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Scientific Certainty in a Time of Uncertainty: Predicting Vulnerability of Canada's First Nations to the H1N1/09 Pandemic¹

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Introduction

On June 11, 2009, Dr. Margaret Chan, the director general of the World Health Organization (WHO), announced that scientific evidence indicated that the criteria for an influenza pandemic had been met: The H1N1/09 virus pandemic—the first in nearly forty years—was officially upon us.

WHO has estimated that as many as two billion people (or between 15% and 45% of the global population) will be infected by the H1N1/09 virus. Scientists and governments have been careful to walk a line between causing mass public fear and ensuring people take the risks seriously. The latest information indicates that the majority of individuals infected with the H1N1/09 virus thus far have suffered mild illness, although very severe and fatal illness has been observed in a small number of cases, even in young and healthy people (WHO 2009c).² To date, there is no evidence that the virus has mutated to a more virulent³ or lethal form; however, as we enter the second wave of the pandemic, a significant number of people in countries across the globe are susceptible to infection. Most importantly, certain subgroups have been categorized as high risk given the clinical evidence to date. One of these subgroups is Indigenous populations (WHO 2009c).

In Canada—a nation with great health care, an educated populace, and a high standard of living—the H1N1/09 pandemic has made its mark already. Poor outcomes have been observed disproportionately in the Aboriginal population. The events that transpired over the last few months in St. Theresa Point and Garden Hill (both remote communities in northern Manitoba where H1N1/09 virus outbreaks occurred) reminded us once again of the plight of First Nations peoples. At the national level, the Public Health Agency of Canada (2009b) released the most recent data on the H1N1/09 pandemic for the week ending August 22, 2009, illustrating the disproportionate impact of the pandemic. Aboriginals constitute 3% of the national population, yet they represent 12.6% of confirmed cases of the H1N1/09 virus, 17% of associated hospitalizations, and 14% of cases admitted to intensive care units (ICUs) (Public Health Agency of Canada 2009b). The rate of infection among Aboriginals has not gone unnoticed. The related decisions of

policy-makers have been subjected to much debate and scrutiny over the last few months where major breakdowns in the provision of service by the government, including a shortage of pandemic supplies, inadequate health care, and insufficient training were experienced. Dr. Kim Barker, the public health physician with the Assembly of First Nations warns, “We’re talking about a handful of communities right now ... If they can’t shift a few masks onto an airplane right now, what will it be like when we’re dealing with dozens and dozens of First Nations communities this fall and winter?” (White 2009b). Overall, a survey of the coverage on this issue has centred on a recurring theme for those versed in Aboriginal issues, including the social determinants of health (SDOH) (access to health care, access to clean water, socio-economic status, housing, etc.). Of pressing concern is how Aboriginal peoples will fare as we enter the second wave of the pandemic.⁴

On May 8, 2009, Dr. Chan of WHO was quoted as saying, “This is a time of great uncertainty for all countries, and great pressure on ministers and ministries of health. The only certain thing that can be said about influenza viruses is that their behaviour is entirely unpredictable. No one can say how the current situation will evolve” (WHO 2009f). Although we now know more than we did in May, we are still in a state of uncertainty in many respects as we enter the fall flu season. As scientists, our main objective is to bring attention to this matter and to develop ways to assist in mitigating the effects of the pandemic. Our work starts with a review of the factors most likely to increase susceptibility to H1N1/09 infection, with the goal of understanding the vulnerability of Aboriginal people, with a focus on First Nations in Canada.⁵ We will also outline some of the main issues that have surfaced since the initial H1N1/09 virus outbreak earlier this spring, and, in light of these events, we suggest a model for predicting outbreaks in First Nations communities, identifying those communities lacking the capacity to adequately deal with the burden of a pandemic. In a time of fiscal restraint, such information is important in allocating resources strategically. WHO warns that capacity will be tested as countries face outbreaks and tough decisions must be made (WHO 2009a).

Background: The Context of Susceptibility

Let us begin by exploring what we currently know about the H1N1/09 pandemic. The virus responsible for the pandemic is novel swine-origin influenza virus 2009 A(H1N1).⁶ It is deemed novel due to its never-before-seen physical characteristics acquired by a combination of genes with swine, avian, and human viruses (Chang et al. 2009; Maines et al. 2009). This is not the only novel aspect of this H1N1 virus, as its infection patterns are proving to be quite interesting and unexpected as well. As Dr. Donald Low, chief microbiologist at Mount Sinai Hospital in Toronto, says, “This thing has not followed any of the rules. It obviously didn’t read the pandemic plan that we had formulated” (Alphonso and Galloway 2009). Specifically interesting about this virus is how it targets young persons, pregnant women, and Aboriginal populations (Dawood et al. 2009; Jamieson et al. 2009;

Kermode-Scott 2009). All of these warrant further investigation, but the focus of this paper is Aboriginals. The implications for this group are easy to see when one considers that although Aboriginal people compose one-tenth of the population in Manitoba, they make up approximately one-third of all documented cases of the H1N1/09 virus in the province (Barber 2009a). We will show that this disproportionate burden of infection can most likely be explained by the social characteristics of the Aboriginal population that is “at risk.”

This task is perhaps more difficult than it seems, as the virus’s recent emergence means that data on at-risk populations is still in the collection stage (Chang et al. 2009). A solution to this shortcoming is to look at data from seasonal influenza and past pandemics, specifically the 1918 influenza pandemic. Comparison to seasonal influenza is not an oversimplification as it has been shown that although the H1N1/09 virus has produced elevated respiratory disease compared with seasonal influenza viruses, it had less efficient respiratory droplet transmission while efficient direct contact transmission was retained (Maines et al. 2009). Thus, it can be reasonably expected that those most at risk for seasonal influenza will also be at a higher risk for contracting H1N1/09 (Chang et al. 2009). Moreover, observations and lessons learned from the 1918 Spanish influenza pandemic can be applied to today’s pandemic, as there are many similarities between the two viruses. That being said, there are now many more mechanisms to mitigate the disastrous outcomes associated with the 1918 pandemic, which killed between twenty and fifty million people worldwide and decimated Indigenous communities. Our comparison is not unique; the H1N1/09 pandemic has been compared to the 1918 pandemic by others. Dr. Ethan Rubinstein, a professor of infectious diseases at the University of Manitoba, argues that the H1N1/09 virus will follow the pattern of the 1918 pandemic and the spread of the disease will likely be similar (Skerritt 2009b). These similarities are fairly complex, and are deserving of their own review, but to put it very briefly, both viruses are novel influenza A(H1N1) viruses with high transmission rates (Reid and Taubenberger 2003).

Impairment of Host Defense

Any characteristic of a population or community that impairs the ability of people to produce a sufficient immune response will result in an elevated infection rate. One such characteristic would be high malnutrition rates. Deficiencies in micronutrients, such as vitamin E or selenium, have been tied to compromised immune response and increased susceptibility to infection (Louria 2007). High rates of smoking will also exaggerate the infection rate as smokers are more likely to contract influenza than non-smokers (Arcavi and Benowitz 2004). Particularly relevant to today’s pandemic is a strain of influenza A(H1N1) that circulated in the 1980s and was shown to infect smokers more often than non-smokers (Kark, Lebiush, and Rannon 1982). Furthermore, existing chronic disease impairs immune function, resulting in an increased likelihood of influenza infection and an elevated mortality rate (Barker and Mullooly 1982; Szucs 1999). Therefore, it

can be assumed that populations with increased incidence of chronic disease will have an increased risk of infection.

Exposure to Virus

Factors that increase exposure to any form of influenza will also result in elevated infection rates of the H1N1/09 virus. An obvious contributor to this is housing conditions. Overcrowding of households not only increases frequency of exposure, but also causes larger doses of the infecting virus (Mathews et al. 2009). Larger virus dose is associated with increased illness severity and infection rate (Conenello et al. 2007), as it overwhelms the immune system before it can produce a response (Matthews et al. 2009). Education has also been shown to be associated with the rate of respiratory infection. In fact, the respiratory infection rates in children of mothers with primary and vocational education were more than twice that of those in children of mothers with a university education, even when economic variables were held constant (Pawlinska-Chmara and Wronka 2007). Presumably, these mothers, in comparison to mothers with higher education, were deficient in teaching proper techniques to avoid exposure to illness (such as hand washing), and less likely to seek out proper medical care. Thus, individuals with less education can be expected to be at higher risk of contracting influenza.

Access to Care

Inadequate access to quality care will no doubt influence complications associated with contracting the H1N1/09 virus, particularly in severe cases. Isolated rural communities are particularly vulnerable as they generally have “local health-care systems” that are smaller, a greater distance from patients, and under-resourced in comparison to those in urban areas (Rowland and Lyons 1989). Furthermore, children from low-income families have limited access to care, as shown by the increased likelihood of having unmet health-care needs, no regular health-care provider, and less prescription medicine use when compared to their high socio-economic status counterparts (Larson and Halfon 2009).

Compounded Effects

It is important to note that the above categories are not mutually exclusive or exhaustive. Many factors have compounded effects that make the population possessing these characteristics even more vulnerable to the H1N1/09 virus. Take, for instance, overcrowded housing conditions. Under normal circumstances, isolation or reduced contact with those individuals who are severely ill and possess a highly virulent strain of a virus can have a negative selection effect on the viral genes as fitness and transmission of the genes are decreased. However, in overcrowded conditions where exposure to the virus cannot be mitigated, there is no environmental or behavioural negative selection process at work, meaning that any mutation resulting in increased reproduction will have a selective advantage that may be more virulent in nature as well (Mathews et al. 2009).

Isolation, discussed earlier with regards to its effects on access to care, also plays a very important role in immunity. New variants arise from, and subsequently replace, ancestor strains (Nelson and Holmes 2007). This relatedness results in significant cross-immunity between variants with a specific subtype, such as within H1N1 types (Ferguson, Galvani, and Bush 2003). Thus, those populations in isolation with no past exposure to many forms of influenza are not protected by any prior immunity; in other words, they are immunologically naïve, which likely results in higher viral multiplication, burden, and transmitted dose, as well as increased virulence (Mathews et al. 2009).

Even malnutrition has further effects other than its impairment of host defense. In fact, it has been shown that malnutrition causes genomic changes in the virus that make it more virulent, although the exact mechanism is unknown (Louria 2007).

Socio-Economic Status

It should be noted that the overarching cause of many of the problems mentioned above is low socio-economic status. Not only is it responsible for creating these conditions through material/social deprivation, but low relative socio-economic status has been associated with a greater likelihood of influenza infection as well (Cohen et al. 2008).

Deviation from Seasonal Influenza

Many individuals have compared seasonal influenza to the H1N1/09 virus. According to WHO (2009d), there are four major differences between the H1N1/09 virus and seasonal influenza based on observations to date:

- The H1N1/09 virus infects more people in affected areas.
- Seasonal influenza infects people of all ages, but the vast majority of H1N1/09 virus cases have been under the age of fifty.
- Seasonal influenza is most likely to cause severe illness in the very young and elderly, but the H1N1/09 virus has caused such symptoms in healthy people between twenty-five and forty-four. In seasonal influenza, the elderly are more likely to contract respiratory infections due to a weakening immune system (Meyer 2001); however, during an influenza pandemic, as seen in the 1918 pandemic, the elderly might display partial immunity if they had been exposed to a previous related virus at some point in their lives. Very young children are still protected by innate immunity (Ahmed, Oldstone, and Palese 2007; Mathews et al. 2009). These factors mean that the burden of disease falls on young adults (Murray et al. 2006). This phenomenon is being observed once again in Canada where the median infection age is twenty-one (Alphonso and Galloway 2009).
- Unlike the seasonal flu, 40% to 50% of those ill with the H1N1/09 virus have suffered from diarrhea.⁷

Are Aboriginals “At Risk”?

Having identified the conditions or variables that may increase susceptibility to the H1N1/09 virus, we shall briefly provide an overview of the distribution of these variables among Aboriginals and the general Canadian population in order to assess the relative risk of the former. Always keep in mind that influenza pandemics develop based on three sets of factors—the characteristics of the virus, the characteristics of the population under attack, and the environment.

The 2002–03 First Nations Regional Longitudinal Health Survey (FNRLHS) revealed that First Nations adults have four times the Canadian diabetes rate, and that 40% are overweight, suggesting malnutrition and inadequate physical activity (Assembly of First Nations 2007). Furthermore, nearly one-half of all individuals who are First Nations are daily smokers, and adults have a higher frequency of various chronic diseases when compared to the general Canadian population (Assembly of First Nations 2007). In 2006, the number of First Nations living in overcrowded conditions was four times greater than the rate for all of Canada (Macaulay 2009).

The FNRLHS also reported socio-economic conditions: Over 50% of First Nations adults living in First Nations communities did not graduate high school, compared to just one-third in the Canadian population (Assembly of First Nations 2007; White et al. 2009). Approximately 50% of First Nations adults reported working for pay compared to 57% of the Canadian population (Assembly of First Nations 2007). In terms of geography, just over one-half of First Nations people live either on-reserve or in rural, non-reserve areas (Assembly of First Nations 2007), whereas approximately 20% of the general Canadian population resides in rural areas (Statistics Canada 2005). According to the survey, access to care was associated with residing in reserve and rural non-reserve areas, with one in five adults reporting having no doctor or nurse available in his or her area (Assembly of First Nations 2007).

All of these characteristics would contribute to increased risk of H1N1/09 virus infection in First Nations. However, First Nations people have additional, unique characteristics beyond the conditions mentioned above that make them particularly vulnerable. For example, demographically, one-fifth of First Nations are under the age of nineteen, double the proportion of Canadians in that age group. They also have higher fertility rates, indicating high pregnancy rates as well (Assembly of First Nations 2007). As discussed earlier, pandemic influenza targets young adults and pregnant women, which would, once again, result in a disproportionately high infection rate among this relatively young ethnic group with high fertility rates.

In assessing risk, it is important to note the drawbacks of this research. First of all, homogeneity of Aboriginals and Canadians is typically assumed, when, in fact, these populations are incredibly varied (Groom et al. 2009). Although the comparison of the H1N1/09 pandemic and seasonal influenza viruses is

well-recognized, deviation has been noted earlier in this paper. This raises the issue of whether further deviations will be observed. At this point, it can be concluded that the elevated risk of infection among First Nations can be attributed—at least partially—to poor social conditions.

Out of necessity, most studies we looked at related either to what makes a population vulnerable to infection or to the current state of First Nations conditions. References used in this review were, for the most part, not a direct investigation of the effects of social conditions in First Nation populations on pandemic influenza susceptibility and transmission. In fact, despite its importance, there is a limited body of research investigating the direct effect of social conditions on pandemic influenza transmission in Aboriginal and non-Aboriginal communities. Although it will never be argued that efforts should not be focused on reducing the negative effects of current pandemics, we must remember that that occurrence of future pandemics is not a question of if, but when (Reid and Taubenberger 2003). In order to best prepare for this pandemic and the inevitable ones of the future, especially among vulnerable populations, studies must be developed that will fill the existing void in literature. Only then—with a better understanding of the importance of social determinants in the control of the spread of infectious disease—can certain social health issues be prioritized and brought to the forefront of public policy to better the health of vulnerable populations and the world as a whole.

Indigenous Populations at Risk: Patterns Across the Globe

What is the global picture? International data on the links between Indigenous socio-economic conditions and health are noteworthy given the global nature of the H1N1/09 pandemic. As seen in **Table 11.1** (page 168), there is a pattern of inequality between Indigenous peoples and the respective general populations of different countries. The correspondence between low socio-economic conditions and health is far from shocking.

The relative standard of living of the Indigenous segment of populations across the world, including Australia, Canada, New Zealand, and the United States is well below what we would expect in these highly developed countries. For example, in an adaptation⁸ of the United Nations Human Development Index (HDI) to measure Aboriginal conditions in Canada in 2000–01, it was found that, as a country, Canada scored near the top of the international HDI rankings, but registered Indians living on-reserve ranked fifty-fourth in the world, with significantly lower income, education, and life expectancy (Cooke et al. 2007).

Congruent with this data, reports of Indigenous populations being infected with the H1N1/09 virus at a much higher rate than the general population have been documented globally. For example, in Australia, as of late July 2009, the highest per capita H1N1/09 flu outbreak had occurred in the Northern Territory (NT),

Table 11.1: 2000/2001 International Comparison of Human Development Indicators for Indigenous and General Populations Across Four Countries

	Australia non-Aboriginal	Aboriginal and Torres Strait Islander	Aboriginal- non-Aboriginal gap
Life expectancy (years)	82.8	59.6	23.2
Median income (2000 PPP\$)	21,767	12,268	9,499
Education*	0.69	0.31	0.38
HDI rank	4	104	100
	Canada non-Aboriginal	Canadian Registered Indian	Gap
Life expectancy (years)	78.7	72.9	5.8
Median income (2000 PPP\$)	27,617	14,824	12,793
Education^T	0.79	0.44	0.35
HDI rank	8	54	46
	New Zealand non-Aboriginal	Maori	Gap
Life expectancy (years)	79.6	71.1	8.5
Median income (2000 PPP\$)	29,756	23,024	6,732
Education^L	0.63	0.37	0.27
HDI rank	20	74	54
	United States non-Aboriginal	American Indian and Alaska Native	Gap
Life expectancy (years)	76.6	70.6	6.0
Median income (2000 PPP\$)	21,050	16,000	5,050
Education^R	0.75	0.67	0.08
HDI rank	7	31	24

Source: Adapted from Cooke et al. 2007

*Proportion 18–24 still in school or with highest educational qualification year 12 or equivalent

T Proportion 18–24 with secondary school certificate, some college, trades or technical, or university

L Proportion 18–24 with sixth form or higher qualification

R Proportion 18–24 with high school graduation, GED, or higher educational attainment

where 30% of the population is Indigenous. Furthermore, it has been reported that Indigenous people are five times more likely than the general population to be hospitalized when infected with the H1N1/09 virus (Ryan 2009). Dr. Paul Bauert, who serves as the president of the NT branch of the Australian Medical Association explains that “Many (Indigenous people) are living in conditions of poverty and there is a lot of crowding in houses so that this infection, which is spread very easily, tends to run very quickly” (Ryan 2009). Sadly, this is the norm worldwide.

In South America, reports have confirmed that members of the Matsigenka ethnic group in the Peruvian Amazon have tested positive for the H1N1/09 virus. The tribe makes its home along the Urubamba River, near a reserve set aside for so-called uncontacted tribes. Human rights groups fear the H1N1/09 virus could spread to the more isolated people in this region. There is worry that some Indigenous communities living in voluntary isolation have historically been vulnerable to diseases brought by outsiders, with Indigenous populations in the Americas having suffered centuries of losses after Europeans arrived (Cuthand 2009). As mentioned earlier, these immunologically naïve populations are at risk of high attack rates and mortality (Mathews et al. 2009). WHO senior influenza expert, Dr. Keji Fukuda, commented in early June that reports from Manitoba on the Aboriginal population were troubling since these vulnerable populations have been struck quite heavily during previous pandemics (Skerritt 2009a). For example, the Spanish flu pandemic of 1918 decimated Aboriginal populations, with the death rate up to six hundred per one thousand people in remote areas of Alaska, and forty-two per one thousand people for the Maori in New Zealand. To put these figures into perspective, worldwide the approximate deaths per one thousand were between two and twenty-five (Mathews et al. 2009). Health authorities have attributed this to the social conditions of this population. The infection of Indigenous people is particularly troubling in poorer countries lacking the capacity to adequately care for the majority of the population, much less the relatively impoverished Indigenous peoples (WHO 2009a).

Early Outbreaks of the H1N1/09 Pandemic in Manitoba, Canada: A Sign of Things to Come?

With growing public concern about the H1N1 virus in Canada, Prime Minister Stephen Harper was quoted on April 30, 2009, as saying, “I think we are doing everything that is necessary to respond to this situation at this time” (CBC News 2009). This reassurance was far from comforting given the events that would eventually transpire in First Nations communities in northern Manitoba.

The end of the flu season tends to coincide with early spring; however, the H1N1/09 virus had begun wreaking havoc over the summer months, with Aboriginal communities being afflicted at a disproportionate rate when compared with the general population (Canwest News Service 2009). Most notably, in Manitoba, by mid-July, while Aboriginals constituted 14% of the population, they accounted

for one-third of all cases and two-thirds of the cases in intensive care for the H1N1/09 virus (Alphonso 2009a, 2009b; Lang 2009).⁹ Two reserve communities in the Island Lake area (St. Theresa Point and Garden Hill), approximately six hundred kilometres northeast of Winnipeg and accessible by plane only, were hit hard.¹⁰

First Nations leaders in Manitoba have stated that reserves do not possess the capacity to handle large-scale outbreaks, given the social conditions of their communities, which include inadequate access to quality health care and safe drinking water as well as overcrowded and poor housing conditions (Skerritt 2009a). Indeed, reports of inadequate basic medical resources and treatment as well as delays in responding to the situation in First Nations communities have been documented (Godbout 2009; White 2009a). For example, oftentimes nursing stations were inadequate for treating cases, with patients having to be medevaced to hospitals in urban centres such as Winnipeg (Godbout 2009). The effects on the health-care system had been a cause of concern, with reported strains on emergency rooms and ICUs (Canwest News Service 2009).

In the midst of an outbreak, in mid-June, Chief David Harper of the Garden Hill First Nation indicated that the band had spent \$15,000 for basic pandemic supplies, such as hand sanitizers, and surgical masks, which were supposed to be supplied by the federal government as per the Canadian Pandemic Influenza Plan (Marks 2009; White 2009a, 2009b). The money came from the community's education fund, which was intended to be used to buy laptops and to reward students with perfect school attendance (Engelhart 2009). Antiviral medication was incredibly scarce in Garden Hill and St. Theresa Point, and chiefs have expressed doubts regarding its availability in the near future (Santin 2009a; Skerritt and Santin 2009). The situation had become so severe that community leaders from the Island Lake area requested a personal meeting with Federal Health Minister Leona Aglukkaq and Indian Affairs Minister Chuck Strahl to outline the serious concerns of their communities. They made calls for an emergency field hospital in the Island Lake region to provide surrounding communities with a more appropriate level of care. This proposal was rejected on the basis that it would slow down efforts to prevent the outbreak in their respective communities (Barrera 2009a, 2009b).

Federal health officials have stated that they are committed to protecting the health and well-being of First Nations across the country, but critics such as senators, Aboriginal leaders, and opposition politicians have expressed deep concerns with the response by the federal government. For example, NDP MP Niki Ashton has argued that the pandemic plan is full of paper but thin on resources (Barrera 2009b). In a similar vein, Manitoba Senator Sharon Carstairs described the situation as not gaining the attention it deserves given the lack of planning before the outbreak, including medevac flights with improper infection control in place, a lack of hand sanitizers, and inadequate pandemic training of chiefs (Rabson 2009c).

The situation in Manitoba showed that the provincial and federal governments had their share of problems during the earlier stages of the crisis. This is evidenced by some of the issues that have arisen:

1. Health Canada and the Province of Manitoba have not reached an agreement on how to deal with pandemics on reserves. Provincial Health Minister Theresa Oswald, expressed frustration with jurisdictional issues preventing the province from contributing more in response to the H1N1/09 virus. Concretely, the federal government turned down the province of Manitoba's offer to assist Ottawa with pandemic planning on First Nations thirteen times over a four-week period this last spring until the flu outbreak had occurred in St. Theresa Point (three confirmed cases of the H1N1/09 virus and hundreds more reporting flu-like symptoms as of early June).
2. There was a lack of leadership in disseminating key information on pandemics to First Nations, including communication issues related to provincial privacy laws, which were prohibiting authorities from sharing confirmed or suspected cases on reserves with Aboriginal leaders (Huber and Rabson 2009; Rabson and Kusch 2009).

In June 2009, a Senate probe of the federal government's response to the H1N1/09 virus outbreak on remote reserves in Manitoba was conducted. It was revealed that the government had made several controversial decisions, including delaying sending hand sanitizers to communities in the early stages of the outbreak reportedly because of fears that individuals would ingest the alcohol-based gel. Masks, respirators, and hand sanitizers were not delivered to the region even as conditions had deteriorated. The federal government eventually delivered 2,500 bottles of alcohol-based sanitizer to Garden Hill First Nation after the community had waited for two and a half weeks despite community leaders pleading with officials in Ottawa for these supplies (Kirbyson 2009; White 2009a). This was a problem as about four thousand people in the community do not have running water and are unable to wash their hands frequently. Critics have called the reason cited for inaction paternalistic, racist, and ignorant given the small number of individuals in the community who might abuse such substances (Fitzpatrick 2009). Essentially, as the government discussed the merits of alcohol-based sanitizer, major outbreaks were occurring by the day. It was also disclosed that some communities requested alcohol-free hand sanitizer given the "dry" policy of the reserves, but the government did not have any, according to Deputy Minister Anne-Marie Robinson of the First Nations and Inuit Branch of Health Canada (Goar 2009).

By late June, Aboriginal leaders around Manitoba declared states of emergency in order to free funds for federal assistance (Barber 2009b). The private sector jumped in to help fill gaps left by the government, with CIBC donating \$10,000 to the Assembly of Manitoba Chiefs to assist in purchasing fifteen thousand swine flu kits for northern communities impacted greatly by the H1N1/09 pandemic. The Assembly of Manitoba Chiefs hopes to raise \$1.5 million to cover the costs of

the kits (Welch 2009). By mid-August, the Province of Manitoba stepped up and announced that it would provide outstanding funds for the kits, with the federal government refusing involvement and even problematizing some aspects of the kits (Preprost 2009; Rabson 2009a). We draw attention to these problems not to be critical of the government, but to make clear the point that Canada is not fully prepared for the pandemic. We have structural, jurisdictional, resource, and planning problems.

In sum, it appears that in the early stages of the outbreak, the \$1-billion Canadian Pandemic Influenza Plan failed to protect one of the most vulnerable groups in our society—Aboriginals. Inaction, a lack of coordination and planning/readiness, a failure to translate policy into reality, and pre-existing poor socio-economic conditions contributed to the events observed. Have we learned our lesson? Only time will tell. Things could get worse, as there have been reports that medical stations in remote communities of northern Manitoba may have to close because Health Canada is having problems recruiting and retaining nurses to work in isolated areas (Puxley 2009). There is, however, hope as some mistakes have already been identified and corrected. For example, three weeks after the outbreaks in Manitoba reserve communities, an outbreak in the isolated reserve community of Sandy Lake, Ontario, prompted an aggressive response by the government, with hundreds of doses of antiviral medication brought into the community and drugs administered to 160 patients. As a result, no residents had to be flown out of the community for treatment (Santin 2009b). According to the chief medical officers of health for Manitoba and Ontario, if an outbreak occurs again in the fall, any Aboriginal showing flu-like symptoms will be prescribed the antiviral drugs (Santin 2009b). We will later propose a model which may be a policy-planning tool to aid in preventing further negative outcomes associated with the H1N1/09 pandemic.

As evidenced by the events over the summer in Manitoba, the ability to provide acute health care to Aboriginals in remote communities is essential given their vulnerability during this pandemic; however, this is a difficult task, given the very high associated costs. Many infected individuals may end up being transported to larger centres, social support networks which have been associated with positive health outcomes will be disrupted, and absenteeism from work and productive endeavours could severely cripple these impoverished communities.

WHO warns of a high proportion of people becoming infected which could put a serious strain on health-care systems with increased demands on emergency rooms and ICUs. This could result in a diminished capacity to treat other serious health ailments (WHO 2009a). Dr. Bruce Martin, a doctor sent to lead work in St. Teresa Point, said it very clearly: “Just keeping the building open under this kind of workload is very difficult.” The fifty cases that came out of the small, two-thousand-person community had an overwhelming effect on the large, modern Winnipeg hospital system (Patterson 2009).

Prevention: Vaccination

In Canada, we are fortunate that the issue is not whether we will have enough vaccines for everyone, but how quickly everyone will be vaccinated (Public Health Agency of Canada 2009a).

As we enter the second wave of the pandemic in the coming months, questions surrounding the availability of the vaccine have been receiving much attention. An editorial appearing in the *Canadian Medical Association Journal (CMAJ)* on August 31 was highly critical of Health Canada's vaccination plan. Essentially, Health Canada was criticized for its plan to use an adjuvant vaccine.¹¹ *CMAJ* suggested that this decision would delay the introduction of the vaccine to the public by about a month (beginning in mid-November) due to the greater regulatory guidelines. They reasoned that the virus is not highly virulent for most of the population; therefore, vaccinating high-risk groups with the non-adjuvanted vaccine before the epidemic season peaks would be the best strategy, while the rest of the population at lower risk waits for the adjuvant vaccine (Hebert and MacDonald 2009). This claim was quickly disregarded by Health Canada, as the organization stated that adjuvanted and non-adjuvanted vaccines would be received at about the same time.¹² It was suggested that any delays in receiving the vaccine compared to other countries, such as the United States and Australia, was a product of Canada placing its order at a later date (White and Alphonso 2009). Of concern are the gaps in communication being observed. If the largest association of medical doctors is unclear of the government's plans, how will ordinary citizens, particularly the vulnerable (including First Nations) fare? Interestingly, as of September 2, 2009, according to a news release by the Public Health Agency of Canada (2009a), the Government of Canada had yet to identify those people who should receive the vaccine first, although news reports indicate that Aboriginals will be one of those groups.

Moving Forward: A Predictive Model

Dr. David Butler Jones, Canada's chief public health officer, in discussing the risk on reserves commented that any influenza outbreak will affect some communities more than others. He further stated on June 12, 2009, "We've never been able to understand why that is ... To make conclusions based on a couple of communities ... it's way too early" (Rabson 2009b). While trying not to be alarmist, and staying cautious based on the observations at that time, we would argue that the literature does indicate the SDOH, including poverty, a lack of capacity, and lack of access to health resources would be a powerful predictor of vulnerability, regardless of the health issue in question. As indicated earlier, there is a body of research suggesting that those populations with poor socio-economic outcomes are most vulnerable to seasonal influenza and H1N1. We suggest that an implementation of this information to predict vulnerability would be useful.

In addressing the complexity of the situation, Dr. Chan of WHO remarked, “The emergence of the H1N1 virus creates great pressure on governments, ministries of health, and World Health Organization to make the right decisions and take the right actions at a time of great scientific uncertainty” (WHO 2009a).

Researchers and policy-makers have a social responsibility to mitigate potential harm and catastrophe. How can this be accomplished? We suggest removing as much uncertainty from the situation as possible, as well as policy and planning based on informed decision making.

Although there are debates on the projected severity of the H1N1/09 pandemic, few experts doubt that vulnerable communities, particularly First Nations, will be impacted most by the pandemic. This begs the question, which communities are vulnerable? In Canada, we have a potential model. Work originating from research attached to the Aboriginal Policy Research Consortium (International), housed at the University of Western Ontario, and the Strategic Research and Analysis Directorate of Indian Affairs Canada, has produced and refined the Community Well-being Index (CWB). The CWB measures well-being at the community level using data from the census. It is composed of four variables identified in the literature as key SDOH: income, housing, education, and labour-force status.¹³ It assesses differences between First Nations communities themselves and between First Nations communities and other Canadian communities over time. No doubt, on average, First Nations communities fare worse than other Canadian communities; for example, only one of the top one hundred Canadian communities is a First Nation, and ninety-two of the lowest scoring communities are First Nations (O’Sullivan and McHardy 2007). Perhaps less well-known is that the differences between First Nations communities are great, in some cases greater than between First Nations and the Canadian population (O’Sullivan and McHardy 2007; Spence 2007).¹⁴ This coincides with many news reports that have found that some communities have been hit much harder than others by the H1N1/09 virus.

We have been unable to secure data to examine the relationship between the CWB and H1N1/09 outbreaks across Canadian First Nations communities. However, the CWB is probably the best tool for predicting those communities that will be at greatest risk of being affected by the pandemic. We do not wish to overstate the effectiveness of the CWB’s predictive power. However, in the absence of extensive empirical testing, the sites of early H1N1/09 virus outbreaks, St. Theresa Point, Garden Hill, and Sandy Lake, all have relatively low CWB scores. St. Theresa Point and Garden Hill are in the bottom 10% among First Nations communities, and Sandy Lake is around the twenty-fifth percentile. Increased surveillance and resource allocation are considerations given this data.

The impact of the H1N1/09 virus will be seen in the coming months. The manner in which the story of this pandemic will play out will be a product of decisions and (in)actions of key stakeholders. Targeted use of interventions will be important.

This pandemic has centred attention on the inequalities First Nations experience in Canada. Given the importance of the SDOH (WHO 2008), health outcomes are inseparable from the inequality we observe across all domains of the social sphere, including education, housing, income, and labour-force participation. One feature of pandemics is that they strive to survive; we, as humans, must work to do the same.

Conclusion

We are defined by how we deal with adversity. The coming months will test policy-makers and citizens worldwide, and the future will challenge researchers and policy-workers to become more effective. How will the story of the H1N1/09 pandemic play out? We know Indigenous populations across the globe will face a disproportionate degree of illness, suffering, and devastation, just as they have from first contact through the spring 2009 outbreaks. Efforts to mitigate the impact of the pandemic are underway; however, many of these solutions, while noteworthy given the current crisis, fail to address the underlying social factors that leave many communities “at risk.” Until these social factors are ameliorated, we will continue to witness disastrous outcomes in Aboriginal communities for years to come.

The international data captures the systematic inequality of Indigenous peoples worldwide. International reports have indicated that Indigenous people will continue to endure an inordinate amount of anguish resulting from this pandemic. We have proposed a model for predicting the differential vulnerability of First Nations communities in Canada. We believe the CWB could also be very useful as a tool in other countries.¹⁵ The main strength of the CWB is that it is a theoretically rooted measure, composed of basic SDOH. We see the CWB approach as a potentially useful tool for identifying the state of Aboriginal communities along the continuum of disadvantage, allowing policy-makers to plan accordingly. While two of the three communities we examined that had outbreaks in the spring fell in the bottom 10% of First Nations communities, and the third fell in the bottom 25%, we would likely say that the bottom one-third of any measured communities would be at the greatest risk. This is a working hypothesis. We wish to continue our investigations on this important issue as we feel it a duty incumbent upon us to contribute to understanding during this time of great scientific uncertainty.

Endnotes

- 1 Editor's note: This paper was written in 2009. As such, at the time of print, the H1N1 pandemic had ended.
- 2 The severity of a pandemic is typically assessed based on two criteria: (1) the "attack rate," which is the proportion of people who become ill over the course of the pandemic; and (2) the "mortality rate," which is the proportion of people who die over the course of the pandemic (Mathews et al. 2009).
- 3 Virulence is defined as a quantitative measure of the degree of pathogenicity (i.e., the ability to inflict damage) of a parasite; it is usually measured as the dose or cell number that will produce a pathological response over a given time period (Brock et al. 1994).
- 4 According to WHO (2009b), the historical record of influenza pandemics indicates that they strike in two, and sometimes three, waves. During the previous century, the 1918 pandemic, the deadliest of all, began with a mild wave, and then returned in one far more deadly. In fact, the first wave was so mild that its significance as a warning signal was missed.
- 5 We focus on First Nations and their communities for four reasons: (1) the first true test of pandemic preparedness occurred in Canada's First Nations communities; (2) we argue that First Nations communities are unique social spaces given their historical, cultural, political, and socio-economic attributes. They are geographically meaningful places in which First Nations people live. Reserves can be host to a variety of initiatives and policies that impact the day-to-day lives of their constituents, for example, the building of schools, and the creation of health projects. These social spaces are historically important locations for First Nations of Canada. A distinct set of social networks, norms, and attitudes are formed within these geographical spaces (Mignone 2003; White, Spence, and Maxim 2005). A similar argument was put forth by the Royal Commission on Aboriginal Peoples (1996), which suggested that an understanding of community norms and broad social conditions is necessary for positive outcomes to occur; de facto crime, alcoholism, sexual abuse, and suicide are merely symptoms of a structural problem. The importance of this context is also strategic given the demographic characteristics of the communities. According to 2001 census data (Statistics Canada 2004), there were about 1.32 million people who self-identified as having Aboriginal ancestry. According to departmental data from Indian Affairs, the Registered Indian population is numbered at 703,800 in over six hundred Bands, with approximately 419,800 (60%) living on-reserve (Indian and Northern Affairs Canada [INAC] 2004). If the migration assumption is correct, the proportion of registered Indians living on-reserve is projected to increase from an estimated 60% in 2001 to 75% in 2021. Thus, our understanding of the dynamics surrounding Aboriginals and their communities would be profitable as the future on-reserve population increases substantially (INAC 2004), and we try to curb the threat of potential disasters in the future, including pandemics; (3) First Nations, living on-reserve (in home communities), are the most disadvantaged subgroup of Aboriginals in Canada; and (4) there is an application to other countries where Indigenous peoples live in their own communities and have measurable disadvantage.
- 6 We have adopted WHO's terminology of the pandemic virus: H1N1/09.
- 7 If virus shedding is detected in fecal matter, this would introduce an additional route of transmission (WHO 2009a). The significance could be especially great in areas with inadequate sanitation, such as some First Nation communities in Canada and some Indigenous communities worldwide.
- 8 See White, Beavon, and Spence (2007) for a description of the development and importance of the First Nations Human Development Index.
- 9 The disproportionate rates of illness have not gone unnoticed by other residents. In June, residents from St. Theresa Point First Nation (where a few cases had been documented), staying at a Winnipeg hotel for health checks unrelated to influenza, were asked to leave the hotel for fear they had H1N1/09 given their home community (Godbout, Kusch, and Rollason 2009).
- 10 The degree of isolation of these communities is troubling given the previous discussion on "immunologically naive populations."
- 11 Adjuvant vaccine allows more vaccine to be produced (dosage sparing) and it provides better cross-protection in the case of mutating virus strains; in fact, WHO advocates use of the adjuvant

vaccine based on its merits (Public Health Agency of Canada 2009c; WHO 2009e).

- 12 In an interview with the Canadian Press, Dr. David Butler-Jones, chief public health officer, stated that Canada would purchase 1.2 million doses of unadjuvanted vaccine for pregnant women given the lack of data on its use in this demographic. This strategy is meant to improve rates of immunization among pregnant women who typically are less likely to be vaccinated yet are at high risk of contracting the virus (Branswell 2009).
- 13 For extensive coverage of the Community Well-being Index, methodological issues, and trends across Canada over time, see White, Beavon, and Spence (2007).
- 14 All too often, the diversity of Aboriginal people tends to be missed in discussions across a variety of audiences and arenas. This simplification of the Aboriginal condition is sometimes based on pragmatic grounds, but the danger of this process is far from benign. It is imperative to highlight the diversity of histories, cultures, and socio-economic circumstances of the Aboriginal population to adequately address the various needs of these people. Young (2003) states in his review of Aboriginal research that intra-group differences are often overlooked, homogenizing the geographic, cultural, socio-economic, and health status of Aboriginal people. Waldram, Herring, and Young (1995) voice similar concerns in their work:

Beyond the obvious and well-known need to understand the historico-cultural context of health, it is vital to appreciate that the concept of "Aboriginal health" is itself a convenient but ultimately false representation of the problem at hand. It masks the rich diversity of social, economic, and political circumstances that give rise to variation in health problems and healing strategies in Aboriginal communities. If nothing else, this [work] should make it clear that health and health care patterns show extensive variation across the country, despite the tendency for national, regional, and provincial databases to create the impression of widespread trends and homogeneity of experience. (258–9)

- 15 It should be noted that some work has attempted to capture the relative disadvantage of Indigenous peoples in a number of countries, including Australia and New Zealand (e.g., Cooke et al. 2007). Moreover, in the spring of 2009, Aboriginal Policy Research Consortium researchers (Martin Cooke of the University of Waterloo, Erin O'Sullivan of McMaster University, Jerry White of the University of Western Ontario, and Dan Beavon of Indian Affairs and Northern Development) conducted a training institute for scientists and Indigenous peoples from Moscow and Novosibirsk. The delegation was shown how to construct and use the CWB so they could start developing it at home.

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