CHRONIC & INFECTIOUS DISEASES

PROMOTING VACCINE CONFIDENCE AMONGST FIRST NATIONS, INUIT AND MÉTIS PEOPLES DURING THE TIME OF COVID-19

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On March 11th, 2020, a global pandemic was declared by the World Health Organization. Since that time, the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), or COVID-19, has swept across cities and nations around the world, including Canada.

COVID-19 is a respiratory virus which spreads within a population when a person who is sick comes into contact with others. An airborne disease, it can be spread through coughing, laughing, singing, and speaking, even when a person is experiencing mild symptoms or is asymptomatic. Unknowingly, COVID-19 can be passed between strangers, friends, families, communities and colleagues. As Yong (2020) notes, "SARS-CoV-2 is something of an anti-Goldilocks virus: just bad enough in every way. Its symptoms can be severe enough to kill millions but are often mild enough to allow infections to move undetected through a population. It spreads quickly enough to overload hospitals, but slowly enough that statistics don't spike until too late" (para. 6). The number of positive cases, hospitalizations and deaths have risen and fallen with each of the four waves of the pandemic, which have crisscrossed, with varying degrees and severity, across all regions in Canada. The disease has proven to be challenging to understand in terms of how it moves, how it affects the body, how to treat it and how it continues to mutate.

At the same time, the pandemic quickly drew attention to the socio-economic and health inequities that place certain populations, including First Nations, Inuit and Métis peoples, at higher risk for contracting

> *It is said, do not fear the virus, respect it. Respect is one of the cornerstones of our values. When we respect something, we lose fear of it and attitude and behavior changes. Like learning to swim, you must respect both the beauty and the danger of water. Same with the virus, we need to obey the precautions and safety practices, because fearing it may result in behaviour that is dangerous.*
>
> *Elder Simon Brascoupe, Algonquin/Haudenosaunee*

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COVID is really tricky, it's sneaky. I use the idea of a trickster tale that we use in First Nations about the stories of Nanabush. He is there to tell a story and also teach us a lesson about how to behave and treat each other. Let's think of COVID-19 as a trickster.

Dr. Sarah Minwanimad Funnell.

COVID-19 and having worse outcomes as a result of the disease (Auditor General of Canada, 2021; Giroux et al., 2020; Inuit Tapiriit Kanatami [ITK], 2020; Mashford-Pringle et al., 2021, Power et al. 2020, Richmond et al., 2020; Statistics Canada, 2020). It also highlighted First Nations, Inuit and Métis peoples' history of trauma and mistrust with the healthcare system and medical interventions, including their removal from communities for hospitalization and their potential lack of trust in the roll-out of COVID-19 vaccines (Greenwood & MacDonald, 2021; Mosby & Swidrovich, 2021).

This fact sheet aims to enhance an understanding of how experiences with diseases and current best practices may affect Indigenous Peoples' uptake of the COVID-19 vaccines. It will begin by touching upon First Nations, Inuit and Métis peoples' experiences with past pandemics and the legacy of health inequities, which continue to plague many communities, potentially placing them at greater risk for contracting COVID-19 and experiencing more severe outcomes as a result. It will then turn to addressing the COVID-19 vaccination roll-out and some of the underlying factors that may contribute to vaccine hesitancy amongst Indigenous populations. It will conclude by highlighting examples of Indigenous-led, community-based responses, and by providing actionable advice and best practices for healthcare professionals in promoting vaccine confidence within the context of COVID-19.

Methodology

On January 12, 2021, a collaborative webinar entitled Vaccine hesitancy and First Nations, Inuit and Métis populations: Potential implications during the COVID-19 pandemic was co-hosted by the National Collaborating Centre for Indigenous Health (NCCIH) and the National Collaborating Centre for Infectious Diseases (NCCID). Presenter Dr. Sarah ***Minwanimad*** Funnell, a First Nations Family Physician, public health specialist, and Associate Medical Officer of Health at Ottawa Public Health, explored some of the specific challenges for COVID-19 vaccine uptake amongst First Nations, Inuit and Métis populations, including their negative historic and contemporary experiences with mainstream healthcare systems, health care professionals, and vaccine providers in Canada. This fact sheet draws primarily on Dr. Funnell's presentation, supplemented with additional peer reviewed and grey literature identified through a search of google and google scholar, using the terms: First Nations, Inuit and Métis in conjunction with COVID-19, social determinants, cultural safety, trauma/violence

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informed care, health equity, vaccine uptake, vaccine hesitancy, and vaccine confidence.

Indigenous Peoples and past pandemics

Since the time of colonization, Indigenous Peoples in Canada have experienced novel diseases to which they had no prior immunity, including smallpox, influenzas, and tuberculosis (TB). These diseases have all disproportionately impacted the health and well-being of First Nations, Inuit and Métis peoples and communities (Daschuk, 2013; Giroux et al., 2020, Richardson & Crawford, 2020). When faced with a pandemic, Indigenous Peoples in Canada, as well as globally, "suffer higher infection rates, and more severe symptoms and death than the general population because of the powerful forces of the social and cultural determinants of health and lack of political power" (Power et al, 2020, p. 1).

Historian James Daschuk (2013) notes how beginning in the 17th century, colonialism and colonial policies, the expansion of western trade networks and economic development, and the introduction of diseases, including smallpox, measles, whooping cough and TB, devastated First Nations communities throughout the Canadian Prairies. For Inuit in Nunatsiavut, European whalers, missionaries and settlers were responsible for unprecedented illness and deaths due to the introduction of the Spanish Flu. For example, the community of Okak lost 204 of its 263 members while the community of Hebron lost 86 of 100 members (ITK, 2020).

The impact of TB has devastated Indigenous populations. It led to a death rate of 9,000 per 100,000 population in the Fort Qu'Appelle First Nation in in the 1880s (Truth and Reconciliation Commission [TRC] of Canada, 2015). Many communities of Inuit Nunangat[1] have been and continue to be severely impacted by TB. During the 1960s, upwards of 50% of Nunavut residents were transported for treatment to

[1] Inuit Nunangat is comprised of Nunavut, Nunavik in Northern Quebec, Nunatsiavut in Northern Labrador and the Inuvialuit Settlement Region of the Northwest Territories.

southern sanatoria (ITK, 2020). First Nations people, like Inuit, infected by this disease were removed from their communities for treatment in both southern sanatoria and segregated hospitals, often without their consent or knowledge. There they experienced non-consensual medical treatment and experimentation, and at times never returned home, instilling a legacy of fear and mistrust of health care systems amongst Indigenous Peoples (Lux, 2016). First Nations, Inuit and Métis children also died of TB at elevated rates in residential schools (Lux, 2016; TRC, 2015, The Indigenous Health Writing Group of the Royal College, 2019). Mosby and Swidrovich (2021) note that medical experimentation and the enforced administration of the bacilli Calmette-Guérin vaccine for TB amongst some students attending residential schools resulted in Indigenous Peoples' perceptions of being used as guinea pigs, which may be a factor for vaccine hesitancy amongst some First Nations, Inuit and Métis individuals today.[2]

Geography and isolation of communities can initially protect against disease; however, they can also speed up the transmission and severity of infectious diseases once introduced into the community, particularly when coupled with other socio-economic determinants of health. In the two waves of the 2009 H1N1 influenza, research indicates that First Nations and Inuit, in particular, were more severely impacted and hospitalized as a result of the illness. Those at higher risk for H1N1 were living in rural, remote or on-reserve communities where overcrowded households, poverty, and reduced access to clean water and healthcare were more prevalent (National Collaborating Centre for Aboriginal Health [NCCAH], 2016a). Racist perceptions of First Nations and a general ignorance of their realities among federal authorities resulted in the delayed provision of essential personal protective equipment, such as alcohol-based hand sanitizers (NCCAH, 2016b).

The devaluing of Indigenous lives continues today. Recently, an inquiry into the death of Joyce Echaquan, an Atikamekw woman from Manawan Quebec, called into question the unjust and systemic racism she received by medical staff prior to her death on September 28, 2020 (Canadian Broadcasting Corporation [CBC] News, 2021). In November 2020, Dr. Turpel-Lafond's independent review of BC's health care system

[2] Perceptions of being used as a guinea pig for a new vaccine was shown to be a factor for vaccine hesitancy among Métis individuals in relation to the H1N1 vaccine (Driedger et al., 2015).

report, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, was released. The report gave voice to 600 submissions of anti-Indigenous racism within the province and noted that "there is a direct link between the history and experience of colonial health care in B.C. and the challenges of racism within the health care system today" (p. 166).

Just as in past pandemics, Indigenous Peoples face disproportionate risks for acquiring COVID-19 once the disease enters into their communities, as the legacy of unsafe housing, overcrowded living conditions, and lack of access to clean water persists (Richardson & Crawford, 2020; Statistics Canada, 2020). In addition to these issues, the ability of Indigenous people to offset the effects of COVID-19 are hindered by other socio-economic and health determinants, including chronic and pre-existing health conditions, poverty, food insecurity, a lack of access to health services, as well as negative experiences within the health system, including anti-Indigenous racism (Allan & Smylie, 2015; Auditor General of Canada, 2021; First Nations Information Governance Centre, 2020; Greenwood et al., 2015; Inuit Tapiriit Kanatami, 2020; NCCAH, 2016b; Power et al, 2020; Mashford-Pringle et al. 2021, Richardson & Crawford, 2020).

Colonialism, experiences with past pandemics, and continued and disproportionate health burdens must be acknowledged in order to understand First Nations, Inuit and Métis hesitancy in seeking care, including during the current COVID-19 pandemic. This is also an important reason for having prioritized the COVID-19 vaccines for First Nations, Inuit and Métis populations.

COVID-19 in Indigenous communities

According to Indigenous Services Canada (ISC), from the beginning of the pandemic through to August 10, 2021, there were a total of 33,421 confirmed positive cases of COVID-19 among First Nations on-reserve, with 1,610 individuals requiring hospitalization and 384 fatalities resulting from the disease (ISC, 2021a). The rate of infection was highest among First Nations living on reserve in the Prairie Provinces, with rates 6 times higher than for the general Canadian population. The Public Health Agency of Canada (PHAC) reported a fatality rate for First Nations people on-reserve at 70 per 100,000 versus 69 per 100,000 for the non-Indigenous population (PHAC, 2021). Of note, these numbers only represent cases among First Nations people living on

reserve. As of August 3, 2021, the Nunavut Tunngavik Inc. (NTI) reported a total of 657 confirmed cases of COVID-19 in Nunavut, resulting in four fatalities; however, this number includes both Inuit and non-Inuit cases (NTI, 2021).[3]

In the three territories (Nunavut, the Northwest Territories and the Yukon) data is not disaggregated for First Nations, Inuit or Métis, nor does it include First Nations, Inuit and Métis living in urban settings, limiting the ability to assess the full impact of this illness for Indigenous Peoples in Canada. This is emphasized by Skye (2020), who wrote early on in the pandemic that the "public has never been more saturated by data – number of new cases, number of new deaths, flattening curves, best case projections and so on – yet there is a remarkable absence of clear, public data on how this pandemic is affecting Indigenous peoples" (para. 2).

COVID-19 Vaccines

Vaccination is one of the most important cost-effective, population-based, public health achievements for reducing vaccine-preventable diseases, such as polio, measles and diphtheria, which at one point were the leading causes of death worldwide (Immunize Canada, n.d.). According to Immunize Canada (n.d.), thanks to the impact of vaccinations, deaths attributable to vaccine-preventable diseases have decreased dramatically. The Public Health Agency of Canada (n.d.) states that, "Immunization is one of the most important accomplishments in public health that has, over the past 50 years, led to the elimination, containment and control of diseases that were once very common in Canada" (n.p). Within months of the COVID-19 pandemic, the race to develop safe and effective vaccines began. Within Canada, this resulted in the mass roll-out of two authorized mRNA vaccines, Pfizer-BioNTech and Moderna, as well as two viral vector-based vaccines, AstraZeneca/COVISHIELD and to a lesser extent, Johnson & Johnson's Janssen (Government of Canada, 2021a).[4]

In 2021, the National Advisory Committee on Immunization (NACI) developed *Guidance on the prioritization of key populations for COVID-19 immunization*, in which First Nations, Inuit and Métis peoples, among others, were identified as priority populations for receiving the vaccine. This recommendation was made due to: 1) underlying chronic conditions and systemic health equity issues that continue to burden First Nations, Inuit and Métis populations and lead to disproportionate impacts and severity of COVD-19 within their communities; 2) their limited access to health services particularly for isolated, remote and northern Indigenous communities; and 3) the elevated risk of transmission within Indigenous communities due to challenges around physical distancing (NACI, 2021).

Since the beginning of the COVID-19 vaccine roll-out, a record number of Canadians have received their first and second vaccination dose. While data is continuously being updated, as of July 31, 2021, 68.24% of all Canadians over the age of 12 were fully vaccinated and 81.13% had received one dose of the COVID-19 vaccine (Government of Canada, 2021b). The vaccine was rolled out in 687 First Nations and Inuit communities, with Indigenous Services Canada (ISC) reporting a total of 712,776 doses given, with approximately 304,832 being a second dose in the population over 12 years of age as of August 3, 2021 (ISC, 2021b). According to Nunavut Tunngavik Inc., as of July 2, 2021,

[3] According to Indigenous Services Canada (2020), 99% of the population of Nunavut are Inuit.
[4] As of August 11, 2021, the Janssen vaccine remains unused. For more information on viral vector-bases vaccines see: https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/drugs-vaccines-treatments/vaccines/type-viral-vector.html; For more information on mRNA vaccines see: https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/drugs-vaccines-treatments/vaccines/type-mrna.html.

a total of 16,397 Inuit and non-Inuit living in Nunavut have been fully vaccinated and 21,394 had received one dose (NTI, 2021).

There are still a number of Canadians, including First Nations, Inuit and Métis peoples, who may present as vaccine hesitant for a number of reasons. According to the Strategic Advisory Group of Experts on Immunization Working Group (SAGE WG), vaccine hesitancy is the "delay in acceptance or refusal of vaccination despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It is influenced by factors such as complacency, convenience and confidence" (MacDonald & the SAGE WG, 2015, p.4163). The SAGE WG further nuances the definition of complacency as perceiving the risks associated with vaccine-preventable diseases as too low to seek out a vaccine; lacking convenience in terms of the availability, accessibility and affordability of a vaccine; and lacking confidence related to perceived effectiveness, safety, administration and motivations of policy-makers behind a vaccine (MacDonald & the SAGE WG, 2015).

There has been little formal research done on vaccine hesitancy and confidence amongst Indigenous Peoples. What is known are that historical factors, including medical experimentation and enforced vaccinations, may be contributing to concerns or hesitancy in some Indigenous contexts (Mosby & Swidrovich, 2021). Promoting vaccine confidence is paramount given the potential for differential impacts of COVID-19 on First Nations, Inuit and Métis people due to socio-economic marginalization and health inequities.

Healthcare professionals, service providers, community leaders and allies play an important part in communicating information on complacency, convenience and confidence related to vaccines. When First Nations, Inuit and Métis people express hesitancy around COVID-19 vaccination, this hesitancy must be understood within the context of previous or ongoing negative and culturally-unsafe experiences with healthcare providers or within medical settings (MacDonald et al., 2021), as well as to general apprehension around needles or concerns about potential side effects or the rapid development of a vaccine, such as with COVID-19 (Taddio et al., 2021, Task Group on Healthy Living, 2020).

A starting point for promoting vaccine confidence is the practice of culturally-safe and trauma-informed care.[5] The Indigenous Health Committee of the Royal College for Physicians and Surgeons (2019) clarifies that when working with Indigenous patients, physicians need to demonstrate "culturally safe practices, reflexivity and anti-racism interventions…, including empathy, open-mindedness and understanding of how colonialism deliberately excludes indigeneity, and how the determinants of health contribute to the patient's

health status and fall short in meeting it" (p.2). Richardson and Murphy (2018) note that the concept of trauma-informed care informs the need for healthcare providers to be aware of and sensitive to a person's lived experiences in order to refrain from re-traumatizing them within medical settings and care provision. They state that a trauma-informed approach recognizes, "a person's reactions (such as treatment refusal or mistrust) as a possible result of previous experience or injury, rather than just as sickness or bad behavior" (p.11).

Rather than dismissing or refusing to provide care for Indigenous individuals who express vaccine hesitancy, healthcare providers can work towards building trust with them. This can be done on several fronts. The first essential step is to listen to patients' concerns in a non-judgmental and empathetic way. Health professionals can take the time to validate and address patients' concerns and talk honestly about the perceived and actual risks to themselves and the community at large regarding vaccines and vaccine-preventable diseases (MacDonald et al., 2018). It is important to understand why patients are hesitant and where their fears are coming from, which are commonly rooted in

"historical and contemporary experiences with Canadian settler colonialism" (Mosby & Swidrovich, 2021, p. E382; see also Browne et al, 2016; Driedger et al., 2015). By practicing culturally-safe and trauma-informed care, issues related to trust around vaccine safety and effectiveness, as well as the motivations of policy-makers who determine vaccine roll-outs, can be discussed. Indeed, these measures would assist in unraveling mistrust in the COVID-19 vaccines.

When exploring best practices for promoting vaccine confidence, actions must take place at multiple levels, including the individual, the family, and the community, all the while being attentive to the diversity, local histories, and contemporary contexts among and across First Nations, Inuit and Métis peoples and communities. Browne et al. (2016) identify ten strategies that need to be in place to break down systemic, structural, policy, and service-specific barriers and enhance health equity-oriented care for Indigenous Peoples. Broadly speaking, these strategies promote health equity; support internal organizational structures, policies, and processes; meaningfully include Indigenous Peoples and community members in decision-making processes; ensure that health care settings and interactions are welcoming and that healthcare professionals understand the interconnected structural violences and social determinants of health experienced by Indigenous Peoples; and actively dismantle power imbalances, racism

[5] The term violence-informed care has also been used.

and discrimination when providing care to them. When these strategies are in place, Indigenous patients may feel better welcomed, supported, and respected in their health care interactions, including discussions around vaccines and vaccine uptake.

For more information on understanding the vaccine hesitancy continuum, see: Supporting Vaccine Confidence in First Nations, Inuit and Métis. For more information on how to build vaccine confidence, see: Information and Resources to Build Vaccine Confidence for First Nations, Inuit and Métis People (available in Cree, Ojibway and Inuktitut). For more information and tips to support healthcare providers prepare for conversations and questions about immunizations, see Tips and Conversations with Patients about Vaccinations.

Community-based responses to COVID-19 and vaccination

Reflecting their cultural, linguistic, and geographic diversity, First Nations, Inuit and Métis communities and organizations across Canada have responded to COVID-19 and the COVID-19 vaccination roll-out. As sovereign and self-determining nations, some set up road blocks and checkpoints to manage who was entering their territory; others worked with local health authorities to gain assistance with accessing personal protective equipment, contract tracing and supporting community members who needed to isolate or quarantine from community members; and others ensured culturally and linguistically appropriate public health messaging (Mashford-Pringle et al. 2021; Richardson & Crawford, 2020).

Indigenous organizations across Canada have also creatively developed, promoted and provided resources on vaccine

confidence and roll-out for their populations and members. The examples below include community-centred, innovative, culturally-responsive and multimedia resources, developed and designed by First Nations, Inuit and Métis organizations and leadership. Each of these align with the 2020 recommendations of the Task Group on Healthy Living for the Promotion of Influenza and COVID-19 Immunization in Remote and Isolated First Nations, Inuit and Métis Northern Communities in that they are accessible, context-specific, distinctions-based, clear and concise in their messaging, strength-based, grounded in cultural identity and cultural knowledge, and are evidence based wise practices (p. 2).

- Protect Yourself. Protect our People is a Manitoba-made collaboration by the Assembly of Manitoba Chiefs, the Southern Chiefs' Organization, Manitoba Keewatinowi Okimakanak Inc., Keewatinohk Inniniw Minoayawin Inc., and the First Nations Health and Social Secretariat of Manitoba. This website provides COVID-19 vaccine information, resources, steps to booking an appointment, links to social media and sharing stories about receiving the vaccination, as well as laying out the myths and facts around the COVID-19 vaccine. The evidence-based, culturally-grounded, website helps First Nations feel comfortable and informed about receiving the vaccine, https://protectourpeoplemb.ca/
- The Qikiqtani Inuit Association (QIA) has produced numerous Inuit-specific COVID-19 resources. Representing the Qikiqtani Region of Nunavut, the COVID-19 vaccine information includes infographics, posters, and videos in both Inuktitut and English on the QIA website as well as through social media, https://www.qia.ca/covid-19-initiatives/
- The Métis National Council (MNC) has developed information on why it is important for Métis peoples to receive the COVID-19 vaccine. The resources include video messages from Elders, links to provincial vaccine roll-outs, and information on vaccine safety and how they will protect the well-being of the Métis Nation, Elders, Knowledge Keepers, families and communities, https://www2.metisnation.ca/covid-19-vaccination-information/
- Morning Star Lodge, an Indigenous community-based health research lab based in Saskatchewan, has created a vaccine challenge in addition to other COVID-19 resources, including shareable posters, graphics and information on the COVID-19 vaccines, https://www.indigenoushealthlab.com/vaccine-challenge
- Housed within the Women's College Hospital, the Maad'ooking Mshkiki – Sharing Medicine, https://www.womenscollegehospital.ca/research,-education-and-innovation/maadookiing-mshkiki%E2%80%94sharing-medicine, has produced a series of webinars and posters on First Nations, Inuit and Métis perspectives and knowledge sharing on COVID-19 vaccines.

These culturally-grounded sources of information and materials have been developed to increase First Nations, Inuit and Métis peoples' confidence around the COVID-19 vaccine.

Conclusion

In order to facilitate vaccine confidence, and to protect First Nations, Inuit and Métis peoples, families and communities, barriers related to complacency, convenience and confidence need to be addressed. This includes community-centred and culturally-relevant public health messaging around both the risks and benefits of COVID-19 vaccine, delivered through a culturally safe and trauma-informed approach. This requires that healthcare providers recognize First Nations, Inuit and Métis peoples' history and ongoing experiences with colonialism, anti-Indigenous racism, socio-economic determinants of health, and health inequities (Power et al., 2020, Richardson & Crawford, 2020). As stated by the Inuit Tapiriit Kanatami (2020), "The impacts of past epidemics and our experiences with TB in particular suggest the need for governments to enact long-term prevention measures to ensure that COVID-19 does not persist indefinitely within our communities, even after it is eliminated in most other parts of the country" (p. 5). In other words, the health inequities that continue to be experienced by First Nations, Inuit and Métis peoples need to be immediately addressed.

Finally, in the words of Dr. Funnell:

What is the moral of the story of the COVID-19 the trickster? I think the moral is that this little tiny virus came for a reason - to give mother earth a break but also to illuminate the discrimination racism and inequities in our communities. I want to see a better world after this pandemic for our people where we are respected, where we can live our dreams and be well.

What kind of world do we want after this? We ache to return to some kind of normal to be close to one another. As quoted by Yong (2020), "[n]ormal led to this … [to] a world ever more prone to a pandemic but ever less ready for it" (para. 7). For our people, we have the right to so much more than what we had pre pandemic and our hope is that we don't return to normal but we can return to a better state where we are control in our health and wellness as much as possible.

There is hope, I have hope. Why did this trickster come? What is the story they are trying to tell us? We want and we have the right to something more than we had pre-pandemic.

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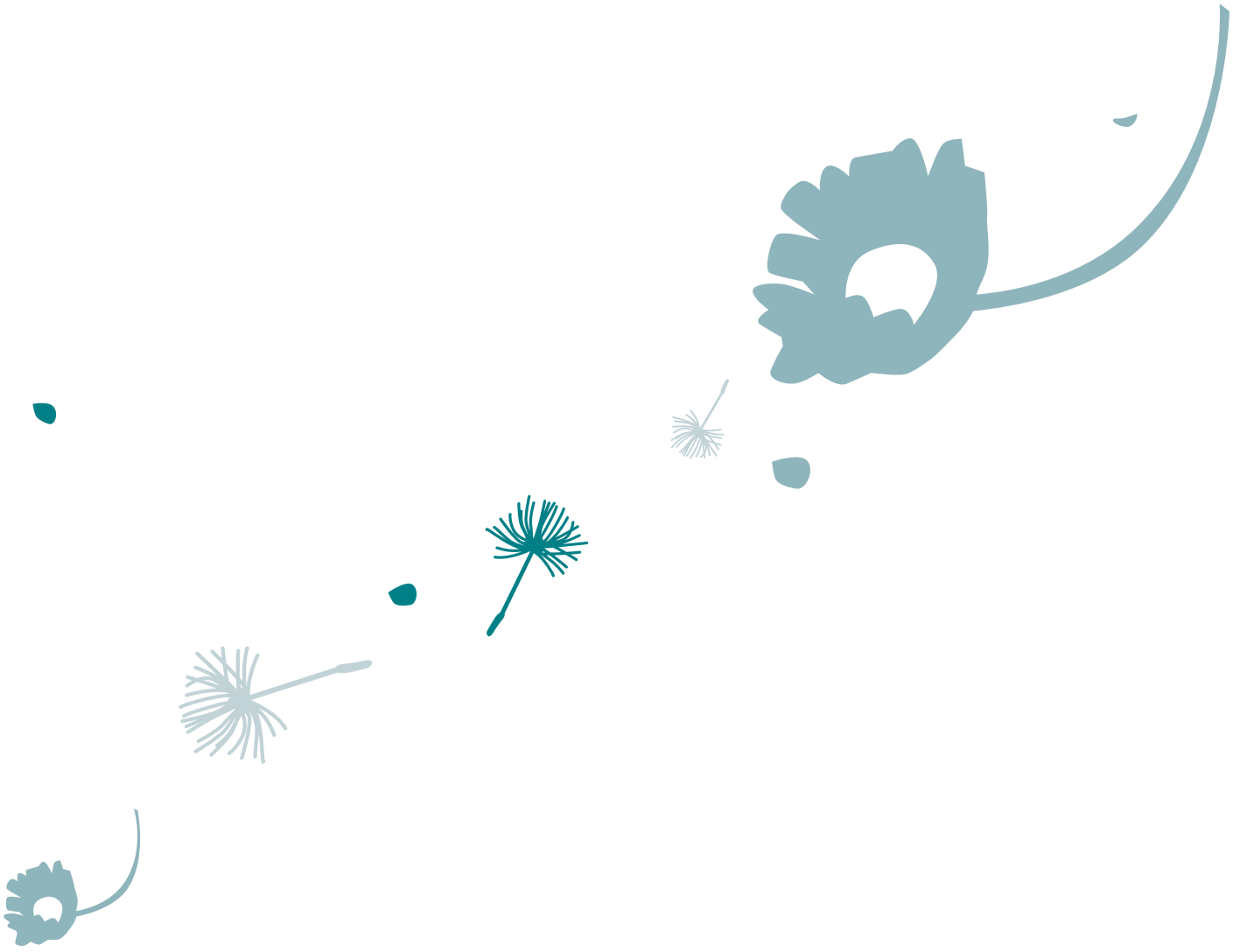

HOW TO USE THIS FACT SHEET

REFLECT

Talk to others in your community, reflect on the content of this fact sheet, and contemplate how you could make a difference in the health and well-being for yourself, your family or your community.

ENGAGE

Find local friendship centers, community organizations or groups where you can volunteer or participate in healthy positive actions. You too can share knowledge and make a difference in the health and well-being of First Nations, Inuit, and Métis Peoples' of Canada.

sharing knowledge · making a difference
partager les connaissances · faire une différence
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