Nuu-chah-nulth Health and Data Sovereignty in the Time of COVID-19

by

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Ethics Statement

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Abstract

This research paper explores Indigenous health and wellbeing, the importance of Indigenous health sovereignty, and the impact of historical pandemics and the COVID-19 pandemic on Indigenous peoples on the Northwest Coast. This has been done through a comprehensive literature review, a critical discourse analysis of public notices, and a series of semi-structured qualitative interviews with health governance experts from the Nuu-chah-nulth peoples. The data collected through the critical discourse analysis and interviews were used to understand health governance measures taken during the COVID-19 pandemic and offer recommendations to improve future emergency management. Key emerging themes include recognizing Indigenous conceptions of health and wellbeing, the role of sovereignty and self-determination in creating effective governance, and the importance of partnerships. The findings encourage meaningful policy changes at the regional, provincial, and federal levels by building nation-to-nation partnerships and increasing the capacity of Indigenous nations. These recommendations are made in support of respecting British Columbia's (BC) and Canada's commitment to upholding the legal framework of the *United Nations Declaration of Indigenous Peoples* (UNDRIP) from 2007 and the British Columbia (BC) *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) passed in 2019.

Key Words: Indigenous Sovereignty, Data Sovereignty, COVID-19, Social Determinants of Health, Decolonization; BC

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Finally, my greatest thanks and love to my family and my husband, Shawn. There have been many days filled with doubt and tears, and having you there, metaphorically and physically, to hold my hand and offer a supportive shoulder means more to me than I can ever express. I love you all, and it is for you that I continue to push myself and grow.

My studies at Simon Fraser University and the majority of my research have taken place in the unceded and ancestral territories of the *xʷməθkʷəy̓əm* (Musqueam), Sḵwx̱wú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) Nations.

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List of Acronyms

BC	British Columbia
BC CDC	BC Centre for Disease Control
CWB	Community Wellbeing Index
DRIPA	Declaration on the Rights of Indigenous Peoples Act
EMBC	Emergency Management British Columbia
EOC	Emergency Operations Centre
FNESS	First Nations Emergency Services Society
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNHDA	First Nations Health Directors Association
FNHMA	First Nations Health Managers Association
ISC	Indigenous Services Canada
NCN	Nuu-chah-nulth
NTC	Nuu-chah-nulth Tribal Council
PHO	Provincial Health Office
SDOH	Social determinants of health
TRC	Truth and Reconciliation Commission of Canada
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
WHO	World Health Organization

Chapter 1.

Introduction

1.1. Research objectives

The COVID-19 pandemic has reaffirmed that wellbeing is tied to the conditions that shape our lives, and COVID-19 is disproportionately impairing the wellbeing and health of Indigenous peoples compared to other populations. Indigenous communities across Canada and the world are more vulnerable to severe outcomes of COVID-19 because of contemporary and historical issues that impact their health and wellbeing (Mallard et al., 2021). Health is not merely the absence of sickness, and our wellbeing is impacted by larger forces, including factors like economic prosperity, happiness, worldview, and social relationships. To bring about better health outcomes, we must understand the social determinants that impact Indigenous health and wellbeing.

Structurally embedded racism, or systemic racism, and discrimination within the healthcare system, the history of colonialism, including subjugation and oppression, negatively impact Indigenous peoples' health and wellness (Turpel-Lafond (Aki-kwe) & Johnson (sɛƛakəs), 2021). The impacts of colonialism, racism and discrimination often started at the time of contact and persist to this day. From historic pandemics like the smallpox epidemics in the 18th and 19th centuries and the Spanish flu from the early 20th century, to more contemporary diseases like the 2009 H1N1 influenza pandemic and now the 2020 COVID-19 pandemic, diseases spread from settlers and colonizers to Indigenous peoples. They have decimated populations of Indigenous peoples with little in the way to prevent the spread (Harris, 1994; Richardson & Crawford, 2020; The National Collaborating Centre for Indigenous Health (NCCIH), 2016; University of Northern B.C. Libraries & Special Collections, n.d.; Van Rijn, 2006).

Throughout the cycles of disease, the tools for Indigenous peoples to use for self-determination over their own health and wellness have been absent or actively dismantled through colonial practices of subjugation. Figure 1 shows how the cycle of colonialism, negative stereotypes, and discrimination have resulted in poor medical outcomes. Pervasive negative labels paint Indigenous people as 'less worthy' or 'less capable' and can result in abusive interactions with medical professionals, including

being ignored or denying service. Stereotypes and discrimination create unwelcoming environments and builds mistrust between Indigenous people and figures of authority and medical professionals, like doctors and researchers. These conditions create a cycle that results in decreased access for First Nations peoples in BC who sought medical care within the healthcare system, and negatively affects health outcomes. This includes higher infant mortality rates, higher rates of suicide, alcohol and drug abuse, and lower life expectancy. This research paper dives into how the COVID-19 pandemic, along with previous pandemics, fit into that cycle which is exemplified in Figure 1. In order to break the cycle of negative health and wellness impacts, it is critical for Indigenous peoples to have self-determination over their lives, including health; and for the provincial and federal governments to recognize the Indigenous right to health as outlined in documents like the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Declaration on the Rights of Indigenous Peoples Act (DRIPA).

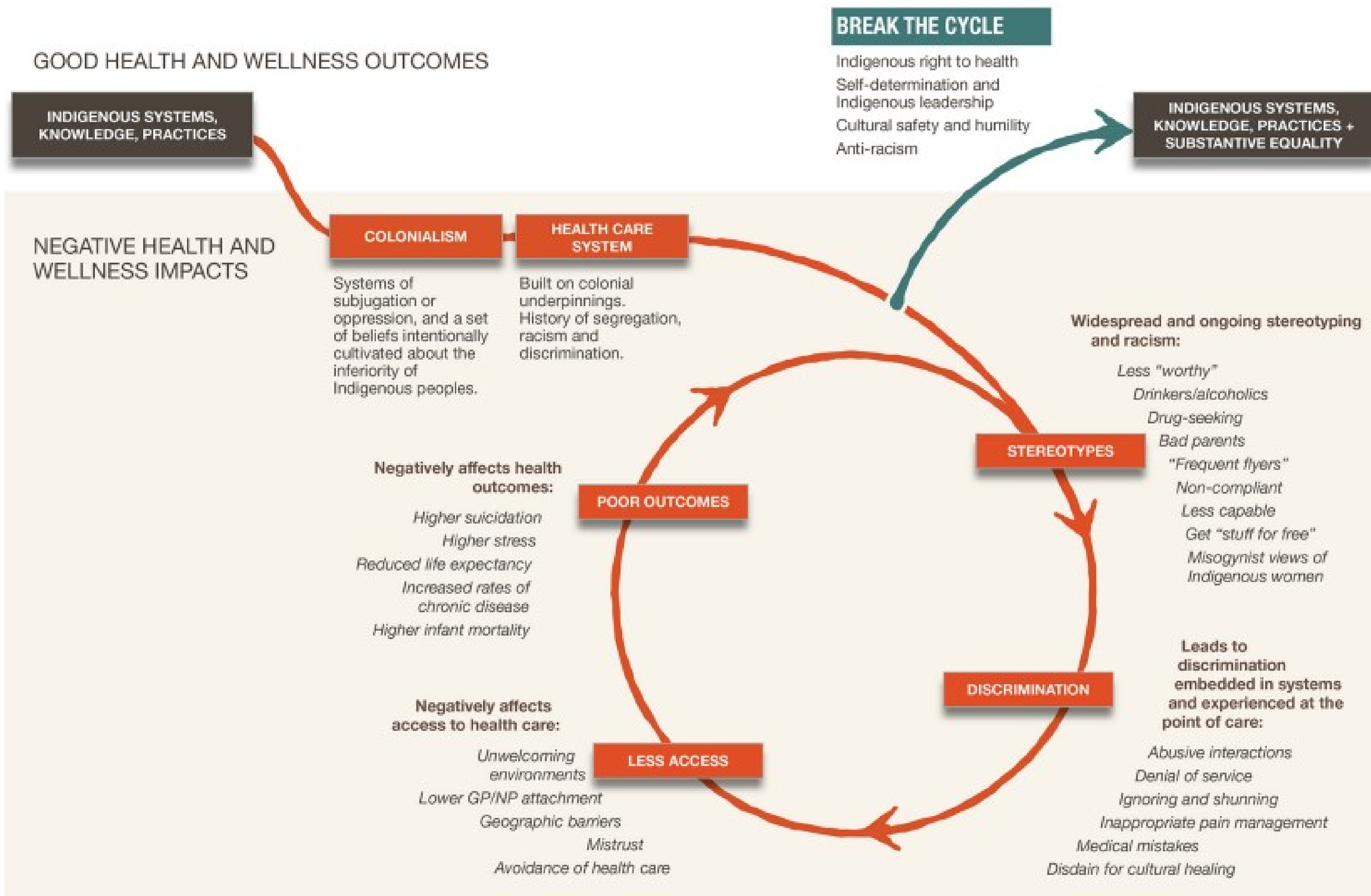

Figure 1. **A visual representation of how to 'break the cycle' of negative health and wellness impacts. Taken from the report: In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care.**
Source: (Turpel-Lafond (Aki-kwe), 2020).

UNDRIP and the Truth and Reconciliation Calls to Action assert that equitable and culturally appropriate access and control over health services are an Indigenous right to health. The right to health stems from the right to self-determination and sovereignty. Sovereignty is the inherent rights and freedoms of Indigenous peoples, which includes self-determination, or the authority, right, and power, to continue to live by Indigenous ways of being and knowing (Mashford-Pringle et al., 2021). Self-determination is “the unconditional freedom to live one’s relational, place-based existence” and is required to exercise sovereignty, giving Indigenous peoples agency (Corntassel & Bryce, 2012, p. 152). Reconciliation within Canada is tied to the government’s relationship with Indigenous peoples and addressing the harms caused through colonial policies and programs, the ”opportunity to reflect on the past, to health and to make right” (Sterritt, 2023). Therefore, self-determination and sovereignty are fundamental to reconciliation and the assertion of Indigenous health rights.

1.2. Research Questions

The research questions that guided this project can be broken down into two main questions. The questions are:

1. Is sovereignty a social determinant of health for Indigenous peoples, and why?
2. How did the Nuu-chah-nulth assert sovereignty during the COVID-19 pandemic?

The first question will be answered through the background literature review, which will seek to connect sovereignty to health and wellbeing and delve into what exactly health and wellbeing are for Indigenous peoples. Furthermore, it will describe why sovereignty is an essential consideration as a social determinant of health. The answer to the second question will be understood through a case study regarding the Nuu-chah-nulth peoples from the west coast of Vancouver Island, British Columbia. The case study will be framed through interviews and a critical discourse analysis of COVID-19 public notices. While each Indigenous community experiences the COVID-19 pandemic differently, the second research question will reveal how the Nuu-chah-nulth asserted sovereignty during the pandemic. It is important to document experiences like this case study as acknowledges their work and show a pathway for further future recognition.

1.3. Positionality Statement

I am writing this positionality statement on September 30th, 2022 – the day marked in Canada as the Day of Truth and Reconciliation. I mention this because, on this day, I have a responsibility as a settler living on Turtle Island to reflect on the history of the nation I claim to be a citizen of. The atrocities that have happened here by my ancestors have enabled me to live the life I am now. The effects of systemic racism, colonialism, and erasure that Indigenous Peoples have faced are still ongoing, and I have a responsibility to understand that these traumas are still present, recognize the power imbalances that exist which highlight my voice above others, and give me a duty to create change by making space for Indigenous peoples. I do so by highlighting Indigenous scholars, activists, experts and people through my research here.

I am a white, cis-gendered settler Canadian from Edmonton, Alberta, Treaty 6 territory. I grew up in a middle-class household under the care of a single mother and with the guidance and care of my father and maternal grandmother. Who I am shapes how I see the world, and my connection to family and place is the foundation of my worldview. My family's time in Canada can likely be traced back to the last hundred years, a short time span which gives me a tenuous, at best, connection to these places. The Indigenous peoples who occupy, care for and govern these lands and waters have been here since time immemorial.

When I first entered the REM program, the topics that captured my interest concerned Indigenous peoples in Canada and their access to resources, equity and justice. Through my education, I have come to realize that the concepts of health and wellness are deeply entwined with equity and justice. Moreover, while health and wellness were not my primary research interests, it gave me an opportunity to reflect on the relationship between the researcher and – whom I define as – the research partners. Decentering my own interests and shifting the focus of my research to a topic that is of great importance to my research partners has allowed me to focus on the relationship between myself with my research partners and the values and understandings they have towards the concepts of 'health' and 'wellness.' I conduct this project not for myself but for those that I am working with.

The project I am working on and submitting to complete my graduate program requirements is co-created by my Nuu-chah-nulth and Tsimshian supervisor, Dr. Cliff Atleo Jr., Stellat'en scholar Dr. Lyana Patrick, and settler scholar Dr. Dawn Hoogeveen. I mention that this project is co-created because I am trying to bring equity to the power imbalance between myself and the communities I am writing about/for. I do not claim to speak for the Nuu-chah-nulth communities and scholars that have informed my work. I assert and will continue to assert that the Indigenous voices and words documented within my writing are the centre of this story.

Chapter 2.

Methodology

My research approach is informed by the teachings and methodologies of Māori scholar Linda Tuhiwai Smith and Opaskwayak Cree Scholar Shawn Wilson, where I seek to 'unsettle myself' as the researcher, placing the communities I am working alongside and the relationships at the centre of this work (L. T. Smith, 2012; Wilson, 2008). I recognize the importance that the knowledge I 'gather' from participants and my relationship with them should not be exploitative and must be part of a reciprocal, mutually-beneficial connection (Datta, 2018; L. T. Smith, 2012). Conducting research with Indigenous peoples means that the Indigenous research "is the ceremony of maintaining accountability to these relationships" (Wilson, 2008). This recognition is of even greater importance because of the historical and continued impacts that First Nations in Canada and Indigenous peoples around the world have endured while advocating for health and healthcare equity (Richmond & Cook, 2016). The things I have read and will discuss within this project are more than just numbers or data. They tell a story of human lives – people who have been loved, cared for and missed. The realities of this story and research are important to acknowledge and treat with respect. Within this section, I outline my main methods including a literature review, a media discourse analysis, and interviews.

Being accountable to the relationships I have built with my Nuu-chah-nulth supervisor, the Nuu-chah-nulth communities I am working with, and the Indigenous scholars I have cited within this document means I must make careful choices in the topics discussed here, my methods used for data collection, the analysis I conduct, and the final presentation of that shared knowledge within this document (Wilson, 2008). As Shawn Wilson says, the Indigenous research paradigm is all about relationality (relationships) between ontology, epistemology, methodology, and axiology. He explains that "ontology and epistemology are based on a process of relationships that form a mutual reality. The axiology and methodology are based upon maintaining accountability to those relationships." (Wilson, 2008, pp. 70-71). He says there is no objective reality, but reality is based on relationships. In my understanding, it means I cannot 'extract' knowledge from my Indigenous partners on this project and use it to paint objective

truths about COVID-19, health, vaccines, etc. What is instead understood is that what has been shared and written within this document is relational. This is not only based on the relationship between myself and my research partners, or my research partners' relationship with the concepts and ideas themselves, but also how I understand those ideas and concepts based on my own positionality in the world. The relationship between subject and object (including concepts, ideas, or even a physical thing like a vaccine – and related understandings of it), and subject and subject connect to an infinite number of other concepts and subjects. They are "interpersonal, intrapersonal, environmental and spiritual relations, and relationships with ideas" (Wilson, 2008, p. 74). Thus, these relationships continue to create and build more relationships, and truth must be understood within the context it is found and cannot be extrapolated – or removed – from those relationships.

Therefore, the principles that I base my research upon are:

- Building respectful and reciprocal relationships between myself as the researcher and my research partners (i.e., the interviewees) and maintaining respectful relationships with my research topics.
- Placing myself not as an objective outsider but situating myself and academia (which I am partaking within) as embedded within the legacies of colonialism and imperialism.
- Place emphasis on the shared gift this research is, based on its origination as a co-created project, aiming to be attentive to whose words I am writing and what they mean.
- Consciously recognize the impacts of racism, exploitation and ethnocentrism that have shaped the relationality my research partners have experienced and, thus, their worldviews.
- Giving back to my research partners – sharing the work that is produced as a result of this project and making it accessible.

2.1. Literature Review

The literature review for this document is based on collecting and reviewing literature written about the 1800s smallpox epidemics impacts upon the North-west coast Indigenous peoples, the 2009 H1N1 influenza pandemic and the current SARS-COV-19 pandemic, known as the COVID-19 pandemic. Literature for this review was identified using Simon Fraser University's online Library database, Google Scholar, and the

Vancouver Public Library system. The key search terms used for the search strategy combined the terms 'Indigenous,' 'Aboriginal,' 'First Nations,' 'H1N1,' 'COVID,' 'Pandemic,' 'Smallpox,' and 'Pestilence' (to capture more historical pandemic-related documents including smallpox) in varying combinations to target the appropriate types of literature desired. Key search terms also included terms like 'Health,' 'Sovereignty,' and 'British Columbia' where necessary, primarily if it was aimed to narrow the scope to more localized impacts of the pandemics.

The publications selected were either peer-reviewed or non-peer-reviewed/grey literature, including policy documents, original research or a review of research, and advocacy pieces. Recognizing that the COVID-19 pandemic occurred within the last three years (and still occurring at this time), there is a gap in current research available that fits the spatial (Northwest Coast) and cultural (Indigenous, specifically Nuu-chah-nulth) area desired for this research project. Due to that constraint, other literature outside the study area has also been included if it has been determined to mirror some of the experiences Indigenous peoples face during the COVID-19 pandemic. The publications were selected if they were found to fit at least two of the following categories:

- Focus on Indigenous experiences of pandemics, with priority towards those living in the Canadian context;
- Focus on Northern Coastal Indigenous peoples' experiences with the Smallpox epidemics during the 19th century;
- Include an analysis of news media publications about Indigenous peoples' experiences during the COVID-19 pandemic – including Indigenous-owned and/or run news media; and,
- Include an analysis of Indigenous health governance and emergency response planning, including the social determinants of health.

Indigenous health and wellness is a vast topic which can be expanded upon and continues to be the centre of much research and study (Carroll et al., 2022; Josewski et al., 2023; Mayes, 2019; Tanner et al., 2022). A targeted search was used to reduce the scope to focus on papers written closer to the goals of this study. The primary literature review resulted in 89 publications being reviewed. The goal of the literature review aimed at familiarizing myself with the topic(s), including the diverse perspectives and

foundational documents related to Indigenous health, sovereignty and pandemic planning/response.

2.2. Media Review & Analysis

A secondary review was also conducted, which consisted of exploring and documenting information shared about the COVID-19 pandemic by the 14 Nuu-chah-nulth communities on their websites. This included things like bulletins, newsletters, reports, safety plans, and website posts. Additionally, a search was conducted analyzing the corresponding Facebook Pages for the communities – if they existed and were public, and if they were used for posting COVID-19 information. The availability of COVID-19 information on Facebook has been documented in Table 1.

Table 1. The accessibility of Nuu-chah-nulth Facebook pages and availability of COVID-19 information

NCN Nations	Facebook publicly accessible	COVID info shared on Facebook
Ahousaht	Public	Yes
Ditidaht	Public	Yes
Ehattesaht	Private	N/A
Hesquiaht[1]	Public	No
Hupačasath	Public	No
Huu-ay-aht	Public	Yes
Ka:'yu:'k't'h'/Che:k:tles7et'h'	None found	N/A
Mowachaht Muchalaht	Public	Yes
Nuchatlaht	Public	Yes
Tla-o-qui-aht	Public	Yes
Toquaht	Public	Yes
Tseshaht	Public	Yes
Uchucklesaht	None found	N/A
Yuułuʔiłʔatḥ	Public	Yes

A newspaper review was also conducted using local and Canadian-based newspapers, including the Nuu-chah-nulth-owned and run Ha-Shilth-Sa, the Campbell River Mirror, Victoria News, and CBC News, to examine the kind of discourse that was

[1] The Hesquiaht Facebook page appears unused completely since 2019

shared about coastal First Nation communities' response to the pandemic. The findings have been recorded in a table for analysis.

The secondary review resulted in 56 notices/social media or media releases being collected. The source material within the review was then analyzed using a critical discourse analysis lens. Critical discourse analysis (CDA) is a research tool used to understand how language or discourse is used as a social practice and investigates the hidden power relations and ideologies embedded in the discourse (Johnson & McLean, 2020). It is an effective tool for understanding some of the underlying meanings of the public notices, newsletters, social media posts and similar media shared during the pandemic by the Nuu-chah-nulth communities. The aim of collecting the notices was to assess what information was being transmitted by the 14 Nuu-chah-nulth nations to community members, what information they felt was imperative to share, and if it demonstrated an assertion of control over accessing their territories.

Neither review is completely exhaustive, as more research is currently being produced at the time of the writing of this report, and because the secondary review items were often duplicated between Facebook and the community websites or were unavailable at the time of collection (as in they were removed from the website as the COVID-19 pandemic progressed), or included as part of a larger newsletter/bulletin and did not warrant its own note within the analysis.

2.3. Interviews

For this project, a total of six interviews (n=6) were held. They were conducted over Zoom by my supervisor, Dr. Cliff Atleo Jr. The interviews were semi-structured, where participants were asked about their experiences as community leaders and within their roles during the COVID-19 pandemic and did not follow a strict script of questions. The interviews focused on Nuu-chah-nulth people who had worked in some capacity in health governance for their Nation. Each participant was an expert in their field, and their information and contact details are publicly accessible. Their roles gave them a unique perspective on the initiatives, interventions, challenges, and successes their communities have faced during the pandemic. The interviews were conducted as part of a larger project entitled "COVID-19 and Indigenous public health sovereignty in British Columbia: Addressing systemic inequity through community-driven solutions" funded by

the Canadian Institutes of Health Research CIHR, ER5-179414. The project received a provincial harmonized ethics certificate, no. H22-01643 and Nations involved in research, including the NTC, wrote letters of support for this work.

Interviewees:

- Judith Sayers (Cloy-e-iis): Member of the Hupačasath First Nation, President of the Nuu-chah-nulth Tribal Council for over five years.
- Ken Watts (waamiiš): Member of Tseshaht First Nation. Elected Chief Counselor of Tseshaht First Nation since December 2020.
- Lynnette Lucas: Director of Health for the Nuu-chah-nulth Tribal Council for over 4 years, acting manager for the Mental Health Department.
- Mariah Charleson: Member of Hesquiaht First Nation, Former Vice President of the Nuu-chah-nulth Tribal Council during the COVID-19 pandemic.
- Terry Dorward (Seit-Cha): Member of Tla-o-qui-aht First Nation. Tla-o-qui-aht Tribal Parks Project Coordinator, overseeing the Tribal Park Guardian program.
- Wickaninnish (Clifford Atleo, Sr.): Member of Ahousaht Nation. Elder Advisor to First Nations Health Council, previous Vancouver Island Representative, and previous President of the Tribal Council.

Chapter 3.

Literature Review

3.1. Indigenous Health & Wellbeing

I start the project by sharing the definitions of ‘health’ and ‘wellbeing’ to ensure that these concepts throughout the work have a shared baseline understanding and because the definitions have many implications for the resulting health and wellness practices, policies and services (Leonardi, 2018). Furthermore, people’s views of health impact their behaviours related to health and wellness (Hughner & Kleine, 2004). However, due to their inherent complexity, health and wellbeing are contested definitions (Placa et al., 2013). Placa et al. (2013) assert that health is generally considered within biomedical and positivist discourses, and wellbeing is more related to the emotional and psychological understandings of health (Placa et al., 2013, pp. 115-116). The currently accepted definition of health by the World Health Organization (WHO) was established in 1947 as a “state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity” (World Health Organization, 1948). It recognizes the social aspects of health, including social and mental wellbeing, within its definition.

The definition by the WHO links health and wellbeing together, but it does not accurately communicate the significance that wellbeing holds. The Cambridge Dictionary defines wellbeing as “the state of feeling healthy and happy” (Cambridge University Press, 2022). There is no international consensus on what wellbeing is, which has resulted in it being measured in many different ways (Simons & Baldwin, 2021). Within Canada, there has been a relatively long history of collecting statistical data on wellbeing compared to places like Australia, Germany, and the United Kingdom (Jarrett, 2021). Despite data collection, there are no consistent criteria for what is being measured. Different wellbeing rankings are used, like the Social Progress Index, Human Development Index, World Happiness Report and the Environmental Performance Index (Jarrett, 2021). Measuring wellbeing is vitally important because it is linked to our health, including decreased risk of illness, mental illness, injury and disease, improved immune functioning and faster recovery, and increased longevity (Centres for Disease Control and Prevention, 2018).

Instead of looking for a better definition of health and wellbeing that accounts for the gaps in the previous definitions, this research understands that health, from a holistic perspective, moves beyond 'disease' and towards a greater conception that includes wellbeing and other socio-economic, cultural, and environmental conditions. The primary factors that shape health are not just medical treatments or care, nor lifestyle choices, but are "rather the living conditions that [we] experience" (Mikkonen & Raphael, 2010, p. 11). The goal of wellbeing is to understand what makes us happy and healthy, which is shaped by the conditions in which we live, work, and age (Jarrett, 2021).

Indigenous perspectives on what health and wellbeing mean can differ greatly from Western conceptions and should not be generalized across all Indigenous peoples. However, there is a common element that "exists for all Indigenous peoples and affects every issue confronting them as a collective: the history of colonization and the associated subjugation of Indigenous peoples" (Commission on Social Determinants of Health, 2007, p. 24). Another commonality, at least for Indigenous peoples residing in Canada, is that health is understood as holistic and interconnected across a network of determinants of health and wellbeing, including emotional, intellectual, spiritual and other components (Carroll et al., 2022). Health and wellbeing should not be understood in isolation, conceptually and at the individual level, compared to the collective wellbeing of the individual's community (Commission on Social Determinants of Health, 2007, p. 24). In Australia, the National Aboriginal Health Strategy in 1989 pushed the WHO's conception of health to include cultural wellbeing and community health because they recognize that the wellbeing of the community as a whole impacts the wellness of an individual (Carroll et al., 2022, p. 3).

One useful model for conceptualizing Indigenous health is the Medicine Wheel, which is used in many North American Indigenous communities. Figure 2 shows one conception of the medicine wheel, which includes First Nations teaching on interconnectedness and "achieving a balance between the physical, mental, emotional, and spiritual domains" (Tanner et al., 2022, p. 2). It is holistic because it includes the "whole person, within the family and within the community" (Mayes, 2019). A sense of belonging, community wellbeing, and connection to land and identity all contribute to overall health. There are many conceptions of the medicine wheel, but at heart, it incorporates Indigenous teachings for achieving health and wellness. The use of the

medicine wheel model is helpful, but it is also generalized and does not include every Indigenous conception of health and wellbeing.

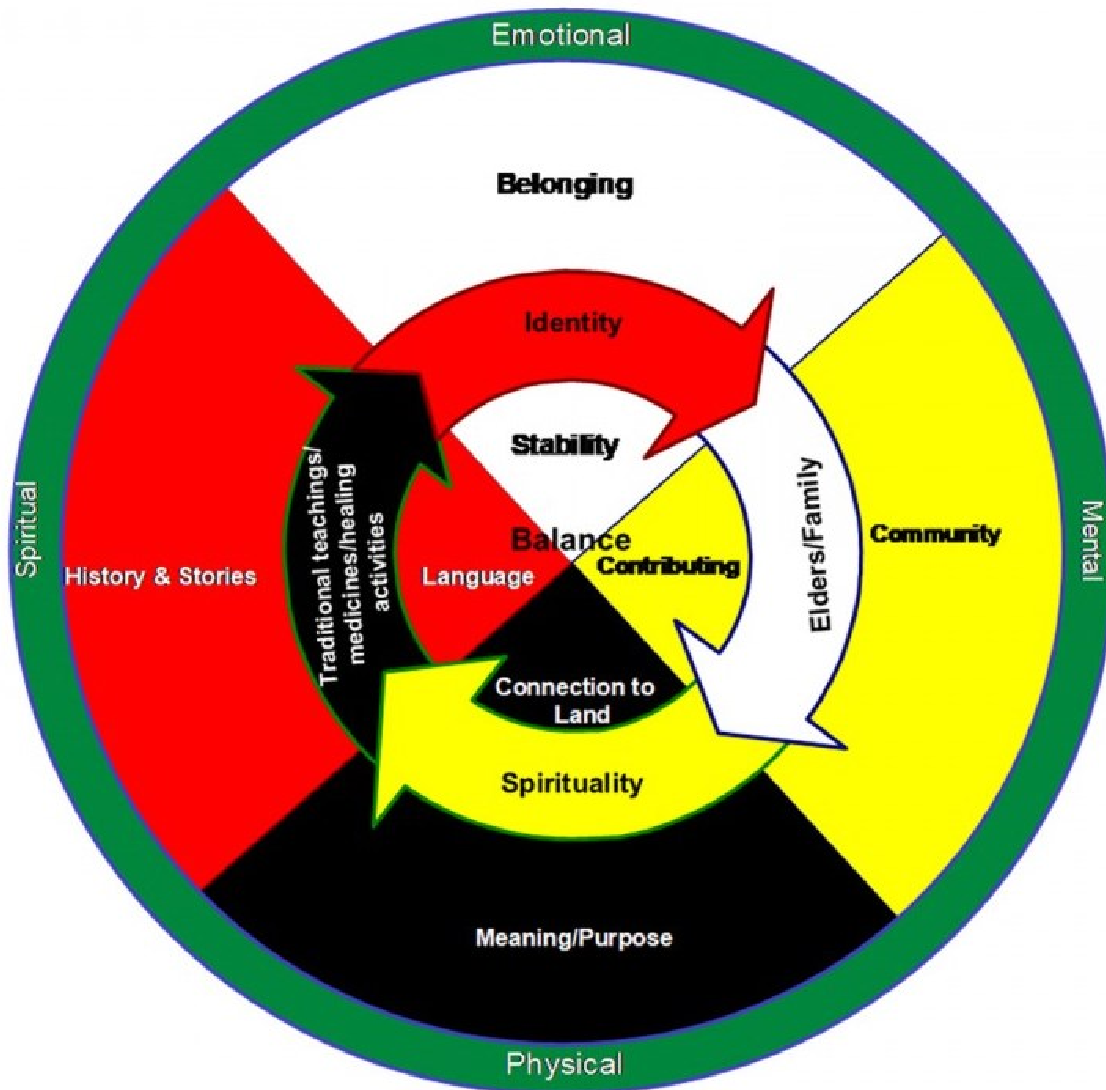

Figure 2. **Strategies for achieving health are understood as interconnected on the Medicine Wheel.**
Source: Mayes, 2019.

3.1.1. Nuu-chah-nulth Perspectives on Health and Wellbeing

Understandings of health and wellbeing are nested contextually within one's own culture and worldview. Sharing an overall Indigenous perspective on health and wellbeing is part of the picture, but there are differences and distinctions between Indigenous cultures. Working to comprehend the Nuu-chah-nulth worldview shows honour and

respect to the NCN and provides a basis for appreciating and gaining insight into their actions and way of life. Furthermore, it is essential in health governance as it shapes decisions and policymaking to meet the needs of the NCN. It allows information to be distilled and presented in their cultural context.

My own understandings of what health and wellness for the NCN are limited to what has been published and made publicly available. Writings from Umeek (E. Richard Atleo) and Charlotte Coté, two prominent Nuu-chah-nulth writers and scholars, have been included here to bridge the gap of what the NCN worldview is. Health and wellbeing are culturally rooted; health has physical, social, mental and emotional aspects that all work together to heal and protect (Coté, 2022, p. 37). Nuu-chah-nulth perspectives of what contributes to health and wellbeing follow similarly to what was found in Figure 2 above, where relationships and balance between the different aspects are foundational for every other aspect.

Umeek's book, *Tsawalk – A Nuu-chah-nulth Worldview* (2004), speaks to achieving balance. *Heshook-ish tsawalk* means 'everything is one' and speaks to how humans and nature are not separate but instead form a harmonious whole achieved through mutual respect and relationships. To achieve balance and happiness, at the foundation, the relationships with family and community are prioritized. It is "unnatural, and equivalent to death and destruction, for any person to be isolated from family or community" (Umeek, 2004, p. 27). Providing necessities to be healthy, including food, shelter, clothing, medicine, governance, and entertainment, is done through a strong community that passes on teachings and support (Umeek, 2004, p. 28). For the Nuu-chah-nulth, the meaning of life is "to create, maintain, and uphold relationships" (Umeek, 2004, p. 30). Having balance and showing respect within the human-nature relationship is a principle increasingly recognized as a critical concept for realizing health (Seymour, 2016). Therefore, relationships are foundational in health and wellbeing.

Spirituality is also intrinsic to health and wellbeing. Unlike Western perspectives, spirituality is connected to physicality and is also relationally understood. Having healthy spirituality means understanding that "we are all related; we are all brothers and sisters not only to each other but also to every life form" (Umeek, 2004, p. 88). The Nuu-chah-nulth-aht believe that nature has spirits, and those spirits are honoured through ceremony and reciprocity (Coté, 2022, p. 30). Spirituality is expressed through kindness,

humility, wisdom, generosity and respect versus exploitation and overuse. Nuu-chah-nulth understand things like earthquakes, fire, floods, famine, and disease as evil. The balance is counteracted by the presence of good, which manifests through health, peace, creation, abundance, and safety. To be healthy means having balance to bring about good. Practicing “mutual recognition, mutual responsibility, and mutual respect” brings balance and good health (Umeek, 2004, p. 91). Spiritual practices like ritual cleansing and prayer can bring good health. Connection to land is also part of health and wellbeing, and that is evident in the important role that traditional foods play in physical, nutritional, and spiritual health. Traditional foods, from their collection, preparation, and then to eating, “reinforces the familial and social bonds of generosity and reciprocity” (Coté, 2022, p. 28). There is an emotional connection to eating traditional foods, and it connects to the social and cultural values the NCN hold, reinforces traditional knowledge, and perpetuates the intrinsic connection to the land (Coté, 2022, p. 45).

All of these aspects of the Nuu-chah-nulth worldview, and those that make up the conceptions of health and wellbeing, are impacted by settler colonialism and the separation from lands and culture. Planning, governance, and policymaking for health and wellness need to be done in a way that recognizes and affirms their unique worldview. This is done through understanding it and then building the tools for them to enact it in the Nuu-chah-nulth way; through sovereignty and self-determination without oppression from settler colonial jurisdictions and authorities (Coté, 2022, p. 46). Building up the capacity of the Nuu-chah-nulth and other Indigenous communities through community-based and regional decolonial planning and governance practices, which re-enforce and respect their traditional worldview, creates a critical pathway to enhance their health and wellbeing.

3.2. Social Determinants of Health & Sovereignty

The World Health Organization defines the social determinants of health as “the non-medical factors that influence health outcomes” or the “wider set of forces and systems shaping the conditions of daily life” (World Health Organization, n.d.). The model by Dahlgren and Whitehead (1991), shown in Figure 3, is commonly understood as one of the most effective illustrations that demonstrate what the social determinants of health (SDOH) are for individuals. It includes topics like working conditions, education, access to health services, housing and amenities, the environment, socioeconomic status,

political systems and much more. Furthermore, the WHO suggests that SDOH can be even of greater importance compared to healthcare access or lifestyle choices and that social determinants of health can account for between 30-55% of health outcomes. Therefore, when discussing health and healthcare, including the surrounding SDOH is fundamental in understanding, addressing and improving health inequities and Indigenous health outcomes.

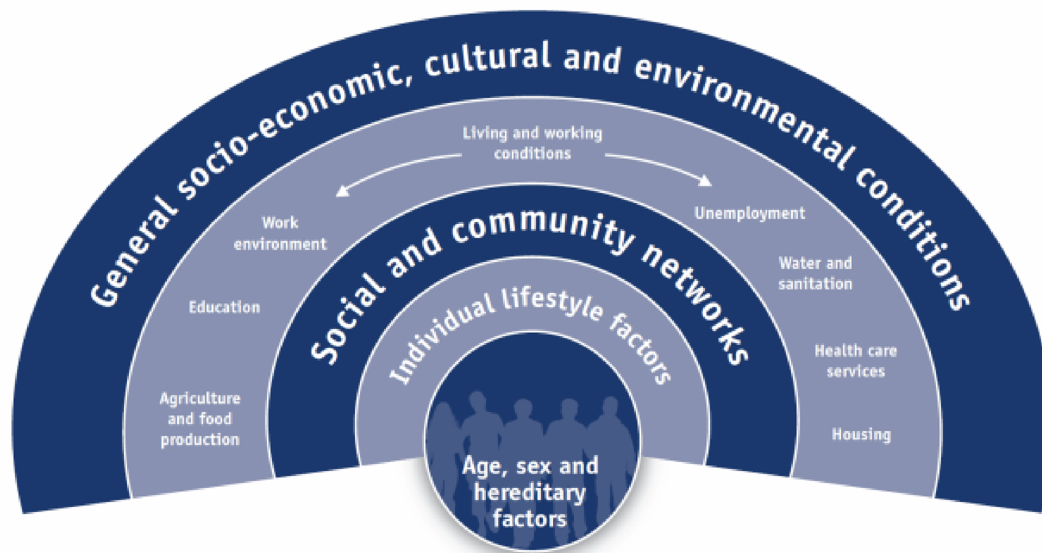

Figure 3. The Dahlgren-Whitehead model of health determinants.
Source: Whitehead & Dahlgren, 1991.

The SDOH for Indigenous peoples have different factors that must be included compared to non-Indigenous peoples. Poor health is often a result of general marginalization and factors like poverty, violence, poor housing conditions and 'deficient physical environments' (Commission on Social Determinants of Health, 2007, p. 25). Previous trauma and legacies from destructive colonial practices have profound consequences that exacerbate health inequities (Vallesi et al., 2018). Traumatic events like residential and day schools, the 60s scoop, the removal of children from families, the suppression of language and cultural practices, and forced resettlement have permeated intergenerationally and still negatively impact communities and individuals today (Tanner et al., 2022). Physical, psychological, spiritual, and sexual abuses were delivered by the hands of those administering the programs. These processes have been described as "an act of cultural genocide" that has impacted survivors with significant psychological challenges, including post-traumatic stress disorder, increased rates of suicide,

substance abuse, and domestic violence (Menzies, 2020), as also evidenced in Figure 1 to lead to decreased access and poor health outcomes (Turpel-Lanfond (Aki-kwe), 2020. These traumatic experiences have then been passed down to subsequent generations through the loss of cultural knowledge, lack of knowledge or skills to cope within the world, and children who grow up within similar trauma-induced environments that have affected the wellbeing of their families and communities (Menzies, 2020).

Historical racist claims like the Doctrine of Discovery and *Terra Nullius* have been used to seize land and forcibly relocate and suppress Indigenous peoples. The 1976 Indian Act and other laws have legally codified these doctrines and continue to have devastating consequences for Indigenous peoples (Assembly of First Nations, 2018; Tanner et al., 2022). Structural issues from current laws, including the Charter of Rights & Freedoms, the Royal Proclamation of 1763, and the Indian Act, impact Indigenous communities because of the inequities, discrimination, and racism that have been built into them (Allan & Smylie, 2015; Mashford-Pringle et al., 2021, p. 12). This is understood as systemic racism, or institutional racism, a power dynamic deeply embedded within a colonial state like Canada (University of British Columbia, 2021). It refers to how whiteness and white superiority are entrenched within the institutions of Canada, like within the justice, education, and healthcare systems.

Intergenerational traumas are met with current racial discrimination and systemic racism. Indigenous peoples within Canada and across the globe face additional barriers to achieving health and wellness that are not shown in the traditional SDOH model by Dahlgren-Whitehead (1991). Recognizing the barriers that are brought by racism, colonialism, the healthcare system, and discrimination may help to ‘break the cycle’ that results in poor outcomes and decreased access to healthcare services (Turpel-Lafond (Aki-kwe) & Johnson (sɛƛakəs), 2021). This cycle is illustrated by Turpel-Lafond (Aki-kwe) and Johnson (sɛƛakəs) (2021) in Figure 1 above. Recommendations from the *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Healthcare* (2020) report reassert the need to uphold the standards of UNDRIP and DRIPA which have been put into law in BC (Turpel-Lafond (Aki-kwe), 2020).

SDOH are not uniform between distinct First Nation communities. For example, northern and rural BC communities located near resource extraction sites (mining, oil and gas, etc.) are likely to have negative and cumulative impacts from resource

extraction compared to southern or urban communities (Aalhus & Fumerton, 2018). The specific environmental and social effects cannot be generalized between distinct communities, although they offer a basis for analysis that can be utilized for other communities. In the Nuu-chah-nulth context, researchers from the 14 nations are currently determining what they consider to be their SDOH. The researchers are conducting a longitudinal study to illustrate the complex factors that determine wellbeing throughout the life stages of participants (Plummer, 2022). The study is led by the Nuu-chah-nulth, with the hope of reclaiming health and moving towards breaking the cycle of shame that has been instilled through trauma by residential schools and which "continues to be perpetuated by authorities and service providers" (Plummer, 2022). Having a Nuu-chah-nulth-built model for SDOH affirms the NCN worldview and asserts sovereignty for NCN communities for addressing their health and wellbeing priorities.

Sovereignty is a difficult term to define concretely. However, it is also critical in improving Indigenous health outcomes. It can be generally understood as the collection of social, economic, political and cultural rights and is closely linked to the right to self-determination (Shrinkhal, 2021). Within traditional SDOH, sovereignty has not been explicitly marked as a foundational principle to achieve wellness. Ownership, control, access to data, and self-governance are important considerations for Indigenous SDOH (Aalhus & Fumerton, 2018; Carroll et al., 2022). High levels of self-governance and control over decision-making are linked to overall improved community health (Aalhus & Fumerton, 2018, p. 21). In 2015, the Native Nations Institute called on the WHO's work on "SDOH to include Indigenous-determined SDOH which centres on sovereignty, Indigenous ways of knowing, and utilizing Western knowledge, as needed." (Carroll et al., 2022, p. 2).

SDOH is a conceptual framework "with deep roots in colonial Canada" and its use risks deepening colonial ways of thinking about Indigenous health and health services (Josewski et al., 2023). For Indigenous peoples, SDOH must be grounded, land-based, and tied to ecology and physical geography. Most research on SDOH does not consider First Nations perspectives. Additional principles and concepts need to be included to represent Indigenous conceptions of health and wellbeing. The Medicine Wheel (Figure 2), often used by North American Indigenous communities, is one concept that can be applied to SDOH to give a fuller picture because it shows the interconnectedness between the four realms that make up wellbeing: the emotional,

mental, spiritual, and physical (Mayes, 2019). However, the lack of available research on Indigenous-specific determinants of health or visions of a healthy society results in a knowledge gap (Carroll et al., 2022).

Updating the Dahlgren-Whitehead (1991) model should include the holistic understandings of the world and interconnectedness that Indigenous peoples hold as part of their ontology, which the Medicine Wheel model includes (Figure 2). The principles that a SDOH model for Indigenous Peoples must:

- Include baseline information,
- Be created through meaningful community engagement and participation,
- Include human rights,
- Recognize the impacts of colonialism, trauma, and past and present harms,
- Include free, prior and informed consent,
- Include traditional and local knowledges,
- Have considerations for gender and other sexual- and gender-based inequities, and,
- Have principles governing ownership, control, access, and possession of data (Aalhus & Fumerton, 2018; Tanner et al., 2022).

3.3. Social Determinants of Health & Data Sovereignty

The Native Nations Institute marked data sovereignty and data governance as critical to improving SDOH (Carroll et al., 2022). Data sovereignty is “the ability for Indigenous peoples, communities and Nations to participate, steward, and control data that is created about themselves” (Wong, n.d.). There are clear data availability challenges that impact Indigenous Nations and communities, and the available data do not usually address Indigenous-specific SDOH (Carroll et al., 2022, p. 6). Access to reliable data will improve decision-making for Indigenous communities, especially for emergency response and pandemic planning (Deer, 2020).

The pervasive role of racism and discrimination is evident in the lack of available data. Specific interventions to address “attitudinal, interpersonal and systemic racism towards Indigenous peoples” cannot be addressed without data (Allan & Smylie, 2015,

p. 3). The stories that are told of Indigenous peoples and their health are largely not written by Indigenous peoples themselves and are usually exemplified by racist stereotypes and images (Allan & Smylie, 2015). There is a lack of statistical transparency and availability for previous pandemics, “further perpetuating the lack of Indigenous voice and increasing the health disparity gap” (Power et al., 2020, p. 3). During the COVID-19 pandemic, BC started to collect disaggregated data – namely race, ethnicity, community, and socioeconomic status – for the impacts of the virus. The Nuu-chah-nulth Tribal Council asked for confidential access to this data to ensure travellers do not bring the virus into their communities, and was refused, reducing the NTC’s ability to make effective decisions (Hunter, 2020).

Having sovereignty over health data – how it is collected, used, and distributed – is critical in rebuilding trust between Indigenous communities and institutions. For healthcare providers and governance bodies, addressing SDOH is a complex and difficult task when trying to provide services to prevent, treat and rehabilitate disease and illness. The barriers created by SDOH are often coupled with a common feeling of distrust by Indigenous communities towards authoritative bodies, authority in general, or “white people” (Barnett & Kendall, 2011; Vallesi et al., 2018). Feelings of mistrust can lead to avoidance of necessary healthcare. To illustrate the historical mistrust in medical governance and research, the ‘bad blood scandal’ in the 1980s saw over 800 blood samples taken from Nuu-chah-nulth-aht under the premise of finding better treatment for rheumatoid arthritis. However, the samples were later found out to be taken out of the country, without consent or knowledge, to be used for genetic anthropology studies and other experiments (Plummer, 2022).

Past experiences at the hands of government and medical professionals created challenges for building trust by Indigenous communities. In addition to the example above, medical experimentation and abuse within hospitals and on children within residential schools were commonly reported experiences across Canada (MacDonald et al., 2021). From 1942 to 1952, the federal government ran an unprecedented amount of biomedical experimentation on Indigenous communities and residential school children without the subjects’ knowledge or informed consent (Mosby, 2013). Indigenous communities and Indigenous bodies, respectively, were viewed by doctors, scientists and bureaucrats as ‘laboratories’ and ‘experimental materials’ to understand the impacts of malnutrition and resulting susceptibility to disease (Mosby, 2013). The ‘results’ of the

‘experiments’ were not used to improve the structural conditions that had led to malnutrition but instead were used to advance the careers of those conducting the tests. We now recognize that horrors like these are akin to war crimes under the Nuremberg Code. The code was developed as a response to the inhumane and unethical human experiments by Nazi doctors in World War II in concentration camps, and sets out ten points for ‘permissible human experiments,’ including having voluntary consent by the subject and an assessment of risks and benefits (Moreno et al., 2017). The code marked an important point for ethical conduct in medical research and is still used today. However, refusing to collect and distribute data for infectious diseases like COVID-19 for the communities that have been disproportionately impacted is not part of the Nuremberg Code.

The failure to collect and distribute data about pandemic mortality rates among Indigenous peoples creates further inequities. It prevents the ability for communities to avert further spread and death. The specific needs of Indigenous peoples should not be reduced to a part of generalized response strategies. A lack of available data creates models that “assumes homogeneity of community in terms of health status, behaviour, and infrastructure limitations” (Lavoie et al., 2020, p. 0). A Pan-Canadian Public Health Network report regarding pandemic planning states that tailored interventions for disproportionately impacted populations must be done through robust data collection (Combden et al., 2022; Pan-Canadian Public Health Network, 2018). Holding trust in those responsible for managing healthcare needs and health data is critical in addressing negative SDOH. Data collection needs to be done in partnership with Indigenous communities with a commitment to “respectful and ethical research engagement” that limits surveillance and places data control in the hands of the Indigenous partners (Nickel et al., 2021). Moreover, data sovereignty agreements must be implemented to give Indigenous communities governance over their own data and create a clear voice for their needs.

3.4. United Nations Declaration on the Rights of Indigenous Peoples and the Truth and Reconciliation Commission of Canada Calls to Action

Indigenous peoples have the right to access healthcare services that are respectful and inclusive of their worldviews and conceptions of health without facing discrimination. As

well, they have the right to self-determination over their healthcare needs. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) outlines the respect and recognition of Indigenous people's human rights (*United Nations General Assembly*, 2007). The rights cut across multiple areas of life, including cultural identity, health, and education. It is a critical step for Canada in supporting reconciliation with Indigenous peoples and supporting their healing. Indigenous rights to health are entirely tied to the rights for self-determination. Having self-determination and sovereignty means Indigenous peoples have control over their health and wellbeing, including having control over the appropriate jurisdictions, laws, and governing institutions (Turpel-Lafond (Aki-kwe), 2020). There are several articles in UNDRIP that apply to Indigenous health and wellness and self-determination, which are included in Table 2 below:

Table 2. UNDRIP articles related to Indigenous Health and Wellness.

Article 3	Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their pollical status and freely pursue their economic, social and cultural development.
Article 4	Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.
Article 5	Indigenous peoples have a right to maintain and strengthen distinct pollical, economic, social and cultural institutions, while retaining the right to participate fully, if they so choose, in the political, economic, social and cultural life of the State.
Article 7	Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person. Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or another act of violence, including forcibly removing children of the group to another group.
Article 11	Indigenous peoples have the right to practice and revitalize their cultural traditions and customs. This includes the right to maintain, protect and develop the past, present and future manifestations of their cultures, such as archaeological and historical sites, artifacts, designs, ceremonies, technologies and visual and performing arts and literature. States shall provide redress through effective mechanisms, which may include restitution, developed in conjunction with indigenous peoples, with respect to their cultural, intellectual, religious and spiritual property taken without their free, prior and informed consent or in violation of their laws, traditions and customs.
Article 21	Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

	States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.
Article 24	Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view of achieving progressively the full realization of this right.

Source: United Nations General Assembly, 2007.

UNDRIP outlines “the minimum standards for the survival, dignity and wellbeing of Indigenous peoples” (Turpel-Lafond (Aki-kwe), 2020, p. 7). The inclusion of sovereignty, self-determination, cultural practices, and equal access to mental and physical health care are all imperatives under UNDRIP, which Canada is responsible for upholding. The Assembly of First Nations calls for current laws like the Indian Act to be reinterpreted to be consistent with UNDRIP and that sovereignty over lands, territories and resources is given, including the right to free, prior, and informed consent (Assembly of First Nations, 2018).

Further imperative to the support of sovereignty in health and wellbeing is the Truth and Reconciliation Commission (TRC) of Canada’s Calls to Action. Included in TRC’s calls to action is a call to fully adopt and implement UNDRIP as the framework for reconciliation and to create concrete measures to achieve the goals of UNDRIP (Truth and Reconciliation Commission of Canada, 2015), shown in Table 3. The calls pertaining to health and sovereignty are as follows:

Table 3. TRC Calls to Action related to health, culture, and self-determination.

Call 18	We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.
Call 19	We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
Call 20	In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.
Call 21	We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.
Call 22	We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

Source: Truth and Reconciliation Commission of Canada, 2015.

The TRC's Calls to Action (Table 3) and UNDRIP's Articles on health and wellbeing (Table 2) illustrate how self-determination, including sovereignty over healthcare and the inclusion of past harms and trauma, are responsibilities that the Canadian federal and provincial governments are responsible for upholding. Within BC, the provincial government passed the Declaration on the Rights of Indigenous Peoples (DRIPA) into law in November 2019 (Province of British Columbia, 2019). The federal government passed UNDRIP into legislation in 2021. The Indigenous right to health, as reflected through UNDRIP, DRIPA, and the TRC's Calls to Action, is firmly established as foundational for addressing systemic racism, discrimination, and progressing toward reconciliation.

3.5. First Nations Health Governance in BC

In British Columbia, the responsibility for First Nation's health governance and health care delivery was transitioned from the jurisdiction of Health Canada to the First Nations Health Authority (FNHA) in 2013. It was created through a framework agreement called the BC Tripartite First Nations Health Plan, which was designed to "give First Nations a major role in the design and delivery of health care for their own people while ensuring increased coordination and integration with the provincial health system" (Government of Canada, 2020). The management of the plan is jointly done with Health Canada, the Province of BC, and the First Nations Health Authority. It is significant because it is the first of its kind, and it gives First Nations increased power over "determining and defining their own health needs" and over the evaluation, design, and delivery of health programs to meet their needs (Government of Canada, 2020).

Marchildon, Lavoie, and Harrold (2021) have created a typology of Indigenous-governed health systems in Canada (Table 4). They argue that these health systems have come about to try and address the "interpersonal and systemic racism" gaps that are present between jurisdictional services (Marchildon et al., 2021, p. 562). As identified in Figure 4 below, the typology is made by classifying the decision-space Indigenous communities have, the level or spatial region they take place in, if the form of governance is visible – or recognized, and if the Indigenous community or organization has claimed or been invited to hold that space of power. Notably, the FNHA in BC is classified as type 3 on the list, which recognizes that it has less control over the decision space compared to those in type 1 or 2. However, the amount of control suggests that it still "encompasses substantive changes in health system governance" (Marchildon et al., 2021, p. 77). This typology is useful because it helps indicate opportunities to address unmet health needs and further establish decision-making control by the FNHA.

Table 4. Typology for defining Indigenous control over health systems.

Type	Decision Space	Level	Form	Power Space	Examples
1	Broad	Territorial	Visible	Claimed	Nunavut
2	Strong	Regional	Visible	Claimed	Athabasca Health Authority; James Bay Cree
3	Strong/Moderate	Regional	Visible/Hidden	Invited	Sioux Lookout Menoyawin; *BC First Nations Health Authority*
4	Moderate	Regional/local	Hidden	Invited/closed	Single Community/ TC Transfer
5	Narrow	Local	Invisible	Closed	Single community/ TC Funding

Note: Grey shading for types 4 and 5 indicates little or no delegation to, or power and control by, Indigenous communities. Source: Marchildon et al., 2021, (licensed under CC BY-NC) *my emphasis added*.

The ability for the FNHA to be invited into a decision-making space was first established through section 35 of the Constitution Act of 1982, which recognized and affirmed the right of Indigenous peoples in Canada to have self-government (BC Treaty Commission, n.d.). This paved the way for the transition to Indigenous-controlled and community-based healthcare systems as opposed to underfunded and structurally racist 'conventional' systems (Marchildon et al., 2021, p. 563). Moreover, while it is easy to identify the flaws in any governance system, it is important to see the path they have travelled in working to improve things, especially in comparison to the healthcare services that many Indigenous people throughout Canada still must participate within.

The FNHA actively works with other health partners to include 'culturally safe practices and humility' into the delivery of services and outcomes for First Nations peoples (First Nations Health Authority, n.d.-b). The FNHA works in conjunction with the First Nations Health Council (FNHC). This provincial-level political and advocacy organization represents and is accountable to BC First Nations (First Nations Health Council, n.d.-a). The FNHC and FNHA, along with the First Nations Health Directors Association (FNHDA), act as the three pillars for First Nations healthcare in BC, and they hold a shared vision: "Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities" (First Nations Health Council, n.d.-c). The relationships they hold with First Nations in BC in the deliverance of health governance are predicated upon seven First Nation developed principles:

1. Directive #1: Community Driven, Nation-Based
2. Directive #2: Increase First Nations Decision-Making and Control
3. Directive #3: Improve Services
4. Directive #4: Foster Meaningful Collaboration and Partnership
5. Directive #5: Develop Human and Economic Capacity
6. Directive #6: Be Without Prejudice to First Nations Interests
7. Directive #7: Function at a High Operational Standard (First Nations Health Council, n.d.-c)

Currently, the FNHA and FNHC have been working on a 10-year strategic plan formulated on the SDOH, intending to improve overall wellness and mental health for BC First Nations through a forum called *Gathering Wisdom for a Shared Journey*, which is held every 18 months (First Nations Health Council, n.d.-b). A recent presentation shown at one of the Gathering Wisdom forums evaluated the FNHA in the progress it has made in its strategic goals, including championing BC First Nations' perspectives on health and wellness. The FNHA has a mandate placing responsibility in areas including:

- *Involving First Nation communities in decision-making processes*
- *Responding in culturally appropriate ways*
- Representing the interests of all First Nations living in BC
- Improving programming
- Generating evidence through data and research
- Providing population and *public health leadership*
- *Focusing on prevention, wellness, and social determinants of health (*First Nations Health Council, 2020*, my emphasis added).*

The evaluation concludes that the FNHA has made significant progress in its mandate over the past eight years, recognizing that there has been noteworthy advancement in the transformation of health care delivery to First Nations (First Nations Health Authority, n.d.-b).

The strategy that the FNHC has been working on for the SDOH to guide future governance work is being steered through engagement with First Nations across BC

(First Nations Health Council, n.d.-d). They recognize that there is more to understanding health and wellness than just having 'the absence of sickness' and that supports must come across sectors, including policing, housing, children and family services, schools, employment, and community health centres (First Nations Health Council, n.d.-d). The factors they include are:

- Culture & Language
- Education
- Income & Social Status
- Physical Environments
- Gender
- Early Childhood Development
- Social Inclusion
- Self-Determination
- Access to Health Services
- Employment & Working Conditions
- Genetics
- Social Support Networks
- Personal Health Practices & Coping Skills (First Nations Health Council, n.d.-d).

These considerations offer a good starting point while further engagement amongst communities continues. However, there are notable absences that arise when comparing the factors noted by Aalhus and Fumerton (2018), as shown in Section 3.2. First, there should be a clear recognition of the impacts of past and ongoing traumas that have impacted Indigenous peoples. Secondly, there need to be principles for data management, access, and control (Aalhus & Fumerton, 2018). Finally, it does not seem to include the Cultural Safety and Humility Standard that has been put out by the FNHA. Cultural safety means having "respectful engagement that recognizes and strives to address power imbalances inherent in the health care system" and to be free of racism and discrimination (First Nations Health Authority, n.d.-a). Cultural Safety is defined as "a process of self-reflection to understand personal and systemic biases and develop

and maintain respectful processes and relationships based on mutual trust" (First Nations Health Authority, n.d.-a). The inclusion of 'culture & language' should be broadened to ensure that these critical aspects are prioritized in any engagement. An First Nation's model of SDOH needs to recognize and protect the different ontological and epistemological understandings First Nations have and make space to include traditional and local knowledges and spirituality. The principles feel like they have been drawn out of the complex, situated cultural contexts of First Nations in BC to be made more understandable within a Western knowledge base, however Indigenous knowledges have been *interpreted,* documented, and disassociated from the communities and people that protect them and have become commodities. When this happens, they can then be "appropriated, marginalized, and even used against [Indigenous peoples]" (Simpson, 2001). The inclusion of 'culture & language' as principles should be broadened to ensure that these critical aspects are thoroughly brought forwards in health management and that the cultural and spiritual meanings are protected and honoured.

A barrier for the FNHC is that perspectives of health and wellbeing for Indigenous peoples and communities in BC are not uniform, and there are also differences between rural and remote communities compared to those located nearer to urban centres. Ultimately, while the FNHA has made progress in its mandates and compared to other Indigenous-controlled healthcare governance systems identified as type 4 and 5 in Marchildon's (2021) paper (Figure 4), there is still much work to be done.

3.6. Historic Pandemics amongst the British Columbia First Nations

Indigenous peoples have existing co-morbidities that make them vulnerable to worse health outcomes from both historical and contemporary issues (Mallard et al., 2021). Current knowledge about Indigenous health and wellbeing "cannot be understood outside of the context of colonial policies and practices," which have roots back to increased contact with colonizers and settlers in the 18th century (Allan & Smylie, 2015, p. 2; Fisher, 1992). The structural inequalities that have become apparent during the COVID-19 pandemic have a history back to the early Contact period when new colonizers settled on the Northwest Coast.

Harris (1994) uses written accounts from First Nation and non-First Nation informants to explore the extent and severity of the smallpox epidemics on the Northwest Coast in the late 18th century. He argues that it is “clear that Europeans carried diseases wherever they went in the Western Hemisphere” and that smallpox has been introduced to peoples with “no immunity to introduced viruses and bacteria, [and] the results were catastrophic” (Harris, 1994, pp. 591–592). The specific number of losses First Nation communities have experienced is likely never to be confirmed. This is due to a lack of data, political bias (because of a need to assert control over lands), and because many accounts have been lost by the passage of time, or from a significant number of casualties among coastal First Nations, by being unspecific in nature, or captured within oral histories that have not been accessible to outsiders (Harris, 1994; Fisher, 1992, p. 217). It has been estimated that Indigenous populations living along the coast fell between sixty-five to ninety percent within a span of a generation, creating a great loss of culture and history through the death of ancestors and entire families (Atleo, 2018).

Diseases like smallpox were used as forms of ‘biological warfare’ through the spread of infected blankets to communities that had no immunity to gain control over lands. This is a type of genocide that has been called Settler Imperialism, which “used biological methods to drive away, decimate or annihilate indigenous populations” (Finzsch, 2008, p. 215). For example, it has been documented and confirmed through personal communications from General Jeffery Amherst, the commander of the British military during the French and Indian War (1754-63), that there were plans to give smallpox-infested blankets to delegations of First Nations (Horton, 2016, p. 145). The subsequent pandemics on the Northwest Coast in the late 18th century and throughout the 19th century indicate that there should be enough knowledge from the settlers and colonial governments to have a basic understanding of how smallpox was spread and the lack of immunity by First Nations communities. The lack of preventative action emphasizes the lack of care by the settlers and colonial government. It shows how smallpox was used to remove First Nations peoples from their lands, decimate entire communities, and then assume control over their lands.

The conflicting accounts between researchers regarding the specific number of losses reflect the bias and lack of knowledge regarding the extent of the impacts of eighteenth and nineteenth-century smallpox epidemics on the Northwest Coast First

Nation communities. However, historians specializing in research of the time, Fisher, Boyd and Harris, all agree that the losses have been severely detrimental. Harris states that at least 90% of the First Nations population had been lost. Boyd says that “the losses were large, and the human suffering was great. Many families were wiped out; virtually everyone lost relatives,” after the epidemic followed village abandonment and consolidation, as well as “hostilities with the Whites, culture loss and replacement, and treaty-making” (p. 173). In addition, efforts to stop the spread of disease by colonists were sporadic and disorganized, and often they blamed First Nations for spreading them and demanded their eviction from colonial settlements (Spaulding & Foster-Sanchez, 2020).

Not only is it important to note the spread of disease from colonizers to First Nations peoples, but it is also where we can start to pinpoint the racism and discrimination against the first inhabitants of Turtle Island. The colonists were described to have reacted with ‘hysteria’ (Fisher, 1992, p. 115), or measures of pity, revulsion, or only concern for their own self-interest (Van Rijn, 2006). They did not take the time to prevent further outbreaks amongst the First Nations populations. Any preventions were “sporadic, poorly planned, counterproductive, or simply minimal, and blamed the disease as “Native ‘immorality’” (Van Rijn, 2006, p. 544).

There is little literature written from Northwest Coast First Nation perspectives during these times, and most were passed on as oral history through families or lost with the great number of casualties. Some families worked to avoid outbreaks during the 1800s by returning to the land and avoiding contact with larger communities (Banning, 2020a). However, many First Nations did not have access to Western epidemiological knowledge of the time and would unknowingly spread the disease back to their communities as they returned from the settlements (Spaulding & Foster-Sanchez, 2020).

This same pattern of discrimination is evident again in the 1918 Spanish Flu pandemic, as noted in *Epidemic Encounters: Influenza, Society, and Culture in Canada, 1918-20* by Fahrni and Jones (2012). Mary-Ellen Kelm’s research shares that First Nations people had death rates seven times compared to the BC provincial average (Kelm, 2012, p. 168). However, the impacts on the First Nations communities were underreported (Kelm, 2012). Reporters, along with Anglo-Saxon settlers, described them – including other minority British Columbians like those of Chinese, Japanese, or South

Asian descent, and those from religious minorities like the Mennonites and Doukhobors – as 'unmodern,' and therefore potential "reservoirs of disease" (Fahrni & Jones, 2012, p. 15). Nearly a hundred years later, the same disgust and lack of empathy were still pervasive in the narratives used about Indigenous peoples.

The 2009 H1N1 influenza pandemic is recent enough that more data are available for study and comparison. Like previous pandemics, the H1N1 pandemic also had a disproportionate impact on Indigenous peoples compared to non-Indigenous Canadians. Research usually focused on Canadians in general, and impacts on Indigenous peoples were just one data point within a larger set (The National Collaborating Centre for Indigenous Health (NCCIH), 2016). However, it was shown that health service availability in isolated and remote areas was often quickly overwhelmed, leading to worse outcomes for rural and remote Indigenous communities (The National Collaborating Centre for Indigenous Health (NCCIH), 2016). Research identified that there were severe infection rates among those who lived in isolated communities. There was a likelihood of significant under-reporting of H1N1 cases and higher hospitalization compared to other ethnic groups (The National Collaborating Centre for Indigenous Health (NCCIH), 2016). It was found that many rural and remote First Nation communities did not have pandemic plans put in place prior to the H1N1 epidemic. A call to address this gap was put out at the FNHA Gathering Wisdom Forum. As a result, many First Nations have developed pandemic plans with the resources to deliver the plans given at the tripartite level (Health Canada, 2013).

Most writings on historic epidemics within BC are patchy, and the area is understudied within academia. Regardless, it is essential to use lessons learned from these previous pandemics for future emergency management and pandemic planning. Some Indigenous communities have utilized past pandemics to prepare for the future, like the Nissaachewan First Nation in Ontario, after the 2002 outbreak of severe acute respiratory syndrome, commonly known as SARS (Banning, 2020b). Remote Australian Indigenous communities have been leading the way in public health planning and response by using lessons learnt from the 2009 H1N1 influenza pandemic (Crooks et al., 2020). In the United States, the Indian Self-Determination and Education Assistance Act (1975) "reestablished the tribe as nations and recognized the value of tribal self-determination and self-governance," and allows them to administer programs and services, primarily enacted through administering healthcare services that are rooted in

culture and that works to address the longstanding effects of underfunding and neglect by the federal government (L. Smith, 2021, p. 302). Sharing the progress that is happening in some places will help other Indigenous Nations to adapt successes to fit in their own contexts and will help us to understand what needs to be done.

While there is still much that needs to be done to address the problems that have arisen from past epidemics, there are some tools that can help with planning. The First Nations Health Managers Association (FNHMA) published *A Pandemic Planning Tool for First Nations Communities* to prepare for future pandemic responses (First Nations Health Managers Association, 2020). The tool gives First Nations a way to have a pandemic response that is connected to community needs and control over how the plan is enacted. Many Indigenous communities within Canada have developed pandemic plans to prepare for the future (Yellowhead Institute, 2020). First Nation communities can also utilize tools like the Community Wellbeing (CWB) Index to assess and predict the vulnerability of entire communities to epidemic diseases. This can guide decision-making by those communities, which can help change the narrative and foster self-determination (Spence et al., 2020). Coupling these tools with recognizing specific, Indigenous-determined SDOH –which the CWB Index does not measure – creates a better tool to improve health outcomes.

Research by the National Collaborating Centre for Indigenous Health put out a call for the federal government to “provide leadership and coordination in responding to pandemic crises” in collaboration with public health practitioners and Indigenous community leaders to “develop and implement interventions that will work within their communities” (The National Collaborating Centre for Indigenous Health (NCCIH), 2009, p. 2). Despite these calls, our knowledge from previous epidemics, and calls from UNDRIP and TRC’s Calls to Action, there is still insufficient action to address the longstanding inequalities stemming from Indigenous-specific SDOH.

3.7. The COVID-19 Pandemic

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2, commonly referred to now as COVID-19) pandemic became public knowledge in January 2020. As the pandemic progressed over the next few years, we saw not only the illness and death of millions of people worldwide but also our modern world's capability – or lack thereof – to

address the pandemic (Gostin & Friedman, 2020). COVID-19 had the ability to highlight the health inequalities that Indigenous peoples face in Canada that have persisted since contact. It also offered a unique opportunity to change the narrative, expanding the realm of possibility to make lasting structural changes that embrace Indigenous sovereignty and self-determination.

During the first wave of the COVID-19 pandemic, cases among First Nations living on reserves were only one-quarter compared to the general population of Canada (Banning, 2020b). However, during the fourth wave, the FNHA reported that First Nations in BC had a disproportionate number of infections while vaccinations remained below the provincial average (Daflos et al., 2021). The BC CDC shared that some BC First Nation communities had lower COVID-19 immunization rates, while other communities had nearly 100 percent immunization (Cordasco, 2021). How could some communities get their entire community vaccinated while others did not? Why were Indigenous people able to prevent the spread of COVID-19 during the earlier stages of the pandemic compared to the latter? Multiple factors influenced the spread of COVID-19 to Indigenous people and communities.

Within Canada, Indigenous Services Canada (ISC) has admitted that there is insufficient data available to inform a comprehensive understanding of Indigenous responses to COVID-19 (Skye, 2020). Even from the start of the pandemic, while cases were comparatively low, discrepancies existed in reporting between ISC and research bodies like the Yellowhead Institute (Skye, 2020). Case counts are only available regionally on the BC Centre of Disease Control (BC CDC) website and are updated weekly (Titian, 2021a). The Ministry of Health has been accused of withholding COVID-19 data from local communities by "citing privacy and potential social harm for patients," despite Coastal First Nations calling for access to the data to be able to install lifesaving measures against the spread of the disease (Plummer, 2020a, 2020b; R. Robinson et al., 2020; Skye, 2020). The coalition between the NTC, Heiltsuk Nation and Tsihqot'in National Government argues that sharing data regarding infections is in accordance with the right to self-determination under DRIPA as it allows the First Nations to make effective decisions based on the data (Plummer, 2020a). Chief Counsellor Marilyn Slett from the Heiltsuk Nation argued that the refusal to share data is both "reckless and colonial" and goes against BC and Canada's promises to uphold UNDRIP and DRIPA (Plummer, 2020a).

Furthermore, a data discrepancy exists. Researchers have shown that data reported by ISC does not match the deaths reported by communities, including not reporting deaths from those living off-reserves (Deer, 2020). Canada's COVID-19 data on Indigenous peoples did not accurately include First Nations people not living on reserves, excluded Métis populations, and researchers gave misleading conclusions due to the lack of accurate data (Mallard et al., 2021; Tripp, 2022). The lack of accuracy means that we will never be entirely sure of how many Indigenous people had COVID-19, how many people died from the disease, and if the measures that communities put in place were effective. The lack of available data on positive COVID-19 cases and deaths has made it nearly impossible for First Nation governing bodies to make effective decisions to stop the spread into their communities (Plummer, 2020a). By rectifying the lack of data for analysis, we would lay bare the existing health inequalities that Indigenous people face. By not gathering, analyzing, and disseminating data, we are limiting the ability of decision-makers to address them (Gostin & Friedman, 2020). The COVID-19 pandemic has reaffirmed the need to have access to reliable and useful data for Indigenous populations around the world.

In 2020, BC released a report stating that Indigenous peoples still face widespread discrimination and racial profiling when seeking medical attention within the province's healthcare system (Coyne, 2020). Similar narratives found during past epidemics like smallpox and the Spanish flu were also shared during COVID-19. Media outlets reinforced inaccurate perceptions of Indigenous peoples while ignoring historical contexts, and mainstream coverage would favour non-Indigenous ideas and sources over Indigenous ones (Azocar et al., 2021). Indigenous peoples were often portrayed as 'vulnerable' that needed outside interventions while ignoring the resiliency and innovative guidance of Indigenous leadership to protect their communities (Donohue & McDowall, 2021).

Canada's history of discrimination against Indigenous peoples is not just historical, and the result is a lack of trust by many Indigenous people and vaccine hesitancy by many (Daflos et al., 2021; MacDonald et al., 2021). Indigenous peoples within Canada have tended to perceive an increased health threat due to COVID-19 compared to settler Canadians, as well as perceive a higher cultural threat compared to settler Canadians (Lou et al., 2022). These feelings were because isolation practices would prevent the collective connections and way of life that Indigenous peoples deeply

value (Lou et al., 2022). As a result, COVID-19 significantly disrupted Indigenous peoples' cultural, relational, and collective practices (Power et al., 2020).

Overall, First Nation vaccine uptake across British Columbia has been reported to be less than that of non-Indigenous peoples (Daflos et al., 2021; First Nations Health Authority, 2021). However, First Nations within British Columbia were prioritized and were some of the first to access the vaccines once they became available (First Nations Health Council, 2021). The communities that were able to get higher vaccination rates were able to do so because they had access to culturally safe testing and vaccination spaces (Smylie et al., 2022). Elders and community leaders would implement health strategies that included vaccination campaigns to overcome feelings of distrust and have high vaccine acceptance rates (MacDonald et al., 2021). Terry Teegee, regional chief of the B.C. Assembly of First Nations, framed the vaccine using Northwest Coast cultural metaphors by describing the needle as a “transmogrifying feather, immuniz[ing] people as it goes, bringing colour and smiles to their lives” to address skepticism and mistrust many First Nations peoples have against the health care system (M. Robinson, 2021).

Lack of access to diagnostic and necessary care, negative SDOH and co-morbidities contributed greatly to the spread of COVID-19 among Indigenous communities (Nickel et al., 2021). Negative SDOH, like having large families living together in one household, has made it difficult to isolate if one person has contracted the virus (Daflos et al., 2021). Additional barriers to health, like inadequate housing, high rates of chronic disease, unsafe drinking water conditions, and barriers to accessing health services, lead to a higher risk of COVID-19 infection (Smylie et al., 2022; Spence et al., 2020). These systematic and longstanding inequalities have put Indigenous peoples at a greater risk of both contracting COVID-19 and “developing more severe cases of the disease” (L. Smith, 2021, p. 297). Underfunding by the federal government for COVID-19 responses and addressing the longstanding SDOH has posed barriers to addressing the pandemic (L. Smith, 2021; Spence et al., 2020; Yellowhead Institute, 2020). However, Indigenous peoples demonstrate resiliency and resourcefulness despite historical and contemporary adversities. They have worked to address not only the COVID-19 pandemic but the impacts of poverty, food insecurity, and insufficient housing (Power et al., 2020).

It is argued that specific, often Indigenous-led, interventions are what slowed down the progression of the COVID-19 virus at the start of the pandemic. For example, having easily accessible COVID-19 data at the start of the pandemic would allow for Indigenous emergency preparedness and response plans to be implemented (Tripp, 2022). Many communities declared states of emergency and were able to temporarily 'close' their communities against non-resident access to prevent further spread through closures, barriers, and checkpoints (Hiraldo et al., 2021; Richardson & Crawford, 2020; Titian, 2021b, 2021c; Yellowhead Institute, 2020). These closures were often far stricter than what was put in place by provincial governments or local municipalities (Richardson & Crawford, 2020). Innovative materials and public health campaigns about prevention and containment measures were written by communities and grounded them in the context of their community, including culture and language (Richardson & Crawford, 2020). Some First Nation communities in Canada made their own protective face masks when there was a shortage of personal protective equipment (Power et al., 2020). Nuu-chah-nulth Nations distributed foods, funds and necessary medical supplies to their communities to enable their members to stay home while also preventing the intrusion of outsiders through security checkpoints and monitoring (see Chapter 4).

Indigenous leadership and knowledge have been key to protecting Indigenous communities during the pandemic. Indigenous health and wellbeing governance must be developed, led by Indigenous peoples, and informed by their cultures, languages, and ways of knowing. Recognizing these principles and putting them at the forefront of pandemic planning through policy and action is what will change the story from past pandemics and bring better health outcomes for Indigenous peoples across Turtle Island. Adapting Western approaches to managing Indigenous health to recognize self-determination will create meaningful and lasting changes.

Chapter 4.

Nuu-chah-nulth Sovereignty in the Time of COVID-19

The Nuu-chah-nulth (NCN), located on the western side of Vancouver Island from Brooks Peninsula in the north to Nitinat Lake in the south, includes the well-known populous communities of Port Alberni and Tofino. The Nuu-chah-nulth Tribal Council is comprised of 14 Nations (see Table 1 above) who have managed their ecologically significant lands and waters since time immemorial. There are also non-NTC member nations as well, specifically Pacheedaht in the southern part of Vancouver island, and Neah Bay in Washington State. The name Nuu-chah-nulth means “all along the mountains and the sea” and is a collective name for all 14 Nations (Nuu-Chah-Nulth Tribal Council, n.d.-b). The first European contact was with Captain Juan Jose Peréz Hernandez from Spain in 1774. In 1778, British ‘explorer’ Captain James Cook made contact in Yuquot, located on Nootka Island in Nootka Sound, west of Vancouver Island (Arima, 2018). Captain Cook mistakenly understood the name of their Nations as Nootka (Umeek, 2004), but it was changed in 1979 to Nuu-Chah-Nulth (Nuu-Chah-Nulth Tribal Council, n.d.-b). Cook’s arrival initiated trading relationships that would have far-reaching consequences (Atleo, 2018). The NCN territory’s beauty and abundant resources have made it a desirable place for settlement and trading since the early 19th century. Their communities, along with many other First Nations living on Vancouver Island, hold similar stories of horrors and population decline in the aftermath of settler contact, the spread of diseases, and the impacts of colonization. During the COVID-19 pandemic, the 14 communities, along with the governance of the Nuu-chah-nulth Tribal Council, asserted sovereignty and control over their territory against the influx of outsiders. In addition, they organized protections against the spread of the disease within their communities. This unique perspective sheds light on how First Nations communities can assert authority and further control over their territories and gives insight into the methods, challenges, and successes of that increased authority.

4.1. Purpose of Analysis and Resulting Themes

The interviews and public notices analyzed as part of this project paint a fuller picture of how COVID-19 has impacted Nuu-chah-nulth communities and, more importantly, how they utilized the pandemic to further the recognition of their sovereignty and control over their territories. Through analyzing these data, a story started to emerge. This story has not been fully captured and shared externally prior to this research project. However, it should be shared as it reveals the power that the Nuu-chah-nulth people hold. Communicating this story will show how the Nuu-chah-nulth *are sovereign people* and reaffirm that Canada and other governing bodies need to work with them at a nation-to-nation level.

Analyzing discourse, including public notices and interviews, are helpful to see how Nuu-chah-nulth communities assert power over their territories or maintain territorial integrity. The existing power relations influence discourse, and by analyzing it, we can understand how those power relations are being sustained, altered, or how new power relations are asserted (Johnson & McLean, 2020). Typical critical discourse analysis (CDA) requires a deep contextual understanding of the topic being analyzed. However, my positionality as a settler limits the depth of my understanding and the resulting depth of the analysis. Regardless, the outcome of this analysis shows the importance of how the NCN Nations asserted agency over their territories, worked collaboratively with outside agencies and partners, and instituted effective measures against the spread of the virus.

The resulting chapter will first situate the Nuu-chah-nulth by describing the geographical context and a brief history of the Nuu-chah-nulth people. The data collected will then be split into three overarching themes that have arisen through analysis: (a) Recognition of Nuu-chah-nulth health and wellness; (b) Sovereignty and Territorial Integrity; and (c) Leveraging Partnerships. Each theme will be described, and then specific examples will be shared from both the public notice analysis and interviews.

4.2. The Nuu-chah-nulth Context

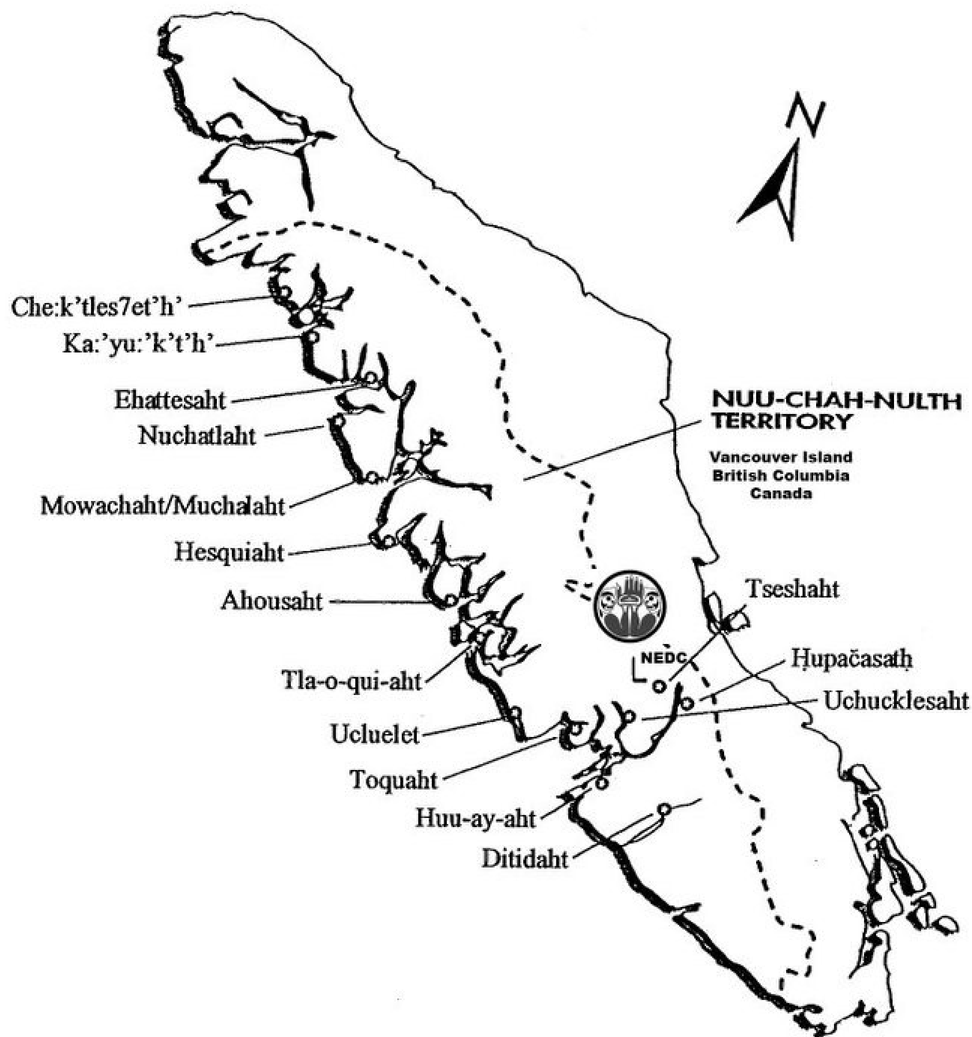

Figure 4. The Nuu-chah-nulth traditional territory.
Source: Native Land Digital, n.d.

The Nuu-chah-nulth traditional territory is located on the western side of Vancouver Island. The territory spans approximately 300km of coast, from Brooks Peninsula in the north to Point-no-Point in the south and inland regions, as shown in Figure 4 above. While the 14 Nations have some shared traditions and culture as well as language, they are each distinct and were traditionally divided into separate nations led by ha'wiih, or hereditary chiefs, and lived off the resources provided by their ha'houlthee, their chiefly territories (Arima, 2018). The Nuu-chah-nulth extend down into what is now known as the United States, with the community of Makah located on the tip of the

Olympic peninsula. Historically, the NCN have never surrendered their territory[2], but the Canadian government sought to control and remove them from their way of life by creating small reserves in the late 19th century while restricting their ability to hunt and fish (Arima, 2018). The population of NCN people, estimated to be about 30,000 at the time of first contact, fell significantly to only about 2,000 people in the 1930s because of diseases brought by Europeans, including smallpox and malaria, and pressures from colonization (Arima, 2018). Now, the total registered population of the NCN has risen to over 10,000 (Crown-Indigenous Relations and Northern Affairs Canada, 2021). Collectively, their organization as one carries weight and power in negotiating for their members' needs.

Five of the Nuu-chah-nulth Nations collectively signed the Maa-nulth Final Agreement, namely Toquaht, Huu-ah-aht, Ka:'yu:'k't'h'/Che:k'tles7et'h, Uchucklesaht, and Yuułuʔiłʔatḥ. The Maa-nulth Final Agreement defines the section 35 rights, the geographic extent of their territory and the Nations' limitations while also defining rights, obligations, jurisdictions and limitations of the province and federal government (Province of British Columbia, 2011). All 14 Nations also collectively act as one through the Nuu-chah-nulth Tribal Council (NTC). The Makah Tribe in the United States and Pacheedaht Nation on Vancouver Island are both Nuu-chah-nulth but not part of the NTC. The Nuu-chah-nulth Tribal Council is a not-for-profit society that provides services and advocacy for over 10,000 members; included in their services is the provision of health care (Nuu-chah-nulth Tribal Council, n.d.). However, many governance decisions for protecting the Nations during the COVID-19 pandemic came from the Nations. In addition, the NTC acted as a communications liaison and advocacy group to outside institutions like the FNHA or the Province of BC.

4.3. Health and Wellness Means Access and Cultural Connection

Each Nation faced different constraints and impacts from the COVID-19 pandemic, including differences like the number of members living on reserve, ease of accessing medical services, and being able to enforce closures of their communities. For

[2] Arguably, the Maa-nulth did surrender territory to some extent through the signing of the Maa-nulth Final Agreement. See: Maa-Nulth First Nations Final Agreement Act, 2011.

example, the Village of Ehthlateese, part of Uchucklesaht, only has boat-in access. Seven of the 14 communities do not have year-round road access to the nearest service centre. Some communities have up to 350km of distance to travel to access services, including groceries and medical care. President Judith Sayers emphasized that transportation is a huge factor for some communities like Zeballos or Fair Harbour, where the nearest service centre is Port McNeill, over two hours away if the conditions are adequate. If sick, the complexity of accessing care because of the lack of road access or considerable distance makes the process difficult and increases the risks of contracting COVID-19. The on-reserve population, off-reserve populations, distance to the nearest service centre, and road access can be found in Table 5 below.

Table 5. The 14 Nuu-chah-nulth Nation on-reserve and off-reserve populations and access to the nearest service centre.

Nations	On-reserve population	Off-reserve population	Road access	Distance to nearest service centre (range)
Ahousaht Nation	754	1478	Boat access only	50-160km
Ditidaht	165	605	Year-round access	50-350km
Ehattesaht	104	448	Year-round access	50-160km
Hesquiaht	117	638	Boat access only	160-250km
Hupačasath	132	229	Year-round access	within 50km
Huu-ay-aht	96	610	Year-round access	50-350km
Ka:'yu:'k't'h'/ Che:k:tles7et'h'	164	420	Boat access only	50-160km
Mowachaht/ Muchalaht	223	392	Year-round access	50-350km
Nuchatlaht	23	146	Year-round access	50-160km
Tla-o-qui-aht	394	809	No year-round access	50-160km
Toquaht	10	138	Year-round access	50-350km
Tseshaht	463	808	Year-round access	within 50km
Uchucklesaht	27	220	No year-round access	N/A - boat access only
Yuułuʔiłʔatḥ	209	462	Year-round access	50-350km

Source: AANDC First Nations Profiles[3]

The distance to nearby service centres was not the only impact that put communities like the NCN at an increased risk. Terry Dorward and Lynnette Lucas both expressed how people felt a lot of fear and uneasiness at the beginning of the pandemic,

[3] The registered population and road access are taken from the AANDC First Nations Profiles for the NTC Tribal Council. The actual membership numbers from the Nations themselves may differ from the numbers published on AANDC's website.

a sentiment relatable for everyone but especially pertinent for rural and remote Indigenous communities. Vice President Mariah Charleson told me that at the beginning of the pandemic, Island Health shared that Indigenous people were more likely to contract Covid-19 and experience more severe symptoms. In addition, Vice President Charleson said, “Rural First Nations communities [are] more vulnerable due to various factors such as: underlying health conditions, lack of access to essential services, multigenerational homes, and limited ways of getting in and out of community (weather is a huge factor to consider).” The distance to receive services also meant it was harder to access necessities – store shelves were empty, there were shortages of essentials like toilet paper, and some businesses were closed. In addition, there were fuel rations for some time, which meant that some communities like Ehattesaht or Zeballos, located far away from service centres, did not have enough fuel to make the roundtrip to resupply necessities.

Early in the pandemic, there were no COVID-19 testing machines within NCN communities. Lynnette Lucas said that most communities did not have nursing outposts, and the capacity to respond to emergencies was limited. Access to testing was incredibly difficult, and nurses only entered communities to do testing once a week or every ten days. The time from identifying and testing a potential outbreak to confirming the outbreak left significant opportunity for the virus to spread. Some communities did not have cell phone service, and many others had no home phone, rendering communicating about outbreaks difficult. Lynnette Lucas added that once vaccines became available, it was risky to transport them into remote communities as they were sensitive to fluctuations in temperature and the long drives along ‘bumpy roads.’

All these structural considerations are part of the social determinants of health and wellness. Vice President Charleson summarized the different factors succinctly when she said, “So much of health is dependent on access to services.” Nevertheless, as we know, health is not just the absence of sickness, and the Nuu-chah-nulth have a holistic and relational understanding of it.

COVID-19’s impact on health and wellbeing can be understood more through its adverse effects on mental health and wellbeing. Close connections with family and community are critical for the NCN, as it is for many other Indigenous communities. All interviewees seemed to have an inherent understanding of the importance of a close-

knit, supportive community. As communities were shut down to try and prevent the spread of COVID, people were urged to stay in their homes and not leave unless for an essential reason (i.e., groceries, doctor's visits, emergencies, etc.). This included not visiting each other to showing support or for companionship. President Sayers said that preventing people from visiting each other "goes against everything that we are as people." Lynnette Lucas recounted in her interview that there were huge impacts from social isolation, where they saw significant increases in domestic violence, child abuse cases, people being shamed for reaching out for help, and increased drug and alcohol usage to cope. In addition, many people lost their jobs, making them more vulnerable to losing their homes. Ken Watts explained when community members passed away people could not grieve properly. He said, "You weren't allowed to visit, you weren't allowed to go into their homes, you weren't allowed to hug them or be in physical contact with them." The inability to come together as one and act as a foundation of support has severely detrimental impacts on the NCN. The experiences during the COVID-19 pandemic shared by interviewees echoed what Umeek (2004) said when he said that separation and social isolation were "unnatural, and equivalent to death and destruction."

Looking back on the pandemic now makes me question whether things could have been different. The negative impacts are still felt in many Indigenous communities, making some respondents ask if the some of the guidelines that were set up by the PHO and some of the Nations went too far. Could measures have been set up differently to keep that community and cultural connection alive while also providing the necessary emergency services? Ken Watts asserted that their community had little to no outbreaks due to a cultural gathering during the pandemic. Many advocated for an 'Australian model' for Vancouver Island, where the entire island instituted a protective 'bubble' to prevent spread. If that had been allowed, perhaps some of the negative emotional, mental, and physical impacts of the virus might have been averted.

The Differences in Access Between On and Off-Reserve Members

Nearly 80 percent of the Nuu-chah-nulth live off-reserve (Table 4 above), and the ability to access resources for wellbeing is different. Those living on-reserve may be further away from service centres and medical support, but those living off-reserve also have decreased access to funding and cultural supports. Vice President Mariah Charleson noted that any funding that flowed through the NTC for member Nations from ISC was tied to the number of people living on-reserve. Despite ISC not providing funds for those living away from home (off reserve or treaty lands), Nations were able to make decisions on how they wanted to spend their money. Many members who did not live at home (on reserve or treaty lands) did not have access to the same amount of supports as those who did. Furthermore, Vice President Charleson added that when away from home NCN people went to access healthcare or receive a vaccine, they may not have had access to culturally-safe medical practices. They perhaps did not see the 'familiar face' of the nurses in their community and may have felt afraid to ask questions or even allow the vaccines to be administered to them. These two problems need to be addressed. Culturally safe medical practices must be available to Indigenous people wherever they live, especially because such a high proportion of Indigenous peoples do not live on reserve. Funding to provide services needs to include NTC members wherever they are located, because the NTC or other Indigenous governance bodies will still seek to support their people regardless of location.

The following list is about the supports and measures that were given to the members by their Nations. The list is crucial because it demonstrates that health is understood to be more than the absence of sickness and highlights the additional supportive measures for health and wellbeing. Access to the necessary infrastructure and services gives communities and individuals the strength to be healthy and support wellbeing.

- In Ahousaht, food and PPE were distributed to community members. In addition, isolation trailers were installed on reserve lands to keep community members within the community.
- In Ditidaht, food and PPE were distributed to community members and grocery and gift cards were distributed.
- In Ehattesaht, after the 2020 flooding and power outages, some community members were moved to hotels nearby medical services. Additionally, Chief and Council implemented a vaccine drive to community that demonstrated vaccine safety to members.
- Huu-ay-aht and Nuchatlaht distributed COVID-19 support funding to members for necessities.
- Tla-o-qui-aht instituted a rent deferral program, distributed food to both on and off-reserve members and distributed essentials and medications.
- While Toquaht closed Secret Beach Marina, they created provisions for members to still participate in traditional food harvesting practices.
- Tseshaht established a community garden, distributed food cleaning supplies, gave out COVID-19 relief cheques and had a rent deferral program.
- Yuułuʔiłʔatḥ delivered foods and essentials, including preparing foodbank hampers for members. They also had a rent assistance and deferral program.

This list is likely not exhaustive, as not every measure of care by the Nations for their members was shared publicly, nor can the emotional supports be separated contextually and fully understood. The importance of recognizing these actions is two-fold. Firstly, it shows how communities found ways to still show support and connection despite the hardships of the COVID-19 pandemic. Despite many communities requiring their members to stay home, thus increasing the risk of food and economic insecurity, the Nations made efforts to show support and address the gaps and shortages their members would face. Notably, Toquaht's assertion that members can still participate in traditional food harvesting, and Tseshaht's community garden, show examples of food sovereignty. Food sovereignty is "the right of peoples to healthy and culturally appropriate food produced through ecologically sound and sustainable methods" (Coté, 2022, p. 28). Ken Watts shared that having the community garden helped to mitigate some of the impacts of inflation, increased the amount of healthy, traditional foods going into community, and "increased people's (especially the youth) desire to be out on the land." Building food sovereignty into the programming highlights the importance of culture in healthcare service provision and calls attention to the importance of

relationships in health. The relationships between community members and the vital relationship between members and nature improve health and wellbeing (Coté, 2022; Umeek, 2004). Terry Dorward said that the Nuu-chah-nulth have a close relationship with the environment and are responsible for caring for it. Caring for it improves the health of the environment and people's health.

The second important reason to recognize these actions is that it recognizes sovereignty. Enacting these programs and services shows the self-sufficiency and capacity of the governance systems to show appropriate care for their people. This nation-building governance process highlights their sovereignty and self-determination (Missens, 2008).

4.4. Sovereignty and Territorial Integrity

The second theme specifically spoke to sovereignty and what is called Territorial Integrity (Joffe, 2020). Territorial Integrity can be understood as Indigenous peoples and nations enforcing territorial boundaries to promote local health sovereignty and protecting the health and wellness of their peoples, lands, and waters. UNDRIP affirms the full right of self-determination for all peoples, without any discriminatory qualification or conditions, which has already been confirmed in international law (Joffe, 2020). This means that territorial integrity cannot be used by a State such as Canada to oppress and undermine Indigenous People's right to self-determination. Indigenous territorial integrity is maintained when Indigenous sovereignty is recognized and affirmed. Interviewees confirmed that all 14 of the Nuu-chah-nulth communities had been closed to outsiders at some point during the pandemic to varying degrees.

President Sayers said that preventing incursion into some communities was easier than others. It was easier for places like Ahousaht, located on an Island, to patrol their waters as they had more fishermen. In contrast, others like Tseshaht are located next to urban centres and have highways crossing their reserves. President Sayers said that their work during the pandemic was quite amazing. At the level of the NTC, much time was devoted to negotiating with external bodies to obtain funding to pay for traffic blocks to prevent people from entering the community and to "stop the flow of COVID going in and out." Vice President Charleson said that they had negotiated and convinced the Province of BC that checkpoints "were critical in maintaining the safety of our

communities," and they obtained funding to staff security checkpoints through amending policy with Emergency Management BC (EMBC) instead of leaving the funding to the Nations themselves. Terry Dorward, the Tribal Parks Project Coordinator who oversees the Guardian Program, noted that in Tla-o-qui-aht, the Guardians were "out on the land, out in the rain forest … to monitor, to patrol, and to assert our Hereditary Chief's title and rights." They set up a roadblock in Esowista, Long Beach, and would make sure people were not intruding on their territory. Wickaninnish emphasized that patrolling and monitoring traditional territory like the Guardians did in Tla-o-qui-aht was "easy… to act on during a pandemic" because it is a physical act that reflects the sovereignty the Nuu-chah-nulth always have had. Territorial integrity flows out of sovereignty, and the pandemic was an opportunity to assert it visibly.

The following list concerns territorial integrity, like enforcing a 'border' or restricting the entry or movement of people in and out of the Nation's territory. All 14 NCN communities enacted some form of 'security checkpoint' in their community. At some point during the pandemic, all had restrictions against non-essential travel by both community members and visitors.

- In Ahousaht, all travel in and out must seek approval from the Director of the Emergency Operations Centre (EOC). Businesses were closed. The Ahousat Hot Springs closed.
- Ditidaht halted tourism operations, closed campgrounds, and prevented those not living in the community from visiting – including members not living in community, displayed in Figure 5 below.
- After an outbreak, Ehattesaht stopped visitation between families located in Ehatis, Oclujee and Zeballos. All outside visitors were not permitted to enter.
- Hesquiaht was closed to tourism and non-essential visitors. Wickaninnish shared that kayakers would monitor the waters and 'scare off' tourists trying to enter their territory.
- Hupačasath restricted travel to essential only, including deliveries and service provision.
- Huu-ay-aht restricted travel to essential only and service provision. Anacla, Bamfield, Nitinaht and Pachena Bay campground were all closed. They had checkpoints, gates, and signage at community entrances.
- Ka:'yu:'k't'h'/ Che:k:tles7et'h' were closed to outside visitors and non-essential travel from members. They also had a 24-hour monitoring system for water-borne traffic.

- Mowachaht/Muchalaht closed their marina to the general public, permitting only members, residents of Gold River, and emergency personnel to use it. See Figure 6 for the signage that was located at Halfway Bridge.

- Nuchatlaht prevented outsiders and visitors to the community. When restrictions started to lift, all visitors must stay on the property of the member they were visiting and sign into the band office.

- Tla-o-qui-aht posted signage at Sutton Pass that read, 'local traffic only,' and had road blockades with screening on exit and return, as well as gate controllers. A curfew was enforced.

- In addition to preventing non-essential travel and tourism, Toquaht also implemented a fine of up to $10,000 or imprisonment for those not abiding by the State of Emergency.

- Tseshaht required all members to submit travel details to the band office. They closed all public spaces, including playgrounds and parks and posted signage. Additional signage indicated that the reserves were restricted access only, and the Emergency Operations Centre (EOC) staffed security checkpoints. However, a thoroughfare through the reserve lands prevented full closure, and local businesses like the Tseshaht Market and cannabis store remained open.

- Uchucklesaht limited access to the Village of Ehthlateese to citizens with homes in the village, essential service providers and staff.

- Yuułuʔiłʔatḥ (Yuu-cluth-aht) only allowed members with essential travel to leave, and citizens that were not living in Hitacu could not return. The State of Emergency implemented a fine of up to $10,000 or imprisonment for those not abiding by the state of emergency.

Figure 5. Signage posted at the entrance to Ditidaht First Nation.
Source: Ditidaht First Nation Facebook. March 24, 2020.

Figure 6. Signage posted at Halfway Bridge preventing access to the Gold River boat ramp and marina.
Source: Mowachaht Muchalaht Facebook. March 15, 2020.

All 14 Nations enacted some sort of restrictions to community access, whether it was through patrolling and signage at their borders or through States of Emergencies. Borders have “huge material and symbolic importance and convey very clear messages” because they reinforce the sovereignty and recognition of a state’s authority (Storey, 2017, p. 117). Unlike the other 12 Nations, Tseshaht and Hupacasath reserve lands are located adjacent to the city of Port Alberni and have the Pacific Rim Highway cutting through their community. This distinction meant they could not entirely prevent the intrusion of outsiders and travellers through their communities. This geographic

consideration meant that Tseshaht and Hupacasath faced different impacts than other communities, like Ehattesaht or Zeballos, which are considered to be remote. Asserting travel bans and community closures are tied to the geography of a space, and the assertion must be supported by other external bodies – like the federal and provincial governments or close by municipalities – to be effective. When thinking about sovereignty and political power to enact these barricades, recognition must be given to the state for jurisdiction to exert control over territory (Storey, 2017). The enactment of borders and checkpoints is a physical assertion of sovereignty by the NCN Nations.

4.4.1. Data Sovereignty

President Judith Sayers and Vice President Mariah Charleson alluded to some of the problems Indigenous governments face when accessing their people's data. They shared that it took over seven months from the start of the pandemic to establish a data-sharing agreement with the Provincial Health Office (PHO), and yet some of the problems that they had encountered are still not fixed. At the beginning of the pandemic, the Board of Directors of the NTC unanimously passed a resolution requiring a commitment from BC's PHO to establish funding for testing, contract tracing, to communicate where cases were in the surrounding communities, and relay information about which of their members had contracted COVID – in order to provide supports if living off-reserve or prevent the spread if within the community if living on-reserve. Unfortunately, the resolution was shot down by Premier John Horgan, making it incredibly difficult to effectively govern and care for their people. Furthermore, the NTC was never consulted when the province implemented travel restrictions. Vice President Charleson said that when it came to actual decision-making First Nations were not in fact a part of the process or consulted in any way.

Lynnette Lucas said that the PHO would not identify which nearby city had COVID-positive cases – for example, distinguishing if the positive cases were located in Port Alberni or Comox. President Sayers explained that the NTC wanted to "figure out how bad COVID was in the outside communities" so they could tell their people to avoid those communities when accessing essential services and have enough information to govern their own communities. Vice President Charleson added that contract tracing was essential to inform community members who may have been exposed to the virus. After being stonewalled by Premier Horgan, they took a complaint to the Office of the

Information and Privacy Commissioner for BC, in which their request was also denied (CBC News, 2021; Plummer, 2020a, 2020b).

However, after seven months, the NTC, along with the T'silqot'in and Heiltsuk, established a data-sharing agreement with the province to rectify some of these problems. President Sayers shared that they were never able to get information about the COVID infections for those living off-reserve. This raises the question of whether the data is available at all or if the Provincial government is unwilling to share that data. President Sayers pointed out that this inability to access data was one of the most frustrating things of the pandemic and that it is "something that we have to address… [to] look at legislation to change under DRIPA… to get the kind of information that we need to govern." Vice President Charleson echoed that sentiment, saying, "We need to be at the table [for] every single thing that impacts our people". "DRIPA is the law in the province of BC, and all laws in BC are supposed to be literally built alongside and with First Nations peoples." She says that BC needs to follow its own laws and that if Reconciliation is a priority, then First Nations need to be treated as equals. Therefore, First Nations in BC need to be consulted and treated as equals, worked with on a nation-to-nation basis. Respecting data sovereignty is a step toward honouring that commitment.

4.5. Leveraging Partnerships

The final emergent theme is about partnerships. This is about creating or building partnerships with other entities or governance bodies. Vice President Charleson credits the NTC and the Nations' successes to having really strong relationship building, where they could communicate their priority issues and develop effective solutions. Existing relationships, like with the FNHA and Island Health, were critical to building resiliency for the health and wellbeing of the NCN. Interviewees shared some expertise about the types of relationships that were built at the level of the NTC:

- A BC Health Table was established that included the province of BC, the FNHA, and the Chilko Region This table is where the information sharing agreement and funding for screening and contact tracing were established.
- Negotiating with the Ministry of Indigenous Relations to exempt remote communities from gas rations.

- Negotiating with the PHO to establish the location of testing machines.
- Negotiating with ISC for emergency funding for security, food, and transportation.
- Working alongside the National Chief Terry Bellegarde to inform him about what is happening locally for the Nuu-chah-nulth and ensure he can lobby for their needs.
- Weekly meetings with Minister Scott Fraser of Parks for the continued closure of provincial parks unless consultation happened with First Nations.

Lynnette Lucas and Ken Watts agreed that the FNHA and Island Health were helpful in providing support to communities and providing information on how they made decisions, including working alongside communities to ensure they can access the maximum amount of support services they are eligible for and making sure they are delivered in a culturally-safe way. Furthermore, there were Nuu-chah-nulth coordination calls, which included each of the 14 Nations, as well as the FNHA, ISC, the First Nations Emergency Services Society (FNESS), and Emergency Management British Columbia (EMBC). Vice President Charleson said that this table proved to be especially useful because "all these external partners would be able to help on the spot, as opposed to what was going on a lot in the pandemic [where] a community [was] not knowing what's going on for a simple question and playing this email and phone game for weeks."

The following list is about the partnerships that were forged and maintained at the Nation-level. All 14 Nations worked with the NTC, and some located geographically close worked with each other to share resources. For example, Ahousaht, Hesquiaht, Tla-qui-aht, Toquaht, and Yuułuʔiłʔatḥ (Yuu-cluth-aht) collaborated with the District of Tofino, the District of Ucluelet, and Alberni-Clayoquot Regional District to prevent tourists from entering their territories, including the closure of Pacific Rim National Park and provincial parks.

- Ahousaht and Ditidaht had patrols in their nations by the Lake Cowichan RCMP with fines for trespassers. Additionally, the Red Cross worked closely with Ahousaht regarding medical transportation.
- Ehattesaht collaborated with the town of Zeballos to prevent tourism and visitor access.
- Hesquiaht worked with the Coast Guard to share auditory messaging via radio that their community was closed to boaters.

- Huu-ay-aht collaborated with Parks Canada to prevent tourism and use of the West Coast Trail.
- Ka:'yu:'k't'h'/ Che:k:tles7et'h' collaborated with floatplanes and water taxi operators to ensure that travellers have gained permission before entering or exiting the community.
- In Tla-o-qui-aht, they collaborated with Bed and Breakfast units in Tyhistanis and Esowista to close and prevent the draw of tourists.
- Tseshaht worked with local businesses to reduce their hours and with Parks Canada to stop tourism in Pacific Rim National Park.

The respectful coordination between Nuu-chah-nulth governments and other agencies builds on the understanding that mutual collaboration increases the saliency of public safety and wellbeing. Building and utilizing these partnerships enables the NCN governments to make effective decisions. It recognizes their authority as sovereign nations to have administration over their territories while also understanding that there are overlapping jurisdictions and interdependence between governmental bodies (Quick, 2021). Proper consultation before making decisions that affect First Nations is a necessity that should happen regardless because of DRIPA. However, this demonstration of effective and healthy government-to-government relationships is important because it proves a path for recognizing Indigenous sovereignty. This theme, along with the previous two themes, clearly demonstrates the sovereignty each of the Nuu-chah-nulth Nations holds in practice.

Chapter 5.

Reflections and Recommendations

Time should be taken to reflect on both the personal and professional experiences of the COVID-19 pandemic, as the impacts are still being felt today. Reflecting on experiences acts as a way to recognize all the work that has been done and understand the work that still needs to happen. Lynnette Lucas said, “I really would like to reflect on where we go from here, you know, post-pandemic – and we're not even really through the pandemic, as far as I'm concerned. How are we going to keep protecting our vulnerable ones, our elders? Sick people, you know?” The following is a list of lessons learned and reflections on experiences from the COVID-19 pandemic shared by interviewees.

- It is vital to prepare for and work to prevent the lasting impacts once the pandemic has ‘finished,’ including supporting mental health and social isolation, increased rates of addictions, and cultural impacts. Unfortunately, the impacts of the pandemic are lasting, and Lynnette Lucas shared that “getting back to … normal living is problematic.”
- Interviewees want to better prepare for the next pandemic as they recognize the sober likelihood of future pandemics. They recognize that it is important to set up the legal framework to ensure service provision runs more smoothly. A lot of political action needs to be taken, including changing legislation around information sharing. Mariah Charleson states, “Any type of legislation, any type of big decisions that are going to be about us, we need to be part of the process.”
- NCN Nations want to assert more jurisdiction over territory and utilize it better for future generations, including through expanded guardianship programs, by increasing food security and food sovereignty. This includes being cognizant of the people entering into territory, for example, into work camps.
- Capacity building is critical. Partnerships established during the pandemic should be maintained and nurtured because those relationships will continue to support communities. Continuing to work with the FNHA and Island Health will help ensure that rural and remote communities have their healthcare service capacity built up, including the ability to administer vaccines and testing.
- Roles and responsibilities must be clarified, including the relationships between governing institutions. However, it is important not to over-prepare and become panicked.

The following is a list of recommendations , in no specific order, for furthering Indigenous health sovereignty and data sovereignty based on the reviewed literature and from the interviewee's experiences.

- Any model conceptualizing Indigenous health needs to recognize and include sovereignty, self-determination, "equitable needs-based funding," and addressing persistent negative SDOH like intergenerational trauma (Moodie et al., 2021).
- Decolonization and recognition of Indigenous health, including SDOH needs to happen within health governance. Legislation related to health, as well as governance in general, needs to recognize Indigenous sovereignty. Legislators and governance bodies must work with Indigenous nations at a Nation-to-Nation level of interaction instead of with paternalistic control that does not enable effective decision-making for those communities (Quick, 2021).
- Health Data Protocols need to be established and/or rectified to give Indigenous Nations access to both on and off-reserve member data.
- Emergency funding constraints (namely by ISC) should be expanded to include provisions for off-reserve members. Not all members can live on reserve, and off-reserve members still need access to additional financial & cultural supports from their home Nation.
- Proper consultation and engagement needs to happen for decisions that affect the health and wellbeing of Indigenous communities. Namely, the federal and provincial governments need to respect UNDRIP and DRIPA. They cannot unilaterally determine if First Nation's territories are 'open' for tourism or access during a pandemic or other emergency (Quick, 2021).
- More work needs to be done to provide culturally safe health care. Funding and support must be given at the Nation-level to ensure it is connected to and understood within the specific culture. In addition, partnerships between Nations and agencies like the FNHA must be encouraged to support culturally-safe work.

Chapter 6.

Limitations & Further Research

This research paper represents an exploration of the impacts of COVID-19 as it relates to Indigenous health, self-determination, sovereignty and territorial integrity. The viewpoints shared in this paper are not representative of all Nuu-chah-nulth people's views, values, and experiences. The largest limitation in this research is from my personal disconnection from Indigenous worldviews and the worldview of the Nuu-chah-nulth. While I have tried to understand what health and wellbeing mean in an Indigenous context, and specifically a Nuu-chah-nulth context, I will never be able to fully grasp the depth and meanings that the NCN or Indigenous peoples themselves have for those concepts. It is my hope that within this research, I have illustrated the important connection between sovereignty and self-determination to achieving better health and wellbeing.

Secondly, a limitation that needs to be recognized is the limited number of participants (n=6) that have been interviewed. Only Nuu-chah-nulth people who participated in some capacity in health governance during the pandemic were interviewed. Therefore, when applying the recommendations and results of this paper, caution should be taken to not generalize about all Nuu-chah-nulth people or Indigenous people in general. This research project was conducted nearer the end of the pandemic, and the opinions expressed during this research project likely changed and were influenced by current events.

The following is a list of potential future research projects that were identified during interviews and background research. These areas are identified as being potentially valuable for Indigenous communities and health researchers in improving health outcomes and generating a better understanding of the impacts of the COVID-19 pandemic.

1. How can Indigenous cultural considerations be better brought into pandemic planning? This speaks to the specific understanding of the need for community connection within Indigenous worldviews. Are there ways to keep communities connected while distancing themselves from others?

2. The efficacy of culturally rooted vaccine campaigns, including the necessary considerations that must be made in planning for Indigenous-specific health campaigns.

3. The intersection of and better management for multiple health and wellness-affecting crises, including climate change, pandemics, the opioid crisis, intergenerational trauma, and more.

4. Overcoming and understanding the lasting effects of the COVID-19 pandemic on health and wellbeing for Indigenous communities, with specific attention to youth and to mental health.

5. Further in-depth research of the similarities between the COVID-19 pandemics and previous epidemics and pandemics, like SARS, H1N1, and Smallpox, on Indigenous communities and weighing whether 'lessons learned' have been implemented.

6. The potential impact of BC's Anti-Racism Data Act, which seeks to identify and address systemic racism, and its intersection with pandemic planning. Specifically looking to understand whether access to data will be granted to Indigenous governing bodies.

Chapter 7.

Conclusions

Through this research paper, the four key takeaways I have noticed intersecting from past to current pandemics were a) a lack of accurate and available data on Indigenous Nations, b) a persistent need to recognize and affirm Indigenous conceptions of health and wellbeing, including self-determination and sovereignty, c) the need to build the capacity of Indigenous Nations to address future emergencies, and d) the resiliency and strength of Indigenous communities across Canada. By addressing the first three takeaways, we will make practical steps toward decolonization and build on the fourth takeaway.

Looking back at the pandemic, we should not isolate it but remember all the concurrent issues happening simultaneously. Ken Watts reminds us of the Nuu-chah-nulth perspective of *Hishukish Tsawalk,* or that all things are interconnected. He says, "We still have to take care of our kids in care, build new homes, take care of our infrastructure… make sure kids are getting educated. And while that's happening, your rivers are getting warm, and fish are going to potentially be impacted. Oh, and there's a pandemic." Wickaninnish shares that the pandemic has taught us the importance of building capacity to enable First Nations to "govern ourselves, govern our health, [and] having responsibility in that area." Every lesson learned that is applied will ensure that when the next emergency occurs, Indigenous Nations will come out stronger. Increasing community capacity, building Indigenous sovereignty into governance and recognizing it within health and wellbeing are all part of the process of Reconciliation, UNDRIP and DRIPA that we have a responsibility to uphold.

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