

The Christian and Missionary Alliance in Canada

Pandemic Influenza Plan

Executive Summary

This plan is intended to be enacted in strategic partnership with whatever provincial, federal, international guidelines, directions and regulations are in place in the event of a pandemic influenza. In addition, being committed to the glory of God and the Church universal, we seek to take every opportunity to communicate, with word and deed, the good news of the gospel of Jesus Christ. Being committed to social responsibility, we minister to the poor, the sick and the oppressed with humility and compassion as though our ministry was to Christ himself - recognizing that this may require the faith-filled and sacrificial gift of not only our resources, time and talents but perhaps also our lives. We do nothing without prayer. Therefore, this plan is subject to whatever revision that may seem good to the Holy Spirit and to us, as the future unfolds.

SECTION I- PLANNING APPROACH – WHY A CHURCH RESPONSE?

The overall goal of this plan is to provide a guide for response to a pandemic at the denominational level that will cover both C&MA local Canadian churches and overseas ministries. In the event of a pandemic, the Church needs to be connected with the community in which it is found¹... it needs to be prepared... to be reachable and relevant to the needs of its surrounding neighbours. The goals are both practical and spiritual:

- a) to provide guidelines/resources that will assist the Church in reducing the morbidity and mortality associated with the detection of a pandemic influenza;
- b) to redeem the time as the Church offers faith in God, a future with a hope, freedom from the fear of death, as well as practical love and support.

SECTION II – PANDEMIC INFLUENZA

Pandemic influenza is a very contagious novel influenza A virus from which the world population has no immunity.² This influenza results in significant illness and death and is prevalent across continents. There will be no escape from this. There will be very little lead time between when the World Health Organization (WHO) declares a pandemic phase 6 and when the virus is identified in major cities in North America.³ (See Appendix A for Phase descriptions.)

In part, this may be due to international air travel. While the timing of a pandemic cannot be accurately predicted, world experts in infectious disease say that it is not a question of if there will be another pandemic; it is a question of when.⁴ Historically, pandemics occur every 30-40 years. In the 20th century, we have survived the Spanish Flu (1918-1919), the Asian Flu (1957-58) and the Hong Kong Flu (1968-69) with the Spanish Flu being the worst. In 2007 the Avian flu, a novel influenza virus, raised the level of pandemic alertness to phase 3.

The widespread nature of the impact is such that no existing formal emergency response structure can be expected to address the many needs that will arise. Estimates predict that 30% of the workforce will be ill – there will be widespread social and economic disruption as these pandemics usually occur in waves – the total duration of which may exceed a year's time. Those ill may be young, previously healthy individuals. Others will take time off to care for their families.

Supply chains from every sector will be disrupted – transportation and other public services may be curtailed which may contribute to further employment absences (e.g. schools). The psychological impact on the public will likely be significant. Community activities may need to be curtailed or cancelled to prevent further spread of infectious disease.

Once Phase 6 is declared, existing medical organizations and structures will be quickly overwhelmed. Vaccines may not be available for 3-6 months or longer and anti-virals will not be available unless they are stockpiled. Even

with this, there will probably be short supply and priority groups have already been identified in the Canadian situation.⁵

It is estimated that:

- About 45% of people who get sick with influenza will not require medical care but will need health information and advice
- About 53% will require outpatient or primary care (family doctor)
- 1.5 – 2% will need hospitalization (hospitals may be overwhelmed)

SECTION III – ROLES & RESPONSIBILITIES WITHIN THE C&MA

A. Global Ministries (GM)⁶

Global Ministries has a three-pronged emergency response system in place by which it responds in times of crisis.

a. Canadian embassy

As citizens of Canada, GM International Workers located around the world are registered at the local Canadian embassy. Some of our workers are official wardens for the embassy in their cities. Information flows through the warden network to every registered Canadian citizen as needed. Embassies give official guidance to their citizens on how to react to various threats.

b. Global Ministries Team evacuation protocols

As a matter of policy every team has a team evacuation plan with triggers appropriate to their context. GM Handbook IV-F Evacuation of Missionaries from Areas of Danger: “Mission ministry is sometimes conducted in areas that are not secure. Missionaries are expected to remain at their assigned locations unless circumstances of great emergency compel them to leave. When possible, the approval of the FD and the CRD are obtained prior to any evacuation.” (p. 58)

c. International Health Management

IHM is our health management system that oversees the health and well-being of GM International Workers. In times of crisis they are our first responder on issues of physical and mental health; they are the link to our health insurance system. Wawanesa continues to be our insurer and they provide world emergency evacuation measures as required.

B. Canadian Ministries

Planning and preparedness efforts are continuing at all levels of government and it is expected that local churches will be governed by their provincial and regional public health directives. As an example, if public gatherings are banned, then the church needs to consider other avenues for providing spiritual care.

The role of Canadian Ministries is to prepare the local Canadian churches to meet the spiritual and physical needs of the next pandemic.

The first step is to PRAY and seek God’s direction.

The second step is to learn the rationale for pandemic preparedness. Depending on the severity of the outbreak in Canada, government resources may be stretched to the limits. There may be widespread societal anxiety with unprecedented demand for timely, detailed information from a trusted source. The response of the Christian community could make a significant difference to how effectively treatment, recovery and restoration begin.

The third step is to encourage each church to form a contingency plan and to think about questions like:

- What services could be expected to increase?
- In the case of staff illness, who would provide back up for critical roles (e.g. pastoral care, funerals)?
- What could be suspended for a month, indefinitely?
- How could the church make any public gatherings as safe as possible? How would the church inform their people – are their membership/adherent contacts up-to-date?
- How would the church collect tithes and offerings?

- Who would qualify for benevolence under extreme situations?
- How would the church provide practical member care – especially for vulnerable populations?
- How could the church assist public health in relaying critical health information?
- What facilities could we offer to local emergency management? (e.g. daycare, gym, industrial kitchen)^{8,9}

The fourth step is to work collaboratively with all Christian groups to increase our social responsibility – the church can use its networks, strategic partnerships to lift up the name of Jesus Christ. The Church has a timeless message of faith, hope and practical acts of sacrificial love.

The fifth step is to PRAY and commit all to the direction of the Holy Spirit.

SECTION IV - PUBLIC HEALTH MEASURES (as related to local churches)

Public health measures should be promoted generally within our churches. These are phase dependent. Recognize that phases may fluctuate – may go from Phase 3 to 4 then back to 3 etc. Utilize your health professionals to promote public health measures and to educate your congregation on preparedness during Phases 3 to 4. You can expect that all employed health professionals will be on 24/7 in the event of a pandemic. They will not be available. There may be a very short time between Phase 5 and Phase 6...

Phase 1-3 (Interpandemic period – human infections(s) with a new subtype of virus but no human to human spread, or at most rare instances of spread to a close contact)

- Offer annual influenza immunization in conjunction with local public health
- Practice protective practices (hand washing, sanitizer, alternative greetings, encouraging people to stay home if infectious)
- Ensure awareness of appropriate custodial services for preventing spread of infectious disease (cleaning agents both viral & bactericidal, frequency of cleaning, attention to contact points, washroom facilities); increase fresh air supply
- Develop community communication strategy with members and adherents (be connected)
- Identify a team of local responders that could coordinate helpful response to emergency situations within the congregation and with outreach to the community
- Provide general emergency preparedness education (6-8 weeks of essential supplies)
- Identify people with special needs (singles, single parents, disabled, seniors)

Phase 4-5 (Pandemic Alert – increased and sustained transmission of the novel virus in the general population)

- Obtain public health information (e.g. Fact sheets) for public dissemination
- Raise social consciousness
- Ensure communication networks are functional and receiving right messages
- Stock building management supplies
- Train people in self-care and basic care giving skills (e.g. observation, hydration, mobilization)
- Train people to “cross the street” – formation of mutual assistance groups
- Recognize there may be travel restrictions, border screenings

Phase 6 (Pandemic – efficient and sustained transmission of the novel virus in the general population)

- Recognize there may be travel restrictions, border screenings
- Public gatherings may be discouraged, schools closed
- Self-isolation practices

SECTION V – VACCINE & ANTIVIRAL MEDICATIONS

Vaccination is the most effective intervention against influenza in humans. The Canadian government has secured a Canadian supplier for pandemic influenza vaccine. However, once a pandemic influenza virus is discovered, it will take 4-6 months to manufacture a vaccine that is specific for the pandemic virus. Note that the first wave of the pandemic will likely have occurred by that time. Vaccine supply may be limited and provincially designated priority groups will receive vaccine sooner than others.¹⁰ Glaxo-Smith-Kline recently reported early

results for a vaccine that was effective against a drifted strain of the avian H5N1 virus. This may or may not be of future significant benefit.¹¹ Antiviral medications are available and are being stockpiled by federal and provincial governments. There are two types of antiviral medications. M2 ion channel inhibitors (amantadine and rimantadine) and neuraminidase inhibitors (Tamiflu and Relenza). They can be used both to prevent specific exposures to the virus as well as to treat influenza although there is some concern that resistance may develop.¹² In terms of treatment, antiviral agents are effective in reducing the duration of influenza if administered within two days of onset of symptoms.¹³ If anti-virals were to be distributed to Global Ministry personnel, then appropriate guidance would need to be given around when to administer the medications (e.g. illness severity criteria, course of treatment, co-treatment with other drugs, management of side effects).

SECTION VI – INFECTION CONTROL

Basic principles of infections control related to influenza must be communicated over and over. Adherence to infection control practices is essential to minimize the transmission. Frequent and careful hand washing is a key infection control strategy and may be the only significant preventative measure available. The vast majority of influenza is spread from person to person by droplets (produced by sneezing, coughing, talking or singing) or by direct contact. Flu virus can survive for 1-2 days on hard surfaces, 8-12 hours on soft surfaces and 5 minutes on hands.¹⁴

Most adults can transmit the virus from 1 day before and up to 3-5 days after the onset of symptoms. The incubation period is 1-3 days. This means that a person may develop symptoms 1-3 days after coming into contact with a person with influenza.

SECTION VII – SELF CARE WHEN ILL

People need to have access to basic information in order to care for individuals with influenza and to protect themselves as caregivers as well as protecting the care-receivers.

Information needed:

- How do I know if I have influenza?
- How do I know if I have a fever?
- What can I do to treat a fever?
- How can I treat other symptoms of influenza?
- When should I see a doctor?

How could the church assist in distributing this basic information? (Hand-outs, web site, small group teaching sessions)

SECTION VIII - CHURCH RESPONSE – MEMBER CARE

There are often more questions than answers, but individual churches could address some of these in information sessions, sermons, small groups. Beginning to think and to talk about this issue is perhaps the best preparation. Responses will differ.

- In the event of a pandemic, how do we live out our Christian faith?
- What does it mean to proclaim Jesus as Healer?
- How do we put into action what we have studied?
- There will be danger to our own lives – how do we respond to our brothers and sisters in Christ who have become ill – who cannot care for their children, who cannot shop, feed or clean themselves?
- God has promised to protect his own in times of danger – will we trust him and his Word and show an unbelieving world Christ's love by preparing our churches to take action?
- How do we assist those who have been unable to work with perhaps no paycheck because of personal or family illness?
- Does the church have finances set aside for such an emergency? Is that the right approach?

SECTION IX – CHURCH RESPONSE – EXTERNAL

- What does it mean to love one’s neighbour as oneself?
- Is the church willing to take in people who do not belong to the congregation?
- Is there a way for the church to partner with emergency response agencies, public health and governments?
- Consider encouraging church members to “cross the street” – talk to a neighbour to your left and to your right and two neighbours across the street. See if some or all of these five family units might want to form an alliance – a mutual assistance group in the event of a pandemic (take turns shopping, take turns with child care, going to the pharmacy, keeping up-to-date with public health info, offer home schooling, provide basic health care – feeding, support economically, support emotionally and in prayer. The church needs to keep it simple but would Christians lead the world in caring for one another?¹⁵

SECTION X - EMERGENCY PREPAREDNESS

- Encourage church members to be personally prepared for any emergency – not just pandemic.¹⁶

Approved by the Board of Directors as the guiding document for use in Canadian Alliance churches, April 2007

APPENDIX A

Pandemic Phases	Transmission in People	Alert Level
Inter-pandemic phase New virus in animals, no human cases	Low risk of human cases	1
	Higher risk of human cases	2
Pandemic Alert New virus causes human cases	No or very limited human to human	3
	Increased human to human transmission	4
	Significant human to human transmission	5
Pandemic	Efficient and sustained human to human transmission	6

REFERENCES

1. Of Churches, Pandemics and Emergency Preparedness – An Emergency Preparedness (Pandemic Focus) Guide for Churches – A Discussion Paper. Marg Pollon & Timothy Foggin, MD at www.churchresponse.org 2006
2. Pandemic Influenza Contingency Plan, Sandra Vessel, RN MHSc CMMIII, Health Services, York Region Presentation March 2006
3. Toronto Pandemic Influenza Plan, November 2006, pg 5
4. Are Churches Ready for the Next Pandemic? Stephanie Douglas quoting Dr. Allison McGeer of Mt Sinai Hospital in *Faith Today*, May-June 2006, pg 31
5. Infection Prevention & Control – Education session with Brian Thompson, Coordinator for Emergency Planning, Toronto Public Health, April 19, 2006
6. BOD Report, November 2006 – The Christian and Missionary Alliance of Canada, Global Ministries, Compliance report on pandemic preparedness. (courtesy of Dr. S. Lightbody)
7. Pandemic Planning in Ontario – Education session with Allison J Stuart, Director of Emergency Management Unit, Ministry of Health and Long-Term Care, Ontario, May 16, 2006
8. Are Churches Ready for the Next Pandemic? Stephanie Douglas, *Faith Today*, May/June 2006, pg31-33.
9. Church Preparedness Checklist – A Guide for Planning, Adapted by the Vancouver Church Pandemic Preparation Working Group, January 2007. www.PROJECTSafetyNet.ca
10. Toronto Pandemic Influenza Plan, November 2006, pg 119
11. Press Release: <http://www.gsk.com/media/flu/gsk-h5n1-vaccine-5march2007.pdf>
12. Personal communication with Ken Gamble, MD, Director of IHM, email dated 17 Mar 2007
13. Toronto Pandemic Influenza Plan, November 2006, pg 130
14. Pandemic Influenza Planning for Business Continuity, Sandra Vessel, RN MHSc CMMIII, Health Services, York Region Presentation at Bayview Glen Church, June 2006
15. Of Churches, Pandemics and Emergency Preparedness – An Emergency Preparedness (Pandemic Focus) Guide for Churches – A Discussion Paper. Marg Pollon & Timothy Foggin, MD at www.churchresponse.org 2006, pgs 30-36
16. http://www.hc-sc.gc.ca/ed-ud/prepar/index_e.html