COVID-19 and Indigenous Peoples: an imperative for action

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We acknowledge the traditional custodians of Country across the world, and their continuing relationship to culture, community, land, waters and sky. We honour children born and yet to be, and pay our respects to Elders, past, present and future.

Introduction

Every person on Earth has been affected in some way by the coronavirus disease (COVID-19) pandemic. However, there is a marked inequity in the impact and threat of the disease for the 370 million Indigenous Peoples worldwide. While honouring diversity in peoples and cultures, this editorial (written by a collaborative of Indigenous nurses from Australia, Aotearoa (New Zealand), Canada, the United States of America and Central America), explores contemporary issues raised for Indigenous communities by this latest public health emergency. Please note, while we may describe a situation about a specific Indigenous group, readers can be assured that the issues we raise are endemic across colonised Indigenous communities globally.

During pandemics, Indigenous Peoples suffer higher infection rates, and more severe symptoms and death than the general population because of the powerful forces of the social and cultural determinants of health and lack of political power. During the 1918 Spanish Influenza pandemic, Māori died at a rate of seven times that of the European population, which is likely an underestimation because of undocumented Māori deaths (Summers, Baker, & Wilson, 2018). First Nations people in Canada were eight times more likely to die compared to non-First Nations (Kelm, 1999). Although COVID-19 infection rates are currently low, in the 2009 H1N1 influenza pandemic, Aboriginal people in central Australia experienced rates five times higher than the non-indigenous

population (Mousseau, 2013). Pacific Island and Māori people were seven times more likely to be hospitalised than Europeans and three and a half times more likely to die (Mousseau, 2013). Mortality for American Indian and Alaska Natives from H1N1 was four times higher than people from all other ethnicities combined (Centers for Disease Control and Prevention, 2009). In Canada, First Nations people were three times more likely to be hospitalised, and six and a half times more likely to be admitted to an intensive care unit (Boggild, Yuan, Low, & McGeer, 2011).

Indigenous Peoples experience a more significant burden of non-communicable and infectious diseases generally, and this is related to social and health inequities stemming from invasion and subsequent colonisation. Colonisation's legacy for Indigenous Peoples includes intergenerational and concentrated poverty, poor physical and mental health, transport and housing issues, increased rates of domestic and family violence, shorter life expectancy, and inadequate access to culturally safe care (Allan & Smylie, 2015; Braveman et al., 2011). Colonisation is known to have a negative effect on the social determinants of health (Greenwood, de Leeuw, & Lindsay, 2018; Sherwood, 2018) and cultural determinants of health (Salmon et al., 2019). In Canada, Australia, New Zealand, and the Americas, invasion and subsequent colonisation has brought about disproportionate inequities that detrimentally affect Indigenous Peoples compared to other groups in their respective countries. Indigenous Peoples in colonised nations share similar histories of invasion, displacement from traditional lands and relocation onto missions or reservations, stolen generations, forced assimilation, genocide, decimation from introduced infectious diseases and the attempted erasure of culture through the banning of languages and cultural practices (Sherwood, 2018). In Central American countries like Guatemala and Panama, Indigenous Peoples have endured centuries of war, internal violence, exile, marginalisation, genocide, and other trauma. The existence of imposed trauma and decimation began when Spaniards invaded Panama in the early 16th century (Central Intelligence Agency, 2020). Despite the world class, universal healthcare systems available in Canada and Australia, Indigenous populations continue to experience much poorer health outcomes due to the legacies and intersections of colonialism and racism (Allan & Smylie, 2015).

Indigenous People's increased vulnerability to disease is unquestionable, evident not only in shorter life expectancies but also in the lower age we become more vulnerable. In Australia, the Health Department advice is for Australians aged 70 years or over, or those aged 65 years or over with chronic medical conditions to stay at home and avoid all contact with other people. However, for Indigenous Peoples, this recommendation is for those aged over 50 years (Department of Health, 2020b). Regretfully, while they do highlight the danger of comorbidities, several of our governments have neglected to explicitly recognise the premature mortality of Indigenous Peoples in their advice

about vulnerability to COVID-19 (Centers for Disease Control and Prevention, 2020; New Zealand Government, 2020b; Public Health Agency of Canada, 2020).

Historical data has demonstrated that poor health and poverty positively correlate with pandemic severity (Clay, Lewis, & Severnini, 2019). Poverty impacts Indigenous Peoples' capacity to respond to COVID-19 on multiple levels. In this current crisis, health outcomes are determined by levels of secure housing, employment, comorbidities, functional literacy, health insurance, food security, access to running water, access to health care and technology. A one-size-fits-all response to COVID-19 ignores the roles of privilege, affluence, and racism in perpetuating inequities and therefore the ability to provide culturally safe care (Best 2018). Globally, many Indigenous Peoples live on missions and reserves. Many of these missions and reserves are geographically rural or remote. Among the 574 tribes in the USA, the Navajo Nation is the third highest population in the nation for per capita infections after New York and New Jersey. As of 28th April 2020, the Navajo Nation had over 1700 positive cases and 59 deaths from COVID-19 (Navajo Department of Health, 2020a). Older age, multigenerational housing, lack of running water, communal wells, increased chronic disease, and poverty have increased the impact of COVID-19. Forty percent of Navajo households do not have access to running water and thirty percent do not have electricity (DigDeep and US Water Alliance, 2020). Lack of access to running water makes it difficult to comply with handwashing recommendations. Additionally, many Native American tribes, such as the Lumbee Tribe of North Carolina, are not eligible to receive federal funds to provide healthcare (Maynor Lowery, 2009, 2018). The marginalisation, segregation and discrimination of these tribes is negatively impacting their health and wellbeing during the COVID-19 situation. These tribes are relying upon their own resources to address their tribal community needs. Likewise, in Central America, many Indigenous groups live in low or middle-income countries lacking fundamental basic human needs such as clean water and environment to live in, resulting in higher rates of infectious disease such as COVID-19 (Babyar, 2019).

To help curb the spread of COVID-19, the Navajo Department of Health ordered all members within their 17-million-acre reservation/jurisdiction, over the age of 2 years to wear masks in public and have instituted isolation measures including weekend curfews. Unnecessary travel is punishable by up to 30 days incarceration or a $1000 (USD) fine (Navajo Department of Health, 2020b). Similar lockdowns are evident across the globe. In Australia, enactment of the Biosecurity Act 2015 has given the Federal Minister of Health extraordinary powers (Maclean & Elphick, 2020). On the 26th March 2020, the Minister invoked biosecurity travel restrictions for remote areas. People wishing to enter remote communities must self-isolate for 14 days prior to entry (National Indigenous Australians Agency (NIAA), 2020). Assurances that 'Governments will support people who do not

have appropriate alternate arrangements to self-isolate' are not trusted (NIAA, 2020). Some communities are hundreds of kilometres and many hours away from regional centres, and where people would be accommodated is not clear. Furthermore, this support has not been evident for other Aboriginal people, with media reports of rough sleepers having camps broken up by police, and possessions thrown into garbage trucks (Hirini, 2020).

A central tension exists between food security and affordability and the closing of missions, reservations, and communities to keep Indigenous Peoples safe from the virus. Pre-pandemic, one in three adult Aboriginal people who lived remotely in Australia reported running out of food and being unable to afford more (Rogers, Ferguson, Ritchie, Van Den Boogaard, & Brimblecombe, 2018). In many remote communities, there is only one store to buy food from, and prices are exorbitant due to transport and access issues (Rogers et al., 2018). In some cases, price-gouging is evident (Central Land Council, 2020). Because of food costing up to sixty percent more in remote communities, many Aboriginal people prefer to travel to regional towns to do their shopping (Central Land Council, 2020). With biosecurity lockdowns in effect, this is no longer possible. COVID-19 exacerbates food insecurity by unexpected increases in unemployment, halts in tourism and people being unable to leave their communities to hunt and participate in cultural determinants of health. This also demonstrates one of the unique differences globally amongst Indigenous populations in locking down communities. Within Australia, Indigenous Peoples have a history of being confined to designated areas called missions and reserves. This was government policy from approximately the 1890s-1970s (Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS), 2019). In other global Indigenous populations, locking down has been a self-determined process. Within Australia the question of triggering episodes of post-traumatic stress has arisen for those older Indigenous Peoples who still live on the missions and reserves. Being locked down again due to government intervention and legislation as they were up until the early 1970's in the state of Queensland is still in the lived experiences of a number of Indigenous Australians.

Characteristics of crises like pandemics include a rapid increase in rape, sexual assault, and violence (Peterman et al., 2020). Indigenous people worldwide are already at increased risk of family violence, a consequence of colonisation and historical trauma, (Wilson, Mikahere-Hall, Sherwood, Cootes, & Jackson, 2019), with prevalence rates of 57% and 80% found for lifetime violence among wāhine Māori (women) (Wilson et al., 2019, p. 15). 'Aboriginal women [in Australia] are 32 times more likely to be hospitalised for family violence as non-Aboriginal women' (Andrews, 2020, para. 3). In Canada, First Nations, Inuit and Métis women are two and half times more likely to experience violence than non-indigenous women (Klingspohn, 2018). In the National Inquiry into Missing and

Murdered Indigenous Women and Girls (NIMMIWG) (2019) in Canada, the sexual and physical abuse and murder of Indigenous women and girls that has been on-going for generations has been labelled genocide. Native American women sustain rates of violent victimization (rape, sexual assault, robbery, aggravated assault, and simple assault) at rates that are two times higher than African Americans, two and a half times that of Hispanics, two and a half times that of Caucasians, and four times that of Asians (Morgan & Oudekerk, 2019). The current COVID-19 crisis has seen 'reports from Australia, Brazil, China and the United States suggesting a sudden rise in violence against women and children' (Peterman et al., 2020, p. 3). Compounding the sudden increase in violence during a pandemic is the intersecting forms of stressors stemming from a sudden rise in economic, emotional and physical pressures; enforced proximity from lockdowns; and, reduced access to support systems, health care and first responders (Peterman et al., 2020). Pre-existing trauma and stress is triggered during disasters so there will also be a corresponding rise in harmful alcohol and substance abuse (Macauley, 2020). Families faced with the stressors associated with COVID-19 may see violence occurring for the first time. These factors all culminate in Indigenous women and children affected by violence, no longer being able to enact the strategies they could take to keep themselves and their children safe. It will also be very difficult to seek help outside of their homes.

The COVID-19 crisis has seen unprecedented disruption to cultural practices and the normal relational and collective practices of Indigenous Peoples. This is detrimental as it has been empirically proven that the cultural determinants of health have an overwhelmingly positive impact on the health of Indigenous Peoples (Bourke et al., 2018). Many Aboriginal and Torres Strait Islander people in Australia travel frequently between communities to attend to Sorry Business (funerals and grieving) (Department of Health, 2020a). In the current environment of lockdowns and social distancing, Indigenous people are having difficulties reconciling coronavirus restrictions with their relationally based cultural obligations, with mourning taking precedence (Wainwright, 2020). Māori in Aotearoa have also been forced to reconsider how they undertake the cultural practices involved to farewell someone who passed away and how they support older people and those with high needs. Traditional greetings of hongi (pressing noses when greeting) and harirū (shaking hands) have a rāhui (temporary prohibition) suspending such practices that breach social distancing regulations (New Zealand Government, 2020a).

Pre-pandemic, governments were already failing in their efforts to reduce the inequities in social determinants and health outcomes between Indigenous and non-indigenous citizens, and Indigenous Peoples are generally under-resourced for responding to the current crisis. A 2019 report on health security across 195 countries found that the majority of countries were ill-equipped to prevent, detect, and respond to health emergencies (Nalabandian et al., 2019). For instance, it is

estimated that there are only 100 ventilators available from Guatemala to Haiti (Burki, 2020). Furthermore, algorithms triaging access to intensive care facilities are likely to exclude Indigenous Peoples because of the co-morbid conditions they may have.

Indigenous Peoples are known to survive historical and contemporary adversities, demonstrating resourcefulness and resilience in adversity. Despite the marginalization of Indigenous Peoples in countries' COVID-19 responses, Indigenous communities are instituting their own measures in the presence of universal approaches to managing not only the spread of COVID-19 but in addressing the needs borne out of poverty, housing and food insecurity. In Aotearoa, Iwi (tribal nations) are distributing food parcels to older people who cannot leave their homes and whanau (Family) rather than expecting people to make their way to a food bank. In some more remote areas, Iwi are monitoring who comes and goes out of their rohe (Iwi region) with roadblocks. In Canada, First Nation populations are gathering their bundles for medicine, food, birthing and death, while developing innovative ways to protect themselves such as making their own protective facemasks (Wright, 2020). Although we, and some allied media are reporting on these initiatives, information on strategies Indigenous Peoples have implemented during pandemics is not routinely collected or acknowledged (Zavaleta, 2020).

To this date, despite known vulnerability and high mortality rates, little information related to the rates of COVID-19 in Indigenous Peoples is obtainable. Even where testing is available, data is rarely disaggregated by ethnicity (United Nations, 2020). Yet data will be essential to understand the true impact of COVID-19 on our communities, justify the demand for resources like food and personal protection equipment (PPE) and allow service access and delivery to ensure already existing inequities do not worsen further (Phelan, 2020). Indigenous communities across Canada, are urging provincial and federal health leaders to disclose COVID statistics to their nations, reporting that these numbers will help nations prepare and respond appropriately to potential outbreaks. In Central America, statistical transparency among Indigenous groups related to previous pandemics and other health outcomes are lacking, further perpetuating the lack of Indigenous voice and increasing the health disparity gap (Babyar, 2019). Failure to recognize the differences in morbidity and mortality among Indigenous Peoples contributes to inequities. There is not only a lack of information sharing but the delay in funding to support nations, and the growing jurisdictional disputes over who will provide these services has once again been intensified in the response to COVID pandemic planning. If ever there was a time to acknowledge the need to collect accurate ethnicity data and disseminate adequate resources to address health disparities among Indigenous people globally, now is that time. The needs of Indigenous Peoples must be made visible and not subsumed instead, in generalized universal response strategies.

In this editorial, we have drawn attention to the existing health and social justice inequities stemming from colonisation. We have discussed the devastating effects pandemics have on our health and capacity to practice culture which is our medicine. We have asked the reader to consider the desperate situation our Peoples face, but recognise the Indigenous led solutions that are being enacted. We request recognition that the harm and hurt and drastically increased morbidity and mortality in our communities during this pandemic, is their legacy of failing to address historical and ongoing inequities. The cultural determinants of health must be recognised as the remedy and be built into health policy, practice and research. Going forward, data needs to meticulously document the damage, naming us by our countries, our communities, our clans and our tribes. So that the next time disease sweeps our planet, we know our weaknesses, we know our strengths, and if more informed and empowered, we will prevail against the next neo colonial wave.

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