SOCIAL INNOVATIONS Journal

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Australian Aboriginal Community Response to the COVID-19 Pandemic

By Rosalie Schultz

Summary

Australian Aboriginal communities planned our initial response to the coronavirus (COVID-19) pandemic as we saw the devastating impacts of outbreaks in parts of Europe and the U.S. Community education and coalition-building led to our response focused on empowerment and guidance for government investment that was proportionate to the potential of the crisis. Travel bans and enforced isolation of visitors were the key mechanisms to keep COVID-19 out of communities. By preventing entry of people infected with COVID-19 into Aboriginal communities, hygiene and physical distancing were less important to stopping the spread of the infection.

In June 2020, Australia appears to have controlled community transmission of COVID-19. However, in the longer term, the risk of entry of COVID-19 to Aboriginal communities remains because of ongoing colonization, racism, and social disadvantage.

Problem and Context

The COVID-19 pandemic emerged from the city of Wuhan in central China in December 2019 with a cluster of cases of severe pneumonia. Australia's first case was a citizen returning from China, who was diagnosed on January 25, 2020. WHO recognized COVID-19 as a Public Health Emergency of International Concern on January 31, 2020, and a pandemic on March 11, by which time 127 cases had been diagnosed in Australia. Australian case numbers were doubling every three days, and health authorities anticipated that hospitals would be overwhelmed by mid-April as they had been in other countries (MacIntyre and Heslop 2020, Evershed, et al. 2020, World Health Organization 2020).

Aboriginal Australians identified themselves as being at risk of infection and death from COVID-19. Aboriginal people have died disproportionately in infectious disease epidemics since British colonization of Australia in the 1700's. Smallpox outbreaks in the 1780's and 1830's and the Spanish influenza pandemic of 1918-19 killed half or more of the people in affected Aboriginal communities (Curzon and McCracken 2006, Kimber 1988). In the 2009 influenza pandemic the age-standardized mortality of Aboriginal people was almost six times that of other Australians (Naidu, et al. 2013). Epidemics of suicide, diabetes, and renal disease also affect Australian Aboriginal communities (Anon 2019, Maple-Brown and Hampton 2020, Hoy 2014).

While Aboriginal people constitute about 3% of Australia's total population, in the very remote regions of central and northern Australia, Aboriginal people pre-dominate both numerically and culturally. Aboriginal Australian languages are spoken, and people maintain strong spiritual relationships with their land (Schultz, et al. 2018). However, remote Aboriginal communities are more commonly represented through their disturbing health, education, and employment statistics. Among Aboriginal people life expectancy is 14.5 years less,

school completion rates 54% lower, and employment rate 40% lower than Australian averages (Australian Government 2020) .

These and other social determinants of health contribute to significant risks of COVID-19 spread and severe impact among Aboriginal people in remote regions (Markham, Smith and Morphy 2020).

Concerns include:

Over-crowded living conditions, making quarantine and physical isolation difficult or impossible;
Multi-generational housing, so older people are exposed to risk of infection from grandchildren;
Language barriers where Australian government resources are produced in English and languages of recent immigrants but not in Aboriginal languages;
Lack of trust in health services and government advice;
Limited access to health services;
High burdens of risk factors, including hypertension, diabetes, and heart, respiratory, and renal disease;
Complementary health care practices including use of traditional medicine which may delay diagnosis, contributing to the spread of COVID-19 (Oliver 2013).

Solution

Aboriginal people moved quickly to keep COVID-19 out of their communities in remote regions by restricting access to both outsiders and returning Aboriginal community members. Governments followed suit by developing legislative support and policing of these measures (Markham, Smith and Morphy 2020). Advocacy by Aboriginal people led to prioritization of Aboriginal communities in Australia's response to COVID-19. An Aboriginal and Torres Strait Islander Advisory Group was established on March 6, 2020 to represent Aboriginal community knowledge, insights, and concerns to government (NACCHO 2020a). After 250 years of colonization of Australia and its Aboriginal people, during which epidemics had contributed to the destruction of Aboriginal communities, this was a significant change in previous relationships and responses. Aboriginal people's health priorities in the response to COVID-19 were primary health care workforce planning, cultural safety, and service continuity. Consistent advice, whole of community involvement, business and welfare support, and food security were priorities outside of the health sector (NACCHO 2020a). Resources in 16 Aboriginal languages were produced. These addressed issues related to the COVID-19 response which were of particular concern to Aboriginal people: staying connected, ceremony, and funerals (Australian Government Department of Health 2020a).

Over the months of March to May 2020 there was growing medical knowledge around COVID-19 and its diagnosis and control, and increased availability of testing in Australia and worldwide. Point of care testing for COVID-19 was established in 83 remote Aboriginal communities by mid-May. This enables immediate diagnosis and isolation of people with COVID-19, although no one has been diagnosed yet in a remote community (Australian Government Department of Health 2020b, NACCHO 2020b).

For a brief period in late March, governments supported Aboriginal people to return to their remote communities. Then in early April the communities were officially designated as biosecurity regions, and access was closed. Non-essential travel such as tourism was banned completely while outside service providers and returning Aboriginal community members were required to quarantine themselves outside the community for

the 14-day incubation period of COVID-19. This ensures infected people can be identified and excluded before they enter the community (Australian Government Department of Health 2020c).

With restrictions on travel, the remote communities became more isolated from global food chains. While there are concerns about food security, local food production has increased, including fishing, hunting, and gathering bush food. Dietary change and physical activity of food production may improve health. Local production of traditional goods also has the benefits of recognizing Aboriginal expertise in local food production, providing empowerment and autonomy (Allam 2020).

While it is likely that COVID-19 will eventually be transmitted into Aboriginal communities, especially with the easing of travel and movement restrictions, delaying disease transmission into and within Aboriginal communities provided time for communities to prepare. Preparations involved community planning, education, and development of greater knowledge about the disease, and the capacity for testing (Markham, Smith and Morphy 2020).

Financing/Funding

Australia's economic support package for COVID-19 of $17.6 billion dwarfs health expenditure of $2.4 billion, which dwarfs the $6.9 million COVID-19 funding for Aboriginal community health organizations (Australian Government Department of Health 2020b, NACCHO 2020b). Epidemiological advice to the government highlighted how the national economy depends on control of the pandemic, and both need resources (MacIntyre and Heslop 2020). Additional expenditures to provide for the needs of Aboriginal communities is relatively insignificant overall but critical for Aboriginal people.

Aboriginal communities remain concerned about government plans to reduce services specifically for them. These plans assume that Aboriginal people will use general community services, despite evidence that mainstream services do not meet the needs of Aboriginal people (Markham, Smith and Morphy 2020). Culture is the key difference in Aboriginal service provision, and it underpins accessibility for Aboriginal people, community participation, culturally appropriate and skilled workforce, flexible and holistic approaches to care, and self-determination and empowerment (Harfield, et al. 2018).

Scaling

The world will emerge from the COVID-19 pandemic with opportunities to rebuild, and responsibility to do this in a way that respects those who have died in the pandemic (Horton 2020). The World Economic Forum has called for a planned response, with increased solidarity both within and between nations, coordination of efforts, respect for rule of law and human dignity, more sustainable development, and addressing climate change (World Economic Forum, 2020).

While Australian Aboriginal communities have contributed to Australia's positive response to COVID-19, this is an exception among indigenous communities globally. Other indigenous groups are being devastated by COVID-19, losing elders and holders of history, language, and knowledge. Indigenous communities have unique understandings of living sustainably and cooperatively which could benefit other societies and humanity as a whole as we emerge from the pandemic (Curtice and Choo 2020). While Aboriginal Australians may have withstood the COVID-19 pandemic, rebuilding should acknowledge the catastrophic consequences of

colonization, and recognize the unique opportunities for decolonization including honoring Aboriginal authority (Howitt, Havnen and Veland 2012).

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