POLICY BRIEF

Lessons Learned from **COVID-19**

Acknowledgement

The Canadian Red Cross acknowledges the Indigenous Peoples, the traditional stewards of Turtle Island, the land now known as Canada. The Indigenous Peoples, including First Nations, Métis, and Inuit Peoples, have been caretakers of this land since time immemorial. As an organization committed to reconciliation, we give thanks for the deep learnings and understanding this relationship entails. We endeavour to be guided by this learning as we walk alongside Indigenous Peoples and communities.

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COVID-19:
Two Years on the Front Lines

> While there is no doubt that COVID-19 has transformed all of our lives, we must recognize the disproportionate impacts on Black, Indigenous and People of Colour and the persistent strain front-line workers continue to experience.

Dear Colleagues,

As we mark the second year of the COVID-19 pandemic, there is much to be proud of. **We have watched as ordinary Canadians from Coast to Coast have come together to help one another in a time of immense need.** From delivering food, to helping in long-term care homes, to supporting vaccination efforts, Canadian Red Cross personnel have been on the front lines since the earliest days of this crisis.

To date, this has been the single largest response in our organization's history. Working in partnership with Federal, Provincial, and Territorial authorities, Indigenous Communities, and other humanitarian organizations, our staff and more than 8,400 volunteers have helped Canadians stay heathy, safe, and supported. These efforts have included responding to more than 21 federal requests for assistance, undertaking more than 110 local, provincial, and territorial engagements at the request of authorities, and partnering with Indigenous communities through 54 COVID-19 initiatives.

While there is no doubt that COVID-19 has transformed all of our lives, we must recognize the disproportionate impacts on Black, Indigenous and People of Colour and the persistent strain front-line workers continue to experience. Canada's seniors and those who have sought to care for them have also faced unimaginable challenges. As such, it will be critical to ensure that recovery programming addressing the physical, emotional, and financial impacts of COVID-19 continues to target those who were made most vulnerable to its impacts.

COVID-19 has also shone a light on the inter-connectedness of our global risks. It is well acknowledged that until we increase vaccination rates around the world, we will continue to collectively battle the continued variants and waves of this pandemic. At Canadian Red Cross we will continue to prioritize both our domestic and global health efforts in the continued fight against this devastating pandemic.

While we cannot prevent emergencies, we can work together to better prepare for them. It is with this spirit of sharing, that we have compiled some our lessons learned from two years of response efforts. It is our hope that together, we can continue these critical dialogues to build and maintain our collective readiness in the months and years ahead.

Conrad Sauve
CEO, Canadian Red Cross

How We Helped

The COVID-19 operation is the largest response in the Canadian Red Cross' history with more than 7,500 Red Cross deployments[1] across the country, in every province and territory.

Surging in Support of Public Health and Acute Care

To bolster efforts when local capacities were overwhelmed and contribute expertise to help keep Canadians safe.

305,000+
COVID-19 tests provided at **sites**, across Canada

Over
people supported in Isolation and Quarantine across **sites**

Over 15,000
people trained in Epidemic Prevention and Control (EPC) and Personal Protective Equipment (PPE)

400 sites
Over **400 sites** supported for Long-Term-Care, Rehabilitation and Correctional facilities

Over **86,500 vaccines** administered by Red Cross including in remote and Indigenous communities

Over 650 vaccination sites supported

Supporting Indigenous Communities

To address disproportionate COVID-19 impacts and pre-existing inequities.

1,140 collaborations
with Indigenous, First Nations leaders and communities for support

700
direct community-engagement consultations

Over **16,000** requests to the Indigenous Peoples Help Desk

Over
informational resources and tools shared

sites in Indigenous communities supported with EPC

6 Indigenous languages
used to provide services by the Help Desk

Strengthening Communities and Local Actors

To combat isolation, create connections, and build capacities for localized response efforts.

$65M
funds distributed to community organizations

Over **13,400**
projects funded with community organizations
99% were new partners

70,000 kits of personal protective equipment distributed to local actors

Over **1,000** community organizations in rapid–test screening and distribution program, with over **1M rapid tests provided**

83,000+
beneficiary contacts made for mental health and psychosocial support

Over **65,000** food hampers delivered

Over **34,000** telephone assurance calls made

Contributing to Global Response Efforts

To address global impacts, support those in need, and recognize that the COVID-19 crisis won't be over until it is over everywhere.

Over [redacted]
in financial contributions

19
personnel deployed internationally to support COVID-19 operations

2 Emergency Response Hospitals deployed internationally during COVID-19 response

80
countries assisted

Over 700,000 Personal Protective Equipment kits distributed internationally, including 50K kits to Zimbabwe, Mozambique, Namibia, Zambia, Uganda, Vietnam, and Nepal.

A Key Outcome: The Building of a Strong and Ready Emergency-Response Workforce

In 2020, with funding from the Government of Canada, through Public Safety and Health Canada helped to build a new Humanitarian Workforce that would strengthen our capacity to respond to COVID-19 and other emergencies.

1. This capacity enabled us to: Respond to **more than 170 engagements**,[ii] including testing, isolation, vaccination, and long-term-care-home support.

2. **More than 7,500 deployments** of emergency-response workers for COVID-19 operations across the country, in support of provincial, territorial, and federal authorities.

3. Distribute **over 7.6M** pieces of PPE for CRC personnel working frontline.

Our Readiness Capacity

300+

Over 300 Emergency Management Personnel

1,200+

Over 1,200 Rapid Responders

8,800+

Over 8,800 Volunteers

Trained, ready and pre-positioned across the country.

"Across Canada, national and community organizations are stepping up to support the most vulnerable, in our fight against COVID-19. They are being asked to deliver the same services and support that we have always depended on, in much more challenging circumstances. It takes resources to do that, and that is why it is important that we support organizations like the Canadian Red Cross. They are there for Canadians, so we need to be there for them."

Justin Trudeau, Prime Minister of Canada

COVID-19 Red Cross Response Timeline

1ST WAVE (JAN 2020 – AUG 2020)

DECEMBER 31, 2019

Cases of pneumonia detected in Wuhan, China, are first reported to WHO.[1]

FEBRUARY 2020

Quarantine support for those returning from travels overseas and isolating.[2]

FEBRUARY 2020

On behalf of the Government of Canada providing global support.[3]

MARCH 11, 2020

WHO declares the novel coronavirus outbreak to be a pandemic. States of emergency start to be declared in Canada in March 2020.[4]

World Health Organization

MARCH 2020

Quarantine services in major Canadian city centers for returning travelers.[5]

Virtual support, friendly call programs and door to door check in program start and expand across Canada.[6]

Distribution of essential items to vulnerable populations in Indigenous and non-Indigenous communities.[7]

Financial distribution on behalf of provincial governments to those impacted starts.[8]

Residences and staff of long-term care facilities are the hardest hit. There were also disproportionate impacts on BIPOC, Indigenous and other equity seeking populations.

APRIL 2020

Red Cross field hospital is deployed to B.C. and Quebec to boost local public health capacities.

Launch of the Indigenous Help Desk.[9] This program remains ongoing.

MAY 2020

Pan-Canadian granting program to community actors launches focusing on equity seeking populations.[10]

JUNE/ JULY 2020

Surge of Red Cross Emergency Response Workforce into Long Term Care homes starting in Quebec.[11]

JULY 2020

Support to isolation for Seasonal Agricultural Workers in Ontario.

2ND WAVE (AUG 2020 – FEB 2021)

OCTOBER 2020

Pan-Canadian granting program to local organizations round two.

Manitoba First Nations Health Authority isolation support in First Nations Communities[12]

Manitoba Contact Tracing surge support to authorities begins and remains ongoing.

Vaccination service support begins in Ontario.

NOVEMBER 2020

Support to Long Term Care by CRC Emergency Workforce (care teams) expands to Manitoba and Ontario.

Start of the Epidemic Prevention Control engagement to support correctional facilities across Canada.[13]

DECEMBER 2020

Deployment of Emergency Field Hospital in Alberta.

DECEMBER 31, 2019

Vaccinations begin in Canada

FEBRUARY 2021

Support to vaccination services commence. This includes the deployment to 14 northern villages of Nunavik.

Support to sample collection sites (testing for COVID-19) across Canada commences at land-border crossings.[14]

3RD WAVE (FEB 2021 – AUG 2021)

In the third wave the sustained number of high cases heavily impacted acute care capacity however overall mortality rates decreased alongside increased vaccination.[15]

MARCH 2021

Vaccination support extends across the country in B.C., Manitoba, Ontario, PEI and Quebec.[16]

APRIL 2021

Testing and isolation service delivery increased across Canada.

MAY 2021

Launch of Stop the Spread Program to support local actors set up their own screening (testing) programs.

SEPTEMBER 2021

Despite a scale down of LTC since its peak, with the increase in cases we saw an uptake in work in Long Term Care.

OCTOBER 2021

Continued volume in testing, vaccination and Health Human Resources services (deployment of health professionals to support government authorities).

NOVEMBER 2021

Scale down and closure of rapid testing sites at border crossings and continued support in testing and vaccination.

Additional dose vaccinations scale up.

DECEMBER 2021

Launch of expanded Health Canada program for community groups to distribute rapid tests to those they serve.

Continue request for deployment of health professionals in support of authorities (Health Human Resource Services).

76% of Canadians are fully vaccinated (2 doses) .

JANUARY 2022

New requests to support to vaccination in PE, NS, ON, QC, AB, MB.

FEBRUARY 2022

Further expansion of Stop the Spread program to distribute rapid tests and masks.

FEBRUARY 2022

Continued and secondary support to Indigenous communities such as Kashechewan FN, Attawapiskat, and Akwesasne.

COVID-19
Lessons Learned & Recommendations for Readiness

SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

The utilization of international medical graduates (IMGs) was, and will remain, critical to mitigating workforce strains and combatting impacts from COVID-19 and other future events.

As cases surged, healthcare capacities were pushed to the breaking point. Many facilities experienced a shortage of healthcare providers; front-line healthcare workers were under extreme strain, resulting in stress and burnout; and non-urgent surgeries, procedures, and treatments were postponed.[iii] Alongside public-health efforts to deal with the overwhelming impacts of the virus there was also the need to scale up urgent vaccination efforts.

The use of IMGs, people who have medical degrees from other jurisdictions but are not yet licensed to practice in Canada, to fill roles related to infection-prevention and -control, COVID-19 testing, contact tracing, rapid screening, physician assistance work, and vaccination efforts (where permissible) has been critical in bolstering public health capacities. Despite workforce shortages, we noted some barriers to inter-provincial deployment of health professionals, including licensing and insurance challenges.

Throughout COVID-19 one of the barriers to effective response has been the lack of a framework to confirm the role of IMGs, inconsistent application across jurisdictions, and the lack of an expedited process for recognizing foreign qualifications and non-registered/alternative healthcare providers. Increased recognition and regulatory changes would ensure full utilization of this workforce to tackle the continued impacts of COVID-19 and future health and all-hazard emergencies.[iv]

Over the last ten years, the Red Cross has worked with and relied on international medical professionals both for our international work as well as domestic response efforts. This was critically important in the context of COVID-19, where demand for health professionals was high. As part of these efforts, the Red Cross utilized 250 IMGs vetted for clinical and/or public health work, including border testing, Epidemic Prevention and Control,[v] and vaccination efforts—where permissible by provincial and territorial regulations.[vi] To support this, a framework for vetting, training, protocols, and medical oversight was developed to ensure there were sufficient controls and quality of service.

SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

The utilization of international medical graduates (IMGs) was, and will remain, critical to mitigating workforce strains and combatting impacts from COVID-19 and other future events.

Approximately 1,000 IMGs move to Canada each year, and there are **hundreds in Canada** who have completed all their Canadian exams yet given limited space in residency programs and have been unable to receive Canadian recognition. As a result, the vast majority work in non-health-related positions. There is an underutilization of these medical professions, who are available to support Canada's readiness and health systems.[vii]

Recommendations for Readiness

1. Accelerating work underway to support the acceptance of IMGs including creating a framework with express regulatory permissibility and an accessible and streamlined process to enable IMGs to perform certain healthcare functions and roles. This framework could also be extended to other professional international graduates in health and non-health-related fields, for future all-hazard emergencies.

2. Policies deployed in the COVID-19 crisis should now be integrated into medium- and long-term policy, as well as legislative and regulatory change. This would help to support readiness in advance of future pandemics and all-hazard risk events. This can be supported by sharing best practices related to training, protocols, vetting, medical oversight, and directives.

3. Capacity shortages will not cease with the end of COVID-19, as the next challenge on the horizon will be to address postponed surgeries, procedures, and treatments. Further strengthening overall healthcare capacity, to address acute pressures and to be prepared for future public health issues, will help in the short, medium, and long terms.

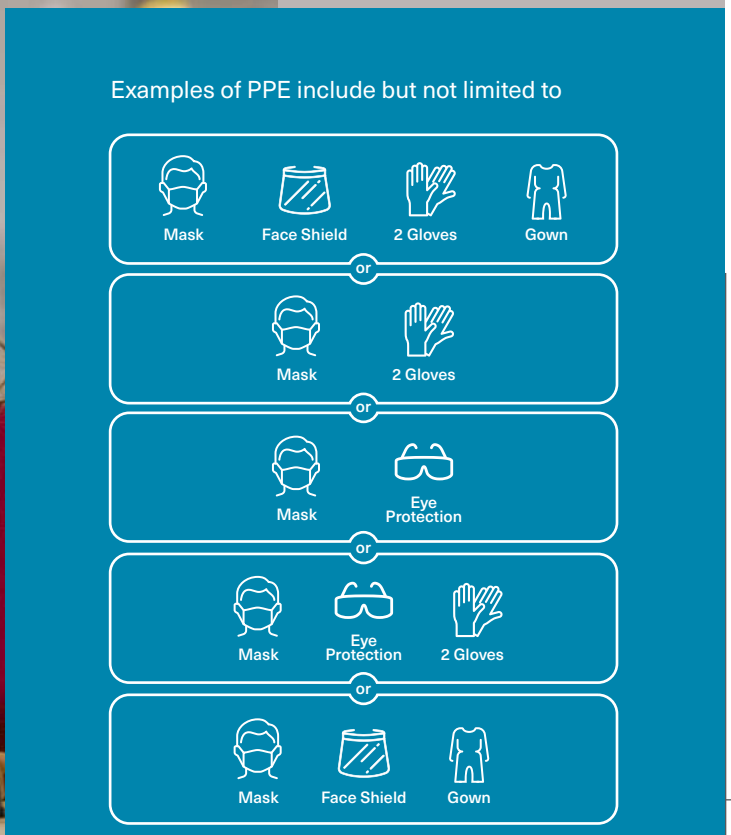
4. Recognizing how interconnected global health risk is, we must ensure sufficient capacity building both at home and internationally. This underscores the need for operational health capacities to be interoperable, domestically and internationally. This would help guard against inequities with migration of experts (brain drain), as well as afford domestic health personnel opportunities to be exposed to events and risks they would not otherwise be, such as pandemics and mass trauma.

SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

The continuous evolution of COVID-19—and our understanding of it—has required agility and adaptation from Canadians and front-facing organizations.

Though in some ways COVID-19 imparts a feeling of stagnation and sameness, there has been a persistent current of change and instability, as the virus and our understanding of it evolve. With each new variant, collective adaptation has been required.

For the Red Cross, keeping front-line personnel and those we support and serve safe has required constant vigilance, agility and adaptation. From the earliest days of the response, starting with the repatriation of Canadian travellers in early 2020 to support Global Affairs Canada and the Public Health Agency of Canada, we leveraged our experience in global health and responses to over 105 epidemic and pandemic events in 54 countries from 2011 to 2019 (including cholera and Ebola) to develop infection-prevention and -control standards. This work transformed into the delivery of Epidemic Prevention and Control (EPC) services across Canada, on behalf of authorities, to safely zone facilities and reduce the risks of transmission.[viii] In terms of impact, we have found that sites in which EPC assessments were conducted reported substantially fewer incidents of protocol breaches that would have resulted in increased risk of exposure.



SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

The continuous evolution of COVID-19—and our understanding of it—has required agility and adaptation from Canadians and front-facing organizations.

> To date we have delivered **EPC support in over 400 facilities and sites, including over 200 Long Term Care homes**, and trained **over 15,000 individuals**. Among these efforts the Red Cross provided EPC support for 100% of Federal Correction Institutions in the country (43 institutions).

Many front-line community groups reported feeling ill equipped to keep up with constantly evolving personal protective equipment (PPE) standards, protocols and best practices, especially in the early months of the pandemic. During our initial intake Front-line community groups reported that the costs of adapting responses to COVID-19, such as meeting evolving public health guidelines and standards, were a top need and impact. Aligning to this, over 40% of the activities that the Red Cross funded related to adapting operations to meet urgent community needs during the pandemic.

To keep their doors open and continue to provide essential services, community groups have had to continue to adapt throughout the pandemic. The Red Cross provided over 1,750 organizations with training and PPE kits as part of the complementary Preventing Disease Transmission Training and Equipment program, to support adaptation efforts. More recently, in partnership with Health Canada, our Stop the Spread program has supported over 1,000 local actors across the country to set up their own screening program for personnel, using rapid tests. Overall, they have provided over 1 million rapid tests and masks to community groups.

Recommendations for Readiness

1. Updating future pandemic plans to include crisis, tailored and targeted communications, and situational awareness. This would help businesses and community groups keep pace with the virus, and with up to date measures to effectively mitigate its impact (including adaptation tools).
2. Include planning in the arsenal of readiness tools, to ensure clear roles and responsibilities and a collaborative mapping across jurisdictional authorities.
3. Carry forward the success story of funding community actors for increased costs related to adaptation and service creation, as well as increased service delivery demands, into future pandemic and all-hazard risk planning.

A **Case Study** in Change: Omicron Impacts

Omicron's highly contagious nature increased transmission risks and the urgency of vaccination programs. The use of N95 masks was encouraged for higher-risk and clinical settings, and cloth masks (until then generally accepted and used in non-medical settings) were noted to be less effective in protecting against transmission. Higher infection rates resulted in critical workforce shortages. PCR testing and contact tracing, which had been relied upon for most of the pandemic, became overwhelmed and unreliable. The resultant lack of reliable availability in testing drove an increase in the demand for, and reliance on, self-monitoring and rapid tests.

Mindful of the virus' impacts (as cases tended to be less extreme) and ongoing workforce demands, provinces and territories considered, and instituted, new rules about shortening isolation and testing requirements.

Today, over 50% of people around the world have been infected with COVID-19. The provinces and territories are now optimistic that a potentially endemic state of the disease is on the horizon, which would result in scaling back public health measures.

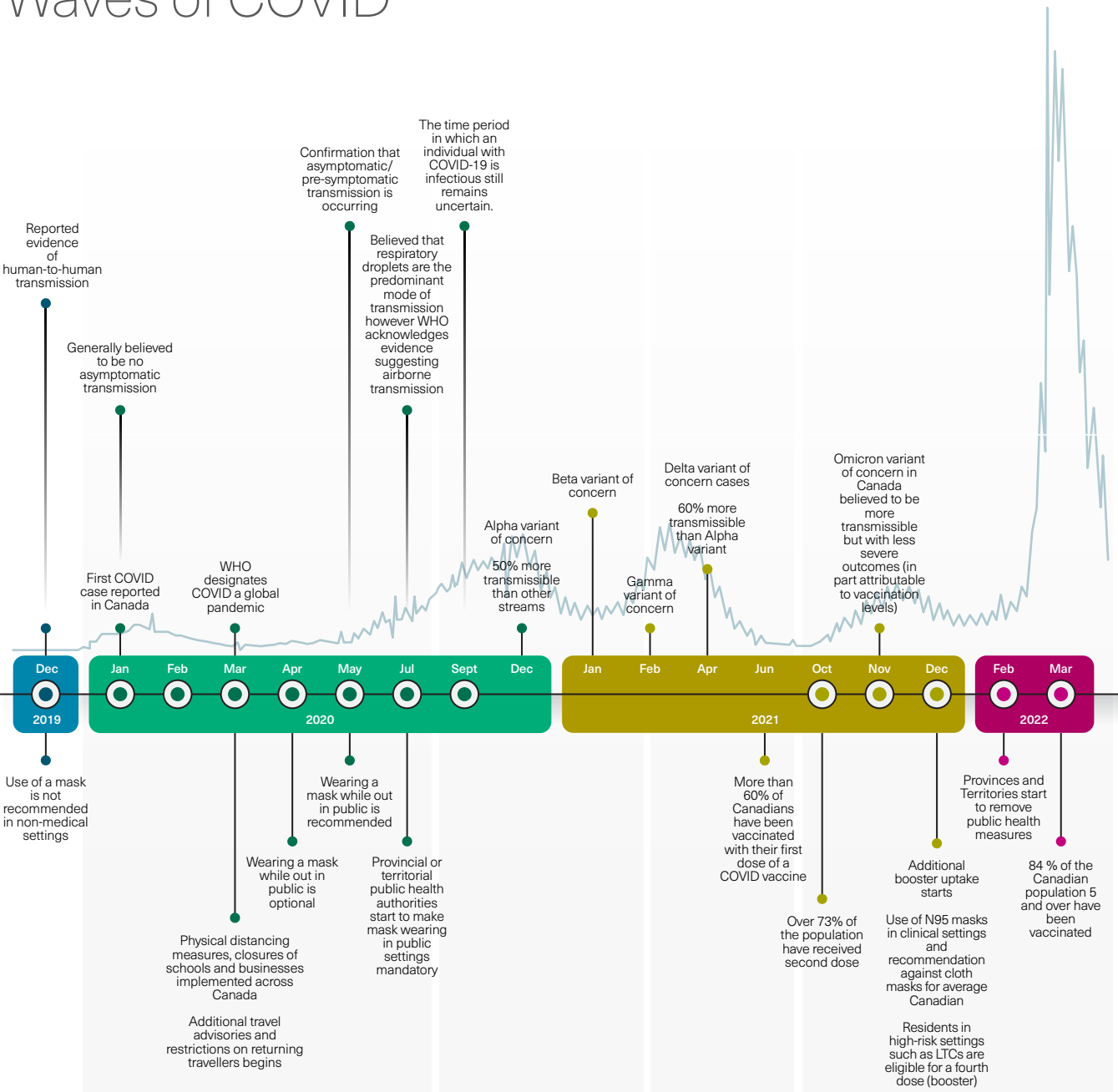
Yet, mutations are possible with every replication of the virus, underscoring the critical importance of vaccine equity worldwide. With global vaccination being under 70% for first doses, the threat of future variants remains, and a disproportionate impact on populations who are already marginalized, persists globally.

Knowledge of Transmission

Cases and Variants

Public Health Guidance

Waves of COVID



WAVE 1

Long-term care facilities were the **most affected groups**.

In the absence of vaccines, **testing and surveillance were limited** and challenges with access to personal protective equipment.

WAVE 2

Community transmission became widespread across Canada to areas not as significantly affected in the first wave (such as the Territories, some Indigenous communities, and younger Canadians).

December 2020 vaccination rates and lessons learned from the first wave **protected some higher risk populations**.

WAVE 3

Easing public health measures and highly transmissible variants of concern fuelled the **third wave affecting many regions across the country**.

Sustained number of high cases heavily impacted acute care capacity.

WAVE 4

Highly transmissible Delta variant of concern, reduction of public health measures, and incomplete vaccine coverage drove an increase of cases.

In December 2021 **an additional spike was caused by the Omicron variant** which caused more breakthrough infections among the fully vaccinated than previous variants. The severity of illness was lower during this phase even as infections rose.

SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

COVID-19, an event with unprecedented impact, challenged our readiness capacities underscoring the need to continue to invest in preparedness.

While individuals, corporations, not-for-profits, and governments are always quick to respond when an emergency strikes, there is a recognized and growing gap in our collective readiness to respond to increasingly complex all-hazard (including public health), large-scale, and concurrent smaller-scale disruptive events. This was true in the context of COVID-19, where response structures were ill equipped for a pan-Canadian response of this magnitude and length.

As a result, there were gaps in our physical and financial readiness, which are already being recognized and identified in preliminary after-action reviews and lessons learned from COVID-19. In terms of structural barriers, large-scale events require coordination between emergencies, health, public-health and social-services functions, as well as inter-ministerial and federal-provincial/territorial, municipal and Indigenous authority action. An unprecedented event like COVID-19 strains these systems designed to work independently, within set authorities, for specific objectives. Further, without a dedicated lens on the intersectionality of risk or a dedicated function coordinating all actors, inefficiencies can occur and populations who are marginalized based on their legal, economic and/or social status are at greater risk of getting lost in the gaps.

The Red Cross has **seconded 91 Clinical Health specialists** to 24 sites including ICUs/hospitals, remote Indigenous communities, and quarantine sites, in response to workforce shortages.

In 2020, as a result of COVID-19's impacts, funding from the Government of Canada, through Public Safety Canada (and partner agencies such as Health Canada), bolstered Canada's operational readiness. There was an investment in the Red Cross' public-health and emergency-response capacities. This enabled us to strengthen our Emergency Support Workforce, purchase much-needed equipment for our health-surge activities, and invest in capacities for rapid deployment of personnel across Canada, at the request of provincial and territorial authorities. With our additional capacity, we were able to respond to over 170 engagements across Canada, in support of provincial, territorial, and federal authorities, for services ranging from testing, isolation, vaccination, and support to Long-Term-Care, made possible through the deployment of 7,500 personnel.

During the COVID pandemic, the Red Cross was relied upon to support the efforts of municipal, provincial, federal, and Indigenous partners, including receiving a request for critical support to a new emergency-response engagement, on average, every **3.5 days.**

At the end of the first wave and beginning of the second wave, when aging populations were disproportionately impacted, infection rates soared in long-term-care facilities.

SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

COVID-19, an event with unprecedented impact, challenged our readiness capacities underscoring the need to continue to invest in preparedness.

However, continued clarity on role and mandate and funding is required for actors like the Red Cross to retain capacities invested in during the COVID-19 response. It has been our experience that we, like other organizations and government actors, scale up for large scale responses to meet the needs and demands of impact. Following these events, we then scale down losing skilled workforce, institutional memory, and capacity. However, the time has come to stop treating these events as exceptional noting that what was once a once-in-100-year event is increasingly becoming the new normal. As such, creating a strong and ready operational capacity that does not need to be scaled up and down will support a more ready Canada.

"Readiness" Checklist

Readiness in subject-matter expertise, by investing in research, workshops, trainings, and the sharing of best practices.

- ☐ Readiness in planning and agility, through scenario planning, tabletop exercises, and simulations.
- ☐ Readiness in communication and coordination between relevant bodies, including formalizing coordination of bodies comprising of all levels of government and third-party actors.
- ☐ Readiness in operational and deployable capacities, through a trained, pre-positioned readiness roster of personnel with relevant experience, through international deployments.
- ☐ Readiness in material resources, through pre-positioned, renewed and deployable resources.
- ☐ Readiness in strong relationships with community actors including in Indigenous communities.
- ☐ Readiness in legislative and regulatory changes, such as liability protection for "good Samaritan" response actors, and clarity on authorities.

Recommendations for Readiness

1. Mindful of successes and challenges in COVID-19, consider a designated lead government agency in response, to support increased coordination and cooperation at a working level, across departments and levels of government and inclusive of humanitarian-response actors.
2. Invest in a coordinated and whole of-society response, aligning to the Sendai Framework, by continuing to invest in all-of-society actors and response agencies, such as the Red Cross.[ix] Learning from the experiences of COVID-19, we recommend clarifying the mandate of all-of-society actors in response plans, as well as increasing tabletop exercises and scenario planning.

SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

COVID-19 tested and strained Canada's logistic capacities, reshaped strategies, and revealed vulnerabilities relating to stockpiles and the supply chain for such an event.

Global workforce shortages, reliance on international production (especially in the Asia-Pacific region), challenges accessing key components and raw materials, and increased demand drove unprecedented supply-chain challenges. Recent shifts towards just-in-time sourcing, lean-inventory management and domestic-manufacturing limitations exacerbated impacts. This was further complicated by sporadic lockdowns, border closures and transportation-industry crises, which increased unpredictability and disruptions. All these factors continue to result in supply-chain bottlenecks and are driving shifts in traditional supply-chain operating models.

Arguably currently systems, including stockpiling, sourcing, and distribution of technology and equipment were not rightsized to the unprecedented impacts of COVID-19—a sustained, two year-long, global pandemic with crises that occurred in waves across Canada. Historically these systems were built to respond to an event impacting one or two provinces, and/or a time-bound event. Further, these systems have been largely untested at scale, with no catastrophic loss events, such as a large-scale earthquake, or public-health crisis occurring in recent history. These challenges, and having to continuously adapt operating models, underscore the need for continued readiness, which includes stocks and supplies strategies.

It has been the Red Cross' experience, through management of our own warehouses and stockpiles both domestically and internationally, that constant use and deployment is required to ensure processes remain up to date and agile, and to ensure equipment, stocks, and supplies are refreshed (mindful of expiry dates) and modern. Continued use keeps institutional memory for rapid inventory intake and deployment that can go to scale in large scale events, while maintaining critical processes in inventory management and monitoring.

The Red Cross has **seconded 91 Clinical Health specialists** to 24 sites including ICUs/hospitals, remote Indigenous communities, and quarantine sites, in response to workforce shortages.

The Red Cross experienced its own supply-chain and logistic challenges through the pandemic, including challenges in securing supplies and distributing them across Canada, including to remote and rural locations, for our front-line operations and personnel. Other challenges included going to scale in distributing regulated goods, which required compliance with regulatory regimes. However, strong from many years of experience in deployment to global and domestic responses—including health responses—we were able to quickly pivot, when required, by leveraging our stock-prepositioning strategies and our network of warehouses, partners, and vendors.

In terms of unique value add in supply chain and logistics for the COVID-19 response, to date the Red Cross has filled a gap domestically in distribution to local community actors in smaller amounts, to more locations, at increased frequency. Community actors cannot manage large stockpiles and can be in remote, harder-to-reach locations, requiring a different approach to distribution. This involves increased administration and oversight, breaking down larger amounts, repackaging, and shipping.

SURGE IN SUPPORT OF PUBLIC HEALTH AND ACUTE CARE

COVID-19 tested and strained Canada's logistic capacities, reshaped strategies, and revealed vulnerabilities relating to stockpiles and the supply chain for such an event.

Domestically, the Red Cross distributed over 7.6 M pieces of PPE to support our own operations and front-line staff. We also provided over 1,750 local organizations with PPE kits, and over 1,000 local organizations with rapid tests (this program has recently expanded to include masks) to support the ongoing COVID-19-response work of community groups.

Internationally, the Red Cross provided over 700,000 PPE kits to support global response efforts.

We have accomplished this by leveraging our close community connections and established logistics capacity for disruptive events, where supplies are moved to support localized responses. Globally, we worked with other Red Crosses and Red Crescents that acted as consignee for their governments and channeled supplies on behalf of the Canadian Government to the recipient countries directly, such as India and Vietnam. In other cases, these Government of Canada supplies were channelled through the International Federation of Red Cross and Red Crescent Societies, such as in Mozambique, Namibia, Uganda, Nepal, and others. We also collaborated with other national societies to distribute aid to people in need. For instance, we signed a bilateral agreement with the Japanese Red Cross, as a contributing partner, to source two oxygen plants for Nepal."

Recommendations for Readiness

1. Update strategies, as part of readiness plans, to manage and maintain emergency stockpiles, including sourcing and pre-positioning strategies. Such solutions should allow for rapid deployment at scale, irrespective of global-supply-chain limitations and ensure supplies are refreshed, ready, and relevant. This can be supported by defined roles and responsibilities across jurisdictions and for whole of-society actors.

2. Leverage successes in partnering with other actors, such as the Red Cross, to support intake and distribution; consider other solutions to the management of stockpiles, such as an interoperable stockpile shared with regional authorities and operational actors.

3. Be mindful that stockpiles require constant management to guard against expiration, outdated, and aged supplies. Consider delegated or outsourced management and the capacity to draw on the stockpile for global response efforts.

PARTNERING WITH INDIGENOUS COMMUNITIES

We collectively need to enhance opportunities to strengthen Indigenous capacities in public health.

Indigenous populations were disproportionately impacted by COVID-19. This was driven by factors including remoteness and isolation (which compromises access to medical care), inadequate and crowded housing, pre-existing structural gaps, the prevalence of existing health conditions, and persistent disparities in socio-economic conditions and the broader social determinants of health.[x] Indigenous populations reported more negative economic, mental health, and physical health outcomes, in relation to COVID-19, which can be linked to such pre-existing vulnerabilities and the broader but continued impacts of colonization.[xi] In addition, the Red Cross heard from multiple communities that, due to past experiences with governmental and non-governmental authorities, well-intentioned interventions sometimes did not resonate with cultural needs and caused distrust or harm towards the populations they were intended to help.

> "At the peak of the second wave in January 2021, the rate of new COVID-19 cases in First Nations living on-reserve was triple the rate in the general Canadian population."[xii]

1,058
Number of connections with Indigenous leaders

80% of the Help Desk identify as Indigenous

Services are provided in **6** Indigenous Languages

2,118
Information provided

750
Tools shared

416
Number of Communities Engaged

Recognizing these challenges and leveraging our experience in risk reduction and adaptive communication to allow for community-based solutions, the Red Cross launched the Help Desk for Indigenous Leadership, in March 2020, in partnership with Indigenous Services Canada.[xiii] This has resulted in partnerships with more than 416 Indigenous communities to carry out virtual services related to Epidemic Prevention Control guidance and training, virtual site assessments, and risk reduction. The objective is to provide tailored risk reduction and public-health communications, leveraging representative experts: 80% of the Indigenous Help Desk identify as Indigenous, and service is provided in six Indigenous languages.

While the principal focus of the Help Desk remains virtual support to Indigenous community leadership, Indigenous members of the specialized teams have been embedded as part of Red Cross emergency-response teams for activities including vaccination campaigns, support to long-term-care facilities, and mitigation and containment of outbreaks. Members have also been deployed as part of social-emergency-response teams, which support community stabilization after crisis events, including suicide clusters. These activities have improved the quality, relevance, and appropriateness of service delivery and culturally safe programming, with the objective of supporting the resiliency of Indigenous populations in Canada.

Although we are proud of the representative workforce within the Help Desk, we recognize the need for improvement in keeping with our commitment to truth and reconciliation. we continue to strive for increased representative leadership across the Red Cross at all levels, but especially in relation to Indigenous programming. Further we are investing in training and enhancing service delivery standards to support risk reduction and align to practices for cultural safety.

It is critical to work in partnership with and invest in Indigenous-owned and -led operational readiness capacities. The Red Cross has a long-standing partnership with the James Bay Cree Nation of Waskaganish and recently provided (Emergency Response Unit) ERU training and support, so this community could have their own deployable operational-response capacity. These types of initiatives are essential to supporting a ready Canada and also fostering inclusive, community led leadership.

We collectively need to enhance opportunities to strengthen Indigenous capacities in public health.

Indigenous Community Leaders

Recommendations for Readiness

1. Invest in Indigenous-owned and -led operational-readiness capacities. These can be enhanced through readiness planning of response actors, including sharing of expertise.

2. Ensure there are regular opportunities to seek knowledge and insights from Indigenous communities. Such opportunities should be built into structures for preparedness and response. These regular engagements are key measures of success for preparedness and mitigation plans.

3. Continue to invest in culturally appropriate, safe, representative and tailored communications to support Indigenous communities in risk reduction, given the threats of the all-hazard risk environment. Programs should address the layered impacts of natural hazards and promotion of wellbeing in risk mitigation and preparedness. Given the efficacy of this approach, this lesson learned can be carried forward to supporting other populations such as BIPOC and others who are marginalized based on their legal, economic and/or social status.

Case Study: COVID-19 Vaccine Confidence in Nunavik

In August and September 2021, as Canada was entering the 4th wave of COVID-19, the Nunavik Regional Health Board expressed concern over low rates of vaccine coverage and asked the Red Cross for support. In response, the Red Cross sent two teams of two Help Desk staff members to Nunavik to visit eight communities, along both coasts, over a month. The teams engaged with communities to better understand the roots of vaccine hesitancy and ensure vaccination strategies were tailored to Nunavik Inuit. They also helped to facilitate discussion and open doors between health partners and key community players.

As a neutral, impartial and independent organization operating outside of the provincial health system, the Red Cross could provide a safe space for community members to voice concerns, ask questions, and share experiences. Through early engagement of local leaders, such as religious and political figures, respected Elders, local midwives, and influential youth, the response team was able to rely on their guidance in navigating vaccine hesitancy and providing tools to make informed decisions.

After these deployments, the Help Desk ensured relationship continuity with community partners in Nunavik by conducting outreach and debriefing sessions. This included sharing mental-wellness resources upon request. Local leaders reported that the Red Cross presence “gave them a second wind” and reinforced their desire to continue fighting COVID-19-vaccine misinformation.

STRENGTHENING COMMUNITIES AND LOCAL ACTORS

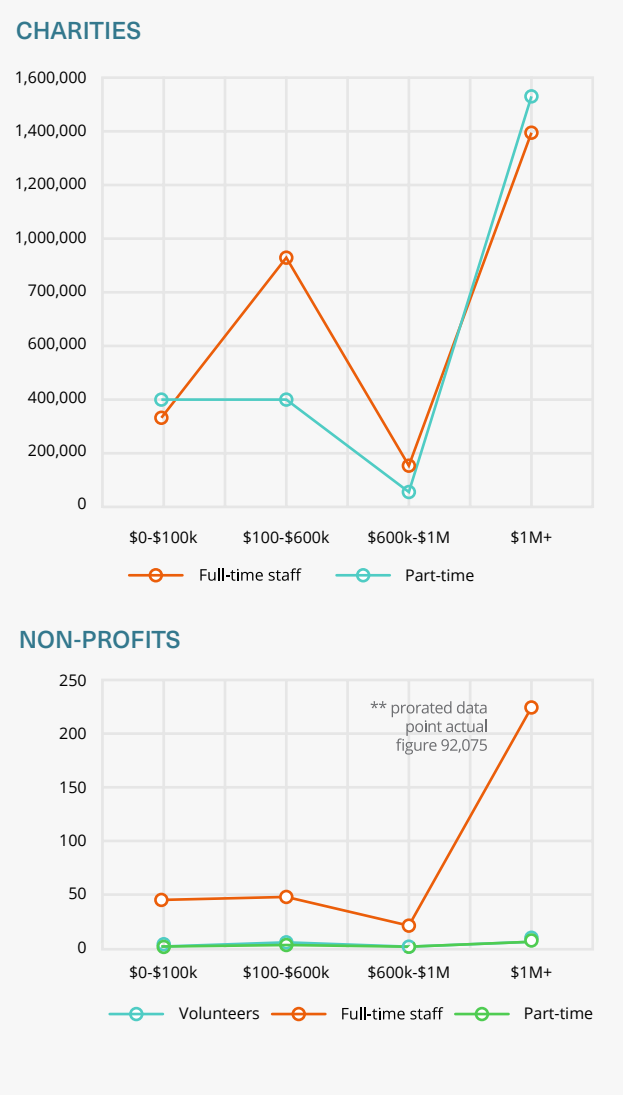
Non-profits, which are distinct from registered charities, have been critical in contributing to the COVID-19 response as well as disproportionately impacted by it. These groups are largely underutilized yet an effective and efficient community resource.

When launching the Emergency Community Support Fund (ECSF), a granting program for community organizations, the Red Cross, in partnership with Employment and Social Development Canada, sought to create a pan-Canadian program targeted at non-profit organizations (NPOs). Non-profits, which are distinct from charities, tend to receive less government funding and less granting from other not-for-profits, and they cannot issue charitable tax receipts. The ECSF fund also included funding opportunities for registered charities through two other national funders.

The non-profit sector is estimated to comprise of 80,000–100,000 organizations in Canada. It remains relatively opaque and not well understood primarily due to inconsistent registration and disclosure requirements (which charities have).

Although the Red Cross has always worked with non-profits, grassroots community associations and registered charities following disruptive events such as floods and fires, it had never undertaken a pan-Canadian program at this scale focused only on non-profits. In administering the ESCF, we learned more about the largely unreached non-profit sector and its impacts in the COVID-19 response.[xiv] NPOs often serve groups that are unseen and unheard, those who are already on the margins and often overlooked during pandemic planning and response. From supporting migrant farm workers to youth formerly incarcerated to sex workers, NPOs are especially vital in the culturally appropriate and safe care they provide communities—especially those that are stigmatized.

Staffing by Revenue



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Red Cross received over 3,500 applications from diverse NPOs catering to an array of community needs. From those who were awarded funding, the top three communities supported by grants were low-income populations or people living in poverty, seniors and elders (not in care), followed by children and youth.

NPOs are similar in size to charities (both have a majority with under $50,000 gross revenue); however, we saw that NPOs are powered almost entirely by volunteers, with limited paid staff. It is difficult to compare volunteer levels between non-profits and charities, as this is not a required disclosure on the annual tax filing for charities. But NPOs report low staffing levels (less than one full time employee) and high volunteer numbers. What is remarkable, is that even NPOs with larger annual revenues do not have an increase in the number of paid staff, only additional volunteers (based on available data). Comparatively, using annual tax-filing data for charities, we see that the number of staff for registered charities generally increases in correlation with the entity's revenue. This suggests that even at scale, unlike charities, NPOs are efficient and can galvanize volunteers to support their humanitarian work. Their volunteers also often come from the communities they serve.

NPOs, many of which provide care and assistance to at-risk, marginalized, under-served, equity-seeking and hidden populations, also faced their own heightened risks during COVID-19. Having limited paid staff members, NPOs were disproportionately disadvantaged in relation to wage subsidies, which many registered charities relied on to continue service provision. Based on data from annual tax-filing submissions, we saw that registered charities mainly rely on government funding (66%). They depended, to a lesser degree, on fundraising revenue, which was more likely to be impacted during COVID-19. In contrast, NPOs reported mainly relying on sponsorship or membership fees and fundraising events, with government support making up only 38% of their overall funding. Where it is projected that fundraising revenue in COVID-19 is being compromised due to economic strain—but government assistance has been steady, if not increased— non-profits have been disproportionately impacted by COVID-19.

Non-Profits and Registered Charities

SIMILARITIES

- Both operate on a non-profit basis and generally would not pay income tax if they have a surplus.
- Both may use similar corporate statutes or be established as unincorporated associations or trusts.
- Both typically have a board of directors or trustees who manage the affairs of the entity.
- Both have legal objects which restrict their activities.
- They may have small or large memberships which effectively control the organization.

DIFFERENCES

- Registered charities are registered with the Charities Directorate of the Canada Revenue Agency, whereas there is no similar comprehensive registry for non-profits.
- Registered charities are divided into charitable organizations, public foundations, or private foundations.
- Non-profits can have very broad objects and can be organized and operated for social welfare, civic improvement, pleasure, recreation, or any other purpose except profit.

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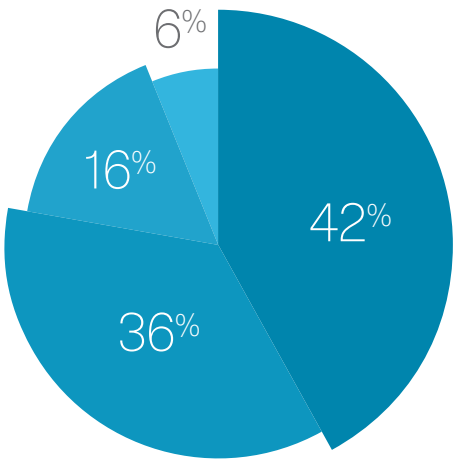
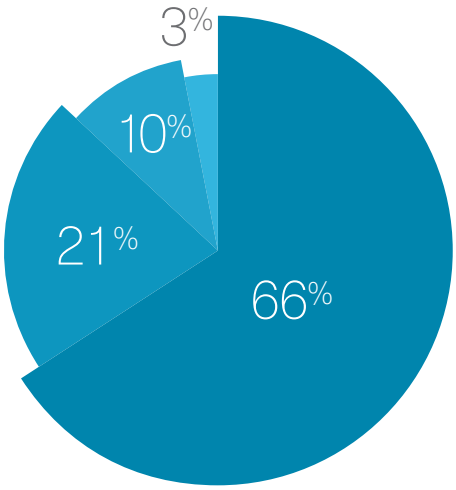
Sectoral Revenue Analysis

NON-PROFITS



- Sponsorship Fees; Fundraising; Events; Membership Fees
- Government
- Other
- Funds from Charities/QDs

CHARITIES



- Government
- Other
- Fundraising
- Funds from Charities/QDs

Recommendations for Readiness

1. Recognizing that non-profits and unincorporated community actors (distinct from charities) tend to be 'left behind' and ineligible for large scale granting programs due to perceived regulatory barriers, continue to create programs targeted at funding non-profits uniquely. Non-profits tend to be less experienced at applying to these types of granting programs, so it is advised to target them with earmarked funding to ensure equal access.

2. Provide more educational opportunities and supports to non-profits for continued learning. We found non-profits eager to better understand and apply best practices, but unsure where to seek support. Consider a centralized registry for non-profits akin to charities (with lesser reporting requirements) that would allow for better benchmarking between non-profits and charities.

STRENGTHENING COMMUNITIES AND LOCAL ACTORS

Community groups have been essential for community-based responses to COVID-19. Continued funding, with an emphasis on reaching marginalized and equity-seeking populations, will remain crucial as we look towards recovery and readiness for future events.

Now more than ever, organizations that serve communities—from youth to new immigrants to LGBTQIA2S+ peoples—are essential for providing services and community-centered care. The Canadian registered-charity sector, even without the inclusion of non-profits, is larger than a number of other Canadian industries, including real estate, mining, oil and gas. Non-profits are estimated to contribute an important amount to nominal GDP, despite the lack of full data available. This means community groups have tremendous impact and are often best placed to understand and meet the needs of the communities they serve. In addition, COVID-19's limitations on mobility and reach increased community reliance on localized supports, so local actors were increasingly meeting community needs.

99% new partners

40,000 + contact points with applicants

3500+ applications received

$65M funded

Funding for adaptation of service delivery was greatest need

Through the ECSF the Red Cross reached 99% of new partners and exclusively funded non-profits (as opposed to registered charities). Grants were awarded to a range of organizations, such as those supporting people with mental-health challenges and addictions, BIPOC, those living with disabilities, and LGBTQIA2S+ groups.

In our programming, we found these community groups extremely effective at reaching populations disproportionately impacted by COVID-19. Within the first round of funding, which represented 77% of the total funds received by the CRC, 30% of funding was awarded to organizations providing care to newcomers, 18% of the total amount awarded went to organizations supporting Black Canadians, and 15% of funding went to those supporting Indigenous communities, so the recipients represented diverse communities across Canada. Further, across both rounds of funding 67% reported that their leadership, workforce or organization was representative of the populations they served. We also found NPOs hugely successful in meeting community needs and responding to COVID-19 impacts, as the needs changed in their own communities. The top services funded were social inclusion and learning, mental health and wellness, information and community navigation, and then food security.

Given current COVID-19 impacts and the long road to recovery ahead beyond its endemic state, community actors will remain critical to meeting the needs of the

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Recommendations for Readiness

1. Funding for community actors related to COVID-19 will be critical for continued service delivery and effective recovery. Noting that recovery can take far longer than expected and is likely to continue for the years to come, sustained funding for services will be critical.

2. Granting programs should continue to ensure reach to marginalized and equity-deserving populations, requiring the creation of new partnerships, and an intentional approach. This can be supported by flexible approaches to funding, including cluster- or consortia-based eligibility. Additional outreach and supports should be put in place for applicants, to ensure equitable funding.

3. Investment in programming to support risk reduction and the resiliency of community actors, prior to events occurring, should be part of our readiness strategies. In particular, we need to assist those supporting at-risk groups, such as the aging population in Canada. This would include service continuity planning to support capacity building and adaptation strategies. This would increase the resiliency of community actors, in times of crisis, and improve their capacity to support their communities.

Case Study: Wapna'ki Kewi'skwaq - Women of First Light

Women of First Light is a not-for-profit organization led by Indigenous women in the Maritimes that seeks to heal communities, families, and society by remembering and returning to the traditional ways of their ancestors.

> *We have diabetes, heart problems, strokes, and high blood pressure. It all relates to our lack of healthy diets. But people can't afford fresh healthy foods, let alone the cost of driving an hour and half each way to pick them up regularly. That is why I want community gardens to provide for my people. I want people to volunteer and learn these skills. And now I can share how to preserve veggies through canning, so we have access all year to healthy foods without the high cost of running freezers.*

JUDY GOOGOO OF WAGMATCOOK FIRST NATION, FOUNDING MEMBER OF WOMEN OF FIRST LIGHT

The group has reintroduced land-based learning activities, such as growing community gardens, in several communities in Nova Scotia and New Brunswick, to support food security for Indigenous communities. They will also distribute fresh vegetables and canned goods to community members in need, including elders and single mothers. As freezers are limited in size and can be expensive, two day canning workshops will also be held in both communities.

As well as providing access to food, recipes, and equipment, to address food insecurity and health challenges exacerbated by COVID-19, there was also the benefit of breaking social isolation as people worked together, talked, and lunched (note that workstations were spaced out and PPE was worn).

As We Look Forward

"[T]he next outbreak... may be even more insidious than SARS. Will we be ready?"

With a long pandemic-recovery process ahead and predicted and predictable emergencies on the horizon, we need to get ahead of emerging needs and be primed for future events. Increasingly complex situations are arising more frequently, where Canadian communities are facing consecutive and concurrent disasters that leave little to no time for recovery before the next shock arrives.

In the aftermath of the devastating SARS outbreak, a "Lessons Learned Report" highlighted the urgent need for readiness, in anticipation of future infectious-disease emergencies. The 2003 report, published by Health Canada and authored by a National Advisory Committee, foreshadowed the global pandemic:

Communities across Canada have pulled together in remarkable ways over the past two years, but we've also felt the impact of stretched resources, rapidly improvised systems, and limiting readiness infrastructure and systems. Let's heed the lessons of the COVID-19 pandemic and make timely investments in readiness and risk reduction, both at home and overseas. We can and must move forward stronger, wiser from our experiences, and fully prepared for the future.

As We Look Forward

Risks and Trends: What the Red Cross is Monitoring

01

Once COVID-19 becomes endemic there is a long road to recovery ahead for Canadians. One ongoing impact that will require focused attention is mental health. Additional supports are likely to be required.

02

A comprehensive review of health supports to aging populations, both in and outside of care, is critical. This includes understanding the impacts of isolation, the need for community and in-person connection, and the navigational challenges of those impacted.

03

Global vaccination equity is imperative. This includes ensuring efficient and effective utilization of aging stocks, supplies and vaccinations, in countries such as Canada to stabilize the pandemic globally. Not only is this important from a humanitarian-imperative perspective but also for collective risk, as mutations are possible with every replication of the virus. The COVID-19 crisis will not be over until it's over everywhere.

04

After action reviews and lessons-learned assessments, we should ensure that populations most prone to risk have their needs considered and their members consulted on solutions. Placing the communities that are most at risk at the center of all decision making is critical. Without direct and meaningful engagement, there is a significant risk of creating more harm for communities who are already marginalized or further entrenching existing inequalities. This is particularly true of Indigenous populations, who should be on the forefront of community-based risk reduction, recovery, and resiliency efforts.

05

In recognition that events can occur concurrently, we must have continued vigilance and readiness for all-hazard-risk events, including extreme weather events, with a particular focus on the upcoming flood and wildfire seasons. With the resiliency of impacted populations compromised by two years of COVID-19, growing unrest and social discord, economic challenges due to inflation, and other compromising factors, the impacts may be compounded.

End Notes

[i] "Deployments" are when our personnel (in this case many from our Emergency Response Workforce) are sent on a set engagement to support a service. These tend to be time bound and can be within a local context, across the country or internationally. For example, a nurse may be deployed to northern Ontario to support vaccination in Indigenous communities for a month.

[ii] An emergency response engagement refers to a request to engage support from the Red Cross through the activation of one or multiple of our service offerings such as testing, vaccination, granting, emergency response to name a few. This can occur through a formal request for assistance from a Province or Territory to a Federal Authority or through direct funding and engagement of the Red Cross.

[iii] According to Statistics Canada, approximately one in five job vacancies in Canada in the first quarter of 2021 was in the healthcare and social-assistance sector. See: "Job vacancies, first quarter 2021," Statistics Canada, page 2, released June 22, 2021, accessed March 3, 2022, **online**.

[iv] IMGs are medical professionals who have successfully completed medical training outside of Canada but do not have a license to practice medicine in Canada. While IMGs are trained and accredited as healthcare professionals abroad, they require additional accreditation and must be Canadian citizens or permanent residents to work in Canada. Once IMGs obtain the necessary credentials to work in Canada in the healthcare system, they must apply through the Canadian Residency Matching Service (CaRMS) where there are limited residency positions and competition between IMGs and Canadian medical graduates (CMGs).

[v] Epidemic Prevention and Control (EPC) measures are Infection Prevention and Control (IPC) measures that have been scaled accordingly to prevent or reduce the risk of transmission of microorganisms between individuals in an epidemic or pandemic context. For further context between EPC and IPC measures, see infra endnote vii.

[vi] The CRC has over 250 IMGs who are vetted for clinical and/or public-health work and has successfully engaged IMGs in response to the surge capacity required to address COVID-19 in certain jurisdictions. In Manitoba, IMGs are used as vaccinators and were deployed to the Canada-US border for collecting specimens for COVID-19 testing and for other public-health operations. CRC-trained IMGs were also recruited by Middlesex London Health Unit, in Ontario, as vaccinators. CRC has developed the training, protocols, vetting and medical oversight/directives to utilize IMGs as additional capacity in a high-quality, safe, and effective manner. As a part of CRC's model for vaccination clinics, there is a requirement of the oversight of a medical director, as well as clinical leadership and stewardship by regulated healthcare professionals at the provincial and site levels.

[vii] Robert Falconer, "Straight Talk with Robert Falconer," Interview by the Macdonald-Laurier Institute. Straight Talk, edition for April 2020, accessed March 3, 2022, **online**. Also see: "Canada - Admissions of Permanent Residents by Province/Territory of Intended Destination and Immigration Category, January 2015 - December 2021," Immigration, Refugees and Citizenship Canada, last modified December 31, 2021, accessed March 3, 2022, **online**.

[viii] IPC measures are evidence-based practices and procedures that can prevent or reduce the risk of transmission of microorganisms between individuals when applied consistently in health care settings. EPC measures integrate IPC measures on a larger scale, to ensure health and safety protocols, as recommended by the public health authorities, and within an epidemic context where the intensity and types of activities may vary (for example: preparedness, containment, mitigation phases). See also supra endnote iv.

[ix] The Sendai Framework for Disaster Risk Reduction 2015-2030 was adopted at the Third UN World Conference in Sendai, Japan, on March 18, 2015. This framework includes recommendations around including all of society actors and shifting focus to risk awareness, reduction, resiliency and building back better.

[x] "First Nations people, Métis and Inuit and COVID-19: Health and social characteristics," Statistics Canada, released April 17, 2020, accessed March 3, 2022, **online**. See also: "Impacts on Indigenous Peoples," Statistics Canada, released October 20, 2020, accessed March 3, 2022, **online**: [Impacts on Indigenous Peoples].

[xi] Impacts on Indigenous Peoples, ibid. See also: "A Vision to Transform Canada's Public Health System: Chief Public Health Officer's Report on the State of Public Health in Canada 2021," Public Health Agency of Canada, published December 13, 2021, accessed March 3, 2022, **online**: [Chief Public Health Officer's Report].

[xii] Chief Public Health Officer's Report, ibid.

[xiii] Over the past 25 years, the Red Cross has worked in collaboration with more than five hundred Indigenous communities and their members throughout Canada. The last decade has seen growth with the development of stronger and more sustainable relationships with Indigenous communities.

[xiv] This analysis is based on the information obtained during the administration of the ESCF granting program and the public disclosures of the T3010. Given so little is known about the non-profit sector further analysis and research is suggested to round out these initial findings.

Timeline End Notes

[1] Timeline of WHO's response to COVID-19.

[2] Inclusive of the deployment of the Emergency Field Hospital.

[3] This included sending medical supplies to China, and a delegation to Japan for Canadians isolated and ill.

[4] Case count starts to rise in Canada starting in March and continue through April and May with the first wave in Canada ending in August 2020 (WHO).

[5] Services include wellness checks, supporting personal care items and meal delivery by volunteers and staff. This work was funded by the Public Health Agency of Canada. Other isolation support later in the response included support in Ontario and in Quebec supporting homeless shelters.

[6] By staff and volunteers to provide comfort, assistance, emotional support and referrals.

[7] Such as cots, blankets, pillows, food (supporting food security assistance) and hygiene kits in Ontario, Manitoba and Alberta (this has continued throughout the last two years).

[8] Ultimately provided in New Brunswick, PEI, Nova Scotia, and Quebec.

[9] Building on earlier support, such as in Manitoba, launch of the Indigenous Help Desk which provides risk reduction and tailored key health guidance in 7 languages to communities across Canada. This program remains ongoing.

[10] Emergency support in the form of grants and personal protective equipment and training to help frontline community organizations across Canada with a focus on equity seeking populations round one (Emergency Support for Community Organizations program) and funded by Employment and Social Development Canada.

[11] Red Cross recruited, trained and mobilized 900 staff to work to support site stabilization due to impacts on personnel and residents. Additional support includes training and EPC support using Infection prevention and control.

[12] Little Grand Rapids First Nation with Epidemic Prevention Control, PPE and COVID-19 training and isolation lodging for those unable to isolate at home in Winnipeg.

[13] EPC services are deployed throughout the last two years. Examples include a deployment to Nunavut as well as virtual support through the Indigenous Help Desk to support an outbreak in the hamlet of Arviat.

[14] Funded by Public Health Agency Canada.

[15] Chief Public Health Officer's Report, ibid. 16 Vaccination support in B.C., Manitoba ,PEI and Quebec with non-clinical support to health authorities begins including providing support to Indigenous Communities in Manitoba. In Ontario outreach and information distribution to support vaccination efforts and vaccination support begins including clinical support to remote communities in Northern Ontario.