2nd STATEMENT FROM THE AUSTRALIAN FEDERATION OF MEDICAL WOMEN REGARDING COVID-19 PANDEMIC (SARS-CoV-2) WITH NEW ADVOCACY STATEMENTS

19 April 2020

Covering letter and Executive Summary

Covering letter:

The 1st AFMW COVID-19 Pandemic (SARS CoV-2) Statement, released on March 12th 2020 as the COVID-19 Pandemic was first announced, remains a very useful document, with most of its content still highly relevant.

The '1st Statement' was revised on 14, 19 and 22 March 2020 as the situation in Australia rapidly changed. We wish to add this 2nd Statement as an update. The renewed AFMW COVID-19 Advocacy Statements highlight concerns that have emerged as the greatest priority to our Medical Women at this time of the COVID-19 Pandemic Crisis.

We re-iterate that this is a constantly evolving situation which we will continue to monitor closely.

The attached Advocacy Statements reflect a consensus from a newly created AFMW Extended Executive Committee with broad representation at a high level within the Australian Medical Community and its governance in both public and private sectors.

Additional and more recent COVID-19 resources will be uploaded to the AFMW Website to support this 2nd Statement.

Executive Summary:

The advocacy issues covered here are as follows:

A. Protection of frontline medical staff, including both in clinical encounters and in workplaces,

B. Women's Health Priorities, and

C. The Welfare of Women in our Communities.

The Extended Executive Committee of the Australian Federation of Medical Women

A/Prof Deb Colville, President
Dr Lydia Pitcher, Vice-President
Dr Marjorie Cross OAM, Secretary
Dr Marissa Daniels, Treasurer
Dr Sharon Tivey, Immediate Past President
Dr Desiree Yap AM, Vice-President Medical Women's International Association (MWIA) Western-Pacific Region
Dr Magdalena Simonis, National Coordinator, Australia, MWIA

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As of 19 April 2020

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2020 04 19 2nd Statement, & Updated Additional Resources
2020 03 22 Updated 1st AFMW COVID-19 Statement, & Resources
2020 03 14 1st AFMW COVID-19 Statement, & Resources

AFMW COVID-19 Pandemic Advocacy Statements

A. PROTECTION OF FRONTLINE MEDICAL STAFF AND SUSTAINING WOMEN DOCTORS

Women comprise a predominance of our healthcare workforce. More than half of our medical workforce under the age of 35 is female.

Gender based professional and occupational health and safety considerations must be incorporated into decision-making processes regarding the protection of frontline medical staff.

1) Indigenous Doctors and Vulnerable Communities

We welcome the increased protection that has been mandated for Aboriginal and Torres Strait Islander people living in regional and remote communities, both medically and geographically.

We additionally recognise that Aboriginal and Torres Strait Islander peoples living in regional centres and urban areas also have particular needs, and that provisions need to be made to ensure responses and care do not perpetuate ongoing health disparities.

We believe this requires ongoing high priority, special consideration and support with input from key stakeholders, including the National Aboriginal Community Controlled Health Organisation (NACCHO), Australian Indigenous Doctors Association (AIDA), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Australian Indigenous Allied Health Association (AIHA), National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA), The Lowitja Institute, and others.

We understand that all these stakeholders have consultation and representation mechanisms in place, including with Aboriginal and Torres Strait Islander Elders who advise in health and wellbeing matters.

2) Protection of Clinicians in Clinical Encounters

Women comprise the majority of general practice specialists in Australia as well as of our younger medical workforce more generally. Women also have different consultation characteristics including longer consultation durations. Ensuring that our medical workforce can adequately assess their own personal risk and ensure they have the requirements to practice safely is paramount.

Approaches to the risk assessment and infection control of COVID-19 have necessarily initially focussed on management of suspected and confirmed cases of disease in community and hospital -based care. Accurate risk assessment by a health professional prior to consultation is often not possible in general practice so the risk of an undifferentiated presentation to a primary care physician leading to inadvertent COVID-19 exposure is an ongoing concern.

A transparent approach to assessing a practice's or medical practitioner's risk of inadvertent COVID-19 exposure during routine primary care would enable primary care physicians to communicate their needs for personal protective equipment more accurately and efficiently to their distribution networks and enable equitable provision of government supplies to primary care. This requires clearer co-ordination of public health surveillance with local Public Health Networks (PHN).

3) Protection of Clinicians within their Workplace

Whilst social distancing outside of the workplace is increasingly protecting Australians from COVID-19 infections, recent data indicates that a large proportion healthcare workforce become infected, with high mortality, with COVID-19. It is unclear whether this is due to COVID-19 patient care or an inability to socially distance in the workplace in contrast to the home environment.

All efforts should be made to ensure social distancing efforts are enforced in the workplace when COVID-19 outbreaks are a risk.

We recognise Personal Protective Equipment (PPE) as an element within a system of protection. Such protection is used in a rational way according to the specific characteristics of the pathogen being addressed.

Females are more likely to be employees and so ensuring that employers enforce this is paramount to the continued health of women in their workplaces. The equitable provision of infection prevention expertise and equipment across the health sectors and other essential services is important as well as recognising gender-based differences in PPE fit (as noted with face shields).

Females are disproportionately represented in primary care where most clinical encounters occur, but provision of personal protective equipment seems disproportionately supplied to hospitals and other male-dominated essential services, such as police and paramedics. A transparent approach to procurement, supply and distribution chains of national stockpiles is essential.

We recommend written, and/or Intranet provision of information to all staff (public and private) regarding adequacy of supply at a local (facility based) and State-wide level.

A pre-existing problem of lack of sufficient remuneration for preventive care through liaison of infectious disease and public health experts, with clinicians, has been laid bare during this pandemic. We recommend that the reimbursement structure for input from infectious disease and public health into front line health care be examined in the light of lack of sufficient proximity of vital information that is locally relevant to front line health care practitioners for their own safety, and that of patients.

Extra training and advice are required to safeguard women doctors who are at risk with increased the implementation of Telehealth consultations. Issues of privacy, consent, information security, and potential for abuse, such as stalking and trolling specifically, require greater attention (see also "Telehealth" below)

4) Transparent Communication of Epidemiological Data and Testing

Contagion control works best when Infectious disease experts, public health experts, and infection control experts work together. Clinically applied public health strategies are required in the COVID-19 era.

Jurisdictional communication about PPE availability appears to be lacking. We advocate more detailed testing and epidemiological information to accurately determine the community prevalence, clusters and spread of COVID-19 infections, associated morbidity and mortality to better gauge the need for the requirements for PPE and ongoing social distancing measures. Proximity of information to clinicians through good communication channels is key. Information may be on public websites but is siloed, making it inaccessible to front-line clinicians in a timely manner. Clinicians deserve to feel that they have access to individualised geographic data sufficient for clinical judgment in their locality and setting, and for their own self-care and protection.

The proposed national mobile phone 'coronavirus contact-tracing app' may partially address these concerns but will require close monitoring for efficacy and privacy issues.

Additionally, the toll of COVID-19 deaths in the elderly (particularly in nursing homes) otherwise deemed to be due to "natural causes", need to be captured and publically reported.

The role of faeco-oral spread, with prolonged live viral shedding in the faeces, even after negative nasal swabs and the importance of toilet hygiene in public and shared workplaces must be more extensively considered, communicated and investigated.

5) Billing

Medical billing requires greater consistency and clarity, with better input from key stakeholders.

Financial security is required for General Practices and other private practices who have been adversely impacted by forced bulk billing, to alleviate the significant additional stress in the context of increased workloads, concerns about vulnerable patients and the supply of PPE, and disconnect from peers. Medical billing from Telehealth consultation in the COVID-19 environment should reflect the time and complexity of consultations.

6) Telehealth

Solutions for communication with the very vulnerable who have limited access to digital technology (lower income patients, the very elderly, vulnerable populations, including people with compromised immunity, and Aboriginal and Torres Strait Islander people) require greater consideration (refer also to privacy issues above in "Protection in the Workplace")

7) Medical Women Work Force and Training Issues

The impact of COVID infection, work requirements, and training delay for our younger medical women in the context of pregnancy, planning pregnancy and fertility requires special attention.

Care is required with the redeployment of junior medical staff and students during the pandemic, to protect their well-being and limit their physical, emotional and educational risks whilst balancing their professional progression, need consideration. Flexible training needs to be prioritised as a matter of urgency.

B. WOMEN'S HEALTH PRIORITIES

Health impacts on women due to the pandemic need to be anticipated with funding for public education and extra support services before during and after this pandemic crisis, to address this equitably.

We refer to the United Nations Women Policy Brief regarding the Impact of COVID-19 on Women (released 9 April 2020):

'The year 2020, marking the twenty-fifth anniversary of the Beijing Platform for Action, was intended to be ground-breaking for gender equality. Instead, with the spread of the COVID-19 pandemic even the limited gains made in the past decades are at risk of being rolled back. The pandemic is deepening pre-existing inequalities, exposing vulnerabilities in social, political and economic systems which are in turn amplifying the impacts of the 'pandemic''.

1) Pregnancy, Obstetric and Neonatal Care

Surveillance is required to identify any adverse trends due to the impact of both COVID infection and social distancing measures on pregnancy, antenatal care, neonatal infection including COVID infection, the incidence and outcomes of home births, breast feeding, unassisted births, and neonatal care.

2) Sexual and Reproductive Health

These clinics are essential services and require adequate funding and supply of PPE and staff throughout the pandemic, and during emergence.

3) Women's Malignancies

Adverse outcomes for breast and gynaecological cancers due to (temporary) closure of screening facilities and reduced access to surgical and medical consultations and therapies need to be audited.

Preventative strategies are welcomed with comprehensive and detailed modelling that identifies possible primary and secondary peaks after the pandemic.

4) Mental Health

We applaud initiatives to reduce the mental health impacts of the pandemic crisis. Women as care givers are particularly at risk during this time. There is a known increased risk of suicide in female doctors and medical students that requires recognition and resources.

C. WELFARE OF WOMEN IN THE COMMUNITY

Regarding women in the community at large, we again refer to the United Nations Women Policy Brief regarding the Impact of COVID-19 on Women (released 9 April 2020 –see above reference in Section B. Women's Health Priorities).

We recognise that attention is needed in identifying and addressing a multitude of complex social inequities, pre-existing, and emerging, in health and health care, during societal recovery from the pandemic.

Women predominate in the community as carers and teachers in the vital role of emphasising basic hygiene, such as 'soap and water' as a key anti-contagion strategy, as well as universal precautions.

1) Intimate Partner Violence

Social impacts of the pandemic including domestic violence need to be recognised with appropriate pre-emptive action as well as funding to minimise effects.

We welcome the extra funding to address the already documented increase in Domestic Violence/ Abuse in Australia during the COVID-19 pandemic. We look forward to advising on strategies.

Specifically, we recommend adoption of strategies outlined in the UN Women Policy Brief Document that include, over and above funding support for existing services, additional effective community alerts through social media, and the provision of easily identifiable emergency safe housing for victims.

2) Addressing the Care Economy, Paid and Unpaid Work

We welcome the Federal Government's support of paid childcare. Financial support for otherwise unpaid work such as childcare should be continued beyond the pandemic.

We would like to highlight some of the creative changes that we would hope to see remain If childcare can be provided free of charge now, and long term. The care of elderly and disabled at home could readily be better incentivised in the longer term.

Acknowledgement

We gratefully acknowledge the input and feed-back from our AFMW members, as well as key representatives from Indigenous Engagement, Public Policy and Infectious Diseases.

REFERENCES: Updated and Recent Resources – see AFMW Website – COVID-19 Section

1st AFMW COVID-19 STATEMENT, 14 March 2020

https://afmw.org.au/afmw-work/statements/covid-19-pandemic-sars-cov-2-afmw-statement/