



Australian Government

BE COVIDSAFE

**NATIONAL GUIDANCE  
FOR URBAN AND  
REGIONAL ABORIGINAL  
AND TORRES STRAIT  
ISLANDER COMMUNITIES  
FOR COVID-19**

# CDNA National Guidance for Urban and Regional Aboriginal and Torres Strait Islander Communities for COVID-19

Revision history			
Version	Date	Revised by	Changes
1.0	9 December 2020	Communicable Disease Network Australia	Developed by the National Aboriginal and Torres Strait Islander Advisory Group on COVID-19

## 1. Acknowledgement

The Communicable Diseases Network Australia (CDNA) acknowledges Aboriginal and Torres Strait Islander peoples and communities and pays respect to Elders past and present. We acknowledge Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia, and as the Traditional Custodians of the land and water on which we live, work and play. We value the principles of self-determination and empowerment, working towards equal participation and equitable inclusion and voice.

Aboriginal and Torres Strait Islander peoples and communities are culturally diverse, with rich and varied customs, histories and experiences. The ongoing impacts of colonisation policies and practices continue to affect the lives of Aboriginal and Torres Strait Islander peoples. Language, lore and cultural knowledge play a critical role in strengthening and empowering Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples are resilient and carry the strength of previous generations, as well as the history of the fight for survival, justice and country that has taken place around Australia. We draw on the wisdom and resilience of Aboriginal and Torres Strait Islander peoples in surviving previous pandemics and recognise this knowledge as vital to public health success.

## 2. Background and purpose

This document gives overarching guidance and considerations for preparing for and responding to COVID-19 cases, clusters and outbreaks in Aboriginal and Torres Strait Islander communities. This document is specifically for urban and regional Aboriginal and Torres Strait Islander communities. It provides a principles-based approach that helps guide health services and local public health authorities in developing and implementing plans at the operational level. Consider this document with the following:

- [Communicable Diseases Network Australia \(CDNA\) Series of National Guidance for Public Health Units on COVID-19](#) (the COVID-19 SoNG)
- relevant jurisdictional plans for responding to COVID-19
- [CDNA National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19](#) (Remote Guidance)
- [the Management Plan for Aboriginal and Torres Strait Islander Populations](#) (The Management Plan).
- [the Management Plan for Aboriginal and Torres Strait Islander Populations](#) (The Management Plan).

## 2.1. Need for this document and specific considerations

The majority of Aboriginal and Torres Strait Islander peoples (78%) live in urban and regional areas of Australia. At this stage in the pandemic (November 2020) the majority of COVID-19 outbreaks among Aboriginal and/or Torres Strait Islander peoples have occurred in urban centres. In these outbreaks several issues have become apparent. These include:

- the spread of infection across major metropolitan areas
- ineffective response plans and inter-sectorial preparedness and response plans not being as coordinated as they could have been;
- the integration of local Aboriginal Community Controlled Health Services (ACCHS)<sup>1</sup> in the response
- the ability of many local ACCHS to provide medical and social and emotional wellbeing care of peoples in isolation or quarantine.

These issues and others show the need for and have helped develop this document.

Specific considerations for Aboriginal and Torres Strait Islander peoples living in regional and urban areas include:

- **Household composition:** Aboriginal and Torres Strait Islander peoples are more likely to live in larger households, and in inadequate housing conditions<sup>2</sup> compared with non-Indigenous Australians. Households are also frequently intergenerational with children and young people living with Aunts/Uncles and grandparents. This increases the risk of household transmission of COVID-19<sup>3</sup> including across age ranges and to those at higher risk of severe disease. Transmission risk may also be compounded by poverty and experiences of financial marginalisation that can impact access to necessary health hardware to prevent household transmission (e.g. cleaning products, disposable masks and other PPE).
- **Cultural obligations:** In Aboriginal and Torres Strait Islander society, families are core to a person's identity and is integrally linked to Aboriginal and Torres Strait Islander culture. Families and kinship are broadly defined and inclusive. In these families and kinship networks, individual and family obligations are central to culture, society and connectedness. These obligations can include caring for Elders, children, extended family, family members with a disability or other community members. Other obligations include attending Sorry Business or other community or culturally significant activities. These can involve people moving between households or communities in urban sprawls or between regional and urban areas, including crossing state borders to attend to these obligations. This can increase the risk of COVID-19 transmission between households in urban locations and geographical spread of disease between urban and regional locations.

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<sup>1</sup> The term ACCHS is used throughout this document. In all instances consideration should be given to whether other local Aboriginal Community Controlled Organisations (ACCOs) can assist in the health response; or provision of wrap around support services needed.

<sup>2</sup> Indigenous Australians at increased risk of COVID-19 due to existing health and socioeconomic inequities - [Aryati Yashadhana, Nellie Pollard-Wharton, Anthony B. Zwi Brett Biles](https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(20)30007-9/fulltext)  
The Lancet Regional Health Western Pacific [https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065\(20\)30007-9/fulltext](https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(20)30007-9/fulltext) Published 24 July 2020

<sup>3</sup> Spread within and mixing between large households within non-Aboriginal families and communities in Melbourne was found to be partially responsible for the rapid increases in the cases in Victoria in mid 2020

- **Barriers to care and engaging with health services:** Even when people are close to clinical health services, barriers to access remain. These include fear and mistrust of mainstream services, structural racism and culturally unsafe service delivery. Distrust and/or fear of government service involvement because of previous experiences with police and child protection, may impact testing and contact tracing systems.
- **Risk of severe disease:** At a population level Aboriginal and Torres Strait Islander peoples have a greater burden of chronic disease than non-Indigenous Australians. This places them at higher risk of severe outcomes from a COVID-19 infection. Disproportionately poor outcomes from COVID-19 infection are recognised in other indigenous populations.<sup>4</sup>

### 3. Overarching principles

The overarching principles guiding preparedness and response to COVID-19 in Aboriginal and Torres Strait Islander communities are:

- **self-determination and empowerment**
- prioritisation of Aboriginal and Torres Strait Islander **cultural and spiritual ways**
- **cultural safety.**

Strategy recommendations that draw on these and recommendations in the CDNA COVID-19 SoNG are summarised below:

- **Shared decision-making and governance and community control.**  
Ensuring Aboriginal and Torres Strait Islander Community Controlled Organisations, and state Affiliates have representation and input into all aspects of COVID-19 planning and response in their communities, and decision making processes. A collaborative partnership model should include key Public Health, Clinical health services and community, and Aboriginal and Torres Strait Islander representation should be embedded in the central pandemic management team.
- **Prioritising Aboriginal and Torres Strait Islander cultural and spiritual ways and a holistic view of health and its determinants.**  
The pandemic response should be framed through an understanding of the holistic, spiritual and cultural ways of being and doing for Aboriginal and Torres Strait Islander peoples. Building connection to culture, family, community and country into approaches across outbreak management and pandemic response and recovery is important. This includes recognition of the ongoing effect of colonisation on Aboriginal and Torres Strait Islander peoples and the consequences of barriers to accessing services, also the effects of racism. Prioritising Aboriginal and Torres Strait Islander cultural ways means responding with a holistic wraparound approach to the whole person including housing, employment, disability status, legal, child protection and income status. The pandemic response must incorporate **social and cultural determinants of health** and **flexible and responsive models of care** working collaboratively with local ACCHSs, and other Aboriginal and Torres Strait Islander organisations and units.
- **Cultural safety<sup>5</sup>.**  
Cultural safety is about creating an environment that is safe for Aboriginal and Torres Strait Islander peoples. This means there is no challenge or denial of identity and experience. Cultural

<sup>4</sup> Dorn, A., van Cooney, R. E. & Sabin, M. L. COVID-19 exacerbating inequalities in the US. *Lancet* **395**, 1243–1244 (2020).

<sup>5</sup> For more information see the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health <https://www1.health.gov.au/internet/main/publishing.nsf/Content/indigenous-crf>

safety is fundamental to communication and community awareness in a pandemic. Cultural safety is about:

- Shared respect, shared meaning and shared knowledge;
- The experience of learning together with dignity and truly listening;
- Strategic and institutional reform to remove barriers to the optimal health, wellbeing and safety of Aboriginal and Torres Strait Islander peoples. This includes addressing unconscious bias, racism and discrimination, and supporting Aboriginal and Torres Strait Islander self-determination;
- Ensuring that individuals', organisations' and systems' cultural values do not negatively effect on Aboriginal and Torres Strait Islander peoples, including addressing the potential for unconscious bias, racism and discrimination;
- Ensuring that individuals, organisations and systems enable self-determination for Aboriginal and Torres Strait Islander peoples. This includes sharing power (decision-making and governance) and resources with Aboriginal and Torres Strait Islander communities.

## 4. Considerations for COVID-19 plans

COVID-19 preparedness and outbreak plans at any level for example:

- community, jurisdictional or health service level should specifically consider Aboriginal and Torres Strait Islander peoples.
- take into account the overarching principles and factors specific to urban and regional Aboriginal and Torres Strait Islander communities outlined in the sections above.

Flexibility and local, place-based solutions that are adaptive to context are crucial. Across urban and regional settings there will be a wide diversity of community structures including:

- Aboriginal and Torres Strait Islander peoples in metropolitan and regional areas that interact with Aboriginal and Torres Strait Islander community members from a range of nations and non-Indigenous peoples.
- Aboriginal and Torres Strait Islander discrete communities that are Aboriginal led and governed but are not physically remote from urban and regional settings<sup>6</sup>.
- Aboriginal and Torres Strait Islander peoples living in metropolitan and suburban areas who may choose to engage predominantly with Aboriginal and Torres Strait Islander peoples and therefore need a targeted, culturally appropriate response that recognises and respects this choice.

Plans should be developed in partnership with local ACCHS, state Affiliates and other representative bodies and feature opportunities for community to lead and to contribute. This will enable identification of specific local considerations, risks and the options for managing them.

This will also allow creation of a plan that will be efficient and effective in outbreak management. Where plans are multi-agency, it's important to:

- clearly define roles and responsibilities (including clarity about who is responsible for developing the plan, and a coordinator to lead implementation ahead of time)
- ensure there is enough resourcing.

Plans should include details on how ACCHS and organisations that deliver allied and other health

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<sup>6</sup> Examples include Lake Tyers in Victoria, Cummergunja in New South Wales and Yarrabah in Queensland.

services will be integrated into the response, particularly how they will work with public health units (PHUs – see section 7). They should also address how local cases will be communicated to local ACCHS and state affiliates, and, given the high mobility of the population, to the broader ACCHS community, while respecting consent and privacy. Circulating daily situation reports to ACCHS and state Affiliates will ensure ongoing response integration and coordination.

Other specific areas that should be addressed in the plan can be found in the subheadings below.

## **4.1 Whole of community support mechanisms**

In recognition of the importance of community to Aboriginal and Torres Strait Islander Peoples, plans should include whole of community support mechanisms (at any stage of community restrictions) in addition to management of individual cases and contacts. Cross sectoral approaches to support the Aboriginal and Torres Strait Islander community should include developing linkages between PHUs, ACCHS, other relevant service providers and with other community organisations to give holistic support that address physical needs and social and emotional wellbeing.

## **4.2 Mental health trauma and healing**

Plans should include strategies to address high rates of mental health problems and stress experienced by the community during the COVID-19 pandemic. Many Aboriginal and Torres Strait Islander peoples are already living with high rates of stress because of:

- poverty
- racism
- underemployment
- poor health
- inadequate access to culturally safe services
- substance misuse
- Intergenerational trauma.

COVID-19 has exacerbated this through multiple pathways including:

- worries about personal and family member's health
- increased financial strain
- shortfalls in essential supplies
- movement and social gathering restrictions.

These affect the ability to undertake cultural practices and responsibilities as well as the ability to connect with family and country. Provision of culturally safe mental health and emotional and social wellbeing services is essential and should include references to healing.

## **4.3 Groups at higher risk**

Particular groups in the community are likely to be at higher risk from COVID-19 and/or find it more difficult to access health services. These may include:

- people living with a disability
- people experiencing domestic or family violence
- people in contact with the judicial / child protection systems



- people experiencing homelessness
- people with mental health problems
- people with substance misuse or addiction issues.

Ensuring access to testing and health services for these groups is important to include in the planning process, and may need specific outreach services including through local ACCHSs. Adapting communications to target people experiencing high levels of marginalisation and multiple risk factors is important. It helps them access up to date and accurate information in a pandemic which is crucial, as is engaging ACCHSs in the communications response. Where possible, trusted and existing service pathways to undertake expanded outreach of service and communications.

## 4.4 High risk settings

There are specific settings where the risk of rapid COVID-19 transmission has been documented as being particularly high. These include:

- High density residential settings with high levels of contact between inhabitants, such as prisons, residential aged care facilities, group housing facilities, hostels or high density housing, town camps
- Workplaces with high risk of exposure to cases such as healthcare and residential aged care
- Specific workplaces such as meat and other food processing works, distribution centres and among security guards where COVID-19 has shown to spread rapidly
- Prisons and juvenile justice facilities, boarding schools and other institutional settings.

Individuals in other settings may be at higher risk of acquiring disease because of their relatively high number of contacts. These include:

- Those working in public transport including taxis
- Those involved with children on out of home care orders with engagement across multiple households and workers.

Other settings may not have a high chance of transmission, but may have a high proportion of Aboriginal and Torres Strait Islander peoples who use, work or visit them. Depending on the area this may include the transport industry, community centres and community organisations.

As part of their planning PHUs and ACCHS may consider proactively identifying these settings and working with them to minimise risk. This may include providing advice to develop the COVID Safe plans and ensuring they are aware of relevant contacts, services and guidance.

### 4.4.1 Cluster and outbreak management in high risk settings

Guidance for outbreak management in high risk settings is available in the [COVID-19 SoNG](#). There is specific guidance on [outbreak management in prisons](#) and [residential aged care facilities](#). Note that all of these guidelines recommend implementing an outbreak type response to notification of a single case of COVID-19. This may include widespread testing of others in the facility/site (even if asymptomatic) and in some settings, whole of community movement restrictions. Outlined in the [Remote Guidance is the use](#) of whole of community movement restrictions, alongside whole of community testing.

Early evacuation of cases and contacts is the preferred method for management of outbreaks of COVID-19 in remote Aboriginal and Torres Strait Islander communities<sup>7</sup>. This approach is considered by some urban and regional Aboriginal and Torres Strait Islander communities to prevent transmission in and outside their community. Public health authorities may implement restrictions in the event of an escalating outbreak. Wherever possible, it's important that decisions are community led, or enacted in consultation with key community leaders and with sufficient time to allow dialogue with the broader community. It is important that any kind of response is implemented sensitively, and wherever possible identifiably 'health-led' and not 'police / military-led' including local Aboriginal health services and community engagement staff.

## 4.5 Border restrictions

Closure of state and territory borders with or without local movement restrictions or creation of areas of restricted movement within a state may prevent some community members from accessing their usual services, and in some cases may prevent access to culturally safe services.

Proactive planning is necessary to address any barriers due to border closures.

- Contingency plans for identification of alternate services for individuals who access services on the other side of the state (or other) border in which they live.
- Cross border collaboration between Public Health sector, Hospital/Health Service sector and ACCHS sector. This will assist in supporting community members who may be vulnerable and require additional support during border closures.
- Attention is essential to support community members in accessing permits for cross border travel, when they don't have the required forms of identification. ACCHS can help community members through liaison with police or other agencies; ideally systems and linkages for doing this are developed prior to border restrictions are in place.

## 5 Surveillance and testing

COVID-19 is a predominantly droplet spread disease, with likely smaller contributions via airborne and fomite spread. The disease has high transmissibility and significant pre-symptomatic transmission. Experience so far has shown that uncontrolled outbreaks can spread rapidly within and outside of households. It is likely to be compounded by crowded housing and high levels of mobility between households experienced by many Aboriginal and Torres Strait Islander peoples. Therefore early and complete identification of cases and contacts is critical for containing the spread of COVID-19. Immediate isolation of cases and quarantine of contacts will minimise the risk of onwards transmission. This requires testing to be culturally safe and barriers to accessing this be minimised.

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<sup>7</sup> This was informed by modelling work undertaken by the University of Melbourne and the Kirby Institute (commissioned by the Commonwealth Department of Health) under the guidance of the Aboriginal and Torres Strait Islander Advisory Group on COVID-19. Results of the modelling are summarised in the remote guidance and a full report can be found [here](#)



## **5.1 Testing strategy**

Rapid identification of cases relies on symptomatic individuals seeking health care as soon as they experience symptoms. Appropriate recognition by clinical staff of the need to test those with a clinically compatible illness and rapid laboratory turnaround of tests. High uptake of testing is necessary:

- during periods of no or low community transmission to ensure that undetected chains of transmission in the community are found as early as possible
- during periods moderate to high community transmission to ensure that public health action is taken around cases as soon as possible.

It is important to have a testing strategy that encourages high uptake of testing among Aboriginal and Torres Strait Islander peoples. Considerations for development of a strategy are outlined below. Planning should include arrangements for prompt testing of asymptomatic close contacts, and the ability to quickly increase testing sites in response to increased community cases and demand for testing. Community messaging to encourage testing uptake is outlined in section 6 (below).

### **5.1.1 Culturally safe testing**

Ensuring access to culturally safe testing for Aboriginal and Torres Strait Islander peoples is imperative to ensure uptake of testing. Where there is a local ACCHS it should be consulted to establish:

- if have capacity to embed testing capability in their own services
- whether they will refer clients to another testing facility
- whether mobile whole-of-community testing services could co-locate temporarily at their facility or another setting that is appropriate for the community.

Every testing site must have culturally safe processes in place to support Aboriginal and Torres Strait Islander peoples. This should include testing sites actively seeking partnerships with ACCHS and ensuring culturally safe supports are available and staff are briefed on culturally safe practices. Targeted place-based solutions should be negotiated with existing service providers.

### **5.1.2 Addressing other barriers to testing**

People are more likely to be tested when results are available quickly. Enabling fast turnaround of tests for Aboriginal and Torres Strait Islander peoples encourages testing uptake. It recognises that Aboriginal and Torres Strait Islander peoples may find it more difficult to isolate at home or take time off work while awaiting a test result. Enabling faster access to testing may include utilising point of care tests where available and working with labs to encourage prioritisation of samples for Aboriginal and Torres Strait Islander peoples who have difficulty isolating. Ensuring awareness of relevant payments such as the Pandemic Leave Disaster Payment (where available), will help alleviate financial disincentives for those who are unable to earn an income while awaiting a test result.

To allow individuals to remain at home while awaiting test results, home access to essential goods and services, such as a food bank and required medicines (particularly those which may require daily dosing such as opiate replacement therapy) should also be considered. Mobile testing facilities that provide outreach to specific areas should also be considered, and/or consideration of transport support to testing facilities.

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### **5.1.3 Accurate identification of Indigenous status at point of testing**

All testing should include the Standard Indigenous Question to ensure accurate identification. It is important testing staff are provided with context and training about why this question is important and how to frame the way the question is asked. The critical focus is on supporting the person presenting and ensuring accurate representation of pandemic data including the ability to monitor testing uptake among Aboriginal and Torres Strait Islander peoples.

Consideration should be given to systems that will transfer Indigenous status from testing sites to pathology systems to the relevant State Government Public Health notification records to ensure completeness in data reporting.

With patient consent (taken at point of test), the individual's usual primary health care provider should be automatically notified of test taken and any results. Consideration should be given to implementing a system where Aboriginal and Torres Strait Islander peoples who do not have a usual primary care provider are offered the option of having their test results automatically sent through to an ACCHS. This will facilitate the individual being able to seek further care for their illness (if required) and to assist with clinical and public health follow up should they test positive to COVID-19. See section 7 for further details on how ACCHS may be able to work alongside public health units to support Aboriginal and Torres Strait Islander COVID-19 cases and contacts.

## **6 Communications and health messaging**

Culturally safe communication is key to pandemic management success. Developing communication strategies with Aboriginal and Torres Strait Islander peoples and will be most effective when driven by the community controlled sector in partnership with public health authorities. It is important public health messages consider:

- Aboriginal and Torres Strait Islander ways of living and being
- the importance of sharing knowledge and storytelling. This includes social connectedness, connectedness to country and values and how these might conflict with messaging around restricting travel and social gatherings<sup>8</sup>.

Aboriginal and Torres Strait Islander Health Workers play a vital and key role in delivering information to community and can break information down in plain language, and rectifying misinformation. Health authorities should utilise Aboriginal and Torres Strait Islander community health connections that are already established and trusted to deliver health messages.

It is important to consider strategies to protect individual privacy when sharing information with the

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<sup>8</sup> Strong examples of culturally safe health messaging include Victoria's campaign led by the Department of Premier and Cabinet and the Aboriginal Health and Research Council of NSW. Messaging was culturally safe and delivered key points through appropriate art work and visual representation of crucial information.

public or the media, as Aboriginal and Torres Strait Islander communities are often small and interconnected and communities and individuals may be easily identified. Decisions to release information will need to balance the importance of sharing information with communities to inform the response against individual privacy implications.

## 6.1 Key messages

Communication messages need to be realistic and make sense to Aboriginal and Torres Strait Islander people. Developing and delivering messages in Aboriginal and Torres Strait Islander languages ensures inclusivity of people where English is a second language. Communications messages should include:

- information about the disease process, transmission and infectivity and information as to why it's important to quarantine, isolate and get tested.
- health promotion messages on staying COVIDSafe including handwashing, social distancing regular cleaning and wearing a mask (where recommended);
- the importance of isolating including staying away from school and work and being tested for COVID-19 when unwell or symptoms are present. There is no shame or stigma associated with this.
- the importance of complying with public health measures like limiting travel and social gatherings and not visiting other people's homes.
- information on where to seek help when a person, family or household is required to isolate or quarantine, as well as psycho-social supports.

Its important messaging consider patterns of behaviour or epidemiology in the community and focus on particular target groups where required. For example young people may not see themselves at risk of severe disease. If they're aware of the potential to infect others (e.g. Elders) who are at risk, they are more likely to comply with public health advice. Its possible messages will be more effective in some groups if they focus on positive examples of responsible behaviour. Disincentives for complying with public health messaging, for example financial disadvantage from staying away from work if sick, should be considered and addressed through messaging where possible (e.g. through accessing Pandemic Leave Disaster Payment). Proper community engagement will enable understanding of reasons why people are not complying and where possible policy levers should be developed to address these. There is likely to be value in developing frequently asked questions resources; including how to manage questions from the 'worried well'. Developing these in partnership with health care providers and particularly ACCHS is important.

It is critical during a pandemic to reinforce messaging around the importance of not delaying other health care. It's important to collaborate with health services to deliver messaging around not deferring health care. Highlight safety protocols that are in place including the availability of telehealth appointments. This is particularly important for Aboriginal and Torres Strait Islander peoples because of the higher burden of disease.

## 6.2 Communication mediums

Designing communication materials with Aboriginal and Torres Strait Islander peoples, and where possible, with the local context incorporated into the design, is important. Using a variety of mediums and platforms ensures that messaging is received by as wide an audience as possible. This includes harnessing printed materials, social media and radio and television. Where possible, engaging Aboriginal and Torres Strait Islander owned or managed services is advised. Materials can include a

range of methods for sharing public health information including art, music and messages from respected peoples, Aboriginal Health Workers and Elders.

## **7 Supporting cases and contacts**

### **7.1 Systems and links between Public Health Units (PHUs) and ACCHS**

To date, public health management of cases and contacts of COVID-19 has sat within jurisdictional public health units. There is recognition that primary care services can play a role in both the clinical and public health management of lower risk cases and contacts during the isolation or quarantine period.

Aboriginal people working in Public Health, Aboriginal Health units, ACCHS, state and territory Affiliates and other community controlled organisations are well positioned to be able support Aboriginal and Torres Strait Islander peoples who are cases or contacts of COVID-19. They can provide wrap around care and cultural support for the person, family and household through strong community links, contextual knowledge and capacity for culturally safe care. There are different models of doing this, depending on which services are in a position to provide assistance; the setting, and local systems. Some ACCHS can also play a role in public health follow up (such as contact tracing, see below). It is important to acknowledge that some Aboriginal and Torres Strait Islander peoples may have had poor experiences with government agencies in the past and may prefer to engage directly with an ACCHS, while other people have no routine contact with ACCHS. It is therefore important to form strong links between ACCHS that deliver health services, other relevant primary care providers and public health authorities and determine how to work together effectively. Ideally relationships, systems, and roles and responsibilities will be developed and formalised (through memoranda of understanding and/or shared standard operating procedures). This is done prior to a response being required and also reviewed regularly. It's important that engagement is driven by principles of self-determination and cultural safety.

### **7.2 Embedding cultural safety within PHUs**

As the agencies responsible for public health management of COVID-19, PHUs need to ensure that staff are providing culturally safe care to Aboriginal and Torres Strait Islander peoples. This may include:

- designated Aboriginal and Torres Strait Islander liaison roles
- community engagement officers
- Aboriginal and Torres Strait Islander peoples working in the contact tracing team.

All roles at all levels require cultural safety training for all staff. Given the relatively high prevalence of many communicable diseases in Aboriginal and Torres Strait Islander peoples, this is an opportunity to ensure culturally safe practices across all public health actions.

### **7.3 Contact tracing**

Given the higher household occupancy and increased mobility for many Aboriginal and Torres Strait Islander peoples, timely and accurate contact tracing is critical to minimising the risk transmission. Contact tracing among Aboriginal and Torres Strait Islander communities may be complicated by:

- high levels of geographic mobility

- high turnover of contact details
- marginalisation from mainstream health and government service providers.

Where ACCHS are in a position to, they are likely to be well placed to assist with contact tracing. These services are likely to have the trust of individual clients and may be able to obtain more accurate and complete contact histories. Models exist for ACCHS to be involved in contact tracing for other communicable diseases, and (in some areas) for COVID-19. Models will differ by location with PHUs and ACCHS needing to work together to maximise existing opportunities to address identified barriers<sup>9</sup>.

Options for ensuring public health units undertake culturally safe contact tracing include:

- establishment of an Aboriginal and Torres Strait Islander contact tracing pod within the contact tracing team
- a dedicated Senior Aboriginal Cultural Adviser or an Aboriginal and Torres Strait Islander specific contact tracing team.

Interview forms need to be culturally appropriate, and all materials should be reviewed by Aboriginal people to ensure the interviewees are asking the questions in an appropriate way. Embedding Aboriginal or Torres Strait Islander staff (from ACCHS or other areas of the health service or department, including redeploying those in non-clinical roles) within contact tracing teams could be considered, or a PHU contact tracer within an ACCHS.

Approaches to contact tracing should be refined on an ongoing basis following feedback from the sector and Aboriginal and Torres Strait Islander stakeholders.

## 7.4 Managing cases and contacts

Management of Aboriginal and Torres Strait Islander COVID-19 cases and their contacts should be according to the COVID-19 SoNG and relevant jurisdictional and local guidance. During isolation and quarantine cases and contacts will require holistic support that addresses physical needs and social and emotional wellbeing. It's recommended a cross-sectoral approach be used by integrating:

- PHUs
- hospitals
- primary and community care including ACCHS, state Affiliates and other Aboriginal and Torres Strait Islander community organisations.

It is important that the case and contact have a single point of contact for their needs, and as such one consistent case manager per family who liaises across all organisations is recommended.

Making additional/tailored care available to Aboriginal and Torres Strait Islander cases and contacts is important. Depending on the local context and capacity this may include:

- a specific cultural support team within the PHU
- ACCHS providing client support while respecting confidentiality and privacy
- a partnership model.

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<sup>9</sup> Previously identified barriers may include public health and privacy legislation, non-government employees being able to access to information technology systems, training and accreditation and workforce surge capacity.

Regardless it is recommended that systems are developed to enable automatic notification (with individual consent) of an ACCHS or other primary care provider if their client is tested for COVID-19 (at any testing site), and included when results are available. Where local clinical management pathways for cases are not through the patient's usual primary care provider, it is still imperative an ACCHS is notified if one of their clients tests positive, or if one of their clients becomes a contact, to ensure they are able to provide support. Consideration should be given to developing systems for referral to an ACCHS when an Aboriginal and Torres Strait Islander person becomes a case or a contact, even if they are not a current ACCHS client; noting that this will always require the individual's consent.

Specific public health considerations for managing COVID-19 cases and contacts who are Aboriginal and Torres Strait Islander include their higher likelihood of living in large households, crowded or insecure housing and/or intergenerational families. The risk of transmission will be reduced by encouraging Aboriginal and Torres Strait Islander COVID-19 cases and or close contacts to isolate in safe and comfortable accommodation outside of their home, where the home situation does not allow effective isolation. This is particularly important where there are others in the same household who are vulnerable to severe disease (e.g. Elders, older people, peoples with high risk chronic health conditions and people living with a disability). There should be consideration of who may be most trusted by Aboriginal and Torres Strait Islander COVID-19 cases and close contacts to discuss these options in a confidential and culturally safe manner with the household, recognising this is a key component for uptake of the offer of emergency accommodation.

Where cases or close contacts cannot safely isolate at home, safe and comfortable accommodation (see [Appendix 1](#)) should be provided to reduce risk of transmission to other household members. It is important to note that relocation will not be possible or desirable for all peoples (e.g. those with caring responsibilities who are unable to organise alternate care). Unless there are extreme circumstances, cases should not be forced to isolate outside their own home. If the case remains in the household, in some situations it may be more appropriate and acceptable for household contacts who are vulnerable to severe disease to relocate to other accommodation.

It is important that cases and contacts in isolation and quarantine are able to access financial support where required. Different models should be explored for this.<sup>10</sup>

## **8 Planning within health services**

### **8.1 Infection prevention and control within the workplace**

Protecting the health workforce is imperative during a COVID-19 response. ACCHSs have specific considerations for workforce including:

- their workforce is likely to contain a percentage of those at higher risk of severe disease
- their workforce is likely to live in households with those at higher risk of severe disease.

Ensuring appropriate infection prevention and control procedures are followed within the workplace, including between staff. Even in situations with very low levels of transmission, it reduces the risk to individuals and the risk of large numbers of staff having to isolate. If possible, redeploy staff who are at high risk, into lower risk areas and tasks when there is community transmission.

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<sup>10</sup> An existing model that could be modified is crisis brokerage, based on the family violence model of flexible funding support during crisis.



Intelligence sharing between PHUs and ACCHS, when an ACCHS staff member tests positive is important. It allows organisations to be proactive in contact tracing and implementing prevention measures amongst their own staff.

## **8.2 Workforce fatigue and surge capacity**

The need for surge capacity is likely during a response due to increased demand, furloughing of staff, staff becoming unwell and/or workforce fatigue. Planning for surge capacity should include identification of alternate workforce through:

- Redeployment across and between organisations
- Use of agency staff, casual staff, and government led surge workforce pools (respecting any single site recommendations in place to reduce risk of transmission)
- Increasing staff through external telehealth providers.

Early identification of support required for staff, including training and upskilling of the workforce to increase flexibility across roles is important to build readiness for surge capacity. Consideration should also be given to the potential need for extended hours or emergency/on-call provisions if a response is required outside of usual business hours.

Surge capacity planning will need to take into account the type of surge services likely to be required (e.g. contact tracing, clinical, family and household support) and the most appropriate people to do this. Considering how to access a culturally safe surge workforce in urban and regional settings will be beneficial in longer-term planning. Changes to policy levers to achieve this should be considered.

During a pandemic response it is important to promote and monitor the wellbeing of staff to reduce risk of fatigue and burnout. This includes providing options for support and early intervention when needed. Support should be provided to all staff, not just clinical. Staff rotation on and off site and through roles, rostering leave or changing clinics hours may also be used to manage staff fatigue. The Aboriginal Health and Medical Research Council of NSW (AHMRC) has developed HR strategies to effectively manage workforce capacity. Read it in [Appendix 2](#).

It needs to be recognised that services, which may already be very stretched, will very likely find it challenging to respond to an outbreak. To manage this, services can develop risk stratification of usual clients and prioritising service delivery in the short term. This is effective for managing acute health and wellbeing needs, chronic conditions with high risk of deterioration and hospitalisation, and priority preventive activities such as vaccination. If possible, services may consider a network of backup services to ensure ongoing care for their clients and service sustainability for their service.

## Appendix 1: Requirements for safe isolation and quarantine

Guidelines for safe isolation and quarantine can be accessed through the [World Health Organization](#)

Separate facilities should be designated for confirmed and suspect cases and their close contacts (keeping these groups separate) where home facilities are inappropriate to allow for adequate separation of cases and contacts.

The ideal requirements for quarantine and isolation are a well-ventilated single room with access to a private toilet.

If single room cannot be provided, beds should be placed at least 1.5m apart with no more than one person per 4m<sup>2</sup>. Facilities need to be provided for:

- Provision of food, water, and hygiene
- Protection for baggage and other possessions
- Communication with family members who are outside quarantine
- Assessment by clinical staff
- Social support

## Appendix 2: Suggested measures for developing and effective pandemic human resources strategy<sup>11</sup>

<b>Workforce capacity</b>
<ul style="list-style-type: none"> <li>• Train staff in alternative roles to prevent interruption to service delivery due to staff absenteeism from illness</li> <li>• Establish policies for employee compensation and sick leave absences</li> <li>• Manage staff exposed to the pandemic and develop policies regarding return to work for previously infected staff members</li> <li>• Identify programs/services that can be downsized or closed if required during a pandemic that will minimise service disruption or postpone non-essential / routine consultations</li> <li>• Incorporate flexible hours and staggered shifts during pandemic</li> <li>• Identify additional potential staff for pandemic surge (e.g. local hospital casual staff, recently retired GPs and nurses)</li> <li>• Appoint one GP and nurse to solely manage suspected cases, with back-up staff if required</li> <li>• When appointing staff for this position consider the following questions: - Do you or your immediate family have health restrictions that may affect your ability to work during the pandemic while being exposed to suspected and confirmed cases of influenza? - Are you prepared to be exposed to suspected cases of influenza?</li> </ul>
<b>Mental health and staff wellbeing</b>
<ul style="list-style-type: none"> <li>• Consider mental health support for staff, especially in dealing with anxiety and stress</li> <li>• Engage culturally safe support for staff including debriefing and less formal supports through the local ACCH</li> <li>• Prepare to institute a system once a pandemic has been confirmed and the action phase commences.</li> <li>• Encourage self-reporting of mental health concerns and ensure all staff have contact details for mental health services</li> <li>• Set up mental health support clinics consisting of a psychologist and mental health nurse</li> <li>• Identify groups (including staff) that may need psychosocial support and refer them to support organisations that could assist</li> <li>• Using online resources including Australian Psychology Society (APS) tip sheets for information about how to psychologically prepare for a disaster</li> <li>• Regularly source feedback from staff and act to prevent further escalation.</li> </ul>
<b>Building a culturally safe workforce</b>
<ul style="list-style-type: none"> <li>• Where possible, surge workforce should involve predominantly peoples who identify as First Nations. Where there is a shortage of health staff, efforts should be made to source staff from settings where there is a history of engagement with Aboriginal and Torres Strait Islander communities.</li> <li>• Regular cultural safety training should be undertaken particularly with surge workforce to ensure continuous learning and a strengthening of cultural safety.</li> </ul>

<sup>11</sup> AHMRC Pandemic Toolkit [https://mk0ahmrchvhy3q0clf.kinstacdn.com/wp-content/uploads/2020/03/AHMRC\\_Pandemic-Toolkit\\_Final\\_March-2020-v5.0.pdf](https://mk0ahmrchvhy3q0clf.kinstacdn.com/wp-content/uploads/2020/03/AHMRC_Pandemic-Toolkit_Final_March-2020-v5.0.pdf)