COVID-19 and Community Collaboration: Protecting High Risk Groups in Response and Recovery

ACOSS Proposal

15 September 2020

Just over six months since the first case was reported, Australia remains in the thick of the COVID-19 Pandemic crisis.

Australian governments have implemented a range of measures to stop the spread of the virus, with physical distancing becoming a way of life, and health and movement restrictions implemented in varying degrees in all jurisdictions of Australia. The benefits of these measures are clear.

Right now, Victoria remains in lockdown and cases in NSW are increasing. Whilst most jurisdictions in Australia report low or negligible cases, isolated cases and potential hot spots means the entire country remains on high alert, whole borders are closed and the risks of COVID-19 remain a national concern.

People on lower incomes and people from more disadvantaged communities or with specific vulnerabilities are being hit the hardest and are likely to be hit the longest by the health, economic and social risks associated with COVID-19. We know that the conditions in which people are born, grow, live, work and age affect their economic and social wellbeing, but also their health. These circumstances are affected by how money, power and resources are distributed.

People who are more disadvantaged or vulnerable need to be at the heart of the public health response. People who have fewer options and opportunities are disproportionately affected by recent outbreaks. This includes people who couldn't afford to take time off paid work and those living in larger households where transmission is more likely. Partnership with people who are more disadvantaged and vulnerable is therefore a critical public health and economic strategy as we respond to outbreaks and prevent their recurrence.

In order to respond and recover from this pandemic, we need to ensure strong collaboration with community groups representing people most at risk. COVID-19 does not impact everyone equally.

Ph (02) 9310 6200 E: info@acoss.org.au
www.acoss.org.au
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In this briefing note, we set out some of the high risk health issues for a number of key population groups in this pandemic, whilst noting this is not exhaustive. There are many population groups that face equity issues associated with the health, economic and social crises posed by COVID-19

These issues and recommendations were developed in consultation with ACOSS members, particularly those representing people from higher risk population groups.

People and communities at higher risk

While COVID-19 affects everyone in our community, there are a number of groups that face specific risks in relation to it, particularly (but not exclusively and not in order of need):

- Older people
- Aboriginal and Torres Strait Islander peoples
- People experiencing poverty and homelessness, including those in overcrowded housing, or high density low income/social housing
- Temporary visa holders, refugees and asylum seekers
- People from culturally and linguistically diverse communities
- Women and their children, including those at risk of family and domestic violence
- People with chronic physical or mental health conditions or compromised immunity
- People with low levels of language, literacy, numeracy and digital skills
- People in regional, rural and remote areas
- People in prison or immigration detention
- People with disability
- Lesbian, gay, bisexual, trans, intersex, queer (LGBTIQ) people

People of course can and do belong to more than one group or community. The social, economic and health impacts may be further compounded as a result of having multiple intersectional identities. The risks and impacts also vary, depending on the community affected. Some people and communities are at higher risk of serious illness or death if they acquire COVID-19. Others cannot socially distance or self-isolate. Still others are already experiencing higher rates of mental ill health before the additional stress, isolation, and anxiety associated with COVID-19.

Key health and related risks during COVID-19

There are a number of key health issues related to COVID-19. Particular communities are at higher risk of one or more of these health issues, for example, Aboriginal and Torres Strait Islander communities and people with a disability.

Poverty and homelessness

People who are on very low incomes, in insecure work, or exposed to insecure housing conditions are at greater risk of facing barriers to protection from acquiring and spreading COVID-19 and the impacts of the pandemic response. Barriers include severe restrictions on being unable to self-isolate for e.g. need to perform unsafe paid work, no or inadequate income support, overcrowded housing conditions) and

severe effects of sustained lockdowns to financial distress and associated mental health risks.

Chronic illness

People with chronic health conditions are more likely to experience symptoms of COVID-19 and are at greater risk of developing serious illness if they do acquire the virus. People experiencing poverty and disadvantage are more likely to have chronic illness and all of the COVID-19 risks associated with it.

Mental ill health

There is a range of mental health impacts experienced by people as a result of COVID-19. These include isolation, anxiety and stress, as a result of the pandemic, the health and movement restrictions and the economic crisis. These impacts are exacerbated in communities already experiencing higher rates of mental ill health, such as LGBTIQ communities, or because of poverty, disadvantage, stigma and discrimination.

Domestic and Family Violence

The onset of COVID-19 and the associated health and movement restrictions have led to an increase in domestic and family violence, predominantly experienced by women. A survey conducted by the Australian Institute of Criminology in May 2020 found that in the three months prior to the survey almost 9 per cent of women in a relationship had experienced violence from a current or former cohabitating partner[11] Among those women who reported they had experienced physical or sexual violence in the three months prior to the survey, one in three (33.1%) said that this was the first time their partner had been violent towards them.[2] LGBTIQ people may also be separated from "families of choice" and friends not in their household leading to greater risks of family of origin violence and intimate partner violence.

Age

There are a number of COVID-19 related risks faced by older people in Australia. People aged over 70, and people aged over 65 with chronic medical conditions are at greater risk of serious illness if they contract COVID-19[3]. The vast majority of COVID-19 related deaths in Australia (85%) to date have occurred among people

[1] Boxall H, Morgan A & Brown R 2020. The prevalence of domestic violence among women during the COVID-19 pandemic. Statistical Bulletin no. 28. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/sb/sb28

[2] ibid

[3] https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/advice-for-people-at-risk-of-coronavirus-covid-19/coronavirus-covid-19-advice-for-older-people

aged over 70 years old[4]. At the same time, older people are facing greater risks of elder abuse as a result of increasing isolation and financial pressures[5].

Disability

People with disability face differing risks of exposure, susceptibility and impact related to COVID-19 depending on the type of disability they have and demographic and other factors (like their age, gender, where they live, and their underlying health). A significant proportion of people with disability come from multiple 'priority' population groups, which has a compounding impact on their health needs and outcomes[6]. Aside from risks to their health, people with disability are also more likely to experience poverty and disadvantage.

Racism

During this pandemic, we have seen an increase in both overt and more subtle racial discrimination towards people of Asian descent in Australia. Racism is not a new problem for people from CALD communities, however racist attitudes and discrimination that are not checked are problematic to the response and are destructive to community cohesion.

Digital Divide

COVID-19 has driven changes to how people access medical care, including a shift towards telehealth. At the same time, we are increasingly using technology to undertake homeschooling and connect with one another. These changes present challenges for people who do not have access to these technologies, particularly people on low incomes and older people.

Structural access barriers to healthcare

Some communities and individuals have experienced or anticipate experiencing discrimination and stigma when accessing healthcare, including discrimination on the basis of sexual orientation, gender identity or race. This can result in underutilisation of services as well as inappropriate or inadequate healthcare.

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[4] https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#cases-and-deaths-by-age-and-sex

[5] https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#cases-and-deaths-by-age-and-sex

[6] https://www.health.gov.au/sites/default/files/documents/2020/04/management-and-operational-plan-for-people-with-disability.pdf

Partnership, collaboration, engagement, and communication

Genuine collaboration and partnership with affected communities, particularly where those communities have been historically disadvantaged or marginalised, is critical to the success of the response to COVID-19. Indeed the Australian Health Sector Emergency Response Plan for Novel Coronavirus states that "Consultation with responders and with the public will be essential to inform decision-making"[7], and goes on to outline a comprehensive strategy for communicating and consulting with the relevant stakeholders and the public on the response.

The Federal Government has established formal mechanisms to engage with some communities affected by COVID-19 (eg Aboriginal and Torres Strait Islander peoples and people with disability). That said, there are significant gaps in this engagement and many communities are excluded from decision-making and not routinely consulted as the government crafts its health or economic response to the pandemic.

Communities and the organisations that represent them, including the COSS network, have on the ground experience and knowledge of their own context that is invaluable to governments developing responses to the pandemic. Representative community organisations can also help facilitate active open feedback loops with affected communities to enable governments to understand in real time how policy and other decisions impact on people and communities.

There are key messages that governments need to hear about the impact of COVID-19 and associated policy responses on communities and people, particularly those who are disadvantaged or marginalised. It is vital that governments establish appropriate mechanisms to work closely with community groups, in collaboration, building trust, in order to improve the quality of decision making, and ensure that the pandemic response is the best it can be.

Community leadership and trust

During the COVID-19 pandemic in Australia, the Aboriginal Community Controlled sector has played a leadership role in planning protective strategies and communicating health messages about prevention, risk and health restrictions to Aboriginal and Torres Strait Islander peoples and communities. Aboriginal and Torres Strait peoples have turned to their ACCHOs for health promotion and education messages and guidance during this pandemic, as the trusted actors on health issues for their community. This trusted community leadership has been critical for getting

[7] https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.pdf

strategies right and communicating the right messages out about the risks and impacts of COVD19 on Aboriginal and Torres Strait Islander people and communities[8].

Other non-Aboriginal community-controlled organisations, including in CALD communities, LGBTIQ communities and communities of people with disability have also worked hard to plan and communicate health promotion and education messages to their communities. All of this work has occurred in the absence of a coordinated national strategy for working in close collaboration with higher risk groups, and without funding for community-controlled organisations to deliver it.

Community leaders are particularly important in both building trust for sustained ongoing response and recovery planning, and for providing rapid feedback to government and health decision-makers about how to improve protective action both from the health and associated economic and social risks playing out in specific communities.

While national and state-wide health promotion and health education is important, it is also important that these efforts are complemented by a strategy to reach specific at-risk and hard to reach populations with messages about prevention, testing and isolation. This strategy must be backed up by funding for targeted health promotion and education led by community organisations representing hard to reach and at-risk populations.

Recommendations

To strengthen the response and recovery to the health, economic and social crises of COVID-19, the Federal Government needs to work more closely with community leaders and organisations representing people facing higher risks. We recommend that the following actions be taken without delay to rapidly enhance existing engagement structures:

Federal Government Level

Collaborate and Partner with Community Leadership

1. Establish a **Community Partnership Group** to work closely with the Chief Medical Officer and PMO.

   The CPG would bring together community leaders representing people experiencing poverty, older people, Aboriginal and Torres Strait Islander peoples, CALD people and communities, people with disability, LGBTIQ people, and other groups who are at high risk of the health, economic and social impacts of COVID-19. This committee would be tasked with providing a rapid feedback and advisory process to inform Federal action ongoing that responds to the various health-related crisis impacts of COVID-10, including communication strategies, federal policies and local community supports.

[8] Crooks K, Casuarina NT, Casey D, City C, Territory AC, Ward JS. 'First Nations people leading the way in COVID-19 pandemic planning, response and management'. Medical Journal of Australia. 2020 April 29

2. Embed **"Specific Population Strategies"** that are community partnerships providing detailed advice to the Chief Medical Officer and the Federal Government on the needs of specific population groups in relation to COVID-19.

   Different communities will require different responses to this crisis. We strongly support the advocacy of FECCA, an ACOSS member, to establish a partnership focussing on the needs of CALD communities, and their first task should be developing a Management and Operational Plan for CALD people in relation to COVID-19. The Chief Medical Officer and Prime Minister should immediately invite submissions and recommendations from community organisations about how the Federal Government can assist to further strengthen partnership and collaboration amongst specific populations, including at the local and community level.

3. Create at least **two dedicated Commissioners for the COVID Commission** who have the expertise and represent the needs and interests of people experiencing poverty and facing higher risks.

   It is not appropriate to separate out advice regarding economic recovery from the health and social risks of communities. It is vital that the voice of people who are most at risk of all the impacts of COVID-19 are on the inside of the COVID Commission. The Federal Government should consult with community sector and First Nations peak bodies to identify candidates.

Make targeted investments in community-led health promotion

In order to ensure that health promotion and education messages about COVID-19 prevention, testing and isolation are reaching hard to reach and at-risk populations, we recommend the following:

4. Develop formal health promotion and education strategies for specific hard to reach and at-risk populations that are informed by the data and evidence, and developed in partnership with the relevant communities and the organisations that represent them.

5. Develop a partnership approach between government and community organisations delivering health promotion and education, where decision making on health promotion and education activities is led by community organisations and relevant epidemiology data is shared.

6. Provide targeted funding for community organisations representing key population groups to deliver peer-led health promotion and education to their own communities.

Engagement at state, territory, regional and local levels

7. A community partnership approach should also be taken at state, territory, regional and local levels. Appropriate structures will vary depending on the specific context and the extent to which these approaches are already in place. State, territory, regional and local approaches should seek to:

   a) put people at the centre, ensuring that diverse individual needs of people at risk are prioritised and met;

b) involve and empower local communities from the outset, recognising their expertise and experience in effective planning, service delivery and communications that are suitable for their own community members;

c) use the skills and expertise of the COSS network and other relevant peaks and representative organisations in shaping health, economic and social policy and responses; and

d) take a health rather than policing approach, with responses led by public health officials and community health services.