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First Nations people leading the way in COVID-19 pandemic planning, response and management

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Abstract

- COVID-19 is a serious public health risk for Aboriginal and Torres Strait Islander people
- Previous pandemic plans did not identify or include Aboriginal and Torres Strait Islander people as a priority population group
- Research following the 2009 pandemic found that infectious disease control measures must be developed in collaboration with Aboriginal and Torres Strait Islander peoples where Aboriginal and Torres Strait Islander people are actively engaged in pandemic preparedness, response and management.
- Aboriginal and Torres Strait Islander public health practitioners and researchers have been pivotal in identifying the issues, setting priorities and suggesting solutions for culturally informed strategies

Aboriginal and Torres Strait Islander (respectfully hereafter First Nations) peoples of Australia have experienced poorer health outcomes than the rest of the Australian population during recent pandemics.(1,2) In 2009, during the H1N1 pandemic, diagnosis rates, hospitalisations and intensive care unit admissions occurred at five, eight and three times respectively the rate recorded among non-Indigenous peoples.(1,2,3)

The vulnerability of First Nations people to COVID-19 is well understood by community leaders and non-Aboriginal policy makers and clinicians alike. The risk for First Nations from COVID-19 taking hold are immense - the oldest continuous culture on the planet is at risk. This is because of all of the following inter-related factors: an already high burden of chronic diseases; long-standing inequity issues related to service provision and access to health care, especially because 20% of First Nations people live in remote and very remote areas; and pervasive social and economic disadvantage in areas such as housing, education and employment. Finally and ironically many of the interventions put in place to curb SARS COV2 are counter cultural or almost near impossible because of overcrowded housing and extended family groups living together. This means interruption of cultural life as it was to be adapted to be consistent with new social isolation concepts.

Using lessons learnt from the H1N1 pandemic of 2009 First Nations clinicians, public health practitioners and researchers are strategically leading the way in public health planning, response and management for COVID-19 alongside our non-Indigenous dedicated allies.

The omission of First Nations Peoples from the 2009 National Action Plan for Human Influenza Pandemic(4,5) not only disadvantaged those who most needed protection, but failed to identify First Nations peoples as being a high-risk population group, which resulted in worse outcomes previously mentioned. Research following the 2009 pandemic found that a ‘one size fits all’ approach to infectious disease emergencies is unlikely to work, and partnerships between communities and government agencies for the management of public health emergencies could be improved(6,7); and future pandemics should ensure First Nations peoples are appropriately engaged as active and equal participants in pandemic preparedness, responses, recovery and evaluation.(6,8) During the early days of the COVID-19 pandemic we as a community have proactively proceeded to ensure this occurs.

Recognising that public health measures, containment strategies and risk communication often do not consider the socioeconomic, historical or cultural context of First Nations peoples it is appropriate that First Nations Peoples lead the way in pandemic planning. Pandemic plans developed and implemented with First Nations people leading, will likely mitigate risks and prevent from what happened in 2009 again.

On March 6, 2020, the Australian Government, Department of Health convened the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 to provide advice to ensure preparedness responses and recovery were planned for COVID-19. The Advisory Group works on principles of shared decision-making, power-sharing, two-way communication, self-determination, leadership and empowerment. The National Aboriginal Community Controlled Health Organisation (NACCHO) co-chairs the Advisory Group with the Department of Health and includes membership from the Aboriginal Community

Controlled Organisation Sector, State and Territory Government representatives and Aboriginal communicable disease experts.(9) The Advisory Group links to the Communicable Diseases Network Australia (CDNA) and reports to the Australian Health Protection Principal Committee (AHPPC).

Our brief is to ensure all stages of the pandemic are considered with an equity lens, are proportional to the risk of disease in communities, to discuss and work through logistical issues related to the pandemic especially in planning phases and that these actions should be locally-led, holistic and culturally safe to communities. The group initially met three times per week and currently meets twice weekly via video or teleconference.

The Advisory Group has provided strategic input into the development of the National Management and Operational Plan for Aboriginal and Torres Strait Islander Populations(10), and has made significant contribution to the COVID-19 Series of National Guidelines.(11). To prepare communities for COVID-19 actions and advocacy of the Advisory Group have included;

Legislative changes: Strong advocacy and input to Government has ensured minimising non-essential travel by visitors to remote communities.(12) The enactment of the Biosecurity Act has enabled restrictions being placed on many state/territory borders as well as national borders. In addition many Aboriginal Land Councils have closed access and refused to issue new permits for visitors to communities within their remit.

Development of national guidelines: on COVID-19 to ensure Aboriginal and Torres Strait Islander people are accorded priority in the national response.(11) Separate guidance focused on remote communities have also been developed, addressing circumstances and logistical challenges in these areas such as medical evacuation, community wide screening, limited isolation and quarantine spaces if SARS-COV2 initial cases are detected in this setting.

Health Services Planning: Almost all communities with significant First Nations populations have been in preparedness mode and have enacted local action plans to respond to COVID-19. In many cases this has extended beyond the development of a local plan, but has included initiatives such as reconfiguring of clinics to facilitate testing, isolation of suspected cases as well as preparing staff in infectious disease training relevant to COVID-19. The Commonwealth Government has expanded telehealth (phone and video-based calls with health providers), ensuring those with chronic disease and other health conditions can receive health consultations via phone.

Establishing rapid testing in remote communities: The Advisory Group is working with the Kirby Institute to rapidly establish increased SARS COV2 testing capacity in communities across Australia using point of care platforms (nucleic acid amplification testing) that provide a result within 45 minutes from a nasopharyngeal swab. Overall 87 rapid testing platforms will be placed in remote and regional settings, using a hub and spoke model. Trained existing health care workers in communities will be provided with online training in the use of the platforms. This strategy will greatly enhance the ability to rapidly turn around test results reducing current test results times down from between 3-10 days to within a few hours for most communities across Australia. This strategy will enable contacts to be tested early and ensure local action plans and strategies are enacted to minimise community transmission.

Infrastructure planning: Many communities have planned additional spaces for isolation and quarantine in the advent of an outbreak in communities, especially made difficult in the contexts of already overcrowded housing. In some cases the Minerals and Exploration industry have offered communities unused accommodation and facilities during COVID-19 period.

Expanding Testing sites: The Commonwealth Department of Health has facilitated the opening of GP-led respiratory clinics, including some in Aboriginal Community Controlled Health Services (ACCHS).

Workforce planning: Much discussion is still ongoing on the need to protect and maintain workforces in Aboriginal health care settings. Much of remote Australia is reliant on locum staff that will require quarantining prior to starting clinical activities within communities but this places additional strain on existing workforce capacity. Recent outbreaks among health care workers in remote Australia highlight the vulnerability of remote community populations.

Health promotion materials: Targeted communication resources for Aboriginal and Torres Strait Islander Australians have been developed.(13) Health organisations have stepped up and developed local resources appropriate for their own community populations. Many of these can be found on the NACCHO website. Other organisations have also created health education materials to help inform and educate their community populations. In many cases the development of culturally specific resources has been conducted by Aboriginal Health Workers and Practitioners.

Epidemiological tracking of COVID-19: Work has commenced to ensure accurate timely surveillance of cases among First Nations Peoples occurs. This will enable responses to be actioned swiftly and prevent loss of precious time in an outbreak situation.

Infectious disease modelling to help inform approaches: Mathematical models are being used to investigate the best approaches to use in communities once cases are identified. Additional social distancing, isolation, quarantine measures, contact testing, testing strategies are currently being developed to inform responses.

Advocacy: Significant advocacy across all levels of the response continue such as the ongoing need for adequate supply of personal protective equipment for the ACCHS sector, quarantine measures, and testing guidelines to name a few.

Pandemics are a serious public health risk for First Nations communities here and globally. Measures to reduce risk of COVID-19 have been addressed swiftly taking the lessons from 2009 H1N1. The involvement of communities has been fundamental and pivotal to early change and action. Making space for First Nations peoples to define the issues, determine the priorities, and suggesting solutions for culturally informed strategies that address local community needs may reduce health inequities and has potential to influence system changes. Privileging First Nations voices, within a culturally appropriate governance structure, to develop and implement planning, response and management protocols can make a real difference. The model has the potential to be replicated where public health agencies and First Nations practitioners and researchers have developed shared understanding. Only time will tell now how we will fare over the coming months.

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