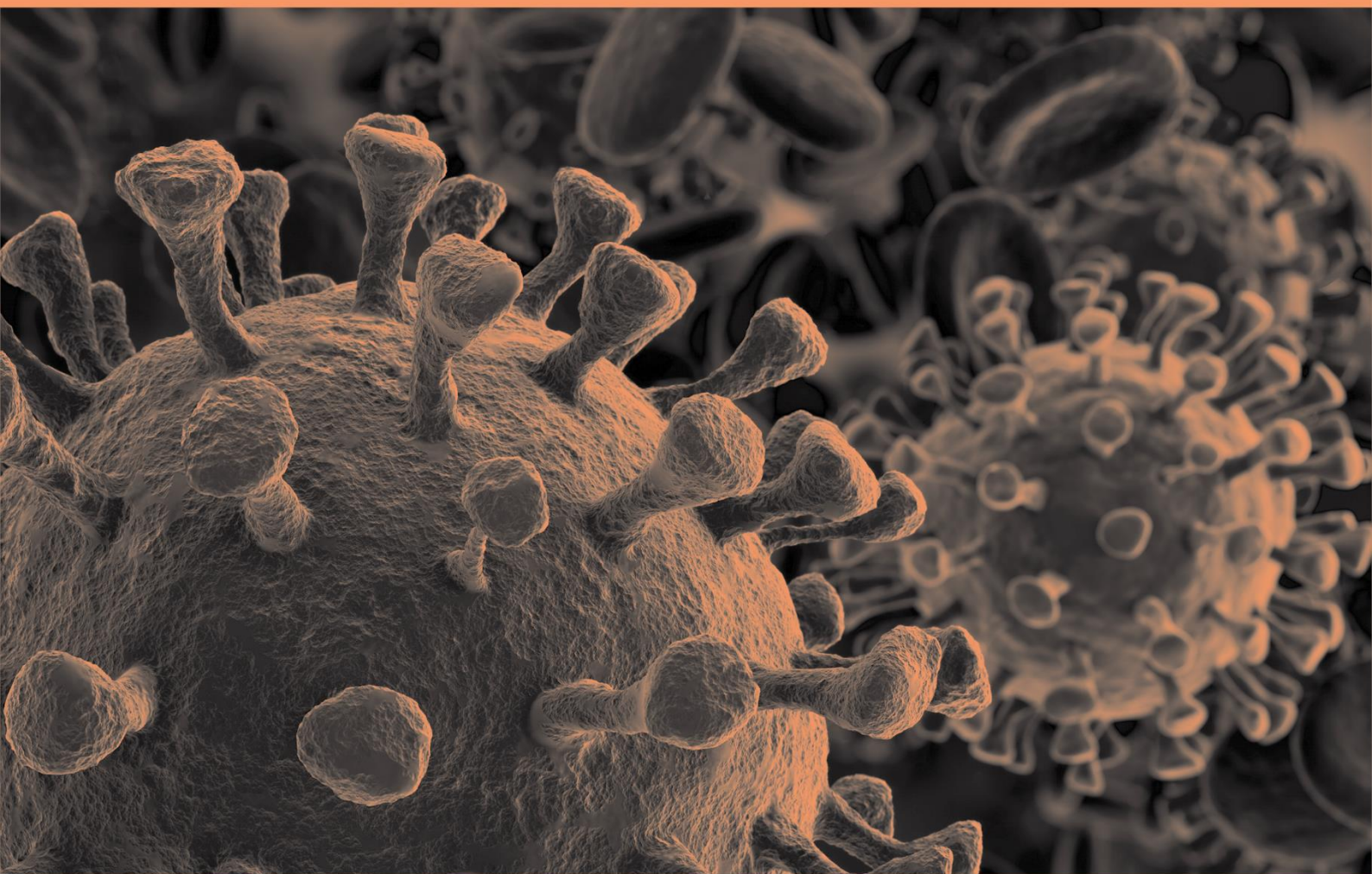




Australian Government

Department of Health



AUSTRALIAN HEALTH SECTOR EMERGENCY RESPONSE PLAN FOR NOVEL CORONAVIRUS (COVID-19)

Management Plan for Aboriginal and Torres Strait Islander populations
Operational Plan for Aboriginal and Torres Strait Islander populations

July 2020

‘Let’s Walk and Talk out Bush’

Walking and talking to family while doing physical exercise is deadly for the emotional wellbeing of First Nation peoples.

Going out bush walking with mob can benefit communities socially, culturally and does wonders for your mental health.

The two coolamons show abundance of bushtucker picked while out bush.

The two boomerangs represents our Past and our Future.

The six U symbols at the bottom represents male and female leadership in our past, in our present, and our emerging health leaders

Women’s business and Men’s business is vital to our health - engaging in these ground in communities have health and cultural benefits.

Being active shows our children that it’s good to be outdoors learning culture and showing Yindyamarra (Respect) to Elders and ancestors while out bush

Luke Penrith

Proud Aboriginal man from Brungle, my great grandmothers Country

Connected culturally to the Wiradjuri, Wotjoboluk, Yuin and Gumbaynggirr Aboriginal Nations

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Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)

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PART 1

Overview of approach to COVID-19 as it relates to Aboriginal and Torres Strait Islander peoples and communities

Introduction

This *Management Plan for Aboriginal and Torres Strait Islander Populations* (the Management Plan) has been developed by the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 and endorsed by the Australian Health Protection Principal Committee (AHPPC).

It is expected that the Management Plan will be a living document that will be periodically updated to support and meet the objectives of the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* (the Health Sector Plan).

The Management Plan acknowledges that states and territories and Primary Health Networks are also implementing and adapting their own responses as the situation evolves and these are not explicitly addressed in the Management Plan but are referred to in the Resources section.

Aboriginal and Torres Strait Islander peoples are at a higher risk from morbidity and mortality during a pandemic and for more rapid spread of disease, particularly within discrete communities. Pandemic preparedness requires engaging and working with Aboriginal and Torres Strait Islander peoples and communities to develop culturally appropriate and safe risk reduction and pandemic strategies. The Management Plan outlines the key issues and consideration in planning, response and management for COVID-19 that need to be addressed at all levels of governance, in collaboration with key partners and stakeholders, including with the impacted communities themselves.

The Management Plan contains two parts as follows:

Part One: Overview outlines the guiding principles, context, key issues and targeted action for planning, response and management for COVID-19 that need to underpin all engagement with Aboriginal and Torres Strait Islander peoples.

Part One is particularly relevant for organisations that do not have an ordinarily regular or large client population of Aboriginal and Torres Strait Islander peoples.

Part Two: Operational Plan is directed at health care professionals working with Aboriginal and Torres Strait Islander communities and peoples to support the development and implementation of local operational plans. Other local /jurisdictional guidance documents should also be considered.

Part Two contains four phases for planning responses to COVID-19. These four phases generally align with stages outlined in the Health Sector Plan:

Phase 1 is an “Initial action stages”,

Phases 2 and 3 are “Targeted action stage” and

Phase 4 outlines a “Stand down stage”.

Initial Action Stage

- Phase 1: **Preparedness** - What communities and health services can do to mitigate risk and prevent cases occurring still at a stage when no cases have been identified locally or in an Aboriginal and/or Torres Strait Islander community.

Targeted Action Stage

- Phase 2: **Suspected cases or initial cases detected** - What communities and health services can do when suspected cases or an initial case/s are detected in an Aboriginal and/or Torres Strait Islander community.
- Phase 3: **Outbreak situations** - What communities and health services can do when an outbreak is declared of COVID-19 in an Aboriginal and/or Torres Strait Islander community (multiple cases of sustained community transmission).

Stand Down Stage

- Phase 4: **Stand down and evaluation** - What communities and health services can do when the outbreak is controlled.
- Transition of the Management Plan to a National Aboriginal and Torres Strait Islander Pandemic / Communicable Disease Response Plan.
- Evaluation of effectiveness of response and lessons learnt.

The **Management Plan** adopts COVID-19 responses already underway in Australia, but with specific operational guidance and tailoring relevant for Aboriginal and Torres Strait Islander communities and how the health sector can best respond in an effective and culturally and appropriate safe way.

The management plan is developed to enable communities to adopt strategies at any phase outlined above that is relevant to the local context.

Objective

The Objective of the Management Plan is to adapt the Health Sector Plan for Aboriginal and Torres Strait Islander communities. This Plan focuses on clinical and public health actions and responses as well as having a broader emphasis on effective communication and the social determinants pertinent to Aboriginal and Torres Strait Islander communities.

The Management Plan will specifically assist to:

- inform, engage and empower Aboriginal and Torres Strait Islander peoples in COVID-19 responses; specifically Preparedness, Targeted action and Stand down phases;

- support the development, implementation and evaluation of local Action Plans in Aboriginal and Torres Strait Islander communities;
- minimise transmissibility, morbidity and mortality in Aboriginal and Torres Strait Islander populations; and
- Support health systems, especially Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHS) to respond to the outbreak and to continue to provide other health services to Aboriginal and Torres Strait Islander people.

Principles

The strength of Aboriginal and Torres Strait peoples are in connection to culture, country, family and community. The following principles have been adopted in the development of the Management Plan and should inform Local Action Plans in communities.

1. Shared decision-making between Governments and Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples must be involved in assessing COVID-19 risk and responses in Aboriginal and Torres Strait Islander communities. Responses must be centred on Aboriginal and Torres Strait Islander peoples' perspectives, ways of living and culture, developed and implemented with culture as a core underlying positive determinant.

Clinical and public health responses to COVID-19 outbreaks in Aboriginal and Torres Strait Islander communities should be collaborative, but responses must ensure local community leaders and communities are central to the response.

These responses should be co-developed and co-designed with Aboriginal and Torres Strait Islander peoples, enabling full contribution and participation in shared decision-making. Further, Aboriginal and Torres Strait Islander cultural governance groups, initiated and led by Aboriginal and Torres Strait Islander peoples, can bring advice and guidance on culturally-specific responses including communication strategies.

2. Community Control

The Aboriginal and Torres Strait Islander Community Controlled Health Sector (ACCHS) is supported and resourced to deliver services and programs. ACCHS and local health clinics are able to understand and support individual and community needs, responsive to priorities determined by the community. A long term and flexible funding model for ACCHS allows Aboriginal and Torres Strait Islander people access to effective high quality, comprehensive, culturally appropriate, primary health care services in urban, regional, rural and remote locations across Australia. This has been demonstrated through the sector's engagement and leadership in responding to the planning and implementation of COVID-19 measures to date.

3. Cultural safety across the whole-of-population system

Ensuring that all Aboriginal and Torres Strait Islander peoples have access to the care they need when they need it. This requires that all government agencies and institutions provide appropriately informed, culturally safe care, consistent with the Australian Health Ministers' Advisory Council (AHMAC)-endorsed *Cultural Respect Framework 2016-2026*, and that responses are proportionate to the circumstances impacting Aboriginal and Torres Strait Islander peoples and their communities. Equity should be an underlying determinant of health care delivery during this pandemic. Failure to implement an equitable response commensurate with the situation will result in significantly poorer outcomes for Aboriginal and Torres Strait Islander peoples.

4. Data and evidence

Responses developed and implemented during this pandemic should be based on the best possible evidence and data inclusive of Aboriginal and Torres Strait Islander knowledge.

5. Human rights

Any approach to addressing COVID-19 in Aboriginal communities must be based upon the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples*¹.

International human rights standards require governments to guarantee the right to the highest attainable standard of health for all citizens, and obligates them to take steps to address serious public health threats, recognising that this may require restrictions on some individual rights. Such restrictions must be non-discriminatory, strictly necessary, time-limited, evidence-based, and proportionate to the risk (that is, using the least restrictive measures necessary to protect the community)².

¹ United Nations. *United Nations Declaration on the Rights of Indigenous Peoples*. 2007; Available from: <http://www.un.org/esa/socdev/unpfii/en/drip.html>

² Human Rights Watch. *Human Rights Dimensions of COVID-19 Response*. 2020 [13 May 2020]; Available from: <https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response>

Rationale for the Management Plan

Aboriginal and Torres Strait Islander peoples are central to assessing and responding to COVID-19 risk in their communities. This is to ensure responses are embedded within cultural frameworks and settings unique to their own communities. Some specific considerations for preparedness and response planning are:

1. *Mobility patterns:*

Aboriginal and Torres Strait Islander peoples may travel frequently between cities, towns and communities. This travel is often associated with obligations tied to family and cultural connections, as well as for attendance at community events. Travel can occur, quickly, often and can involve long distances. Close contact with people in communities, outside one's normal community residence may occur for extended periods (for example attending cultural ceremony or sorry business).

2. *Some communities have high flows of visitors:*

Some Aboriginal and Torres Strait Islander communities have a high flow of visitors, potentially exposing residents to COVID-19. This is particularly relevant if visitors to communities: are presymptomatic or asymptomatic at time of visit; have travelled to community from a COVID-19 hotspot; have not self-isolated prior to visiting nor been tested for COVID-19. Examples include tourist areas, visiting health clinic staff, other personnel visiting communities (e.g. tradespeople), fly-in fly-out (FIFO)³ workers attending sites close to community, and Aboriginal and Torres Strait Islander FIFO workers returning off-shift to their own community.

3. *An existing primary health care infrastructure to implement this plan exists:*

The strength and leadership of the Aboriginal and Torres Strait Islander community controlled health sector means that locally-led holistic, comprehensive, and culturally appropriate and safe primary health care can be delivered to communities.

4. *Access to health care is less than optimal:*

However, Aboriginal and Torres Strait Islander peoples still experience reduced access to acute and primary health care and other health services due to location, including lack of workforce, lack of available transport and differing health care literacy. This may inhibit COVID-19 presentations and unwell people may present late in disease progression. This occurs because of concern about racism; feelings of shame; fear of being evacuated away from loved ones and family as well as mistrust of mainstream health services.

There can also be tensions relating to the traditional public health measures, which use a command and control structure and, on some occasions, require rapid decisive action. In addition, there are few Aboriginal and Torres Strait Islander peoples working at high levels in health bureaucracies, which means that public health measures do not always consider culture, ways of living and cultural appropriateness and safety considerations.

³ FIFO is considered to cover both fly-in fly-out as well as drive in drive out workers.

5. *High burden of chronic disease:*

Aboriginal and Torres Strait Islander peoples experience a high burden of chronic disease and are therefore more susceptible to severe outcomes arising from COVID-19. In addition, older Aboriginal and Torres Strait Islander peoples (over 50) with one or more chronic disease and children who have experienced reduced quality of nutrition may also present as immunocompromised. The Health Sector Plan recognises Aboriginal and Torres Strait Islander peoples as a priority group, reflecting many of the challenges outlined throughout this Management Plan.

6. *Workforce issues:*

Many communities rely either on a workforce that is in short supply, locum supplied, or with a high turnover. ACCHS and other remote clinics are usually at full capacity and are often reliant on locum staff under normal circumstances.

7. *Tertiary care systems inability to cope with large outbreaks:*

An uncontrolled outbreak in a community where very high levels of comorbidities are present would significantly test the jurisdictional tertiary care system with significant number of residents requiring hospitalisation. In many cases aeromedical retrieval would be required to isolate and quarantine potential or diagnosed people.

8. *The social determinants of health: Housing*

Many communities experience shortages of housing, often with poor health hardware and housing infrastructure. This results in many people living under one roof, in close proximity and with little space for isolation or quarantine. Additionally, Aboriginal and Torres Strait Islander populations experience higher rates of primary homelessness (sleeping rough or in improvised dwellings or shelters) than non-Indigenous populations. Interpersonal issues (such as domestic and family violence) and under-resourcing of housing infrastructure and maintenance can be key reasons for homelessness. Additionally restricted access to hygiene aids (such as soaps) and other sanitation supplies may facilitate disease transmission, particularly from unidentified cases.

Nationally, Aboriginal and Torres Strait Islander people are over-represented in the homeless population. On Census night in 2016, 1 in 28 Aboriginal and Torres Strait Islander people were homeless (an estimated total of 23,437 across Australia), about ten times the rate for non-Indigenous people⁴.

The Northern Territory contributes disproportionately to these figures. The jurisdiction has by far the highest rate of Aboriginal and Torres Strait Islander homelessness in Australia and over half (12,131 or 52%) of the national number of homeless Aboriginal and Torres Strait Islander people live in the Northern Territory. More than 1 in 5 Aboriginal Territorians were homeless in 2016, 25 times the rate for non-Indigenous people.

⁴ Australian Bureau of Statistics (ABS). 2049.0 - *Census of Population and Housing: Estimating homelessness, 2016*. 2018; Available from: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/2049.0Main+Features12016?OpenDocument>.

The Australian Bureau of Statistics' definition of homelessness comprises six categories and includes those people living in severely overcrowded dwellings, defined as one that needs four or more extra bedrooms to accommodate the people who usually live there⁵. In 2016, almost 9 out of 10 (88% or over 10,700) homeless Aboriginal and Torres Strait Islander people in the Northern Territory fell into this category, with a further 800 (7%) living in improvised dwelling, tents, or sleeping out. It is not hard to appreciate that homelessness needs to be addressed to prevent pandemics like COVID-19 disproportionately affecting Aboriginal people.

As with all populations that experience disadvantage, there may be additional challenges around healthcare literacy in Aboriginal and Torres Strait Islander communities, which impacts community understanding of, and compliance with, isolation and precaution measures.

High rates of poverty limit capacity of families and communities to adapt to rapidly changing emergencies. There is also a reduced ability to tolerate the financial impact of loss of work in the event of isolation. Low levels of income will also impact people's ability to purchase food, medicines and other hygiene products such as tissues and cleaning products, especially in the event of lockdowns or where pre-purchasing is required. This increases susceptibility to COVID-19 due to the potential for inadequate nutrition, compromised hygiene, or non-compliance with isolation requirements.

Populations and settings for special consideration

Aboriginal and Torres Strait Islander peoples live in a variety of settings across Australia, including urban, regional, remote and very remote locations. In addition, special considerations are needed for Aboriginal and Torres Strait Islander peoples living in hostels; detention centres; aged care and other residential facilities; town camps; and homeless populations.

Aboriginal and Torres Strait Islander leadership has the best ability to provide advice on responses for each of these groups most easily accessed through the Coalition of Peak Aboriginal organisations. People and groups at the intersection of these populations and settings may need specific attention and strategies during the pandemic, as risk of acquiring COVID-19 and risk of severe disease may be compounded.

⁵ Australian Institute of Health and Welfare, *Homelessness among Indigenous Australians*, in *Cat. no. IHW 133*. 2014, AIHW: Canberra.

Each setting and each community has its own unique circumstances and responses will need to be tailored to those circumstances. Mathematical modelling which takes into account considerations specific to remote communities and regional centres will also help inform recommendations for response measures in these population settings. Information to assist public health professionals to adapt and apply this modelling is currently under development and will be available soon. Specific guidance documents developed by Communicable Diseases Network Australia (CDNA) and/or AHPPC regarding aged care settings, people with disabilities, prisons and detention centres and homelessness services should be read in conjunction with the Management Plan.

Aboriginal and Torres Strait Islander peoples with a disability may face a number of additional barriers in accessing health care and services during the COVID-19 pandemic. *The [Management and Operational Plan for People with Disability](#)* provides direction and guidance for people with a disability (including Aboriginal and Torres Strait Islander peoples) to ensure equitable access to health care during the outbreak. It is important to note that there may be a different cultural mindset such that people may not associate themselves as having a disability or impairment, but rather may associate with language such as “not working well”, as an example. Therefore, it is important for health services and providers to engage and consider disability and people with disability within their planning and response. Health services could consider training to upskill engagement and diagnosis during this time.

By any measure, Aboriginal and Torres Strait Islander people with disabilities are some of the most disadvantaged of all Australians. This is because they often face discrimination based upon their disability and/or Indigeneity. Therefore, it is critical that any health response that seeks to address the needs of Aboriginal and Torres Strait Islander peoples with disabilities recognise the intersectional nature of this discrimination. In practical terms, this means that Aboriginal and Torres Strait Islander people with disability must be included in both disability and Aboriginal and Torres Strait Islander programmatic responses and policies. A further key consideration is the fact that many Aboriginal and Torres Strait Islander people with disability and their families live in poverty and their access to basic and critical health supports is often compromised as a result.

Meeting the needs of Aboriginal and Torres Strait Islander people with disability is one of the most urgent and critical social justice issues in Australia today and as a result, their needs must be prioritised to ensure their health and safety.

Refer to [Appendix A](#) for further detail.

Roles and Responsibilities

The roles and responsibilities of the many critical partners, including the Australian, state and territory governments, the National Aboriginal Community Controlled Health Organisation (NACCHO), the Community Controlled health sector and Primary Health Networks (PHNs) support efficient, coordinated use of resources that will benefit Aboriginal and Torres Strait Islander communities and give consideration to targeted actions of the response, which are operationalised throughout Part 2.

1. Planning

The **Australian Government Department of Health** will undertake a range of specific planning measures relevant to Aboriginal and Torres Strait Islander communities, including:

- implementation of the Management Plan, in partnership with states, territories, ACCHSs and other key stakeholders, and provision of secretariat support to the Aboriginal and Torres Strait Islander COVID-19 Advisory Group (see below);
- coordinating and communicating with jurisdictions who are undertaking most of the day-to-day public health and pandemic planning activities;
- preparation and dissemination of national guidelines and procedures to support the Management Plan, including: case definitions; pathology testing; use of personal protective equipment (PPE); travel protocols for visitors to remote communities, in consultation with jurisdictions and communities; and advice for health care workers. These will be available on the Department of Health website;
- increasing the capacity of the National Medical Stockpile in deploying PPE, as priority is identified;
- supporting a national communications plan to promote awareness and prevent the spread of COVID-19 specific to Aboriginal and Torres Strait Islander populations; and
- **ACCHS and other local health services in remote and very remote locations will be supported by the Australian Government to facilitate whole of community preparedness activities.**

State and territory governments will develop and implement consistent and comprehensive operational plans for public health and clinical responses, and will lead the mainstream health service response within their jurisdictions, in partnership and consultation with local stakeholders from the ACCHS sector. States and territories are also responsible for surveillance, communication of new cases and outbreaks and for providing alerts to communities. **State Public Health Authorities also manage outbreaks in their own jurisdiction including those involving Aboriginal communities.**

Primary Health Networks (PHNs) will distribute PPE from the National Medical Stockpile, including a limited supply of surgical masks and P2/N95 respirators for general practices (including ACCHS), and community pharmacies with a demonstrated need distributing supplies when available. They will also coordinate the rollout of GP Respiratory Clinics across their regions.

NACCHO and jurisdictional Sector Support Organisations support the Aboriginal Community Controlled Health Sector with public health and clinical issues and with policy and advocacy support. ACCHS will develop individual response plans based on the Management Plan and jurisdictional plans, tailored to their settings.

Clinicians and public health professionals and practitioners should have real, meaningful and respectful engagement with Aboriginal and Torres Strait Islander peoples in planning processes.

Aboriginal Health Practitioners, Aboriginal Health Workers, and Aboriginal and Torres Strait Islander health professionals working in the areas of public health and Aboriginal Health will be essential to ensure engagement of community at all levels and in any response

2. Ongoing assessment of the epidemiology of COVID-19 specific to Aboriginal and Torres Strait Islander communities

The **Australian Government** works with state and territory public health units and the Communicable Diseases Network of Australia (CDNA) to review data and evidence about the spread of COVID-19 especially for the purposes of the Management Plan among Aboriginal and Torres Strait Islander peoples and in communities.

This information will be reported at the earliest time possible, preferably in real-time, to enable adequate resourcing and responses to be implemented to prevent further spread of the virus. Detailed information about the number and location of cases in Aboriginal and Torres Strait Islander peoples should be shared as widely as possible to guide local planning and response.

State and territory governments will collect notification data in their own jurisdictions, including evidence from the sector of what responses are required in communities, which also contributes to understanding the spread of the disease across the country and inform their own jurisdictional public health response activities. Once cases are detected among Aboriginal and Torres Strait Islander peoples, states and territories will implement responses as appropriate with guidance from the Management Plan, in collaboration with Aboriginal and Torres Strait Islander people.

NACCHO and the Aboriginal and Torres Strait Islander Community Controlled Sector Support Organisations, in partnership with the Australian Government Department of Health, will play a key role in collecting information from the sector, regarding suspected cases, risks for communities and any emerging issues. This will assist in national characterisation of COVID-19. In addition, ACCHS will provide data on their needs around preparedness, staffing requirements, other clinical assistance and PPE throughout the pandemic. Reflection of Aboriginal and Torres Strait Islander peoples' values and voice in data collection, analysis, use and reporting processes are important to achieve positive health outcomes. All information and data collected and accessed will be de-identified.

3. Provision of Clinical Services

ACCHS staff, mainstream health care providers, remote community clinic staff, Aboriginal and Torres Strait Islander peoples and others working with Aboriginal and Torres Strait Islander peoples in identified risk settings will be able to access a range of available national resources required for clinical care for COVID-19.

A number of Australian Government funded activities will specifically benefit Aboriginal and Torres Strait Islander communities, including:

- [Expanded telehealth items.](#)
- Progressive establishment of at over 100 respiratory health clinics across Australia to provide dedicated services to people with mild to moderate respiratory symptoms. ACCHS are eligible to become GP Respiratory Clinics.
- Additional support for remote communities including:
 - funding to support ACCHS and other local health services in remote and very remote locations to facilitate whole-of-community preparedness activities;
 - funding for medical evacuations of cases of people with COVID-19, being a select form of aeromedical or road transport, including low-acuity and early evacuation cases where this is the best public health option; and
 - funding for deployment of mobile respiratory clinics during outbreaks to ensure supplementary health services.
- Support for the primary health care workforce including through the Remote Area Health Corps (in the Northern Territory); and nationally through the *Remote Health Workforce Surge Capacity Program*.
- Consideration of options for pathology testing support, including point of care testing, in consultation with jurisdictions in regional and remote communities to assist with mitigating delays in testing for COVID-19.
- Providing input into modelling of how an outbreak in an Aboriginal community would respond to various public health strategies to control it.
- Provide advice on the best strategy to contain an outbreak based on modelling, and local, national and international experience of outbreak control.

Clinical service preparation and provision could be further supported by:

- establishing cohorts of surge health care teams (medical, nursing and potentially allied health) prepositioned in regional centres to be on standby to assist remote communities in the case of an outbreak (or identified community transmission) or illness among current health care staff.
- Developing isolation / quarantine guidelines to assist communities, both remote and urban, to ensure infrastructure and support mechanisms are in place to meet quarantine requirements. These guidelines would identify the minimum conditions for safe quarantine, however individual community situations and requirements will need to be taken into consideration by public health units, in collaboration with Aboriginal and Torres Strait Islander people. Importantly they will help communities to understand why these activities are needed.

ACCHS should work with their local Public Health Unit (PHU) in responding to the pandemic and should have regular communication channels established. Sector Support Organisations will support communication from the local PHU, PHN and the Australian, State and Territory Governments.

ACCHS and other remote community clinics and settings identified as high risk will need to consider a range of measures in the provision of clinical services to Aboriginal and Torres Strait Islander peoples and communities, including:

- determination of the cause of respiratory disease outbreaks and ensuring that appropriate diagnostic tests are performed as quickly as possible in all Aboriginal and Torres Strait Islander communities;
- collaboration with community leaders in determining culturally appropriate and effective clinical and public health responses to suspected or confirmed COVID-19 outbreaks;
- identification of community members at higher risk and collaborative identification of appropriate responses, including early presentation if they become ill, isolation or relocation outside of remote communities during an outbreak. Crowded housing in all locations means housing facilities suitable for isolation will need to be provided in metropolitan, regional, rural and remote locations;
- consideration of flexible health service delivery and healthcare models (e.g. pandemic assessment centres, access to antiviral medication/vaccination, flexible ACCHSs clinic hours/location, and consider home visits);
- support for the health care workforce, including training of staff in all aspects of managing COVID-19, and consideration of flexible workforce strategies;
- maintaining essential services including health care (non-respiratory), chronic disease programs and maternal and child health services; and
- consideration for the safe management of home and supported renal dialysis patients.

Further detail on measures are outlined further in the Operational Plan at Part 2.

4. Implementation of public health measures

To reduce the concurrent burden of influenza on communities and the confusion regarding diagnosis/causes of outbreaks, influenza vaccination should be strongly promoted by Governments, ACCHS and other health care settings serving Aboriginal and Torres Strait Islander peoples. The Australian Government, through the National Immunisation Program (NIP) will provide free seasonal influenza vaccines from mid-April 2020 to those most at risk of complications from influenza, including all Aboriginal and Torres Strait Islander people aged 6 months and over.

ACCHS will work with state and territory health departments to ensure expeditious and equitable supply of influenza vaccinations including to very remote communities. Any concerns about delays in provision of influenza vaccination should be rapidly escalated.

In addition, the pneumococcal vaccination is available through the NIP to Aboriginal people aged 50 and older, people at higher risk of pneumococcal disease aged 15-49 and a pneumococcal booster is available to children aged six months in Queensland, NT, WA and SA.

ACCHS and other health care settings providing care to Aboriginal and Torres Strait Islander peoples should implement public health measures to minimise the spread of COVID-19, including:

- preventive health advice directed at minimising droplet spread of the virus. This includes messaging around keeping hands clean, hand washing, cough and sneeze etiquette and physical distancing. Health services should work with communities to develop culturally appropriate methods of disseminating this advice; and
- training the workforce in areas including:
 - infection control practices;
 - contact tracing;
 - personal protective equipment; and
 - data management.
- training information can be found at the Australian Government Department of Health's online COVID-19 training at <https://covid-19training.gov.au/>.

Should control measures, such as isolation and / or quarantine, be required in communities, mitigation strategies and decisions should be implemented in collaboration with Aboriginal and Torres Strait Islander individuals, families and organisations. Key messages for reducing risk at home and for family gatherings are in **Appendix B**.

5. Workforce

The workforce particularly in rural and remote regions has a high degree of turnover and unfilled vacancies. A proportion of the current workforce will have comorbidities or be in an age bracket that puts them into a higher risk category for acquiring COVID and may need to be away from front line duties in the event of an outbreak. This will be particularly true for an Aboriginal and Torres Strait Islander workforce. There is a very limited capacity at a local level to provide a surge workforce that will be required to combat an outbreak. Modelling has determined that a large surge workforce would be required to contain an outbreak in a contained Aboriginal community with overcrowded housing.

The Australian Government will:

- 1) Fund a *Remote Health Workforce Surge Capacity Program*;
- 2) Work with the States to ensure a surge workforce is available quickly in the event of an outbreak drawing on resources such as the National Trauma Centre, Australian Medical Assistance Teams (AUSMAT) and the Australian Defence Force (ADF); and
- 3) Work with jurisdictions with large remote populations to ensure that a bank of staff are available who have undertaken emergency outbreak management training.

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 will advise on strategies to ensure a surge workforce is available and has appropriate training.

6. Outbreak response strategies

The Australian Government is working with expert infectious disease modellers to test outbreak containment strategies for discrete Aboriginal communities. These models show that without very assertive action, outbreaks are likely to be long lasting and severe. The Commonwealth will provide the modelling to jurisdictions and NACCHO to inform outbreak planning and with the support of the Advisory Group, provide advice on a consistent outbreak strategy that is most likely to contain an outbreak in a discrete Aboriginal community.

7. Researching, planning and building specific novel COVID-19 outbreak control strategies

The Australian Government will commission research on the effectiveness and impact of public health measures. National, state and territory governments will use this information to inform their plans.

NACCHO and the ACCHS will provide advice on the feasibility and impact of COVID-19 outbreak control measures on Aboriginal and Torres Strait Islander communities and support dissemination and advice on the measures.

All parties should make available the latest medical science in real time to inform the response.

8. Coordination

The Australian Government will coordinate national COVID-19 outbreak measures and allocate available national health resources across the country. It will support the health response in any jurisdiction, through AHPPC to coordinate assistance, if jurisdictional capacity becomes overwhelmed.

The Australian Government and state and territory governments will work together to consider data and evidence, resource and political information to determine whether and when a national response is required; advise on thresholds for escalation; share information on resource availability; and coordinate access to resources to maximise the effectiveness of the response.

State and territory governments will coordinate and provide COVID-19 healthcare services, including assessment and treatment centres as required. State and territory governments will undertake public health management of the response including contact tracing and directing isolation and quarantine.

State and territory governments will identify appropriate ways to engage with ACCHS, such as: consulting with the Sector Support Network and community stakeholders; establishing regular meetings for updates and communication; sharing important updates and information in a timely way; and establishing systems to build trust and collaborative links.

The Aboriginal Community Controlled Health Sector, supported by NACCHO and jurisdictional Sector Support Organisations; and other health care settings serving Aboriginal and Torres Strait Islander peoples will deliver COVID-19 outbreak health measures as part of the coordinated response and maintain business continuity of essential services.

9. Stand down and Evaluation

The Australian Government will: coordinate the stand down of enhanced measures; manage the transition of COVID-19 outbreak specific processes into normal business arrangements; and undertake public communication regarding changing risk and the stand down of measures, noting that stand down may be gradual and progress at different rates in different locations.

The ACCHS and other health care settings providing care to Aboriginal and Torres Strait Islander peoples will: advise on the timing and impact of reducing enhanced clinical COVID-19 outbreak services; support stand down of measures; manage the transition of novel coronavirus outbreak-specific processes into business as usual arrangements; and participate in communicating public messages regarding changing risk and stand down of novel coronavirus outbreak measures.

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 will provide overarching guidelines on this phase and provide input into a national evaluation of the effectiveness of the response

Decision Making and Engagement

Initiating Aboriginal and Torres Strait Islander governance groups, led by Aboriginal and Torres Strait Islander peoples, to provide advice/guidance on culturally specific risk reduction and communications strategies is important at national, jurisdictional and local levels.

1. COVID-19 Advisory Group

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 (COVID-19 Advisory Group) reports to the AHPPC and is co-chaired by the Department of Health and NACCHO. The COVID-19 Advisory Group includes: Public Health Medical Officers and leaders from the Aboriginal Community Controlled sector; Aboriginal Health Services; state and territory government public health and medical officials; Aboriginal communicable disease experts; the Australian Indigenous Doctors' Association; and the National Indigenous Australians Agency.

The COVID-19 Advisory Group is also supported as necessary by other key advisory committees that report to AHPPC, including the:

- CDNA, which provides leadership in surveillance, the analysis of epidemiological information and strategies related to the management of communicable disease;
- Public Health Laboratory Network (PHLN), which provides leadership in guiding human health microbiology and laboratory practice;
- National Surveillance Committee (standing committee under CDNA), which provides leadership in guiding the implementation of COVID-19 surveillance activities and strategies;
- National Immunisation Committee, which provides leadership in guiding the implementation of immunisation measures;
- Australian Technical Advisory Group on Immunisation, which provides technical advice on immunisation issues; and
- Chief Human Biosecurity Officers who will provide advice to Australia's Chief Medical Officer on human biosecurity matters at the international and state borders.

2. Health Sector Engagement

Wherever possible, engagement will be conducted through established channels. In addition to providing expert advice, the COVID-19 Advisory Group will also consult and engage with the Aboriginal Community Controlled Health Sector.

Feedback from the sector will reflect the on-the-ground experience of health sector and public concerns, and evidence of the effectiveness of approaches and specific interventions. This will enable input into decision-making processes to better tailor the response to Aboriginal and Torres Strait Islander community needs.

3. Decision making processes under the Management Plan

The Management Plan will guide the management of a COVID-19 outbreak as it relates to Aboriginal and Torres Strait Islander peoples and communities, including clinical and public health considerations, with a broader emphasis on communication and social determinants issues, representing an approach agreed between the Australian Government and state and territory governments and the Aboriginal Community Controlled Health Sector.

Reflecting a flexible approach, choices may vary to reflect the jurisdictional context and different community needs, particularly in relation to timing of implementation and stand down in Aboriginal and Torres Strait Islander communities, however negotiation within the Management Plan will ensure a coordinated and consistent approach.

The continuing appropriateness of measures will be regularly reviewed as more information becomes available across the progress of the COVID-19 outbreak.

Communications

National communications plans and materials have been developed for COVID-19 as part of the Health Sector Plan. However, tailored communications and a comprehensive communications strategy is essential to the successful response to the COVID-19 outbreak for Aboriginal and Torres Strait Islander peoples, particularly those in remote communities.

Tailored communication strategies could be used for a variety of stakeholders, including: individuals; families of individuals with COVID-19; remote communities; health and allied health care workers; ACCHS; and FIFO workers who may live in, close to and/or interact with Aboriginal and Torres Strait Islander communities. There may be different strategies for stages of the response, such as during: the first wave of cases, a new 'COVIDSafe environment', use of the COVIDSafe app, maintaining vigilance, and resurgence or subsequent outbreaks.

The Department of Health will manage the national communications campaign, supplemented by additional communication services to adapt and supplement the national materials and information for the Aboriginal and Torres Strait Islander health sector and communities.

This will include targeted information provision in local languages and working with community and stakeholder intermediaries to share the latest information and resources to keep communities safe and reduce the impact and severity of COVID-19. Jurisdictional Health Departments and affiliates will also provide communication about their COVID response. Locally developed materials by ACCHSs and other respected organisations or individuals will be tailored to local regions or communities including in language.

1. Australian Government and state and territory governments

Specific information on the status of the outbreak and key response documents will be posted and regularly updated on the Department of Health website and on Australia.gov.au, with content relevant to Aboriginal and Torres Strait Islander peoples additionally shared by the NIAA on their website and social media channels.

Ongoing, regular and timely communication should occur that involves mass media especially Aboriginal television and radio, as well as social media channels shared through local community networks, for both prevention and control measures. Appropriate and timely national health messaging (both prevention and control) will be developed and tailored for Aboriginal and Torres Strait Islander peoples, in consultation with the COVID-19 Advisory Group. All communications materials will abide by the following principles:

- Messaging should encompass factors that may contribute to risk such as social and cultural determinants of health including living arrangements and accessibility to services.
- Messaging should encompass Aboriginal and Torres Strait Islander ways of living including family-centred approaches in both prevention and control phases. Acknowledging traditional practices may empower communities and may be a way to encourage hand hygiene practices.
- Stigma can be reduced if messages from the government include input from peak Aboriginal and Torres Strait Islander bodies and/or ACCHSs locally, who will be key in developing and disseminating health messages to the public, including in local language.

- Messaging should account for the uncertainty, anxiety and stress people may be feeling, as well as be tailored to the needs of different communities. It should therefore extend to secondary issues, in particular mental health and cultural considerations.
- Messaging will be coordinated with and complement other local work, including messaging by Aboriginal and Torres Strait Islander organisations and state and territory departments.

2. Communication with health services and workers

Messaging and alerts for health services and workers in the ACCHS and jurisdictional Sector Support Organisations will be through NACCHO and the Sector Support Network, who will link in with local communication networks. The NACCHO website will be a particularly important vehicle for disseminating information, including key decisions from the COVID-19 Advisory Group.

Targeted communications should be developed for: communication with staff; training in infection control; and advice to Health Care Workers that become ill.

The Sector Support Network has a key role in collating national, jurisdictional and regional information including information from their local PHN and providing it to their services.

3. Communication with Aboriginal and Torres Strait Islander communities

The Department of Health will work closely with NACCHO and First Nations Media Australia to keep the public and the media informed during the COVID-19 outbreak by providing consistent and coordinated media and public responses. In developing the messaging, key considerations for Aboriginal and Torres Strait Islander populations are outlined below:

- Local messaging should occur simultaneously that synergises with national messaging but also reflects local priorities.
- Targeted communications should be developed on culturally appropriate approaches to: travel restrictions to communities; effective hygiene practices; access to influenza and pneumococcal vaccinations; advice on reporting illness and seeking advice and/or attending health services; attending family or social gatherings and events; appropriate use of limited PPE stocks; isolation and quarantine arrangements; maintaining food and essential services and supplies; and elements of the response such as travel restrictions and the COVIDSafe app.
- Consideration should be given to the translation of materials into local language and/or visually appealing materials and infographics.
- Information about why Aboriginal and Torres Strait Islander peoples and other people at risk of severe disease may be prioritised for eventual antiviral and/or vaccination is crucial.
- Information about why public health measures such as isolation, quarantine, testing, and remote community closures are necessary, and how to direct local support to ensure these measure can be done effectively.
- Communication should encourage early presentation of people with fever or respiratory symptoms to the local ACCHSs or GP respiratory clinic. Vulnerable community members should be supported in accessing care from telehealth or from home, to minimise exposure risk.

- Risk prioritisation should also be undertaken and include identification of people in the community at higher risk, and strategies for chronic disease management and active follow-up, as well as broader health care requirements that need to be maintained.

4. Media Engagement

Key media strategies for managing the COVID-19 response for Aboriginal and Torres Strait Islander peoples will include:

- regularly updating health.gov.au, australia.gov.au, indigenous.gov.au and the NACCHO website with important messages and links to the state and territory and Sector Support Network websites;
- use of the Department's, NACCHO's, and NIAA's existing social media accounts to provide up-to-date information;
- appropriate and consistent spokespeople that are trusted by the community during the response to the outbreak;
- activate a media campaign targeting Aboriginal and Torres Strait Islander peoples with culturally appropriate information on appropriate hygiene practices and prevention from contracting the disease;
- develop content for placement in community service radio, including placement through First Nations Media Australia;
- develop information for ACCHS waiting room television screens with and via Aboriginal Health TV; and
- regular updates to media outlets to address emerging issues as they arise, such as the use of masks, good hygiene and specifics for health professionals.

5. Communication methods

A variety of communication mechanisms can be considered, including: radio, social media, internet, webinars, handout fact sheets, posters, mainstream TV and waiting room TV advertising, protocols and guidance. Specific materials and translations for Aboriginal and Torres Strait Islander peoples and community, in addition to the main population-level campaign, are required. Materials and placement should recognise intersectoral considerations included in Part 2 to ensure communication messages reach all people, including for example Aboriginal and Torres Strait Islander peoples who are homeless or affected by a disability.

Due to the rapidly changing nature of a pandemic, an emphasis on radio communication, both paid and unpaid, is appropriate.

6. Key Resources

Key links to stakeholder resources are outlined in [Appendix C](#).

PART 2:

Operational Plan as it relates to Aboriginal and Torres Strait Islander peoples

Phase 1: Preparedness – No cases in an Aboriginal and/or Torres Strait Islander people

Aim: Reduce the likelihood of a case in an Aboriginal or Torres Strait Islander community and facilitate community preparedness through:

- preparing and tailoring plans and guidance materials;
- preparing and supporting the health workforce;
- assessing and preparing medical equipment;
- maintaining and preparing clinical care and public health management, including existing services;
- tailoring and targeting communications;
- community planning and preparedness;
- understanding the disease; and
- establishing leadership and decision making.

Focus	Possible actions	Special considerations
<i>Preparing and tailoring plans and guidance materials</i>	<p>Prepare and update the Management Plan as it relates to Aboriginal and Torres Strait Islander peoples.</p> <p>Prepare and update national guidelines for Aboriginal and Torres Strait Islander peoples, service providers, employers, health services and others as needed to support the Management Plan, including but not restricted to case definitions, use of PPE, travel protocols for remote communities and advice for healthcare workers.</p> <p>Prepared guidance and plans related to Travel restrictions which may restrict international and domestic movement of health care workers. Guidance around exempting essential personnel to ensure the delivery of services continues, isolation. Contingency planning for workforce requirements. The Management Plan to inform jurisdictional plans and ACCHS plans which will be tailored to local settings.</p> <p>ACCHSs, Aboriginal PHC services and other Local community based organisations to facilitate whole of community preparedness activities.</p>	<p>Urban/regional, Rural/Remote, Other: Hostels; Prisons; Detention Centres; Aged Care and other residential facilities; Town Camps; Homeless populations; people with disabilities.</p> <p><u>For all settings:</u></p> <p>Tailor national guidelines and protocols to special settings such as remote communities.</p> <p>Support maintenance of essential health care, such as dialysis, childbirth, cancer treatments, which may require travel between towns or communities with clear guidelines.</p>
<i>Preparing and supporting the health workforce</i>	<p>Ensure local Aboriginal Health Practitioners, Aboriginal Health Workers, and Aboriginal and Torres Strait Islander peoples working in public health and Aboriginal Health are engaged in response activities.</p>	

	<p>Consider workforce needs including training in all aspects of managing COVID-19. Application of standard infection control strategies (including clear guidance on the appropriate use of PPE) and encourage infection prevention and control training such as the Australian Department of Health's online COVID-19 training modules https://covid-19training.gov.au/</p> <p>Consider training local health staff (especially Aboriginal Health Workers) in contact tracing and providing advice on quarantine and isolation measures and decreasing transmission.</p> <p>Consider Surge Staff options- at a local, regional, jurisdictional and national level</p> <p>Provide training to staff working within PHC and the acute health care system on outbreak management in jurisdictions with large Aboriginal populations so that they can be available to support an outbreak response</p> <p>Identify staff who are more vulnerable to poor outcomes from COVID and ensure that they are not in the front line if there is active COVID in the community or nearby communities.</p> <p>Consider wellbeing support for health care professionals who may be experiencing high levels of anxiety and stress.</p> <p>Physical distancing where possible (e.g. pre-quarantined staff, different locations, alternating shifts, work from home, teleconference rather than meetings, essential-face-to-face in larger rooms, reduce gatherings at canteens etc.)</p>	
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	<p>Prioritise influenza vaccination for staff.</p> <p>Business continuity planning.</p>	
<i>Assessing and preparing medical equipment</i>	<p>Assess national stockpile of PPE. Supply of PPE to ACCHS via PHNs. Prioritisation of PPE and other essential resources.</p> <p>Considerations for PPE prioritisation in areas where ACCHS are sole providers of care.</p> <p>Assess pharmacy stocks.</p> <p>Assess system integration.</p>	
<i>Maintaining and preparing clinical care and public health management</i>	<p>Maintain Health Service Provision in local health facility.</p> <p>Risk prioritisation - monitor vulnerable people who have moderate to severe chronic disease and work with them to identify courses of action, such as early presentation if they become ill and isolation or relocation outside of remote communities during an outbreak.</p> <p>Ensure care plans are up to date to manage existing conditions such as hypertension, renal disease, diabetes and cancer. Ensure where possible scripts are filled in advance, doctors to provide repeat prescriptions where appropriate; and ensure CTG PBS Co-payment measure is noted on the script.</p> <p>Consider maximal safe dispensing of medications to minimise traffic through clinic.</p> <p>Prepare clinic, triage protocols including for transport staff.</p> <p>Establish protocols for early evacuation and retrieval.</p>	<p><u>For all services:</u></p> <p>Consider support to families, such as development and distribution of infection control information packs.</p> <p>Consider immunisation outreach teams to enable influenza and pneumococcal vaccines to be given in people's homes without requiring people to come into clinics. Consider also innovative ways to deliver chronic medications to people in their homes without requiring them to come into health services. Maximise the opportunity to treat and vaccinate the whole family, not just the individual.</p>

	<p>Consider an enhanced effort to achieve a high coverage of influenza and pneumococcal vaccinations.</p> <p>Consider access to Australian Government funded telehealth, including IT capacity of service.</p> <p>Identify how outgoing specialist review may be maintained if visiting services or outpatient clinics are suspended.</p> <p>Consider flexible health service delivery and healthcare models, including telehealth to assess patients and/or to access GPs who are in isolation, flexible ACCHS clinic hours/location, home visits and mobile clinics.</p> <p>Consider flexible testing options, including at home or in-car testing.</p> <p>Consider an Aboriginal and Torres Strait Islander Cultural Support model led by Aboriginal and Torres Strait Islander health professionals to provide additional welfare support for confirmed cases and close contacts.</p> <p>Ensure and encourage appropriate advanced care directives are in place.</p> <p>Consider a plan for the management of the deceased.</p> <p>Initiate meetings between PHUs, ACCHOs and other key health and health-related partners, including higher level emergency state-wide planning.</p>	
<i>Tailoring and targeting communications</i>	<p>Provide essential information about the coronavirus and symptoms to the community (in language where appropriate) and coordinate between national, state and local resource development.</p>	<p><u>For all settings:</u></p> <p>Engage and collaborate with Aboriginal and Torres Strait Islander health workers, community champions, and community groups about appropriate and practical ways to</p>

	<p>Provide advice on respiratory etiquette and hand washing and increase access to hygiene-related products to ensure that widely disseminated public health advice can actually be adhered to by Aboriginal and Torres Strait Islander families.</p> <p>Provide clear guidance about what is needed , what it means to quarantine or self-isolate at home, and why this is an important protective activity.</p> <p>Advise community on how to engage with health services when they are sick e.g. ring ahead.</p> <p>Advise community on limitations of PPE, including the appropriate correct use of facemasks in social and healthcare settings.</p> <p>Advice to community about early presentation for influenza like illness.</p> <p>Clear advice on hospital visitor restrictions.</p> <p>Clear information on testing procedures and various testing clinics.</p> <p>Consistent updates to guidance for Aboriginal and Torres Strait Islander peoples, service providers, employers, health services and others as needed.</p> <p>Designated point(s) of contact (e.g. outreach workers, community members where relevant) to facilitate targeted communication.</p>	<p>minimise risk and to determine culturally appropriate responses to issues as they arise, including:</p> <ul style="list-style-type: none"> • Ask families and communities what is needed to reduce risk at family and community gathering such as sorry business, celebrations and other events. Support communities to understand national restrictions on large gatherings due to the risks and potential impacts. • Educate communities on the importance of physical distancing and assist their adaption of the process for their community in a culturally appropriate way. • Consider mechanisms for communication to community during a local outbreak. • Discuss where appropriate difficult issues, such as end of life, being unable to return to country to die, or having limited hospital visits. <p>However, the need to protect the entire community may mean that individual and family preferences are over ridden. This needs to be explained carefully and with support.</p> <ul style="list-style-type: none"> • If specific strategies such as ‘contain and test’ are proposed as a potential response mechanisms, specific communications and community-led planning will be required, to explain why this is the recommended action, how community will be supported, and to prepare the community mentally and practically,
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	<p>Advice on physical distancing measures, including for individuals, schools and community groups.</p>	<p><u>For prison settings:</u></p> <p>Consider peer-based COVID-19 and infection control educators in prison settings. Televisions may be used to share general COVID-19 information. Consider and plan for housing to support isolation when leaving detention and before returning to communities.</p>
<p><i>Community planning and preparedness</i></p>	<p>Consider options to support physical distancing in communities - following the national government recommended population numbers per setting:</p> <ul style="list-style-type: none"> • Provision of tents to crowded houses • Setting up camp on outskirts of community • Use of outstations, teacher accommodation and tourist accommodation <p>Establish environmental measures to reduce transmission of COVID-19 throughout communities e.g. access to clean running water to enable good hand washing practices. Consider health promotion and education strategies to support environmental measures.</p> <p>Consider maintenance of food, water and other essential supplies. Additional supplies may need to be ordered to support a larger number of people remaining in community, or to guard against temporary transport disruption.</p> <p>Discussions at the community level regarding outbreak management strategies, including the development of specific community response plans.</p>	<p><u>For remote settings:</u></p> <p>Individual communities may decide to restrict access of non-essential personnel and visitors to delay or prevent exposure of the virus. Communities may apply additional quarantine and isolation requirements as a condition of entry or engagement of services.</p> <p>All visitors, residents, service providers, fly-in fly-out, and mobile outreach workers, including Government workers, should follow national and jurisdictional guidelines for remote communities and individual community requirements.</p> <p>Members of the community need to consider the risk they may pose to other members by returning to or travelling between communities. Consider impact of and options for children returning from boarding school.</p> <p>Manage drug and alcohol dependencies during a lockdown situation.</p>

		<p><u>For prison settings:</u></p> <p>Diversionary programs to reduce overcrowding in prisons.</p> <p>Implement strict screening and staff illness policies in prisons, maximise video-link up with court to reduce transport to towns from prison.</p>
<i>Local / organisational Pandemic planning</i>	<p>Services to develop a local pandemic plan based on the relevant regional jurisdictional and national plan in partnership with police and other agencies and informed by considerations listed in this management plan,</p> <p>Work with other local agencies (Shires police) to ensure that the plan is well understood including roles and responsibilities.</p> <p>Ensure health staff understand the plan</p> <p>Work through scenarios to test out the plan and modify as needed.</p>	<p>Remote plans will need to cover quarantine and isolation facilities.</p> <p>Plans should be based on the most effective strategies as determined by outbreak modelling and other relevant information. <u>In remote and other discrete communities the best approach should be based on the contain and test approach , along with early evacuation of cases and close contacts</u></p> <p><u>See also 'Communications' (above) with relation to 'contain and test' strategies</u></p>
<i>Understanding the disease</i>	<p>Collect and share data and evidence about the spread of COVID-19 in the community and the health impacts.</p> <p>Maintain systems to collect data on and detect early signals of outbreaks in Aboriginal and Torres Strait Islander communities.</p> <p>Share latest medical science to inform the response.</p>	

<i>Establish leadership and decision making</i>	Regular meetings of the COVID-19 Advisory Group.	Expert advice from Advisory Group members will be used as a vehicle for consultation between key parties engaged in the response, including the Australian Government, jurisdictions and health services.
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Phase 2: Suspected or initial cases in an Aboriginal and/or Torres Strait Islander people

[The Interim National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19](#) has been developed by the National Advisory Group and endorsed by the AHPPC to ensure consistent clinical management of suspected or confirmed cases within communities. These Guidelines should be used in conjunction with the [Interim COVID-19 CDNA National Guidelines for Public Health Units](#).

Aim: Prevent sustained community transmission through:

- reviewing previously implemented actions;
- triaging patients and potential patients;
- preparing and implementing laboratory testing;
- early identification of cases;
- reporting and contact tracing;
- early retrieval and evacuation
- supported isolation facilities provided; and
- managing and supporting the health workforce.

The Northern Territory has adopted a 'contain and test' strategy as best practice for managing suspected or actual community transmission in a remote community. Further information can be found at [Appendix D](#).

Focus	Possible actions	Special considerations
<i>Review</i>	Review “Phase 1” steps above.	Urban/regional, Rural/Remote, Other: Hostels; Prisons; Detention Centres; Aged Care and other residential facilities; Town Camps; Homeless populations; people with disabilities.
<i>Triage patients and potential patients</i>	<p>Individuals and health services to use HealthDirect where possible.</p> <p>Establish respiratory/fever clinics with heightened infection prevention and control capacity for people presenting with respiratory symptoms to:</p> <ol style="list-style-type: none"> redirect demand away from Emergency Departments and usual primary health care providers; reduce transmission risk by focussing care for respiratory presentations in a dedicated setting prepared to manage those patients; and conserve use of limited PPE supply. <p>Where respiratory/fever clinics are not available, use local clinics as frontline in the response, prepared and with access to appropriate PPE. Consider containment activities for health services such as: reduce risk of infected persons entering the site (educate members, notices, screening, reduce visitors).</p>	<p>Consider respiratory clinics for different settings</p> <ul style="list-style-type: none"> <u>For urban settings</u>: patients may be directed to a mainstream or ACCHS respiratory clinic . Patients presenting at ACCHS may require transport to a respiratory clinic. Consider PPE for drivers. Consider other options for the establishment of culturally safe clinics, including partnership models between mainstream providers and ACCHS. <u>For rural and remote settings</u>: a separate building, room, mobile clinic or outside area may be set up for patients presenting with symptoms. For both settings: Respiratory Clinics should be operated by ACCHS when appropriate.

<p><i>Prepare and implement laboratory testing</i></p>	<p>Follow clinic testing protocol:</p> <ul style="list-style-type: none"> • If patient presents to clinic- who sees them • Then – where do they get tested • Then – how do they get there • Then – where do they go after testing. <p>Prompt transport of samples to a relevant laboratory and tests to confirm COVID-19 as the cause of respiratory disease.</p> <p>Consider options for rapid and safe assessment, approval, registration and rollout of novel point of care testing technology.</p>	<p><u>For remote settings:</u></p> <p>Remote areas often experience delays between collection of specimen for and return of results. Consider local strategies to expedite samples to laboratories e.g. driving to town rather than waiting for the weekly plane to collect samples; and Point of Care Testing.</p> <p>Fast track availability of COVID-19 polymerase chain reaction (PCR) point of care testing as a priority for remote settings building on infrastructure-already in place in communities.</p>
<p><i>Early identification of cases</i></p>	<p>Should COVID-19 be suspected or detected in an Aboriginal or Torres Strait Islander community or household:</p> <ol style="list-style-type: none"> 1) Contact State and / or Territory Health Departments to assess risk, consider mobilising additional staffing to assist in testing, treating and medical evacuation if required. 2) If appropriate, treat people with symptoms that fit the clinical case definition, until laboratory confirmation of the cases and instigate outbreak control measures including isolation logistics. 3) Quarantine close contacts and suspected cases in consultation with Aboriginal and Torres Strait Islander families. 4) Reduce the risk of severe complications by clinically appropriate treatment of cases with specific clinical criteria identifying them as vulnerable or who have moderate to severe disease. 	<p><u>For all settings:</u></p> <p>Families should be part of decision-making around quarantine and isolation, how it might impact on the household and if unsuitable, identify alternative housing for the quarantine and/or isolation period, including:</p> <ul style="list-style-type: none"> • home isolation; • communal isolation in community property; • relocation and isolation in regional centres; or • utilising medihotels. <p><u>For prison settings:</u></p> <p>Guidance will be updated when AHPPC guidelines on this are issued.</p>

	<p>5) If laboratory confirmation of the cases and contacts, instigate outbreak control measures, including isolation of confirmed cases and contact management, as per the Communicable Diseases Network Australia Series of National Guidelines (CDNA SoNG).</p> <p>Management of the population, including health care workers, to minimise the risk of transmission while waiting for test results needs careful planning.</p> <p>Community to consider how they will support individuals or households who are in quarantine or isolation. E.g. safe delivery of food and social support on a regular basis. Work with community to identify innovative local solutions.</p> <p>Use of community leaders to facilitate communication; importance of precautions, keeping in (phone) contact with community members in isolation, having designated point of contact for isolated community members - noting that some elders may fall into the category of high risk for poor outcome in the event of COVID-19 infection.</p> <p><u>Isolation / Quarantine</u></p> <p>To prevent transmission of COVID-19 within households it is recommended to remove infected people from their households rather than isolation within a household. This is particularly important in:</p> <ul style="list-style-type: none"> • large households where there is increased likelihood of transmission due to crowding and several generations of transmission; and / or 	<p><u>For remote settings:</u></p> <p>Consider alternate communication pathways for monitoring contacts who remain in community when there is limited phone/internet access. Consider using trained community workers to assist with contact tracing and to conduct daily review for those in isolation e.g. check on family from the veranda.</p> <p>Medical evacuations from remote communities via aeromedical or road transport of:</p> <ol style="list-style-type: none"> 1) severe cases of people with COVID-19 to tertiary facility; evacuation of confirmed case and/or contacts is the agreed strategy of the jurisdiction to minimise spread <p>Deployment of additional PPE during retrieval.</p> <p>Consider capacity to treat and care for patients if evacuation and retrieval is delayed or not possible.</p> <p>Consider the best transport options for relocation of cases to regional/major centres.</p> <p>Patient retrieval / evacuation also needs to consider when / how patients will be returned to community. Consider travel restrictions in and out of community to limit spread.</p>
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	<ul style="list-style-type: none"> households which contain people in higher risk groups (e.g. the elderly, those with chronic conditions). <p>Removal of confirmed cases of COVID-19, requires safe, appropriate, supported and comfortable accommodation including access to an outdoor area. These provision will improve the likelihood of uptake of isolation facilities.</p> <p>It is recognised that in some cases individuals may not wish and/or feel able to move to isolation facilities. To maintain trust with authorities, participation in testing and compliance with public health advice, it is important that people should not be forced to leave their homes. It is however, important that individuals are supported in their decision making including clear communication of the risks of staying at home explained. The Taskforce also recommends that if the removal of the confirmed case is not possible, options for supported accommodation for other vulnerable household members should be provided.</p>	<p><u>For hospital settings:</u></p> <p>Discuss with patients and their families issues regarding ICU bed capacity, and ethical values applied to who gets care and who does not. Discuss with patients and their families issues regarding ICU bed capacity, and ethical values applied to who gets care and who does not. Hospitals to ensure appropriate Aboriginal and Torres Strait Islander health professional representation on Boards, and Ethics Committees including Aboriginal and Torres Strait Islander peoples from the community as part of the outbreak preparations.</p> <p><u>For aged care facilities:</u> Department of Health website provides specific advice for aged care facilities, residents, visitors and family members.</p>
<i>Manage and support health workforce</i>	<p>Implement surge workforce options, such as a cohort of backup medical, nursing staff and Aboriginal and Torres Strait Islander health practitioners to assist with the increased workload in remote communities and backfill positions when current staff become sick or leave.</p> <p>Ensure other surge workforce is activated- welfare, logistics, SEWB support and essential services.</p>	<p><u>For remote settings:</u></p> <p>If travel restrictions are in place, consider how temporary staff can be gainfully employed if they are required to be in quarantine before entering the community for example, provision of telehealth or HealthDirect services.</p> <p>Consider housing options for temporary staff in quarantine.</p>

	<p>Activate national support options such as AUSMAT at an early stage if there is a high risk situation</p> <p>Consider workplace relations advice about how to support staff that may be infected or in quarantine or supporting family who are infected or in quarantine and clarify leave and remuneration entitlements. Maximise the utility of staff in quarantine if possible e.g. through appropriate telehealth services.</p> <p>Consider best use of limited supply of PPE.</p> <p>Consider capacity of infrastructure, particularly in remote settings to use telehealth.</p> <p>Consider ways to support the wellbeing of health workforce.</p>	
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Phase 3: Outbreak in an Aboriginal and/or Torres Strait Islander community (multiple cases of sustained community transmission)

Aim: Deliver an effective response to outbreaks in communities through:

- reviewing previously implemented actions;
- protection of at-risk people;
- increased infection prevention and control measures;
- resourcing and support;
- mobile respiratory clinics; and
- health service continuation.

Focus	Possible actions	Special considerations
		Urban/regional, Rural/Remote, Other: Hostels; Prisons; Detention Centres; Aged Care and other residential facilities; Town Camps; Homeless populations; people with disabilities.
<i>Review</i>	Review “Phase 1” and “Phase 2” steps above.	
<i>Implementation</i>	<p>Implement the agreed outbreak response strategy which should be put into action with the first high risk case (e.g. a case in an Aboriginal person who has been living in community prior to the diagnosis)</p> <p>Notify local public health authorities who will then implement outbreak response plan.</p>	<p>In remote or other discrete Aboriginal community, implement agreed strategy based on modelling of outbreak strategies and experience of outbreak containment.</p> <p>This could include community wide testing and quarantine of whole community in a high-risk situation, and with consideration to the likely level of community transmission already occurring.</p>
<i>Protection of at-risk people</i>	Based on risk prioritisation, early management of people at risk of severe disease.	<p><u>For remote settings:</u></p> <p>Preparations for multiple retrievals.</p>
<i>Increased infection prevention and control measures</i>	Increase isolation and quarantine measures and physical distancing where possible.	<p><u>For remote settings:</u></p> <p>Review access control measures.</p> <p>Consider travel restrictions in and out of community to limit spread.</p>
<i>Resourcing and support</i>	<p>Implement systems for accessing additional medical supplies and aeromedical services, deployment of soft accommodation facilities, mobile respiratory clinics, prioritisation of PPE and other essential resources.</p> <p>Review surge workforce options.</p>	<p><u>For remote settings:</u></p> <p>Deployment of appropriately trained surge workforce to undertake widespread testing and manage cases and contacts. Collaboration between the local health service, state and territory jurisdiction and the Australian Government Department of Health.</p>

<i>Health service continuation</i>	Maintain Health Service Provision in local health facility which may require additional staff support.	Home visits may be required, including to support people who are isolating or quarantining in community.
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Phase 4: Stand down and evaluation

Aim: Stand down enhanced measures and resume normal operations through:

- sharing information between responders;
- public communication;
- monitoring for a second wave;
- community actions;
- industry liaison; and
- review and learning.

Focus	Possible actions	Special Considerations
		Urban; Remote; Hostels; Prisons; Detention Centres; Aged Care and other residential facilities; Town Camps; Homeless populations; people with disabilities.
<i>Sharing information between responders</i>	Meetings and small group discussions with Aboriginal Health Workers, Aboriginal Health Practitioners, ACCHOs, ACCOs, and families.	
<i>Community Actions and Public Communication</i>	<p>Provide specific information to the community about the transition of services to business as usual.</p> <p>Conduct community meetings at the local, regional, state and national levels to explore and understand the perspectives and experiences of Aboriginal and Torres Strait Islander peoples in the response. Explore issues, barriers, containment strategies and ways to improve and develop culturally appropriate and effective strategies to reduce risk in future pandemic outbreaks.</p> <p>Consider Participatory Action Research framework as a culturally appropriate and acceptable way of engaging Aboriginal and Torres Strait Islander peoples to understand experiences and perspectives.</p> <p>Meet with community and health leads for feedback on key evaluation findings and or lessons learned.</p>	<p><u>For remote communities:</u></p> <p>Stand down enhanced border measures for remote communities.</p>
<i>Assess and restock medical equipment</i>	<p>Assess the status of PPE and equipment, restock resources that are depleted.</p> <p>Assess workforce needs.</p>	
<i>Review clinical care</i>	Stand down enhanced measures and resume non-urgent work.	<u>For remote communities:</u>

	Consider mental health consequences of the pandemic. Consider trauma care depending on severity of the outbreak.	Advise fly-in fly-out workers of transition to normal arrangements.
<i>Monitoring for a resurgence in the virus</i>	Monitor for a resurgence or change in virus. Analysis of data and review processes and policies. Review laboratory capacity, processes and policies.	
<i>Review and learning</i>	<p>COVID-19 Advisory Group to:</p> <ul style="list-style-type: none"> • review processes and policies in collaboration with Aboriginal and Torres Strait Islander peoples; and • update protocols and plans in line with lessons learnt. <p>Explore options for leveraging existing evaluation mechanisms, such as the <i>Evaluation of the Australian Government's Investment in Aboriginal and Torres Strait Islander Primary Health Care through the Indigenous Australians' Health Programme (IAHP)</i> (www.iphceval.com).</p>	<p>As part of the review, consider both qualitative and quantitative information. Aspects for consideration may include: continuity of care; community engagement with COVID-19 response measures; communication strategies use of telehealth and broader MBS items; and reasons why clinics closed due to COVID-19 (i.e. staff shortages, no appropriate facilities to effectively isolate, lack of PPE etc.).</p> <p>Cultural lens to be applied, particularly to qualitative metrics, and interpretation of quantitative findings.</p>

APPENDICES:

APPENDIX A: Population Settings

APPENDIX B: Reducing risk at home and for family gatherings

APPENDIX C: Key Resources

APPENDIX D: Northern Territory Contain and Test Strategy

APPENDIX A:

Population Settings and special considerations

Aboriginal and Torres Strait Islander peoples live in a variety of settings across Australia, including urban, regional, remote and very remote locations. In addition, special considerations are needed for Aboriginal and Torres Strait Islander peoples in hostels; prisons; detention centres; aged care facilities; town camps; homeless populations; and people with a disability.

While Aboriginal and Torres Strait Islander peoples experience many health vulnerabilities, the strength of the sector and the Aboriginal and Torres Strait Islander leadership has the best ability to provide advice on the response.

Each setting has its own unique circumstances and responses will need to be tailored to those circumstances.

Remote and very remote communities

The Northern Territory, Western Australia, South Australia and Queensland have the highest proportion of Aboriginal and Torres Strait Islander peoples living in remote and very remote communities. In addition to the broader issues, outlined previously, specific issues to remote and very remote settings also include:

- a. a high prevalence of co-morbidities in remote communities. This is compounded by distance from tertiary health care, indicating that residents of remote communities are likely to be vulnerable to an outbreak;
- b. limited transport between home and local clinics, and/or between local community and major centres if tertiary care is needed. This includes the risk of transmission to drivers and the ability of people to travel home following care; and
- c. limited access to basic essentials such as food, safe and adequate water supply, quality housing and medicines.

Particular challenges for primary health care services in remote and very remote communities in managing a COVID-19 outbreak include:

- a. diversion of patients: health clinics in remote communities do not have the ability to divert patients to alternate health facilities, or have quick access to respiratory clinics, in contrast to health centres in regional centres and cities. Transport issues of patients to other settings can be an issue;
- b. isolation of suspected and confirmed cases: due to crowded and inadequate housing, effective quarantine and isolation may not be feasible in the home for many Aboriginal and Torres Strait Islander peoples and alternate housing may be needed;
- c. evacuation of patients: some communities may not have infrastructure, or may experience delays in response, to support medical evacuations. This may require health staff to treat and manage cases of severe illness due to COVID-19, which is resource intensive;

- d. delays in testing: remote clinic staff will need to rely more on clinical diagnoses of cases, because swabs, once taken, will need to wait for transport to a regional laboratory. For many communities (without PoCT), there will often be delays of a week or more while awaiting test results. Therefore all patients with respiratory symptoms will need to be treated as a suspected case. Reduced transport implemented to minimise the spread of COVID may have flow on effects to pathology waiting periods;
- e. workforce issues: remote clinics may already be highly dependent on fly-in fly-out (FIFO) staff, many of whom come from overseas. With travel restrictions in place, this could strain the workforce for remote primary health care services. In addition, staff have caring responsibilities for families at home which can impact on their ability to work. If staffing in remote primary health care services is reduced then mortality from existing chronic disease may increase in addition to the lack of capacity to cope with COVID-19;
- f. isolation of staff: remote clinic staff will themselves be susceptible and will need to exclude themselves from work if they have respiratory symptoms. Some staff may choose to leave. Staff shortages are likely. Furthermore, if a remote health centre ceases to function, there will usually be no other health service available in that community;
- g. capacity of IT infrastructure: alternate services such as telemedicine may be limited by infrastructure and cost, and the sharing of phones among the community pose additional risks;
- h. access to Personal Protective Equipment (PPE), intensive care units (ICU) and high-dependency units (HDU): many remote clinics do not usually have access to adequate supplies of PPE, and may experience shortages sooner than their regional and urban counterparts. In addition, access to ICU and HDU beds is unavailable in clinics; and
- i. maintaining essential services: including health care (non-respiratory), chronic disease programs and maternal and child health services.

Key issues of concern for regional hospitals that service key remote communities include:

- a. limited capacity to scale up the number of ICU beds with the required support systems. Ethical guidelines have been developed by the Australia New Zealand Intensive Care Society regarding the allocation of ICU support;
- b. these hospitals are already dealing with patients who need to continue to receive life-sustaining care;
- c. the workforce in these hospitals may also be depleted as staff are affected by travel barriers, become sick themselves or decide to return to care for family in other parts of Australia; and
- d. hospitals servicing large Aboriginal populations are often above capacity already and have limited capacity to transfer patients to neighbouring hospitals.

Urban and regional communities

The Aboriginal and Torres Strait Islander population is becoming increasingly urbanised, especially in jurisdictions such as the ACT, Victoria and NSW. Specific issues in urban settings include:

- a. access to patient information: if a patient with multiple chronic conditions moves between services (ACCHS, general practice, testing facility or hospital) the patient's health care information may not be available to allow best quality of care in consideration of their broader health needs;

- b. lack of respiratory clinics in ACCHS: clients may need to be referred to mainstream clinics where they are not familiar or comfortable;
- c. lack of cultural safety in mainstream settings: these are likely to be managing the majority of specialised respiratory clinics and hospitalisations for severe cases of COVID-19;
- d. isolation of suspected and confirmed cases: due to crowded or inadequate housing, effective quarantine and isolation may not be feasible in the home for many Aboriginal and Torres Strait Islander peoples and alternate housing may be needed;
- e. access and transport: of patients from ACCHS to mainstream settings, including risk of transmission to drivers, who may often be taxi drivers. Mainstream services may not offer the same transportation services that ACCHS do; and
- f. particularly at-risk cohorts with higher burdens of disease that may require outreach. For example high rates of homelessness and mobility of clients – including to regional and remote settings.

Other settings

Specific issues in other settings, such as hostels, prisons, detention centres, aged care and other residential facilities, town camps, homeless populations, and private residential schools include:

- a. potential exposure in some settings due to shared spaces for sleeping, eating and bathrooms provide limited ability to self-isolate;
- b. short stay (24 to 48 hours) and transience between facilities, unclear pathways for release into the community and loss to follow up; and
- c. other high-prevalence risk factors such as mental health conditions which require management while in care, but may also reduce likelihood to engage with services or to understand and comply with public health measures such as isolation.

Aboriginal and Torres Strait Islander peoples with a disability may face a number of additional barriers in accessing health care and services during the COVID-19 pandemic.

It is important to note that there may be a different cultural mindset such that people may not associate themselves as having a disability or impairment, but rather may associate with language such as “not working well”, as an example. Therefore, it is important for health services and providers to engage and consider disability and people with disability within their planning and response.

APPENDIX B:

Information for community leaders and local communities

Who is this information for?

This fact sheet applies to community leaders and community members. It outlines key questions, information and actions you, your family and your community can take to reduce the spread of COVID-19.

Sometimes it can be hard to follow the actions to stop the spread of COVID-19, so this fact sheet also includes some **practical examples** of how you could adapt these actions in your local community. It is important communities work in partnership with health workers to find ways that work to prevent spread of COVID-19 and look after those that are unwell.

What is coronavirus/COVID-19?

COVID-19 (also commonly called “coronavirus”) is a new virus that originated in Wuhan, China in 2019. In many people COVID-19 will look like a normal cold (fever, a cough, sore throat, tiredness and/or shortness of breath). However, **most people with these symptoms will probably not have COVID-19**. Other people with COVID-19 will be much sicker. Some might have a chest infection and might need to go to hospital.

As it is a new disease we are still learning and this may change in the future.

How do you catch COVID-19?

COVID-19 spreads between people from our coughs, sneezes or when we wipe our nose. You can catch it directly from people who are sick with COVID-19 or by touching something that someone with COVID-19 has also touched after coughing, sneezing or wiping their nose.

What do I do if I get sick?

If you have a fever, cough, sore throat, tiredness and/or shortness of breath you should go to your local health service for help. If you can, call the health service before you go. This is because it is important the health service knows you might be sick with COVID-19 so they can make sure you don't give the virus to others. If you can't call in advance, it is even more important to:

- cover your coughs and sneezes – but not with your hands – with a mask, other clothing or materials as long as you don't use them twice, or use the inside of your elbow
- try not to be close to other people
- keep a safe distance from other people, at least 1.5m (two big steps or the length of two arms) and be outdoors or on an open veranda (an undercover area with only one side wall) - being outside in the fresh air is safest
- sit / stand at the back of the group
- avoid being with other people indoors

The doctor may ask you about your symptoms, where you've travelled recently and if you've had contact recently with someone that has COVID-19.

If the doctor has confirmed you have COVID-19, it is important to also follow the advice below – to stop yourself, your family and your community from catching COVID-19.

How do I stop myself, my family and my community from catching COVID-19?

The best way not to get COVID-19 is to:

- wash your hands often with soap and water
- cover your coughs and sneezes – but not with your hands – with a mask, other clothing or materials as long as you don't use them twice, or use the inside of your elbow
- avoid touching your eyes, nose, and mouth with unwashed hands
- try not to shake hands with others

You can also encourage others to do the same.

Even though many people feel like they have a normal cold when they have COVID-19, as it can be more serious for Elders and people that are already sick it is important to try not to give it to others.

It is also important to show understanding that other people may be worried and anxious about what will happen to them, their family and community, and so might behave differently.

Some practical examples:

At home and around other people

- Reduce the chance of giving COVID-19 to others by eating and sleeping alone in your own bedroom or donga. If your home is not suitable for quarantine or isolation, talk to the health service about alternative housing options.
- Clean surfaces with soap and water or detergent
- Reduce shared hygiene items – sharing towels, toilets, laundry and consumables such as drinks and cigarettes.
- Avoid being with other people indoors, e.g. office, meeting room or dining room, or any other enclosed spaces, e.g. motor vehicle
- Help kids to wash their hands - ask and remind them often
- Consider alternative ways of connecting with other family members, including sick people or people in quarantine, such as FaceTime.

Attending cultural commitments

- You should keep up to date on national restrictions about going to group events (which could include law, sorry camps, funerals and cultural ceremonies).
- If you can, use other methods of communication (e.g. video calling)
- If you attend a group event, ensure there is hand gel, tissues and bins
- Only be in a room with others for less than two hours. Being outside in the fresh air is preferred, at least 1.5m (two big steps or the length of two arms), and be outdoors or on an open veranda (an undercover area with only one side wall)

You may have lots of other questions about helping or visiting family members who are ill or what your options are if you get sick. Always talk to your health care worker about any questions you may have.

Where can I get more information?

For the **latest advice, information and resources**, go to the Australian Department of Health www.health.gov.au

If you have concerns, go to HealthDirect www.healthdirect.gov.au or call the National Coronavirus Helpline on 1800 020 080. The line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

The contact details from the **NIAA regional network** are available at <https://www.niaa.gov.au/contact-us/regional-network-addresses>

The phone number of your **state or territory public health agency** is available at www.health.gov.au/state-territory-contacts

APPENDIX C:

Key Resources

1. International

World Health Organization: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

7. National

Australian Government, including important updates and resources such as the Emergency Response Plan; Series of National Guidelines for Public Health Professionals; and Fact Sheets: <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert>

National Aboriginal Community Controlled Health Organisation, including COVID-19 Advisory Group Communiques and other key information relating to the Aboriginal and Torres Strait Islander health sector <https://www.naccho.org.au/home/aboriginal-health-alerts-coronavirus-covid-19/>

8. State and Territory

New South Wales:

<https://www.health.nsw.gov.au/Infectious/diseases/Pages/covid-19-latest.aspx>

Victoria:

<https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19>

Queensland:

<https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19>

<https://assetlibrary.health.qld.gov.au/web/1df8be3cb80ca716/covid-19-aboriginal-and-torres-strait-islander-audiences/>

Northern Territory:

<https://health.nt.gov.au/health-alerts/novel-coronavirus-covid-19>

South Australia:

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/infectious+diseases/covid+2019/coronavirus+disease+2019+covid-19>

Tasmania:

https://www.dhhs.tas.gov.au/publichealth/communicable_diseases_prevention_unit/infectious_diseases/coronavirus

Western Australia:

<https://www.wa.gov.au/government/coronavirus-covid-19>

https://healthywa.wa.gov.au/Articles/A_E/Coronavirus/Coronavirus-information-for-Aboriginal-people

Australian Capital Territory:

<https://health.act.gov.au/about-our-health-system/novel-coronavirus-covid-19>

APPENDIX D:

Northern Territory Contain and Test Strategy

The Northern Territory has adopted a 'contain and test' strategy as best practice for managing suspected or actual community transmission in a remote community. This strategy would be triggered when an Aboriginal person who has been living in the community for at least a few days is unexpectedly found to be positive. It would not be triggered if the first case was in someone who had just arrived in the community from outside. Epidemiological modelling shows it to be the most effective response in terms of minimising the number of people infected and the duration of possible outbreaks, if a very high level of compliance can be achieved. This modelling shows that the traditional public health approach, which does not require community household level quarantine and community wide testing, will not find the probable asymptomatic or pre-symptomatic positive cases that are already likely to be in the community at the time of the first case. As a result, over time, more and more people become infected. The traditional public health approach tests selected people on the basis of epidemiological risk whereas this strategy assumes everyone in the community is at significant risk from the outset. The 'contain and test' strategy involves immediately on identification of an initial or suspected case:

- restricting all movement in and out of community;
- offering relocation of particularly vulnerable elderly or sick people;
- confining all community members to their house and yards;
- multiple rounds of testing for COVID-19;
- relocating people identified with COVID-19 out of households to hospital or a safe isolation facility outside the community;
- mobile delivery of health services including social and emotional wellbeing and addiction services;
- delivery of food, communications, other essential services to people to their houses;
- implementing environmental controls (decontamination etc);
- enforcement of movement restrictions; and
- use of face masks.

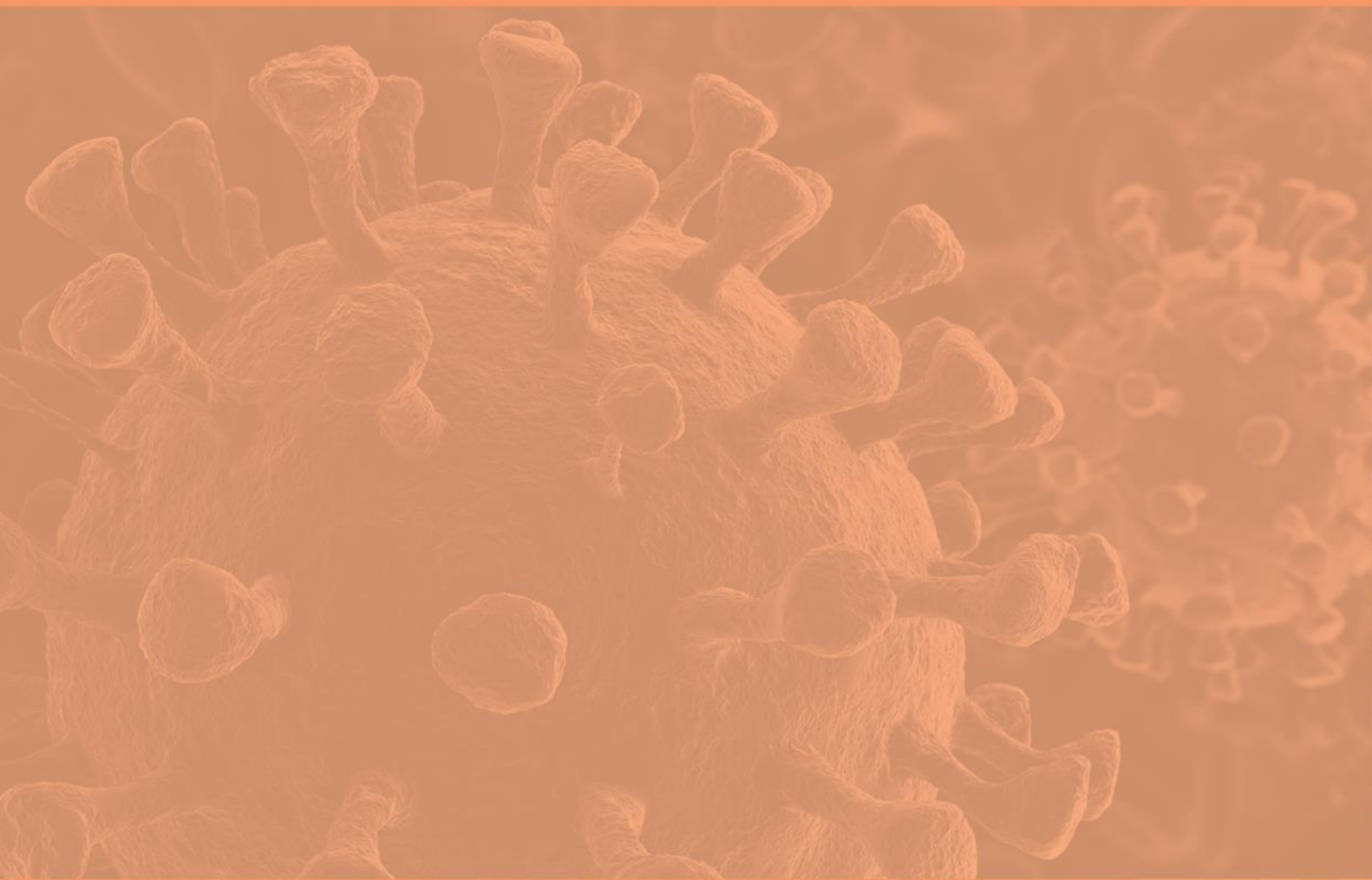
A 'contain and test' approach would need community input and leadership, significant external support for the remote health team, support to provide essential services such as delivery of food to households, and some way of enforcing restrictions which not all community members may accept. It would also require increased COVID-19 testing capacity being available for the health system, and include plans for keeping neighbouring communities safe given the difficulty of ensuring absolute enforcement of movement restrictions. This should include increased testing; liaison to identify an influx of visitors from the index community; and heightened planning for implementing their own community plans

Implementation plans for 'contain and test' will need to be developed on a community or regional basis by health authorities / services in consultation with other government and non-government agencies and Aboriginal community controlled health services and Land Councils.

Despite the evidence of its potential effectiveness, and as with any attempt to address a public health emergency, implementation of a 'contain and test' faces significant risks. Contingency plans should be developed in case it becomes apparent that implementation is ineffective. Strict and timely monitoring of implementation is therefore required.

A high-level description of 'contain and test' can be found at:

<https://www.caac.org.au/uploads/images/Congress-AMSANT-Contain-and-Test-Position-Paper-version-2.0-18-May-2020.pdf>



www.health.gov.au