Indigenous Primary Health Care Council

Covid-19 Vaccination

Prioritization and Dissemination

Date: December 7, 2020

The IPHCC has developed the following input for inclusion into the provincial prioritization and dissemination strategies for Covid-19 vaccines.

Indigenous Primary Health Care Council (IPHCC)

As reference, the IPHCC was recently incorporated on November 20, 2019, although it has been operating informally for many years. The IPHCC is made up of members and associates from 28 Indigenous community health care organizations, including Aboriginal Health Access Centres (AHACs), Indigenous Interprofessional Primary Care Teams (IPCTs), Indigenous Community Health Centres and Indigenous Family Health Teams (refer to map for locations throughout Ontario). The sector has been around for thirty plus years, and as a result of ongoing expansion, the IPHCC made a decision to establish ourselves provincially. On behalf of our members, the IPHCC coordinates and advocates for all aspects of health and well-being for the Indigenous population. We operate in locations across Ontario and provide primary health care services to Indigenous people in urban, rural, remote and First Nations settings. As of 2016 estimates, our sector serves 66,000 people annually. We are actively updating these numbers to reflect the impact more accurately we have on the population we serve and have recently recruited a Data Quality Analyst to support this effort.

AHACs and ACHCs are community-governed, primary health care organizations where clients can see a doctor, nurse, or other health professional such as a physiotherapist, dietitian, or mental health counsellor. They provide access to traditional healers, medicine persons, Elders, traditional teachers, and Indigenous counsellors. Our approach is to work together to address the physical, spiritual, emotional, and mental needs of the First Nations, Inuit, and Métis (FNIM) people and communities we serve.

The organizations reduce barriers to care by working with FNIM communities and provincial health systems to optimize federal and provincial health resource capacity. This model of care enables innovative solutions for delivering comprehensive health services focused on improving health outcomes and accelerating Indigenous health gains.

Our approach to wellbeing addresses the underlying causes of poor health including intergenerational trauma, impacts of systemic racism and the stress caused by the daily pressures to assimilate. AHACs and ACHCs help people to reconnect to each other, their families, communities, culture, and languages. They are a liaison and support for FNIM people and communities to help facilitate relationships of respect and dignity with mainstream health care providers. We recognize that inequities in social determinants of health, such as income, education, housing, food security, etc., contribute to poor health outcomes. We provide comprehensive client care, which includes traditional healing to address the social and spiritual determinants of health, health promotion and illness prevention programs, as well as better access to social services.

The IPHCC is also a leader in cultural safety training through our Ontario Indigenous Cultural Safety Approach. The Ontario ICS Approach is focused on supporting Indigenous Health transformation as part of the overall health and social service system transformation. The goal is to improve Indigenous healthcare experiences and outcomes by increasing respect and understanding of the unique history and current realities of Indigenous populations.

IPHCC is not a political organization and we work collaboratively to provide wholistic health care to Indigenous Peoples regardless of what affiliation they have. We are the health care providers who work tirelessly to ensure safe and equitable care daily. As always, we are prepared to respond and act for the best interests of our communities. We do this as professionals with compassion and we acknowledge that we need to work together as system partners to ensure the best possible health outcomes for our patients and clients.

The IPHCC is open to further engagement and welcomes the opportunity to discuss these feedback comments as they apply to the work of the provincial task force on COVID-19 vaccination.

Background

- There has been a lot of planning happening by PHAC on vaccination strategy but very little meaningful engagement of Indigenous leaders and communities
    - Indigenous Services Canada is responsible for planning with respect to Indigenous communities, but focus is on First Nations on-reserve communities.
    - Urban Indigenous are not being considered nor being engaged in meaningful way. This is particularly problematic as the province's urban Indigenous population continues to increase, with approximately 85.5% of Indigenous Peoples living off-reserve in Ontario.
    - COVID-19 hits cities first and people are bringing COVID-19 back to their communities after having visited city for resources.
    - It is important that urban Indigenous Peoples are prioritized in a vaccine dissemination plan.
    - Advocacy needs to present this as an "and/and" situation, so we are also supporting our relatives who live on reserve.

How do we assess Priority?

- how do we assess priority populations?
    - distribution chains – existing supply networks
    - utilizing all available information to assess need
- how do we look at remote access?
    - mortality rates need to be factored into decision points
    - Need to advocate for FN, Inuit and Metis people < 50 years old getting priority for the vaccine.
        - General population, the cut off is typically 65; however, there is evidence around premature aging of FNIM people and Indigenous folks tend to have many comorbidities
        - multiple co-morbidities (high incidences of diabetes, chronic kidney disease, transplant etc.)
    - how do we assess on-reserve needs vs. urban needs - benchmarks we need to put in place that more effectively addresses population need?
        - Homelessness
        - Vicariously housed

    - remember to include health care practitioners in priority populations - it is difficult to promote use widely - if the provider themselves have not taken the vaccine - it helps to promote trust in the rollout process
    - how are urban and rural populations looked at?
    - What about Metis communities?
    - What about Inuit communities?

Alignment with Existing Structures

- aligning with existing community based primary care structures like AHACs - they currently deliver flu clinics and primary care - they already have established trust within communities
    - we are located in urban centres
    - we are located in some on-reserve communities
    - we support surrounding First Nation communities within our catchment areas
    - we support rural communities
    - we support some remote communities
    - we work with Metis patients and clients
    - we work with Inuit patients and clients
- remember location of clinics - need to go to the most vulnerable - bring vaccine to them - do not expect them to go to it
    - this poses challenges for some of the available doses - so need to think strategically where those placements will be throughout the province (the centralized locations)
    - it is important to bring the providers in to support the localized clinics and locations – people need to recognize trusted faces – they need to feel comfortable asking questions

Accessibility

- considerations for weather - and transporting vaccine to remote communities - is it possible to do this in the winter?
    - Depending upon requirements for vaccine
    - winter breakup and freeze up - add further complications and logistics until the ice roads go for some locations
- may have to use existing structures such as medical travel via non-insured health benefits program – bringing community members out of the community and having them vaccinated at central locations
    - Weeneebayko Area Health Authority – operates a medical transportation charter
        - Major referral sources are Kingston and Timmins
    - Sioux Lookout First Nation Health Authority
        - Supports medical travel
        - They operate a medical hostel in Sioux Lookout
    - These existing structures offer solutions to build off of for remote access communities
- central locations for the north can include the following considerations:
    - Timmins
    - Kingston
    - Sudbury
    - Sault Ste. Marie
    - Thunder Bay
    - Sioux Lookout

    - Red Lake
    - Kenora
- Consider other methods of dissemination
    - Pop up clinics
    - Within existing primary care offices
    - Within community health centres
    - Via mobile units (Anishnawbe Health Toronto and Wabano Health in Ottawa)

Public Health Messaging

- there is a need to appropriately align public health messaging - needs to be done in collaboration with Indigenous communities - this is not effectively happening right now
    - why is it important to get the vaccine?
    - is it safe?
    - dispelling any myths about it
    - addressing fear
    - what happens if there are side effects
    - language translation - especially for elders
        - ensuring we have language to explain what is happening
        - this is especially important for remote access communities
            - Cree dialect translations (in James and Hudson Bay region)
            - Oji-Cree (in Sioux Lookout region)
    - literacy considerations (plain language)
    - how do we respectfully respond to residential school effects – the target groups will include those firsthand survivors
        - there was a point in history when medical experiments were done on students (some of those included immunization)
        - fear is massive in this population
- we also need to balance military presence – military is seen as an authority (similar to RCMP with residential schools and sixties scoop) – and this elicits fear in some communities
    - authoritative structures get communities guard up – they are viewed as outsiders
    - this is aligned to the "Indian Agent" coming into the community and removing children – and communities did not have any control or power over this circumstance
    - power and control – needs to be balanced – they need to feel like they are part of the process and this process is not being posed on them
- aligning messaging with Traditional Healers is also advantageous – they are a source of information and education
    - some communities and individuals rely on traditional medicines to avoid the flu
    - flu vaccine uptake is traditionally quite low in First Nation communities (so it is important to align all available and trusted messaging and disseminate to those in positions of trust)
- messaging needs to be inclusive of all primary health care providers (integrated teams so that the message is consistent and reinforced)
    - validated by several sources of truth

Racism and Discrimination

- racism in the system - how this will not be tolerated - how do we create checks and balances in the system to ensure inclusion
    - how do we address unconscious bias?
- how do we report occurrences?
- What is the accountability?
- How do we ensure that we set up systems that do not perpetuate inequities?

Jurisdictional Alignment

- federal and provincial (on and off reserve) - different public health jurisdictions - these systems need to talk to each other - to ensure effective coordination
    - federal band health services
    - provincial based health services
    - PHUs
    - what roles do each of these players have? these systems need to talk to one another
    - communication is key (must be open and transparent) with each other and the communities

Data Collection Systems

- data collection systems - race based data - support to collect this information - establishing structures to support this - this is more than just adding a few self-identification questions
    - educate the public about the importance of self-identification
        - identify reasons why it is important to self-identify
    - educate front line providers on how to ask the questions and educate them on why it is necessary and important
        - they need to display a comfort in addressing questions - providing them an understanding of the importance of this type of information
    - have checks and balances in place to address discrimination and racism (who, where do people report issues or concerns with service provided)
    - cultural safety training - understanding biases ahead of time
- ensuring we have systems in place that support data ownership
    - Indigenous communities need to understand the data and the need for potential responses if required
- We need to continue building infrastructure in Indigenous communities to collect valuable health data
    - We cannot solely rely on cross referencing the Indian Status Verification System to IC-ES databases
    - This method only shows a piece of the story – it does not effectively explain what is happening in urban communities
    - It does not adequately account for Indigenous specific indicators

Infrastructure Requirements

- do we have appropriate infrastructure supports in place to address those who do not get the vaccine?
    - testing and assessment sites
    - primary care access
    - hospital access
    - case management support and integrated care

    - traditional healing supports
    - home and community care etc.
- Need to consider front-line service providers as well who do not have 20 years of IPAC experience with donning and doffing PPE, or when appropriate to wear (or even access to PPE that physicians and nurses have).
    - These workers, once safely vaccinated, can support vaccination roll-out for urban Indigenous community.

Equity and Inclusion

- ensure that the doses allocated within the Indigenous population - stay within the Indigenous population
    - disseminate among the communities - based on a buy-in process (not forced to participate)
- the Indigenous communities are very diverse, and the dissemination strategy must also be diverse
- Need to highlight importance of vaccinations for urban Indigenous population … present this as "FN communities AND urban Indigenous"
    - We need to recognize that many First Nation people travel external to their communities – come to urban centres and bring back the virus with them
    - This is why it is important to not exclude the urban populations
- Need for Indigenous primary care providers and other Indigenous service providers to be central to the vaccination strategy
    - They understand grassroots challenges
    - They are trusted and known
    - They understand what is means to approach services differently (thinking outside of the box) – strategies for inclusion
    - They understand current dissemination points
    - They are aware of community hotspots
    - They are used to working within jurisdictional restrictions and designing responses that are more inclusive

Key Contacts:

Caroline Lidstone-Jones
CEO, IPHCC
clidstone-jones@iphcc.ca
647-991-2139 (cell)

Nicole Blackman
Director, IPHCC
nblackman@iphcc.ca