Propelled by the Pandemic: Responses and Shifts in Primary Healthcare Models for Indigenous Peoples

Propulsé par la pandémie : réponses et changements dans les modèles de soins de santé primaires pour les peuples autochtones

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Abstract

The COVID-19 pandemic posed a significant risk to the health and well-being of First Nations and Métis communities in Alberta. Communities' self-determined and integrated responses with embedded cultural supports – in collaboration with governments, organizations and providers – were key to minimizing morbidity and mortality. Maintaining and building these relationships in the continued pandemic response, broadening approaches to healthcare delivery and continuing to include culture will support attainment of the Indigenous primary healthcare model while addressing logistical challenges in transforming and sustaining healthcare systems in the background of ongoing inequities in the social determinants of health.

Résumé

La pandémie de la COVID-19 a posé un risque important pour la santé et le bien-être des communautés des Premières Nations et des Métis en Alberta. La réaction autodéterminée et intégrée des communautés avec le soutien culturel intégré – en collaboration avec les gouvernements, les organisations et les prestataires – a été essentielle pour minimiser la morbidité et la mortalité. L'établissement et le maintien de ces relations dans la réaction face à la pandémie, l'élargissement des approches pour la prestation des soins de santé et l'inclusion des éléments culturels permettront d'atteindre un modèle autochtone en matière de soins de santé primaires, tout en relevant les défis logistiques liés à la transformation et au maintien des systèmes de santé dans le contexte des inégalités qui persistent dans les déterminants sociaux de la santé.

Introduction

The statement in the final report of the Truth and Reconciliation Commission of Canada (2015), "Best practices for Aboriginal wellness involve a range of service from mainstream health care to traditional practices and medicines, all under community leadership and control" (p. 163), speaks to a broader consideration of what the scope of primary healthcare should be in Indigenous communities, with Indigenous culture and self-determination being focal in changing the narrative of existing health outcomes. Indeed, Harfield and colleagues' (2018) systematic review of characteristics of successful Indigenous primary healthcare service delivery models highlights the centrality of culture to these systems while also promoting accessibility, community participation, continuous quality improvement, a culturally skilled workforce and flexible and holistic approaches to health with self-determination and empowerment. These aspects have been consistently demonstrated through the COVID-19 pandemic response in two Indigenous communities in Alberta, which we share here as evidence of emerging systems transformation and as an anchor for primary healthcare delivery and policy through the ongoing pandemic recovery phase.

COVID-19 Pandemic Response in Indigenous Communities in Alberta

As of July 14, 2021, Alberta First Nations communities had 8,961 confirmed cases of COVID-19 infection, accounting for 27.5% of all on-reserve cases in Canada (Government of Canada 2021) despite representing just 14% of the total population (Statistics Canada 2017). At that time, there had been 166 deaths in both on- and off-reserve First Nations residents, accounting for 7.2% of COVID-19–related deaths in Alberta (AFNIGC 2021). Case and mortality data for the Alberta Métis and Inuit populations are not known. As expected through the experience of other modern-day public health crises, additional strains occur in under-resourced communities facing structural racism, inequities in physical environments and poor access to quality health services. Management of past infectious pandemics, such as the H1N1 influenza pandemic, was fraught with inadequate surveillance and delayed provision of necessary supplies and healthcare worker supports to Indigenous communities, and characterized as having poor federal government leadership, communication and coordination (National Collaborating Centre for Aboriginal Health 2016). Fragmented or "siloed" healthcare and social care systems are exposed when challenged with adapting to crises that require an urgent and collaborative response (International Foundation for Integrated Care 2020; Montesanti et al. 2022; Valentijn et al. 2013).

However, with the COVID-19 pandemic, the sovereignty, leadership and knowledge of Indigenous communities proved to be an essential foundation for the public health response. Supported by respectful relationships and coordinated efforts between federal, provincial and on-reserve governments that have developed over the many recent public health crises (the 2013 floods in southern Alberta, the 2016 wildfires in northern Alberta and the opioid epidemic), we observed an innovative and creative mobilization of resources beyond health services alone in a self-determined response in two communities. A focus on maintaining cultural approaches and activities to support wellness was equally critical to the response, supporting community members and leaders in the uncertainty of the overwhelming situation with ongoing inequities through the social determinants of health.

How Did Indigenous Communities in Alberta Mobilize to Facilitate the First Phase of the COVID-19 Pandemic Response?

The Siksika Nation includes approximately 7,000 Blackfoot members and is located one hour southeast of Calgary. Siksika is an example of a First Nations community that has developed robust governance emergency response systems (Montesanti et al. 2019) and was able to swiftly mobilize health supports throughout the Nation to maintain critical operations. Health services leadership rapidly assembled a response team consisting of representatives from health, education, band council and both federal and provincial government agencies. Public health experts were engaged to develop protocols and processes for testing – including the mobile COVID-19 Response Unit and drive-through testing sites – obtain personal protective equipment and establish infection prevention and control

procedures within the Nation's facilities and congregate living sites. Communication was effective with call lines for COVID-19 concerns, including Blackfoot translation services and the COVID-19 "chatbot" providing information via social media. A taskforce specifically ensured that the Nation's Elders and persons with disabilities could access information and resources. Strengthened relationships between Alberta First Nations communities and Indigenous Services Canada, which respected Indigenous self-determination, facilitated the pandemic response. A structural change two years ago to dissolve Indigenous and Northern Affairs Canada and transfer the First Nations and Inuit Health Branch from Health Canada to form Indigenous Services Canada streamlined points of contact for the health centres and the bands. Communication directly with the Regional Office representatives through video conferencing, bulletins and individual discussions facilitated information sharing and rapid identification of community needs that could be supported, such as housing for those requiring isolation. Federally employed public health providers utilized centralized computerized contact tracing in real time, and public health officials liaised directly with primary care providers both on reserve and in surrounding communities. Thus, the federal resources were directed to what the communities requested, and were accessible. While the mechanistic public health and health system responses support aspects of diagnosis, treatment and transmission prevention, culture supports mental, spiritual and emotional wellness while coping with pandemic restrictions and losses. As pandemic responses commenced in Siksika, their Nation's Elders were a source of support and strength, providing guidance to health leadership. Sharing and service to community were evident, with volunteers and redeployed staff delivering food hampers to Elders and isolated Nation members.

The Métis Nation of Alberta represents the interests of approximately 47,000 Métis peoples province wide; it does not receive direct supports from Indigenous Services Canada, and its citizenship accesses health services through the provincial health authority. Thus, rather than needing to mobilize direct health supports, the organization initiated its own community-based response by distributing financial support through the provincial office, with regional offices tailoring supports to local realities. A robust communication strategy included translation of COVID-19 information into Michif and Cree and distribution of resources in both written and oral formats. The youth of the Métis Nation of Alberta developed online programming and assembled mail-out kits that included cultural activities, mental health resources and traditional medicinal plant guides. Educational programs could be continued through the distribution of donated technology via the Rupertsland Institute (https://www.rupertsland.org/). Métis Nation's citizens volunteered to teach cultural traditions such as beading, dancing and music through online sessions. Elders shared stories that were recorded for online viewing. Ceremonies and celebrations such as the annual Métis Fest were adapted to the online platform.

These two leading examples demonstrate an integrated response in supporting determinants of health for Indigenous communities throughout the pandemic. Public health

measures and pivoting health services were not the sole focus; the health directorates also ensured access to education, housing, financial and cultural supports. This approach should be upheld within the primary healthcare system during pandemic recovery.

What Are the Anticipated Indigenous Primary Healthcare Needs in the Post-Pandemic Recovery Phase?

Health systems are beginning to contemplate the needs for the pandemic recovery period. Healthcare utilization patterns rapidly changed throughout primary healthcare domains, with physical distancing protocols, redeployment of service providers and the redirection of health infrastructure to support the COVID-19 response particularly impacting ambulatory care services provided through primary healthcare and public health. There will now be a need to address health concerns that were deferred. As a reflection of the historic difficulties in access to high-quality primary healthcare leading to deferral of care (Blanchard et al. 2003; Browne et al. 2011), Indigenous populations, especially in the north of the province, rely on emergency departments as the entry point to the health system (Dell et al. 2016; Ospina et al. 2016). Thus, the 50% decline in emergency department use seen in the total population (CIHI 2020) likely has had substantial impacts on Indigenous people's access to healthcare services. Services including preventive initiatives, such as vaccination programs, were placed on hold to redistribute the available workforce to support COVID-19 testing and contact tracing and will need to catch up. Many patients require reassessment of chronic medical conditions and diagnosis and management of new acute concerns, including new mental health threats. It will be necessary for health surveillance teams to monitor and report on excess deaths and consequences of later disease presentation. This will require that the issue of Indigenous identification in health data be addressed (Carroll et al. 2021). Most jurisdictions do not have the appropriate processes needed to safeguard the ownership and stewardship of Indigenous persons' identifiers, limiting the availability of Indigenous-specific data needed to inform an evidence-based response (Smylie and Firestone 2015).

How Can Indigenous Primary Healthcare Models Enacted during the Pandemic Be Sustained to Respond to These Needs?

Sharing examples of sustainable innovations in Indigenous primary healthcare is a first step toward inspiring change in policy and service delivery (Henderson et al. 2018). Successful approaches for Indigenous primary healthcare during a public health crisis must be anchored in the principles of self-determination for Indigenous peoples as articulated in the 2007 United Nations Declaration on the Rights of Indigenous People (United Nations 2007). The demonstrations of self-determined actions in the examples illustrated – which prioritized culture and collaboration in integrated responses across determinants of health during the COVID-19 pandemic – were instrumental to healing and promoting health for Indigenous communities.

Human resources in healthcare will be needed to respond to the anticipated healthcare needs listed earlier, and thus the post-pandemic recovery phase presents an opportunity for community-based employment. The training of Indigenous health practitioners will help reduce the reliance on out-of-community health practitioners providing services to Indigenous communities and, more importantly, address surge workforce planning in Indigenous and rural communities in anticipation of future outbreaks of COVID-19 and the associated mental health and social impacts. While some may say virtual healthcare – which has rapidly been established as a critical activity to maintain health services while minimizing in-person contact where appropriate – may fill these gaps, there are anticipated limitations. There are logistical factors to resolve, such as how communication portals can be put in place for all Indigenous community residents, especially if in a location with tenuous telecommunication service (Graves et al. 2021) or with limited accessibility related to income. We must also consider how virtual care will impact patient experience (Donelan et al. 2019) as limited evidence on acceptability of telemedicine by Indigenous patients is available (Roberts et al. 2015). Relationship building and engaging culture as a facilitator to care is a critical element of care delivery in Indigenous communities and with Indigenous patients (Crowshoe et al. 2019). There is a risk that shifting to remote provider models alone will result in reduced provider knowledge of a community's culture, making it difficult to utilize this care facilitator in practice.

Conclusion

Enactment of the principle of primary healthcare in self-determined service delivery and the incorporation of Indigenous culture have facilitated a strong COVID-19 response in diverse Indigenous communities. This provides policy direction for health service delivery recovery in the post-pandemic period, with ongoing collaboration between providers and ensured cultural safety for patients in the delivery of sustainable, effective and acceptable Indigenous primary healthcare.

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