WEAVING THE PAST TO THE PRESENT: INDIGENOUS TRUST DURING THE COVID-19 PANDEMIC

Alicia Clifford is a white settler Ph.D. candidate in the department of Health, Aging and Society at McMaster University. They stand in solidarity with and work alongside Indigenous women to explore what healing, health, and well-being mean in prison from the perspective of those with lived experience. Alicia wants their privilege to serve those targeted by the legal system because there is no justice system in the settler colonial state of Canada, only a legal one.

Nikol Veisman recently finished her undergraduate Sociology Honours degree at the University of Manitoba and will be starting her Master's in Migration and Diaspora Studies at Carleton University. Her research focuses on issues of immigration and integration in Canada and the effect of discrimination on immigrant identity.

Jihad (Rosty) Othman graduated from the Salahaddin University, College of Arts, Sociology Department in 2011. He holds a master's degree from University of Cincinnati, College of Arts and Sciences, Sociology Department in 2015. He taught various undergraduate courses from 2015 to 2019 in the Salahaddin University, Social Work Department. He also worked on various Human Rights Protection Programs with refugees, IDPs, Syrian refugee children, and asylum seekers in the KRG with UNHCR funded NGOs in Iraq, including TDH-Italy, USAID, PFO. His specialities are migration and refugee studies, sociology of health, research methods. He is currently a Ph.D. student at the University of Manitoba, College of Arts, Winnipeg, Canada.

Kezia Wong is a fourth-year undergraduate honours psychology student studying at the University of Manitoba.

Avery Hallberg is a Métis woman from Winnipeg, Manitoba. Her research interests include political sociology, women's rights and race relations in Canada and the United States. She recently completed her Honours degree at the University of Manitoba where her thesis research concerned right-wing social media discourse in the United States and the former president's role in spreading misinformation. She is currently a Master's student with the COVID Impacts study and works for the Government of Manitoba as a policy analyst.

Lori Wilkinson, PhD, is Professor of Sociology at the University of Manitoba. She holds a Canada Research Chair in Future Migration (2021-2028). Her research program focuses on the integration experiences of newcomers to Canada, with a particular interest in refugee families. She recently received the Dr. and Mrs. Ralph Campbell Award for Community Engagement from the University of Manitoba (2019) and the Metropolis Canada Award for Research Excellence (2021).

Kiera Ladner holds the Canada Research Chair in Miyo We'citowin, Aboriginal Governance and Digital Sovereignties. She is Professor Emeritus of Aboriginal and Canadian Politics at the University of Manitoba, where she is the founder of Mamawipawin. Her research interests include Canada, Australia and Aotearoa/New Zealand, comparative Aboriginal constitutional law and politics, digital sovereignties, missing and murdered Aboriginal women and girls (MMIWG), and treaties and Aboriginal representation.

Jeremy Patzer (Metis, Saulteaux, & German) is an assistant professor in the Department of Sociology and Criminology at the University of Manitoba. His research interests lie in Indigenous rights (particularly in settler state courts), the forms of legal-political resolution and repair employed by settler states in the wake of colonial dispossession, as well as the sociology of law and contemporary theory.

INTRODUCTION

The COVID-19 pandemic brought significant changes to lives around the world; however, to call it an "equalizer" is misrepresentative (Mein, 2020). Due to historical context, socioeconomic status and discrimination, certain groups found themselves particularly vulnerable throughout the pandemic (Statistics Canada, 2020). This paper investigates how relationships of trust affected Indigenous Peoples in Canada during the pandemic. We propose that trust played a significant role in Indigenous Peoples' pandemic experiences and health outcomes. However, before we can understand the pandemic's implications and potential areas of policy change, it is necessary to place the current concerns within a broader context. The health disparities among Indigenous Peoples compared to non-Indigenous Peoples in Canada are directly tied to the historical and political contexts and ongoing colonialism (Allan & Smylie, 2015; Gunn, 2016).

SETTLER COLONIALISM: PLACING THE PRESENT WITHIN THE CONTEXT OF THE PAST

For Indigenous Peoples, colonialism is not a thing of the past, some historical event, a page to be turned, or a long-forgotten chapter in a history book. Rather, colonialism is ongoing as Europeans came, settled, and have not left what is now known as Canada. Colonialism continues as an everyday reality as it has is woven into the fabric of the Canadian state—through its structures, systems, and institutions (Lowman & Barker, 2015; McCallum & Perry, 2018; Wolfe, 1999, Wolfe, 2006; Woolford, 2014; Woolford & Gacek, 2016). Western values, norms and institutions were imposed on Indigenous Peoples as the church and state moved to remove Indigenous peoples from their territories and to destroy Indigenous institutions, ways of being, understanding, and doing. We must not forget that arriving settlers brought (and often systematically spread) diseases from Europe which for generations resulted in multiple pandemics and decimated (even eliminated) Indigenous nations (Daschuk, 2013; MacIntosh, 2017; McCallum & Perry, 2018).

Though the Canadian government talks about renewed relationships and reconciliation with Indigenous Peoples, colonial structures, policies, and laws (such as the Indian Act) remain in place (Lowman & Barker, 2015; McCallum & Perry, 2018; Wolfe, 1999, Wolfe, 2006; Woolford, 2014; Woolford & Gacek, 2016). These historic and ongoing processes of colonialism create and sustain societal inequalities, systemic institutional racism and sustained intergenerational traumas which are most often attributed to or measured as social determinants of health: namely, lack of access to basic needs such as housing, food security, employment and education (Allan & Smylie, 2015). They also contribute to decreased trust in government institutions and public services.

BARRIERS TO HEALTHCARE

Historical and ongoing colonial processes create barriers for Indigenous communities and individuals when attempting to access healthcare in Canada (George et al., 2019; McCallum & Perry, 2018; Nelson & Wilson, 2018; Wylie et al., 2019). Barriers to adequate healthcare services for Indigenous Peoples include inadequate funding for services, poverty, housing, individual and systemic racism and social exclusion, not to mention a distinct lack of culturally inclusive training for healthcare practitioners (McCallum & Perry, 2018; Nguyen et al., 2020). For example, Indigenous Peoples in urban areas are frequently denied care or experience discrimination during treatment (MacIntosh, 2017; McCallum & Perry, 2018). Whereas, for Indigenous Peoples on reserve or in remote communities, healthcare remains inaccessible mainly due to geographic location and availability of services (Nguyen et al., 2020; Wylie et al., 2019). To this we can also add the complex patchwork that finds a maze of differential coverage (and different sources of coverage) for Indigenous Peoples. While the latest case law establishes that the federal government has primary constitutional responsibility for First Nations, Inuit, and now Métis, the First Nations and Inuit Health Branch only offers coverage and services for status First Nations and Inuit—and this within limited geographical and bureaucratic contexts. Provincial/federal disputes over responsibility for services to Indigenous patients led to the institution of Jordan's Principle in order to compel governments to give priority to servicing patients and save jurisdictional squabbling for after the fact (see Blackstock et al., 2005).

Before COVID-19, the successive generations of underfunding of social services for Indigenous peoples, and the jurisdictional refusal to address gaps responsibly, resulted in a patchwork system of under-funded and under-serviced healthcare for Indigenous peoples. Needless to say, the systemic crisis of Indigenous healthcare became even more critical, and compounded, during the pandemic. While reconciliation and the pandemic have started to make this crisis visible, and public pressures are increasing for reducing the inequality gap between Indigenous and non-Indigenous communities, COVID-19 has also exacerbated the issue for Indigenous Peoples as they have confronted a lack of services, chronic underfunding, systemic racism and jurisdictional refusal in the healthcare system.

OVERLOOKED BY THE SYSTEM

The Canadian healthcare system appears as an inclusive environment where individuals in need of medical care receive it regardless of circumstance, but that does not always happen (Goodman et al., 2017). The case of Brian Sinclair, an Indigenous man in his 40s who died after waiting 34 hours in a Winnipeg ER waiting room, is one such case of Indigenous

Peoples being overlooked when seeking treatment due to the assumptions and stereotypical notions held by non-Indigenous healthcare practitioners and the general public. The inquest into Sinclair's death brought more attention to the racism and discrimination inherent in Canadian healthcare institutions (Provincial Government of Manitoba, 2014; Brian Sinclair Working Group, 2017; Provincial Implementation Team, 2015; Geary, 2017). The media has many articles about the mistreatment and racism directed at Indigenous Peoples who engage with the healthcare system. However, for many other Indigenous Peoples, inquests were denied.[1] The contemporary controversies concerning medical care for Indigenous Peoples are not isolated and they have not disappeared with increasing public awareness and the arrival of discourses of reconciliation. Never has this been clearer than in the cellphone video documenting the racist attitudes and refusal to provide treatment to Joyce Echaquan in Joliette, Quebec as she lay dying in September 2020. Echaquan's death came one year after the release of the final report from the Viens Commission in Quebec, which conducted a public inquiry into the relationship between public services and Indigenous Peoples in the province. In the section on health services, Justice Viens (2019) observed that "many voices were heard to state that First Nations members and Inuit feel unsafe when they have to entrust their health to public services" (p. 368).

These are not isolated events. As a result, many Indigenous Peoples feel they can neither trust the healthcare system or trust the government to address the systemic racism that inherent in the healthcare system.

WHO SHOULD BE TRUSTED? WHY DOES THIS ALL MATTER?

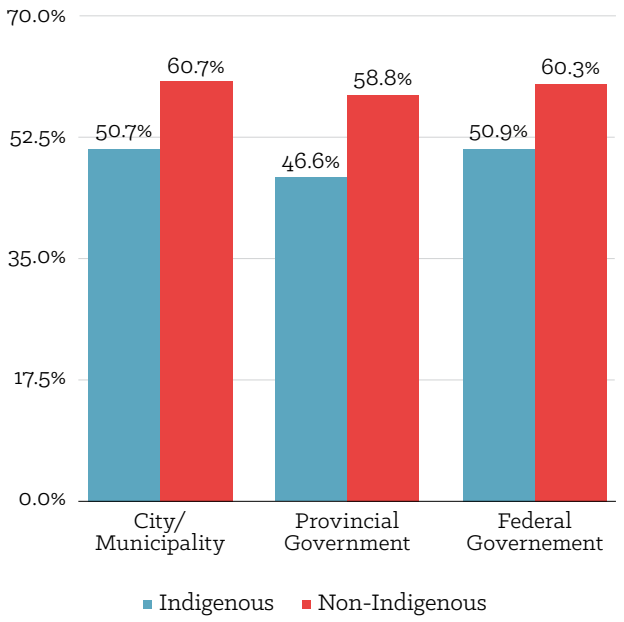
Trust is both difficult to measure and difficult to define. Yet, we all know how it feels when it is absent or lost. It is considered a fundamental element of any functioning society. Trust in public institutions and government is vital to social and economic progress and social order. The Organization for Economic Co-operation and Development (2017; 2019) defines trust as an individual's belief that other people, communities, or institutions will treat them or act in a positive manner. Some argue that institutions or people who are in a position to be trusted make societies successful (Nikolakis & Nelson, 2019). Furthermore, the strength of general trust can be seen as an indicator of social and economic success in communities fostering cooperation and stability (Fukuyama, 1996).

Indigenous Peoples' lack of trust in Canadian institutions is due to historic and ongoing forms of colonialism and discrimination (Vogel, 2015; Hwang, 2017). Through Canada's ongoing reckoning with its history of abusive and assimilative institutions, historians, the TRC, and class action lawsuits have brought to light a stark history of involuntary medical and malnourishment experiments and abuses perpetrated against Indigenous Peoples in both educational and medical settings (Dangerfield, 2018). In the contemporary context, a critical step for building trust among the general population is to address the political and social issues that can help eradicate discrimination against Indigenous Peoples (Hotte, 2020). Broadly, Canadians show a high level of trust in their healthcare system and its associated professionals, including nurses and doctors (Newswire, 2022). However, that changes when we look at Canada's Indigenous population. When looking at those numbers, we see that Indigenous Peoples distrust Canada's medical establishment because of its contributions to increased health inequalities compared to the rest of the non-Indigenous population (Vogel, 2015).

Our survey data indicates Indigenous Peoples have less trust in government compared to the non-Indigenous population. Figure 1 shows that Indigenous Peoples trust their provincial government the least (46.6%), while their non-Indigenous counterparts have a higher rate of trust (58.8%). Indigenous Peoples' trust increases to 50% for both municipal and federal governments. As expected, the non-Indigenous population has a higher level of trust in all levels of (settler) government (58–60%) than do Indigenous Peoples.

Our data also shows that trust in local, provincial, and federal governments is moderate and increases toward public health officials. We also see that Indigenous People's trust

FIGURE 1. TRUST LEVELS IN GOVERNMENT, INDIGENOUS AND NON-INDIGENOUS COMPARED, WAVE 4 (N-2765).



1 For more detailed stories see Baxter, 2022; Lampa, 2022; Maxwell, 2022; Roberts, 2022; Petz, 2022.

in their tribe/band/nation's government differs by region. Indigenous peoples in all the regions except the Prairies and the Maritimes have a 64–70% trust in their tribe/band/nation. This is higher compared to the prairies (52.5%) and lower than the Maritimes (89.7%). These statistics show that Indigenous Peoples' trust in non-Indigenous institutions is lower than in their trust in their own community/band/nation governments. It also suggests the need for additional research on the regional differences in trust in Indigenous governments across Canada.

The fact of the matter is that, while Indigenous Peoples have been pervasively victimized by an entire history of discriminatory and assimilative treatment in Canadian institutions, *trust itself* is also a victim of colonialism. Trust in institutions and their services, or trust in governments, will be harmed by ongoing service problems for Indigenous Peoples as well as by the history of betrayals and the continuing (but necessary) revelation of these controversies. This gives some context to higher levels of mistrust expressed by marginalized groups to medical services such as vaccines. This can be seen in Figure 4, with Indigenous and Black respondents in Canada expressing a somewhat higher rate of agreement, when compared with other groups, with the statement that all vaccines are dangerous. Similarly, in Figure 5, Indigenous respondents demonstrated lower intentions to vaccinate against COVID-19

FIGURE 2. LEVELS OF TRUST IN TRIBE/BAND/NATION BY REGION WAVE 4 (N-633).

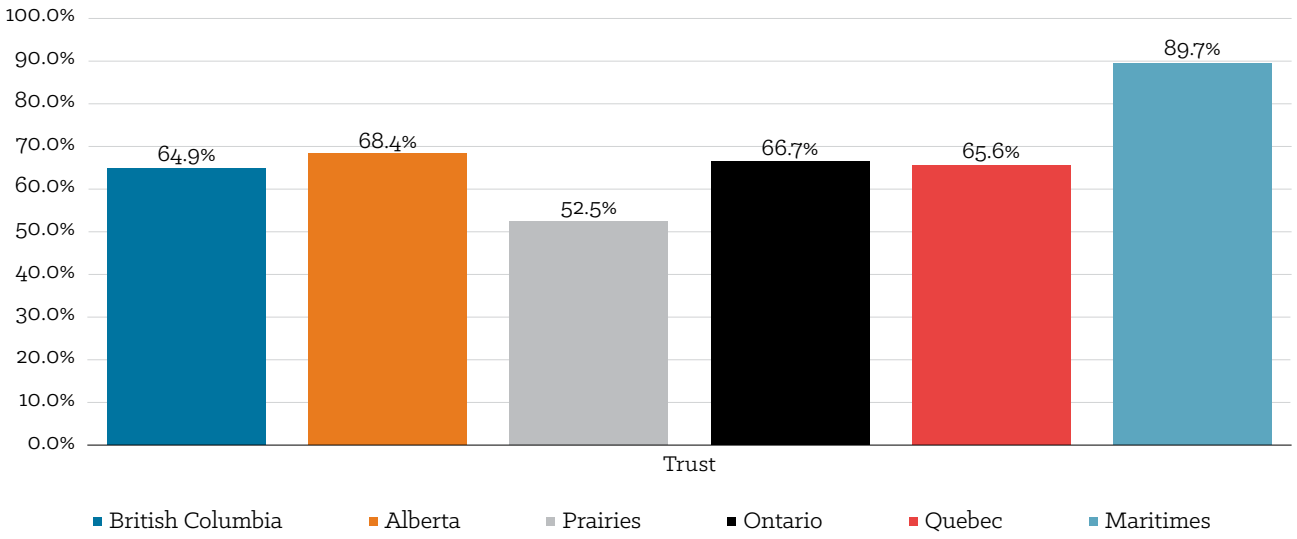
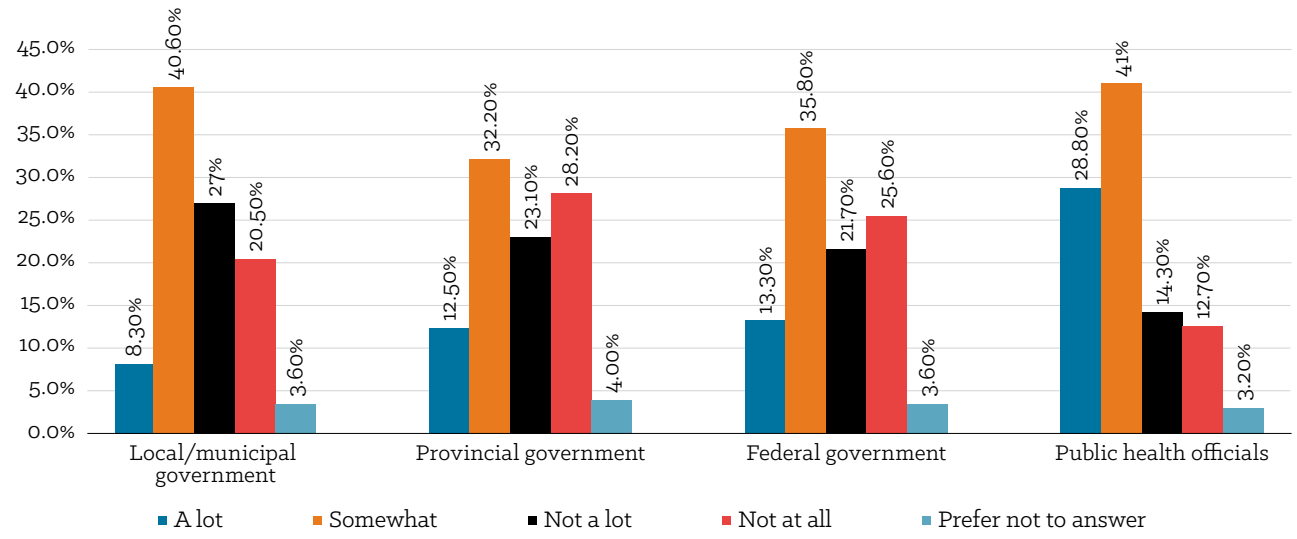


FIGURE 3. INDIGENOUS PEOPLES TRUST IN LEVELS OF GOVERNMENT AND HEALTH OFFICIALS WAVE 4 (N-503).



when compared with non-Indigenous respondents in Canada, although both groups' intentions to obtain the vaccine increased from October 2020 to March 2021.

CONCLUSION

Factors such as geographical location, differences in the funding of healthcare services (by Indigenous group or across the on-reserve/off-reserve divide), the persistent federal underfunding of Indigenous health, and discrimination within the Canadian healthcare system all pose barriers to Indigenous Peoples seeking treatment. By understanding these factors and reflecting on the actions of federal and provincial governments—past and present—we are better situated to address the disproportional effect of the COVID-19 pandemic on Indigenous Peoples and their health and well-being.

Reading contemporary data relating to the Indigenous experience of the COVID-19 pandemic, however, suggests that trust is also a key pathway to addressing systemic inequalities in services to Indigenous peoples. Our research shows that Indigenous respondents reported having moderate trust in all three levels of government and public health officials, which is less trust than non-Indigenous respondents reported. The data highlights the need to focus on the meaning of trust and how it can be built between Indigenous Peoples, the government, and healthcare institutions. Addressing the disparities within the western healthcare system, increasing awareness of racism and mistreatment, and listening to the needs of First Nations, Métis, and Inuit Peoples are the first steps toward reducing health inequalities experienced by Indigenous Peoples in Canada and increasing Indigenous trust in health institutions. Indeed, trust and service efficacy are likely mutually dependent and mutually reinforcing.

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