Indigenous Engagement in COVID-19 Vaccination Clinics

Urban Indigenous Vaccine Working Group and Peterborough Public Health

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Executive Summary

This study looks at the experiences of Indigenous leaders and Peterborough Public Health (PPH) during their collaboration to plan and implement Covid-19 vaccination clinics for the Indigenous population in the Peterborough/Nogojiwanong area. This report documents how leaders representing First Nations, Métis, and urban Indigenous peoples fought for Indigenous prioritization in the vaccine rollout, and subsequently implemented vaccine clinics. Between March 3, 2021 and March 4, 2022, thirty-five Covid-19 Indigenous vaccine clinics were held in Curve Lake and Hiawatha First Nations, and in communities where urban Indigenous peoples reside (PPH, 2022).

This study builds on interviews with eleven Indigenous leaders and PPH managers who were engaged in this collaboration. Storytelling was used as a decolonizing methodology and method following current practices in respectful Indigenous research. The report incorporates the leaders' voices in sharing their perspectives.

The story of this collaboration between Indigenous peoples and PPH is told in three ways. The first approach reconstructs the relationship's chronological development, including getting organized, holding the vaccine clinics, and moving forward. In the preliminary period, urban Indigenous and Métis leaders formed the Urban Indigenous Vaccine Working Group (UIVWG) to plan the urban vaccine strategy with PPH. In addition, local First Nations assisted in securing local vaccine priority for urban areas, and the UIVWG successfully gained a seat at PPH decision-making tables. In the next phase, Indigenous organizations mobilized volunteers from their agencies and the Indigenous community to plan and administer culturally engaging Indigenous vaccine clinics, organize appointments, and address vaccine hesitancy. These clinics were successful, although faced some challenges, particularly with non-Indigenous peoples new to working in Indigenous settings. After a year of frequent meetings to plan and exchange information, the UIVWG began imagining new collaborations in health and other areas of Indigenous community life.

The second telling of this story focuses on relational accountability, emphasizing themes of respect, responsibility and reciprocity that contributed to the collaboration's success.

The third telling of this story responds to the six specific questions that PPH asked the research team to address. These questions became the framework for summarizing the results of the study: 1) How and in what ways were the vaccination clinics for Indigenous groups successful? 2) What were the contributing factors to this success? 3) How and in what ways did Indigenous groups collaborate in the overall local vaccination roll-out strategy? 4) What challenges arose during the planning and implementation of the clinics? 5) What can be learned from these experiences that can be brought forward to inform relationships in the future? 6) What are some opportunities to consider in deepening relationships between PPH and Indigenous communities?

Key Words: Indigenous peoples and health; Indigenous peoples and Covid-19; urban Indigenous peoples; Indigenous vaccine hesitancy; Métis health; Indigenous-settler alliance building

Table of Contents

Executive Summary 1
Table of Contents 2
Acknowledgements 4

1.0 Background 5
1.0 The Pandemic and Indigenous Health 5
1.1 Indigenous Jurisdictional Context 5

2.0 Peterborough Public Health 6
2.1 PPH Engagement Strategies 6
2.2 PPH and Vaccinations 7

3.0 What We Did
3.1 Who Are We? 8
3.2 Research Goals 9
3.3 Scope of Research 9
3.4 Participants 9
3.5 Methodology 9
3.6 Methods 10

4.0 Findings: What We Found 10
4.1 Getting Organized 11
4.1.1 Organizing the Urban Indigenous Vaccine Working Group (UIVWG) 11
4.1.2 Getting to the Table 12
4.1.3 Getting Access to Vaccine 13
4.1.4 Three Objectives 13
Urban Indigenous Data 14
Vaccine Hesitancy 14
Planning for Vaccine Clinics 15

4.2 Vaccine Clinics 16
4.2.1 Organizing the Indigenous Vaccine Clinics 16
4.2.2 Creating Culturally Welcoming Clinics 16
4.2.3 Volunteers and Indigenous-non-Indigenous Encounters 17
4.2.4 Learning and Shifts Over Time 18
4.2.5 Sharing Curve Lake First Nation Experiences 19

4.3 Moving Forward 21

5.0 Relational Accountability 22

6.0 Research Goals for the Study 24
6.1 How and in what ways were the vaccination clinics successful? 25
6.1.1 Vaccinations 25
6.1.2 Indigenous Led Clinics 25
6.1.3 The Urban Indigenous Vaccine Working Group Collaboration....................26
6.1.4 Communication....................26

6.2 What were the contributing factors to this success? 26
6.2.1 Established Relations 26
6.2.2 PPH's Openness and Willingness to Learn 26
6.2.3 Finding Unity 27

6.3 How and in what ways did Indigenous groups collaborate in the overall local vaccination roll-out strategy? 28
6.3.1 The UIVWG Collaboration 28

6.4 What challenges arose during the planning and implementation of the clinics?28
6.4.1 Jurisdictions 28
6.4.2 Vaccination Priorities 29
6.4.3 The Vaccine Clinics: Indigenous-non-Indigenous Relations 29

6.5 What can be learned from these experiences that can be brought forward to inform relationships in the future? 30
6.5.1 Indigenous Competence 30
6.5.2 Structural Issues 31
6.5.3 A Commitment to Keep Learning for PPH Staff and Volunteers 31

6.6 What are some opportunities to consider in deepening relationships between PPH and Indigenous communities?.................... 33
6.6.1 Plan Now for the Next Pandemic 33
6.6.2 Collaborate in Designing and Implementing a Métis and Urban Indigenous Peoples Health Needs Study 33
6.6.3 Connect with Broader Decolonizing Movements in Indigenous Public Health 34
6.6.4 Long Term Alliance-Building 34

7.0 Limitations of the Study 35
8.0 Conclusions 35
9.0 Miigwech – Marsi – Nia:wen....................36
10.0 References....................37
Appendices
Appendix A – Consent Form 40
Appendix B – Interview Questions.................... 42
Endnotes 43

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Indigenous Leaders (alphabetically)

Lori Flynn	Executive Director, Nogojiwanong Friendship Centre
Christa Lemelin	President, Métis Nation of Ontario, Peterborough & District Wapiti Métis Council
David Newhouse	Nogojiwanong Friendship Centre VP and Director, Chanie Wenjack School of Indigenous Studies, Trent University
Ashley Safar	Nogojiwanong Friendship Centre (formerly with Fleming College)
Robin Steed	Health and Family Services Manager, Curve Lake First Nation
Liz Stone	Indigenous Knowledge Leader, Fleming College
Rebecca Watts	Long-Term Care Coordinator, Lovesick Lake Women's Association
Emily Whetung	Chief, Curve Lake First Nation

Peterborough Public Health Leaders (alphabetically)

Hallie Atter	Liaison Officer, Peterborough Public Health
Laurie Hess	Manager, Vaccine Clinics (August 2021+), Peterborough Public Health
Gillian Pacey	Manager, Vaccine Clinics, Peterborough Public Health

Miigwetch – Marsi – Nia:wen - Thank you for sharing your experiences and perspectives. We have tried to do justice to the stories you entrusted to us through this research process. All quotations appearing in the report have been used with permission.

We acknowledge the help of Peterborough Public Health staff, particularly Hallie Atter, Jane Hoffmeyer, and Sterling Stutz who endured many pesky questions as we tried to understand the structure and process of the relationship and experiences. They were patient and kind in their responses, all the while negotiating the heavy demands of their work to protect the community during the Covid-19 pandemic.

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1.0 Background

1.1 The Pandemic and Indigenous Health

From March 11th, 2020, when the World Health Organization declared the global Covid-19 pandemic, countries around the world were plunged into chaos. National, provincial and local health services, including public health agencies, took their place on the front lines of combatting the SARS-CoV-2 (a.k.a. COVID-19) virus, which was unknown and for which there was no existing vaccine. In Canada, the economy locked down to slow and prevent the spread of the coronavirus. Individuals and families were warned to remain at home, practice hand-washing, and maintain physical distancing. The media tracked diagnosed cases, hospitalizations, and deaths. In Canada, the Prime Minister, senior health officials, premiers and senior health officers reported daily on constantly changing health information and the race to find a vaccine.

Indigenous Health

The vulnerability of Indigenous peoples in the pandemic crisis was widely recognized internationally (UNDESA, 2022), as well as by federal and provincial levels of government and Indigenous leaders. In Canada, colonization and settler colonialism are significant in the historical and contemporary contexts of Indigenous health. For example, infectious diseases brought by settlers such as smallpox and tuberculosis ravaged large populations of Indigenous peoples. Ongoing disparities in Indigenous wellbeing and life expectancy can now be addressed with an "Indigenous Social Determinants of Health" framework (NCCIH, 2021). This health strategy recognizes the intersection between poor states of health and Indigenous social inequities, including higher rates of unemployment, poverty, food insecurity, malnutrition, overcrowded housing, poor access to clean water, intergenerational trauma, and inequities in accessing health services (NCCIH, 2021). Given that colonial policies persist in Canada's health system, self-determination in health is a necessary step in actualizing the UN Declaration on the Rights of Indigenous Peoples (UNDRIP), Article 23 (NCCIH, 2021).

1.2 Indigenous Jurisdictional Context

Indigenous life in Canada takes place in a complex environment of contested sovereignties and jurisdictions. The State has imposed its jurisdiction over Indigenous Nations. In Canadian provinces, services for Indigenous peoples are divided between the federal and provincial governments and depend upon the classification and residency of Indigenous individuals. First Nations, Métis and Inuit Nations are recognized in Canada's Constitution. In this complex environment, individuals who are members of First Nations communities would normally be eligible for services provided from federal funding.[1] Non-First Nations members, Métis and other Indigenous individuals normally would access provincially funded services (Vides and Morin Dal Col, 2021, p. 12). In the case of Covid-19, vaccine funding was allocated from the federal government to the provinces, bringing all Indigenous peoples in Ontario into

negotiations with the provincial government, the Ministry of Health and provincial public health units in relation to vaccine rollout and clinics. The classifications of Indigenous peoples by the State would prove to have significant impacts on the story of vaccine rollout and access in Peterborough and other provincial health units.

2.0 Peterborough Public Health Unit (PPH)

Located in south-eastern Ontario, Peterborough Public Health (PPH) is one of thirty-four public health units in Ontario. This is the territory of the Michi Saagiig Nishnaabeg, and is covered by Treaty 20 and the Williams Treaties. Peterborough is adjacent to two First Nations communities, Curve Lake First Nation (CLFN) and Hiawatha First Nation (HFN) who have longstanding relationships and involvement with PPH. The history of PPH-Indigenous relations has a bearing on understanding how the Covid 19 vaccine clinics unfolded and so a short historical account is included here.

Curve Lake FN (CLFN) joined the PPH Board in 1998 and Hiawatha FN (HFN) began sitting on the PPH Board in 2009 (PPH, Our History, n.d.) Former Chief Keith Knott of Curve Lake sat on the PPH Board from 2002-2012, and served as Chair of the Board in 2004. In 2015, PPH established a First Nations Working Group to discuss strengthening its relationship with Indigenous Peoples, coinciding with the Truth and Reconciliation Commission of Canada's Calls to Action in 2015. The goal of this committee was "To deepen awareness, sensitivity and meaningful actions on issues that are of relevance and public health importance to indigenous people living within the Peterborough County-City Health Unit (PCCHU) catchment area." (First Nations Working Group, 2016). The committee membership was set to include a Chair and a minimum of three Board members, with representation of CLFN and HFN (First Nations Working Group, 2016).[2] From 2016, membership expanded to include Indigenous peoples who were not living in CLFN or HFN but who were still accessing local health services, specifically Lori Flynn representing the Nogojiwanong Friendship Centre and Liz Stone representing Niijkiwendidaa Anishnaabegkwewag Services Circle (First Nations Working Group, 2016).The Métis Nation of Ontario joined in 2018. The committee meets quarterly and the Chair and Vice-chair are elected by the committee at the beginning of each year (First Nations Working Group, 2016). The First Nations Committee was renamed the Indigenous Health Advisory Circle in 2018, to represent broader representation (inclusion) which extended beyond First Nations representatives. Meetings did not take place in 2021 due to the Covid-19 pandemic.

2.1 PPH Engagement Strategies

Peterborough County-City Public Health Unit has been guided by its strategic plan. Its vision states that "PCCHU will build on the strengths of our local communities, including both First Nations, and work strategically with external partners to ensure that local health needs are identified and addressed. These needs will remain a focal point for all our choices and decisions when planning and delivering public health programs and services."(PPH, n.d.) There are

several community engagement strategies, policies and guidelines that operationalize this vision.

PPH uses a generic community engagement strategy that outlines a continuum of engagement, from informing, consulting, involving, collaborating and empowering. This model uses the language of "stakeholders" to describe the relationships built by PPH. For example, the collaborative approach is described as "To partner with stakeholders in each aspect of the decision from development to solution." The empowerment approach is described as "Shared leadership of community-led projects with final decision-making at the community level."

While the generic community engagement strategy seems to guide PPH's thinking, there are Indigenous-specific engagement models as well. The Ministry of Health and Long-Term Care of Ontario issued a document entitled "Relationship with Indigenous Communities Guideline" (2018). The intent of this guideline is to provide "boards of health with the fundamentals to begin forming meaningful relationships with Indigenous communities that come from a place of trust, mutual respect, understanding, and reciprocity." The document traces the complex historical and jurisdictional environment of Indigenous health and outlines a range of relationship-building approaches including partnership building, and informal and formal agreements. First Nations, Métis and Inuit as well as urban Indigenous contexts are addressed. In addition, the Indigenous-led, Indigenous Primary Health Care Council (IPHCC) released "Gashkiwidoon Toolkit: Covid-19 Vaccine Implementation" (2021), a comprehensive guide to Indigenous vaccine implementation, including the development of Indigenous partnerships with public health units.

2.2 PPH and Vaccinations

PPH organized to deliver vaccines and issued its implementation plan in January, 2021. Four groups and teams were established. The Peterborough Covid-19 Inter-Agency Vaccination Planning Team (PIVPT) was the high-level planning group created to oversee the vaccination strategy, aiming to vaccinate at least 80% of the eligible Peterborough population by September 2021. The Vaccine Sequence Strategy Work Group, a sub-group, was charged with planning prioritization for the vaccine distribution strategy. There were also two implementation teams, one focused on organizing clinics, and the other focused on community liaison with community organizations and leaders (PPH, 2021a).

PPH approved a mandate for the Peterborough Covid-19 Inter-Agency Vaccination Planning Team in December 2020 or January 2021. Curve Lake FN and Hiawatha FN were included members of this group, but urban Indigenous peoples were not members at its inception.

Vaccination priority was a critical issue at the beginning of vaccine rollout when vaccine supply was extremely limited. As Treble (2021) noted, "Queue-jumping is perhaps Canada's ultimate social transgression, especially when it comes to our health care system. And butting into line is

particularly egregious right now, when people are desperately waiting to be vaccinated against COVID-19." In the PPH context, the Vaccine Sequence Strategy Work Group was to ensure "the roll out of the COVID-19 vaccine over time to promote consistency, stewardship, accountability and public trust." In the COVID-19 Vaccine Distribution Plan dated January 29, 2021, priorities were established for vaccine distribution within the PPH area (PPH, 2021a). Following the provincial vaccine strategy, there were three phases, with Phase 1 lasting from January-March 2021; Phase 2 from April – July 2021; and Phase 3 from August onwards. PPH had the flexibility to adapt the provincial phased plan to local conditions. First Nations, Métis and Inuit populations were prioritized in Phase 1 (January-March 2021) and Urban Indigenous Peoples became eligible for vaccines starting in March, 2021. One of the Phase 1 goals was to "Engage Indigenous Leaders in planning for the provision of the COVID-19 vaccine to members of their communities. Provide supports for vaccination (e.g., education, implementation, after action reviews) as requested by Indigenous leadership". Once vaccines became readily accessible, the Vaccine Sequence Strategy Work Group was no longer needed to sequence priority groups.

3.0 What We Did

3.1 Who Are We?

This research was conducted by a student research group under the guidance of the course instructor, Dr. Lynne Davis, a settler scholar teaching in the Chanie Wenjack School for Indigenous Studies at Trent University. Students were enrolled in a third year Indigenous Studies research course that emphasizes respectful Indigenous research and decolonizing methodologies. Twenty of the forty students in the course were engaged directly in this research project, and other students provided support such as summarizing a source review. Students were both Indigenous and non-Indigenous; some of the First Nations students come from Curve Lake First Nation or the local areas, or from First Nations in other regions. Some identify as Métis and others have urban-based Indigenous identities. All students signed an Oath of Confidentiality related to the project.

3.2 Research Goals:

Chanie Wenjack School for Indigenous Studies was approached by PPH to undertake a study on PPH's engagement with Indigenous peoples in planning and implementing Covid-19 vaccine clinics. They were aware that this research would be undertaken by students in a third year undergraduate Indigenous Studies course, under the direction of their professor Lynne Davis.

The goals of the study were to assess the Indigenous engagement strategy of PPH in the specific context of planning and implementing Covid 19 vaccine clinics. PPH provided the student research group with a set of six questions to guide the study. These questions are:

1. How and in what ways were the vaccination clinics for Indigenous groups successful?
2. What were the contributing factors to this success?

3. How and in what ways did Indigenous groups collaborate in the overall local vaccination roll-out strategy?
4. What challenges arose during the planning and implementation of the clinics?
5. What can be learned from these experiences that can be brought forward to inform relationships in the future?
6. What are some opportunities to consider in deepening relationships between PPH and Indigenous communities?

The UIVWG were aware of the study and members were asked to volunteer to be interviewed.

3.3 Scope of Research

While the study was primarily focused on the experiences of the Urban Indigenous Vaccine Working Group (UIVWG), it became clear very quickly that the story of the urban Indigenous vaccine clinics was intertwined in a variety of ways with that of local First Nations and Indigenous peoples as a whole. Based on the interviews, we have included certain aspects of Curve Lake First Nation's experiences with vaccine clinics and the larger political context due to the intersections with the UIVWG's work. As documented by Mashford-Pringle et al. (2021), it is recognized that organizing successful vaccine clinics represents just one of the many challenges that Indigenous peoples were juggling during the Covid-19 pandemic; others related to care of Elders, food security, inadequate housing, movement of people in and out of communities, income insecurity, mental health issues and other obstacles.

3.4 Participants:

Members of the UIVWG and Peterborough Public Health were invited to volunteer to share their experiences. All the participants are busy leaders and managers who carry many responsibilities. Participants included individuals who represent urban Indigenous, First Nations and Métis experiences in the UIVWG, and key staff leaders from Peterborough Public Health. Their names appear in the acknowledgement section of this report.

3.5 Methodology:

We are guided by a decolonizing methodology that places primacy on the voices of Indigenous peoples (Smith, 2021; Archibald, 2020; Kovach, 2009). Storytelling as both methodology and method in Indigenous research is widely accepted and used as a respectful, culturally appropriate research approach (Argue, 2022; Archibald, 2019; Rieger et al., 2020; Martin, 2018). Powerful forms of media have long dominated the storytelling landscape in settler society. By truly listening to the stories of Indigenous people in a self-reflexive way, and with an open mind, we begin to reimagine popular narratives (Argue, 2022). By placing Indigenous voices in the driver's seat, we can take away the power of mythological concepts such as "objectivity", which categorically work against Indigenous interests and silence alternative voices. The people we interviewed in this research were not merely participants in a semi-structured interview. They were, and are, storytellers. It *was* our responsibility to sit and

listen, and now that we have compiled their stories into a written report, our responsibilities carry-on. The report you are reading would not exist without these stories.

Given the fraught history of relationships between Indigenous peoples and researchers, it was important to approach this study with an emphasis on hearing the experiences of both the Indigenous and PPH leaders in this collaboration. In health research, "evidence-based," data-driven research is valued and privileged, but we have not collected quantitative data. We have aimed to tell the story of this Indigenous collaborative relationship through the voices of the individuals who have lived the experience of the collaboration.

3.6 Methods:

From the original research questions, we developed a set of semi-structured interview questions (Appendix B) that would tap into the experiences of participants. We placed an emphasis on gathering individuals' stories related to the vaccine clinics. The consent form (Appendix A) asked individuals whether they could be quoted, or remain anonymous, or if they wanted to see any quotes proposed for use. Most of those interviewed asked to see and approve their quotes.

Interviews took place in middle and late January, 2022. The original plan was to offer both an in-person or a Zoom option for the interview. However, because the omicron variant was at its peak when the interviews took place, it was decided to do all interviews on Zoom. Zoom allowed interviews to be recorded for transcription. Most interviews were undertaken in student pairs. The Zoom platform provided some technical challenges for the student interviewers but they were successful in completing and recording all interviews. Transcripts were coded and stored securely. It was agreed to destroy the interviews and transcripts at the completion of the study.

Prior to the research commencement, the research study was reviewed and approved by two ethics review processes at Trent. Trent's Research Ethics Board reviewed and approved the study ((# 26780). In addition, the study was reviewed and approved by the Indigenous Education Council ethics review process, the review process for all Indigenous research at Trent.

There was some uncertainty at the beginning of the research as to whether sharing circles would also be used in the research, particularly with vaccine clinic volunteers. Accessing volunteers proved difficult in the Covid-19 context and in the research timeframe. Not having the participation of vaccine clinic volunteers is one of the limitations of the study.

After reading interviews, it became clear that more information was needed about the political environment at the provincial and federal levels where vaccine priorities were being negotiated. Chief Emily Whetung agreed to be interviewed to fill in gaps in our understanding of the dynamic interactions that were taking place in the broader political context.

4.0 Findings – What We Found

There are many ways to tell a story. In fact, we will talk about what we found using three different story-telling approaches. The first telling, "What We Found" is a chronological reconstruction of the phases of the collaboration as derived from the interviews: Getting Organized, the Vaccination Clinics, and Moving Forward. The second telling interprets the interviews using the Indigenous values of relational accountability, with an emphasis on respect, responsibility and reciprocity. The third reading of the interviews addresses the six specific questions that PPH asked the research team to comment upon.

4.1 Getting Organized

4.1.1 Organizing the Urban Indigenous Vaccine Working Group

The necessity of organizing became apparent as the pandemic unfolded and vaccination priorities started to be announced. Indigenous peoples (First Nations, Métis and Inuit) were high priority at a provincial level, but priority for urban Indigenous peoples was yet to be established. The idea of bringing urban Indigenous organizations in the Peterborough/Nogojiwanong area together came from the Nogojiwanong Friendship Centre, where Executive Director Lori Flynn and Vice President David Newhouse discussed the importance and urgency of a proactive move. It is uncertain as to whether Lori Flynn contacted Hallie Atter, the community liaison officer at PPH or Hallie Atter reached out to Lori Flynn first. Lori Flynn also initiated contact with leaders in the different Indigenous organizations in the area. In interviews, leaders of the organizations spoke about getting a call from Lori Flynn to become involved. Together they formed what they called the Urban Indigenous Vaccine Working Group (UIVWG). Their first meeting was held in late February, 2021.

Members of the initial group included Nogojiwanong Friendship Centre, Sir Sandford Fleming College, Trent University, Lovesick Lake Women's Association, Métis Nation of Ontario-Peterborough, and Niijkiwendidaa Anishnaabekwewag Services Circle. Some of its members were already on the Indigenous Health Advisory at PPH and so had experience in working with PPH. Some leaders had a history of working together, and some knew each other only informally. The organizations differ in size and financial resources with some having large service delivery capability with paid staff and some being small with a mixture of paid and volunteer staff. Rebecca Watts from Lovesick Lake Women's Association spoke positively about the inclusive approach of forming the UIVWG, "I was grateful for Lori reaching out to all the organizations to get involved." Although there were clear differences, such as participants who had paid employment and those who were attending the UIVWG on a volunteer basis, everyone commented on the inclusivity of the process.

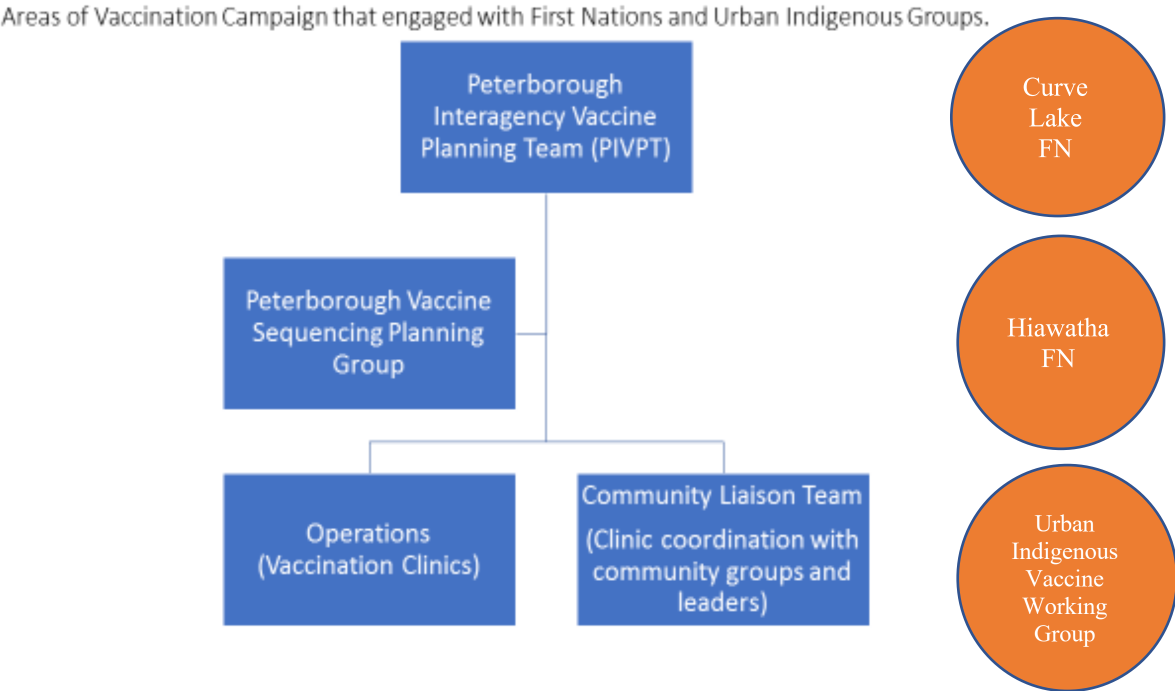
David Newhouse explained the internal process of the working group: "Here's what would happen. On the Friday meetings, every group had to give a quick status report. So we would hear what Curve Lake was doing. We would hear what Hiawatha was doing, and they would hear what we were doing as well. They also talked about the overlap. Sometimes Curve Lake

would say that some of our members went to the urban clinic. And we would say some of the urban residents, who were members of Hiawatha, went to Hiawatha or to Curve Lake. So people recognize the inter-connection."

4.1.2 Getting to the Table

While the Urban Indigenous Vaccine Working Group was forming and getting organized, they were not yet linked into the high level decision-making governance of the PPH vaccine operation. Curve Lake and Hiawatha First Nations did have a seat at the two high level tables, the Peterborough Covid-19 Inter-Agency Vaccination Planning Team (PIVPT) and the Vaccine Sequence Strategy Work Group where local vaccine priorities were being determined. Health Manager Robin Steed who represented Curve Lake First Nation at the high level tables recalled learning about the formation of the Urban Indigenous Vaccine Working Group and asked to attend their meetings. She recalled sharing information with the UIVWG about the high level decision-making tables and the importance of getting a seat at the table. Subsequently, David Newhouse was appointed to represent the Urban Indigenous Vaccine Working Group at both tables. David Newhouse pointed out: "What most people don't realize is that, in the health district, there are probably about 7,500 Indigenous people, and about 6,000 of them are in Peterborough. So the population skews very much towards the urban population. So if you want to create safety for everyone, you've got to think about how to reach out to the urban population."

Figure 1: PPH Organization in relation to 2 Local First Nations and Urban Indigenous Vaccine Working Group (UIVWG)



4.1.3 Getting Access to Vaccine

Although the Métis and urban Indigenous organizations had formed the vaccine working group, there was no guarantee that vaccines would be made available to the urban Indigenous population on a priority basis. The provincial priorities initially were First Nations, Métis and Inuit people. In the early days of the collaboration between the UIVWG and PPH, there were tensions in the meetings since PPH could not respond to whether Métis and urban Indigenous peoples would be prioritized. The environment was fast-paced and in flux when vaccine rollout began and eligibility was shifting.

In fact, important decisions were being made at the provincial level that would impact urban Indigenous peoples in Peterborough and elsewhere. Vaccine priorities were being set at high level decision-making tables at the provincial level and Indigenous organizations like the Chiefs of Ontario, Anishinabek Nation and the Ontario Federation of Indigenous Friendship Centres were lobbying for prioritization. The Province of Ontario established a 9 member Ministers' Covid-19 Vaccine Distribution Task Force under Major Rick Hillier to develop and implement the province's vaccination plan. Ontario Regional Chief Roseanne Archibald (later National Chief of the Assembly of First Nations) was appointed to this high level task force. Chief Emily Whetung of Curve Lake First Nation remembered being called to the task force to present her arguments for maintaining a 21 day schedule for the second vaccine dose for First Nations. At the local level, Chief Whetung and Chief Laurie Carr of Hiawatha First Nation pushed for prioritizing urban Indigenous peoples and whole families, regardless of the Indigenous status of the family members, recognizing that their own members lived in or travelled back and forth to urban centres for employment and housing. At the local tables, Curve Lake representative Robin Steed echoed their support for prioritizing urban Indigenous peoples and families. Liz Stone expressed, "We really truly reached out to people we know, to leaders in the First Nations community and said we need your help, and then it was fixed." At the provincial level, the Ontario Federation of Indigenous Friendship Centres were similarly advocating for the inclusion of the urban Indigenous peoples.

This brief description is only a glimpse into the complex political world where Indigenous vaccine access was being negotiated through numerous health committees and tables in the early days of vaccine rollout. Speaking to the political processes that resulted in Curve Lake First Nation becoming one of the first First Nations to be vaccinated, Robin Steed commented, "We were already at the right tables, and we were just marked out in the rubric to be one of those First Nations to receive vaccines, which was very fortunate for us."

4.1.4 Three Objectives

The Urban Indigenous Vaccine Working Group (UIVWG) established three objectives: 1) to understand the needs of the local urban Indigenous population with respect to vaccines 2) to address vaccine hesitancy with accurate information and 3) to support the vaccine clinics.

1) Indigenous Urban Data – While Indigenous organizations know their clients, there does not exist a data base of Indigenous urban people in the Peterborough area and their health needs. For example, it was not known how many people had special needs, how many might need support in getting to a vaccine clinic and what other supports they may require. It was believed that Statistics Canada data were not accurate or useful for their purposes. The UIVWG undertook an on-line survey to try to gather more information, with the intention of using it for planning purposes. One of the factors in understanding Indigenous needs in Peterborough is the fact that it is a college and university community. Indigenous students come from many different places and Indigenous Nations while attending school and then may return to their home communities after the school term. This meant that while PPH vaccine clinics might inoculate those who were resident temporarily, they may not be living locally at the time when a second dose was scheduled. This characteristic of the local Indigenous population necessitated working with other public health units in Ontario and outside of Ontario.

2) Vaccine Hesitancy - Researchers have been documenting the extensive vaccine hesitancy of Indigenous peoples (IPHCC, 2021; NCCIH, 2021; Mosby and Swidrovich, 2021). *Gashkiwidoon Toolkit: Covid-19 Vaccine Implementation* (IPHCC, 2021) addresses vaccine hesitancy as a significant issue in the Covid-19 vaccination campaign for Indigenous peoples. They point out the historical injustices that have taken place in Indigenous health, including using Indigenous peoples in medical and health experiments without informed consent (IPHCC, 2021). For that reason, giving priority to vaccinating Indigenous peoples raised the question in the minds of some as to whether they were being used as "guinea pigs" for the new vaccines. Robin Steed shared that at Curve Lake residents remember that as children, they had been inoculated at the Indian Day School with a single needle, and had no knowledge of what they were being given. Chief Whetung recalled that the Curve Lake health team had to work very hard to inform people that they were being prioritized because the Indigenous leadership had fought for this priority. The overall approach of Curve Lake and the UIVWG was to provide accurate information to people about the vaccine so that they could make an informed choice. In doing this, they drew upon the expertise of PPH to ensure that they had and were transmitting accurate information.

   Rebecca Watts shared what it was like to be encouraging people to get vaccinated. "When I posted on my Facebook at work I did get some nasty comments, and from Indigenous people from all over. Not a lot, don't get me wrong, but just 'why are you promoting this, why are you allowing our people to get vaccinated when you know all they've been through'. It was very hard…"

Accurate medical information was something that PPH was able to bring to the table. Christa Lemelin commented on how useful it was to have accurate information through PPH and that Métis citizens had opportunities to attend information sessions on-line with the Medical Officer of Health. Robin Steed similarly expressed gratitude for the information sharing and the availability of top PPH staff to provide information directly to Curve Lake citizens. Rebecca Watts also praised PPH for being available with good information. Ashley Safar noted, "Peterborough Public Health was really great in that we were able to have some Q&A sessions virtually for community members, specifically for Indigenous community members with Dr. Rosanna Salvaterra [past Medical Officer of Health], and then more recently, with Dr. Piggott [new Medical Officer of Health]." All the partners were able to advertise information sessions through social media and to send out accurate information to address vaccine hesitancy. Christa Lemelin recalled, "So I think people … maybe heard through word of mouth that this is going to be a great place to go. And now's the time to get your vaccination done but also at the same time, being prioritized to have vaccines I think helped with that too."

3) Planning for Vaccine Clinics

PPH's plan was to hold a mass vaccination clinic. The UIVWG had serious doubts that urban Indigenous people would attend a mass clinic. David Newhouse commented, "We developed a series of Indigenous-specific clinics. Curve Lake did the same thing, and Hiawatha did the same thing."

An Indigenous vaccine clinic is "one that either took place within a First Nation community or was organized uniquely for Indigenous community members and any non-Indigenous household contacts, in partnership with local Indigenous agencies" (PPH, email communications, March 13, 2022).

The urban Indigenous clinic was planned for a large Peterborough community facility called the Healthy Planet Arena (formerly, the Evinrude Centre). It was felt that the Nogojiwanong Friendship Centre, the largest Indigenous facility, was not large enough. A PPH staff member recalled, "By the time it was ready to start putting plans in place, we already knew who we were talking to. They were ready and then we could put those plans in place pretty quickly."

The planning of the vaccine clinics turned out to be an important site of learning and relationship building. Ashley Safar who was representing Fleming in the early stages commented: "It was a learning curve I think, for all of us! But it was positive to have that space for discussion and feel supported by Peterborough Public Health."

One of the tensions that arose in the planning was the non-coincidence of service boundaries. Different organizations had catchment areas that did not coincide with each other or with PPH. Defining the boundaries for recruitment and marketing of the vaccine clinics proved to be

difficult as the UIVWG tried to determine how best to reach out. Beyond the initial clinics, the UIVWG would form new partnerships and add new members to its original core to protect Indigenous peoples living in communities beyond the Peterborough area (e.g. Lindsay, Haliburton, Cobourg).

4.2 Vaccine Clinics

4.2.1 Organizing the Indigenous Vaccine Clinics

To create an Indigenous-specific vaccine clinic, all the members of the UIVWG mobilized. UIVWG took responsibility for booking, rather than have Indigenous individuals go through the provincial on-line system. The organizations set up a telephone booking system with lines that individuals could phone. This booking system meant that staff members were diverted from their regular job responsibilities to work on the vaccine clinic booking or took on the booking responsibilities on a volunteer basis. It was necessary to use personal cell phone numbers to create enough response capacity. David Newhouse commented, "The staff in the Indigenous service organizations were incredibly strong. We used the organizations to create the schedule for vaccinations. Those staff members worked incredibly hard."

One of the issues that came up in clinic planning was the potential for protest at the vaccine clinic sites by those opposing vaccines. After consideration, it was decided to use security services rather than have a visible police force, given the sometimes strained relationship between Indigenous peoples and the police.

4.2.2 Creating Culturally Welcoming Clinics

Whatever the challenges of setting up and running the Indigenous clinics, the success of the first as well as subsequent Indigenous-specific clinics stood out as a moment of deep accomplishment for the UIVWG leaders. Those interviewed made powerful comments about this success, for example:

David Newhouse offered: The first clinic we held in March was like old home week. It was an Indigenous only clinic for the entire day…There were long line-ups and people were waiting in their cars, but they also talked to each other. People were reconnecting after being apart for such a long period of time. They all said that this was a community-building event. This allowed us to connect with each other, in person, for the first time, so that was good.

Lori Flynn recalled, "Our staff from the Indigenous organizations were volunteers at the clinic. This meant that when people screened into the clinic they were greeted by familiar faces. The building was smudged every morning and sacred medicines were offered. Familiar faces, ceremony and sacred medicines made the clinics feel like a safe place."

Christa Lemelin remembered: They had a really awesome group of volunteers. The clinic itself was very welcoming and we were there for the first clinic. There were people handing out tobacco ties, and there was visibility. The one wall had a medicine wheel, for example, and it just felt welcoming and just the people that were there knew who was coming to the clinic. It was like a [laughing] family gathering because we knew people there. Everybody seemed to know everybody so it was a friendly atmosphere, which was really great.

Rebecca Watts commented: We gave out tobacco ties to the people when they came in so they had that to hold when they're waiting to get their vaccinations. And it's our elders and our younger people and stuff but it was amazing. They had the medicines there if people needed, and it was just very "wow"!

Ashley Safar related: I remember that first vaccine clinic in March. I volunteered at those clinics and we had to be in all this PPE. But it was really great to see community! it had been a while since we'd seen each other. And it was this really, really neat… It's hard to explain, just like this feeling of like being engaged, and involved in, and supportive, and excited!

Liz Stone shared: There's a number of people that I'm aware of that hadn't otherwise felt comfortable in identifying as Indigenous and wouldn't necessarily have signed up for the Indigenous clinics. But because we did calls where people could call in and speak to a real person and then maybe get a follow up call for the second dose, they came. They came and they said they felt proud. They felt OK to go to an Indigenous clinic.

4.2.3 Volunteers and Indigenous-non-Indigenous Encounters

The Indigenous organizations provided volunteers for the clinics and there were also non-Indigenous volunteers who worked in the clinics through the PPH volunteer processes. The encounter of the two groups of volunteers did not always go smoothly. The Indigenous organizations, under the leadership of Liz Stone of Fleming College, took care to smudge the space when they were preparing for the clinic. Smudging as a spiritual cleansing practice was unknown to PPH clinic organizers and volunteers initially, and non-Indigenous volunteers interrupted the ceremony with questions. Liz Stone explained, "Some of the venues were reluctant because they look at smudging as smoking and then they think about logistically the buildings are going to set off any alarms. So at the very start when I would go in and smudge, the Fire Marshall would meet me there early in the morning and just stay in there while I smudged. They wouldn't follow me around or anything; they were just basically staying there and they didn't have a whole lot of knowledge about what it was."

The need to educate the non-Indigenous volunteers became a recurrent tension as the clinics were scheduled. Non-Indigenous lack of awareness and everyday acts of racism were something that Indigenous organizers and volunteers faced, while trying to create a welcoming environment for Indigenous people who were coming to get inoculated.

Still, there was learning that went on as non-Indigenous clinic organizers and volunteers became more knowledgeable about Indigenous protocols and practices. PPH clinic organizers began to ask if it was appropriate to do a smudge when setting up for a clinic. In June, 2021, when 215 bodies of children were found on the grounds of a former residential school at Kamloops, British Columbia, the levels of upset, grief, anger and frustration in the Indigenous community were raw and palpable. Liz Stone described the intervention they made at the beginning of the June clinic: "We asked Indigenous volunteers what they needed. They needed to be able to express themselves. They created ribbons and pins and orange shirts[3] and said they needed not to be asked about it. They needed to just be where they're at and they were OK to continue to volunteer. And then I talked to the non-Indigenous volunteers and I said what do you need. And they came with orange shirts and everything, which was really awesome and beautiful to see. And they said we just need people to know that we're sorry, and we're in mourning as well and this is horrific and we're going to try to do things about it."

Ashley Safar recalled the clinic in June, 2021. "Everyone wore their orange shirts for that clinic. All volunteers, even the non-Indigenous volunteers wore their orange shirts and they wanted to ask questions, and they wanted to do more, and they wanted to do better. And we were able to hold space for that at the beginning of the day and take a moment to acknowledge all those children and acknowledge what we all might be feeling. And I do believe Liz Stone expressed that the emotions are challenging to navigate, and that takes time. So that everyone would be aware, right? In terms of the conversations or the questions, maybe that non-Indigenous volunteers might ask Indigenous volunteers unintentionally, maybe cause some harm, but that didn't happen! We were able to mitigate that and I think we learned that along the way through our other experiences, and so it really showcased our growth... and that collaboration, that meaningful collaboration."

4.2.4 Learning and Shifts Over Time

Alliance building can be an uncomfortable process and entails learning and transformation (Davis and Shpuniarsky, 2010). It is evident in the interviews that the collaboration was a learning experience both for Indigenous leaders and PPH staff. Both parties faced new challenges and worked together to find solutions. Trust evolved as the partners got to know one another. PPH staff described how they learned from each clinic and worked to bring their learning into subsequent clinics, for example, opening the clinics earlier so that the space could be smudged. PPH volunteers were also learning as they became more familiar with Indigenous cultural protocols and norms.

PPH staff member Laura Hess noted: "We have a lot of community volunteers, we have a lot of different health care providers, and there was a lot of really great communication prior to these urban Indigenous clinics, letting them know that we would be welcoming others from the community that would be coming in to support the cultural sensitivities and competencies and making sure that everybody was aware and open and excited to be a part of the collaboration between the communities."

Still, there were some communication issues that came up later in the process. As time went on, providing Indigenous volunteers for clinics grew more difficult as staff at Indigenous organizations who were volunteering got busier with the return to in-person services in their own organizations.

4.2.5 Sharing Curve Lake First Nation Experiences

Curve Lake was one of the first First Nations in Ontario to receive the Covid-19 vaccine and their clinics took place well before the urban Indigenous vaccine clinics. Curve Lake representative Robin Steed was able to share their experiences with UIVWG members. Chief Emily Whetung and Robin Steed worked closely together and both talked about the intense political negotiations that took place to obtain the vaccines. They had to address the vaccine hesitancy in the community, and offered information so members could make informed decisions. Chief Whetung shared, "I was at the vaccine clinic walking around talking to people [to] continue the education piece, as they were waiting to get vaccinated. I made sure that I had the information necessary to answer those questions."

The initial clinic was designed with great care. Chief Whetung recalls, "Our Elders walked in the door en masse, just one after the other. There were all of these Elders coming in, and they were grateful and they were excited and they were happy to see each other… and they were the first ones. I don't remember in the first hour of the first clinic seeing anyone under the age of 60."

The vaccine clinic was held at the Curve Lake Community Centre, the site of many community events. Unlike the straight rows of the mass vaccination clinics, the chairs were arranged in lines with chairs tilted to face each other so that people could chat with family and friends. Chief Whetung recalled, "It was very celebratory. A lot of really hard work, but it made people feel safe and it totally needed [to be] a safe space for people to get vaccinated and we made it an information space, so if you had questions, you got them answered. There were doctors there, there was nurses from Public Health. We fed lunch to the Public Health staff every day to make them feel welcome in our community and to show appreciation for their efforts."

Members of the community volunteered at the vaccine clinics and at the same time, there were volunteers through PPH. As at the Indigenous vaccine clinics in Peterborough, there were growing pains as PPH volunteers adjusted to Indigenous relational norms, as Robin Steed reported, "I said, the vaccine clinic will go a lot easier for all of us if people can face one another. And I kept moving the chairs back. Well, the chairs would get moved and I'd go back and move them back. I had a conversation with the individual who had been moving the chairs [PPH volunteer] but they continued to move the chairs. I spoke to them again and said, 'if you move that chair one more time, you're going home. You don't need to be here.' And she said, 'Who are you to speak to me that way?' And she went to her site lead through Public Health and they said, 'no, she's right'."

The Curve Lake vaccination team extended the ethic of community care to the children and youth when it was time for them to be vaccinated. As Chief Emily Whetung described: "For our

children's clinic we put a movie on at the front of the group, we divided it differently, we had all of these backdrops from different movies, and we made it super fun. And then every kid as they came in, got a stuffed animal that said, 'I Got My First Dose in Curve Lake' and they got a Curve Lake squeezy eagle and we had community volunteers… giving out popsicles or treats that were semi-healthy… then there was stuff to distract everybody when the little ones had a hard time."

Curve Lake and PPH have had a decades-long relationship. The virtual information sessions convened with Peterborough Public Health where community members could have their questions answered contributed a great deal to the vaccine effort. However, there were some bumps in the road during the pandemic. Chief Emily Whetung shared her frustration in getting a firm commitment to the second vaccine dose. The Province of Ontario had shifted strategies to give a first dose to as many Ontarians as possible, despite earlier promises of second doses to the first people vaccinated. As Chief Whetung explained: "We hit a point with Public Health, where they had given away our second dose clinic date. We had already booked 1000 people… And Robin stepped up and said to Public Health at the time, 'Well, your new direction from the province is to ensure that Indigenous people get it in that 21 to 30 day window. So if you move our clinic to the new date, you're actually in violation of your own regulations that have been sent out from the province', at which point we got our original date."

Robin Steed described the tremendous collective effort of the whole team in making the vaccine clinics a success: "And I wanted to use this analogy, like how my home maintenance workers, my snow blowers, and all of them just show up and they do vaccine clinic. My team has told me that this is it. This is a big game. We're the Mighty Ducks, and we got to the NHL. That's the analogy, right? We're just these guys who do healthcare out here, and we've been kind of doing our own thing. And now the NHL called us up and we're winning the game. It's kind of stupendous. So that's kind of how we're feeling. And we're going to keep playing in the NHL now that we're there."

The Curve Lake experience with procuring vaccines and implementing the clinics was shared with the UIVWG, in a rich exchange of information that all members could draw upon. The regular meetings of the UIVWG offered a collaborative space that would allow the group to move forward in a variety of ways. As David Newhouse commented, "Robin Steed from Curve Lake would always talk about the clinics they were setting-up, and the way in which they were reaching-out to members. You got a sense that these were well-organized communities who knew what they were doing."

4.3 Moving Forward

The formation of the UIVWG crystalized a set of relationships that already existed in a less formalized way. Collaboration was solidified among urban Indigenous and Métis organizations and with local First Nations. As Ashley Safar noted: "It's created an opportunity to get to know each other. We've been meeting pretty regularly now for over a year… having this opportunity to come together so regularly, get to know one another, that makes a difference."

The IUVWG has created a legacy on which to build. They got to the decision-making tables, they obtained vaccine priority, they organized Indigenous vaccine clinics successfully and they created solid relationships with PPH that are foundational for future work. Indigenous leaders spoke in strong voices about the future. They have already moved on to new projects, broadening the scope of their collaborations beyond the vaccine clinics. Liz Stone summarized how the UIVWG and its partner PPH have moved beyond the Covid-19 vaccine partnership:

> *Because of the pandemic, we were brought together to make sure that urban communities were taken seriously and acknowledged as being at risk as well. But now we have grown that …so we decided that we will stay together. The group actually just started. [We've met] with Dr. Pigott and he said, "OK, so where are we moving from here? What do you need? I want to hear what the issues are with the urban Indigenous community [besides] the pandemic." So we've expanded it, we're talking about mental health, we're talking about addiction, we're talking about homelessness-- all those social determinants of health that are specific to the Indigenous community.*

Robin Steed emphasized the importance of having formal structures to get recognition from higher up government decision-makers. "I see us continuing to have an urban Indigenous table, and maybe it changes from the vaccine table to the urban Indigenous partnership agencies or something with a health focus… So I think you'll see more partnering and working together."

David Newhouse expressed the necessity of gathering more information about the needs of urban Indigenous population, "We don't know a great deal about the urban Indigenous communities, and I'm going to try over the next few years to find ways in which we can collect some of that health data and thinking about our programming."

One of the challenges in the initial efforts of planning vaccine clinics was the non-coincidence of geographical borders. There were Indigenous people being left out of protection because of service gaps. In the fall, 2021, the UIVWG expanded to include service to additional Indigenous people including Lindsay, Haliburton and Cobourg and the Haliburton-Kawartha-Pineridge District Health Unit. New partners joined in the collaboration to reach out to Indigenous peoples. This meant that the Indigenous vaccine clinics grew to include new vaccination sites.

These thoughts and ideas speak to the opportunity to think about urban Indigenous governance structures at a time when urban Indigenous people in Ontario constitute over 85% of the Indigenous population in Ontario[4]. This initiative of working together has added momentum to the movement for urban Indigenous self-determination and stronger partnerships among urban Indigenous organizations and with local First Nations.

5.0 RELATIONAL ACCOUNTABILITY

Relational accountability was a critical factor in the success of the COVID-19 Vaccine strategy. Relational accountability speaks to the sense of accountability Indigenous organizations have to one another, the communities they serve and to future generations. It also speaks to the accountability that state agencies like Peterborough Public Health must respond to, in order to provide equal and respectful protection to Indigenous peoples at a time of global health risk and societal stress.

Indigenous values in relationships are often expressed with "R" words, such as respect, responsibility and reciprocity (McGregor et al., 2018, Wilson, 2008; Archibald, 2019; Smith, 2021). Relationality and relational accountability have been described as fundamental to building trust. Here we discuss how relationships were manifested in ways that emphasize relational accountability.

Respect

> *She [Hallie] was dedicated and very flexible with us and really respectful of our thoughts and our perspective on what we felt we needed to do. (Lori Flynn)*
>
> *We needed to be able to drive the bus so to speak, so it was great. They asked a ton of questions, they were very open to letting us lead so it was really good*. (Liz Stone)

Indigenous leaders spoke with great respect about the efforts of Hallie Atter who had been PPH's point person with the UIVWG. She had an open attitude and humility in the learning process. She was able to ask for advice, admit her uncertainties and stand out of the way so that Indigenous leaders could engage in their own planning processes.

The UIVWG operated using the cultural processes that are customary in Indigenous communities. As an organization, PPH was challenged to consider its own norms and values and to open itself up to other styles of leadership and practice. Liz Stone gave this example: "At the first Indigenous clinics, we all wanted to take pictures and post on social media, the needle going in our arm. And the Health Unit was like, 'well, you can't do that; it's privacy' and I said, well, it's just me and my son, or it's just me and my auntie, taking a picture. So the first clinic we kind of got away with that. We got pictures because they were just too surprised that we were so open about those things."

The UIVWG established an inclusive circle. Despite differences in staffing and available resources, all the urban Indigenous organizations were invited to participate. Indigenous leaders commented that they had already known one another and who does what. But the

sharing and respect within this circle intensified existing relationships and created the conditions for collaborations into the future, as noted below:

> *I honestly feel very honored to have been a part of the rollout of it… I really appreciate all the different organizations and the inclusivity of helping people and helping community and bonding as one great big organization.* (Rebecca Watts)

> *It also strengthened our relationship with the local First Nations communities: with Curve Lake and Hiawatha, who then began to recognize the urban Indigenous community organizations and their strengths as well.* (David Newhouse)

Responsibility

> *It also was our willingness to say we're going to do whatever it takes to make our community safe. (Liz Stone)*

> *It was recognition and work from the heart of helping people that made it work. And nobody really knew what we were doing, but we were doing it together. And I think now we have a much broader understanding of what needs to be done and who does what, and we can kind of go back to our routine. But early on it was just really get in there, do what needs to be done, do what's right*. (Robin Steed)

The overwhelming sense of urgency felt by Indigenous leaders flows out of a sense of responsibility for the well-being of the community. "The community" includes spouses, children, mothers, fathers, sisters, brothers, aunties, uncles, friends, co-workers and colleagues. Responsibility was demonstrated not only in fighting for the priority of gaining access to the vaccines but also in the efforts to overcome vaccine hesitancy, to create culturally safe clinics, and to stand against non-Indigenous interactions that might affect the trust and safety of Indigenous community members. Indigenous staff volunteered to participate in this effort that exceeded their paid time, stepped beyond their job responsibilities, and required even heavier workloads. They were unrelenting in their sense of responsibility, as evidenced in all the interviews.

Reciprocity

> *We've bridged gaps and we're able to connect with one another. Because it goes both ways right… if something comes up on Hallie's end of things, she knows that she can connect with us too. And so, we didn't always have that before…* (Ashley Safar)

Reciprocity is a process of exchange where benefit flows between the parties involved. Indigenous leaders described the relationship with each other as mutually beneficial, closely focused on the goal of helping community. The Covid-19 collaboration has allowed new partnerships to form to work together around a range of mutual issues from Indigenous mental health to food security.

The relationship between Indigenous organizations and PPH are seen as reaping benefits that flow in both directions. On the one hand, the relationship with PPH has been solidified through the invaluable support role played by PPH in helping the UIVWG to protect Indigenous peoples. At the same time, PPH has grown its own capacity to collaborate with Indigenous communities and organizations through a deep learning process. Not only were new contacts made and friendships developed, but the ways of working respectfully with Indigenous communities and organizations were clarified and can be applied in the future.

Creating and maintaining respectful and mutually beneficial relationships between PPH, the UIVWG and the people that they serve was and will continue to be of utmost importance moving forward. Respect, responsibility, and reciprocity were established through the synergy of the collaboration and formed the backbone of relational accountability. As a result, interconnectedness was strengthened, and many lessons were learned with all parties benefitting.

6.0 RESEARCH GOALS FOR THE STUDY

PPH provided the research group with a set of overarching research questions.

1. How and in what ways were the vaccination clinics for Indigenous groups successful?
2. What were the contributing factors to this success?
3. How and in what ways did Indigenous groups collaborate in the overall local vaccination roll-out strategy?
4. What challenges arose during the planning and implementation of the clinics?
5. What can be learned from these experiences that can be brought forward to inform relationships in the future?
6. What are some opportunities to consider in deepening relationships between PPH and Indigenous communities?

Through sharing our findings, we have addressed these research questions drawing upon the voices of the participants and the themes they addressed. We now return to the original research questions, using them as a framework to summarize the experiences of those interviewed, echoing what has been discussed above.

6.1 How and in what ways were the vaccination clinics for Indigenous groups successful?

We did not try to define "success" at the outset but have gathered an understanding of how different individuals understood "success" in assessing the collaboration and the vaccination clinics.

6.1.1 Vaccinations: The most visible evidence of success was the achievement of vaccinations both for community members living in First Nations communities and for the Métis and urban Indigenous peoples, including their families and those who have shared residences. Between March 3, 2021 and March 4, 2022 – one year after the vaccines had rolled out, 35 Indigenous vaccine clinics had been organized by the two First Nations and the UIVWG and Peterborough Public Health: 12 in Curve Lake First Nation, 13 in Hiawatha First Nation, and 10 for urban Indigenous peoples (PPH Email, March 11, 2022). Approximately 3,000 people received a first dose at the Indigenous vaccine clinics, about 3,000 people received a second dose, and about 1,400 received a third dose. (PPH Email, March 11, 2022).

David Newhouse expressed, "We have no idea at this point what percentage of the population was vaccinated… but we did as many as we could, reached out to as many as we could." One leader expressed that the experiences of the individuals attending the clinic had to be considered in assessing success.

6.1.2 Indigenous-Led Clinics: Both Indigenous leaders and PPH worked with their strengths in planning and implementing the vaccination clinics. Indigenous leaders were able to "drive the bus" to create Indigenized clinics that were culturally welcoming with visible Indigeneity within the clinics, from smudging and other cultural practices to clinic volunteers to those who were assisting with the booking of appointments. Instead of using a government website or a 1-800 number, appointment bookings were accomplished through phone calls and emails, bringing a more personal and holistic approach to the process.

PPH provided accurate health information, as well as clinical and logistical support based on their experience in organizing vaccine clinics. The data and information consistently shared were up-to-date and very punctual. Having accurate data allowed the partners to address vaccine hesitancy and to have confidence in their communications with community members.

6.1.3 The Urban Indigenous Vaccine Working Group Collaboration: The collaboration among the Indigenous organizations, including First Nations, Métis and urban Indigenous organizations, was a successful process that reflected shared purpose. As Robin Steed remarked, "I think was a lot smoother than other places because we already knew each other and we already had rapport and we already knew who to reach out to". It was strengthened by meeting regularly and exchanging information of great value to the partners. It became a mighty force that could expand the scope of collaboration into addressing other areas of well-being in the Indigenous communities served.

6.1.4 Communications: The level of communication between organizations and individuals became an important support in enabling the success of the vaccination roll-out. The communications were meaningful enough that they have continued a bi-weekly basis, discussing other important topics such as mental health issues amongst community members.

6.2 What were the contributing factors to this success?

6.2.1 Established Relationships

The relationships in the UIVWG were not forged from scratch in the face of the pandemic. As David Newhouse observed, "Something we can learn from all of this is that there is a great deal of value in long-standing working relationships. Curve Lake and Hiawatha have been part of the Health Board now for close to two and a half decades… They didn't have to build a relationship. So I've been thinking about that in terms of reconciliation. I mean there was no hesitation."

It might also be recalled that UIVWG leaders Lori Flynn, Liz Stone, and the Métis Nation of Ontario had become members of PPH's Indigenous Health Advisory Circle in 2016, bringing urban Indigenous peoples into relationship with PPH on a regular basis, although not with a seat at the PPH Board table.

Indigenous leaders felt that their existing informal and formal relationships prior to the PPH collaboration created the foundation upon which this new working group could grow. In this sense the UIVWG grew from the soil of existing relationships that could be mobilized for the pandemic response and for new endeavours.

6.2.2 PPH's Openness and Willingness to Learn

> I absolutely think there is success. What contributed was the health unit's willingness to work with us and to accept our ways of being and doing (Liz Stone)

There were challenges in relationship-building that stem from different worldviews and approaches to working together. Liz Stone noted, "They're raised and educated for keeping that arm's length approach and not mixing personal and professional, whereas from an Indigenous perspective, we're fine, we're cool with that."

"Accepting our ways of being and doing" requires being open to re-examining one's own "truth" and recognizing there are other "truths". Robin Steed shared the shift in relationships that took place with PPH as a result of working together on the vaccine clinics: "There's a stigma with mainstream services that they look at us and they think we don't have the right credentialing to do certain things we do. They don't understand that there's different types of credentialing or life experience … And there's been a real recognition of the value of my team

and their knowledge base that wasn't there before. So, they're now trusting that my community health rep. He's an Aboriginal diabetes specialist, and he's not a nurse and he's not a doctor, but he has a role to play, and he has insight, and he has knowledge that may be valuable… But I think that they really have had a chance to see that they can trust us."

There is another sense in which PPH displayed learning. The agency opened its decision-making tables to the UIVWG. David Newhouse, as a representative of the UIVWG, took a seat on Peterborough Covid-19 Inter-Agency Vaccination Planning Team (PIVPT) and the Vaccine Sequence Strategy Work Group. Having a seat at the table was crucial to meaningful participation in decision-making that would affect the interests of urban Indigenous peoples.

This openness to listening and learning is an essential quality in alliance-building. PPH staff who were on the front line of organizing the vaccine clinics spoke about the high-level collaboration between First Nations and urban Indigenous peoples with PPH and how that commitment to Indigenous-led clinics filtered down from the top leadership to the front-line PPH staff. There was an openness to learning and doing better over time.

6.2.3 Finding Unity

Liz Stone commented that the success of the collaboration can also be attributed to the diversity of Indigenous leaders coming together and their mutual respect:

The collaboration of Indigenous people and organizations worked so well because we respect and acknowledge the diverse knowledge and expertise on the committee. From a Western perspective, it may appear to be a group of urban Indigenous leaders, but within the group, we recognize that we represent the diversity of the Indigenous community: Traditional, contemporary, post-secondary, families, marginalized and, of course, areas of intersectionality.

The Indigenous leaders of the UIVWG are highly cognizant of the larger colonial environment and are constantly navigating its challenges. Despite all the divisions caused by the Indian Act and jurisdictional mandates, the pandemic crisis brought them together to accomplish a common purpose. First Nations reached out to their urban counterparts, and urban leaders reached out to First Nations. Member organizations, both large and small, came together into a circle. The Métis brought their distinct needs to the table. Each brought with them the exceptional expertise they have as organizers in their communities and challengers of a system that is often antagonistic to them. Everyone fought to protect the health and well-being of the Indigenous community, regardless of classification. Tensions were negotiated and solutions sought. They pooled their strengths and created a successful collaboration on which they are now building for the future.

6.3 How and in what ways did Indigenous groups collaborate in the overall local vaccination roll-out strategy?

This report has discussed Indigenous group collaboration in sections 6.2.1 and 6.2.3, as well as 4.1.1. The following is a brief summary of points already discussed.

6.3.1 The UIVWG Collaboration

Prior to the pandemic, there were already working relationships in place between the Indigenous communities in Peterborough, which facilitated the current collaboration (see section 6.2.1). However, new bonds were formed during the vaccination campaign, as local First Nations, the Métis Nation, and urban Indigenous organizations worked together in the face of an urgent threat. The collaborating parties mobilized into a formidable force focused on ensuring Indigenous protection. Despite the serious focus of their work, the process of working together was often enjoyable, and many leaders expressed a sense of newly found unity. These comments by Lori Flynn and Christa Lemelin convey how this experience created a new common purpose:

> We have our own mandates to achieve, and sometimes they do overlap, which is great. But life is very busy-- our organizational work is very busy. And sometimes we don't get to collaborate as often as we would like. This clinic, the collaboration, really brought us together and it gave us an opportunity to really work together in a very focused way, so it was fun. We actually enjoyed spending that time together. We often say, one of the great things about it was that we actually got to play together right in the same sandbox. It was fun! (Lori Flynn)
>
> There's always been a relationship there, but the strength of that relationship definitely got a lot stronger over the last couple of years. [We] got to meet different people, not just one person on an advisory committee. We really got to know who certain people were and what their intentions were, and they were all in this to really help. (Christa Lemelin)

6.4 What challenges arose during the planning and implementation of the clinics?

6.4.1 Jurisdictions

Canada has adopted the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) which contains strong provisions for Indigenous self-determination, including health (Article 23). Nevertheless, Canada's federal and provincial jurisdictions overlay Indigenous sovereignty, creating complex relationships. Negotiations of federal and provincial health mandates, including how First Nations, Métis and Inuit peoples would fit in, took place in a highly

politicized environment where health information was rapidly evolving in a global context. First Nations and urban Indigenous peoples had to fight for priority in the significant effort to protect the national population from the Covid-19 virus.

The PPH decision-making structures had been evolving from the historical membership of local First Nations on the PPH Board, to expanding to include Métis and urban Indigenous peoples on an advisory committee, responding to the Calls to Action of Canada's Truth and Reconciliation Commission (2015) and the UNDRIP. Yet in the Covid-19 environment, there were many decisions beyond the mandate of PPH. In the interviews, Indigenous leaders gave examples of disputes that required strong advocacy to get their needs met. Members of the UIVWG understood that PPH had to take some things up the line to higher decision-making levels. This meant that Indigenous leaders sometimes came into conflict with PPH who were mediating policies and regulations from the higher up decision-makers.

6.4.2 Vaccination Priorities

Getting vaccines on a priority basis was a huge accomplishment for both the First Nations and the UIVWG. But it was not an easy victory. It took strong determined leadership to achieve. Chief Emily Whetung (Curve Lake FN) and Chief Laurie Carr (Hiawatha FN) were successful at the provincial and local levels in lobbying for vaccines both for their reserve communities and for the urban Indigenous peoples, including their First Nations members and their families. The UIVWG had to keep up their lobbying efforts both to get to decision-making tables and then to secure vaccine priority.

Chief Whetung described the fight to maintain their scheduled second dose clinics. When vaccines were in short supply, there were lots of tensions that affected the early relationship-building between the UIVWG and PPH.

6.4.3 The Vaccine Clinics: Indigenous-non-Indigenous Relations

The vaccine clinics were/are a microcosm of Indigenous-settler relations in Canada. Indigenous leaders' actions to Indigenize the vaccine clinics were met with resistance from some regular volunteers and facility managers who were not familiar with local Indigenous and Métis protocols, practices, medicines and teachings, including the smudging and preparation of the space. Robin Steed commented, "sometimes they say things that they don't realize come across in another way".

The priority of Indigenous leaders and volunteers was to create a vaccine environment that was warm and inviting to the Indigenous community. Indigenous leaders often took on the emotional labour of educating non-Indigenous volunteers who made insensitive comments or exhibited unacceptable behaviours. As Liz Stone shared, "We as Indigenous people have been living with this kind of crap for a long time. We're a little bit more forgiving …we're a little bit more used to it…"

The discovery of 215 bodies of First Nations children at the Kamloops Residential School in June, 2021 left Indigenous peoples traumatized and sent shock waves through a country that has long denied its own history of violence against Indigenous peoples (Regan, 2010). One of the defining images from the June urban vaccine clinic was the wearing of orange shirts by Indigenous and non-Indigenous volunteers, a moving act of solidarity. It was a particular moment that showed the learning and the shifts in consciousness that were evolving as Indigenous and non-Indigenous volunteers worked together. It also showed the deep skill and experience of Indigenous leaders in calming the complex emotional terrain that can emerge in Indigenous and non-Indigenous encounters.

Challenging insensitivity was exhausting work for Indigenous leaders and volunteers. Liz Stone remembered an incident when they were doing a vaccine clinic: "The [non-Indigenous] volunteers themselves had no knowledge or very little knowledge so the Indigenous volunteers were dealing with offhanded comments. Somebody came up and said "so I don't understand why we're having an Indigenous clinic because there's no Indigenous people here." Liz Stone responded forcefully: "It shouldn't be me or any other Indigenous, visibly Indigenous person or not, made to validate or justify their existence." She challenged the volunteers to do their own research if their leaders had not provided them with accurate information. "There is a good majority of those non-Indigenous volunteers that had a quick ah ha moment."

In the wake of the Truth and Reconciliation Commission's (TRC) Calls to Action (2015) and the continuing discovery of children's bodies at former residential schools, more Canadians are seeking to learn about Canada's historical and ongoing violence through the voices of Indigenous peoples and to understand why the TRC called Canada's policies acts of genocide. As the vaccine clinics demonstrated, disrupting the current narratives through which Canadians understand themselves and Indigenous peoples is critical in any endeavour that brings Indigenous and settler peoples together in meaningful relationships.

6.5 What can be learned from these experiences that can be brought forward to inform relationships in the future?

6.5.1 Indigenous Competence

The successful implementation of the Indigenous vaccine clinics is a remarkable achievement at a time of national and global crisis. It is an accomplishment that shines with relational accountability and Indigenous competence. Indigenous leaders shared their reflections on this experience. Lori Flynn commented, "[It showed] just what we're all capable of doing. As organizations we're all underfunded, we're all understaffed. But we're so capable of doing great things, you know, we're resourceful. So I think there's so much more we can do. This is a lesson in what we were able to achieve. We can do a lot with what little we have."

David Newhouse offered, “It was also good for the non-Indigenous participants to see the level of action that the First Nations, Inuit, Métis and urban groups were capable of. So that was good to see. They realized that we were indeed capable of doing incredible things.”

6.5.2 Structural Issues

> “If something like this happens again, we're going to have the same challenges. and we will have to advocate all over again” Liz Stone

In this statement, Liz Stone pointed out the reality that urban Indigenous peoples live in a highly political and contested jurisdictional environment where federal and provincial governments’ mandates and funding manifest and sometimes clash. There can be disputes over which level of government is responsible for addressing the particular service needs of First Nations, Métis and Inuit, Treaty and Non-Treaty, Status and Non-Status Indigenous peoples living on or off reserve.[5] These political dynamics came into play in determining how “classes” of Indigenous peoples would receive priority in the Covid-19 vaccine rollout.

In its “Indigenous Peoples and Covid-19: What We Heard” Report (2021), Mashford-Pringle et al. noted, “Community members shared that sovereignty is applied when they have the capacity to govern the public health of members within their communities and have decision-making ability to develop their own plans and protocols.” Urban Indigenous governance is still emerging and as was pointed out earlier, having formalized structures helps to elevate Indigenous demands when negotiating with other government structures such as federal and provincial governments and their agencies such as Peterborough Public Health. One of the lessons from the Covid-19 experience is that formal structures and ongoing relationships matter and need to continue. A step forward in urban Indigenous governance would be to have a seat on the PPH Board, beyond membership on an advisory body.

6.5.3 A Commitment to Keep Learning for PPH Staff and Volunteers

In Section 4.2.4 we have mentioned that learning and transformation are essential components of alliance-building. PPH demonstrated a strong commitment to learning, although the relationship had its tensions related to decision-making that affected First Nations communities as well as Métis and urban Indigenous peoples. The intense working relationship, all in the face of the uncertainties of the pandemic, created new relationships and new learning opportunities. For example, Christa Lemelin shared, “There was a learning curve for the Peterborough Public Health Unit in terms of how the Métis community works versus how the First Nation community works. Our Nation is governed differently and not many people understand it. We had the opportunity to explain how it works for our citizens.”

It is evident that the vaccine clinics were a microcosm of Indigenous-settler relationships. PPH has a real opportunity to make important interventions by instituting Indigenous awareness and foundational education for its staff and volunteers.

PPH can widen the scope of its staff who have Indigenous cultural competency. PPH staff who have worked with the Indigenous vaccine clinic planning and implementation have been building relationships and acquiring relevant expertise for ongoing collaboration with Indigenous peoples. But individuals may be re-assigned or leave an organization, so to create deeper organizational capacity for reconciliation, agencies such as PPH need to reach towards training multiple staff members who are ready to engage with Indigenous peoples by understanding the history of Indigenous-settler relationships such as settler colonialism and residential schools, what current issues face Indigenous peoples, Treaty 20 and Williams Treaties responsibilities, the TRC Calls to Action, UNDRIP provisions, as well as Indigenous resurgence and self-determination initiatives such as the movement towards Indigenous primary health care provision (IPHCC, 2021). By working with Indigenous partners, including its Board members and Indigenous advisory committee members, PPH can realize its own potentiality to support and contribute to Indigenous self-determination, resurgence and reconciliation.

PPH has developed important relationships with non-Indigenous community organizations in the Peterborough/Nogojiwanong area that have supported the vaccine clinics by providing volunteers. These volunteers have played a significant role in the success of PPH in protecting the health of the whole community. In its relationship-building with community organizations, PPH can use its influence to encourage its partner organizations to undertake similar educational initiatives, thus increasing the capacity of their volunteers to work with Indigenous peoples with respect and dignity.

Finally, language matters. New community engagement models are emerging that are aligned with the directions of PPH in reconciliation. The "Indigenous Peoples and Covid-19: What We Heard" report (2021, p. 5) speaks about "Indigenous sovereignty". IPHCC's "Gashkiwindoon Toolkit" (2021, p.2) refers to new Indigenous-governed, culture-based and Indigenous-informed organizations. The Ministry of Health Guideline for "Relationship with Indigenous Communities" (2018, p. 17), speaks in terms of self-determination, one of the social determinants of Indigenous health:

> Self-determination acknowledges the inherent rights of Indigenous People to freely determine their own pathways and to make decisions about all aspects of their communities and livelihoods. To support this principle in the context of this guideline, community-based Indigenous organizations need to be provided with the opportunity to lead or influence relevant decision-making processes that will impact Indigenous people and communities, and facilitate greater opportunities for Indigenous control over health.

In its *Gathering and Sharing Learning Report* on Indigenous-public health relationships, the Talking Together To Improve Health Research Team (2020, p. 38), put forward a "First Nations and Public Health Engagement Framework". At the centre of its circle model are the values of respect, trust, self-determination, and commitment. Four outcomes are placed along the outside: relationships, systems change, accountability and understanding. This model provides another way of envisioning good relations between Indigenous peoples and public health units.

These documents provide a strong framing of relationship between PPH and Indigenous communities and organizations. Such framing can lead to the language of partnership, based on Indigenous leadership and self-determination.

6.6 What are some opportunities to consider in deepening relationships between PPH and Indigenous communities?

6.6.1 Plan Now for the Next Pandemic

A lot of learning has flowed out of the months of vaccine planning and implementation. Health planners and policy makers must be harvesting lessons from the Covid-19 pandemic to prepare for future pandemics. With current relationships between PPH and Indigenous Nations, Métis and urban Indigenous organizations in place, it is an opportune time to think about how to address the persistent jurisdictional issues and strengthen systems, communications and personnel needed to enact emergency preparedness into the future.

In Ashford-Pringle et al.'s (2021) study of First Nations communities, "Indigenous Peoples and Covid-19: What We Heard", the researchers report, "Community members shared that sovereignty is applied when they have the capacity to govern the public health of members within their communities and have decision-making ability to develop their own plans and protocols." We have already acknowledged that First Nations, Métis and urban Indigenous communities function in different jurisdictional environments, leading to different health outcomes. In terms of jurisdictional incongruencies, PPH can play an advocacy role since there are multiple layers of provincial and federal jurisdictions where such issues are being addressed. Creating seats for Métis and urban Indigenous peoples on the PPH Board will help to strengthen the formal structures through which Indigenous voices can be heard and urban Indigenous peoples can be supported in further evolving their own urban Indigenous governance processes.

6.6.2 Collaborate in Designing and Implementing an Indigenous-led Métis and Urban Indigenous Peoples Health Needs Study

Accessing accurate data on the health needs of Métis and urban Indigenous peoples was a barrier in planning the Indigenous vaccine clinics. As Indigenous leaders continue to put forward their health service priorities, there is an opportunity in a non-pandemic time to gather

vital information that can inform future responses to Indigenous health priorities. Such a study is likely to attract funding from diverse sources.

It should be noted that there is a serious lack of health information related to Métis people (Vides and Morin Val Col, 2021). Building a data base that includes disaggregated data would strengthen future responses to Métis health needs.

The collection of health data has many sensitivities, including its ownership. Indigenous protocols of ethical research in Indigenous contexts come into play as well as appropriate controls to ensure confidentiality and stewardship of information collected.

6.6.3 Connect with Broader Decolonizing Movements in Indigenous Public Health

This is an important time to engage in public health as Indigenous peoples are taking leading roles in defining, developing, and implementing public health solutions and campaigns. A 2021 report from the NCCIH has articulated a vision for Indigenous public health:

> This Indigenous public health vision uses a determinants of health approach as a framework through which to address inequities experienced by Indigenous peoples across the spectrum of population and public health challenges: racism; infectious diseases; self-determination; data; governance; environment; urban Indigenous populations; mental well-being; and assessment of and response to First Nations, Inuit, and Métis Peoples' well-being.

PPH's existing emphasis on the social determinants of health is aligned with the social determinants of Indigenous health framework and the decolonizing movements that are under way. Indigenous-led initiatives happening locally and elsewhere feed into the larger decolonizing Indigenous health movement that is articulating pathways forward.

6.6.4 Long-Term Alliance-Building

Local First Nations and PPH have been engaged in alliance-building over decades. The Covid-19 pandemic has created the conditions for the partners involved to reach a deeper level of relationship, both Indigenous-PPH, and amongst the Indigenous partners of the UIVWG. In a study of long-term alliances between Indigenous peoples and settler organizations, Davis et al. (2022) noted that their three case studies reveal "many common themes regarding settler ally roles and responsibilities and the kinds of (un)learnings and relationships required to contribute to decolonial and Indigenous-led movements. These insights include: the importance of deep listening; taking time to build trust; respecting differences and boundaries; recognizing and amplifying Indigenous voices; centering treaty principles; being humble, accountable and flexible; using one's skills, talents, or resources to advance Indigenous causes; strategizing together; and following direction from Indigenous peoples." Evidence of these themes can be

found in the stories told by participants in this research, and provide a solid foundation for continuing the alliance-building process between Indigenous organizations and PPH.

7.0 Limitations of the Study

This research was conducted in a limited timeframe during the Covid-19 pandemic with peaking levels of the omicron virus. The Indigenous leaders and the PPH leaders were all very busy in their organizational contexts battling the pandemic and were also trying to restore normal services. Limitations of this study include:

- Interviews were conducted online using the Zoom platform rather than having an in-person option;
- We interviewed individuals who volunteered to participate and so there were organizations excluded that may represent other viewpoints and experiences;
- We did not access volunteers nor individuals who received vaccinations at the clinic and so their perspectives are missing from this study.
- The study emphasized story-telling, so quantitative information regarding the clinics was not collected except for some rich and important data provided by PPH (PPH, 2022).

We also want to acknowledge that we brought Indigenous Studies research expertise to this project, but none of the team members had advanced expertise in Indigenous health.

8.0 Conclusions

As our world navigates the new realities of pandemics and vaccine distribution, it is important to consider the mechanisms through which health of Indigenous people is prioritized and protected. This research has taught us that collaborations between non-Indigenous and Indigenous organizations can be remarkably successful when all parties are willing and have the resources to communicate effectively and build positive relationships. The pre-existing network of organizations working to support Indigenous people within the Peterborough/Nogojiwanong area was extremely valuable to the overall success of the vaccine clinics.

Relational accountability was a critical factor in the success of the COVID-19 Vaccination strategy. Creating and maintaining respectful and mutually beneficial relationships between PPH, the Métis and urban Indigenous organizations, and the people they serve was and will continue to be of utmost importance. Respect, responsibility, and reciprocity were established through the synergy of the collaboration and formed the backbone of relational accountability. As a result, interconnectedness was strengthened and many lessons were learned by all parties.

9.0 Miigwech – Marsi – Nia:wen

We are grateful to have been entrusted with the many stories shared in this study. Every individual holds a piece of the whole, and it was remarkable to see these stories come together. Miigwech – Marsi - Nia:wen for the opportunity to engage in this project.

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APPENDIX A

CHANIE WENJACK SCHOOL
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CONSENT FORM

Peterborough Public Health's Covid-19 Vaccination Program In Collaboration With Hiawatha First Nation, Curve Lake First Nation, and Urban Indigenous Peoples in Peterborough.

The purpose of this research is to understand the experiences of collaboration between Indigenous peoples and Peterborough Public Health, including successes and challenges in planning and implementing the vaccination clinic campaign for Indigenous peoples. The research involves one-on-one interviews with leaders in the collaboration. Interviews should be approximately 45 minutes. This research is being conducted by Trent University students to gain experience in respectful Indigenous studies research.

By understanding what did and did not work, the expected benefits of the research will be informing future engagements and collaborations between groups. Data from the research gathered will be compiled in a final report, which will be presented to all participating organizations. All co-researchers have signed confidentiality agreements. All data collected will be stored in encrypted form on password protected computers. The risks associated with this research are minimal; however, a list of relevant counselling services will be made available. Within this research, all participation is voluntary and you do not have to answer any questions you do not want to answer. You may also end your interview at any time.

All transcripts will be destroyed upon the completion of the project. You may request a copy of your transcribed interview before materials are destroyed.

Participants can choose to engage through Zoom or in-person interviews depending on their preference. Recordings will be taken over Zoom application, by phone or recording device.

In signing this form participants are acknowledging that they are fully informed and freely give their consent to participate in this research project. Participants will receive a copy of this consent form for their records.

I understand that participation is completely voluntary. Yes ___ No___

I understand that this interview will be recorded for accuracy purposes only, and then destroyed.
Yes ___ No ___

I would like a transcribed copy of my interview. Yes___ No ___

The use of quotations:
Check with me before quoting me _____
You can quote me, but don't use my name ______
You can quote me and you can use my name _______

I agree to include my name in a list of thank you's for participating in this research.
Yes ___ No ___

This research was reviewed and approved through the Indigenous Education Council ethics review process at Trent University. This research was also reviewed and approved through Trent University's Research Ethics Board (# 26780). Any concerns about the ethics of this research can be directed toward Jamie Muckle (jmuckle@trentu.ca).

Name (Please Print) ___________________________________ Date: ____________________________

Signature ____

Contact Information:

Witness:____

APPENDIX B

Background Questions for Collaboration Leaders

Background Questions

1. How did you become involved in the collaboration between Peterborough Public Health and the Urban Indigenous Working Group?
2. What were your expectations for the project at the beginning of the collaboration?

Collaboration Questions

3. What was it like in the early stages of the collaboration?
4. Which specific challenges arose in the collaboration, and how were they addressed?
5. How have relationships among the collaborating parties evolved over time?

Clinic Questions

6. What worked well in implementing the clinics?
7. What were the challenges in the planning and implementation of the clinics? How were they addressed?
8. Do you think the vaccination clinics have been a success? If so, what has contributed to this success?

Closing Questions

9. Are there any particular moments or experiences in the collaborative process or vaccination clinics that stand out to you?
10. What have you learned from the experience of being part of this collaboration?
11. Looking into the future, what are your hopes for the relationship between Peterborough Public Health and Indigenous communities and urban Indigenous peoples?
12. Is there anything else you would like to add?

ENDNOTES

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[1] This report does not address the context of Inuit communities and funding.

[2] This information, first accessed from the PPH website, no longer appears on the website.

[3] Orange shirts are the symbol of solidarity with residential school survivors. The national movement “Every Child Matters” has mobilized around this symbol and Canada now commemorates residential school survivors on September 30th each year.

[4] Ontario Federation of Indigenous Friendship Centres. 2022 Federal Pre-Budget Submission, November, 2021. https://ofifc.org/wp-content/uploads/2020/03/2021-11-30-Federal-Pre-Budget-Submission.pdf

[5] Jordan’s Principle was introduced to ensure that First Nations children receive timely service and are not denied service where there are disputes over whether the federal or provincial government will pay for the essential services needed by the child. https://www.sac-isc.gc.ca/eng/1568396042341/1568396159824