



RESEARCH BRIEF

**EQUITY CONCERNS IN THE
CONTEXT OF COVID-19**

A FOCUS ON FIRST NATIONS, INUIT, AND MÉTIS
COMMUNITIES IN CANADA

Canadian Child Welfare Research Portal

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Introduction

COVID-19 and the quarantine measures put in place to stop its spread have had a devastating and far-reaching impact around the world. Since it was first detected, the virus has infected and killed people from all backgrounds, prompting some to refer to it as “the great equalizer” (Evelyn, 2020). Yet, similar to previous pandemics, the effects of this disease and related containment strategies magnify inequities, exerting a disproportionate impact on disadvantaged groups such as Indigenous peoples¹, visible minorities, and people of lower socioeconomic status (DeBruin et al., 2012; La Ruche et al., 2009; Uscher-Pines et al., 2007). Inequity predisposes people to the pre-existing conditions that are co-morbid with the worst cases of COVID-19 and prevents the timeliness and quality of pandemic response. While this research brief addresses the broad inequities exacerbated by COVID-19, it focuses more specifically on their potential impact on First Nations, Métis and Inuit peoples and communities in Canada², recognizing that current realities are shaped by racial discrimination and the ongoing legacy of colonialism. In this sheet we explore health inequities underlying COVID-19’s spread, the uneven socioeconomic burden it places on communities, and the need to adequately prepare and respond using a social justice lens.

I. Health Inequities

A. Evidence of Current and Historical Health Inequities

Health inequities refer to the systematic differences in health resources and outcomes for specific populations that are driven by the unequal social conditions they are born into, and live in later in life (Marmot & Bell, 2012; Marmot, 2020; WHO, 2017). Over the past 30 years, research in the field has consistently shown “a marked social gradient, with higher levels of disadvantage being associated with worse health outcomes” (Marmot & Bell, 2012, p. S5). This relationship is so strong that the health of a population can be seen as a reflection of “how well a society is meeting the needs of its members” (Marmot, 2020, p. 1414). The public health crisis sparked by COVID-19 exposes the cracks in each country’s health and social systems – laying bare the health inequities that existed prior to its spread.

For instance, early COVID-19 data from outside Canada reveals stark health inequities in the mortality rates among infected individuals. As of April 10, 2020, approximately 70% of people who died of COVID-19 in Louisiana, Chicago, and Milwaukee county were of African American descent, even though they represent 32%, 29%, and 26% of the population in these respective areas (Louisiana Department of Health, 2020; Milwaukee County, 2020, Ramos & Zamudio, 2020). On June 10, 2020, data from 43 states indicated that black Americans were around 2.3 times more likely to die from COVID-19 compared to Asian, Latino, and White populations (APM Research Lab, 2020). Rates for Native Americans in the USA are also climbing. In the Navajo Nation, which spans Arizona, Utah, and New Mexico, there were 6,110 positive cases of COVID-19 as of June 9, 2020 (Becenti, 2020) – representing the highest infection rate in the country (New York Times, 2020). At that date, the death toll of 277 (Becenti, 2020) was higher than in eleven US states (New York Times, 2020). In the United Kingdom, a report on the first 2,249 patients

¹ In this paper, we use the term “Indigenous” to refer to First Nations, Métis, and Inuit populations in Canada. Given the significant diversity within and across Indigenous populations, disaggregated information will be presented whenever possible.

² We recognize that other factors including - but not limited to - socioeconomic status, gender, sexual orientation, disability, and ethnicity all further influence experiences of discrimination and health inequity. However, given space constraints, we will not be able to delve into these intersectional realities further in this Research Brief.

admitted to hospitals with COVID-19 found that visible minorities represented 35% of the cases, even though they only account for 13% of the population (ICNARC, 2020). The rate of death among British black populations during the first month of the pandemic was found to be 4.2 times higher than that of white populations (Office for National Statistics, 2020).

In Canada, information on the race/ethnicity of people who are hospitalized with or died from complications of COVID-19 has yet to be released. As of July 15 2020, there were 351 positive cases and 6 deaths on First Nations reserves (Indigenous Services Canada, 2020a). This does not account for First Nations off-reserve or Métis and Inuit populations. Importantly, data from previous pandemics in Canada show significant and persistent disparities in the health outcomes of different groups. For instance, during the first wave of the 2009 H1N1 pandemic, Indigenous populations, who represent four percent of Canada's general population, accounted for 27.8% of hospital patients, 21.9% of ICU admissions, and 17.6 % of deaths in provinces that reported Indigenous status (Helferty et al., 2010; Kelly-Scott & Smith, 2015). More specifically, during the first wave of the disease, Inuit, First Nations, and Métis people were respectively 63.8, 9.3, and 1.6 times more likely to be hospitalized compared to non-Indigenous people³ (Helferty et al., 2010; Kelly-Scott & Smith, 2015). A study conducted by Janjua and colleagues (2012) in British Columbia found that the rate of transmission of H1N1 amongst First Nations on-reserve was higher than that of First Nations living off-reserve.

Similarly, during the 1918-1919 influenza pandemic, despite potential underreporting linked to a lack of available data, the mortality rate for Indigenous populations was found to be five times higher than the rate in the general population – with the highest recorded mortality rates (reaching up to 78.7%) found in isolated Inuit communities in Labrador (Mamelund, 2011). In British Columbia, First Nations were over seven times more at risk of dying of the 1918-1919 flu compared to non-Indigenous populations, and in some First Nations communities two thirds of elders over 65 died of the disease (Kelm, 1999). Further, a comparison of three predominantly Cree and Métis trading communities in what was formerly known as Keewatin district in present-day Manitoba, all had different mortality rates, which were shaped by the populations' social organization and response to the pandemic (Sattenspiel & Herring, 1998).

The mortality rates of these pandemics are a stark reminder of the destruction brought by the smallpox epidemic in Indigenous communities upon the arrival of European settlers (Kelm, 1999). The disproportionate burden of previous influenza pandemics on Indigenous peoples highlights the urgent need to take action to mitigate the spread of COVID-19 within communities as quickly and as effectively as possible. Importantly, differences in health outcomes between First Nations, Inuit, and Métis individuals listed above show that an effective response strategy will involve recognizing, measuring, and adapting to each community's needs and realities.

B. Conceptual Framework Informing the Analysis

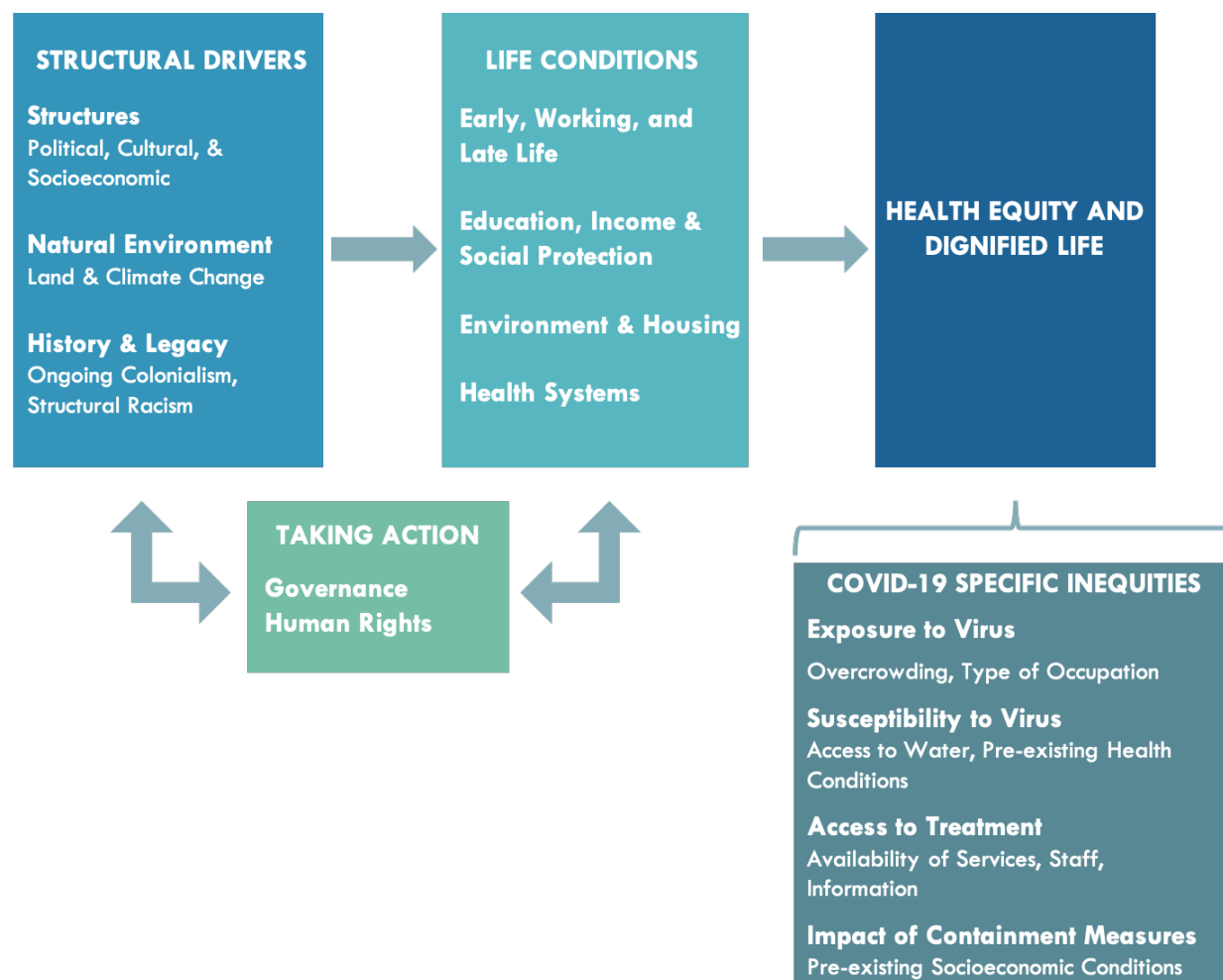
In order to better understand the presence of disparate health outcomes, many scholars have underlined the importance of recognizing how broader, structural factors, such as political and socioeconomic structures, as well as the ongoing legacy of colonialism and racism impact living conditions across the life course and ultimately shape experiences of wellbeing (FNIGC, 2012; PAHO, 2019; PHAC, 2018). Blumenshine and colleagues (2008) developed a conceptual model that describes more specifically how different life conditions can shape health outcomes during a pandemic influenza outbreak, such as COVID-19, by influencing: (1) the likelihood of being exposed to the virus, (2) the likelihood of contracting the virus once exposed, and (3) the likelihood of receiving effective treatment after the disease has developed (Blumenshine et al., 2008, p. 10).

³ Calculated using Disparity Index measurements (see Shaw, Putnam-Hornstein, Magruder, & Needell, 2008).

Figure 1 below presents the conceptual framework developed by PAHO (2019), which retraces the impact of structural drivers and life conditions on health (in)equity and the ability to live a dignified life. We have included specific COVID-19 considerations from Blumenshine et al.'s (2008) model that reflect pathways to inequities that are exacerbated in the context of pandemics.

Figure 1.

Conceptual Framework of Factors Driving Inequities in a Pandemic (PAHO, 2019; Blumenshine et al., 2008)



C. Risk Factors Associated with Disparities in Exposure to, Susceptibility to, and Treatment of COVID-19

a. Heightened Exposure to Virus

The transmission of COVID-19 has been shown to take place directly, through close contact with a person who is infected, or indirectly, through contact with infected surfaces (Government of Canada, 2020). There is an increased risk of exposure to viruses in situations of crowding and prolonged contact with individuals (Blumenshine et al., 2008; Quinn et al., 2011).

According to the 2016 Census, one quarter of the First Nations population and 40% of the Inuit population lived in housing that was overcrowded in Canada, compared to 4.9% of the general population (Statistics Canada, 2017a). During the H1N1 pandemic, overcrowded housing was associated with higher

rates of transmission within First Nations reserves (Janjua et al., 2012), as well as in Northern and remote communities (Mostaço-Guidolin et al., 2012). Overcrowding in these regions has been linked to socioeconomic difficulties and the consistent lack of available housing and government funding for housing construction (Ruiz-Castell et al., 2015; WHO, 2018). Similarly, for urban Indigenous populations, a lack of available and affordable housing - coupled with experiences of discrimination - has been associated with high rates of homelessness, a situation that also greatly heightens the risk of contracting COVID-19 by rendering social-isolation impossible (Reading & Wien, 2009).

In parallel, First Nations individuals have been shown to disproportionately work in certain occupations that require them to remain in contact with others despite the pandemic. For instance, 2016 Census data shows that First Nations workers are proportionally more likely to work as social workers or in a front-line protection job such as police officer or firefighter compared to non-Indigenous workers (Statistics Canada, 2018a). This puts workers at increased risk of contracting the disease and transmitting it to their families and communities. The risk is compounded by the fact that many essential workers might need to put their children in childcare settings where transmission rates are high (Blumenshine et al., 2008).

b. Heightened Susceptibility to Contraction of and Development of Complications Related to COVID-19

Exposure to COVID-19 itself does not automatically lead to contracting the virus. For example, if someone touches a contaminated surface, they can reduce the likelihood of contracting the virus by washing their hands regularly (Government of Canada, 2020). Unfortunately, even though access to safe water is a fundamental human right, water supply to many First Nations reserves is “contaminated, hard to access, or at risk due to faulty treatment systems” (Human Rights Watch, 2016, n.p.). The Office of the Parliamentary Budget Officer (2017) estimates that 28% of homes on First Nations reserves do not have piped water with 1.5% of them having no access to water at all. Similarly, most Inuit communities in Northern regions of Canada do not have access to piped water and rely mainly on trucked water systems, which make them particularly vulnerable to water shortages and poor water quality (Daley, Castleden, Jamieson, Furgal, & Ell, 2014). Inequitable access to water in Indigenous communities has been tied back to colonial settler’s excessive use of draining and farming, which contributed to destroying the quality of natural water sources (Gasteyer & Flora, 2000). It is important to note that access to water is also a concern for urban Indigenous populations living in homelessness, given the scarcity of running water in public spaces (Bui, 2020). Lack of safe water increases the likelihood of contracting the virus by impacting First Nations and Inuit peoples’ ability to follow public health guidelines that can help protect them from COVID-19.

Symptoms of COVID-19 range from mild conditions to the development of severe respiratory deficiencies that can lead to death. According to the Centres for Disease Control and Prevention (CDC), the likelihood of developing severe complications after contracting COVID-19 is increased for older populations, people with chronic lung disease, people who have serious heart conditions, as well as those with obesity and diabetes amongst others (CDC, 2020). On average, First Nations, Métis and Inuit communities are younger than non-Indigenous populations (Statistics Canada, 2017b), which protects against developing complications related to COVID-19. However, the death of Elders has a significant impact on the cultural perpetuity of First Nations, Metis, and Inuit given that Elders are the keeper of the traditions in these Nations and colonialism strategically targets cultural knowledge and security. Moreover, data show that the prevalence of comorbid diseases is particularly high among First Nations, Métis, and Inuit communities as shown in Table 1 below.

Table 1.

Differences in Prevalence Rates of Underlying Conditions Associated with COVID-19 Complications

Underlying conditions associated with COVID-19 complications	Difference in prevalence rates of diseases in different Indigenous communities compared to non-Indigenous adults in Canada
Lung diseases	Asthma <ul style="list-style-type: none"> • 1.6 times higher among First Nations off-reserve and Métis (PHAC, 2018) • 1.2 times higher among First Nations on-reserve (FNIGC, 2018a; PHAC, 2018)
	Tuberculosis <ul style="list-style-type: none"> • 24 times higher among First Nations off-reserve (Vachon et al., 2018) • 56 times higher among First Nations on-reserve (Vachon et al., 2018) • 300 times higher among Inuit populations (PHAC, 2018)
Heart problems	<ul style="list-style-type: none"> • 1.8 times higher among First Nations off-reserve and Métis (Garner, Carrière, Sanmartin & LHAD Research Team, 2010) • 1.6 times higher among Inuit populations (Garner, Carrière, Sanmartin, & LHAD Research Team, 2010)
Type 2 Diabetes	<ul style="list-style-type: none"> • 1.9 times higher among First Nations living off-reserve (PHAC, 2018) • 1.5 times higher among Métis adults (PHAC, 2018)
Obesity	<ul style="list-style-type: none"> • 1.6 times higher for First Nations off-reserve and Inuit adults (PHAC, 2018) • 2.2 times higher for First Nations living on-reserve (FNIGC, 2012; PHAC, 2018)

The increased prevalence of such diseases must also be understood within the context of colonialism and its ongoing legacy on Indigenous communities. The high rate of respiratory conditions among First Nations and Inuit populations – including asthma and tuberculosis – has been linked to exceptionally poor housing conditions (Kovesi, 2012; PHAC, 2018). For instance, many homes on First Nations reserves and Inuit communities lack adequate indoor ventilation, which can contribute to severe mould contamination and the proliferation of other indoor air pollutants (Larcombe et al., 2011; Minich et al., 2011; Lawrence & Martin, 2001). In 2015-2016, approximately 40% of First Nations peoples living on-reserve reported having mould or mildew in their houses in the previous year (FNIGC, 2018a). Ultimately, poor living conditions have been tied back to the forced displacement of First Nations and Inuit populations into permanent and inadequately built settlements coupled with a continuing lack of government funds for repairs on reserves and in Northern communities (Kelm, 1999; Penney & Johnson-Castle, 2020).

Furthermore, the disproportionate presence of heart disease, obesity, and type 2 diabetes among First Nations, Inuit, and Métis peoples is associated with changes in diets brought by their forced displacement and the repurposing of land resources (PHAC, 2018; Ramraj et al., 2016). Namely, imposed land boundaries and the destruction of natural habitats through urbanization, pollution, and industrialized farming have considerably decreased the diversity of food accessible to Indigenous communities over the years (PHAC, 2018). This has inhibited the ability of communities to harvest traditional foods and transmit this knowledge across generations whilst increasing reliance on highly processed, store-bought foods (AFN, 2007; Laurie et al., 2019; Kelm, 1998; Kuhnlein & Receveur, 1996). In more remote communities, many families cannot afford nutritious food due to its high price, which has been found to be up to three times the national average in certain regions such as Nunavut (Nunavut Bureau of Statistics, 2016; Reading & Wien, 2009). For instance, a report on the Inuit village of Kugaaruk showed that food costs amounted to 91% of most families' budgets after paying for rent, with 83% of households indicating that they could not afford healthy meals (Lawn & Harvey, 2003).

These dietary changes occurred in conjunction with Indigenous peoples' experiences of trauma, unemployment, and social exclusion over time. Canada's history of genocide, Indian Residential Schools, the Sixties Scoop, and continued systemic discrimination and oppression contribute to toxic stress for Indigenous peoples that can further influence the development of diseases and compromise their immunity (Iwasaki et al., 2004; PHAC, 2018).

c. Disparities in Treatment

Timely access to effective treatments also shapes health inequities. While there is currently no established cure for COVID-19, infected people are still presenting at health care centres and receiving medical care to help manage their symptoms. First Nations, Inuit, and Métis populations face significant barriers in accessing healthcare. For instance, in 2016, approximately one in ten First Nations adults living on-reserve or in Northern territories reported they did not receive care for their required healthcare needs in the last year (FNIGC, 2018b).

Barriers to receiving healthcare for Indigenous communities are numerous. A survey of First Nations living on-reserve found that these included a lack of available medical personnel, the scarcity of culturally appropriate services, and long wait times (FNIGC, 2018b). The shortage of medical personnel also greatly impacts isolated Inuit communities – who are often hard to reach because of the absence of adequate transportation infrastructure and difficult weather conditions – resulting in high staff turnover (NCCIH, 2019). In 2017-18, in Nunavut and the Northwest Territories, only 14% and 40% of the population respectively had a regular healthcare provider, against 84% in the general population (CIHI, n.d.). The lack of services and qualified staff in remote First Nations and Inuit communities and the prohibitively expensive travel to urban settings to access healthcare facilities create critical delays in care that can have grave medical consequences (King et al., 2018; NCCIH, 2019; Oosterveer & Young, 2015; Penney & Johnson-Castle, 2020).

This is compounded by a dearth of communication in the specific first language of different communities across Canada (Webster, 2018), which hampers access to life-saving information, especially in the midst of a pandemic. First Nations, Inuit, and Métis populations additionally experience significant gaps in services as a result of fragmented and ambiguous health coverage across provincial and federal divides (Lavoie, 2018; Horrill et al., 2018; NCCIH, 2019). In Canada, health insurance for First Nations individuals with status and Inuit peoples is covered through the Non-Insured Health Benefits (NIHB). This program has been criticized for its complicated and shifting approval processes, as well as its exclusion of Métis, non-status First Nations, and certain off-reserve populations (Allan & Smylie, 2015), which further increases inequities in access to healthcare within Indigenous populations.

Researchers have also underlined the influence of power differentials affecting healthcare-seeking behaviour (Horrill et al., 2018). Namely, negative past interactions with healthcare providers in the form of racism, stigmatization, and intimidation have been shown to create a sentiment of distrust and fear that reduces the propensity of First Nations, Métis, and Inuit people to seek care and denies them the right to receive the quality of care they deserve (Browne et al., 2011; Cameron et al., 2014; NCCIH, 2019). This distrust in institutions is rooted in continual traumas and disregard for Indigenous rights to self-determination and self-governance, coupled with systemic over-surveillance (Allan & Smylie, 2015; Horrill et al., 2018; NCCIH, 2019). For example, narratives from the 1918-1919 influenza highlight that access to non-Indigenous medicine, then proclaimed to be the best form of treatment (and later proven to be ineffective in treating influenza) was often denied or delayed for First Nations peoples (Kelm, 1999). During this time, many First Nations in British Columbia used traditional medicines instead - such as devil's club, sage, and water hemlock – to alleviate some of the symptoms they were experiencing (Kelm, 1999).

II. Socio-economic disruption

A. Economic Impact

The impact of COVID-19 extends far beyond health-related concerns. The negative secondary economic impacts will affect all segments of society, but Indigenous peoples may be uniquely vulnerable as they are already more likely to live in poverty and experience material deprivation (MacDonald & Wilson, 2016; Notten et al., 2017). Using data from the National Housing Survey to calculate the ethno-racial disparities for children living in poverty in Canada, MacDonald and Wilson (2016) found that the worst disparities existed among status First Nation children, where 41% of off-reserve children and 60% of on-reserve children lived in poverty, compared to the overall average of 18% of Canadian children (MacDonald & Wilson, 2016). Thirty percent of non-status First Nations children, 25% of Inuit children, and 23% of Métis children were found to be living in poverty (MacDonald & Wilson, 2016).

In order to limit the propagation of the virus, most countries have put in place essential quarantine measures that restrict the ability of people to leave their homes and move across borders (UN, 2020). The International Labour Organization estimates that COVID-19 could result in the loss of 195 million full-time jobs worldwide, with “1.25 billion workers, representing almost 38 percent of the global workforce [being] employed in sectors that are now facing a severe decline in output and a high risk of workforce displacement” (ILO, 2020, p. 1). Within Canada, all workers who are able to do so are required to work from home, which has had a devastating impact on many industries such as hospitality, entertainment, retail, and transportation for whom it is impossible to do so.

This may disproportionately affect members of Indigenous communities. In 2016, compared to the general population, First Nations workers were more likely to work in accommodation and food services as well as in arts, entertainment and recreation (Statistics Canada, 2018a) and were half as likely to work from home (Statistics Canada, 2018b). As such, these populations are at higher risk of losing their jobs as a result of the crisis, which could contribute to widening the socioeconomic gaps that are already present. Even though federal and provincial governments have put in place emergency economic measures for individuals who have lost their jobs as a result of COVID-19, uncertainty concerning people’s ability to access benefits and the length of time/amount of support received could mean that this period of unemployment has long-lasting, devastating impacts on Indigenous communities.

Furthermore, access to food is particularly impacted for certain communities during this pandemic. Evidence from the United States has already shown that some remote Native American communities are struggling to access food because of severe disruptions in the supply chains (Krishna, 2020). Prior to the COVID-19 pandemic, research indicates that nearly half of First Nations households are food insecure, which is four times higher than the proportion in the general population (Laurie et al., 2019). In Nunavut, the Inuit Health Survey found that 70% of adults were food insecure, representing the “highest documented food insecurity rate for any aboriginal population in a developed country” (UN Human Rights Council, 2012, p. 16). As the impact of the virus on supply shortages and transportation intensifies, First Nations and Inuit peoples will, therefore be at higher risk of running out of food and other basic necessities, and of not being able to re-stock given limited availability and inflated prices – a reality that is further exacerbated by the fact that many remote communities are only accessible by air.

B. Social Impact

a. Access to Education

As of the beginning of May 2020, many Canadian primary and secondary schools as well as universities remained closed. Globally, it is estimated that 80 to 90 percent of learners are impacted by current school closures (Lee, 2020; Van Lancker & Parolin, 2020). The academic losses resulting from school closures have a disproportionate impact on marginalized groups who are already at risk for worse educational outcomes. For example, evidence has shown that school closures such as summer holidays, tend to result in a gap in learning outcomes between children from higher and lower socioeconomic statuses (Alexander et al., 2007; Cooper et al., 1996). In Canada, on-reserve education funding mechanisms disadvantage First Nations children attending on-reserve schools, resulting in worse conditions in band-operated schools compared to provincial schools (Office of the Parliamentary Budget Officer, 2016).

In an effort to maintain educational continuity, many schools and governments have offered online learning materials to students; however, these materials are not necessarily accessible to all students. A 2017 report found a 30% difference in computer ownership and internet use between households with the lowest and highest incomes in Canada (Canadian Radio-television and Telecommunications Commission, 2020). Students whose families do not own computers or have internet access are unable to access online materials and are thus likely to fall behind their peers. Precarious and overcrowded living situations beyond access to computers and internet may also inhibit students' abilities to complete their online homework and tasks (Van Lancker & Parolin, 2020). These factors could disproportionately impact Indigenous families given that they are more likely to live in poverty and experience material hardship.

Moreover, widespread school closures and the accompanying loss in human interactions have impacts on children's social and behavioural development (UN, 2020). Many students rely on school programs not just for learning, but also for access to healthy meals as well as mental health services and sanctuary from maltreatment at home (Lee, 2020; UN, 2020; Van Lancker & Parolin, 2020). For caregivers, schools offer an important respite from the demands of childcare. School closures put increased pressure on caregivers to manage their own work, childcare, and education for their children (UN, 2020). These challenges are exacerbated for families with fewer supports.

b. Protection from Maltreatment and Violence

Concerns have been raised about the impact of the COVID-19 pandemic containment measures on child protection concerns and domestic violence-related concerns (Daya & Azpiri, 2020; Sistovaris et al., 2020). First Nations children are overrepresented in the Canadian child welfare system (Ma et al., 2019; Sinha et al., 2011). An ongoing landmark human rights case against the Canadian government demonstrates how Canada's "willful and reckless" discrimination in the provision of child welfare and other children's services impacts the over-representation of First Nations children (First Nations Child & Family Caring Society of Canada et al., 2019). The case was filed by the First Nations Child and Family Caring Society of Canada and the Assembly of First Nations in 2007 alleging that Canada's systematic under-funding was contributing to the unnecessary family separations. Canada fought the case on legal technicalities but in 2016 the Canadian Human Rights Tribunal substantiated the complaint and ordered Canada to immediately cease its discriminatory conduct (First Nations Child & Family Caring Society of Canada et al., 2016). Nine non-compliance orders have followed and while Canada has made some steps toward compliance it continues to resist equality for First Nations children at the Tribunal and in Federal Court even as billions of dollars are flowed to others in Canada for the pandemic.

Humanitarian crises such as the COVID-19 pandemic pose many child protection risks including family separation, physical or sexual abuse, psychosocial distress or mental disorders, economic exploitation, and death (Alliance for Child Protection in Humanitarian Action, 2019; Sistovaris et al., 2020). Stressors placed on children and families at multiple, nested levels heighten the risk for children experiencing abuse and neglect (Alliance for Child Protection in Humanitarian Action, 2019; Sistovaris et al., 2020). Closure of schools and other social services also might result in the under identification of children in need of protection as visibility of children in their communities is decreased. For example, in Ontario, one third of all child protection investigations and one quarter of child protection investigations involving First Nations children conducted in 2018 were referred from a school source (Joh-Carnella et al., 2020). The closure of these social supports has already resulted in decreased child maltreatment reporting. For example, in New Brunswick in March 2020 there were 40% less reports of suspected child maltreatment compared to March 2019 (Cave, 2020).

There is evidence that Indigenous peoples in Canada are at an increased risk of experiencing intimate partner violence (Brownridge et al., 2017), and the additional stressors present at times of crisis have been associated with increased rates of intimate partner violence (Serrata & Hurtado, 2019). During this pandemic, countries around the world have already reported increases in domestic violence (Taub, 2020). The difficulties of confinement put people at further risk, and many support systems put in place to help victims of intimate partner violence are unable to respond to the increasing demand (Taub, 2020). The result for both children and victims of intimate partner violence is that they are at increased risk for maltreatment or violence and less likely to be able to access necessary support services.

III. The Need to Evaluate Preparedness and Response Strategies

Global crises such as the COVID-19 pandemic put considerable strain on social systems by requiring societal supports – such as social, economic, educational, and health-related supports – to respond to increased needs in unprecedented ways. The planning and development of preparedness and response strategies calls for careful consideration before, during, and after the pandemic (Child Welfare Information Gateway, 2016; Self-Brown et al., 2013; Annie E. Casey Foundation, 2009; Daughtery & Blome, 2009; O'Brien et al., 2007; O'Brien & Webster, 2006; Sistovaris et al., 2020). Given that the previous impact of pandemics on marginalized groups, such as Indigenous communities, the need for pandemic preparedness and response that considers their needs is imperative. Nassif-Pires and colleagues (2020) argue that, despite strong moral obligations, there are also public health (i.e., preventing additional infections and flattening the curve) and economic (i.e., decreasing income inequality to ultimately put less demand on the economy) arguments for addressing the needs of marginalized groups.

In 2006, a group of international experts came together with the specific goal of considering social justice and the needs of the world's disadvantaged communities within the context of the next potential influenza pandemic (Johns Hopkins Berman Institute of Bioethics, n.d.). The group prepared a series of principles that would aid governments and other organizations in meeting the needs of disadvantaged members of society and also developed accompanying checklists to ensure the principles are met. When implemented, the principles would ensure that socially disadvantaged groups have access to information and interventions, are engaged in planning and responding efforts, and are included in evaluations and monitoring of interventions and policies (Johns Hopkins Berman Institute of Bioethics, n.d.). Strategies to combat the inequitable health and social outcomes of COVID-19 virus should consider these principles of best practice.

In Canada, the International Centre for Infectious Diseases (2010) similarly released a series of steps to follow when taking into consideration vulnerable groups in pandemics, which include: (1) identifying communities that are most vulnerable to the disease given known risk factors; (2) enhancing collaboration between community, health organizations, and marginalized communities by including them all in the development of response strategies; (3) facilitating knowledge-sharing and communication by sharing pandemic plans through a centralized source and providing clear and culturally-adapted health guidelines to populations; and (4) ensuring that health workers are adequately trained and that vaccines and treatments can be provided directly to communities. At a governmental level, Canada completed its first pandemic planning plan in 1988, and in 2004, the first iteration of the *Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector* (CPIP) was published with the goal of minimizing mortality and morbidity as well as social disruption resulting from a pandemic (Government of Canada, 2019). The CPIP recognizes that marginalized or vulnerable groups in urban and remote communities might be at greater risk for negative health outcomes and that risk factors impacting these groups need to be considered when developing pandemic responses (Government of Canada, 2019). The document contains an Annexe on Influenza pandemic planning considerations for First Nations communities on-reserve, which underlines the need to take into consideration cultural and language components as well as challenges in accessing care, delivering services and resources, and staff shortages on-reserve.

The federal government announced a \$305-million fund which was designed to help Indigenous communities respond to COVID-19 on March 18, 2020 (Indigenous Services Canada, 2020b). For First Nations communities, the funds will be distributed based on population, remoteness, and well-being. Well-being is measured through a Community Well-Being Index that focuses on education, labour force activity, income, and housing. Importantly, as we have seen, many of the factors identified that put certain communities at heightened risk of COVID-19 infection or suffering the consequences of its containment measures go far beyond these four domains. Furthermore, there is significant diversity in culture, needs, and context among and between First Nations, Métis and Inuit peoples in Canada. It is vital, therefore, to avoid pan-Indigenous approaches to evaluating the risk for, and response to, COVID-19. Table 2 below lists some of the risk factors identified in the report and provides examples of both temporary and permanent strategies that could be used to begin addressing them.

Table 2.

Risk factors identified in First Nations, Inuit, and Métis communities and examples of strategies to begin addressing them

	COVID-19 risk factors identified	Examples of temporary solutions	Examples of permanent solutions
Health Inequities	Overcrowding on-reserve and in Northern regions that prevents self-isolation	<ul style="list-style-type: none"> • Temporary housing supports or the repurposing of public spaces to permit self-isolation (Joannou, 2020; Nassif-Pires et al., 2020) 	<ul style="list-style-type: none"> • Adequate government funding for housing construction on-reserve • Explicit and adequate government action to address poor housing conditions
	Lack of access to clean water in some remote First Nations and Inuit communities and for homeless urban Indigenous populations	<ul style="list-style-type: none"> • Increased production and distribution of hand sanitizers (Ngabo, 2020) • Installation of handwashing stations in public spaces (Bui, 2020) 	<ul style="list-style-type: none"> • Adequate government funding to construct and/or repair water distribution and decontamination facilities • Explicit government policy that guarantees access to clean and safe water and proper sanitation systems for all

<p>Increased presence of underlying health conditions in certain First Nations, Inuit, and Métis communities</p>	<ul style="list-style-type: none"> • Prioritization of health resources to those identified as being most at risk (DeBruin et al., 2012) 	<ul style="list-style-type: none"> • Adequate government funding across public services to address factors such as overcrowded or inadequate housing and food insecurity that contribute to the development of health issues • Systematically record ethnicity in health registries to track overrepresentation and identify populations most at risk
<p>Difficulties in accessing medical supplies and treatment in remote First Nations and Inuit communities</p>	<ul style="list-style-type: none"> • Creation of resource stockpiles that are easily accessible locally (DeBruin et al., 2012) • Promote the use of local traditional medicines that help alleviate symptoms of COVID-19 (Wood, 2020; PAHO, 2020) 	<ul style="list-style-type: none"> • Adequate government funding to improve transportation infrastructure to remote communities and address higher costs related to remoteness • Ensure substantively equitable allocations of medical supplies and equipment and pharmaceuticals for remote communities
<p>Distrust in health structures experienced by First Nations, Inuit, and Métis populations</p>	<ul style="list-style-type: none"> • Outreach and educational activities (DeBruin et al., 2012) • Train available practitioners in the provision of culturally competent care and equitable practice (PAHO, 2020) • Protection of the right of Indigenous communities to hold traditional healing ceremonies, such as sun dances, during COVID-19 (Shield & Martell, 2020) 	<ul style="list-style-type: none"> • Explicit government policy to increase the number Indigenous health practitioners and to integrate Indigenous worldviews into health practice (Lafontaine, 2018) • Implement reforms to eliminate systemic racism in health care provision (e.g., see recommendations in Preston, 2014) • Adequate measures from the government to assist Indigenous communities in preserving and enriching the cultural and linguistic experiences of community members
<p>Lack of public health information available to communities for whom English is not their first language</p>	<ul style="list-style-type: none"> • Translation and dissemination of clear and culturally appropriate information on COVID-19 into local Indigenous languages (PAHO, 2020) 	<ul style="list-style-type: none"> • Explicit government policy that requires all public health information to be translated into each Indigenous language (as is already the case for English and French) • Support Indigenous communities to design and implement public health education programs

Socio-economic disruption	Limited access to food in remote Inuit and First Nations communities	<ul style="list-style-type: none"> • Reliance on networks of traditional harvesting (Krishna, 2020; Wood, 2020) • Provision of school lunches to low-income families (Nassif-Pires et al., 2020) 	<ul style="list-style-type: none"> • Explicit government policy to reinstate access to traditional foods and allow for traditional hunting and fishing practices • Government subsidies for healthy food options and other necessities in communities
	Limited availability of computers and internet to access education during confinement for remote Indigenous communities	<ul style="list-style-type: none"> • Service providers supplying additional internet or hot spots to low-income families or remote areas (Castelo, 2020; Truong, 2020) • Schools' provision of computers/tablets to students (Truong, 2020) or physical take-home materials that do not require internet or computers (Castelo, 2020; Noonoo, 2020) 	<ul style="list-style-type: none"> • Adequate government funding to develop reliable digital communications infrastructure in remote communities (Stollery, 2018). • Funding to ensure IT platforms are responsive to Indigenous languages and cultures.

Providing a full list of measures to address inequities in health and social outcomes of COVID-19 is beyond the scope of this paper⁴. However, the table above shows that solutions – both temporary and permanent – exist to start addressing the inequities observed. Community representatives should be directly involved in evaluating the most appropriate strategies for their populations, whilst being adequately supported in accessing the needs identified.

Since the beginning of the pandemic, First Nations, Inuit, and Métis communities have shown incredible levels of resilience and strength in dealing with COVID-19. To this day, the relative containment of the spread of COVID-19 within First Nations, Inuit, and Métis communities across Canada is a testament to the tireless efforts of communities to protect their people through a series of measures including, but not limited to: the near-complete restriction of travel to certain – more isolated – regions, the efficient establishment of pandemic response strategies to control outbreaks once they occur, and the strong support of community members through the distribution of food and supplies to those most in need. However, it remains the responsibility of the government to redress the structural drivers that put First Nations, Inuit, and Métis communities at higher risk of suffering the consequences of this pandemic in the first place by ensuring that they have equitable access to basic human needs, such as adequate housing, food, water, health and wellbeing. Lack of access to such fundamental human rights is an ongoing emergency that Indigenous communities have been faced with for centuries. This pandemic has highlighted that governments can mobilize resources quickly in the context of an emergency. Given that solutions to address these inequities are available, an immediate response is possible as long as there is political will.

⁴ Further resources are available online that provide guides on how to address health inequities and socio-economic disadvantages posed by COVID-19 for Indigenous peoples both in Canada (e.g., Giroux, Blackstock, Jetty, Bennett, & Gandner, 2020; Spirit Bear COVID-19 Resources) and across the world (PAHO, 2020).

Conclusion

By now, COVID-19 has had a direct or indirect impact on everyone across the globe. The spread of the disease has quickly transformed into a human rights crisis - with the effects of the pandemic exacerbating pre-existing societal inequities and leaving marginalized populations more susceptible to the disease's health, economic, and social outcomes. In the long run, addressing inequities observed in First Nations, Métis, and Inuit communities will need to involve working on the broader structural drivers that shape experiences of risk and vulnerability. This will start by recognizing that racism and colonialism are a reality that is ongoing and that continuously curtails Indigenous peoples' access to basic needs, as well as their inherent rights to self-determination and self-governance (Allan & Smylie, 2015; Greenwood & de Leeuw, 2012; NCCIH, 2019). It also entails acknowledging and valuing Indigenous ways of conceptualizing health and wellbeing, including their relationship to the land, spirituality, and obligations to ancestors and generations to come (PAHO, 2019). Given the diversity of realities experienced by First Nations, Métis, and Inuit communities in Canada, a nuanced, Indigenous-led, and cross-sectoral approach is imperative to begin to address the inequitable effects of this disease. Ultimately, this "pandemic is a spotlight that illuminates underlying problems – economic inequality, racism, patriarchy [which] are the chronic illnesses that weaken us as a society, morally, imaginatively, and otherwise" (Solnit, 2020). Confronted with these inequities, this is a time when societies can fundamentally rethink the way in which they respond to the needs of their populations.

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