Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the COVID-19 Response Inquiry Panel December 2023

Key findings and recommendations

A. *Aboriginal community controlled health services (ACCHSs) played a key role in keeping COVID-19 mortality in Aboriginal communities much lower than that experienced by comparable First Nations communities in other parts of the world. ACCHSs provided a platform for the provision of culturally responsive comprehensive primary health care integrating community engagement and health promotion; population level infectious disease control including access to and promotion of vaccination; advocacy for healthy public policy; and treatment and support for those with COVID and their families.*

B. *Initially there was a high degree of collaborative planning between ACCHSs and Government health sector in the Northern Territory. However, widespread community transmission from January 2022 led almost immediately to NT government health services in Central Australia abandoning these plans, specifically in relation to supervised quarantine, Test, Trace, Isolate and Quarantine (TTIQ) procedures, provision of timely data, and accurate reporting of COVID Deaths in line with the nationally agreed definition.*

C. *Aboriginal community controlled health services are an essential part of the Australian health system, and should be formally recognised as such. ACCHSs require **ongoing resourcing from a dedicated funding stream** to deliver comprehensive primary health care which includes the capacity to partner with state and territory agencies on communicable disease control; on the continuing effects of COVID-19 and other communicable disease outbreaks such as TB; and preparation for future pandemics. This includes meeting infrastructure, recurrent and staffing costs.*

D. *The Australian Government, in collaboration with the ACCHS sector, should develop and implement system-level reforms for the **equitable distribution of key primary health care and public health personnel** across all regions of Australia, and address the employment of Aboriginal and Torres Strait Islander people at all levels of the public health system.*

E. *The Australian Centre for Disease Control currently being established should adopt as one of its key roles the provision of **timely, accurate and consistent data** at a regional and subregional level to inform local public health responses including at a minimum the number of COVID deaths, excess mortality, and rates of long COVID.*

F. *To overcome continued **vaccine hesitancy**, the Australian Government should support ACCHSs to deliver community-specific messaging including in local languages; well-resourced outreach services; and incentives for people to get vaccinated.*

G. *Given the very high number of Aboriginal people unable to safely isolate at home in future outbreaks, Government needs to prepare **regional isolation facilities** that can be stood up at short notice, and which include separate quarantine facilities.*

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Aboriginal health in Aboriginal hands.

About us

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Mparntwe (Alice Springs). We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care (PHC), and a strong advocate for the health of our people. Congress services over 17,000 Aboriginal people living in Mparntwe and remote communities in Central Australia.

2. Our submission is based on our experience of delivering comprehensive primary health care including multidisciplinary clinical care; health promotion and disease prevention programs; and action on the social, cultural, economic and political determinants of health. Over the last four years Congress has led an effective integrated and multidisciplinary public health response to the COVID-19 pandemic in Central Australia.

Congress' response to the COVID-19 pandemic[1]

Background

3. Aboriginal people in Central Australia experienced many devastating infectious disease epidemics during the non-Indigenous invasion of our lands [1]. Aboriginal peoples also suffered disproportionately from subsequent pandemics: during the 1919 Influenza pandemic, mortality rates in our region are estimated to have been amongst the highest in the world (about 260 per thousand) [2]. During the 2009 H1NI influenza pandemic, hospitalisation rates for Aboriginal and Torres Strait Islander people in Australia were 8.5 times those for non-Indigenous people, and mortality rates six times higher [3].

4. Congress and other Aboriginal organisations in Central Australia were therefore highly concerned from early 2020 about the potential catastrophic impact of COVID-19. These concerns were borne out by the devastating impact of COVID-19 on First Nation, Black and low-income communities elsewhere in the world [4, 5].

5. The vulnerability of our communities stems from high levels of poverty, over-crowded housing, low levels of literacy, high rates of chronic disease and an inadequately resourced health system comparative to need.

6. In addition, many in the Aboriginal community were concerned about the particular threat the virus posed to our Elders. The loss of Elders would mean a loss of extensive and valuable cultural knowledge. As Pat Turner, the leader of our community-controlled Aboriginal health services sector nationally, said at the time [6]:

   They are the holders of our history and our knowledge and losing our old people would be like burning down a library.

7. As a result, throughout the pandemic Congress was advocating for the strongest possible public health response, while delivering a range of culturally responsive programs to keep our communities safe. With this strong community support, the Northern Territory Government adopted strict border controls which prevented community transmission in the Territory until borders were opened in December 2021, after which widespread and uncontrolled community transmission spread rapidly across the Northern Territory (see Attachment, Graph 1).

[1] Refers to term of reference 'Key health response measures'

Pandemic Service Model

8. Early in 2020, in anticipation of the threat of COVID-19, Congress developed and implemented a Pandemic Service Model across all service delivery sites that included:

- infection control measures,
- provision of services by telehealth and outreach wherever possible, including the home delivery of medicines,
- support for government quarantine measures, and
- provision of testing through the Congress Respiratory Clinic.

Community engagement and health promotion

9. Congress' clinical responses were supported by extensive community messaging and engagement including:

- radio and television advertisements and service announcements in English and Central Australian Aboriginal languages,
- social media (including Facebook posts sharing news, stakeholder posts, original posts, 'myth-busting', and promoting 'vaccine ambassadors',
- information flyers / banners / mailouts including "No footy, No festivals, No fun" campaign,
- vaccine service promotion posters (town and remote),
- "Community Immunity" beanies and promotional posters,
- media events and appearances including around vaccination of key leaders, and
- support of outreach through attendance and community engagement.

Increasing vaccination rates

10. In common with many marginalised populations living in poverty, vaccine hesitancy was common amongst Aboriginal people in Central Australia. There are many reasons for this hesitancy. For some, there was a historical and understandable distrust of a mainstream health system that had been officially racially segregated until the late 1960s and implicated in policies of child-removal. Others were confused or made fearful by misinformation about vaccinations and COVID-19 on social media. However, there were there are many community members who were not fundamentally opposed to vaccination, but who waited to get vaccinated until they perceived the threat to be imminent. This pattern was also seen in non-Indigenous populations during the pandemic (for example in the large increase in demand for vaccination when the Delta outbreak occurred in Sydney), and is reflected in the spike of vaccinations when outbreaks occurred in the Northern Territory.

11. Congress worked hard to increase the COVID-19 vaccination rate amongst Aboriginal people in Central Australia as soon as vaccines became available in early 2021. This included:

- establishing a dedicated COVID-19 Vaccination Clinic at the Gap Road clinic,
- use of financial incentives ($25 shopping vouchers) for all those being vaccinated,
- promotion of planned and opportunistic vaccinations at all Congress remote clinics,
- a house-to-house outreach program in Alice Springs town camps,
- a 'pop up clinic' and community engagement at local shopping centres and sporting events,
- engagement and vaccination of renal patients, and
- promoting and delivery of vaccinations amongst Congress staff.

Between February 2021 and July 2022, Congress delivered over 18,000 COVID-19 vaccinations (see Attachment, Graph 2).

12. Congress also published peer reviewed articles that had a key impact on national Aboriginal vaccination policy and the subsequent allocation of funding to support the employment of Aboriginal community engagement officers to work alongside nurses in going to door to door to promote vaccination [7, 8].

Advocacy for healthy public policy

13. From early 2020, Congress advocated strongly with government and a range of other agencies to promote a focus on keeping Aboriginal communities safe through public health measures such as border and travel restrictions; vaccination; and safe and appropriate isolation and quarantine measures. Our advocacy included:

    - membership of key public health decision-making bodies including the Northern Territory Public Health Advisory Group (PHAG) and the national Aboriginal and Torres Strait Islander Advisory Group on COVID-19,
    - advocacy to Northern Territory Government including Health Department staff and Ministers by letter, email and in meetings,
    - letters and contact with community groups to counter vaccine misinformation, and
    - radio and print media.

Response to the outbreaks

14. In late 2021, the Australian Government pushed forward with plans to ease COVID-19 public health and travel restrictions [9]. Congress and other Aboriginal organisations such as the Aboriginal Medical Services Alliance Northern Territory (AMSANT) and Land Councils argued that Northern Territory borders should remain closed until vaccination rates for Aboriginal people aged 16 and over were at 90% or more. This position was based on modelling from the Doherty Institute, and on the greater risk of the emerging Omicron variant [7].

15. However, the Northern Territory Government pushed ahead with opening the NT borders from 20 December 2021. This led to immediate widespread and uncontrolled community transmission.

16. It was at this point that a great deal of the collaborative work between government and the Aboriginal health sector that had been carried out previously was undone in Central Australia. Many of response plans that had been made cooperatively between Government and the Aboriginal community controlled health sector during 2020 and 2021 were abandoned by government health services immediately, as follows.

    a. Supervised Quarantine: Agreed plans specified that positive cases would be immediately removed to appropriate supervised isolation from households where it was not feasible for them to safely isolate (as was the case for many Aboriginal people living in overcrowded housing). Instead, many were left in crowded houses for more than 48 hours by which time the virus had spread within and between households and then to other town camps, remote communities and houses.

    b. Test, Trace, Isolate and Quarantine. TTIQ responses were abandoned such that when there was a super spreader event at a New Year's Eve Party in Alice Springs it was already deemed not appropriate to take this approach. This was partly because predictably the workforce capacity for TTIQ was dramatically reduced due to opening the borders during the Christmas holiday leave period. The government's TTIQ system was rapidly overwhelmed. Subsequently, much of the responsibility

for TTIQ in relation to the Aboriginal community was transferred without formal negotiation or agreement from government to Aboriginal community controlled health services.

c. Data systems broke down and it was some time before Congress could get a picture from government of numbers of cases by region or locality, information which was essential for a coordinated and planned response.

d. Under-reporting of COVID Deaths. It became apparent that the number of COVID deaths according to the nationally agreed definition was being under-reported by government health services in Central Australia.

Success of the Aboriginal community controlled response

17. While every preventable death is a tragedy, and despite the failure of government to implement agreed response plans once community transmission occurred, the Northern Territory was successful in protecting the Aboriginal community from COVID.

18. Unfortunately, we are not aware of any published data for the Northern Territory specifically of the numbers of Aboriginal and Torres Strait Islander deaths from COVID-19. During the pandemic, Congress collated NT CDC Situation Reports which suggest that there were 73 deaths in the Northern Territory from December 2021 to September 2022 inclusive; with 14 of these occurring in Central Australia (see Attachment, Graph 3). However, these were not disaggregated by Aboriginality. Nor do they take account of the under-reporting of deaths by the Northern Territory health system.

19. However, we note that the Navajo Nation in the United States, with a similar health and social determinants profile to that of Aboriginal communities in Central Australia, has suffered around 2,400 COVID deaths in a population of around 300,000: a mortality rate of around 0.8% [5]. A similar rate in Central Australia would have seen around 160 Aboriginal deaths. While we do not know the true numbers, and notwithstanding the long-term health effects of COVID infection, the number of Aboriginal deaths in Central Australia is certainly considerably less than this.

20. The Aboriginal community controlled health sector – which provides a very high proportion of primary health care to the Aboriginal communities of Central Australia – was a key part of this success. It provided a strong platform from which to carry out community engagement and health promotion; vaccination; support for healthy public policy; and treatment and support for those with COVID and their families.

A better prepared, more effective system for addressing the needs of Aboriginal communities[2]

Dedicated funding of Aboriginal community controlled health services

21. There is considerable community-controlled expertise in Aboriginal health provided by ACCHSs. The sector has the accumulated experience and authority of over fifty years of operation and embodies the integration of public health; communicable disease management and control; chronic disease prevention and management; and responses to emerging health impacts (e.g. infectious disease, climate change). There are

[2] Refers to term of reference 'Mechanisms to better target future responses to the needs of particular populations'

common root causes to many of the health issues facing Aboriginal communities and we need an integrated and comprehensive approach and not a vertical program or siloed approach to action. This is what the ACCHS sector has a lot of expertise in.

22. The COVID pandemic has shown once more that Aboriginal community controlled health services like Congress are an essential part of the Australian health system, and should be formally recognised as such. The ACCHS sector in the Northern Territory and nationally therefore needs ongoing resourcing from a dedicated funding stream to deliver comprehensive primary health care. This should include includes the capacity to partner with state and territory communicable disease agencies on the continuing effects of COVID-19; other communicable disease outbreaks such as TB; and preparation for future pandemics. The significant infrastructure, recurrent and staffing costs to ensure that primary health care can continue to be provided safely will also need to be met.

Primary health care and public health workforce

23. Australia is facing a substantial primary health care workforce crisis that is particularly severe in regional and remotes areas. This workforce crisis seriously affects the capacity of ACCHSs and governments to respond to health issues – especially disease outbreaks – in Aboriginal and Torres Strait Islander communities.

24. The Australian Government, in collaboration with the ACCHS sector, should develop and implement system-level reforms for the equitable distribution of key primary health care and public health personnel across all regions of Australia, and to address the employment of Aboriginal and Torres Strait Islander people at all levels of the public health system.

Data and reporting

25. One of the challenges throughout the COVID-19 pandemic was getting timely, accurate and consistent data at a regional and subregional level to inform local public health responses, and to enable the community to make informed and safe decisions about their own health. We believe the Australian Centre for Disease Control currently being established could make a major contribution in addressing this gap. Transparent, regular, public data should be released at the regional level, and at a minimum should include COVID deaths, excess mortality, and rates of long COVID.

Supporting vaccination

26. As noted in paragraph 10 above, there was a high level of vaccine hesitancy amongst some Aboriginal people which combined with poor access to primary health care in many areas of the Northern Territory contributed to low vaccination rates in many Aboriginal communities. ACCHSs, as trusted providers of culturally responsive primary health care, are critical to addressing this situation, including during the continuing effects of COVID-19 and in response to other infectious disease outbreaks.

27. To overcome vaccine hesitancy, the Australian Government should support ACCHSs across Australia to deliver:

- community-specific, relevant messaging that hits the mark for Aboriginal people, including messaging in local language(s)
- well-resourced outreach services that reach people in their homes and communities
- incentives for people to get vaccinated including financial incentives (e.g. –store / shopping vouchers or non-financial (e.g. vaccine passports for travel, access to restaurants and sporting events for all citizens)

Isolation and quarantine facilities

28. Given the very high number of Aboriginal people who are unable to safely isolate at home, in planning for future outbreaks of COVID or other infectious diseases, Government needs to prepare regional isolation facilities that can be stood up at short notice. There will also need to be quarantine facilities: these could be established as a separate part of a single facility.

References

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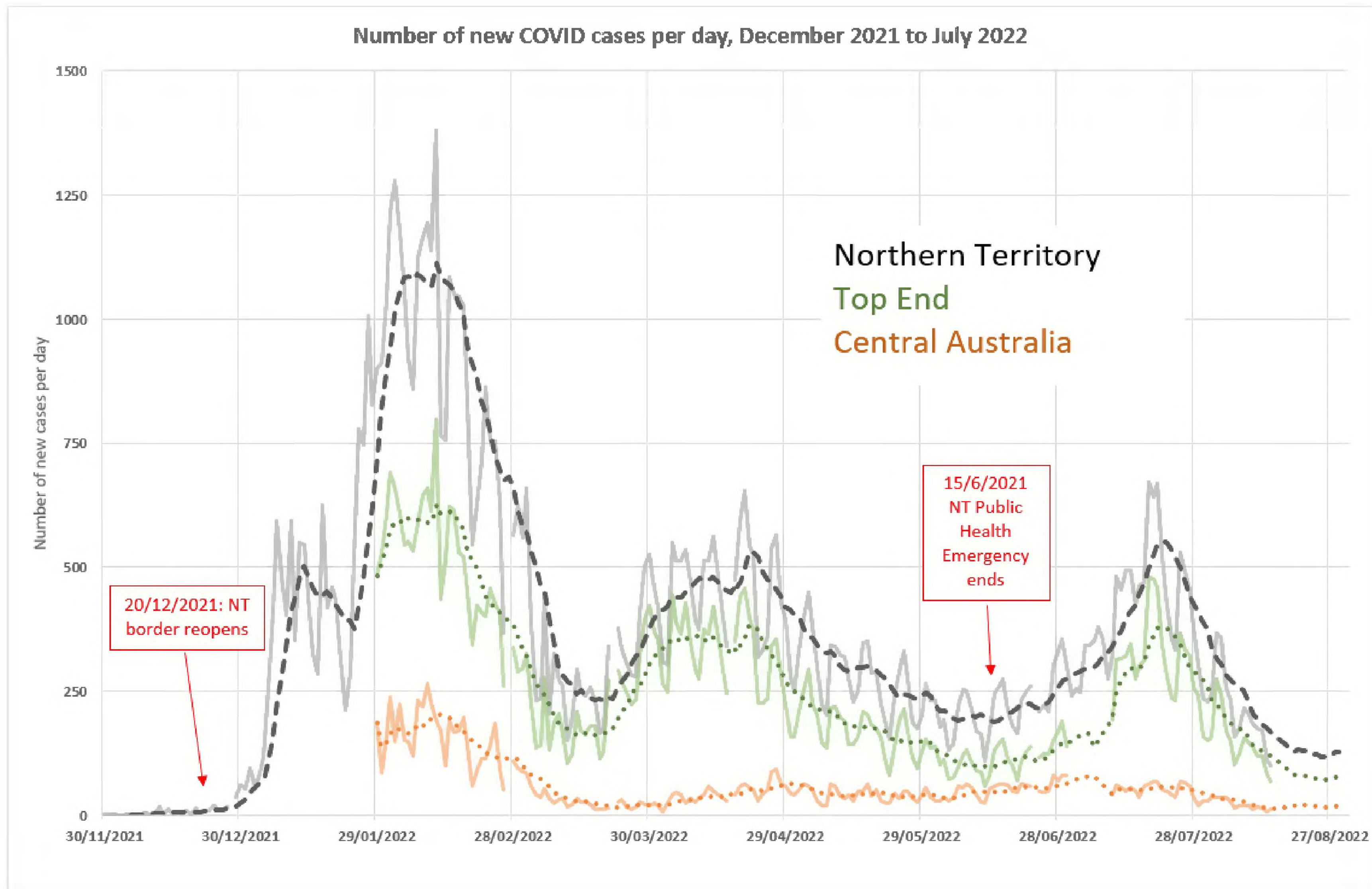
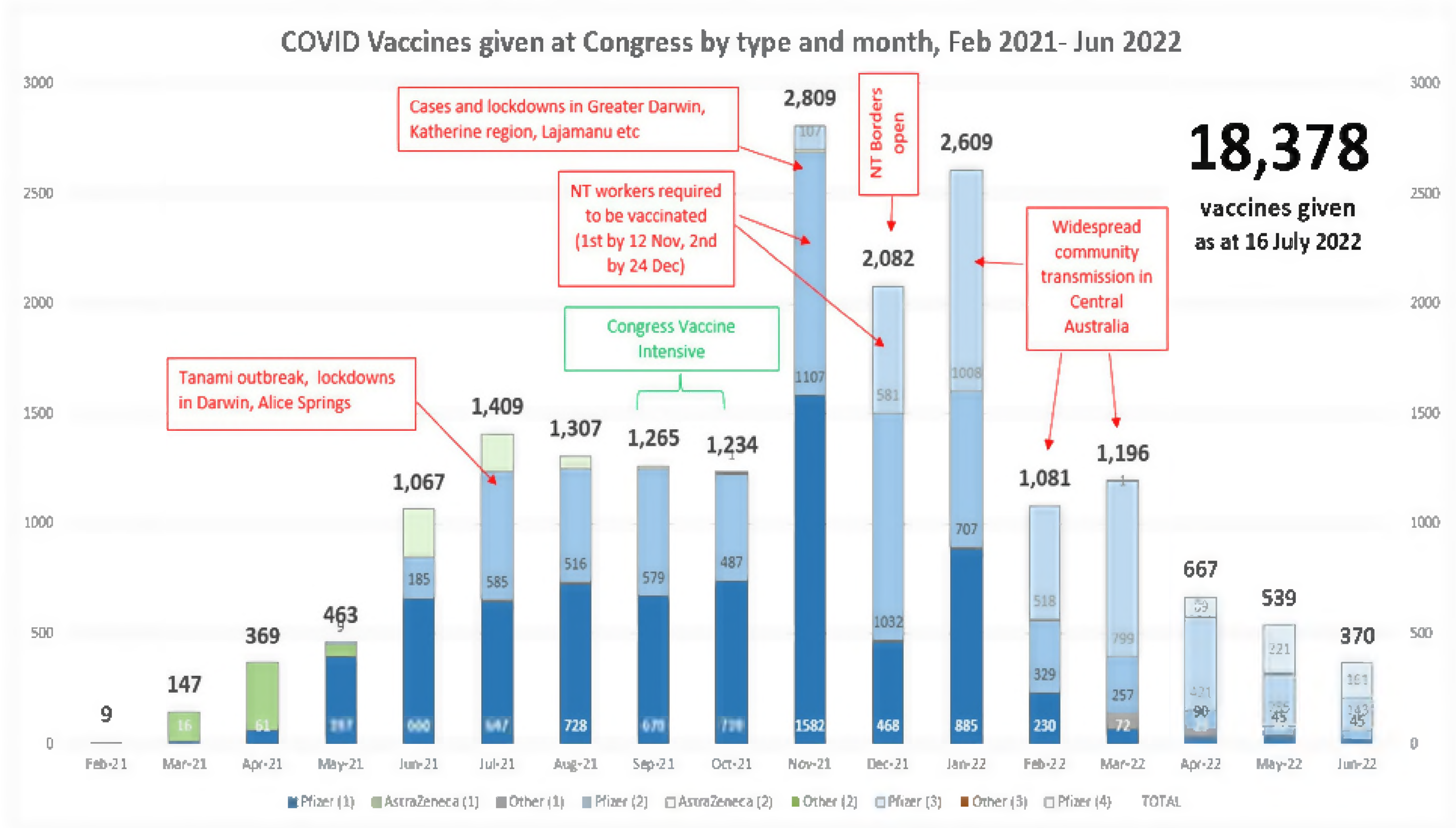
8. Komesaroff P, et al. *Vaccinations need to reach 90% of First Nations adults and teens to protect vulnerable communities*. 2021; Available from: https://theconversation.com/vaccinations-need-to-reach-90-of-first-nations-adults-and-teens-to-protect-vulnerable-communities-167800.
9. Senate Select Committee on COVID-19, *Final Report*. 2022, Commonwealth of Australia: Canberra.

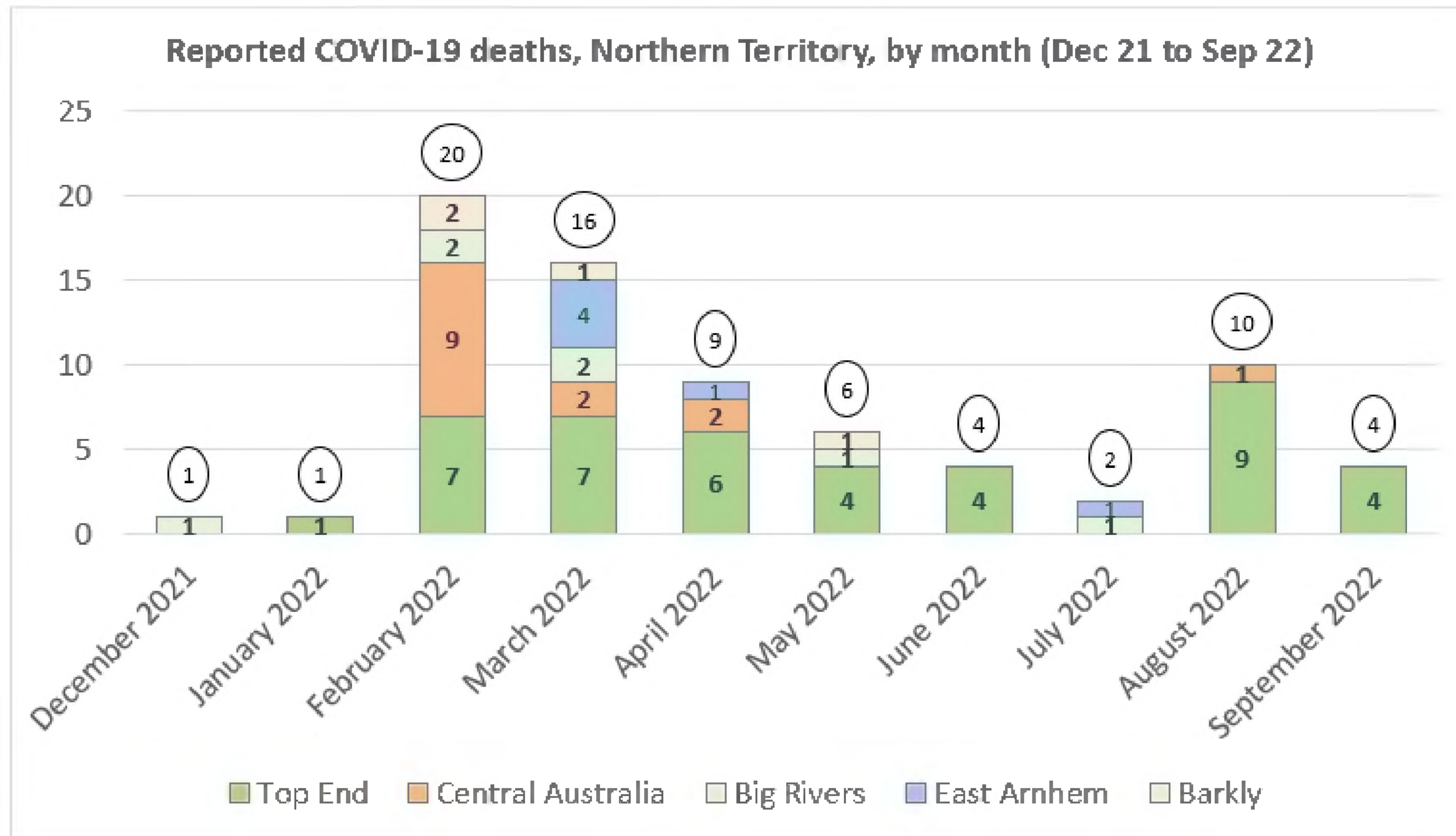
GRAPH 1



GRAPH 2



GRAPH 3



Note that these figures were compiled contemporaneously from NT Health Department CDC Situation Reports which were made available on https://health.nt.gov.au/covid-19/data. These reports are no longer publicly available. Due to Central Australian government health services not reporting COVID-91 deaths in line with the nationally agreed definition, these numbers should be considered a minimum.