in a formalized agreement on the organization's roles, it should include provision for appropriate training and other measures necessary to establish and maintain an appropriate state of preparedness, such as:

- Volunteer and staff training for their roles and functions in a health emergency, especially regarding how to avoid becoming infected;
- Training and preparedness programs for organizations that might experience a surge or shift in demand during a health emergency;
- The development of contingency plans so that organizations can manage their core programs and services during a health emergency;
- The development of new skills and programs based on the public authorities' requirements and the organization's role and function in the response plan;
- Building or securing access to appropriate physical capacities such as emergency communications, warehousing, stocks and transportation;
- Development and implementation of public education campaigns as part of the overall plan to heighten the public's understanding of the threats and responses to a health emergency.
- Provide access to funding for organizations to help support operational expenses such as travel, food and supplies.

Elements of the Framework in the Emergency Phase – Response and Recovery:

Organizations without an emergency response mandate might be well-placed to offer more than their resources and information; they may commit to fulfilling a particular role during health emergencies. This section describes the types of roles voluntary organizations might fulfill.

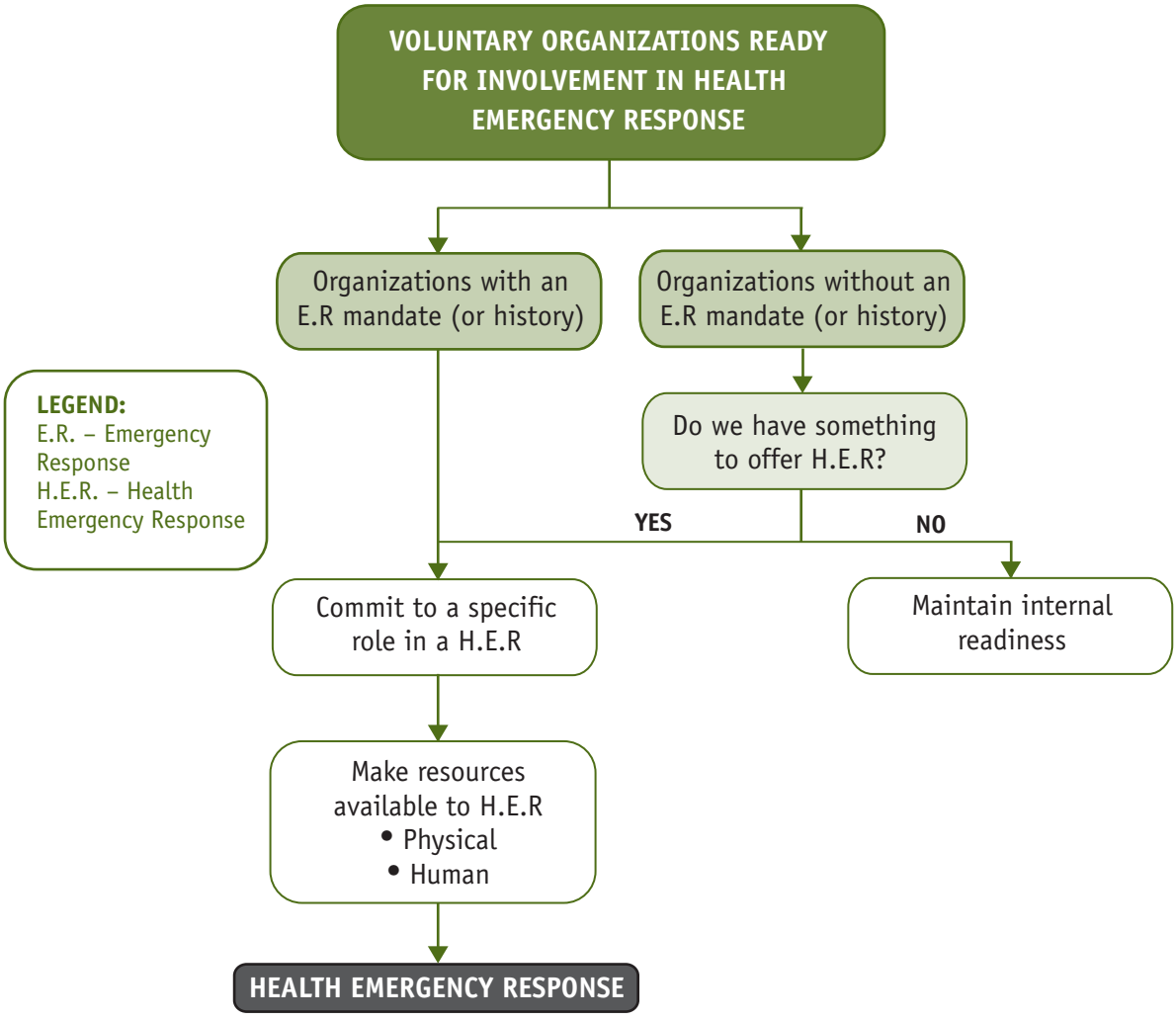
A wide range of functions can be undertaken by the voluntary sector before, during, and after a health emergency. The extent of an individual organization's involvement in any aspect of the **Response and Recovery** stages is dictated by the limits on its own capacities, by the local situation including the role and functions of other organizations and the degree to which the local population has been affected, and by the direction of the responsible authorities. Organizations with experience in this area know that a spirit of mutual assistance and support among voluntary agencies and other actors is critical to a successful operation.

- **Mobilization and Management of Volunteers** Volunteer management and mobilization entails a multi-layered strategy that includes recruitment, screening, training, skills assessment, supervision, and retention strategies as well as the administrative ability to track, contact, schedule, and coordinate the individuals involved. Organizational capacity in volunteer management varies greatly, but some common standards and best practices have been developed. The framework should build on current capacities, and provide for the phenomenon of "episodic volunteers", being those volunteers who spontaneously offer their services to help a specific emergency for a limited period of time. A strategy to manage episodic volunteers is set out in the companion paper, entitled "Maintaining the Passion – Sustaining the Emergency Response Episodic Volunteer". In theory, volunteers can be enrolled and tracked by one organization but assigned to functions with another organization, provided that their respective accountabilities are clear.

Active stage: *Pre-emergency and emergency*

- **Dissemination of Public Health Information and Advisories** The voluntary sector can act as a conduit for information using its own means of communication, for example websites, newsletters, telephone contact, door-to-door delivery. Sector organizations can develop and disseminate advisories and can be part of a team approach to information whereby they assist in the development and dissemination of information under the direction of the public authorities. Some types of

Figure 2 Framework Flowchart: Emergency Phase



Important Considerations

- Episodic volunteers, professional health workers and health care and public authorities will all be involved in the response to a health emergency.
- Potential tasks voluntary organizations may undertake during a health emergency response include volunteer moblization and management, the dissemination of public health information, the provision of first aid, emotional care, shelters, home support, supply management and distribution.
- During a health emergency, public authorities will maintain public order, provide other medical care in addition to other official duties.

voluntary organizations may be well-placed to develop or adapt the public health messages and information dissemination strategies to communicate respectfully within diverse cultures, serve many languages, and address any special communication needs.

Active stage: *Pre-emergency and emergency*

- **Provision of First Aid, Community Health care, and Control of Disease Transmission** This is a set of specialized activities which require standards, training and evaluation but nonetheless will be a crucial service to the public in the event of a health emergency. Only a small number of organizations have a mandate in this field and will need to work closely with health care officials under specialized arrangements.

Active stage: *Emergency*

- **Basic Emotional/Spiritual Care and Support** This type of activity can occur in a variety of settings: to console a bereaved family member, to assuage fears, to help children cope with the abnormal events, to help volunteers and staff of frontline public and voluntary organizations cope with stress. It will be especially important in the event of a prolonged health emergency that involves many casualties and many people quarantined. The activity can be informal (neighbour to neighbour). It can be part of a pre-existing practice of response to loss and tragedy such as the counselling services of many faith-based groups. It can also be a professional level activity under the guidance of the many voluntary sector organizations active in the mental health field.

Active stage: *Emergency*

- **Shelters and Non-traditional Worksites** This activity comes into play when an evacuation has been ordered or health care has to be delivered outside the traditional health care facilities, generally because capacity has been surpassed. These shelters are used to handle those who need extra care, but not those who are affected by the health condition causing the emergency itself. Managing shelters is a complex task requiring specialized expertise and staff. A small number of organizations are qualified to manage these sites as part of their emergency response mandate. Other organizations can potentially participate by supplying volunteers to the frontline agencies and providing other services. Identifying non-traditional sites in a community is an important element of pre-emergency planning. A full description of this function can be found in Annex J (*Shelters and Non-traditional Worksites*) of the Canadian Pandemic Influenza Plan.

Active stage: *Pre-emergency and emergency*

- **Home Support** The preferred approach is to help people stay in their homes, cared for by family members or others, if their needs are straightforward. In some cases, individuals may be asked to stay in their homes as a quarantine measure. Home support services may include delivery of water, food, and essential supplies or help with hygiene. Many voluntary organizations already conduct home visits for these or other purposes, and these roles could be extended during a health emergency.

Active stage: *Emergency*

- **Supply management and transportation** Those involved in emergency and disaster response have particular expertise in the coordination and delivery of basic supplies and services such as food, shelter, and water. Many other organizations also have extensive related expertise that could be tapped during health emergencies. The activity generally requires experience in coordinating transportation, warehousing and procurement.

Active stage: *Pre-emergency and emergency*

- **Special Capacities** Many voluntary sector organizations have existing special capacities that could be utilized in a health emergency. In one recent (but not extensive) survey of organizations, 40% identified such special capacities. The identification of such capacities should emerge during the self-assessment and asset mapping exercises. They can then be described to local public authorities for consideration as part of the organization's role in a health emergency.

Active stage: *Pre-emergency and emergency*

5 A CALL TO ACTION

In summary, voluntary agencies are invited and encouraged to:

- Assess the risks and vulnerabilities their organization and their clients would face during health emergencies;
- Mitigate the risks they can, and prepare to manage the unavoidable risks;
- Take stock of what assets they might have to offer a health emergency response effort; and
- Identify the roles or responsibilities that might best suit their skills and interests. Since voluntary agencies cannot independently determine what role they can assume, with respect to health emergencies, they should communicate their potential interest to public health authorities and their local emergency planning authorities.

Appendix A is a Planning Worksheet for Voluntary Sector Participation in Health Emergency Response. It is designed for use at a community level to match the types of activities carried out by voluntary organizations with the potential functional roles during health emergencies

6 CONSTRAINTS AND LIMITS ON THE INVOLVEMENT OF THE VOLUNTARY SECTOR IN HEALTH EMERGENCIES

Both voluntary sector and public sector organizations should be aware of potential constraints and limiting factors in involving the voluntary sector in health emergencies. While the identification of these constraints and limitations is not meant to discourage the voluntary sector's participation in a health emergency, some of these constraints might be critical factors in the decision-making process and could lead to an organization deciding that the risks of involvement outweigh the benefits. These risks and constraints need to be addressed in the mitigation stage of planning so that strategies can be implemented to limit the consequences of these risks.

It is especially important that the public health and public emergency measures organizations understand and appreciate the constraints and limitations affecting the voluntary sector. Finding mitigation strategies and solutions is a challenge shared by both the voluntary sector and the public sector authorities.

Financial

Constraint: Voluntary organizations typically exist in financial insecurity, and often tolerate chronic under-funding of basic organizational programs, administration and management. Many organizations are already stretched to their limits. It may therefore be unrealistic for them to consider extending beyond their current range of activities to include involvement in health emergencies. Moreover, key capacities such as mobilizing volunteers may depend in part on having the financial capacity to maintain administrative mechanisms such as updating volunteer databases. Financial resources must also be allocated to organizations working with vulnerable populations who are at the highest risk of being affected by a health emergency.

Physical

Constraint: An organization's physical assets (e.g. buildings, vehicles, supplies, warehouse, and information systems) might already be used to capacity. The impact of a health emergency on the physical assets will be severe if they are overused to the extent that they deteriorate. The emergency might also make these resources unavailable for core programs and activities.

Geographic

Constraint: Since 85% of organizations operate in a limited geographic area (smaller focus than a province), a demand to extend activities beyond the organization's normal bounds might raise complexities and unanticipated obstacles.

Risks to Individuals and the Organizations

The considerable uncertainties and high stakes involved as a result of active participation in a health emergency response may cause some organizations to hesitate before committing to participate beyond the scope of their traditional mandates. Some potential risk and liability concerns are listed here.

Constraints on individuals:

- potential to be infected;
- risk of being affected adversely in other ways (stress or psychological impact) by the emergency;
- absence of illness, disability, or liability insurance;
- adverse effect on employment;
- lack of time for proper training leading to poor quality service to the public.

Constraints on organizations (in addition to those mentioned above):

- legal liabilities;
- having roles and functions that surpass capacity and the negative image of poor quality service on the public;
- competition with other organizations;
- potential conflict with the organization's principles and mandates in providing service to broad sections of the public;
- the difficulty in performing background checks on new volunteers during an emergency

Time

An organization's decision to participate in the response to a health emergency implies a substantial time commitment, as much for the preparation to participate as perhaps the participation itself. The time required for consultations and planning with governments and other organizations and service delivery in the health emergency must be factored into the commitment. Organizations already cope with serious human resources workload issues with respect to program and administrative staff and volunteers.

The long-term or recurring nature of health emergencies means that demands on participants may last for a considerable period of time (SARS, for example). Health emergency response planners will need to account for this factor as well.

7 SUMMARY AND CONCLUSIONS

The *"Voluntary Sector Framework for Health Emergencies"* is the composite work of many different agencies that have a vital interest in seeing the sector's contribution to health emergencies developed, recognized and incorporated into the overall health emergency system. It is perplexing but true that the voluntary sector is largely absent from public health authorities emergency plans.

As offered here, the Framework is not a finished product. Future events, added knowledge and experience will cause it to be further developed and elaborated. It is certainly not designed to be a static document.

It is clear that in the event of a health emergency that the voluntary sector will be called upon by the public to provide a range of services that the health care system cannot provide whether or not it has been involved in the planning process. It is also clear that when a voluntary agency serves a specific at risk clientele in the community, it must do all in its power to ensure the safety and well-being of that clientele. The voluntary sector as a whole is motivated by its collective tradition of humanitarian service to provide whatever services it can under whatever conditions that may pertain during the crisis. Yet if the sector's effectiveness is to be improved, it should be involved now in planning and preparation for the health emergency. To wait until the crisis is upon us will be too late.

The voluntary sector is not only willing to provide service in the event of a health emergency, it is also willing to take the necessary steps before the emergency so that the short and long term effects on the community can be kept to a minimum. The Framework describes in detail what the contributions of the voluntary sector can be in a health emergency. These services are not peripheral; they are central to helping the community cope with effects of a health emergency. Voluntary sector agencies are willing to form cooperative partnerships with public health authorities, emergency service organizations and with other agencies. As a part of this commitment, the voluntary sector will work hard to ensure that its core services will be maintained and that its volunteers and staff are trained and equipped to provide services to those in need. This will in turn lessen the burden on public authorities to care for those affected by the emergency.

The question is always: what next? It is clear that as a strategy the voluntary sector must engage in a dialogue with government agencies to ensure that its roles and functions in a health emergency are delineated and that they are integrated into planning and preparation programs. The process will be one of education, of sharing of knowledge and experience and of offering service. The *"Voluntary Sector Framework for Health Emergencies"* will be deemed a successful initiative if it helps to advance the process of integration.

GLOSSARY OF TERMS

Determinants of Health – The range of personal, social, economic and environmental factors that determine the health status of individuals or populations. They include the following factors: income and social status, social support networks, social and physical environments, healthy child development, education, employment and working conditions, personal health practices and coping skills, biology and genetic endowment, health services, culture, and gender.

Emergency mandate – Organizations with an emergency mandate consist of those with emergency relief services as part of their constitutional mission and/or their established tradition of community service delivery.

****Emergency response** – Actions taken in anticipation of, during, and immediately after an emergency to ensure that its effects are minimised, and that people affected are given immediate relief and support.

Health Emergency – is an occurrence or imminent threat of a serious or life-threatening illness or health condition to a population that exceeds its capacity to cope. While other emergencies such as natural disasters may affect public health, a health emergency is one where the health threat is the cause, not the consequence, of the emergency. For example, it may be caused by the appearance of a novel or previously controlled or eradicated infectious agent of biological toxin that poses a significant risk of substantial future harm to a large number of people in the affected population. However, health emergency preparedness activities take an all-hazards approach by anticipating and preparing for the full range of possible hazards that could require health and emergency social services support.

Mitigation – is "sustained action that reduces or eliminates long-term risk to people and property from natural hazards and their effects." Mitigation is the ongoing effort to lessen the impact disasters may have on people and property, and involves such activities as avoiding construction in high-risk areas such as floodplains, and engineering buildings to withstand wind and earthquakes.

National Framework for Health Emergency Management – In 2001, the Federal, Provincial and Territorial Ministers of Health recognized the necessity for a more integrated and coordinated strategic plan for emergency management in the health and social services sectors across Canada. The Deputy Ministers of Health, through the Advisory Committee on Population Health and Health Security (ACPHHS) and the Federal/ Provincial/ Territorial Network for Emergency Preparedness and Response, tasked the Council of Health Emergency Management Directors (CHEMD) to develop a pan-Canadian framework for health emergency management. A key outcome was the development of the National Framework for Health Emergency Management, which provides a set of guiding principles for the development of an integrated and comprehensive health emergency management system in Canada.

Pandemic – refers to an epidemic disease of widespread prevalence around the globe, as a consequence in part of the lack of resistance to a new infectious agent.

Preparedness – refers to developing and readying response and recovery actions to increase the community's ability to respond to future impacts. Governments, community groups, service providers, businesses, civic and volunteer groups, are all partners in this effort.

Prevention – is a method of averting health problems (e.g. disease, injury) through interventions. Preventing and reducing the incidence of illness and injury may be accomplished through three mechanisms: activities geared toward reducing factors leading to health problems; activities

involving the early detection of, and intervention in, the potential development or occurrence of a health problem; and activities focusing on the treatment of health problems and the prevention of further deterioration and recurrence.

Recovery – is the process of returning to normal following the response phase of an emergency. It may extend for many years and involves the physical, social and economic component of the community. Salvage, resumption of business processes, and repair are typical recovery tasks.

Response – refers to the actions involved in responding to an emergency when it occurs. The response phase focuses on the immediate efforts to limit further harm and meet the community's basic needs.

Surge Capacity – refers to a system's ability to rapidly expand beyond normal services to meet the increased demand for qualified personnel, and services in the event of large-scale emergencies or disasters.

Volunteer (including episodic volunteer) – a volunteer is a person who willingly carries out unpaid activities in the form of time, service or skills, through an organisation or group. Volunteers are generally unpaid, although circumstances exist where they may be compensated for expenses or receive honoraria.

Voluntary Agency (organization) – Organizations are considered to be part of the non-profit and voluntary sector if they are:

- organized (i.e., have some structure and are institutionalized to some extent, but not necessarily legally incorporated); nongovernmental (i.e., are institutionally separate from governments);
- non-profit-distributing (i.e., do not return any profits generated to their owners or directors);
- self-governing (i.e., are independent and able to regulate their own activities); and,
- voluntary (i.e., benefit to some degree from voluntary contributions of time or money).

Voluntary Sector – includes both volunteers and those entities that are neither for profit nor agencies of the state. It includes incorporated non-profit organizations as well as unincorporated volunteer community groups. It is also known as the community-based-sector, the non-profit sector, the third sector or the public benefit sector. The common feature is their reliance on volunteer boards of directors to govern their activities

APPENDIX A

Voluntary Sector Roles and Functions in Health Emergencies

This chart is a tool organizations can use to map out potential roles they can play in a health emergency. Locate the category which best describes your organizations activities, then find the emergency activities which your organization has the capacity to perform. The special capacity function refers to the unique services your organization can provide.

VOLUNTARY ORGANIZATIONS BY MANDATE	VOLUNTEER MOBILIZATION & MGMT	DISSEMINATION OF PUBLIC HEALTH INFO	FIRST AID & INF CONTROL	EMOTIONAL CARE & SUPPORT	SHELTERS & N-T WORKSITES	LOGISTICS	SPECIAL CAPACITIES
Culture and recreation							
Media and communications							
Visual arts, architecture, ceramic art							
Performing arts							
Historical, literary and humanistic societies							
Museums							
Zoos and aquariums							
Sports							
Recreation and social clubs							
Service clubs							
Health*							
Mental health treatment							
Crisis intervention							
Public health and wellness education							
Health treatment, primarily outpatient							
Rehabilitative medical services							
Social services							
Child welfare, child services and day care							
Youth services and youth welfare							
Family services							
Services for the handicapped							
Services for the elderly							
Self-help and other personal social services							
Disaster/emergency prevention and control							
Temporary shelters							
Refugee assistance							
Income support and maintenance							
Material assistance							
Environment							
Pollution abatement and control							
Natural resources conservation and protection							
Environmental beautification and open spaces							
Animal protection and welfare							
Wildlife preservation and protection							
Veterinary services							

* *(Quasi-government institutions beyond the scope not listed here)*

NB: (ICNPO: See http://www.statcan.ca/english/freepub/13-015-XIE/2004000/icnpo.htm for more detail)

VOLUNTARY ORGANIZATIONS BY MANDATE	VOLUNTEER MOBILIZATION & MGMT	DISSEMINATION OF PUBLIC HEALTH INFO	FIRST AID & INF CONTROL	EMOTIONAL CARE & SUPPORT	SHELTERS & N-T WORKSITES	LOGISTICS	SPECIAL CAPACITIES
Development and housing							
Community and neighbourhood organizations							
Economic development							
Social development							
Housing associations							
Housing assistance							
Job training programs							
Vocational counselling and guidance							
Vocational rehabilitation and sheltered workshops							
Law, advocacy and politics							
Advocacy organizations							
Civil rights associations							
Ethnic associations							
Civic associations							
Legal services							
Crime prevention and public policy							
Rehabilitation of offenders							
Victim support							
Consumer protection associations							
Political parties and organizations							
Philanthropic intermediaries and voluntarism promotion							
Grant-making foundations							
Volunteerism promotion and support							
Fund-raising organizations							
International							
Exchange/friendship/cultural programs							
Development assistance associations							
International disaster and relief organizations							
International human rights and peace organizations							
Religion							
Congregations							
Associations of congregations							
Business and professional associations, unions*							
Professional associations (health-related)							

* *(Quasi-government institutions beyond the scope not listed here)*

NB: (ICNPO: See http://www.statcan.ca/english/freepub/13-015-XIE/2004000/icnpo.htm for more detail)