AMSANT Brief on COVID 19 and lifting biosecurity restrictions

20 May 2020

Context

The decision to relax COVID 19 restrictions, including lifting the Biosecurity restrictions for remote communities, requires fully resourced measures to be in place at the commencement of the changes to:

1) reduce the risk of further virus transmission and,
2) rapidly respond to any potential outbreak in communities.

This will require careful adherence to public health evidence as well as clear processes and guidelines to ensure shared planning, swift decision-making and clear lines of responsibility for government, Land Councils and Aboriginal health and other organisations.

A checklist of key criteria to enable the safe lifting of biosecurity restrictions has been developed. However, these are part of a broader framework that will need to be in place to provide ongoing management and support of the new arrangements.

The experience of AMSANT and our member Aboriginal Community Controlled Health Services (ACCHSs) of the pandemic response in the NT to date raises a number of issues and concerns that will need to be addressed to ensure a coordinated and effective response is developed and maintained.

Background to COVID 19 in Australia and the NT

COVID 19 is a viral infection that is very infectious. In around 80% of people, it causes a mild to moderate illness which does not require hospitalisation but in 20% of people it is severe with mortality rates ranging from 1 to 7%. In Australia, there have been 7065 cases with 11 % of cases requiring hospitalisation and 1.4% (100) of all cases have died. The NT has had 30 cases and no widespread community transmission. There have been no deaths and no cases in Aboriginal people in the NT. In Australia, less than 1% of all cases are in Aboriginal people.

Older people and those who are obese or /and who have illnesses such as uncontrolled diabetes and heart disease are more likely to get a serious illness and to die. At present, multiple treatments are being tried but there is no proven treatment that substantially reduces the death rate and no vaccination likely for at least twelve months.

Public Health management of an outbreak

Conventional public health measures to control infectious disease outbreaks aim to diagnose cases quickly (through scaled up accessible testing) and isolate people with COVID19 and those who have been in close contact with a person with COVID during the infectious period, from the rest of the population so that cases and close contacts do not further spread the illness.

It has become increasingly clear that people who have COVID and who are either not yet showing symptoms or who never develop symptoms (asymptomatic) can be a major source of infection (European Centre for Disease control)**.** Therefore, simply separating people who are confirmed with COVID or who have been in contact with a person with COVID from everyone else is not sufficient to

quickly stop the virus from spreading further because people without symptoms will continue to spread it. Strictly enforced physical distancing across the entire population has been needed to slow the transmission to the point where the outbreak has eventually been controlled – but in some cases this has taken months and cost many lives. Australia instituted physical distancing measures in time to stop a more severe outbreak.

Remote communities have very overcrowded housing making physical distancing almost impossible, and housing often lacks infrastructure to support effective hygiene. There are also high rates of obesity and chronic disease that are likely to markedly increase the death rate from COVID 19. In addition, studies in the United Kingdom indicate that poverty and marginalisation seems to independently increase poor outcomes (Williamson et al 2020). Singapore has recently had a severe rapid spread in migrant workers living in overcrowded dormitories, despite being able to maintain excellent control in the rest of the population (Yea 2020). This demonstrates the effect of social determinants on spread. Recent evidence from the United States has demonstrated transmission is four times higher in Indian reservations compared to overall rates of transmission. Risk factors for rapid spread in Indian reservations include poor housing (particularly lack of plumbing) and not speaking English as a first language- both of which are very common in the NT (Akee 2020).

NT emergency management of COVID 19

The Emergency Management and Coordination Structure is legislated in the NT. The TEMC (Territory Emergency Management Council) is a statutory council which operates under the Northern Territory Emergency Management Act 2013), and reports directly to the Minister for Police, Fire and Emergency Services. The membership of the TEMC consists of the Police Commissioner and Chief Executive of the Department of Chief Minister (who are Co-chairs), Executive Director of the Northern Territory Fire, Rescue and Emergency Services and chief executives of key government agencies. The council directs emergency and recovery operations in the NT and approves emergency plans. The Emergency Operations Centre (EOC) is the operational arm of the EM structure under which sit 16 Functional Groups.

NT emergency planning processes devolve down to regional and local level where police are the Incident Controllers. Police based in Aboriginal communities are in charge of developing a local COVID response plan with community leaders and key organisations, including the health clinic, in each community. This covers such aspects such as enforcing public health measures to reduce further spread of the virus including providing quarantine facilities, transport, logistics, communication and provision of essential services.

Role of the Commonwealth Government

The Commonwealth has substantial powers in a pandemic under the Biosecurity Act. The Commonwealth Chief Health Officer chairs the AHPPC – Australian Health Protection Principle Committee, which consists of Chief Health Officers across Australia. The Commonwealth Health Department has convened an Aboriginal and Torres Strait Islander COVID 19 Advisory Group which reports up to the AHPPC and which is co-chaired by NACCHO. AMSANT is on this committee. The Advisory Group has reviewed and endorsed an Aboriginal plan as well as a guide to managing COVID cases/outbreaks in remote communities and these documents have now been endorsed by the Commonwealth Government and National Cabinet. There has also been Federal funding for additional evacuation capacity if needed for remote communities. The Commonwealth has also supported some ACCHSs to become testing clinics for people with respiratory illness and is planning

to fund additional workforce capacity particularly for remote Aboriginal PHC which could be used to support routine service delivery or to supplement jurisdictional surge workforce capacity if there was an outbreak.

Issues of concern with the NT COVID 19 response

Ensuring clear and inclusive governance

- Under the EOC structure, Police are in charge of the response to a complex, evolving, long term health emergency, which may work well for a cyclone but is not ideal for a pandemic. However, it is legislated and unable to be significantly changed.
- The governance of the NT emergency response is very complex with over 16 different, primarily governmental Functional Groups meeting to discuss issues such as transport and welfare. We have observed that there has been poor communication between the groups and also between the groups and external stakeholders, particularly ACCHSs and other Aboriginal organisations. AMSANT and the Land Councils are on a Regional and Remote Taskforce and Decision Makers group but most decision-making is occurring within the EOC structure. There is no AMSANT representation within the EOC structure.
- In terms of a coordinated public health response, it is not clear how the Commonwealth Aboriginal and Torres Strait Islander COVID 19 Advisory Group articulates with the NT structure and what resources the Commonwealth will bring to any major NT outbreak – particularly in a remote community.

Ensuring comprehensive, coordinated response plans

- Police have their own emergency plans that do not appear to be well informed by health knowledge and public health experts.
- Current COVID plans are not comprehensive, up-to-date or universally accessible. AMSANT and our members do not have access to many of the key planning documents at NT, regional or local levels and some of them appear not to have been developed or have not been revised to reflect new knowledge about how to effectively control transmission which has developed in the last two months. There is not a publicly available NT-wide overarching COVID plan that is up to date. A remote community COVID plan was developed in March but requires revision. There is a comprehensive Southern Medical COVID 19 plan but not an equivalent in the Top End.
- Central Australia /Barkly and the Top End are operating as two autonomous regions which is problematic in a small jurisdiction where resources may need to be moved rapidly from one region to another.
- It is not clear how the Commonwealth national remote communities plan relates to the NT plan and what resources the Commonwealth may provide in the event of an outbreak.
- How the Commonwealth and NT interact in other areas is also not clear. For instance, the NT has convened a critical goods committee that covers food security and there is also a NIAA convened food security group but they are not working together and neither have community controlled organisation representation.

Concerns with Police response

- Under the EOC structure, Police are in control of a health emergency but have limited knowledge about pandemics.

- Senior police have more awareness of the public health issues as they are at higher level meetings with public health and clinical staff but this knowledge is not always reflected on the ground.
- Police at the local level are in charge of developing local pandemic plans but in some regions have only engaged with the local clinic and refused to work with the parent health service organisation that operates multiple clinics (e.g. Katherine West Health Board, Sunrise Health Service). This is a serious breach of ACCHSs' governance and authority and has been additionally frustrating for ACCHSs that have developed regional pandemic plans informed by considerable public health and cultural knowledge.

Ensuring effective public health measures in Aboriginal communities

- Public health measures require wide ranging legislative powers that are outlined in the NT Notifiable Diseases Act, Public and Environmental Health Act and the Emergency Management Act. For Land Trust areas, the Commonwealth Aboriginal Land Rights Act also must be considered. Our current understanding is that the Commonwealth Biosecurity Act would be required to enforce robust public health control of an outbreak on Aboriginal land whilst NT legislation can be used elsewhere. As with the current arrangements, the framework for lifting to biosecurity restrictions will create a complicated and potentially confusing operating environment.
- Rapid spread is likely once the first case is diagnosed given transmission would already have started, and this is now backed up by real world experience in Indian reservations in the United States and modelling being carried out in Australia.
- Rapid access to testing results is critical to instituting effective control measures. In remote communities there are potentially very long delays to pathology testing. This is partly being addressed through introduction of Point of Care testing machines in remote communities but lack of sufficient machines and testing cartridges means that this will not enable rapid access for all testing results (even in communities with a machine) without additional measures such as charter flights /additional drivers.
- The current approach is to evacuate the first and ongoing confirmed COVID cases to hospital whilst the system has capacity and quarantine those who have been in close contact with a COVID case in suitable accommodation, which should ideally be single rooms or rooms shared with one person according to the WHO standards for quarantine. Close contacts would be evacuated to regional centres whilst there is capacity to ensure effective isolation from the rest of the community and to ensure appropriate quarantine accommodation. Additionally, close contacts and front line workers would be tested for COVID. Vulnerable people such as elders and those with severe chronic disease would be offered relocation to a regional centre in quarantine even if they were not a close contact.
- The AMSANT- Congress Contain and Test strategy takes this approach further by closing the community and asking everyone to stay in their house and yard whilst successive waves of voluntary testing are conducted in the entire community. Confirmed cases would still be evacuated to hospital and close contacts could also be relocated if agreed to by those contacts.
- Any measures involving restriction of people's movement would require a sound legislative basis as well as a prior process to secure community support and consent.
- AMSANT believes that the Contain and Test strategy approach of closing the community and instituting community wide testing and removal of infected people to either hospital or a

separate facility is required to stop the outbreak due to the role of asymptomatic transmission and the very high risk that people will leave the community once they know that a case has been diagnosed, risking further spread of the virus.

- Effective public health and clinical management of an outbreak will require additional clinical and public health workforce (surge workforce) to supplement the resident workforce. Ongoing essential primary health care would need to be provided along with diagnosing and evacuating COVID cases and there would also need to be daily monitoring of everyone in quarantine. If the regional centre runs out of capacity, cases that are still relatively well and close contacts would need to be looked after in community, increasing the load on the resident staff.
- Other services that would also be required include Social and Emotional Well Being services/mental health /AOD support, provision of food and other essential services to the whole community, logistics, transport and communication support.
- A sustained outbreak would require external support from the Commonwealth, including provision of a surge workforce (likely to be required for at least four weeks), logistics and other support.

References

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