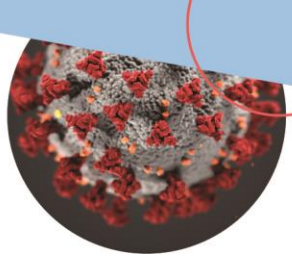


**Situational report on the Indigenous Health Response to the COVID-19 Pandemic.** ***Prepared by ASHM, members of the Taskforce's Indigenous Health Cluster Group, the Testing Cluster Group and the Taskforce Chair.***

**Document last updated:** May 14th 2020

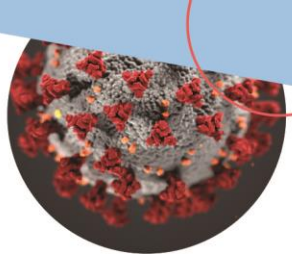
**Disclaimer:** This ASHM document is designed to provide available, relevant information to clinicians and other healthcare providers to optimise the health and wellbeing of people living with HIV, hepatitis B or hepatitis C and those with Sexual Health needs during the COVID-19 pandemic. The recommendations provided are the opinions of the authors and are not intended to provide a standard of care, or practice. This document does not reflect a systematic review of the evidence, but will be revised to include relevant future systematic review findings of the National COVID-19 Clinical Evidence Taskforce and other relevant information.

**Background**

The COVID-19 pandemic has presented a complex set of issues to Indigenous communities globally, that have been tested more than ever in modern colonised histories. These issues encompass community and government leadership, the agility of both public health and health service systems, as well as major changes to social and cultural ways of being and doing. The pandemic has highlighted and exacerbated the already-present inequalities in health outcomes for Indigenous populations globally including higher rates of communicable diseases, mental health and chronic health conditions, access to health care services, crowded housing and food and other necessary daily living supplies.

Global data indicate those at risk of severe disease from COVID-19 including mortality occur much more commonly among population groups such as older persons and those with underlying health conditions. A significant barrier for understanding the impact of COVD-19 among Indigenous peoples is that data for Indigenous peoples is often not available for notifications, testing nor outcomes of COVID-19. Thus far outbreaks have been publicly reported among the Navajo Nation of North America, whose infection rate is ten times higher than the general population of Arizona, among Indigenous peoples in Brazil and in Panama and Peru.

Here in Australia, Aboriginal and Torres Strait Islander public health practitioners, researchers and



communities have led a multi-strategic response to the COVID-19 pandemic that was initiated early in the pandemic and with sufficient potency to protect the population. This was done in recognition that First Nations people of Australia were at much higher risk of morbidity and mortality than the rest of the Australian population. This is due to continued inequalities experienced in access to health care services, a high burden of chronic diseases,[1] significant inequalities including intractable social and economic disadvantages that existed pre-pandemic and will continue to exist beyond COVID-19.[3] Furthermore, Aboriginal and Torres Strait islander people are highly mobile, often live with extended family groups and in crowded housing, both of which increase the risk of exposure to the SARS-CoV-2 virus that causes COVID-19 illness.[2] People living in remote communities are also subject to increased exposure because of the high flow of visitors to these communities.[4]

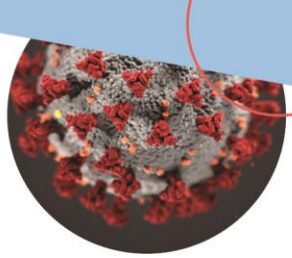
**Management plan for Aboriginal and Torres Strait Islander populations**

In March 2020, the Australian Government Department of Health assembled the Aboriginal and Torres Strait Islander Advisory Group (Taskforce) on COVID-19 to provide expert, culturally appropriate guidance and advice to the Department of Health during the COVID-19 pandemic.[3] The Advisory Group swiftly created the Management Plan for Aboriginal and Torres Strait Islander Populations, which has been endorsed by the Australian Health Protection Principal Committee. This national management plan is a living document and aims to inform state, territory and primary health networks as they each work to meet community needs during COVID-19.[4]

Key principles of the Management Plan include:

- Shared decision-making between Government and Aboriginal and Torres Strait Islander people
- Sufficient support and resources for the Aboriginal and Torres Strait Islander community-controlled sector to continue to deliver services and support communities

[1] https://www.mja.com.au/system/files/2020-04/Crooks%20preprint%2029%20April%202020.pdf
[2] https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
[3] https://www.health.gov.au/committees-and-groups/aboriginal-and-torres-strait-islander-advisory-group-on-covid-19
[4] https://www.health.gov.au/sites/default/files/documents/2020/03/management-plan-for-aboriginal-and-torres-strait-islander-populations.pdf



- Cultural safety for all Aboriginal and Torres Strait peoples engaging in services and care, in-line with the AHMAC-endorsed Cultural Respect Framework 2016-2026
- Responses during COVID-19 are developed and implemented are evidence-based and inclusive of Aboriginal and Torres Strait Islander knowledges[5]

The Management plan outlines an operational plan that encompasses four phases for Aboriginal and Torres Strait Islander peoples:

Phase 1: preparedness to prevent any cases

Phase 2: management of suspected, or initial cases

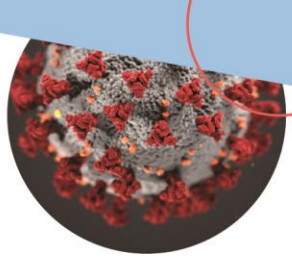
Phase 3: the response to an outbreak

Phase 4: standing down and evaluating the effects of the pandemic

An accompanying document to the Management plan is a document produced by the Communicable Diseases Network of Australia that provides guidance specific to remote Aboriginal communities recognising conditions present in many of these communities pose grave risks should an outbreak of COVID-19 occur. These include surge workforce issues, transport logistics, crowded housing, testing delays and limited space for quarantine and or isolation of suspected and confirmed cases.[5]

Another key piece for the First Nation's response to COVID-19 is highlighted within the Roadmap to Recovery – A Report for the Nation, written by the academics from Group of Eight Australia (Go8) Universities. The need to address key factors, including housing insecurity, that pose an increased risk for Indigenous Australians to suffer disproportionately during the COVID-19 pandemic, is one of the six imperatives outlined by the Roadmap. A further key point noted in the Roadmap was that Indigenous communities are heavily reliant on interstate and overseas workforces[6], including healthcare workers. How the pandemic impacts communities will continue to shift as new guidelines and recommendations are released.

[5] https://www.health.gov.au/resources/publications/cdna-interim-national-guidance-for-remote-aboriginal-and-torres-strait-islander-communities-for-covid-19
[6] https://go8.edu.au/research/roadmap-to-recovery



**Travel restrictions to remote communities**

On March 26th 2020 travel restrictions came into place to restrict travel into remote communities in order to protect vulnerable populations within these communities[7]. The Commonwealth Minister of Health instituted this requirement under the Commonwealth's Biosecurity Act, 2015. Broadly, individuals must meet criteria to enter remote regions and to have undertaken 14 days of self-isolation prior to entry to remote communities[8], with the exceptions being urgent situations and entry of people providing essential services[9]. Essential worker status is determined by the Commonwealth Biosecurity Act, 2015 and includes services related to healthcare, education, emergency services, child protection, policing, food, fuel, mail and medical supplies[9]

A comprehensive flowchart from the Commonwealth Government regarding entry requirements into remote communities is available[10].

The geographical locations where these travel restrictions apply are in the Northern Territory, South Australia, Queensland and Western Australia. The decision on whether to restrict travel to remote communities was made by disease management groups in each State and Territory, which included Indigenous Australians, government officials, healthcare specialists and the Police forces. Maps detailing the exact locations of these restricted areas are available[11].

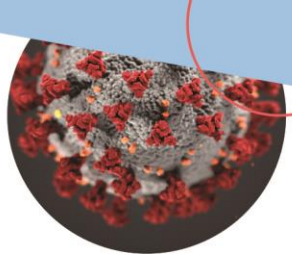
**Details from each State and Jurisdiction related to Indigenous populations, including biosecurity areas, where relevant are as follows:**

**New South Wales**: https://www.health.nsw.gov.au/aboriginal/Pages/covid-19.aspx

**Victoria**: https://www.dhhs.vic.gov.au/coronavirus-information-aboriginal-communities

**Western Australia**: https://www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/covid-19-coronavirus-remote-aboriginal-communities-restrictions-entering

[7] https://www.niaa.gov.au/news-centre/indigenous-affairs/travel-restrictions-remote-communities-%E2%80%93-covid-19
[8] https://www.health.gov.au/sites/default/files/documents/2020/04/remote-community-entry-requirements-in-place-under-the-biosecurity-act-2015_0.pdf
[9] https://coronavirus.nt.gov.au/community-advice/remote-work-and-travel/approved-remote-essential-workers
[10] https://www.health.gov.au/resources/publications/keeping-communities-safe-from-coronavirus-remote-area-travel-restrictions
[11] https://www.niaa.gov.au/resource-centre/indigenous-affairs/designated-biosecurity-travel-restricted-areas-australia



**Northern Territory**: https://coronavirus.nt.gov.au/community-advice/remote-work-and-travel/designated-areas-and-remote-communities

**South Australia**: https://www.covid-19.sa.gov.au/restrictions-and-responsibilities/restrictions-on-movement-into-aboriginal-communities2

**Queensland**: https://www.datsip.qld.gov.au/coronavirus/travel-restrictions-remote-communities

Of note, in New South Wales the approach has been to develop Community-focussed COVID Action plans rather then create geographical biosecurity areas[12].

**Examples of the impact of travel restrictions upon some remote communities**

In Palm Island, Queensland, the land of the Manbarra people and the indigenous Bwgcolman people, residents are a two-hour ferry trip from the mainland. Reduction in access to transport options has left local communities without access to specialist care that is required, as well as freedom to engage with sorry business and other crucial cultural elements for the community.

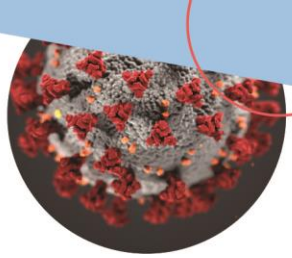
In Yarrabah, Queensland, the land of the Gunggandji people, overcrowding is proving to be a problem. The community is 45-minute drive from Cairns. A sense of disparity around essential workers being able to enter and leave communities freely, while others in remote communities are not permitted to travel has exacerbated the situation. Yarrabah community members who need to travel to Cairns for treatment and care are left stranded as access to transport options has begun to diminish. Community concerns existed long before COVID-19, but are certainly exacerbated by the current restrictions. In Cairns, some First Nation's people are sleeping rough before they can safely move back to their communities – a period of enforced quarantine is required before people are permitted back in their communities.

**Changes that have occurred in response to the COVID-19 Pandemic**

Telehealth

In response to the COVID-19 pandemic the Commonwealth Government responded by increasing the number of Medicare rebatable items that can be claimed for Telehealth for both general

[12] https://www.health.nsw.gov.au/aboriginal/Pages/covid-19.aspx



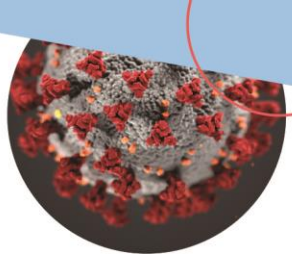
practitioners and medical specialists[13]. For remote communities Telehealth has had increased utilisation in the provision of care during the pandemic, and has been in place as a healthcare service tool for First Nations people since 2012[14].

Whilst telehealth can present a range of complex issues like lack of privacy and lack of culturally appropriate care, it can assist in breaking down the inequalities caused by lack of access to face-to-face services. Prevalent issues present themselves with the utilisation of telehealth, including privacy and confidentiality concerns for patients, especially for those with mental health concerns, as well as blood borne viruses (BBV) and sexually transmitted infections (STIs) diagnosis and treatment. With Aboriginal health workers and nurses needing to be present for videoconferencing calls with patients, the service is often not appropriate for those that need to use it. This lack of privacy and confidentiality is also prevalent when treatment is sent to patients in community.

GeneXpert®Point of Care Test machines

Leading up to the COVID-19 pandemic there were 33 GeneXpert® machines available for use in healthcare settings that provide care to First Nations people. These machines were already in place in remote communities for microbiological diagnostic testing for sexually transmitted infections chlamydia gonorrhea and trichomoniasis. On March 20th 2020 the Federal Drug Administration in the United States authorized the use of Xpert® Xpress SARS-CoV-2 cartridge (Cepheid, Sunnyvale, United States of America)[15] for use by GeneXpert® machines. The test is fully automated and can provide results within 45 minutes[16]. The Therapeutic Goods Administration provided rapid approval for the test on March 22nd 2020[17]. In response to the COVID-19 pandemic there are now 87 GeneXpert® machines available, or en route to remote primary health care services that provide care to First Nations people. A key question is whether these machines will remain available in Aboriginal healthcare settings beyond the period of the pandemic, given their capacity to diagnose a broad range of infections, including STIs.

[13] http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB
[14] https://clinicalexcellence.qld.gov.au/improvement-exchange/queensland-health-telehealth-program
[15] https://www.cepheid.com/coronavirus
[16] http://www.euro.who.int/__data/assets/pdf_file/0005/436631/Rapid-communication-COVID-19.pdf?ua=1
[17] https://www.tga.gov.au/covid-19-test-kits-included-artg-legal-supply-australia



**Workforce**

As articulated in the Go8 Roadmap to Recovery, COVID-19 is presenting unique challenges for the locum workforce in Aboriginal communities. In Palm Island for example, residents are able to access urgent and acute specialist appointments, especially birthing (which is not able to be done on the island) on the mainland if needed, but the process is quite restricted with no contact allowed with the rest of the community. The added complexities and inequities for the community present when those who are classified as essential workers and can move between areas are most often contract workers who do not identify as Aboriginal & Torres Strait Islander, creating discussions of possible inequality among locals.

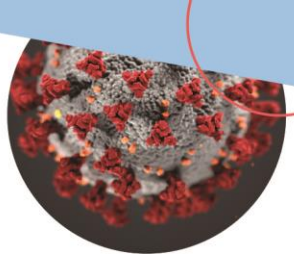
A consideration for the healthcare workforce, is the blood borne virus and STIs testing rates throughout the pandemic. In Palm Island for example, testing rates have remained relatively stable, whilst diagnoses have dropped. For other communities, business as usual is not occurring, where both diagnoses and testing rates are down, raising questions about changes in community behaviour, including engaging in sexual activity, as well as presenting for testing. Challenges are sure to present themselves as social distancing and travel regulations change in the near future.

Prior to this pandemic Australia was in the midst of a major syphilis outbreak occurring across four jurisdictions, amassing over 2500 cases among Aboriginal and Torres Strait Islander people living in remote communities.[18] Given much of the public health workforce have been diverted to COVID-19 it remains to be seen how the outbreak will have fared during this period of intense pandemic period.

**The Future**

In the immediate future, decisions will be made regarding whether to maintain biosecurity areas in Australian jurisdictions to protect remote communities from COVID-19 illness. Important work will need to be undertaken to determine the nature of any beneficial or adverse health outcomes for First Nation people associated with having restricted travel into remote regions. Ongoing work is occurring and led by the Aboriginal and Torres Strait Islander COVID-19 Taskforce to better comprehend what must be in place at community, public health and health service levels when

[18] https://kirby.unsw.edu.au/sites/default/files/kirby/report/KI_Annual-Surveillance-Report-2018.pdf



biosecurity determinations for communities are lifted. Also, a key analysis of any potential gains made during COVID-19, such as broader Telehealth availability and more POCT testing equipment in remote communities, which may improve BBV and STI health outcomes for Indigenous populations, needs to be undertaken.

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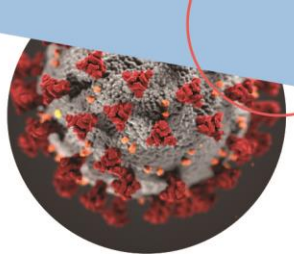

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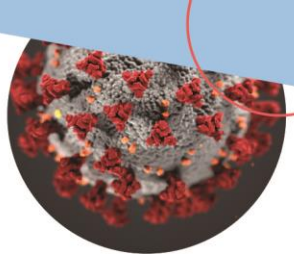

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