Aboriginal Health Council
of South Australia Ltd.

Dear Covid-19 Response Inquiry Panel,

Thank you for the opportunity to provide feedback on Australia's response to the COVID-19 pandemic, as it related to the Aboriginal Community Controlled Sector in South Australia.
The Aboriginal Health Council of South Australia (AHCSA) is the peak body for Aboriginal Health, including the Aboriginal Community Controlled Health Sector, in South Australia. AHCSA provides support and representation for 11 member Aboriginal Community-Controlled Health Services (ACCHSs) and a member substance misuse service. AHCSA is an affiliate of NACCHO, the National Aboriginal Community Controlled Health Organisation. During the COVID-19 pandemic, AHCSA has fulfilled multiple roles, including: representation on the National Aboriginal and Torres Strait Islander Advisory Group on COVID-19; collaboration with State Government health services; facilitating the supply of Personal Protective Equipment (PPE) for member services; N95 mask fit-testing; supporting the roll-out of the Aboriginal and Torres Strait Islander COVID-19 Point-of-Care Testing (POCT) Program; and practical support and guidance regarding vaccination, antiviral treatment and public health measures. AHCSA was able to draw on previous planning conducted during the 2009 H1N1 influenza pandemic.
The following reflections, developed in consultation with the SA Aboriginal Community-Controlled Health Sector, are provided on relevant aspects of the national and state COVID-19 response, in order to guide further consultation, highlight successful strategies and suggest areas for improvement in future pandemic planning.

Governance

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19, co-chaired by NACCHO and the Department for Health, was an important mechanism for developing guidance on COVID-19 prevention and management in Aboriginal communities, and for the dissemination of information. It will be important that this group, which has now become the National Aboriginal and Torres Strait Islander Health Protection Subcommittee of the Australian Health Protection Principal Committee (AHPPC), is composed and resourced to respond to future outbreaks in an agile fashion.
During the pandemic there were various regular inter-agency meetings in South Australia, including state Aboriginal Affairs, government health, South Australia Police and the community-controlled sector, to address the needs of Aboriginal communities. Keeping safe was a shared goal of multiple agencies and fostered collaboration, while in other circumstances there might be competing priorities. There was recognition that not only was a technical response required, but also a pragmatic and context-driven response that recognised the needs and resources of individual communities.
Local planning and collaboration was key to the on-the-ground response, including community-controlled and other non-government organisations that understood community needs and had credibility, such as Aboriginal Community Councils. There were excellent examples of local collaboration between SA Health and the ACCHO sector. Local plans enabled creativity which could be harnessed in future responses, and the expertise of Aboriginal workforce and communities should be recognised.
AHCSA supported ACCHSs to develop outbreak response plans that considered clinical, public health and community responses, and which outlined the lead agencies with regard to each action.

Key Health Response Measures

Pika Wiya Health Service in Port Augusta, an AHCSA member, functioned as a Commonwealth-funded Respiratory Clinic, greatly increasing access to testing for the Aboriginal community. However, at the time South Australia's borders opened, there were not sufficient state-run testing facilities to accommodate government requirements for traveller testing (Port Augusta being located

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at a crossroads with Western Australia and the Northern Territory). At that time, the large number of requests for testing resulted in Pika Wiya being placed in a difficult position as they were meant to provide testing for symptomatic clients only. A further challenge relating to testing was the three types of documentation required: the clinics own Patient Information System, the state pathology provider website and the Federal GP Respiratory Clinic website. This increased processing time and could be reconsidered in future outbreak responses.

Point-Of-Care Testing (POCT) was valued for early detection, education and treatment. POCT has been positively evaluated https://www.health.gov.au/sites/default/files/2023-05/evaluation-of-covid-19-point-of-care-testing-in-remote-and-first-nations-communities_0.pdf. AHCSA staff supported participating services in becoming operational prior to widespread COVID transmission. This included facilitating operators' meetings and collaborating with the Kirby Institute and Flinders University International Centre for Point-of-Care Testing. This program was able to benefit from the existing TTANGO POCT program. Future Commonwealth responses should consider a sustainable funding model that includes remuneration for services conducting point-of-care testing for a range of communicable diseases.

Rapid Antigen Tests were also important, although barriers included a delay in availability and lack of understanding by community members in how to use them. There was some inconsistency in brands provided to ACCHSs. Having antiviral medication available onsite at ACCHSs assisted in same-day treatment, although the process of receiving oral antivirals from the National Medical Stockpile did not always work for all SA ACCHSs.

Pandemic restrictions, while crucial in stopping the spread of COVID-19, led to personal challenges, such as being unable to visit people in hospital. The period of border closures provided valuable time for Community to be vaccinated, although being closed-off from other states may have led to a false perception that COVID-19 was not a significant threat.

Having local requirements in place, such as a requirement for testing when returning to the community, were also useful in keeping people safe. However, this was challenging when there was a long turn-around time/wait time to receive test results. Those communities requiring an entry permit could impose requirements to ensure that visitors had been vaccinated.

Early COVID-19 cases in South Australian Aboriginal communities were managed via evacuation to Adelaide. Although important to protect the community, this was very difficult for individuals as people did not have local family to drop off needed items to them. In future responses, this expenditure on evacuation could instead be allocated to support communities, recognising that less remote communities also required supports. However, it is acknowledged that the state government services were making critical decisions in an unknown situation, and provided excellent supports to communities, including vaccinations and PPE. When regional isolation facilities were established for cases and contacts, there was more support in place for those staying there and people were able to be accommodated closer to home.

The Vaccine Administration Partners Program (VAPP) provided a very helpful mechanism to support Aboriginal health services in COVID-19 vaccination activities, and services could engage VAPP staff in a private arrangement to meet other workforce needs. However, there were challenges with this program, including restrictions on what activities VAPP staff could perform under the funded program (for example, not providing influenza vaccinations). With regard to vaccination, it was noted that walk-in clinics were an essential component for the Aboriginal community, and a combination of static and pop-up clinics improved community access.

In South Australia, the ability of Aboriginal and Torres Strait Islander Health Practitioners (ATSIHPs) to work to their full scope of practice in medication administration has been governed by a complex set of requirements. However, during the COVID-19 pandemic, ATSIHPs were specifically able to

vaccine against COVID-19 while an Emergency Declaration was in force in South Australia, under a modification of the operation of Section 18 of the *Controlled Substances Act 1984.*

Early on, messaging at a national level was not transparent with regard to the benefits of mask-wearing, and that there were early debates about efficacy. Mask usage should be widely promoted in future pandemics. Although delays were noted between changes in public health guidance and the updated written resources, the SA Health Aboriginal-specific resources were valued. At times, multiple emails received by health services, including from government agencies, were overwhelming. One concern noted was the role of social media in promoting unhelpful messaging. It was felt that the Commonwealth could potentially have the resources to address this disinformation in future.

Using local people to provide health messages, and having messages in both English and local languages, were seen as important measures. In some situations health services needed to create resources, such as signage that community members in isolation could choose to use. Some messages changed over time, for example, as new COVID-19 variants emerged and vaccine recommendations changed, which may have led to mistrust.

The process of infrastructure improvement was slow, which had implications for infection prevention and control within health services. For example, at times, community members needed to wait under tarpaulins for testing, despite extremes of weather, and people with chronic diseases could be exposed to COVID-19 cases in this environment. As there is now widespread recognition of the importance of ventilation and adequate clinic space for infection prevention measures, future funding should support this.

Thanks to existing reach and relationships, during the pandemic AHCSA was able to administer philanthropic funding. The South Australian Aboriginal Community Controlled Health sector used this to support a variety of activities including telehealth, hygiene, and clinic refit to support infection prevention and control.

Broader Health Supports

ACCHSs worked to provide support for community wellbeing and for those who were required to isolate, included check-ins and hygiene packs. Local community met other needs, for example, entertainment or food packs.

Individual health services had to make decisions early in the pandemic about which essential health services could be continued under stay-at-home orders in place in South Australia, and given the resources available. Although innovations to support this included templates for telehealth, there were barriers such as clients not having a consistent phone number or telephone access. For GPs in ACCHSs, the pandemic increased flexible ways of working, including telehealth.

Mechanisms to better target future responses

The Commonwealth could provide additional guidance on how to keep clients connected with their local health service in periods of reduced service access.

A 'Cross-health' pandemic plan should be coordinated by the Commonwealth government and regularly updated, and consideration should be given to pre-placement of PPE in health services.

Training workshops, such as via AUSMAT, could be further capitalised on to bring participants together to collaborate on work in their jurisdictions.

Future legislative changes are required to simplify the legal basis under which Aboriginal and Torres Strait Islander Health Practitioners are able to administer medications. This will have benefits for improved vaccination delivery and potentially the delivery of antiviral medication.

Kind regards,
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