MNP

A Review of the Government of Nunavut's Department of Health COVID-19 Pandemic Response

Prepared for the Government of Nunavut, Department of Health

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MNP

Executive Summary

Background and Scope

Coronavirus disease 2019 ("COVID-19") is a contagious disease caused by the novel coronavirus SARS-CoV-2. The first known case was identified in Wuhan, China in December 2019, with the virus spreading rapidly worldwide. On January 30, 2020, the World Health Organization ("WHO") declared COVID-19 a Public Health Emergency of International Concern ("PHEIC"), and on March 11, 2020, it was confirmed as a pandemic ("the pandemic").

The Government of Nunavut declared a state of public health emergency in response to the COVID-19 pandemic on March 18, 2020. This declaration was renewed every two weeks until the emergency was determined to be over on April 11, 2022. On May 5, 2023, the WHO declared an end to the global PHEIC for COVID-19.

The pandemic required the Government of Nunavut Department of Health ("the department", "Health" or "HEA") to swiftly adapt its policies, processes, programming, and workflow to ensure a coordinated, effective pandemic response. In 2022, HEA engaged an independent consulting firm, MNP LLP (MNP), to conduct a review of its response to the COVID-19 pandemic (the "COVID-19 Pandemic Response Review" or "review"). The review aims to bring forward learnings in support of the development of policies that will influence future public health emergency responses.

In keeping with this purpose, the review looked at five topics: Governance; Emergency and Health Management Preparedness; Emergency and Health Management Response; Emergency and Health Management Recovery; and Communication and Engagement. A thorough assessment of vaccine delivery was outside the scope of this review as it has been addressed by the Office of the Auditor General of Canada. As well, a thorough assessment of the whole-of-government approach to the COVID-19 pandemic was not part of the review as this has been reported on by the consulting company DPRA Canada (2023), and a report on the Isolation Hub Program was produced in early 2023.

Approach

The approach to this project was tailored to meet the specific needs of HEA for a balanced and credible evaluation. A document review included procedures, past studies, Auditor General reports, guidebooks, briefing notes, and other materials that were provided by HEA. The findings of the document review were used to support learnings and takeaways from the consultations. To ensure these consultations captured a range of perspectives and voices, MNP conducted interviews with 36 HEA representatives as well as members of select communities in each of Nunavut's regions. Following outreach by HEA to elected officials and Community Health Representatives ("CHRs") in approximately 10 communities, based on availability, MNP engaged with Mayors and/or Senior Administrative Officers ("SAOs") to gather insights from six communities and CHRs in two communities.

Summary of Findings

The evaluation findings were presented to and validated by the HEA project team. The key findings related to each of the project topics include:

- **Governance:** While HEA was able to rapidly set directions as well as establish and adopt needed policies and procedures, it did so with an emergency response plan that was out of date. HEA looked to the 2012 "Pandemic Influenza: Planning and Response Guidelines for the Health Sector" during the beginning of the pandemic, which was dated and more general in its guidance. In the future, ensuring a shared along with more specific understanding of decision-making, authorities, and accountabilities as much as roles and responsibilities would be helpful, as would be the consistent, open consideration of Inuit Qaujimajatuqangit Principles.
- **Emergency and Health Management Preparedness:** Although HEA was able to respond quickly, and with communities feeling prepared overall, going forward there should be some focus put toward securing appropriate technology and being able to further resource a response.
- **Emergency and Health Management Response:** Recognizing that collaboration underpins the success of the response to the pandemic, there are opportunities in the future to strengthen the roles and contributions across different departments, to better the accessibility of funding, and to ensure a range of supports are available to address the many impacts of isolation.
- **Emergency and Health Management Recovery:** The COVID-19 pandemic had notable impacts on the mental health of government leaders and staff, as well as on the mental health of community members. This needs to be accounted for in future pandemic planning.
- **Communication and Engagement:** While communications within the government and with communities were timely and frequent, it is important to ensure that this outreach is suited for the audiences and that any changes in direction, policy or procedure are readily understood.

Recommendations

Several opportunities for change based on the key findings were developed for consideration by HEA, including:

1. **Provide for a Comprehensive, Action Oriented Emergency Management Plan:** HEA should have in place an overarching, Emergency Management Plan that serves to unite more specific planning, like the 2012 Pandemic Influenza Plan. And it should be implementation oriented in that it accounts for how decision-making will unfold including references to guiding principles such as Inuit Societal Values; addresses shared accountabilities through descriptions of aligned efforts and processes; and sets out the ways in which general roles and responsibilities will be enacted and communicated on. This plan should also be reviewed on an annual basis, with part of this being the consideration of alignment to current policies, procedures, and protocols.
2. **Enhance Internal and External Communication Protocols:** HEA should adopt an integrated approach to both internal and external communications with a focus on community consultation, all as part of ensuring a robust and resilient approach to addressing public health challenges. This collaborative approach promotes transparency, inclusivity, and responsiveness, ultimately enhancing the effectiveness and sustainability of pandemic response efforts across the department.

3. **Advance the Use of Digital Health Information and Inventory Management Technologies:** HEA should advance the use of digital public health information coupled with real-time inventory management to provide for efficient and accurate tracking of resources, dissemination of critical information, and coordinated efforts across healthcare networks. This could also provide for timely and effective interventions to safeguard public health. To support this, HEA may be required to implement formal Health Information Legislation that establishes formal guidelines and protocols for accessing and utilizing health information in health professional's day-to-day work.
4. **Adopt an Inter-Departmental Collaborative Resourcing Model as Part of the HEA Response to Complex Emergencies:** In planning and preparing for future health emergencies, HEA should consider comprehensive inter-departmental resourcing that embraces a whole-of-government approach, to ensure coordination and collaboration across all relevant departments and agencies as well as to reduce the extreme workloads placed onto HEA staff during an emergency response.
5. **Review and Optimize Staff Health and Wellbeing Supports:** HEA should consider developing a robust recruitment strategy to attract and retain qualified staff and bolster capacity across the territory, which includes a memorandum of understanding with the federal government to ensure that there is support and assistance with staff recruitment and retention, particularly during future emergencies. Also, HEA should explore the completion of a Workplace Culture Survey along with a review of existing supports that makes a distinction between helping staff address the residual impacts of the COVID-19 pandemic, and accommodating the likely demands that will be placed on staff during a future emergency event, all from a health and wellness point of view. When it comes to residual impacts of the COVID-19 pandemic, key supports would be employee assistance programs, mental health resources, and wellness initiatives. And in taking a future perspective, added to this would be employee benefits packages, flexible work arrangements, daycare supports, compensation, and bonus structures.

The COVID-19 pandemic tested the limits of healthcare systems across the world. Nunavut was not an exception and was further challenged by the remote geography and smaller population relative to other jurisdictions. With the results of this review, HEA can determine what improvements can be made and where efforts may be focused in the face of a future public health emergency.

Table of Contents

1.0 Introduction 1

1.1 Background 1

1.2 Purpose and Scope of the Review 1

1.3 Approach 2

2.0 Context Setting 4

2.1 About the Department of Health 4

2.2 The COVID-19 Pandemic in Nunavut 8

3.0 Key Evaluation Findings 15

4.0 Recommendations 20

5.0 Appendices 35

Appendix A Detailed Evaluation Findings by Guiding Area 35

Appendix B References 49

Appendix C Topics of the MNP COVID-19 Pandemic Response Review 52

Appendix D Guiding Evaluation Questions 53

Appendix E Project Logic Model 55

Appendix F Report Limitations 59

Appendix G Master Interview Guide 60

Appendix H Interview Guide for The Minister of Health 66

Appendix I COVID-19 Related Committees and Working Groups 69

1.0 Introduction

1.1 Background

Coronavirus disease 2019 (COVID-19) is a contagious disease caused by the novel coronavirus SARS-CoV-2. The first known case was identified in Wuhan, China in December 2019, with the virus spreading rapidly worldwide. On January 30, 2020, the World Health Organization (WHO) declared the novel 2019 coronavirus outbreak a Public Health Emergency of International Concern (PHEIC), and on March 11, 2020, stated that COVID-19 was a pandemic ('the pandemic").

In Nunavut, a public health emergency was declared on March 18, 2020, and the first case of COVID-19 was found in November 2020. The public health emergency was renewed every two weeks until it was determined to be over on April 11, 2022. On May 5, 2023, the WHO confirmed an end to the global PHEIC for COVID-19.

The pandemic required the Government of Nunavut Department of Health ("the department", "Health" or "HEA") to swiftly adapt its policies, processes, programming, and workflow to ensure a coordinated, effective Pandemic response. From the onset of the pandemic, HEA worked in collaboration with other departments and communities on the Government of Nunavut's Pandemic response to minimize the health, economic, and social impacts of this rapidly evolving public health emergency.

1.2 Purpose and Scope of the Review

HEA engaged an independent consulting firm, MNP LLP (MNP), to conduct a review of its response to the COVID-19 Pandemic (the "COVID-19 Pandemic Response Review" or "review"). The review aims to bring forward learnings in support of future public health emergency responses.

Purpose of the Review

The review seeks to:

- Understand the aims of HEA's COVID-19 Pandemic response and how HEA was successful in achieving these goals along with objectives; and,
- Gain insight into what worked well, the lessons learned, and what could have been improved with HEA's COVID-19 Pandemic response.

Scope of the Review

Appendix C outlines the five topics that the COVID-19 Pandemic Response Review sought to address, and Appendix D provides the questions that guided the review. A thorough assessment of vaccine delivery is outside the scope of the review as this has been addressed by the Office of the Auditor General of Canada. As well, a thorough assessment of the whole-of-government approach to the COVID-19 pandemic was not part of the review as this has been reported on by DPRA Canada (2023), and a report on the Isolation Hub Program was produced in early 2023.

The evaluation was performed in alignment with five guiding areas:

- **Governance.** This relates to the structure and evolution of policy setting, legislation and regulation, planning, and decision-making within HEA. It will also touch on how HEA collaborated with other departments and considered Inuit Qaujimajatuqangit to ensure alignment with its COVID-19 Pandemic Response.
- **Emergency and Health Management Preparedness.** This relates to the state of HEA's preparedness before the COVID-19 Pandemic.
- **Emergency and Health Management Response.** This relates to the actions taken throughout the COVID-19 pandemic to promote and protect the health and wellbeing of people.
- **Emergency and Health Management Recovery.** This relates to the impacts of the COVID-19 pandemic on Nunavut's health workforce and healthcare system more broadly.
- **Communications and Engagement.** This relates to how guiding policies and procedures related to HEA COVID-19 Pandemic Response were communicated internally within the government and externally with communities.

Under each of these topics, guiding evaluation questions and a logic model were developed and used to inform both the document review and engagement with HEA representatives and community members.

1.3 Approach

The approach to this project was based on a proven methodology that is aligned with that of central government agencies including the Treasury Board of Canada and tailored to meet the specific needs of HEA to create a balanced and credible evaluation.

The overall design of the review considered other evaluation frameworks including:

- World Health Organization Monitoring and Evaluation Framework 2020;[1]
- National Collaborating Centres for Public Health 2020 Report on Public Health Governance;[2]
- Canada Public Health Association Review of Pandemic Response, 2021;[3] and,
- PHPC Pandemic Lessons Report, 2022.[4]

A draft evaluation framework was presented to the Project Steering Committee and, in collaboration with HEA, MNP finalized this document. The evaluation framework is based on key guiding topics as outlined above: Governance; Emergency and Health Management Preparedness; Emergency and Health Management Response; Emergency and Health Management Recovery; and Communication and Engagement (Appendix C).

Under each of these topics, guiding evaluation questions were developed and used to inform both the document review and engagement with HEA representatives and community members (Appendix D). The document review covered policies, procedures, past studies, Auditor General reports on vaccine

[1] World Health Organization. 2020. "Monitoring and Evaluation Framework: COVID-19 Strategic Preparedness and Response." https://www.who.int/publications/i/item/monitoring-and-evaluation-framework

[2] National Collaborating Centres for Public Health. 2022. "Governing for the Public's Health: Governance Options for a Strengthened and Renewed Public Health System in Canada." https://nccph.ca/projects/canadas-chief-public-health-officer-2021-report-and-associated-commissioned-reports/governing-for-the-publics-health-governance-options-for-a-strengthened-and-renewed-public-health-system-in-canada/

[3] Canada Public Health Association. 2021. "Canada' Initial Response to the COVID-19 Pandemic." https://www.cpha.ca/sites/default/files/uploads/policy/positionstatements/2021-02-covid-19-initial-review-e.pdf

[4] Public Health Physicians of Canada. 2022. "Public Health Lessons Learned from the COVID-19 Pandemic." https://www.phpc-mspc.ca/resources/Documents/PHPC_Public%20Health%20Lessons%20Learned%20from%20the%20COVID-19%20Pandemic.pdf

delivery and the state of the healthcare system in Nunavut, guidebooks, briefing notes, and other materials that were provided by HEA. The findings of the document review were used to support learnings and takeaways from the consultations. To ensure these consultations captured a range of perspectives and voices, MNP worked with HEA to identify individuals from within the department who were involved in the COVID-19 response and who could speak to the topics of the evaluation. HEA provided MNP with a list of positions that, based on previous experience, could speak to the various topics, and HEA identified those individuals within the department's structure. Due to staff departures and staff changing roles, not all of the positions identified were available to be interviewed. In those cases, the HEA project team identified substitutes who could speak to the evaluation topic areas.

MNP conducted interviews with 36 HEA representatives as well as members of select communities in each of Nunavut's regions. Following outreach by HEA to elected officials and Community Health Representatives (CHRs) in approximately 10 communities, based on availability, MNP engaged with mayors and/or senior administrative officers (SAOs) to gather insights from six communities and CHRs in two communities.

After the document review and engagement, MNP compiled all learnings and developed main themes under each guiding topic. A summary of the findings was provided to the HEA's Project Steering Committee to allow for review and validation of these findings. The validated findings informed opportunities for change that MNP has put forward in this report for consideration by HEA as they continue to develop policies and processes to address future public health emergencies.

2.0 Context Setting

2.1 About the Department of Health

The department is responsible for setting the policies and legislation governing the healthcare system, along with delivering healthcare services in Nunavut. The department works collaboratively with several other Government of Nunavut departments to deliver on its roles and responsibilities.

Two territorial statutes, the *Public Health Act* (2016) and the *Emergency Measures Act* (2010) and other plans, such as the "Pandemic Influenza: Planning and Response Guidelines for the Health Sector," help guide HEA service delivery. These statutes and plans, and how they were implemented, influenced how HEA led the pandemic response.

2.1.1 Inuit Qaujimajatuqangit

The department's mission is to promote, protect, and enhance the health and wellbeing of all Nunavummiut, and to incorporate Inuit Qaujimajatuqangit ("IQ") at all levels of service delivery and design. IQ refers to Indigenous Knowledge of the Inuit, recognized to be a "unified system of beliefs and knowledge characteristic of the Inuit culture."[5] The Government of Nunavut recognizes the following IQ principles:[6]

- **Inuuqatigiitsiarniq:** Respecting others, relationships and caring for people;
- **Tunnganarniq:** Fostering good spirit by being open, welcoming and inclusive;
- **Pijitsirniq:** Serving and providing for family and/or community;
- **Aajiiqatigiinniq:** Decision-making through discussion and consensus;
- **Pilimmaksarniq / Pijariuqsarniq:** Development of skills through observation, mentoring, practice, and effort;
- **Piliriqatigiinniq/ Ikajuqtigiinniq:** Working together for a common cause;
- **Qanuqtuurniq:** Being innovative and resourceful; and,
- **Avatittinnik Kamatsiarniq:** Respect and care for the land, animals, and the environment.

The whole of the Government of Nunavut has committed to incorporating IQ principles into how its policies and laws are developed as well as in the delivery of programs and services.

2.1.2 The Health System in Nunavut

As HEA looks to learn from the experiences gained from the COVID-19 pandemic and to develop policies that will influence future public health emergency responses, it is important to understand *who* healthcare services are provided to and *how* they are currently provided.

The 2021 Canada Census reports that the population of Nunavut is 36,858 people, a 2.5% increase from the 2016 census.[7] Approximately 85% of the population identified as Inuit, 0.5% as First Nation, 0.01% as Métis, and 13% as non-Indigenous. The five most populous communities are Iqaluit, Rankin Inlet, Arviat, Baker Lake, and Igloolik. There are rich sociocultural strengths in Inuit culture and traditional knowledge. There are also significant social and economic inequities that impact the health and wellbeing of Inuit in

[5] Tagalik, S. 2010. "Inuit Qaujimajatuqangit: The Role of Indigenous Knowledge In Supporting Wellness in Inuit Communities in Nunavut." *National Collaborating Centre for Aboriginal Health*. [PDF]. Accessed December 2023, January 2024, March 2024.

[6] Government of Nunavut. N.d. "Inuit Societal Values." [PDF]. Accessed December 2023, January 2024, March 2024.

[7] Statistics Canada. 2023. "Census Profile, 2021 Census of Population: Nunavut." Accessed March 2024.

Canada. A 2018 statistical profile prepared by Inuit Tapiriit Kanatami ("ITK")[8] illustrates this, with Table 1 providing some statistics showcasing the inequalities of the health system for Inuit.

Table 1: Health System Inequalities for Inuit People[9]

52%	12.3	63%
of Inuit in Inuit Nunangat live in crowded homes, compared to **9%** of all Canadians.	The infant mortality rate per 1,000 for Inuit infants, compared to the non-Indigenous population at **4.4**.	of Inuit adults in Inuit Nunangat smoke daily, compared to **16%** of adults in Canada.

The federal government is the main funding agent for almost all health delivery in Nunavut. However, "Inuit organizations, hamlets, non-governmental organizations, and charities all participate in the health system by offering health and wellness programs at the community and regional level, the bulk of the funding for which also originates from the federal government."[10]

There are over 30 health facilities across Nunavut[11] providing primary and public healthcare to Nunavummiut, including health centres, a general hospital, and continuing care centres (Table 2). The primary health care approach places the community, rather than the nurse, doctor, and other health workers, at the centre and does not exclude traditional healing methods.[12] Public health services, such as health promotion and education (including healthy children and family and addiction reduction programs), vaccine distribution, and tracking diseases are also delivered out of these, amongst other centres, and are an essential component of Nunavut's health system. The Government of Nunavut's Public Health Strategy "recognizes that many organizations contribute to public health and it is, therefore, founded on working collaboratively and in partnership with other departments and non-governmental sectors."[13]

Table 2: Health Facilities in Nunavut

Facility Type	Number	Location	Services Provided
Qikiqtani General Hospital	1	• Iqaluit	• 35-bed acute care facility. It provides in and out-patient hospital services as defined by the *Canada Health Act*. QGH offers 24-hour emergency services, in-patient care (including obstetrics, pediatrics and palliative care), surgical services, laboratory services, diagnostic imaging, respiratory therapy, and health records and information.

[8] ITK. 2018. "Inuit Statistical Profile 2018." https://www.itk.ca/wp-content/uploads/2018/08/Inuit-Statistical-Profile.pdf. Accessed March 2024.
[9] Ibid.
[10] NTI. 2008. "Nunavut's Health System: A Report Delivered as Part of Inuit Obligations Under Article 32 of the Nunavut Land Claims Agreement." Accessed May 2024. https://www.tunngavik.com/documents/publications/2007-2008%20Annual%20Report%20on%20the%20State%20of%20Inuit%20Culture%20and%20Society%20(English).pdf
[11] Government of Nunavut. n.d. "Nunavut Seniors' Information Handbook." https://assembly.nu.ca/sites/default/files/TD-286-4(3)-EN-Nunavut-Senior-Information-Handbook.pdf Accessed March 2024.
[12] NTI. 2008. "Nunavut's Health System: A Report Delivered as Part of Inuit Obligations Under Article 32 of the Nunavut Land Claims Agreement." Accessed May 2024. https://www.tunngavik.com/documents/publications/2007-2008%20Annual%20Report%20on%20the%20State%20of%20Inuit%20Culture%20and%20Society%20(English).pdf
[13] Ibid.

Facility Type	Number	Location	Services Provided
Regional Health Facilities	2	• Rankin Inlet • Cambridge Bay	• 24-hour care for in-patients; out-patients receive care by on-call staff • Daily clinic hours and emergency care are available, and on-call, 24-hour a day
Public Health and Family Health Clinic	2	• Rankin Inlet • Iqaluit	• Public health programming and home care • Public health programming, home care, and a family practice led by nurse practitioners
Community Health Centres	22	• 22 (of the 25) Communities Across Nunavut	• Provide public health services, home care, out-patient services and urgent treatment services.
Continuing Care Centres	3	• Igloolik • Gjoa Haven • Cambridge Bay	• Igloolik and Gjoa Haven are 10-bed facilities, +1 palliative care bed, offering 24-hour, 7-day nursing and personal care • Cambridge Bay has an 8-bed facility offering 24-hour, 7-day nursing and personal care
Elders Homes	2	• Iqaluit • Arviat	• Both are 8-bed assisted living facilities
Mental Health Facilities	2	• Iqaluit (Akausisarvik Mental Health Facility) • Cambridge Bay	• The Akausisarvik facility has 16 beds for in-patient programming. It also provides 24/7 in-patient and drop-in programming • The Cambridge Bay facility has 12 beds for in-patient programming. It also provides 24/7 in-patient and drop-in programming

Due to the remote nature of Nunavut's communities, all of which are only accessible by air or sea (in warmer months), access to southern health facilities is supported by a medical transportation program. Regular commercial flights are available for non-emergency travel and air ambulances are used for emergencies.

In 2017, the Office of the Auditor General reviewed the health services in Nunavut to examine, "whether the Department of Health adequately managed and supported selected healthcare personnel who deliver services in local and regional health centres in Nunavut."[14] The review found that there are strengths in the delivery of health services, such as community health nurses who are the "backbone of community health centres."[15] However, staffing challenges were also noted, with the review finding that as of December 2016, 46% of positions were vacant and filled by temporary staff, such as casual or private agency nurses.[16] At the time of the Auditor General review, the department could hire nurses and can

[14] Office of the Auditor General of Canada. 2017. "Report of the Auditor General of Canada to the Legislative Assemble of Nunavut - 2017- Health Care Services Nunavut." [PDF] Accessed December 2023, January 2024, March 2024.
[15] Ibid.
[16] Ibid.

manage contracts with health professionals, while the Department of Finance could hire non-nursing employees. Any organizational changes to HEA had to be approved by the Department of Finance, which also develops human resource policies and procedures. In June 2016, HEA was working with a consultant to complete a service re-design process,[17] although it is unclear at the time of this report if and how that process was completed.

The findings from the Auditor General report, especially related to staff capacity issues and the role of the Department of Finance in organizational changes and developing human resource policies and procedures, are important to understand in the context of the COVID-19 response. They highlight the existing capacity issues before the pandemic and the limitations of HEA's decision-making ability in developing a response.

[17] Office of the Auditor General of Canada. 2017. "Report of the Auditor General of Canada to the Legislative Assemble of Nunavut - 2017- Health Care Services Nunavut." [PDF] Accessed December 2023, January 2024, March 2024.

2.2 The COVID-19 Pandemic in Nunavut

The World Health Organization declared COVID-19 as a pandemic on March 11, 2020. In response, the Government of Nunavut declared a public health emergency on March 18, 2020, and introduced measures to reduce the spread of the virus. The public health emergency order was extended every two weeks until April of 2022. As part of these restrictions, Nunavut implemented travel restrictions and mandatory isolation requirements, which helped keep COVID-19 out of the territory for several months. During this time, the Government of Nunavut, including HEA, was able to learn from other jurisdictions to prepare their response.

Throughout 2020, cases of COVID-19 were identified in the mines and there were also false positive results in some communities. The first confirmed case of COVID-19 in community was identified in November of 2020 in Sanikiluaq. More cases and significant outbreaks were later identified that same month in Rankin Inlet, Whale Cove, and Arviat. As the pandemic continued into 2021 and 2022, other cases and outbreaks emerged and a vaccine was developed, leading to the need for HEA to adapt their response. HEA modified their response by redirecting resources and changing health directives as new information and research emerged about the virus, and shifting the focus to a vaccination campaign as vaccines became available. The stages of adaptation are outlined in the Government of Nunavut's 2021 "Living with COVID-19" plan, which is a strategy for the government's "approach and criteria for the gradual elimination or gradual increase of public health measures based on knowledge of the virus, our tools to combat COVID-19 and the latest public health evidence."[18]

A summary of HEA's preparation and responses, based on the document review conducted for this report, is described in this section.

2.2.1 COVID-19 Pandemic Response Plan and Operating Procedures

At the onset of the pandemic, the COVID-19 Executive Committee ("the Executive Committee") was established to lead the government-wide pandemic response. The interdisciplinary Executive Committee was comprised of:[19]

- The Chief Public Health Officer ("CPHO");
- Deputy Minister, Executive and Intergovernmental Affairs;
- Associate Deputy Minister, Executive and Intergovernmental Affairs – COVID-19 Response;
- Deputy Minister, Department of Health; and,
- Deputy Minister, Department of Community and Government Services.

The Executive Committee developed a "COVID-19 Nurse Staffing Surge Capacity Contingency Plan" in March 2020 to provide strategies to address the need for additional nurses during the pandemic.[20] The plan was intended to be flexible to respond to the severity of the pandemic as it evolved. However, it can be noted that in the version provided for this report, the conditions to activate steps of the contingency plan were not indicated.

The Government of Nunavut Incident Command Structure ("ICS") was established in 2020 to provide

[18] Government of Nunavut. 2021. "Nunavut's Path: Living with COVID-19." https://www.gov.nu.ca/sites/default/files/documents/2021-11/nunavuts_path_living_with_covid-19_-_eng.pdf. Accessed March 2024.
[19] DPRA Consulting Ltd. 2023. "Review of the Government of Nunavut's Response to the COVID-19 Pandemic." [Draft Report to the Government of Nunavut, Department of Executive and Intergovernmental Affairs]. Accessed December 2023, January 2024, March 2024.
[20] Government of Nunavut. 2020. "Nunavut COVID-19 Nurse Staffing Surge Capacity Contingency Plan." [Word Document]. Accessed December 2023, January 2024, March 2024.

logistical support to the CPHO. The ICS was led by the Associate Deputy Minister of the Department of Executive and Intergovernmental Affairs (EIA) leading the COVID-19 Response and supported by the Director of Nunavut Emergency Management (Department of Public Safety and Emergencies). The ICS was responsible for liaising with HEA on a coordinated COVID-19 outbreak and emergency response and ensuring essential government services along with support continued to be delivered in communities impacted by COVID-19.

In the early days of the pandemic, the COVID-19 response was based on the government's 2012 "Pandemic Influenza: Planning and Response Guidelines for the Health Sector." However, in June of 2020, HEA developed the "Government of Nunavut: COVID-19 Pandemic Response Plan" to address the specific challenges of COVID-19. The stated objectives of the plan were:[21]

- "To prevent outbreaks, delay spread, slow and stop transmission;
- To provide optimized care for all patients, especially the seriously ill; and,
- Minimize the impact of the epidemic on health systems, social services and economic activity."

The plan outlines four levels of response aimed at slowing and stopping transmission (Table 3) and how they would be triggered. Each level outlines specific tasks and individuals responsible for each task. The plan also acknowledges that the intention was for the plan to be continually reassessed as the pandemic changes over time.

Table 3: Levels of Response in the Government of Nunavut COVID-19 Pandemic Response Plan

Level 0: Preparedness Plan: Prepare plans that can be quickly activated in response to COVID-19 activity in the territory to ensure a coordinated and efficient response. The focus is on ensuring public, health system and health staff readiness.
Level 1: Rapid Response Plan: Prevent transmission within the community and between communities through strict containment, screening, and contact tracing measures.
Level 2: Enhanced Community Health Services Plan: Prevent further transmission (flatten the curve) and keep unwell community members in their homes by increasing local health system capacity to conduct frequent home health assessments. The focus is on isolating patients and families in their own homes and avoiding the need for cohort isolation sites.
Level 3: Regional Monitoring Site Plan: Transfer mild-moderately ill patients, who require increased health monitoring, to a designated regional monitoring site.

To support the Pandemic Plan, HEA also developed standard operating procedures ("operating procedures") to, "provide a best practice and evidence-based framework to guide actions and decisions related to the management of a COVID-19 outbreak in Nunavut […] and outline clear roles and responsibilities to inform the public health response."[22] These operating procedures were updated throughout the pandemic and distributed to the healthcare team, including:

- Executive Directors;
- Directors of Health Programs;
- Directors of Population Health;
- Supervisors of Health Programs;

[21] Government of Nunavut. 2020. "COVID-19 Pandemic Response Plan." [Word Document]. Accessed December 2023, January 2024, March 2024.
[22] Government of Nunavut. 2020. "Standard Operating Procedure – COVID-19 Outbreak Management Team." [PDF MEMO]. Accessed December 2023, January 2024, March 2024.

- Regional Communicable Disease Coordinators;
- Territorial Communicable Disease Specialist(s);
- Iqaluit Public Health Manager;
- Nurse Educators;
- ED Iqaluit Health Services;
- Medical Quality;
- Programs Administrator;
- Territorial Director of Oral Health;
- Director of Travel Health Programs;
- Director of Mental Health; and
- Territorial Director of Home and Community Care.

In a memo attached to the updated operating procedures, it is noted that older versions were to be replaced in each health centre's communication binder and communicable diseases manual. The memo also highlighted key changes to the updated operating procedures for ease of reference. The operating procedures outline the Health team members and their roles and responsibilities, outbreak management procedures, and a flow of information for an outbreak response. A series of appendices are also provided with the operating procedures such as templates for meetings, contact tracing forms, testing procedures, and information flowcharts for healthcare providers. The development, update, and communication of the standard operating procedures indicate that HEA was renewing the direction to frontline staff as the information about the pandemic evolved. However, it is unclear if or how any feedback from the frontline was incorporated into iterations of the plans or if unique community circumstances were taken into account.

Between the earliest operating procedure reviewed for this report (2020) and the most recent (2022), a notable difference is a section on "cultural safety" that is present in the 2020 version but not the 2022 update. The "cultural safety" section in the 2020 version invites healthcare professionals to "remain mindful of the historical and intergenerational trauma caused by communicable diseases to Inuit communities."[23] However, specific references to IQ principles are not noted. The lack of reference to IQ principles and the removal of "cultural safety" from the standard operating procedures provides uncertainty as to how IQ principles were considered in developing and operationalizing the procedures.

2.2.2 Creation of the HEA Special Operations COVID-19 Division

In late 2020, EIA and HEA submitted a request to the Department of Finance's Financial Management Board for the creation of a temporary Pandemic Response Secretariat.[24] As part of this initiative, HEA created the Special Operations COVID-19 Response Division and Client Services Division. The Special Operations Division was comprised of "dedicated members that provide the necessary capacity, leadership, and guidance to meet the emergent and time-sensitive challenges of COVID-19."[25] Key focus areas of the Special Operations Division included:

- Focusing on coordinating outbreak responses and the vaccination strategy;
- Administering the Isolation Hubs and the CPHO Travel Review program;
- Supporting the public health response by developing evidence-informed options and recommendations and liaising with the EIA Intergovernmental Affairs Division;
- Supporting the COVID-19 Communications Group; and
- Assisting in documentation of processes and technologies to support the response.

[23] Ibid.
[24] Government of Nunavut. 2020. "Health Pandemic Response Secretariat." [Submission to the Financial Management Board]. Accessed December 2023, January 2024, March 2024.
[25] Government of Nunavut. 2023. "Annual Report 2022/23: Special Operations Division- COVID-19." [Word Document] Accessed December 2023, January 2024, March 2024.

The Special Operations Division provided regular briefing notes on the status of the pandemic and members of the team also participated in the more than 15 COVID-19-related Committees and Working Groups (a list can be found in Appendix I). The working groups appear to have been represented by only HEA staff. It is unclear how these committees reported to each other or how they connected to other GN department work, and vice versa.

The Client Services Division was created to administer and oversee the Isolation Hubs and the CPHO Travel Review program.

2.2.3 The Mining Industry and Fly-In/Fly-Out Concerns

One of Nunavut's major economic industries is the mining sector. There are four mines operating in Nunavut: Meliadine gold mine in Rankin Inlet, Meadowbank gold mine in the Kivalliq Region, Hope Bay gold mine in the Kitikmeot Region, and the Mary River iron mine on Baffin Island.[26] In addition to these established operations there are exploration projects underway in the territory.[27] The established operations and exploration activities employ local Nunavummiut but also rely heavily on fly-in/fly-out workers who come from various locations and backgrounds entering and leaving Nunavut on a regular basis.[28] These workers often have contact with local workers and populations.

At the start of the pandemic, the mining companies were faced with the decision of continuing operations, which had implications of putting local communities at risk of exposure to COVID-19, or shutting down operations which would have implications for the Nunavut economy and income of workers. Additionally, with the unknown number of workers at operating and exploration sites, there was a potential added burden to the healthcare system in the territory.[29] The mines did not shut down during the pandemic, but increased testing capacity for COVID-19 on-site to limit labour impacts as much as possible.[30]

Throughout the pandemic, the mining companies met regularly with the Department of Economic Development and Transportation, HEA, and other government departments (Appendix I) to discuss outbreaks, the response, and support being provided on both sides.

2.2.4 Rapid Response Teams

HEA developed a Rapid Response Program to minimize the impact of COVID-19 in communities. As part of the program, Rapid Response Teams ("RRT") were deployed to affected communities within 24 hours of identifying a positive case. The RRTs were multidisciplinary teams, including physical and virtual resources, that initiated containment measures, conducted contact tracing, and monitored the health and wellbeing of individuals on home isolation orders (Figure 1).[31] As of February 2022, RRTs were deployed to 24 communities.[32]

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[26] NWT and Nunavut Chamber of Mines. N.d. "Our Industry." Accessed April 2024. https://www.miningnorth.com/our-industry

[27] The number and location of exploration mines and activities have not been disclosed.

[28] Pike, M., Cunsolo, A., Babujee, A., Papadopoulos, A., and Harper, S. 2021. "How Did the Media Report the Mining Industry's Initial Response to COVID-19 in Inuit Nunangat? A Newspaper Review." *International Journal of Environmental Research and Public Health., 18(21).* doi: 10.3390/ijerph182111266

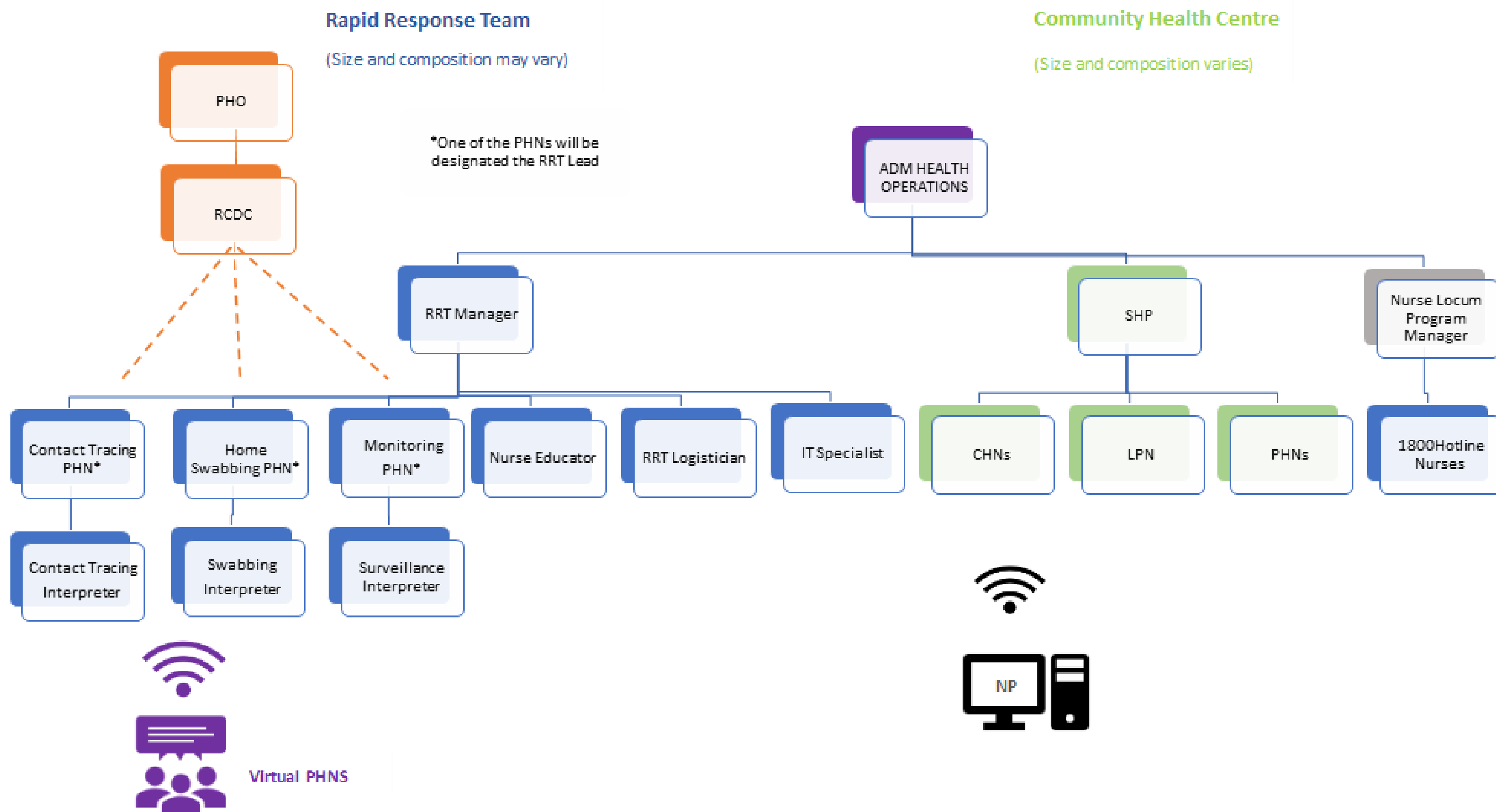
[29] Ibid.

[30] Government of Nunavut. 2021. "Government of Nunavut (GN) Department of Economic Development and Transportation (EDT) COVID-19 Business Recovery Plan." *Department of Economic Development and Transportation COVID 19 Business Recovery Plan.* Accessed April 2024. https://assembly.nu.ca/sites/default/files/TD-415-5(2)-EN-EDT-COVID-Business-Recovery-Plan.pdf

[31] Government of Nunavut. 2020. "COVID 19 Response plan RRTCHC structure and R R Draft v3 May 14 2020." [Word Document] Accessed December 2023, January 2024, March 2024.

[32] Government of Nunavut. 2023. "Annual Report 2022/23: Special Operations Division- COVID-19."[Word Document] Accessed December 2023, January 2024, March 2024.

Figure 1: Rapid Response Team and Community Health Centre Staff Temporary Reporting Structure[33]



Footnote: This RRT structure was created to demonstrate the lines of responsibility of the Operations team when the RRT was activated for clinical management of COVID-19. It does not explicitly include direction and support from different parts of the department, including the Office of the Chief Public Health Officer (CPHO), Health Information Unit (HIU), and others. The role of territorial epidemiologists, public health physicians, and communicable disease nurses in those other structures was an especially important complement to these RRT structures.

[33] Government of Nunavut. 2020. "COVID 19 Response plan RRTCHC structure and R R Draft v3 May 14 2020." [Word Document] Accessed December 2023, January 2024, March 2024.

An RRT Binder of information was developed that included a flowchart of processes, contact lists, and checklists for pre-deployment and supply kits.[34] No date was noted for when this document was developed. The development of the binder resource indicates a level of preparedness HEA took to ensure that the RRTs had all the necessary information for responding to an outbreak. Debriefs were conducted with the RRTs after outbreaks; however, it is unclear if or how any feedback from the frontline was incorporated into subsequent updates of the binder or if unique community circumstances were taken into account.

2.2.5 Testing

The CPHO's "2020-21 Report on COVID-19" notes that at the start of the pandemic, the Territory's testing capacity was a significant challenge because of a reliance on out-of-territory labs. This led to a 6 to 7 day average turnaround time for results.[35] In the Spring of 2020, in-territory testing was implemented in Iqaluit and Rankin Inlet, decreasing turnaround time to between 2 and 3 days.

2.2.6 Virtual Public Health Nurses

Virtual care became an integral component of Nunavut's pandemic response. The Government of Nunavut worked with an independent contractor, Calian Ltd., to design and manage a virtual COVID-19 program that included a Virtual Public Health Nurse ("vPHN") and a COVID-19 Nursing Hotline Service.[36] Through the pandemic, the vPHNs were integrated into much of the COVID-19 response. Duties included:[37]

- COVID-19 monitoring of identified cases/contacts within Nunavut;
- Contact tracing;
- Virtual coordination of COVID-19 care;
- Client education surrounding COVID-19 isolation and other related topics;
- Notification of COVID-19 test results; and
- Other COVID-19-related tasks (as required).

vPHN services changed throughout the pandemic based on territorial outbreaks and capacity. At the height of the pandemic, there were 81 nurses staffing the vPHN program, with shifts varying between 16 and 24 nurses taking up to an average of 170 calls per day.[38]

2.2.7 Isolation Hubs

To reduce the spread of COVID-19 into Nunavut, on March 24, 2020, the CPHO enacted a travel restriction, establishing conditions and prohibitions on travel to Nunavut originating from outside of the territory's borders. Seven isolation hubs across Nunavut's gateway cities and in Iqaluit were established (Table 4). Travellers from outside of the territory were required to complete a fourteen-day isolation period at a designated location and to obtain a letter of authorization from the CPHO before entering Nunavut.

[34] Government of Nunavut. N.d. "Rapid Response Team (RRT) Binder." [PDF] Accessed December 2023, January 2024, March 2024.
[35] Government of Nunavut. 2021. "The Chief Public Health Officer of Nunavut's 2020-21 Report on COVID-19." [PDF] Accessed December 2023, January 2024, March 2024.
[36] Calian Ltd. 2023. "Virtual COVID-19 Nursing Services Program Exit Report." [PDF] Accessed December 2023, January 2024, March 2024.
[37] Ibid.
[38] Ibid.

Table 4: Nunavut's COVID-19 Isolation Hubs[39]

Hub Location	Hub Management	Clients
Ottawa	Qikiqtaaluk Corporation and subcontractor Malti Consulting	All travellers
Ottawa	Community and Government Services and supported by Health	Construction staff coming into Nunavut.
Quebec City	Community and Government Services and supported by Health	Construction staff coming into Nunavut.
Winnipeg	Government of Nunavut	All travellers
Edmonton	Qikiqtaaluk Corporation and subcontractor Malti Consulting	All travellers
Yellowknife	Qikiqtaaluk Corporation and subcontractor Malti Consulting	All travellers
Iqaluit	Qikiqtaaluk Corporation and subcontractor Malti Consulting	All travellers

A protocol manual for the isolation hubs was initially developed in April of 2020. It was further updated in July 2020 and April 2021 to reflect "new developments and operational realities." Some of the changes that the updated versions responded to include a more detailed incident report and management response process, additional procedures and considerations for mental health concerns, and the ebbs and flows of the pandemic that impacted isolation hub capacity.

From March 25, 2020, to April 12, 2022, the Isolation Hubs accommodated over 22,800 individuals[40].

[39] 2023. "Government of Nunavut Department of Health Isolation Program Review." [Word Document] Accessed December 2023, January 2024, March 2024.
[40] Ibid.

3.0 Key Evaluation Findings

The following findings (Table 5) were developed based on the review of documents provided for this report, as well as the results of interviews with 36 HEA staff and 14 community members from ten different communities. The evaluation findings were presented to and validated by the HEA project team.

Data from interviews with HEA staff and community members were analyzed through a manual coding process, which included inserting comments and key information from the notes into a spreadsheet organized by evaluation area. Responses in each evaluation area were coded and themed accordingly. Evaluation findings were leveraged in the development of the recommendations provided in this report.

Table 5: Key Evaluation Findings

Guiding Topics	Related Findings
Governance	**While HEA was able to rapidly set directions as well as establish and adopt needed policies and procedures, it did so with an emergency response plan that was out of date. HEA looked to the 2012 "Pandemic Influenza: Planning and Response Guidelines for the Health Sector" during the beginning of the pandemic, which was dated and more general in its guidance. In the future, ensuring a shared along with more specific understanding of decision-making, authorities, and accountabilities as much as roles and responsibilities would be helpful, as would be the consistent, open consideration of Inuit Qaujimajatuqangit Principles.** • In the early days of the pandemic, the COVID-19 response was based on the government's 2012 "Pandemic Influenza: Planning and Response Guidelines for the Health Sector," which staff noted was not comprehensive enough to provide guidance down to the community level. In June of 2020, HEA developed the "Government of Nunavut: COVID-19 Pandemic Response Plan" to address the specific challenges of COVID-19. • Though priorities were being set and decisions made during this challenging time, those interviewed in HEA raised that there could have been more of a shared understanding of roles and responsibilities. The strategic and policy directions taken during the pandemic response were widely understood by HEA representatives. Yet, there was some ambiguity over who held accountability for crucial decisions and who was tasked with setting these directions. Providing this clarity in concert with common principles to help guide decision-making, such as equitable vaccine and PPE distribution, should be a

	part of future pandemic planning as much as preparations[41]. • Among those interviewed, it was generally agreed that HEA was able to rapidly adopt, and communicate in a timely way on, policies and procedures that supported the operationalization of the COVID-19 response. • Some HEA representatives spoke about how the inclusion of Inuit Qaujimajatuqangit Principles was central to the COVID-19 response framework. Others, including community members, noted that there were opportunities to broaden the consultation of Inuit individuals to help ensure the response was reflective of the needs along with knowledge of Nunavummiut. It should also be noted that the governance and policy documents provided and reviewed for this report did not specifically refer, in any substantive way, to Inuit Qaujimajatuqangit. A 2021 report by Inuit Tapiriit Kanatami, Systemic Discrimination in the Provision of Healthcare in Inuit Nunangat, raised the importance of culturally appropriate care in the territory. Only one pandemic-response document provided as part of this review, the "COVID-19 Protocol Package V7" from 2021 had a section on "cultural considerations", although this was not found in a later version of the same document. This suggests that in the future, there could be more consistent and open use of Inuit Qaujimajatuqangit in the planning and preparations for a pandemic response. • HEA conducted debriefs after each outbreak to identify lessons learned. However, some of these debriefs took up to six months after the original outbreak, which complicated the use of the gained insights as part of the logistics, workflow, communication, and deployment of virtual public health nurses.
Emergency and Health Management Preparedness	**Although HEA was able to respond quickly, and with communities feeling prepared overall, going forward there should be some focus put toward securing appropriate technology and being able to further resource a response.** • HEA was able to rapidly respond once COVID-19 became an imminent threat, through the setting up of isolation hubs and strict travel restrictions. However, the common view among HEA representatives was that the Government of Nunavut, the department included, was not fully prepared for the pandemic. According to those interviewed, HEA could have put more attention toward establishing virtual case and contact management systems along with vaccine and medication inventory systems. It

[41] During the interview process, staff were asked to describe what principles guided decisions. Examples of such principles were given, which included making decisions that: *Built and maintained trust among the public; was inclusive (e.g., fair access to services, prioritization of vaccines); respected the importance of communities and people being able to give voice to their views and belief; and minimized the risk of harm and suffering.*

	was also mentioned though, that insufficient human resources, combined with high turnover, made preparing for the pandemic more difficult. What did help was the significant teamwork and collaboration that occurred within HEA and with other departments. • HEA representatives emphasized that frequent and consistent updates to the pandemic planning policies and procedures should occur to ensure improved preparedness in the event of a future health emergency. • From the perspective of the community, six of the community members interviewed pointed to how a delay in the onset of the first cases in Nunavut provided HEA with some ability to learn from the experiences of southern jurisdictions. While there were some issues, community representatives generally felt that the territory was prepared for COVID-19 when it did appear.
Emergency and Health Management Response	**Recognizing that collaboration underpins the success of the response to the pandemic, there are opportunities in the future to strengthen the roles and contributions across different departments, to better the accessibility of funding, and to ensure a range of supports are available to address the many impacts of isolation.** • The actions and supports provided by HEA and team members such as the Virtual Care Program, vaccine rollout, and distribution of personal protective equipment were in keeping with the established aims and priorities. However, some HEA representatives expressed concern about the restrictiveness of isolation rules as well as movement in and out of the isolation hubs with related worries over the mental health impacts on those staying in the hubs. As well, some HEA representatives noted how the scope of practice for virtual care was sometimes too narrow (i.e., consideration could have been given to case and contact management), and that this took needed nurses and physicians among others off the ground, leading to higher workloads for those who remained in the community. • It was also noted among those interviewed that HEA was able to provide adequate funding to support all aspects of the COVID-19 response. While funding was available to address the pandemic, some HEA representatives and community members experienced challenges with accessing it to address non-COVID-related health and social impacts that arose throughout the pandemic (e.g., mental health challenges and substance use within communities). • With ongoing challenges in the territory, many HEA representatives took on additional roles and responsibilities that were outside of their intended scope of work. Such circumstances show the importance of prioritizing recruitment and retention of healthcare among other professionals in the territory to lessen workloads and significant overtime as experienced during the pandemic. This finding is supported by a 2017 Office of the Auditor General Report on healthcare services in Nunavut. While

	HEA developed a "COVID-19 Nurse Staffing Surge Contingency Plan," it is unclear how this was used during the response.
	• HEA representatives were split on the strength of partnerships with other departments. While it was believed that such collaboration was critical to the success of the response, some expressed concerns that other departments relied almost entirely on HEA to manage what was taking place. From this, being clear on what collaboration with different governmental departments means, such as for the EIA and CGS, is important in future pandemic responses.
	• Community members asserted that the various partnerships and collaborations contributed to a successful response. Those interviewed raised the following as examples of effective collaboration:
	  ○ The Government of Nunavut and health centres regularly shared messaging and information with the community.
	  ○ Partnerships with organizations such as Nunavut Tunngavik Incorporated allowed for support such as food hampers, isolation baskets, and activities for kids to help ease the burden of the pandemic on communities.
	• While there was general agreement among community members that the collaboration was effective, it was suggested by one of the interviewees that municipalities could be further empowered to lead on-the-ground responses and that this could be addressed in the pandemic planning.

Emergency and Health Management Recovery	**The COVID-19 pandemic had notable impacts on the mental health of government leaders and staff, as well as impacts on the mental health of community members and the development of youth, which needs to be accounted for in future pandemic planning.** • From the interviews with HEA representatives, people are experiencing the challenges that can follow high-pressure, stressful situations, which can be likened to posttraumatic stress disorder. According to interviewees, the extreme demands and expectations placed on HEA leadership and staff contributed to high levels of stress and fatigue (e.g., comments were made on not being permitted to leave the territory and working without time off for over a year). • Those interviewed also emphasized the importance of both appreciation and support. This includes equitable distribution of bonuses and pandemic pay incentives along with being able to access mental health and wellbeing supports. • Interviewed community members spoke to the mental health impacts the pandemic had and continues to have, on communities and healthcare workers. Generally, they expressed how there was not enough consideration given to the impact that various measures (e.g., isolation requirements and hubs), would have on communities – especially when considering Elders and Inuit values of "togetherness".

	Interviewees gave voice to concerns about the rise in suicide rates and feelings of disconnection post-pandemic. Tied to this was the desire for mental health to be considered in future emergency response planning. • Several post-COVID-19 pandemic reports and reviews have explored the impact of pandemic responses on youth, especially as it relates to education and social development. These studies have found that many Canadian youth have experienced chronic attendance problems, declines in academic achievement, and social development, and declines in mental health. Interviews with HEA representatives and community members echoed some of these concerns, also noting that the pandemic's effect on Inuit youth has led to a disconnection from their culture.
Communication and Engagement	**While communications within the government and with communities were timely and frequent, it is important to ensure that this outreach is suited for the audiences and that any changes in direction, policy or procedure are readily understood.** • Communication with communities was frequent and delivered through various means such as radio, news broadcasts, and social media, to disseminate information to as many individuals as possible. Radio broadcasts were seen to be a critical communication pathway for communities to receive information and to ask questions of local and Government of Nunavut leaders on how COVID-19 protocols and policies will impact them. There was though, less in the way of consultation and involvement of community leaders and members when it came to the messaging used. Community members noted that communication did not always consider the audience, with one example being written content that was complicated and hard to understand. • Communications within the government were seen to be frequent enough to enable changes in policies, procedures, and protocols. However, HEA representatives also noted that when policies were updated, the changes made were not always evident, which then impacted training and communications. As a result, the recommendation put forward by those interviewed was that explaining changes in policy, procedure or directions taken would make it easier to reflect this in operations and ensure that related activities can be adapted as needed.

4.0 Recommendations

This section presents the recommendations based on the key findings. Each recommendation section includes an overview of the opportunity for change, followed by context of what the change means for HEA, and guidance to assistant with implementation. Relevant approaches and/or tools are highlighted, all to aid in advancing the relevant recommendation.

Recommendation 1: Provide for a Comprehensive, Action-Oriented Emergency Management Plan

Guiding Area:

The Opportunity

Although HEA was able to rapidly adopt policies and procedures to support an effective COVID-19 Pandemic Response, participants noted that there was often a lack of clarity and shared understanding of roles and responsibilities throughout the response. Ongoing challenges with staff turnover and high vacancy rates created challenges with governance and finalizing processes, policies, procedures, and communications. Combined with other findings, HEA should create an overarching Emergency Management Plan that:

1. Is founded on an "all hazards" approach that addresses all four phases of emergency management (Mitigation and Prevention, Preparedness, Response, and Recovery);
2. Clearly describes the HEA emergency response structure, governance, decision making and roles along with responsibilities;
3. Specifies how Inuit Societal Values and Inuit Qaujimajatuqangit Principles will be taken into account;
4. Includes a documented process for engaging with and making intentional spaces for Inuit and community stake(rights)holders throughout the development of the Plan and during health emergencies to ensure alignment with community needs and key considerations for success.
5. Is coordinated with federal policy and planning efforts;
6. Clearly outlines an Incident Command System (ICS), that identifies roles and responsibilities of HEA staff and leadership, Government of Nunavut leadership, and other departments that could be instrumental to the pandemic response such as Education and Family Services; and,
7. Aligns with the efforts being undertaken by other Government of Nunavut departments to update their plans or legislation, as recommended by other independent reviews (i.e., whole-of-government review, Auditor General Report on vaccine distribution).

This plan should also be reviewed regularly to ensure that policies, procedures, and protocols are aligned with current best practices.

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What it Means for HEA

Comprehensive Emergency Management Planning serves as a critical blueprint for navigating crises effectively, and a key aspect of their efficacy lies in the clarity of their governance models. Clear governance models, which incorporate decision-making principles, delineate roles and responsibilities, and establish accountability (reporting) structures are essential components of any robust emergency management plan. Such models provide a framework for swift and decisive action, ensuring a shared understanding of roles and responsibilities, and the appropriate steps to take in a crisis. By optimizing these foundational frameworks and models, HEA can enhance their readiness to respond to future pandemics and other health emergencies, minimizing confusion and maximizing the effectiveness of response efforts.

Implementation Considerations

To successfully implement this recommendation, HEA should consider using the workshop and collaborative planning approach. This approach sees a series of focused facilitated plan development workshops that take into consideration the points below:

- **Stakeholder and Rights Holder Involvement:** Ensure that key stake(rights)holders, including public health officials, medical professionals, government agencies, and community representatives are involved in the development and review of the Emergency Management Plan. Early and consistent involvement of community leaders, for example, when health emergencies do occur will help make sure that there is awareness of the plan and associated actions of the coordinated response.
- **Flexibility:** Governance should be adaptable to different scenarios and evolving circumstances. Flexibility allows for adjustments based on the nature and severity of the pandemic and/or health emergency at hand, emerging best practices in crisis management, and differences in operational realities between each community.
- **Training and Education:** Provide comprehensive training and education to all personnel involved in the implementation of the Emergency Management Plan. This includes not only understanding their specific roles and responsibilities but also familiarizing themselves with decision-making protocols and accountability measures. Training should be refreshed as a part of the annual review process.
- **Communication Protocols:** Establish clear channels and protocols for disseminating information, coordinating responses, and providing updates to stake(rights)holders, both internally and externally.
- **Resource Allocation:** Assess and allocate the necessary resources, including personnel, equipment, funding, and infrastructure to support the implementation of the Emergency Management Plan. Recognizing ongoing challenges with staff turnover and vacancy rates, collaborating with an outside agency/organization may be required to implement this recommendation. If outsourcing this work is necessary, a collaborative framework should be developed to ensure that ethical considerations are included, along with ensuring Inuit perspectives and values are interwoven throughout the Emergency Management Plan.

Optimizing the Emergency Management Plan will require significant time commitments to ensure that the plan takes the above considerations into account.

Recommendation 2: Enhance Internal and External Communication Protocols

Guiding Area:

The Opportunity

Communications with communities and within the government were seen to be frequent and delivered through various means such as radio, news broadcasts, and social media. Radio broadcasts were a critical communication pathway for communities to receive information. However, there was a perceived lack of consultation and involvement of community leaders and members when it came to messaging used. In addition, clear communication to HEA staff on the changes made to key policy, procedures, and protocols was not always evident, impacting training and communications.

Community Emergency Communications

HEA should strengthen community emergency communication protocols that:

- Document processes and guidelines for community consultation when shaping policy, procedure, and protocol decisions.
- Tailor strategies to accommodate diverse audiences, considering factors such as language preferences, cultural backgrounds, and health literacy levels.
- Through clear delineation of authority established prior to future health emergencies, empower regional centres to adapt guidelines and policies to address local context and operational needs.

Internal Emergency Communications

HEA should also optimize internal communication protocols to ensure staff are adequately informed, understand their roles and responsibilities, and receive clear and timely updates regarding changes to pandemic policies, procedures, and protocols. Related areas of focus would be:

- Establish streamlined channels for disseminating information.
- Ensure clarity of roles and responsibilities related to internal and external communications between EIA and HEA during emergencies.
- Provide training and support to staff members on effective communication strategies, cultural competence, and sensitivity to diverse audiences.
- Implement mechanisms for transparent communication of policy updates to staff.
- Include requirements and guidelines for developing and disseminating daily Consolidated Situation Reports to all individuals involved in the emergency response, thereby supporting a cohesive and effective emergency response. This also will help ensure that updates to policies, procedures, and protocols are communicated frequently and consistently to all staff members.

By integrating both internal communications protocols and community consultation into pandemic planning and response strategies, HEA can create a more robust and resilient framework for addressing

public health challenges. This collaborative approach promotes transparency, inclusivity, and responsiveness, ultimately enhancing the effectiveness and sustainability of pandemic response efforts.

What it Means for HEA

Improving internal communications protocols will help HEA to ensure that staff members are well-informed and equipped to fulfill their roles effectively in the event of a future health emergency. Establishing clear and transparent communication channels will enable the timely dissemination of critical information, updates on policies and procedures, and guidance on evolving public health recommendations.

In parallel, enhancing protocols and guidelines for community consultation and tailoring information to diverse audiences is equally imperative. Community consultation will ensure that the perspectives and needs of all stake(rights)holders, including marginalized and vulnerable groups (e.g., LGBTQIA2S+ individuals, persons with physical or mental disabilities, etc.), are considered in decision-making processes related to emergency health response. By actively consulting communities in the development of protocols and policies, HEA can build stronger partnerships, foster inclusivity, and promote a sense of ownership and accountability within communities.

Tailoring information to diverse audiences acknowledges the cultural, linguistic, and socioeconomic diversity across all of Nunavut’s 25 communities. Providing information in languages, dialects and formats that are accessible helps overcome barriers to understanding and ensures that messages resonate with different cultural and linguistic backgrounds. This will help enhance the reach and impact of HEA communication efforts and promote trust, collaboration, and compliance with public health guidelines.

Implementation Considerations

To successfully implement this recommendation, HEA should take several considerations into account, including:

- **Establishing Protocols Prior to the Next Health Emergency:** Consultation can be challenging to undertake once a public health, or any, emergency has begun. Engaging early and ahead of future emergencies will ensure that protocols are in place when they are required.
- **Stake(rights)holder Engagement:** Involving stake(rights)holders from diverse backgrounds, including HEA staff members, community leaders, external organizations (i.e., NTI), and community representatives such as Elders and CHRs in the development and implementation of communication strategies and protocols can enhance the effectiveness of messaging and ensure that communications are tailored to unique community realities, literacy rates, and languages.
- **Review and Adaptation:** Providing for continual improvement in communication protocols and strategies based on, in part, community and stake(rights)holders feedback will help ensure needs are understood and, in turn, being met. During emergencies and given ongoing capacity constraints, regular review and adaptation may not be feasible. HEA should make efforts to communicate updates in a timely manner during emergencies to the best of their ability.
- **Resource Allocation:** HEA must be able to allocate resources including staff, budget, and technology infrastructure to ensure sufficient support is available for training, protocol development and implementations, and ongoing communication activities.
- **Risk Management:** HEA should have a contingency plan and mitigation strategies in place to

address potential risks such as resistance to change, misinformation, or capacity constraints.

By considering these factors, HEA can develop realistic and effective communication protocols and strategies that are tailored to the needs of both staff and diverse communities in the event of a public health emergency.

Recommendation 3: Advance the Use of Digital Health Information and Inventory Management Technologies

Guiding Area:

The Opportunity

The implementation of the virtual care program along with the dedication and collaborative teamwork of HEA were significant contributing factors to the overall success of the COVID-19 Response in the territory. However, the limited use of digital public health information along with real-time inventory management systems was a noted concern among those interviewed.

Other jurisdictions such as British Columbia and the First Nations Health Authority worked to rapidly expand virtual health initiatives including virtual Emergency Room triage, virtual care visits with family physicians, and the First Nations Virtual Substance Use and Psychiatry Service.[42] Yet, these jurisdictions experienced similar challenges with access to technology, particularly in remote communities and amongst refugee, immigrant, and racialized communities.[43]

Achieving better health outcomes and nimble responses to threats rely on informed decision making by health care providers, policy makers, and individuals. This is made possible through a robust health data foundation and system that provides timely access to information that is critical to make up-to-date decisions. To prepare for future public health emergencies, HEA should implement systems that will enable efficient and accurate tracking of resources, dissemination of critical information, and coordinated efforts across healthcare networks, ensuring timely and effective interventions to safeguard public health. These public health information and real-time inventory management systems should enable the following critical functions:

- **Centralized Data Collection and Analysis:** Sourcing real-time data on disease trends, outbreaks, and healthcare utilization, and providing a central place for it to be managed and accessed will enable rapid analysis and interpretation by HEA.
- **Contact Tracing and Case Management:** Supporting contact tracing efforts by efficiently identifying and notifying individuals who may have been exposed to infectious diseases will bolster the efficacy of the response.
- **Communication and Public Awareness:** Facilitating the dissemination of timely and accurate information to healthcare providers, policymakers, and community members, such as updates on public health guidelines, vaccination campaigns, and preventive measures, will promote

[42] First Nations Health Authority. 2024. FNHA's Statement on the Societal Consequences of BC's COVID-19 Response. Accessed May 2024.

[43] BC Centre for Disease Control. 2024. Emergency Department Use in B.C. During COVID-19 Pandemic. Accessed May 2024.

awareness and adherence to recommended protocols.

- **Collaboration and Coordination:** Fostering collaboration and coordination among diverse stake(rights)holders involved in a pandemic response, and in areas of data sharing, communication, and collaborative decision-making, enhances the effectiveness of efforts to address public health challenges.
- **Resource Tracking and Distribution:** Such systems enable effective tracking and distribution of essential resources, like vaccines and personal protective equipment (PPE), ensuring optimal resource allocation and use to frontline workers and communities.

Together these systems, will enhance situational awareness, facilitate evidence-based decision making and foster collaboration among stake(rights)holders, ultimately strengthening HEA's capacity to mitigate the impacts of pandemics and safeguard the health of Nunavummiut.

What it Means for HEA

In undertaking this recommendation, HEA will modernize its public health infrastructure in response to the growing complexity of events like pandemics. By capitalizing on advanced technologies to enhance its capacity for pandemic preparedness and response, HEA will be:

1. Improving data management;
2. Enhancing coordination and collaboration;
3. Optimizing resource allocation;
4. Streamlining case and contact management; and
5. Enhancing preparedness and resilience.

This will better protect the health and wellbeing of Nunavummiut, mitigate the impact of future pandemics, and build a more resilient healthcare system for the future.

Implementation Considerations

To successfully implement this recommendation, HEA should take several considerations into account:

- **Health Information Legislation**: HEA should ensure that legislation is formalized before the development and implementation of a public health information and real-time inventory management system. Health Information Legislation should include policies related to patient record access, digital record access, and privacy and data security. Ensuring that digital-age health policies are included in health information legislation enables HEA to prioritize data use for the public good while also ensuring data security and confidentiality.
- **Needs Assessment and Prioritization:** Systemic ways to build trust and identify individual and community requirements for health data are critical. HEA will have to build trust through meaningful engagement with staff members and applicable stake(rights)holders to gather information on what technologies are required to support healthcare and service delivery and prioritize technologies by identified need.
- **Resource Allocation:** Implementing these systems will require significant time investment for GNDH staff and leadership as well as funding commitments from both the Government of Nunavut and the federal government. It will also be important to ensure technology is available to staff, including provision of laptops/computers and establishing broadband connectivity to successfully implement these systems.

- **Testing and Implementation**: HEA should ensure that technologies are thoroughly tested and evaluated prior to implementation. This will help to reduce disruptions to workflows and ensure that the systems are able to meet the needs and requirements for health service delivery.
- **Training and Capacity Building:** It will also be crucial for HEA to provide training on data security and confidentiality, to ensure compliance with privacy regulations and legislation.

By considering these factors, HEA can build its capacity to address the evolving demands and needs of staff members in delivering efficient and consistent care, along with better insight into the evolving health needs of Nunavummiut.

Recommendation 4: Adopt an Inter-departmental Collaborative Resourcing Model as Part of the HEA Response to Complex Emergencies

Guiding Area:

The Opportunity

HEA staff demonstrated significant dedication, time commitment, and adaptability throughout the COVID-19 pandemic. However, interview participants identified concerns with the allocation and distribution of workloads, with HEA staff often leading the charge throughout the response, and challenges with cross department coordination. As a reaction to the pandemic, over 15 committees and working groups were established within HEA (Appendix I) and appear to have been represented primarily or only by HEA staff. It is unclear how these committees reported to each other or how they connected to other GN department work, and vice versa. This potentially added to the concerns around distribution of workload to HEA staff. The overall impression amongst health staff was that HEA staff faced an uneven distribution of workload, along with highlighting the importance of establishing formal onboarding and training processes as a part of preplanning initiatives.

To support HEA in planning and preparing for future health emergencies, a process should be employed to develop comprehensive inter-departmental resourcing, such as a task force model, that embraces a whole-of-government approach to emergency-specific responses. Adopting task forces for emergency-specific responses such as the Isolation and Travel Restriction Response, can ensure coordination and collaboration across all relevant departments and agencies, in turn helping to reduce the extreme workloads placed onto HEA staff during pandemics. It is imperative to ensure an understanding of the broad and unique skillsets of GN staff that are available in emergency events, including individuals who do not have health backgrounds. This is complimentary to the use of interdisciplinary task forces and working groups. To support an effective response while equitably distributing workloads, HEA should:

- Structure task forces with dedicated teams responsible for different aspects of emergency management, including frontline and virtual healthcare delivery, logistics planning and coordination, communications, and mental health support.
- Ensure that teams are equipped with adequate resources, training, and support to carry out their responsibilities effectively.
- Include protocols and guidelines that are founded in Trauma Informed Principles to ensure regular breaks, rest periods, and timely access to mental health resources should be incorporated into staffing models.

The task force models should include several components to ensure its effectiveness in the event of a future emergency response:

1. **Clear Objectives and Mandate:** Define the mission, goals, and scope of the task forces, outlining primary objectives and areas of responsibility to provide clarity and direction for task force

members and stake(rights)holders.

2. **Multi-Disciplinary Representation:** Ensure that the task forces are comprised of members across the GN who have diverse backgrounds, expertise, and disciplines relevant to pandemic response, such as healthcare, public health, and emergency management. It is also important to ensure that individuals who do not have health-specific backgrounds or experience are included in this task force model and their respective skills and experience are identified and leveraged.
3. **Leadership Structure:** Establish a leadership structure within the task forces, including a designated leader responsible for overseeing operations, facilitating decision-making, and liaising with relevant stake(rights)holders.
4. **Functional Team Structures:** Organize the task forces into functional teams or working groups responsible for specific aspects of the pandemic response, such as frontline and virtual healthcare delivery, logistics and supply management, communication and public outreach, data analysis, and mental health support. The roles and responsibilities of each dedicated team or working group should be clearly defined and outlined.
5. **Communication Protocols:** Include clear communication protocols and channels for information dissemination, updates, and decisions within the task forces and with external stakeholders and rights holders.
6. **Ethical Decision-Making Frameworks:** Define transparent decision-making processes and ethical frameworks within the task forces, including criteria for prioritization, consideration of structural, social and systemic inequities, escalation procedures for addressing issues or challenges, and mechanisms for conflict resolution.
7. **Training and Capacity Building:** Establish clear training and capacity-building procedures and guidelines for various topics, including pandemic preparedness, crisis management, PPE use, communication strategies, and mental health support. Training should extend beyond HEA employees, through cross-training of staff across the GN as necessary to ensure resources can be allocated from various departments.
8. **Monitoring and Evaluation Protocols:** Ensure that mechanisms for monitoring and evaluating the effectiveness of the task force models are implemented. Such mechanisms include regular assessments of progress towards objectives, feedback from task force members and stake(rights)holders, and lessons learned from response efforts.
9. **Flexibility and Adaptability:** Maintain flexibility and adaptability in the task force models to respond effectively to changing circumstances, emerging challenges, and evolving needs throughout the pandemic response effort.

By integrating these considerations into planning structures and staff models, HEA can support a holistic and sustainable approach to its emergency response. Integrating diverse competencies and capacities into emergency response is crucial for maximizing efficiency, effectiveness, and adaptability in addressing complex challenges and promoting comprehensive resilience within government and within communities.

What it Means for HEA

During the COVID-19 Pandemic, the Government of Canada established several advisory groups and task forces composed of stakeholders from various areas, including public sector, private sector, and/or academia and research community. Stakeholders involved in the task forces provided recommendations

and/or actions to address COVID-19 in Canada. Some of the advisory groups and task forces that were established include COVID-19 Vaccine Task Force, COVID-19 Therapeutics Task Force, Virtual Care Task Force, and the Expert Advisory Group on the pan-Canadian Health Data Strategy. The task forces and advisory groups were critical in helping the Government of Canada make evidence-based decisions and solutions to protect the health and safety of Canadians during the pandemic.[44]

Adopting task force models that embrace a whole-of-government approach to emergency response, is of paramount importance to HEA for several reasons:

- **Effective Resource Allocation:** A coordinated task force will enable HEA to pool resources, expertise, and capabilities from various government departments, stake(rights)holders, and agencies. This will allow HEA to be better prepared and proactively address the diverse challenges posed during a pandemic.
- **Collaborative Decision Making:** Involving stakeholders from multiple departments and areas of expertise facilitates collaborative decision-making processes that are informed by diverse perspectives and insights.
- **Comprehensive Response:** A whole-of-government approach ensures that all aspects of effective pandemic response, including frontline and virtual healthcare delivery, logistics planning and coordination, communication, and mental health support are addressed comprehensively. Coordinating efforts across government departments and agencies helps to facilitate the sharing of information, resources, and best practices, leading to a more coherent and effective response effort.
- **Public Trust and Confidence:** A coordinated and proactive response to the pandemic, coupled with transparent communication and visible efforts to support staff wellbeing fosters public trust and confidence in HEA and the broader Government of Nunavut's ability to manage health emergencies and other crises effectively. This in turn encourages compliance with public health measures and contributes to overall community resilience.

Adopting a task force model with a whole-of-government approach to pandemic response, while prioritizing staff wellbeing will be essential for HEA to effectively manage the challenges posed by future emergencies and protect the health and wellbeing of Nunavummiut.

Implementation Considerations

To successfully implement this recommendation, HEA should take the following considerations into account:

- **Clear Leadership and Governance:** HEA should establish clear leadership structures and governance mechanisms to oversee the task force's activities and decision-making processes. It will be crucial for HEA to clearly define roles, responsibilities, and reporting structures to ensure accountability and effective emergency response coordination.
- **Interdepartmental Collaboration:** It will be important for HEA to develop and establish formal mechanisms for sharing information, coordination, and conflict resolutions to ensure a cohesive and integrated emergency response.
- **Staff Training and Support:** HEA will have to invest in training and capacity-building procedures

[44] Public Health Agency of Canada. 2020. COVID-19 Advisory Groups and Task Forces Fact Sheet. Accessed May 2024.

and guidelines to ensure that upon deployment of this model, staff members are provided with the skills, knowledge, and resources needed to carry out their roles effectively. Training on topics such as pandemic response protocols, effective crisis communication, mental health support, and self-care will be integral to the staff training model. HEA should consider engaging in discussions within the department and with other departments on the cross-training of employees to ensure that staff from across the GN can be assigned duties as necessary.

By considering these factors, HEA can effectively implement task force models for emergency-specific responses with a whole-of-government approach, which will foster collaborations, evidence-based solutioning, resilience, and effectiveness in pandemic response efforts.

Recommendation 5: Review and Optimize Staff Health and Wellbeing Support

Guiding Area:

Recovery Governance Preparedness

The Opportunity

HEA staff demonstrated significant dedication, teamwork, and adaptability throughout the COVID-19 pandemic. However, interview participants also raised concerns with the high level of stress, fatigue, burnout, and mental health challenges amongst HEA staff members following the height of the COVID-19 Pandemic Response. Flowing from this was the expressed need for improved staff supports and appreciation, along with improved recruitment and retention of healthcare staff.

Recommendation 5a:

To address residual impacts of the COVID-19 pandemic while also bolstering preparedness in the event of a future health emergency, HEA should:

- **Develop a Recruitment Strategy:** A robust recruitment strategy should be developed as soon as possible to help HEA attract and retain qualified staff members, particularly in roles that could be critical to any future pandemic response, including non-clinical such as Community Health Representatives. This may involve offering competitive compensation, benefits, professional development opportunities, and flexible work arrangements to attract top talent. As part of this strategy, a memorandum of understanding with the federal government should be developed to ensure that there is support and assistance with staff recruitment and retention, particularly during future emergencies. Developing this memorandum of understanding now will help to avoid potentially complicated and resource-intensive processes in the future that would be required to request supports during an emergency.
- **Review Existing Supports:** Conduct a formal review of existing supports such as employee benefit packages, employee assistance programs, mental health resources, wellness initiatives, flexible work arrangements, daycare for HEA staff members with children, compensation, and bonus structures to determine alignment with industry standards.
- **Tailor Support Initiatives:** Develop and implement tailored support initiatives based on survey findings and staff feedback. This may include additional mental health resources, peer support programs, stress management workshops, and wellness activities designed to meet the specific needs of employees.
- **Conduct a Workplace Culture Survey:** Engage with staff through a Workplace Culture survey to identify motives, beliefs, and required supports for staff. This will help HEA to better understand staff's perspectives on the workplace culture and ensure that staff members receive the support and appreciation they need. Survey results could be used to identify priority areas and inform the development of tailored support initiatives.

Recommendation 5b:

In the event of a future health emergency, HEA should ensure that staff members are supported throughout the response. HEA could consider incorporating the following supports throughout future emergency health responses:

- **Equitable Distribution of Roles and Responsibilities:** Establish transparent decision-making procedures, provide training and resources tailored to diverse needs of staff members, and promote open communication channels to ensure that all staff members are empowered and engaged in response efforts, fostering a culture of inclusivity and collaboration. As well, trauma-informed practice and principles should be used when working across HEA teams and broadly with other departments, explicitly sharing successes and strengths of the team and highlighting accomplishments and milestones.
- **Track Workload of Team Members:** Develop a simple system to track the workload of staff members in an effort to identify significant imbalances of tasks, roles and responsibilities. Such a tracking system should be designed as to not create additional work for team members, ensuring it does not take resources away from critical tasks.
- **Frequent Check-Ins:** Implement frequent informal check-ins with staff during the pandemic to assess their wellbeing, address concerns, and provide ongoing support. These check-ins can be conducted spontaneously, and do not require extensive time commitments. They may take the form of a brief inquiry such as a simple "how are you?", which fosters open communication and promotes a supportive environment for staff members.
- **Promote Vacation Use:** Actively promote the use of vacation time, as appropriate, and among staff to prevent burnout, reduce stress, and promote work-life balance.
- **Monitor and Adjust:** Continuously evaluate the effectiveness of the staff support program throughout the pandemic and adjust as needed based on feedback. Added to this would be the monitoring of utilization rates, satisfaction levels, and outcomes to ensure that support initiatives are meeting their intended objectives amidst the challenges of the pandemic.

What it Means for HEA

Ensuring staff supports are in place and continue throughout a pandemic response is critically important for the HEA for several reasons:

- **Staff Wellbeing:** Prioritizing the mental and physical health of staff members is crucial for maintaining morale, resilience, and productivity during prolonged and demanding response efforts. By providing adequate support and resources, HEA can help prevent burnout, spread out workloads more effectively, and ensure the wellbeing of staff members.
- **Workforce Resilience:** A resilient workforce is essential for sustaining effective pandemic response efforts over time. By prioritizing staff supports immediately, HEA can help employees to begin or continue to recover from their experiences from the COVID-19 pandemic, cope with the demands of their roles, adapt to rapidly evolving circumstances, and remain productive and engaged prior to and during the pandemic response.
- **Retention and Recruitment:** Investing in staff supports enhances employee satisfaction and loyalty, helping to reduce turnover rates and ensure continuity of operations. Prioritizing employee wellbeing may make HEA more attractive to prospective candidates, facilitating

recruitment efforts prior to and during a pandemic. Bolstering staff capacity levels will help to reduce the high workload and expectations that are often placed on HEA staff. Ensuring that retention and recruitment strategies and staffing models include non-clinical staffing roles and supports is critical, to ensure that HEA has a diverse and interdisciplinary workforce.

Ensuring that staff supports, to the best of HEA's ability, are in place before and continue throughout the pandemic response is crucial to maintain and bolster employee wellbeing, sustain workforce resilience, retain, and recruit talent, and foster employee engagement and morale.

Implementation Considerations

To successfully implement this recommendation, the HEA should take several considerations into account:

- **Leadership Commitment:** HEA leadership should demonstrate their commitment and support to prioritize staff wellbeing and allocate resources towards implementing support initiatives.
- **Accessibility and Availability:** HEA should ensure support initiatives are easily accessible and available to all staff members regardless of their location, work schedule, or role within the organization.
- **Promotion and Awareness:** It will be important for HEA to promote and raise awareness about available support initiatives through various communication channels, including email, staff meetings, and posters in common areas.
- **Flexibility and Adaptability:** HEA should remain flexible and adaptable to changing circumstances and evolving needs. Continuously monitor staff wellbeing and adjust support initiatives as needed to address emerging challenges in a timely and efficient manner.
- **Resource Allocation and Prioritization:** HEA must be able to allocate resources including staff, budget, and technology infrastructure to ensure sufficient support is available for staff engagement, comprehensive review of existing supports, support incentive development and implementations, and ongoing communication activities. Given ongoing challenges with staff vacancies and turnover, HEA may have to prioritize some actions or initiatives over others, meaning that some work will go undone during some periods. Ensuring that a prioritization system is established to make effective decisions may help to reduce high workloads and unintended harms to staff members.

By considering these factors, HEA can effectively support their staff members, promote wellbeing, resilience, and productivity in the face of evolving and challenging circumstances. Prioritizing the health and wellbeing of staff members not only enhances their resilience and productivity but also contributes to the overall effectiveness and success of the pandemic response efforts.

5.0 Appendices

Appendix A Detailed Evaluation Findings by Guiding Area

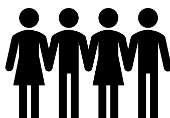
Overview of Interview Participants and Documents Reviewed

The document review covered policies, procedures, past studies, the Auditor General report, guidebooks, briefing notes, and other materials that were provided by the HEA. The findings of the document review were used to support learnings and takeaways from the engagement.

To ensure the engagement captured a range of perspectives and voices, MNP conducted interviews with 36 HEA representatives as well as members of select communities in each of Nunavut's regions. Following outreach by HEA to elected officials and Community Health Representatives (CHRs) in approximately ten communities, and based on availability, MNP engaged with mayors and/or senior administrative officers (SAOs) to gather insights from six communities and CHRs in two communities.

36 HEA Representatives

were interviewed for this project. In total, approximately 41 HEA representatives were invited to participate in interviews, however not all were available or accepted the invitation.



14 Community Members

including CHRs, SAOs, and hamlet mayors provided insights from seven different communities for this project. In total, approximately 10 communities were invited to participate in interviews; however, not all were available or accepted the invitation.

50+ Documents

including policies, procedures, reviews conducted by other consultants and the Auditor General, guidebooks, briefing notes, and other documents were provided by HEA and reviewed for this project. It is understood that these are not all of the documents that were developed as part of the COVID-19 pandemic response.

3 Regions of Nunavut

Qikiqtaaluk, Kivalliq, and Kitikmeot are represented by the community members interviewed.

Key findings from the engagement are not attributed to individuals but are reported thematically. The guiding evaluation questions (Appendix D) informed the development of the interview questions in the Master Interview Guide (Appendix G). However, this guide was adapted for each interview group. Further, interviewees may not have answered all questions during the review, either due to time constraints or the nature of their role during the pandemic.

Governance

Goals and Priorities

When the pandemic was declared in March 2020, two territorial statutes, the *Public Health Act* (2016) and the *Emergency Measures Act* (2010) and other plans, such as the "Pandemic Influenza: Planning and Response Guidelines for the Health Sector (2012)," guided HEA service delivery and response. These statutes and plans, and their related implementation influenced how HEA led the COVID-19 pandemic response. However, it is worth noting that the Pandemic Plan was eight years old and there was no indication it had been updated since it was developed in 2012.

In June of 2020, HEA developed the "Government of Nunavut: COVID-19 Pandemic Response Plan," adapted from previous guidelines, to specifically address the specific challenges of COVID-19. The stated objectives of the plan were to:[45]

- "To prevent outbreaks, delay spread, slow, and stop transmission;
- To provide optimized care for all patients, especially the seriously ill; and,
- Minimize the impact of the epidemic on health systems, social services, and economic activity."

Staff and community members were asked to describe the goals and priorities of the COVID-19 response to determine whether these were well understood and communicated. From this, it was found that interviewees had varying understandings of the goals and priorities of the HEA response. Some staff expressed that goals and priorities were not always clear, particularly at the beginning of the pandemic, which was attributed, in part, to the "lack of a formal Pandemic Plan for the territory." As noted, the Government of Nunavut did have a plan in place at the start of the pandemic. However, as it was eight years old, it is possible that staff were unaware of it or that the applicability did not align with the realities of the pandemic. In contrast, other staff members affirmed that the overall goals, priorities, and aims of the HEA response were clear and widely understood by all staff members and community members. A few staff members expressed that the central goal was to limit spread due to an overall lack of staffing, infrastructure, and equipment capacity to adequately respond and address health challenges associated with COVID-19 infection. Interviewed community members agreed, reflecting that the Government of Nunavut's objective was to keep cases low and provide care close to home. Some of the key goals and priorities of the COVID-19 response identified by staff members included:

- Prevent the introduction of COVID-19 into Nunavut;
- Mitigate and minimize the transmission of COVID-19;
- Protect the health and wellbeing of Nunavummiut;
- Plan and prepare for rapid COVID-19 vaccine rollout; and,
- Logistics Planning for PPE and other resource distribution, and medical travelers.

[45] Government of Nunavut. 2020. "COVID-19 Pandemic Response Plan." [Word Document] Accessed December 2023, January 2024, March 2024.

Staff members reflected on how the goals and priorities shifted from a COVID zero approach to a mitigation and protection approach once COVID-19 arrived in the territory, which is in alignment with the intention of the "Government of Nunavut: COVID-19 Pandemic Response Plan."

> *"All levels of government reacted as quickly as they could with what information they had at that time. Looking back at it now you can be critical but understanding that we were making decisions based on the science at that time." – HEA Staff Interview Participant*

As a summary, the general understanding of directions aligned with stated goals and priorities in the "Government of Nunavut: COVID-19 Pandemic Response Plan," indicating relatively effective communication of pandemic response objectives.

Decision-Making Structure

At the onset of the pandemic, the COVID-19 Executive Committee was established to lead the government-wide pandemic response. The interdisciplinary Executive Committee was comprised of:[46]

- The Chief Public Health Officer ("CPHO");
- Deputy Minister, Executive and Intergovernmental Affairs;
- Associate Deputy Minister, Executive and Intergovernmental Affairs – COVID-19 Response;
- Deputy Minister, Department of Health; and,
- Deputy Minister, Department of Community and Government Services.

The Government of Nunavut Incident Command Structure ("ICS") was established in 2020 to provide logistical support to the CPHO. The ICS was led by the Associate Deputy Minister, EIA, COVID-19 Response and supported by the Director of Nunavut Emergency Management. The ICS was responsible for liaising with HEA for a coordinated COVID-19 outbreak or COVID-19-related emergency response and ensuring government services and support continued to be delivered in communities impacted by COVID-19.

Interviewed participants reflected that HEA used a top-down approach to the setting of policies and directives, noting an insufficient involvement of staff members, other departments, and communities in the setting of policies and processes. In addition, some staff members expressed the need for a 'whole government' approach, noting challenges in achieving interdepartmental coordination. Those interviewed affirmed that HEA was often held solely responsible for coordinating the pandemic response. While a review of the whole-of-government response to the COVID-19 pandemic was out of scope for this review, a separate study of the whole-of-government response conducted by DPRA Consulting Ltd. in 2023 corroborated these findings: "[...] except for those directly involved with EIA, public servants were unaware of the GN-wide pandemic response governance structures (e.g., COVID-19 Secretariat, the GN ICS, COVID-19 Executive Committee) and their roles in the pandemic response. As a result, public servants described having unclear leadership and direction from senior levels of government. Second, like in many other areas of the GN, there were not enough people working in EIA and the COVID-19 Secretariat to support the required work effectively."[47]

In late 2020, the Department of Executive and Intergovernmental Affairs and HEA submitted a request to the Department of Finance's Financial Management Board for the creation of a temporary Pandemic

[46] DPRA Consulting Ltd. 2023. "Review of the Government of Nunavut's Response to the COVID-19 Pandemic." [Draft Report to the Government of Nunavut, Department of Executive and Intergovernmental Affairs] Accessed December 2023, January 2024, March 2024.
[47] DPRA Consulting Ltd. 2023. "Review of the Government of Nunavut's Response to the COVID-19 Pandemic." [Draft Report to the Government of Nunavut, Department of Executive and Intergovernmental Affairs] Accessed December 2023, January 2024, March 2024.

Response Secretariat.[48] As part of this initiative, HEA created the Special Operations COVID-19 Response Division. The Special Operations Division was comprised of "dedicated members that provide the necessary capacity, leadership, and guidance to meet the emergent and time-sensitive challenges of COVID-19."[49] Key focus areas of the Special Operations Division included:

- Focusing on coordinating outbreak responses and the vaccination strategy;
- Administering the Isolation Hubs and the CPHO Travel Review program;
- Supporting the public health response by developing evidence-informed options and recommendations and liaising with the EIA Intergovernmental Affairs Division;
- Supporting the COVID-19 Communications Group; and
- Assisting in documentation processes and technologies to support the response.

The Special Operations Division provided regular briefing notes to the Pandemic Response Secretariat on the status of the pandemic, and members of the team also participated in more than 15 COVID-19-related committees and working groups. Staff commented that committee meetings and working groups were essential for disseminating information and decision-making early in the pandemic. However, some staff members noted that the frequency of such meetings decreased over time, and meetings became less productive as many staff were handling extremely high workloads and did not have time to attend the high number of meetings occurring at the time.

Staff perception and understanding regarding the decision-making structures put in place to respond to the COVID-19 pandemic were varied. While the strategic and policy directions to be taken during the pandemic response were widely understood by HEA representatives, there was some noted ambiguity over who held accountability for making and implementing crucial decisions. Staff members highlighted the importance of providing this clarity in concert with common principles to help guide decision-making on pandemic matters, including equitable vaccine and PPE distribution.[50] Some staff members interviewed raised concerns with decision-making structures, particularly around the overall ethics of decisions. Those staff members understood that there was no established ethics framework for decision-making and expressed the need for increased input from Inuit staff members and community members to ensure that decisions are in the best interest of Nunavummiut. Some staff members also raised concerns with the ICS structure, as there was no rotation of leadership throughout the pandemic. This raised questions amongst those staff members about the governance and decision-making aspects and structures of the COVID-19 response. Those staff members asserted the importance of having Inuit leaders who can provide insight and input on key decisions, to ensure that Inuit Qaujimajatuqangit is honoured and incorporated into the response.

Some staff interviewees noted that decision-making structures supported the rapid mobilization of key protocols and decisions related to the pandemic response. Specifically, they associated the overall success of the COVID-19 Response with the team-based decision-making structures – decisions were a team effort and often represented the input of key leaders.

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[48] Government of Nunavut. 2020. "Health Pandemic Response Secretariat." [Submission to the Financial Management Board] Accessed December 2023, January 2024, March 2024.

[49] Government of Nunavut. 2023. "Annual Report 2022/23: Special Operations Division- COVID-19." [Word Document] Accessed December 2023, January 2024, March 2024.

[50] During the interview process, staff were asked to describe what principles guided decisions. Examples of such principles were given, which included making decisions that: *Built and maintained trust among the public; was inclusive (e.g., fair access to services, prioritization of vaccines); respected the importance of communities and people being able to give voice to their views and belief; and minimized the risk of harm and suffering.*

Policies and Procedures

At the beginning of the COVID-19 pandemic, the response was based on the government's 2012 "Pandemic Influenza: Planning and Response Guidelines for the Health Sector." However, in June 2020, HEA developed the "Government of Nunavut: COVID-19 Pandemic Response Plan," adapted from previous guidelines, to specifically address the specific and unique challenges of COVID-19. HEA also developed standard operating procedures ("operating procedures") to support the Plan to, "provide a best practice and evidence-based framework to guide actions and decisions related to the management of a COVID-19 outbreak in Nunavut […] outline clear roles and responsibilities to inform the public health response.".[51] These operating procedures were updated throughout the pandemic and distributed to the healthcare team.

For this review, 2021 and 2022 operating procedures were provided and reviewed. Memos were attached to each, noting that old versions of the operating procedures were to be replaced with new versions in each health centre's communication binder and Communicable Diseases Manual. The memo also highlighted key changes to the updated operating procedures for ease of reference. The memo indicates that the operating procedures were distributed to:

- Executive Directors;
- Directors of Health Programs;
- Directors of Population Health;
- Supervisors of Health Programs;
- Regional Communicable Disease Coordinators;
- Territorial Communicable Disease Specialist(s);
- Iqaluit Public Health Manager;
- Nurse Educators;
- ED Iqaluit Health Services;
- Medical Quality;
- Programs Administrator;
- Territorial Director of Oral Health;
- Director of Travel Health Programs;
- Director of Mental Health; and
- Territorial Director of Home and Community Care.

Despite some evidence that memos indicated proposed changes, some staff noted difficulties in distinguishing changes to the various iterations of the policies and procedures. This indicates that there may have been some miscommunication and issues with the distribution of related materials and memos. The development, update, and communication of the standard operating procedures indicate that HEA was renewing the direction to frontline staff as the information about the pandemic evolved. However, it is unclear if or how any feedback from the frontline was incorporated into iterations of the plans or if unique community circumstances were considered.

Among those interviewed, it was generally agreed that HEA was able to rapidly adopt, and communicate in a timely way on, policies and procedures that supported the operationalization of the COVID-19 response. Staff members expressed that policies and procedures were typically communicated in a timely and effective manner both internally and externally to communities. In contrast, other staff members reflected on challenges, including ineffective communication and training of new virtual care technologies, along with broad stroke policies which were not operationalizable within the specific community context.

[51] Government of Nunavut. 2020. "Standard Operating Procedure – COVID-19 Outbreak Management Team." [PDF MEMO] Accessed December 2023, January 2024, March 2024.

Roles and Responsibilities

Overall, interviewees noted that priorities were set and deliberated rapidly. However, some staff members raised that shared and clear understanding of roles and responsibilities could have been improved, with challenges being raised on HEA's ability to set clear responsibilities given the rapidly evolving nature of the pandemic. This feedback is counter to what is outlined in the COVID-19 Pandemic Plan and the standard operating procedure, which outlines roles and responsibilities for various positions. This indicates that there may have been a miscommunication or misinterpretation of how the plans and procedures were communicated and implemented or that the procedures did not provide sufficient insights to operationalize effectively.

Staffing capacity, recruitment, and retention led to further complications, as some staff members were expected to take on responsibilities outside of their qualifications and/or job scope, creating high workloads and a lack of ability to take time off. A few staff members also expressed inconsistencies between the messaging from the Human Resources department and HEA as it related to how hiring could be done during the pandemic, and messaging around working from home. This finding regarding inconsistencies between Human Resources and other department policies was also present in DPRA Canada Ltd.'s whole-of-government review.

Consideration and Incorporation of ISVs and IQ Principles

HEA's mission is to promote, protect, and enhance the health and wellbeing of all Nunavummiut, and to incorporate Inuit Qaujimajatuqangit ("IQ") at all levels of service delivery and design. IQ refers to Indigenous Knowledge of the Inuit, recognized to be a "unified system of beliefs and knowledge characteristic of the Inuit culture."[52]

Some HEA representatives spoke about how the inclusion of IQ Principles was central to the COVID-19 response framework. Others, including community members, noted that there were opportunities to broaden the consultation of Inuit to ensure that the response was reflective of the needs along with knowledge of Nunavummiut. It should also be noted that the majority of governance and policy documents provided did not refer, in any substantive way, to Inuit Qaujimajatuqangit. Only one pandemic-response document provided as part of this review, the "COVID-19 Protocol Package V7" from 2021 had a section on "cultural considerations", although this was not found in a later version of the same document. This suggests that HEA did not fulsomely consider IQ principles, and that there are opportunities to be more consistent in the use Inuit Qaujimajatuqangit in future planning and response. Many staff members identified that IQ Principles such as consensus decision-making (Aajiiqatigiinniq), serving family and community (Pijitsirniq), and working together for a common cause (Piliriqatigiinniq/ Ikajuqtigiinniq) should be key considerations as HEA's adapts future pandemic response planning. Staff and community members also identified the need for improved consideration in the incorporation of IQ Principles and ISVs, including more Inuit individuals in decision-making to create a response that is best suited and reflective of the needs of Nunavummiut.

Both staff and community members interviewed highlighted how instrumental respected community members such as Elders and CHRs were to the success of the COVID-19 response due to their deep connections and relationships with community members.

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[52] Tagalik, S. 2010. "Inuit Qaujimajatuqangit: The Role of Indigenous Knowledge In Supporting Wellness in Inuit Communities in Nunavut." *National Collaborating Centre for Aboriginal Health.* [PDF] Accessed January 2024.

Emergency Health Management: Preparedness

HEA was experiencing staffing challenges before the COVID-19 pandemic. As such, high job vacancy rates impacted HEA's capacity to prepare for the pandemic and outline roles and responsibilities. Ongoing challenges with staff recruitment are highlighted in the 2017 Office of the Auditor General report, which reviewed health services in Nunavut to examine, "whether the Department of Health adequately managed and supported selected healthcare personnel who deliver services in local and regional health centres in Nunavut."[53] The review identified strengths in the delivery of health services such as community health nurses who are the "backbone of community health centres."[54] However, staffing challenges were also noted, with the review finding that as of December 2016, 46% of positions were vacant and filled by temporary staff, such as casual or private agency nurses.[55]

The findings from the Auditor General report, especially related to staff capacity issues and the role of the Department of Finance in organizational changes and developing human resource policies and procedures, are important to understand in the context of preparedness for the COVID-19 pandemic and subsequent response. The report highlights the existing capacity issues before the pandemic and the limitations of HEA's decision-making ability and capacities in developing a response. The findings of the Auditor General's 2017 report are supported by the interview participant feedback collected for this 2023-24 review, which highlighted the ongoing and preexisting staffing challenges in the territory.

Readiness for Change and Supports

Several staff members reflected that HEA was able to rapidly respond once COVID-19 became an imminent threat through the setting up of isolation hubs and strict travel restrictions, which helped to significantly delay the arrival of COVID-19. However, the common view among HEA representatives was that the Government of Nunavut, including HEA, was not fully prepared for the pandemic, and did not leverage the extended time before COVID-19 arrived in the territory to prepare. This being stated, a complicating factor according to interviewees was a 2019 ransomware attack. Yet, this also allowed HEA to be better prepared for virtual workflows, leading to the successful establishment of the Virtual Care Program.

According to those interviewed, HEA could have put more attention toward prioritizing staff recruitment and establishing public health information along with vaccine and medication inventory systems. A few staff members also identified a poor anticipation of possible mental health impacts on community members associated with increased isolation and movement restrictions. However, many HEA representatives highlighted that insufficient staff capacity, combined with high staff turnover rates, made preparing for the pandemic more difficult. Instead, HEA had to rely on significant teamwork within the department and externally. In contrast to staff perspectives, some of the community members interviewed pointed to how a delay in the onset of the first cases in Nunavut provided HEA with the ability to learn from the experiences of southern jurisdictions. Some staff members highlighted challenges with warehouse storage and capacity in the territory prior to and during the pandemic, which impacted the HEA's ability to stockpile a large volume of supplies, particularly PPE. While there were some issues, community representatives generally felt that the territory was prepared for COVID-19.

Some HEA representatives emphasized the importance of frequent and consistent updates to pandemic

[53] Office of the Auditor General of Canada. 2017. "Report of the Auditor General of Canada to the Legislative Assemble of Nunavut - 2017- Health Care Services Nunavut." [PDF] Accessed December 2023, January 2024, March 2024.
[54] Ibid.
[55] Ibid.

planning to ensure improved preparedness in the event of a future health emergency. The COVID-19 Pandemic Response Plan, standard operating procedures, and other procedure documents reviewed for this review indicate that updates to the documents were made during the COVID-19 pandemic.

Technology Challenges

HEA representatives highlighted that the department lacked an electronic public health information system for virtual inventory management, patient record access, and case and contact management. Nunavummiut are unable to access digital versions of their health records – for example, many individuals experienced challenges when the federal government required proof of vaccination for air travel. In addition, some HEA staff expressed that departmental systems were not equipped to handle the large scale, day-to-day operations of the pandemic. HEA representatives, particularly those in leadership positions, stressed the importance of having a public health information system. The lack of an overarching virtual territorial public health information system impacted the HEA's ability to respond and prepare for the increased demand brought forward by the pandemic. Interviewees affirmed that the required system and improvements had yet to be implemented, leading to continued impacts to preparedness planning in the territory.

Emergency Health Management: Response

When staff had to take other roles during the pandemic, there were difficulties maintaining consistent levels of service for community members. While HEA developed a "COVID-19 Nurse Staffing Surge Contingency Plan," it is unclear how this was used during the response, as most staff members expressed that the HEA continued to operate at a 50% vacancy rate through most of the pandemic.

Those interviewed expressed that HEA was able to provide adequate funding to support all aspects of the COVID-19 response. They also reflected that funding decisions seemed to be made quickly to address changing needs. However, while funding was available to address the pandemic, some HEA representatives and community members experienced challenges with accessing it to address non-COVID-related health and social impacts that arose throughout the pandemic (e.g., mental health challenges and substance use within communities).

The HEA Response was centred around four areas: rapid response teams, testing, virtual public health nursing, and isolation hubs. The following findings of this section are presented according to these areas of response.

Rapid Response Teams

As previously mentioned, HEA developed a Rapid Response Program to minimize the impact of COVID-19 in communities. As part of the program, Rapid Response Teams ("RRT") were deployed to affected communities within 24 hours of identifying a positive case.

An RRT Binder of information was developed for the deployment teams that included a flowchart of processes, contact lists, and checklists for pre-deployment and supply kits.[56] The development of the binder resource for the RRTs indicates a level of preparedness HEA took to ensure that the RRTs had all the necessary information for responding to an outbreak.

[56] Government of Nunavut. N.d. "Rapid Response Team (RRT) Binder." [PDF] Accessed December 2023, January 2024, March 2024.

Some staff members spoke of their colleagues who developed separate worksheets and tracking sheets for tasks and activities. HEA-created templates for these activities were provided in the RRT Binder and the standard operating procedures. The fact that staff were creating their own templates when some already existed, indicates that while resources were built, they either weren't well communicated or not well suited to the need of the users.

Outbreak debriefs from six RRT deployments were provided for review for this report (Table 6). The outbreak debriefs included interviews with key members of the RRT to reflect on what went well and the lessons learned.

Table 6: Date of Outbreak Debriefs

Location of Outbreak	Date of Outbreak	Date of Debrief
Pond Inlet	April 29, 2020 (False Positive)	May 2020
Hope Bay Mine (at the mine site)	September 19, 2020	October 2020
Sanikiluaq	November 6, 2020	November 26, 2020
Whale Cove	November 11, 2020	January 2021
Rankin Inlet	November 12, 2020	November 30, 2020
Iqaluit	April 15, 2021 – June 20, 2021	January 2022

The debriefs have similar findings for areas of improvement, categorized into themes including, but not limited to:

- Pre-Deployment Logistics;
- Arrival Logistics;
- General Logistics;
- Communications;
- VPHN; and
- Additional Lessons Learned.

A need for role clarity among the RRT, Virtual Health Nurses, and the local health staff, better communication amongst the team and to community, and a need for pre-deployment meetings were noted in four of the debriefs. Some debriefs occurred months after the original outbreak, and in between this time other outbreaks occurred. It is unclear who received the outbreak debriefs and how lessons learned were implemented. However, the consistent identification of similar areas of improvement indicate that the learnings may not have been effectively communicated and implemented, leading to a repeat of similar issues and challenges.

Testing

The CPHO's "2020-21 Report on COVID-19" notes that at the start of the pandemic, the Territory's testing capacity was a significant challenge because of a reliance on out-of-territory labs. This led to a 6 to 7 day average turnaround time for results.[57] In Spring 2020, in-territory testing was implemented in Iqaluit and Rankin Inlet, decreasing turnaround time to 2 to 3 days.

Swabbing procedures that were provided for review for this report aligned with generally accepted protocols during the COVID-19 pandemic.

Virtual Public Health Nurses

Virtual care became an integral component of Nunavut's pandemic response. The actions and supports provided by the Virtual Public Health Nurses were in keeping with the established aims and priorities. The roles and responsibilities of the vPHNs were outlined in many of the operating procedures for HEA response programs, including contact tracing and the RRT. Duties included:[58]

- COVID-19 monitoring of identified cases/contacts within Nunavut;
- Contact tracing;
- Virtual coordination of COVID-19 care;
- Client education surrounding COVID-19 isolation and other related topics;
- Notification of COVID-19 test results; and
- Other COVID-19-related tasks (as required).

Some HEA representatives noted how the scope of practice for virtual care was sometimes too narrow (i.e., consideration could have been given to case and contact management), and that this took needed nurses and physicians among others off the ground, leading to higher workloads for those who remained in the community.

A patient experience report of the virtual monitoring and hotline was completed by Colliers International in February 2021.[59] It found an "overwhelmingly positive" response to the program by those who used them.[60]

Isolation Hubs

To reduce the spread of COVID-19 into Nunavut, on March 24, 2020, the Chief Public Health Officer put a travel restriction in place, establishing conditions and prohibitions on travel to Nunavut originating from outside of the Territory's borders. From March 25, 2020 to April 12, 2022, the Isolation Hubs accommodated over 22,800 individuals.[61]

HEA staff who were interviewed expressed concerns about some of the decision-making processes related to Isolation Hubs, including:

- Restrictiveness of isolation rules in the hubs (e.g., restrictions on movement in and out of the hub and resetting of isolation periods);

[57] Government of Nunavut. 2021. "The Chief Public Health Officer of Nunavut's 2020-21 Report on COVID-19." [PDF] Accessed December 2023, January 2024, March 2024.
[58] Ibid.
[59] Colliers International. 2021. "COVID-19 Virtual Monitoring and Hotline Patient Experience Report." [Draft PDF Report] Accessed December 2023, January 2024, March 2024.
[60] Ibid.
[61] Ibid.

- Lack of consideration of mental health impacts associated with Isolation Hub stays; and
- Harmful and discriminatory treatment of individuals staying in the Isolation Hubs.

A protocol manual for the isolation hubs was initially developed in April 2020. It was further updated in July 2020 and April 2021 to reflect "new developments and operational realities." Some of the developments and operational realities that the updated versions responded to include a more detailed incident report and management response process, additional procedures and considerations for mental health concerns, and the ebbs and flows of the pandemic that impacted isolation hub capacity.

There were over 2,700 incidents reported at Isolation Hubs between 2020 to 2022.[62] A 2023 review of the Isolation Hub Program noted that several issues were brought forward by Nunavummiut in the Isolation Hubs to the Mental Health and Addictions team who were completing wellness checks. The report notes, "the Mental Health and Addictions Division remained on site in Ottawa, Winnipeg, Yellowknife and Edmonton between April and July 2020 to review and oversee operations, provide recommendations, and execute changes to the management of the Isolation Hubs [...] The team handed over the Isolation Hub Management to an agency contracted to take on the field operations in July 2020."[63] Although protocols and supports were in place, many Nunavummiut failed to complete the two weeks of quarantine.

Collaboration

Many staff members interviewed highlighted the strong and dedicated work of the team, and the countless hours of effort poured into supporting Nunavummiut. However, HEA representatives were split on the perceived strength of partnerships with other departments. While some believed that such collaboration underpinned the success of the response, others expressed concerns that departments relied almost entirely on HEA. Support was shown towards clarifying collaboration expectations between various government departments to improve future response. In addition, some HEA representatives emphasized the importance of maintaining the collaborative relationships and partnerships built with external partners/organizations throughout the course of the COVID-19 response.

Several HEA representatives expressed the need for improved collaboration and communication pertaining to delegation of roles and responsibilities within the Department to ensure consistency in planning and supports provided to communities.

Community members affirmed how HEA, and external organizations collaboration contributed to the successful response. Community members reflected on the strong relationship between the Government of Nunavut and health centers, as evidenced through the frequent sharing of messaging and information and the collaboration with the HEA and Nunavut Tunngavik Inc ("NTI") to provide support such as food hampers, isolation baskets, activities for kids were able to be distributed to community members to help ease the burden of the pandemic.

> *"Locally, organizations like QIA [Qikiqtani Inuit Association] and NTI opened their arms to help us in any way they could through pamphlets, food hampers, and other information. We had good support and education and it was something we all tried to understand and try to get the fear away as much as we can." – Community Member*

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[62] 2023. "Government of Nunavut Department of Health Isolation Program Review." [Word Document] Accessed December 2023, January 2024, March 2024.

[63] Ibid.

While there was general agreement among community members that the collaboration was effective, it was suggested by one of the interviewees that municipalities could be further empowered to lead on-the-ground response. Community members discussed the importance of collaborating with the municipality, ensuring that the voices of mayors, SAOs, and CHRs are included as well as that leaders are empowered to direct the response given their intimate knowledge of the local communities. It was stated that HEA could have better engaged with communities and sought their input as the department adapted and shifted priorities throughout the pandemic. Despite this request, relationships with communities were highlighted as a key contributing strength to the HEA COVID-19 response.

"We can have all the emergency plans we want but the plan could outline that you have to take direction from the municipality, but the folks on the ground should be the voice that outlines the types of supports needed for future events." – Community Member

Technology

As previously noted, some HEA staff expressed that the Department was not prepared for the large scale of the pandemic response, and the demand it would place on systems that are often not equipped to handle normal day-to-day operations.

Staff members identified challenges with the implementation and use of technologies such as Microsoft Teams, Meditech, and vaccine inventory systems, along with a high-reliance on paper-based processes. This finding was also present in the Auditor General's 2023 report on COVID-19 Vaccines in Nunavut, which found that "the Department of Health had inadequate systems for monitoring and reporting data on the rollout."[64] Due to HEA's reliance on manual processes to manage vaccine and PPE inventories and supplies, there were errors and misrepresentation of actual numbers of vaccines and PPE received, used, and wasted.

In addition, HEA does not have an electronic public health information system, leading to paper tracking of diseases. The lack of a public health information system has raised concerns among some staff members around patient data safety, confidentiality, and data accuracy.

Emergency Health Management: Recovery

HEA staff at all levels indicated that the most common challenge associated with the recovery phase has been staff mental health and burnout. Many staff members expressed that the demand and expectations placed upon them, and their colleagues led to high levels of stress and fatigue, leading to burnout and a significant number of resignations. Extreme demands, such as no time off for a year, long workdays and the inability to leave the territory contributed heavily to mental health challenges and burnout. Ongoing burnout has exacerbated challenges with staff recruitment and retention within the territory. Staff noted that people are experiencing the posttraumatic stress disorder like symptoms, which they attributed to the high pressure and stressful situation.

[64] Office of the Auditor General of Canada. 2023. "COVID-19 Pandemic: COVID-19 Vaccines in Nunavut." Accessed December 2023, March 2024.

Interviewees emphasized the importance of recognition, appreciation, and supports. Frustrations were raised in inequitable distribution of bonuses and pandemic pay incentives, along with insufficient access to mental health and wellbeing supports.

Effects of the Pandemic on Communities and Youth

Community members discussed the continued mental health impacts of the pandemic on communities and healthcare workers. They expressed that insufficient considerations were placed on the impacts of health measures (e.g., isolation requirements and hubs) to the mental health and wellbeing of communities – especially when considering Elders and Inuit values of "togetherness". Interviewees raised concerns with the rise of suicide rates and feelings of disconnection post-pandemic.

> *"If we were ever to go back into the same situation as COVID – we need to consider the mental toll it takes on people. There should be opportunities for an individual to reach out to talk to someone and have some sort of support mechanism. There were some concerns about mental health amongst staff afterwards. When things like this happen there should be some mental health supports for people " – Community Member*

A few HEA representatives and community members expressed concerns about the impact the COVID-19 pandemic, especially the lockdowns, had on the education and social development of youth. Particularly, there were comments about the pandemic's effect on Inuit youth leading to a disconnection from their culture. There were also concerns amongst a few HEA representatives on the lack of available childcare supports, notably daycare to support frontline staff who were balancing working long hours and having children at home that require care.

The DPRA Canada Ltd. whole-of-government review of the COVID-19 pandemic response notes that the actions the Department of Education took to support the COVID-19 response, and how the various departments worked together to support the pandemic response. Particulars about how HEA and Department of Education worked together were not reflected on by interview participants for this review.

Several post-COVID-19 pandemic reports and reviews have explored the impact of pandemic responses on youth, especially as it relates to education and social development. These studies have found that many Canadian youth have experienced chronic attendance problems, declines in academic achievement, social development, and declines in mental health.[65]

A qualitative study on how Nunavummiut youth coped during the pandemic found that youth in Nunavut were experiencing pervasive sadness and fear for their own health and that of their communities as a result of closure of schools, cancellation of community activities, particularly sports, and fewer social outings and employment opportunities.[66]

Communications and Engagement

Communications within the government were seen to be frequent enough to enable changes in policies, procedures, and protocols. However, HEA representatives also noted that updates made were not always evident, which impacted training and communications. As a result, interviewees recommended explaining

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[65] Royal Society of Canada. 2021. "Children and Schools During COVID-19 and Beyond: Engagement and Connection Through Opportunity." [PDF]. Accessed March 2024.

[66] Thomas, A., Bohr, Y., Hankey, J., Oskalns, M., Barnhardt, J., Singoorie, C. 2022. "How did Nunavummiut youth cope during the COVID-19 pandemic? A qualitative exploration of the resilience of Inuit youth leaders involved in the I-SPARX project." *International Journal of Circumpolar Health,* 81:1. DOI: 10.1080/22423982.2022.2043577. Accessed March 2024.

changes in policy, procedure, or directions to improve operationalization and adaptation of policies to regional contexts. As previously noted, when some protocols were updated, they were accompanied by a memo that highlighted changes in the new document. This indicated that the HEA made efforts to make it easy for frontline staff to understand changes, but given the feedback from staff, this effort may need to be redesigned in the future to ensure that frontline staff are getting the information they need promptly.

Communication with communities was frequent and delivered through various means such as radio, news broadcasts, and social media. Radio broadcasts were seen to be a critical communication pathway for communities to receive information and to ask questions of local and Government of Nunavut leaders on how COVID-19 protocols and policies will impact them. However, findings suggest that consultation with communities seldom occurred. That is, the flow of information was perceived to have been primarily one-way, whereas information was provided to the public and communities; however, community feedback was not necessarily collected or integrated into future communications. Staff members emphasized the importance of using community partners such as Community Health Representatives, as they have deep connections to communities and can advise on the appropriate communication and messaging methods for their communities, including plain language, translation and interpretation requirements. This could also include identification of community spokespeople, such as Inuit Elders or youth. This is particularly important, as community members noted that that communication did not always consider the audience, with one example being written content that was complicated and hard to understand in communities with low literacy rates.

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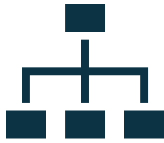
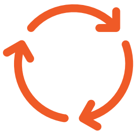
Appendix C Topics of the MNP COVID-19 Pandemic Response Review



Governance. This relates to the structure and evolution of policy setting, legislation and regulation, planning, and decision-making within HEA. It will also touch on how HEA collaborated with other departments and considered Inuit Qaujimajatuqangit to ensure alignment with its COVID-19 Pandemic Response.

Emergency and Health Management Preparedness. This relates to the state of HEA's preparedness *before* the COVID-19 Pandemic.

Emergency and Health Management Response. This relates to the actions taken throughout the COVID-19 Pandemic to promote and protect the health and wellbeing of people.



Emergency and Health Management Recovery. This relates to the impacts of the COVID-19 Pandemic on the GN's health workforce and healthcare system more broadly.

Communications and Engagement. This relates to how guiding policies and procedures related to the HEA COVID-19 Pandemic Response were communicated internally within the government and externally with communities.

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Appendix D Guiding Evaluation Questions

The guiding questions outlined in Table 1 will anchor the COVID-19 Pandemic Response Review. These guiding questions are not intended to be interview questions. A master interview guide will be developed based on these questions, and a set of interview questions will be developed for each engagement group to seek a further understanding of the evaluation questions.

Table 1: Guiding Evaluation Questions

Evaluation Topics	Guiding Evaluation Questions
1. Governance	• What were the overarching goals (objectives) and priorities of HEA when it came to the COVID-19 Pandemic Response, and how did this planning adapt to the experiences in delivery? • How were these same goals (objectives) and priorities of HEA reflected in the policies, procedures, and assignment of accountabilities for the COVID-19 Pandemic Response, within and across other departments? • In what ways did HEA consider Inuit Qaujimajatuqangit to ensure alignment with its COVID-19 Pandemic Response? a. What strengths and challenges were encountered? b. How were the challenges overcome? c. What could have been done differently?
2. Emergency and Health Management *Preparedness*	• What was the state of HEA's preparedness prior to the COVID-19 Pandemic from the perspective of: a. Primary care (e.g., treatment)? b. Public health (e.g., case and contact management, supply management, data tracking)? c. Communities (e.g., connections to schools, isolation hub and travel restrictions)? • From a preparedness perspective, what worked well and what could be improved?
3. Emergency and Health Management *Responses*[67]	• What types of supports were put in place, and what related actions[68] were taken to promote and protect the health and wellbeing of people during the COVID-19 Pandemic, from the perspective of: a. Primary care (e.g., treatment)? b. Public health (e.g., case and contact management, supply management, data tracking)? c. Communities (e.g., connections to schools, isolation hub and travel restrictions)? • How did these supports along with actions align with the HEA's COVID-19 Pandemic Response goals (objectives) and priorities (plans)? • What resources, systems and funding enabled the provision of these

[67] A thorough assessment of vaccine delivery is outside the scope of this Review as this has been reviewed by the Office of the Auditor General of Canada. The full report of this review can be accessed here.
[68] For example, mask regulations, territorial public health restrictions, vaccine delivery and promotion, etc.

Evaluation Topics	Guiding Evaluation Questions

	supports, and the associated actions?
	• What was the decision-making process for identifying and taking those actions?
	    a. In what ways were the ethics of the COVID-19 Pandemic Response considered? Was there shared understanding of the ethics of Response?
	• To what extent were those actions handled in a coherent manner that involved collaboration (coordination) with:
	    a. Community based organizations (e.g., schools) to ensure alignment with its COVID-19 Pandemic Response?
	    b. Other GN departments to ensure alignment with its COVID-19 Pandemic Response?
	    c. Inuit Qaujimajatuqangit to ensure alignment with its COVID-19 Pandemic Response?
	• From a Response perspective, what worked well and what could be improved?

4. Emergency and Health Management *Recovery*	• What were the impacts of the COVID-19 Pandemic on the GN's health workforce and healthcare system more broadly, and how could they be mitigated? • From a recovery perspective, what lessons learned will guide future planning and efforts?

5. Communications and Engagement	• How were guiding policies and procedures related to the HEA COVID-19 Pandemic Response communicated internally within HEA and externally[69]?
	    a. What communication strategies were used to convey public health requirements?
	    b. Was clear and sufficient information provided by HEA to inform and support various groups and communities?
	    c. Were there any challenges with various regional communications? How were these challenges overcome?
	    d. How have communications changed over time and based on experiences, such as with harder to reach populations?
	• From a communications and engagement perspective, what worked well and what could be improved?

[69] For example, to other departments and other groups including communities and Nunavummiut, Nunavut Tunngavik Incorporated, and other jurisdictions.

Appendix E Project Logic Model

The HEA COVID-19 Pandemic Response logic model was developed at the start of the project, based on a review of background documentation provided by HEA. The model was intended to be a living document, to be adapted over the course of the Review.

This logic model is intended to visually depict the relationships between what was put toward the delivery of the Response along with the realization of desired outcomes (to be refined through consultations with partners, stakeholders and Rightsholders).

The key components of the model, further described below, include:

- Enabling Resources
- Delivery Leads
- Activities and Outputs
- Intended Outcome

Enabling Resources

Enabling resources are often referred to as "inputs" and are the financial and non-financial resources that enable the design and delivery of the Response. In the context of the HEA COVID-19 Pandemic Response, enabling resources include:

- **Financial resources** to help maintain critical services as well as additional COVID-19 supports (i.e., operational costs associated with COVID-19 response efforts).
- **Human resources**, including healthcare (within and outside the territory) that helped respond to COVID-19 outbreaks.
- **Infrastructure,** including facilities (e.g., community health centres, isolation hubs) and measures to support physical distancing.
- **Supplies,** such as testing kids, vaccines, personal protective equipment.
- **Territorial statutes** that guided GN's Pandemic Response actions.

Delivery Leads

With the support of community health organizations, centres and focused committees and working groups, the government departments that primarily led COVID-19 Pandemic Response Plan efforts (including the logistics for planning and implementing the rollout) included the HEA, CGS, and EIA.

Please note that the focus of this Review is on the HEA's Pandemic Response.

Activities and Outputs

This component of the logic model represents the activities (i.e., work carried out by staff, key stakeholders, Rightsholders and partners to deliver on the Pandemic Response) as well as to produce core outputs which contribute, in turn, to progress toward the attainment of the intended outcomes. These are events which happen(ed) as part of Response processes.

As this Review is focused on the HEA's Pandemic Response, the activities and outputs presented in the logic model are only reflective of this department.

Activities and outputs include:

- **Developing protocols, guidelines, and strategic documents to guide HEA's Pandemic**

Response. This includes, but is not limited to, protocols for case tracking; guidelines including for isolation rooms in health centres and infection control; COVID-19 protocols for health centres; department-wide business continuity plans; research and options papers for decision-makers; frameworks for easing public health measures.

- Researching, tracking, and coordinating the review, approval, and communication of public health measures.
- **Re-assigning and training of staff to support COVID-19 related activities** on a full or part-time basis (e.g., mandatory COVID-19 training for all healthcare providers coming to the territory, training on new COVID-19 protocols).
- Organizing health centre facilities to ensure readiness.
- Activating a coordinated response to COVID-19 cases and outbreaks in communities across the territory. This included the:
    - Creation of a Rapid Response Plan.
    - Set-up of a COVID-19 hotline.
    - Set-up of a travel program and management of travel requests into and across the territory.
    - Set-up and management of isolation hubs.
    - Establishment of mental health support in hubs.
    - Establishment of virtual solutions in collaboration with federal, provincial, and territorial (FPT) partners. This included investing and making enhancements in technology and infrastructure to better link Nunavummiut to healthcare services despite the Pandemic.
    - Delivery of mass vaccination clinics across communities.
- **Liaising with other departments and organizations** to seek feedback, provide education and resources (e.g., GN and Health committees related to COVID-19).
- **Participating and collaborating with FPT governments** to ensure that Nunavut's Pandemic Response was in coordination with other jurisdictions.
- **Managing a database of lessons learned and successes** to inform future initiatives and Pandemic Response planning.

Intended Outcomes

Outcomes relate to the changes that are realized by carrying out the activities and producing related outputs. An "outcome" is an external consequence that can be reasonably attributed[70] to the Pandemic Response. Outcomes are usually qualified by their expected time frame for realization.

HEA outcomes within this model have been developed as follows:

- **HEA outcomes** are those that are expected to take place upon implementation of the activities and are most closely attributable to the activities and outputs of the Pandemic Response. For example, "re-assignment and training of staff to support COVID-19 related activities (i.e., the "activity") led to ensuring "sufficient resources are available and trained to support the response" (i.e., the "HEA outcome").

[70] Attribution is the connection that can be made between actions and their outcomes. In performance measurement, there are long-term outcomes that organizations want to achieve through their programs. Although external forces make it difficult to attribute these long-term outcomes to the organization's programs, the hope is that they contribute, at least in part, to the desired outcomes. The degree of attribution or influence that a program has on desired outcomes begins to diminish in the longer-term, as there are many other factors influencing the change.

Territorial outcomes within this model have been sorted as follows:

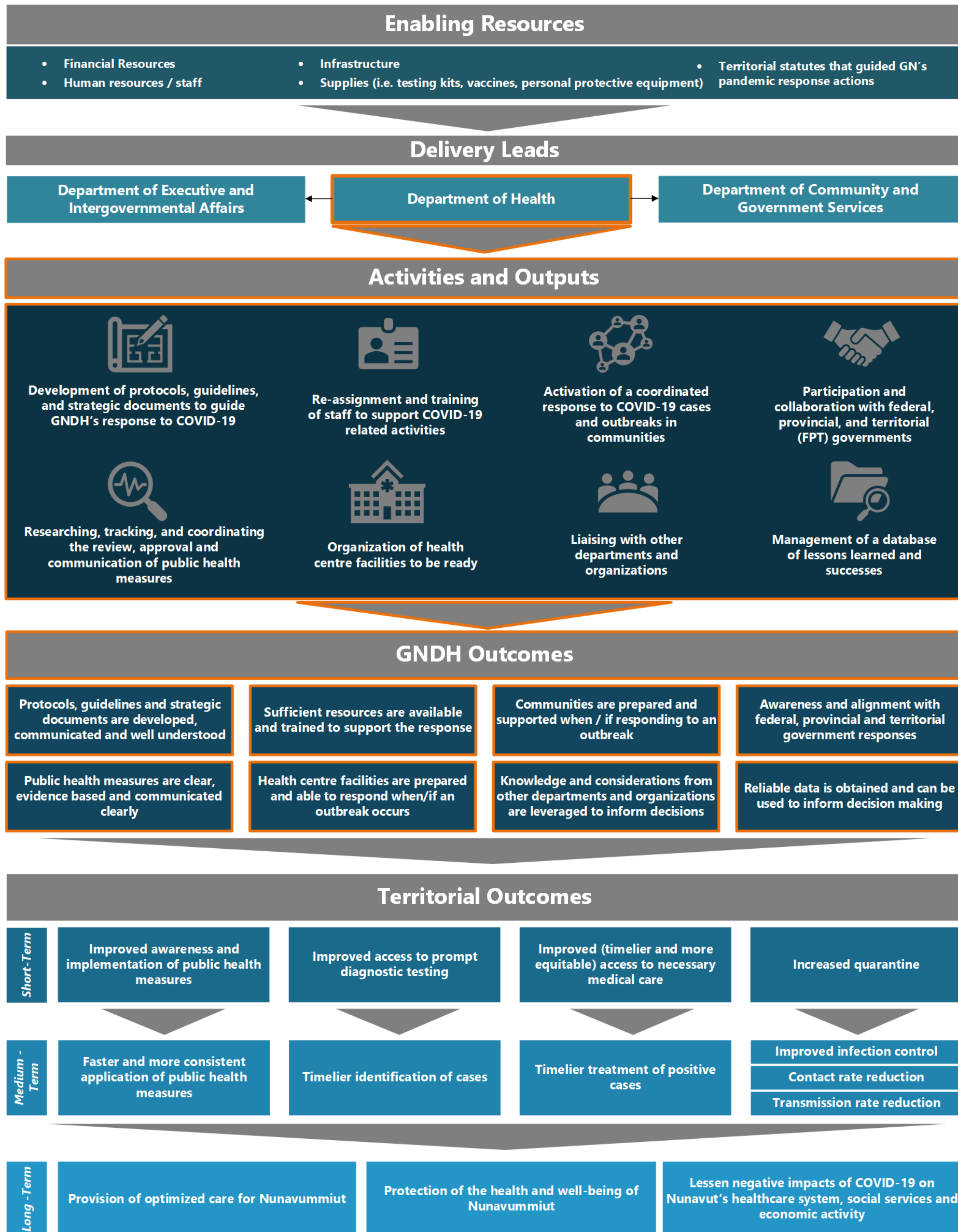
- **Short-term outcomes** are those that are expected to take place upon achievement of HEA outcomes. For example, the ensuring "public health measures are clear, evidence based and communicated clearly" (i.e., the "HEA outcome") led to improved awareness and implementation of public health measures (i.e., the "short-term outcome").
- **Medium-term outcomes** are expected to occur and be maintained progressively after implementation. They are expected to logically occur after at least one immediate outcome has been achieved. Building on the above example, improved awareness and implementation of public health measures (i.e., the "short-term outcome") can be reasonably expected to lead to faster and more consistent application of public health measures (i.e., a "medium-term outcome").
- **Long-term outcomes** represent the utmost desired outcomes of the Pandemic Response. They can be reasonably associated with the Response yet are also influenced by other factors and events. Building on the above example, faster and more consistent application of public health measures (i.e., a "medium-term outcome") contributed to the optimization of care for, and protection of, the health and wellbeing of Nunavummiut (i.e., "long-term outcomes").

It should be noted that the realization of outcomes is contingent upon several underlying assumptions, as outlined below.

<u>Assumptions</u>

- Availability and sufficiency of needed funding, staff, and other resources.
- Adequate training to deliver the activities as intended.
- Implementation of protocols, guidelines, tools that guided HEA's Pandemic Response.

Figure 2: HEA COVID-19 Pandemic Response Logic Model



Appendix F Report Limitations

There were a few limitations encountered during this project as described below:

- **Project Timeline:** MNP was initially engaged in November 2022 to conduct the COVID-19 Response Review for HEA. The project was intended to be completed by June 2023. Due to shifts in project accountabilities within the department and delayed approval of the Evaluation Framework and guiding questions, HEA agreed to extending the timeline for this review to be completed by April 2024.
- **Project Scope:** As the review unfolded, the scope has also changed. As outlined in MNP's initial proposal and the contract, various methods for engagement with community members, including interviews and story-telling sessions, were expected to be used. From this engagement, MNP was also intending to complete case studies to showcase various aspects of the response. Under the direction of the department, and given the challenges in project timelines, the community story-telling engagement sessions and case studies were removed from the project scope.
- **Project Interviews and Documents:** All HEA representatives and community members interviewed for this project were identified by the department. MNP contacted and followed-up with all individuals identified by HEA; however, not all responded to the request or agreed to participate in an interview. Those interviewed shared their perspective on the COVID-19 response, which may not be representative of the whole of the department or communities across the territory. Similarly, it is understood that not all of the documents that were developed as part of the COVID-19 pandemic response were sourced and reviewed. MNP has relied upon the completeness, accuracy, and fair presentation of the information that was obtained from the interviews and documents made available.

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Appendix G Master Interview Guide

Introduction to Project

The Government of Nunavut, Department of Health (HEA), has hired MNP, a Canadian firm, to review how it has responded to the COVID-19 Pandemic. This review will cover:

1. **Governance:** The setting of priorities and goals along with the policies and procedures that guided the response of the government. It will also touch on how HEA collaborated with other departments and considered Inuit Qaujimajatuqangit during the response.
2. **Emergency and Health Management Preparedness:** The state of HEA's preparedness *prior to* the COVID-19 Pandemic.
3. **Emergency and Health Management Responses:** The actions taken throughout the COVID-19 Pandemic to promote and protect the health and wellbeing of people.
4. **Emergency and Health Management Recovery:** The impacts of the COVID-19 Pandemic on the Government of Nunavut's health workforce and health care system.
5. **Communication and Engagement:** The ways in which guiding policies and procedures related to the COVID-19 Pandemic response were communicated within HEA and beyond.

Getting to know the experiences of those involved in preparing for, responding to, and recovering from the COVID-19 Pandemic will provide learnings on what worked well and what might be improved in the future.

This interview will take about 45 to 60 minutes of your time.

For data recording purposes, I would like to ask for your permission to transcribe/record this meeting. I should also mention that your comments will be anonymous. We will not name you or anyone else when it comes to what we discuss. Instead, we are going to report on the main themes, in a summary format.

We are grateful for your taking the time to speak with us. May we begin?

INTERVIEW INFORMATION	
Date:	
Name and Role:	
Interviewed By:	

MNP

Questions

1. To start, can you tell us more about your role (involvement) in the COVID-19 Pandemic response?

Governance

2. In your words, what was the Department of Health hoping to achieve through the response to the COVID-19 Pandemic?

   Put another way, what were the goals or objectives of the department?

3. Given these aims, what would you say were the priorities when it came to addressing the COVID-19 Pandemic?

   a. Do you think these same goals (objectives) and priorities changed during the course of responding to the pandemic; and if so, how?

4. Turning now to the policies and procedures of the Government of Nunavut, and given what you know or heard from others:

   a. Would you say that the government's policies and procedures were consistent with what we discussed as the goals (objectives) and priorities for the COVID-19 Pandemic response?

   b. Do you feel there was a shared understanding among staff of their responsibilities for putting these policies and procedures into practice; and if not, what would have helped with making this clearer?

   c. In what ways do you think the Department of Health's, and as needed the Government of Nunavut's, policies and procedures could be improved to better respond to future pandemics?

5. To the best of your understanding, how did the Department of Health consider Inuit Qaujimajatuqangit in its COVID-19 Pandemic response?

   a. What worked well when it came to drawing on Inuit Societal Values (ISVs)?
   b. Were there any challenges with this, and if so, how were they overcome?

c. What, if anything, could have been improved on, when it came to having Inuit traditional knowledge inform the COVID-19 Pandemic response?

Emergency and Health Management Preparedness

6. Building on what we have talked about up to now, would you say the Department of Health was prepared for the COVID-19 Pandemic when it comes to:

a. Providing treatment (*primary care*)?

b. Taking care of the health of the public?

Prompt: For example, with how cases were tracked and managed?

How about with managing supplies of equipment, materials or vaccines?

c. Working with communities?

Prompt: This would include working with schools, the isolation hubs and travel restrictions.

7. With these experiences in mind, what would you say are the lessons learned when it comes to the Department of Health, and more broadly the Government of Nunavut, being prepared for the COVID-19 Pandemic?

Emergency and Health Management Response

8. What supports were put in place, and actions taken, to protect the health and wellbeing of Nunavummiut in terms of:

a. Treatment (*primary care*)?

b. Helping the public deal with, and communities respond to, the COVID-19 Pandemic?

Prompt: This would include mask regulations, vaccine delivery and immunizations, and ongoing restrictions.

9. Bringing back what we talked about as the goals (objectives) and priorities for the pandemic response, would you say the supports along with actions of the government were consistent with these aims?

10. How was the government able to provide these supports?

In other words, what resources, systems, and funding were used to deliver these supports to residents and communities?

11. How could the government have improved on its use of funding when responding to the pandemic?

    Put another way, what was learned from the COVID-19 Pandemic response when it comes to how government budgets and then spends funds?

12. Coming back to the types of supports provided, and related actions taken, by the government, how do you think these decisions were made?

    Prompt: What might these decisions, such as on access to care like ventilators, or putting in place restrictions, have been based on?

    a. How about the ethics guiding these same decisions, what do you think the government considered?

       Prompts: For example:

       - *Building and maintaining trust among the public.*
       - *Being inclusive (e.g. fair access to services, prioritization of vaccines).*
       - *Respecting the importance of communities and people being able to give voice to their views and belief.*
       - *Minimizing the risk of harm and suffering.*

13. Would you say that the pandemic response was founded on collaboration:

    a. With community based organizations (such as schools, Inuit Tapiriit Kanatami (ITK) and Nunavut Tunngavik Incorporated (NTI))?

    b. Across the various departments?

    c. With Nunavut Inuit, in part to draw on Inuit Qaujimajatuqangit?

14. With these experiences in mind, what would you say are the lessons learned when it comes to the Department of Health, and more broadly the Government of Nunavut, responding to the COVID-19 Pandemic?

    Prompt: What are the two to three things you wish someone had told you as you were starting to respond to this pandemic?

Emergency and Health Management Recovery

15. What were the impacts of the COVID-19 Pandemic on the:
    a. Doctors, nurses and others that make up the health workforce?
    b. The overall health system in Nunavut?

16. How could such impacts of future pandemic's be lessened?

17. What are the lessons being learned from the recovery, and to consider in the event of any future pandemics?

Communication and Engagement

18. We talked earlier about the policies and procedures guiding the pandemic response of the government.

    What comes to mind when you think about how government went about communicating on these?

    Prompt: For example, the means for protecting public health, such as restrictions?

19. Would you say that communities and organizations received enough information on the COVID-19 Pandemic response; and if not, what might have been missed, or was it a matter of not being consistent in the communications?

20. Does anything else come to mind when you think of how communication was handled, for example:

a. Public communication (i.e., from the Department of Health outwards to the public)?
b. Within health teams (e.g., regional teams, along with teams with specific expertise such as in Pharmacy)?
c. Across the Government of Nunavut (i.e., between the Department of Health and Executive and Intergovernmental Affairs, or the Department of Health and Community and Government Services)?
d. With harder to reach or remote communities?

21. How about the ways in which people and communities were consulted by the government, what worked well and what could have been improved?

Closing

22. Is there anything else you'd like to share with us that you think is important to include?

Thank you for your responses.

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Appendix H Interview Guide for The Minister of Health

What Is This About?

The Government of Nunavut, Department of Health, has hired MNP, a Canadian company, to review how it has responded to the COVID-19 Pandemic. The findings of the review will help the Government of Nunavut prepare for future emergencies and support communities.

Why Am I Being Interviewed?

We would like to ask you a few questions to learn from your experience as an elected official and Minister of Health during the pandemic.

Will This Be Confidential?

We will not name you or anyone else when it comes to what we discuss. Instead, we are going to report on the main themes, in a summary format.

How Long Will the Interview Take?

This interview will take about 30 to 45 minutes of your time.

What Questions Will be Asked?

We hope to cover the following questions with you:

Governance and Working in an Inuit Context

1. Working in a consensus-based government, how did this impact the way decisions were made on the directions and priorities to follow during the pandemic response?
   - I imagine there would have been difficult discussions around conflicting priorities or concerns, can you share with us how these situations were handled?
   - Are there other teachings that can be applied during the next pandemic when it comes to setting priorities and making related decisions?
2. Did any of these directions or priorities change during the pandemic, and how was this handled?
3. Working in Nunavut, it's important to uphold and lead with IQ principles and ISVs across government (e.g., decision-making, developing policy, deciding priorities or objectives of initiatives).

What was most helpful for you in ensuring that oversight of Health's response was grounded in (informed by) ISV throughout the pandemic?

Planning, Preparedness and Response

4. When planning and preparing for the various aspects of the COVID-19 response, what was your role as Minister, working in partnership with your Ministerial counterparts and MLAs? Was there anything that was particularly helpful for future reference?
   - Was there anything from your community perspective, living and fulfilling your role as elected official in Arviat during the height of the pandemic, that helped inform your decisions once you were appointed Minister?

- Are there any other teachings (things that worked well, things you would do differently) that would be especially helpful to carry forward, for others in this executive role and who may be faced with this kind of situation?

5. Much of the role of the Health Ministers across every jurisdiction was grounded in creating and keeping public trust.

What do you think helped with building and maintaining such trust across the territory, with community members, local/F/P/T leaders, and other partners?

6. How did you work with Inuit partners (community members, NTI, ITK, RIAs, HTOs) to:
   - Inform your decision-making?
   - Ensure you were able to meet various objectives of Health's response (e.g., protect the health and wellbeing of Nunavummiut, minimize impacts, and minimize along with control disease transmission)?

Recovery

7. Coming out of the pandemic, what were some of the most important things in planning for recovery from your perspective?
   - What were the things that Health has been putting into operation during the recovery, and what was the role of the Minister in these actions?
8. Looking back at the ways Health pursued innovation (e.g., virtual NP program), and how Nunavummiut came together and supported each other throughout the pandemic, are there particular successes you think are important to capture?

Communication

9. Holding the unique position of Minister of Health, communication must have played a critical role throughout all aspects of Health's response, and also may have changed throughout the pandemic.
   - How did you manage all of the information being received and needing to be shared, especially when territorial messaging was overseen by a different department?
   - What were some effective strategies to:
     i. Streamline communications, internally and externally?
     ii. Manage the pace (speed) of information flow?
     iii. Handle the prevalence and/or spread of disinformation?
     iv. Address conflicting information?
   - Was there any opportunity for community engagement (e.g., virtual town hall, call-in opportunities) to allow the communities to feel heard?
10. Is there anything that we have not yet discussed that you would like bring forward to help inform recommendations for preparation for future emergency responses such as the COVID-19 Pandemic?

Thank you for your time!

MNP

Appendix I COVID-19 Related Committees and Working Groups

Source: Government of Nunavut. 2022. "Special Ops COVID-19 Response." [PDF Report] Accessed April 2024.

Note that this does not include many committees that were operational starting in early 2020, before the establishment of the Special Operations team, such as the COVID-19 Communicable Disease and Epidemiology (CD-Epi) working group that met weekly. It does not include the outbreak meetings established and typically occurring daily for communities most impacted by COVID-19 in the early months of the pandemic. It also does not reflect the breadth of FPT committees such as the Special Advisory Committee and Technical Advisory Committee which met 2-3 times per week throughout much of the early pandemic and continued to meet until 2-3 years into the pandemic. The list should be taken as examples of communications as opposed to a comprehensive list.

Committee / Working Group (WG)	Frequency	Description
Vaccine Strategy Working Group (VSWG)	Originally Weekly As Needed	Multi-division group within Health which reviews latest evidence/guidance about vaccines, provides recommendations for vaccine rollout, and supports vaccine rollouts.
CNO Directors Meetings	Monthly -shifted away from COVID January 2023.	General discussion on current health issues and initiatives. Gives opportunities to highlight any important information and updates related to IPAC.
CRN (COVID Resource Nurse) Meetings	Monthly (with ad hoc additions as necessary) -shifted to broad public health education and communication in May 2022	Discussion on COVID-19 Public Health protocol and COVID-19 vaccine updates, training, education, Q&A's, etc.
Logistics Advisory Committee (LAC) (FPT)	As needed	Forum for discussions on logistical capability assessments, procurement, and distribution of supplies. Includes requests for mutual aid and managing surge capacity demands.
Territorial PPE Committee	Monthly	Regional PPE Leads report the status of PPE usage and stock, and Territorial PPE Lead provides updates on more broadly-scoped PPE statuses and issues.
Vaccine Vigilance Working Group (VVWG)	Weekly	Reports updates on AEFIs, vaccine reporting.

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Committee / Working Group (WG)	Frequency	Description
CIC (Canadian Immunization Committee)	Weekly -shift to bi-weekly and to incorporate broad public health immunizations Summer 2022	Discusses and reports updates on vaccinations, safety signals, research findings
Indigenous COVID-19 Vaccine Planning	Bi-Weekly	Discusses lessons learned regarding vaccine planning, implementation, and barriers. Updates regarding vaccine mandates.
Vaccine Logistics Committee of Practice	Monthly	Discussion regarding vaccine manufacturers and logistics updates
Health ICS (Incident Command Structure)	Dependent on COVID-19 transmission in-territory.	Conversation about cases in-territory (ranges from 0-3 times per week).
Health COVID-19 Planning Ops Meeting	Bi-Weekly	Discussions on future planning and addressing gaps in programming.
Vaccine Planning Working Group	As needed	Partnership between the Health Protection Team (CPHO and TCDS) and Special Operations Division to ensure timely rollout of vaccine across the territory. The committee addresses protocol writing, training, logistics, staffing, communications, etc.
Territorial COVID-19 Executive Committee	Once a week	Interdepartmental senior leadership meeting.
Ad Hoc Meetings with: • Mines • Government Agencies (bilateral) • Municipal Governments / Regional Mayors • Other special initiatives	As needed	