ISC INDIGENOUS SERVICES CANADA

Lessons Learned: Vaccine Roll-Out for Indigenous Communities

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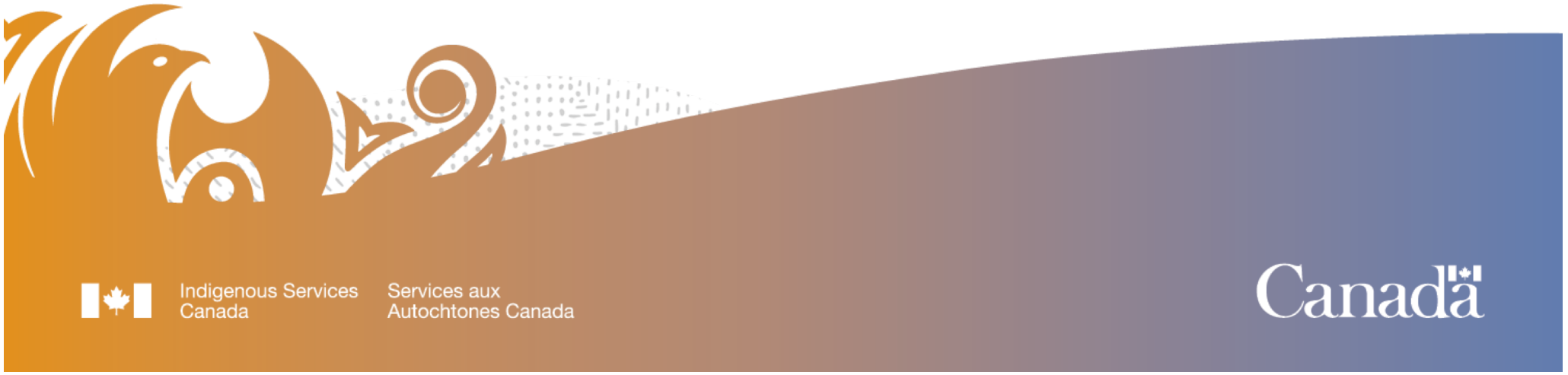
Evergreen document



Indigenous Services Canada | Services aux Autochtones Canada

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Purpose

- The purpose of this document is to illustrate:
  - How various levels of government can better support Indigenous partners in vaccine roll-out,
  - Partner-led success
  - Encountered challenges
  - Key takeaways for a more collaborative, Indigenous-led way forward

Context

- The COVID-19 pandemic has presented challenges and lessons for all Canadians, including First Nations, Inuit and Métis communities, and First Nations, Inuit and Métis living in urban, rural, remote and northern communities.
- First Nations, Inuit and Métis communities and organizations have responded with leadership, resiliency, innovation, care and compassion in order to protect their community members and those they serve.
- Indigenous Services Canada (ISC) continues to advocate for alignment between federal, provincial/territorial and local regional public health systems and support for First Nations, Inuit and Métis communities to have improved access and governance over health services to ensure federal, provincial and territorial health systems are more responsive to their needs.
- Provinces and territories are responsible for the allocation, distribution and administration of the COVID-19 vaccine and providing the supplies to support vaccinations (including syringes, personal protective equipment and other supplies) for First Nations, Inuit and Métis communities and organizations.

Vaccine Allocation and Prioritization

- Successes
  - The recommended **prioritization of Indigenous populations** by the National Advisory Committee on Immunization was a success, rooted in Indigenous advocacy and partnerships
  - While vaccine supply was limited, **the age for Indigenous prioritization** (in some jurisdictions) was lowered to reflect health disparities
  - Allowing **communities to allocate** within who should receive the vaccine first in order to best met the needs of communities
  - Having the **same brand of vaccine** (i.e. Pfizer or Moderna) allocated to a community for both first and second dose increased vaccine confidence
  - Early on, the '**push**' method of vaccine allocation allowed a large number of vaccines to be allocated to communities, as vaccine roll-out progressed, a '**pull**' method allowed to communities to have more autonomy in their vaccine supply and reduce wastage
- Challenges
  - The messaging around prioritization was a challenge (i.e. why are we going first?)
  - Though vaccine allocation for all those eligible in the territories early on was a success, many northern **communities did not have the capacity** to roll out the vaccine
  - Having **Indigenous specific data** on COVID was a challenge, though were able to link to broader health outcomes to advocate for prioritization
  - The prioritization of Indigenous peoples **varied by jurisdiction** and did not always include Métis, urban, those living in different locations (i.e. Inuit in the south)
  - At times, an uncertain supply of vaccines created challenges in administration
- Tangible Example
  - When a territory required Pfizer for youth vaccination, a trade for Moderna was able to be made with a province
- Lessons Learned summarized (i.e. what can be done better, what worked)
  - There should be a **coordinated approach** to the vaccine prioritization of Indigenous peoples
  - Indigenous public health experts must be included in decision making on allocation and prioritization at the national and regional levels

Vaccine Supplies and PPE

- Successes
  - Overall, access to PPE was not a major challenge for partners
  - Additional vaccine supplies and PPE provided by ISC offered support as stop gap measures when P/Ts were not able to provide to Indigenous communities and organizations
  - **Partnering with local health authorities** helped increase supplies and PPE for urban vaccine clinics
- Challenges
  - At times it was unclear of where/who partners should be accessing PPE, supplies, and vaccine mini clinic kits from, with **confusion over jurisdiction** and roles and responsibilities
  - Early on, there was a **global supply shortage** of Low Dead Volume Syringes which impacted the number of doses yielded from a vial
  - **Storage space** for PPE and vaccine supplies presented a challenge for partners
- Tangible Example
  - Over 300 mini clinic kits were provided from ISC to communities who indicated a need, which included items needed to run a vaccine clinic, though communication could have been improved over when who was able to receive the kits, what was in the kits, that they were free of charge and when they would be arriving
- Lessons Learned summarized
  - A **consistent supply** of PPE and vaccine supplies is needed in a timely manner
  - It should be clear that this **responsibility lies with the P/Ts** as they are responsible for health care services and were allocated PPE and vaccine supplies based on total population, including Indigenous peoples
  - P/Ts should work with partners to ensure **adequate storage space** for supplies and PPE

Vaccine Storage, Transportation and Delivery

- Successes
  - '**Hub**' sites were useful in storage of vaccines and shipping out to more remote communities
  - In general, when mobile teams were deployed to administer the vaccines, the storage and transportation of the vaccine was well planned
  - Cold chain **losses** during transport were minimal nationally
  - PHAC NESS was able to supply ULT and regular freezers, vaccine fridges and storage equipment where there were **gaps** for Indigenous communities and service delivery sites
  - In some clinics, the community was able to **smudge the vaccine**, leading to a sense of cultural safety
- Challenges
  - There were **delays in receiving the cold chain equipment** needed to move and store the vaccine, due to delays in shipping from suppliers
  - **Short notice** of vaccine arrival in community led to vaccine hesitancy due to lack of community engagement, repeating historical trauma and reinforcing lack of trust in health care system
  - In some communities, there were issues in **finding space** for the needed freezers and vaccine storage, and some communities were not adequately stocked with supplies
  - Weather was an issue in delivering vaccines to **remote and isolated locations**
  - Communications of the vaccine delivery dates needed to be improved
- Tangible Example
  - For some communities the planned 'week of vaccine delivery' date was interpreted that the first day of the week vaccines would be arriving. When this was not the case, clinics had to be postponed
- Lessons Learned summarized
  - Vaccine roll out had to be **flexible**, **adaptable**, and advocated for at every stage
  - Confusion at times as to whether **cold chain equipment** from NESS was to be requested through the PT or through ISC.
  - **Clear communication** is needed for all aspects of vaccine storage, transportation and delivery

Vaccine Administration: Location

- Successes
  - **Culturally safe clinics**, in welcoming locations such as community and Friendship Centres promoted vaccine confidence
  - Using varied locations methods, such as **door to door** vaccination, **pop up clinics**, clinics **in gathering places** (i.e grocery store) were successfully used to ensure availability and accessibility of vaccines
- Challenges
  - The ability to hold Indigenous-run vaccine clinics varied across jurisdictions, in some areas partnerships were established to meet the needs of communities, while in others **more advocacy** was required
  - The presence of security, RMCP and law enforcement at vaccine clinics created a general sense of unease among community members leading to vaccine hesitancy. Successful clinics had **limited security** or community members providing those services
  - Some communities did not always have the infrastructure to support vaccine clinics, in particular mass clinics
  - There are **high costs** associated with holding a culturally safe clinic in a community setting
  - Early in the vaccine rollout, large mass vaccination clinics in urban settings were prioritized for vaccine supply over **smaller, more accessible urban locations**. This delayed vaccine being available for more harder to reach populations in local, more readily available, culturally safe locations
- Tangible Example
  - In one jurisdiction, it was determined early on in the vaccine roll-out that Indigenous-led vaccines clinics would yield the highest uptake
- Lessons Learned summarized
  - Indigenous-led, culturally safe vaccine clinics, in a location that is easily accessible to Indigenous peoples are the most successful
  - Adequate funding should be provided to support these efforts and to increase uptake

Vaccine Administration: Immunizers and other supports

- Successes
  - Having **Indigenous staff** and health care providers at clinics is seen as best practice and creates a more welcoming environment, in particular if the staff are able to speak **Indigenous languages**/have translators
  - Some PT jurisdictions ensured cultural safety training was provided to their immunization staff travelling to communities as well as working in urban locations
  - When communities/leadership were able to **invite/welcome mobile immunization** teams into the communities, there was a higher uptake, versus teams of 'outsiders' simply arriving
  - Having additional staff/time to provide **education** to those who were hesitant
  - Education of health care providers on each of the vaccine was needed for a smooth roll-out and information sharing
  - Utilizing other health care professionals, such as paramedics and nursing students, as immunizers **increased the workforce**
- Challenges
  - Overall there was a **shortage of health care workers**, especially nurses. This was exasperated by burn out cased by the ongoing pandemic
  - There is also a shortage of Indigenous health care providers
  - There is a need to **expedite emergency licensing** for vaccination to allow health care workers to move between P/Ts to vaccinate
- Tangible Example
  - One partner spoke of the importance of having **mental health supports** at vaccine clinics, as vaccine clinics were overwhelming for many amidst COVID
- Lesson Learned summarized
  - There is a need to address the shortage of health care providers, in particular supporting Indigenous peoples in pursuing health care careers

Vaccine Administration: Incentives for Vaccination

- Successes
  - Incentives can remove barriers, by providing services such as transportation and child care- known as **enablers**
  - Incentives can also be providing a culturally safe space with cultural food, music and community members present
  - Partners offered prizes, raffle tickets, lotteries, food, outdoor equipment, masks, sanitizer, etc.
- Challenges
  - There is a financial **high cost** associated with incentives
  - Some health care providers and partners experienced an **ethical dilemma** in providing incentives (i.e. it could be perceived as bribing or coercion)
  - In some communities, incentives were perceived to decreased uptake, as community members saw it as '**suspicious**' to be offered a prize for a vaccine
- Tangible Example
  - One Indigenous led vaccine clinic offered **culturally relevant gifts**, food and music to create incentives for uptake
- Lesson Learned summarized
  - Incentives can be tangible rewards as well removing barriers, though funding should be provided to support these efforts

Vaccine Administration: Data

- Successes
  - Leveraging **existing data agreements** with P/Ts supported the collection Indigenous vaccine data
  - Existing health data supported the prioritization of Indigenous peoples for vaccination
  - FNHA, MNBC, FNIGC-AB, FNHSSM, COO, MNO successes in Indigenous led reporting and ownership of data with support from PTs in establishing collaborative linkages
- Challenges
  - There remains **large gaps** in Indigenous data, and the collection of Indigenous data varies across P/Ts and distinction
  - Lack of data surrounding Indigenous peoples living in **urban and other areas** was a large challenge in that it complicated the work to advocate for, and ensure adequate supply for these populations to accessing vaccines
  - **Capacity** is needed to support health care workers in the collection of vaccination data
  - Varying vaccine data collection system led to **operational challenges**
  - Need to define appropriate population **denominator** that will be acceptable to all partners
  - Indigenous leaders may have not been consulted in the **development** of the data collection process which then led to some reluctance to use this process
- Tangible Example
  - In one jurisdiction, Inuit living in urban areas were not prioritized due to a lack of data of the number of those living in the south
- Lessons Learned summarized
  - Consistent and culturally safe processes for **Indigenous self-identification** should be determined in the planning process
  - Limited resources and multiple communities with varying levels of resources along with platform issues/education all contributed varying levels of **data quality issues**.
  - Indigenous peoples should be part of the data collection and analysis process, working with P/Ts and respecting **Indigenous peoples rights** and data **ownership**

Engagement and Partnerships

- Successes
  - Partnerships and relationships with P/Ts increased over time and roles and responsibilities became easier to understand
  - **Partnerships** were established between distinctions, communities and organizations to support vaccine allocation and roll out
  - **Intercommunity** support and ownership of the vaccine roll out process, this took the form of informal conversations around logistics, shadowing vaccine clinics to learn best practices, to seconding staff to assist in the vaccine rollout process
  - Having governmental representatives knowledgeable in the vaccine science and roll-out, attending Indigenous led meetings provided a **sense of trust** as well an effective means to receive information
  - The various **Working Groups**, supported by ISC, provided a key place of information sharing, though cannot be seen as an advisory body due to the size of the groups
- Challenges
  - There is a need for **funding/capacity** to support engagement and partnerships
  - There is a considerable difference between **advisory and decision** making committees-Indigenous organizations /communities/leadership were engaged in advisory capacities but not always decision making bodies-and even when included in these bodies their input was **not always actioned**
  - Engagement with Indigenous partners at times felt **optional**, and that decisions were going ahead with or without Indigenous input
- Tangible Example
  - In various jurisdictions there were partnerships across distinctions (i.e. First Nations and Métis, First Nations and Inuit) to support a Indigenous safe space for vaccines clinics. Further, early and ongoing engagement with partners, for example at the AFN, ITK, MNC, FNHMA as well as Regional Indigenous organizations ensured that governments could support Indigenous leadership had what they needed to support comprehensive vaccine planning.
- Lessons Learned summarized
  - Indigenous partners being included from the beginning, as part of the **decision making process**, leads to better decision that meets the needs of communities
  - Providing communities with up to date **information** in a timely manner allowed for representatives to brief leadership and have strong messaging to support vaccination

Communications: Sources of Hesitancy

- Successes
  - Addressing misinformation in a **timely, clear and culturally appropriate** manner helped to increase confidence
- Challenges
  - As information on the vaccine was ever changing, this led to hesitancy
  - Prevalence of misinformation on social media
  - **Conflicting messages** from National Advisory Committee on Immunization and the provinces (e.g., timing of second dose recommendations varied by province) lead to confusion
  - Concerns over how **quickly** the vaccines were developed
  - General **mistrust** in the government based on colonization, systemic racism and traumatic experiences with the health care system. This mistrust was compounded with the confirmation of graves at residential school sites
- Tangible Example
  - In communities misinformation would spread quickly, and therefore there was a need for leadership, local role models, etc. to deliver facts on vaccines
- Lessons Learned summarized
  - Be **proactive** in addressing vaccine hesitancy as early as possible
  - Survey Indigenous peoples and health care professionals on their thoughts on hesitancy and plans to address
  - Better **science programming** in schools could address the misinformation and provide a basis of understanding
  - Vaccine confidence messages are most effective coming from **trusted individuals** and Indigenous organizations. Elders, community leadership and Indigenous health professionals are the most effective.
  - Do not assume hesitancy when there are **tangible barriers** to accessing vaccination (transportation, child care, physical location and hours of vaccine clinics, work schedules, scheduling systems with long delays or require internet access)
  - Local **community organizations** are best suited to advise on potential factors influencing local confidence and hesitancy, which are often varied and community specific.

Communications: Getting the message out there

- Successes
  - Providing information in **Indigenous languages** increased the reach of the messaging and confidence in the information
  - **Word of mouth**, as well **social media** and **radio** were effective in reaching Indigenous populations
  - Online **live sessions/townhalls** with a Q & A format allowed for individuals to pose questions
  - Having leadership, Indigenous health providers and trusted sources delivering messaging (at the national, regional and local level) is seen to have increased confidence
- Challenges
  - The need for **funding** to support communications capacity was evident. If a targeted communications strategy was supported from the outset there, this may have increased uptake
- Tangible Example
  - In one jurisdiction, the P/T vaccine campaign did not resonate with the Indigenous population, who were prioritized to get their vaccines as one of the first group. Should partners have had core communications funding a targeted campaign could have rolled out parallel to vaccine roll out
- Lesson Learned summarized
  - There is a need for **capacity/communications funding** to partners to have targeted messaging to reach Indigenous populations

Summary

Key Takeaways:

- Indigenous communities, public health care providers, community support organizations and leadership have played a substantial role in helping to achieve the vaccination rates in Canada that are among the highest in the world, both in communities and urban settings.
- Indigenous-led response to COVID (i.e. allocations, clinics, communications) are a best practice to reach populations
- There is a need to better support First Nations, Inuit and Métis living in urban and other locations, to access prioritization of vaccines, vaccine clinics and other supports
- There is a need to support capacity for Indigenous partners, in communications, engagement and providing Indigenous-led services and human health resources
- Through the vaccine roll-out partnership proved to be a key asset, though relationships took time to build that could have been existing through more efforts for Indigenous self-determination prior to the pandemic