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Embedding Aboriginal cultural governance, capacity, perspectives and leadership into a local Public Health Unit Incident Command System during COVID-19 in New South Wales, Australia

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ABSTRACT

This case study describes the development and implementation of a governance structure that prioritised First Nations peoples in a local public health Incident Command System activated for the COVID-19 pandemic response in New South Wales, Australia. Using lessons learnt from past pandemics and planning exercises, public health leaders embedded an approach whereby First Nations peoples determined and led community and culturally informed pandemic control strategies and actions.

In March 2020, First Nations governance was embedded into the local public health emergency response to COVID-19 in the Hunter New England region of New South Wales, Australia, enabling First Nations staff and community members to actively participate in strategic and operational decision-making with the objective of minimising COVID-19-related risks to First Nations peoples and communities. The model provided cultural insight and oversight to the local COVID-19 response; strengthened and advanced First Nations leadership; increased the First Nations public health workforce; led the development of First Nations disease surveillance strategies; and supported working groups to appropriately respond to local needs and priorities. This model demonstrates the feasibility of reframing a standard Incident Command System to embed and value First Nations principles of self-determination and empowerment to appropriately plan and respond to public health emergencies.

SUMMARY BOX

- ⇒ This case study describes the development and embedding of Aboriginal governance in a standard Incident Command System (ICS), using decolonising approaches and anti-racism framework to respond to COVID-19 in a local public health unit.
- ⇒ Embedding Aboriginal governance in a public health emergency management system, which embodies principles of empowerment, self-determination and shared decision-making, can lead to a more culturally informed and appropriate pandemic response, governed within a system where Aboriginal peoples are respected, trusted, engaged and listened to.
- ⇒ This model strengthened and increased Aboriginal workforce, advanced Aboriginal leadership, and enabled strong, collaborative and meaningful partnerships with the ICS teams, Aboriginal health units, Aboriginal Community-Controlled Health Organisations, and other government and non-government agencies.
- ⇒ The model is a systematic way of engaging Aboriginal peoples in making decisions about public health emergencies and is an effective way to identify and address local community needs and concerns.
- ⇒ The ICS cultural governance model should be replicated and applied to public health emergency management systems and other infectious disease responses.

INTRODUCTION

The COVID-19 pandemic has disproportionately impacted First Nations peoples, a pattern seen in previous influenza pandemics.[1] Key determinants include the historical and contemporary impacts of colonisation and systemic racism, which manifest most notably in health and socioeconomic inequities.[2] First Nations peoples experience many factors that amplify the risk of COVID-19 including: higher rates of chronic disease, inadequate and crowded housing,[3] lower vaccination uptake, and limited access to culturally appropriate health and essential services.[2–6]

First Nations peoples have been disproportionately impacted by previous pandemics,

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including over-representation in hospital and intensive care admissions.[7 8] These negative experiences served as a driver for a strengthened and adaptable response to the COVID-19 pandemic.[1 9]

Previous Australian pandemic plans and strategies have not considered or reflected the needs of First Nations peoples. This deficiency highlighted the need for culturally informed systems and culturally appropriate, respectful and meaningful models of engagement with First Nations peoples in public health emergency decision-making.[10]

At the beginning of the COVID-19 pandemic in Australia, there were increased efforts at all levels of government to strengthen public health systems and COVID-19 plans to include and prioritise First Nations peoples and communities.[11 12] The Australian Government Department of Health responded quickly to establish a national Aboriginal and Torres Strait Islander Advisory Group on COVID-19.[12] This group provided advice on preparedness, response and recovery planning, and developed national guidance and plans.[13 14] National guidelines recommended that partnerships between local public health units (PHUs), Aboriginal health services and Aboriginal Community-Controlled Health Organisations were critical components of pandemic planning, response and management. However, no specific guidance was provided on how this could be operationalised or governed.

Public health governance is defined as controlling, managing, and regulating actions to reduce and mitigate risks and to protect population health.[15] Public health governance has four critical functions: surveillance, protection, response and communication.[16] Good governance practices which are facilitated through the: implementation of preparedness plans, engagement with communities through good communication, and responses that are community driven and autonomous[11 17] can promote trust and equity, and decrease case numbers.[18] Poor governance during public health emergencies, conversely, has the potential to further marginalise already disadvantaged populations,[2 16 19] and can be associated with low testing availability, increased infection rates[18] and distrust of health authorities.[20] Respect of culture,[21] ability to actively participate in decision-making to inform policy[22] and self-determining practices[23] must be embedded in any pandemic governance and responses with First Nations peoples. While there are good governance models within First Nations specific health units and services, there is a paucity of evidence of what good governance looks like within a local public health emergency management system.

This case study outlines how a PHU in New South Wales, Australia embedded First Nations (hereafter Aboriginal) co-governance into the leadership framework of the local COVID-19 Incident Command System (ICS). All authors of this case study were involved in the development and implementation of the ICS governance model. No formal evaluation of this work has been conducted.

CASE STUDY SETTING

Hunter New England (HNE) PHU (HNEPHU) within the HNE local health district, is a government-funded and legislated health protection unit that covers a large geographical region of New South Wales, Australia, providing services to 962 390 people, including approximately 71 983 Aboriginal people. Aboriginal people represent 7.5% of the total population of the HNE, and 25.9% of the state's Aboriginal population.[24] The majority of the Aboriginal population in HNE live in metropolitan regions; however, the rural and regional areas have the highest proportion of Aboriginal people, 48.2% and 51.8%, respectively.[24] HNE includes eight Aboriginal Community-Controlled Health Organisations and eight discrete Aboriginal communities. Since 2017, HNEPHU has implemented a joint governance structure for planning and delivering health protection services underpinned by the principles of voice, self-determination and empowerment of Aboriginal peoples.[25]

Developing the Aboriginal governance model and reframing the local COVID-19 Incident Command System

Hunter New England public health unit COVID-19 Incident Command System structure and governance

In February 2020, HNEPHU formally activated a standard ICS, to respond to the COVID-19 pandemic locally. The overarching structure was governed by the local health district's Health Services Functional Area Coordinator (HSFAC) (figure 1). The public health aspects of the COVID-19 response were led by the public health controller, and existing public health staff, with staff from other health and government sources seconded to the response as required. Public health components of the ICS structure included a public health controller, and operations, planning, logistics and communications teams (figure 1).

Aboriginal public health leaders recognised that there was no cultural governance and a lack of Aboriginal voices and representation within the standard local ICS to ensure strategies and responses were culturally appropriate for Aboriginal communities. Working within an equity, anti-racism and social justice framework,[26–29] HNEPHU Aboriginal staff advocated for the establishment of a Public Health Aboriginal Team (PHAT) to determine and implement culturally informed and appropriate COVID-19 control strategies, with representation on the Incident Management Team to ensure overarching cultural oversight for the entire response. Cultural inclusion was embedded through an accountability framework across all ICS teams.

Strengthening Aboriginal leadership and capacity

PHAT leaders implemented and advised on local COVID-19 control strategies that valued and honoured Aboriginal ways of knowing, being and doing. Through the development of an internal governance system (figure 2), the team created appropriate leadership positions, strengthened the Aboriginal public health

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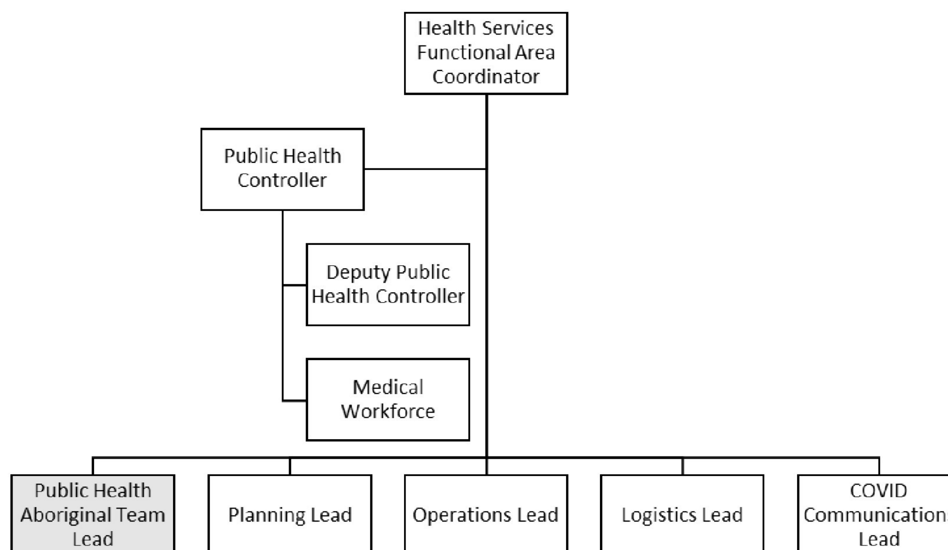

Figure 1 Hunter New England public health Incident Command System for COVID-9.

workforce, created pathways and opportunities for surge staff, and strengthened partnerships with internal and external health and other partners. The PHAT lead roles included: PHAT Lead, Aboriginal Community and Services Engagement Lead, Aboriginal Operations Lead and an Aboriginal Epidemiologist Lead. Other key roles included Aboriginal Communications Officer, Aboriginal Equity and Access Officer and Aboriginal Cultural Support Officers. Aboriginal representation on the HNE Local Health District HSFAC committee was also strengthened, with a total of three Aboriginal leaders in the committee.

Accountability framework and Aboriginal cultural support

An accountability framework was implemented which meant all teams across the response were responsible for ensuring all people had the opportunity to receive culturally appropriate support. If a COVID-19 case identified as Aboriginal or Torres Strait Islander, PHAT staff offered and provided holistic care and follow-up telephone support to the case, their contacts, families and households. Support included: provision of information and education on COVID-19 and rules and regulations; referral to COVID-19 testing and vaccination providers; provision of personal and household items; food, supplies and medications; and referrals to local cultural, community health and well-being support services. PHAT leads shared the model with other local health districts and state departments, to allow adaptation and implementation of their own cultural support models.

Community and partner engagement

The PHAT leads embedded Aboriginal community governance that fostered and promoted open, honest two-way communication with community partners through an effective engagement model. The PHAT leads established the HNE Aboriginal Governance Group on COVID-19 (Governance Group) in March 2020. The group was multisectoral and included representatives across the HNE local health district from Aboriginal Community-Controlled Health Organisations, Local Aboriginal Land Councils, and HNE Child and Family Health Services. The group provided a formal mechanism for Aboriginal leaders from government and non-government organisations, to work collaboratively to

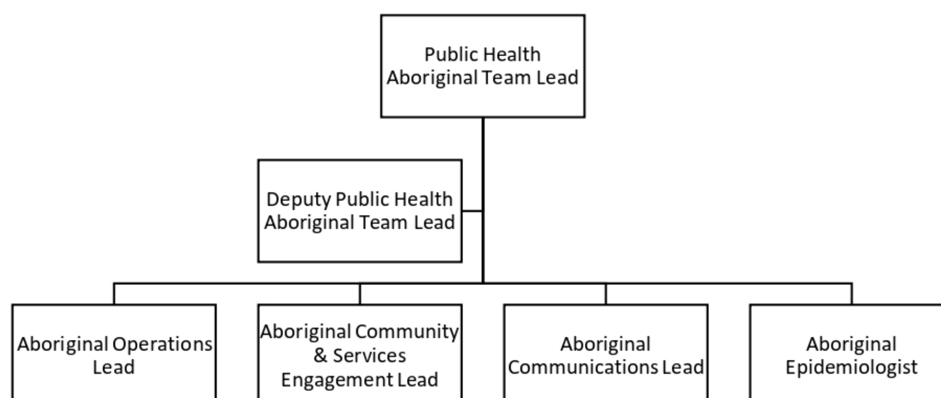

Figure 2 Hunter New England Public Health Aboriginal Team governance for COVID-19.

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inform and evaluate public health measures and services for Aboriginal communities in HNE Local Health District.

Data governance

An Aboriginal data governance group was formed in April 2020, to identify data and research priorities that were strengths-based, and addressed needs identified by the Aboriginal Governance Group. The data governance group advised and provided cultural oversight of COVID-19 data, informed the way data were reported and ensured data were interpreted through a cultural lens. The group advocated for changes to state-level and national-level reporting on Aboriginal and Torres Strait Islander people and COVID-19 that were more strengths-based, focused on the Aboriginal population, and reflective of the social realities of Aboriginal peoples and communities. PHAT leads developed learning modules to educate staff on ethical, strengths-based approaches to public health epidemiology and Aboriginal peoples.

Aboriginal-led surveillance strategies

PHAT leads developed and embedded Aboriginal-led surveillance strategies in the local response, including an early warning system called 'local and cultural intelligence'. Through mapping of affected Aboriginal households, PHAT was able to gain understanding of transmission dynamics across place and time through kinship networks, and culturally linked towns and Aboriginal communities. This intelligence allowed early identification of local outbreaks, with information provided to the Governance Group of any risks to enable partners and government and non-government agencies to plan for and activate local support services and resources. PHAT leads developed and delivered training and education to COVID-19 response staff on Aboriginal-led epidemiological strategies. Epidemiological data for and about Aboriginal peoples were delivered to the Governance Group on a weekly basis, and on a regular basis to other individuals and organisations. These data were tailored to answer questions posed by communities and took an anti-racist approach described next to tackle misconceptions and prejudices held by the broader community.

Aboriginal people were prioritised in the data by reporting Indigenous status. Aboriginal case data were analysed, interpreted and reported with a sole focus on Aboriginal people. Data on non-Aboriginal people were not included. This meant Aboriginal people were viewed as the reference population. Communities were able to visualise data that were aggregated in a way that described local epidemiology. During times when communities were facing threats of other natural disasters, such as flooding, real-time mapping data were used to divert resources and to prepare communities who were at risk of being cut off by floodwaters. Case numbers were also provided to Aboriginal Community-Controlled Health Organisations to allow estimation of the average number of close contacts per household, to inform planning for additional supports to these areas. Crude modelling allowed estimation of potential hospitalisation and mortality burden on the Aboriginal population based on vaccination coverage, which was used to advocate for greater resources to be moved to areas with low coverage.

COVID-19 vaccination governance

It soon became clear that whole-of-population vaccination strategies resulted in a coverage gap between Aboriginal and non-Aboriginal communities. In September 2021, 8 months after the Australian COVID-19 vaccine rollout began, the PHAT leads, in partnership with the HNE Integrated Chronic Care Team and HNE Immunisation Team formed an HNE Aboriginal Vaccination Steering Committee to identify, inform and implement local vaccination activities. The committee was endorsed and supported by other district groups and included representatives from the HSFAC, Nursing and Midwifery Service and Regional Health Services. The group developed and operationalised a coordinated multipartner group to rapidly increase Aboriginal community vaccination rates across the HNE region, using culturally appropriate models of delivery that were informed, guided and governed by Aboriginal people.

Targeted, tailored and culturally appropriate communication

The PHAT developed and disseminated information and messages that were informed by Aboriginal people, and addressed Aboriginal community concerns, needs and priorities. Messages and information were family centred, delivered in an easy-to-understand format and culturally appropriate language across a variety of relevant mediums including social media, video and information sheets. The team also delivered webinars to inform and update Aboriginal health workers and health service providers of the local COVID-19 response. The information presented in these messages was approved through a rigorous and collaborative process between clinical, epidemiology, programme management and communications staff.

REFLECTION AND DISCUSSION

Embedding governance in a standard ICS has added value to a local public health response and led to many positive outcomes for Aboriginal staff and communities including:

- *Aboriginal cultural support:* between April 2020 and January 2022, the PHAT received 7102 cultural support referrals and supported 3690 pre-Omicron COVID-19 cases (n=2980) and contacts (n=710) by linking them to local community services to support isolation and quarantine.
- *Increased COVID-19 vaccinations:* within 5 weeks of establishing the HNE Aboriginal Vaccination Steering Committee, 29 751 vaccines were administered to Aboriginal peoples across the HNE region.
- *Equitable employment strategy:* the model also increased and strengthened the Aboriginal public health

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workforce which during the Delta wave (July–December 2021) included 38 Aboriginal staff.

- *Strengthened collaboration with teams:* it established respectful relationships with non-Aboriginal people and leaders in a public health emergency and encouraged active and equal participation in the response, through principles of shared commitment, shared power, shared responsibility and shared decision-making.
- *Strengthened collaboration with communities:* strategic and respectful engagement processes with Aboriginal communities and stakeholders meant there was strong voice in the local response. This meant we were better able to support people with COVID-19 (or COVID-19 contacts), which helped reduce public health risk.

The model described above was effective because of the existing governance foundation within HNEPHU, previous pandemic planning exercises, support from the PHU controller and was adequately resourced with support of the HSFAC. Importantly, there were already Aboriginal public health leads employed with specific public health expertise including programme management, community engagement, cultural support, epidemiology and communications. These leads also had well-established internal and external partnerships with health staff and stakeholders. This work could not have been done with one staff member only.

Despite no longer being in ICS, the PHAT continues to provide strategic advice and guidance on key COVID-19 mitigation strategies and approaches for Aboriginal communities and has been recognised and shared nationally and internationally.

Although we have demonstrated many successes, we acknowledge that the model is not perfect and has its challenges. Public health systems and institutions were not historically developed to be inclusive of Aboriginal peoples. Standard public health emergency management response systems do not align with, nor know how to effectively embed, Aboriginal perspectives and knowledge as part of routine emergency response practice. Reframing a local ICS by embedding a PHAT in the HNE COVID-19 response and establishing cultural governance frameworks ensured Aboriginal representation and advocacy at all levels to inform public health practice. However, despite its strong collective voice, the governance was not always operationalised to its full potential. Institutional racism and white fragility challenges existed and were barriers to the response. With a new governance model introduced into a local ICS, there need to be clear ICS team functions and processes and communication and reporting pathways. Having clear and defined ICS governance and structure will hopefully reduce the risk of overburdening Aboriginal staff, and ensuring Aboriginal staff are included in all aspects of ICS functions and decision-making processes.

Information about COVID-19 and Aboriginal and Torres Strait Islander peoples was often published with a deficit and/or blaming lens. Through challenging this narrative, we found local and cultural intelligence to be a vital tool when managing an outbreak response in the interpretation and meaning of Aboriginal data and the connection with culture and kinship networks. Continued investment of Aboriginal epidemiological practices and principles such as these is necessary to understand and explore disease surveillance strategies.

Despite these challenges, HNEPHU continues to be committed to the principles of shared governance, mutually respectful and meaningful relationships with Aboriginal staff and stakeholders and promoting Aboriginal leadership. Future pandemic responses must meet the needs and priorities of communities served, which means local voices, representation and community perspectives are critical in planning for public health emergencies. Not only should future pandemic responses embed this way of working, this governance model and approaches should be part of business as usual.

Importantly, the fact that this initiative was locally developed and driven meant that some top-down responses that negatively impacted or were harmful to Aboriginal people and communities continued. Aboriginal public health leads had to balance the impact of harmful measures of public health policy and guidelines, and disease control containment strategies and interventions that often view Aboriginal communities as a risk and not a strength. Often emergency response philosophy is 'to do the best for the most' and apply whole-of-population infectious disease solutions and strategies to all population groups, which lead to worse health outcomes for marginalised and oppressed populations.[8,30] Extra efforts from PHAT leads to reduce public health risk were required to advocate for change at all levels to ensure Aboriginal perspectives were included, and targeted public health strategies and initiatives addressed local health needs. This highlights the importance of having Aboriginal leadership and voices, not just at local level, but across all aspects of a pandemic response.

Our experience in developing and implementing the governance model has been iterative. Aboriginal and non-Aboriginal leaders have had to take risks and foster a high-trust environment, where there is learning and unlearning, lots of reflection, adaptability and acceptance of change. First Nations responses can only be implemented optimally by First Nations peoples, within a strong governance structure.

CONCLUSION

Aboriginal and Torres Strait Islander peoples have long advocated for a voice and adequate representation and inclusion in policy decision-making.[31] The inclusion of cultural governance and Aboriginal perspectives into a local public health emergency management structure had not previously existed in New South Wales, Australia. Our experience showcases the importance of Aboriginal people leading and adapting local systems and processes,

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translating Aboriginal-determined priorities and actions into practice, and advancing Aboriginal leadership. Central to the success of this public health emergency governance model is the respectful shared leadership by Aboriginal and non-Aboriginal public health, open to being challenged, questioned and reminded to do better to foster a culturally inclusive pandemic response. For ICS governance to work, supportive non-Aboriginal staff are required to drive and champion culturally responsive pandemic management. This emergency management model should be replicated by other local public health services globally where there is investment and commitment to adequately resource the Aboriginal public health workforce and leadership to ensure a community-driven and culturally informed and appropriate response.

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