



Australian Government

BE COVIDSAFE

NATIONAL GUIDANCE FOR REMOTE ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES FOR COVID-19

Revision history

Version	Date	Revised by	Changes
1.0	16 April 2020	Communicable Disease Network Australia	Developed by the National Aboriginal and Torres Strait Islander Advisory Group on COVID-19
2.0	10 August 2020	Communicable Disease Network Australia	Removal of Interim from title; restructure of entire document; Consideration of an outbreak response on notification of a single case of COVID-19 in a community; additional information on ACCHOs role; revised suspect case definition; links to jurisdictional plans; addition of modelling; removal of section on surge capacity
3.0	7 December 2021	Communicable Disease Network Australia	Restructure of document; updates to modelling; updates to take into account COVID-19 vaccination and effective treatments; updates resulting from lessons learned from outbreaks in remote communities in western and far western NSW and NT

This National Guidance is to be used in conjunction with Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units (SoNG) and the Management Plan for Aboriginal and Torres Strait Islander Populations. For operational details of local response, please refer to the relevant local or jurisdictional plans:

Jurisdictional plans available online:

Queensland

[Queensland Public Health Guideline for COVID-19 Outbreak in First Nations Communities;](#)
[COVID-19 Protection and Containment Considerations for First Nations Communities](#)

New South Wales

[Pandemic Preparedness and Response with Aboriginal Communities in NSW](#)

Western Australia

[COVID-19 health guidance for remote Aboriginal communities of Western Australia](#)

Additional jurisdictional links will be updated as they become available. Alternatively, please contact the relevant jurisdiction.

CONTENTS

1. Background	4
2. Overarching principles	4
3. Results of modelling.....	5
4. Outbreak preparedness	6
4.1. Community plans	6
4.2. Communication.....	8
5. Surveillance for COVID-19	8
5.1. Definition of a suspect case	9
5.2. Testing technologies and application in remote areas	9
6. Response to COVID-19 in the community	10
6.1. Evacuation of confirmed cases and quarantine of contacts	11
6.2. Considerations for cases and contacts remaining in community	12
6.3. Other community actions in response to one or more cases	13
6.4. Restricting movement to and from the community	14
6.5. Relocation of vulnerable people from community.....	14
6.6. Reactive vaccination	15
6.7. Potential cessation of evacuating cases (with or without contacts) in the event of widespread community transmission	15
7. Coordination of evacuation for suspect and confirmed cases and their close contacts	16
7.1. Return home of confirmed and suspected cases and their contacts.....	16
Appendix 1: Guidance for the rational use of Point-of-Care Testing in primary care	18
Purpose.....	18
Background.....	18
Cartridge Prioritisation	18
Consider prioritisation of the following groups:.....	19
Appendix 2: Key considerations to guide the decision to evacuate suspect and confirmed cases and their close contacts	20
Appendix 3: Requirements for safe isolation and quarantine in community	23
Appendix 4: Decision making algorithm for suspect and confirmed cases	24
Appendix 5: Indigenous Liaison Support Team overview	25

1. Background

This document complements and expands on relevant aspects of the *Communicable Disease Network Australia Series of National Guidance for Public Health Units on COVID-19* (the COVID-19 SoNG) and the *CDNA/PHLN Testing Framework for COVID-19 in Australia*. While much of this document focuses on the circumstances specific to remote Aboriginal and Torres Strait Islander communities, many of the principles and considerations are also applicable to urban and peri-urban settings. This document was initially developed due to the higher risk posed to remote Aboriginal and Torres Strait Islander communities from COVID-19, including a higher risk of severe outcomes of disease and greater risk of disease transmission. Since this document was published, COVID-19 vaccines have now become widely available and novel COVID-19 treatments have been developed. In addition, in 2021, outbreaks occurred in remote Aboriginal and Torres Strait Islander communities in New South Wales, Victoria and the Northern Territory.

Although COVID-19 vaccines are effective at reducing the risk of severe COVID-19, Aboriginal and Torres Strait Islander communities continue to be at higher risk from COVID-19, particularly due to the lower rates of vaccination in many communities compared with the Australian national average and more difficult access to healthcare and COVID-19 treatments. In particular, through the COVID-19 Delta variant outbreak, Aboriginal and Torres Strait Islander people have been infected at almost twice the rate of non-Indigenous Australians (599.8 vs 359.5 per 100,000 as of 18 October 2021).

This document has been updated to take into account Australia's move to a 'living with COVID-19' phase, with the consequent increase in community transmission of cases. In addition, this document includes advances in effective COVID-19 treatments, the positive impact of COVID-19 vaccination and learnings from outbreaks in remote communities in western and far western New South Wales (NSW), the Northern Territory (NT) Tanami mine outbreak and regional Victoria (Vic).

2. Overarching principles

The July 2020 *Australian Health Sector Emergency Response Plan for Novel Coronavirus (Covid-19) - Management Plan for Aboriginal and Torres Strait Islander Populations* contains recommendations on the development of strategies for Aboriginal and Torres Strait Islander communities. Key strategy recommendations are summarised below:

- **Shared decision-making and governance and community control:** Central to this is ensuring that Aboriginal and Torres Strait Islander community leaders, Aboriginal Community Controlled Health Organisations (ACCHOs) and other Aboriginal organisations have representation and input into all aspects of COVID-19 planning, response and recovery in their communities, and particularly decision-making processes at national, jurisdictional and local levels. **Experience shows that Aboriginal and Torres Strait Islander organisations play a critical role in supporting communities.**
- **Risk assessment:** Each community should conduct a risk assessment for their community, including vaccination rates and accessibility to medical care within the community, when there is a suspected or confirmed COVID-19 case to inform their outbreak response. Households should be encouraged to prepare their own plan for alternate care, isolation if there is a suspected or confirmed COVID-19 case.
- **Social and cultural determinants of health.** This should include living arrangements and accessibility to services.
- **Clinical Communication:** Including communication between Public Health Units (PHUs) and health services in the event of a suspected or confirmed case in the region or regional town.
- **Appropriate communication with the community:** Each community action plan should contain recommendations for communication within the community, including about the

disease process and infectivity, safety and benefits of COVID-19 vaccination and information as to why quarantine, isolation and testing are required. This should be done by local health staff (including Aboriginal and Torres Strait Islander Health Workers or Practitioners) in partnership with the relevant PHU and other relevant organisations.

- **Flexible, coordinated and responsive models of care** that acknowledge the lived experience of trauma and racism; including outreach models, the use of point-of-care RT-PCR systems in settings where access to laboratory-based testing is not available or a rapid result is required, options for at-home rapid antigen testing, vaccination and whole of family and community approaches.

3. Results of modelling

To better guide response strategies, modelling work on COVID-19 in remote communities was 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, with publication in July 2020.

The major findings of this were that:

- An uncontained outbreak in a remote community will spread rapidly due to overcrowded housing and close mixing between interconnected households and groups.
- Early case detection with testing and rapid availability of results (within 2 days) is critical to minimise the outbreak.
- Effective isolation of cases and quarantine of contacts are essential for outbreak control.
- Proactive testing of extended household members (assuming cases move between their primary place of residence and two other key houses) at baseline improves outbreak control, but only if results are available within two days.
- Immediate quarantine of remaining households in larger communities (500+) for 14 days is a highly effective strategy for initial containment, but only if high compliance is maintained.
- Clearance or exit testing of all those in quarantine or lockdown on day 12 (so that results are available by day 14) significantly reduces the likelihood of subsequent waves of infection, and the total number of tests required during the outbreak.

Outcomes consistent with the modelling of a full lockdown with quarantine and test of the case's extended households with clearance testing were seen during the COVID-19 Delta variant outbreak in western and far western NSW in 2021. However, most cases in the Delta variant outbreak isolated in the community and were not evacuated.

The Doherty Institute conducted modelling work on COVID-19 in remote communities as part of the work commissioned by the National Cabinet to inform the National Plan to Transition Australia's National COVID Response. This modelling, released 5 November 2021, takes into account varying rates of COVID-19 vaccination within remote communities. The key findings were:

- The younger age profile of remote communities, in addition to overcrowded housing, and close mixing between interconnected households and groups, will contribute to rapid spread of COVID-19 within that community, even with high vaccination rates in the population 12 years and over.
- However, high vaccination rates, and the young age profile of those communities, will result in a small proportion of the community that may develop severe disease.
- There are clear benefits of high pre-emptive vaccine coverage to reduce transmission and disease impacts in remote settings.
- Constraining outbreaks through other measures enables the delayed impact of reactive vaccination to take effect and further reduce outbreak size.
- Even low rates of reactive vaccination lead to large reductions in clinical burden.

- More effective outbreak control is achieved by evacuating both cases and contacts from the community for isolation and quarantine than when close contacts remain in the community.
- High vaccination coverage for children aged 5 to 11 years would dramatically reduce transmission and outbreak size if vaccines become available for this age group.

4. Outbreak preparedness

4.1. Community plans

Community engagement is required to ensure high levels of participation across all sections of the community. Health services should work with the Public Health Unit, emergency services and communities to develop a local COVID-19 action plan that is based on the relevant jurisdictional plan and is tailored to the community's level of vaccination rates, issues, needs and opportunities. The following should be included in the local plan:

1. The leadership and coordination structure for planning and responding to COVID-19 in the community.
2. Roles and responsibilities of all agencies involved, including the need for ACCHOs, to be involved in outbreak planning and response.
3. An outline of any relevant legislation that can be used to enforce public health or other measures.
4. A risk assessment of the impact that a COVID-19 outbreak will have on the community, in particular the impact of community vaccination rates, access to healthcare and other essential services on the management of an outbreak, as this will inform the outbreak management in the community.
5. A plan for identifying someone who is a suspected or confirmed case of COVID-19, including:
 - a. Community messaging from trusted sources and people, such as community elders;
 - b. Support for people who may be reluctant to get a test for fear of having to isolate, mistrust of Government or generational trauma; and
 - c. Testing strategies specific for the community that aims to identify active cases and reduce further spread of infection. In addition, barriers and disincentives to testing uptake and access, both perceived and real, should be identified and addressed to ensure equitable and widespread access to testing.
6. A plan for managing COVID-19 cases including consideration of:
 - a. Plan to house and support cases in community (if this is the preferred option based on a risk assessment of the community, if the case is unwilling to be evacuated from the community or if regional centres are at capacity);
 - b. Plans for medical management of the case, including administration of COVID-19 treatments if required;
 - c. Plans for provision of essential goods and services to individuals in isolation, including food and medicines;
 - d. Plans for medical evacuation; and
 - e. Plans for evacuation for public health reasons (i.e. isolation), including transportation and accommodation plans.
7. A plan for managing contacts of suspected and confirmed cases including:
 - a. Contact tracing strategies specific for the community, including the use of Aboriginal Health Workers as contact tracers;
 - b. Plans for supporting appropriate quarantine in the community, including potential evacuation; and
 - c. Other strategies (e.g. movement restrictions) that may be necessary to respond to one or more cases.

8. Management of cases and contacts who do not adhere to self-isolation and quarantine including how to manage any potential community disharmony. This includes additional support for people who experience fear of testing and isolation from family and community associated with social and cultural impacts.
9. Plans for community mobilisation and recommendations for communication within the community.
10. Capacity of local services to provide surge workforce (which may be very limited) and strategies for linking in with any external outbreak response teams to assist in the public health response, medical management of COVID-19, COVID-19 vaccinations, provision of other essential services, community social and wellbeing support.
 - a. This should include planning for state and territory health workforce to provide surge capacity to ACCHOs if required or for ACCHOs to consider augmenting state and territory workforce to support a culturally safe response.
 - b. This should also take into consideration usual resourcing requirements (which may already be overstretched) and the potential for usual health care providers to be unable to provide services during an outbreak due to their own health risk factors (placing them at higher risk of disease) and/or the chance that some or all clinical staff may become contacts.
 - c. Consider use of jurisdictional public health and medical surge workforce, AUSMAT, Australian Defence Force (ADF), National Indigenous Australians Agency (NIAA), and other response teams, including commercial providers.
 - d. Where external teams are brought in, ensure that they are provided with appropriate cultural awareness preparation.
11. Plans for the clinic/s to maintain essential health services (noting the considerations under point 10).
 - a. COVID-19 exposure risk mitigations including physical barriers and other forms of hazard reduction, effective and consistent implementation of policies and protocols, maintaining staff wellbeing and appropriate use of personal protective equipment (PPE).
 - b. Consideration of the use of Rapid Antigen Tests for screening/surveillance of health workers and clients.
 - c. Protocols to review exposure, assess impacts of work restrictions and implement minimum recommended work permissions and restrictions as specified in *“Work Permissions and Restrictions Framework for Workers in Health Care Settings”*. If actions recommended are not possible or would result in a significant disruption to essential services, it may be necessary to implement alternative mitigation strategies so staff may continue working. These arrangements should be developed with the local PHU.
12. Considerations for response in the event of a community outbreak, including:
 - a. Community messaging;
 - b. Surge capacity (including roles, responsibilities and lines of reporting);
 - c. Involvement of the local clinic in outbreak response, such as assisting with contact tracing and targeted COVID-19 vaccinations to increase community vaccination rates (see below potential options for rapid vaccination considerations);
 - d. Monitor and support COVID-19 positive cases isolating in community;
 - e. Early evacuation and/or provision of COVID-19 treatments to prevent severe disease;
 - f. Continuity plans for existing services and essential services;
 - g. Whole of community containment efforts, including community support for individuals and households required to isolate, such as provision of essential items (food, health based items); and
 - h. Consideration of the scale of accommodation needed to allow individuals to isolate/quarantine in the community and/or to support surge health workforce brought into the community to support management of an outbreak.
13. Rapid vaccinations deployed for community, including surrounding communities to get ahead of any potential impact on spread of disease, including options for:

- a. Facilitating timely requests for support through relevant state coordination centres to ensure prompt access to additional resources including vaccine administration, logistics and planning support and workforce resourcing.
 - b. Requesting additional Cultural Liaison support. For example, the Commonwealth supported an Indigenous Liaison Support Team (ILST), comprising Indigenous public health professionals, being deployed in the west and far western NSW outbreak. Linked with a Commonwealth Health Liaison Officer, the ILST were embedded between the ADF Regional Operational Command and the AUSMAT deployment teams. The ILST were able to coordinate with the various community leaders, organisations, including government and non-government organisations. This ensured that the local leadership and the cultural leadership were engaged and informed. Further information on this team is provided at Appendix 5.
14. A plan for debriefing and reviewing the community response after every outbreak, including lessons learned.

Wherever possible, community plans should be tested (including all agencies involved, community representatives and the community as a whole). Plans should be reviewed at least three-monthly given changes to epidemiology, vaccination coverage, novel treatments and travel restrictions, and retested as needed. In particular, as vaccination coverage in the community increases, the need for certain public health measures and restrictions may be changed or lessened.

4.2. Communication

Clear, culturally appropriate and safe communication with communities is of utmost importance when planning and enacting responses to COVID-19. Communication should occur through a variety of channels and provide opportunities for trusted local community leaders to have a role. Health services should work with communities to develop culturally appropriate methods of disseminating advice including translation to local languages where needed. Engaging with key stakeholders is critical to achieve meaningful engagement with long lasting impacts.

This advice should include preventative messaging around COVID-19 vaccination, such as the importance of hand washing, cough and respiratory etiquette, physical distancing. Communication should clearly explain the symptoms suggestive of COVID-19 and highlight the need and benefit of getting tested.

Communication with the community should also cover outbreak response planning including the possible need for movement restrictions during an outbreak (noting that an outbreak response may be enacted for a single case – see below). Consideration should also be given to developing a communications strategy that would be rapidly deployed in the event of one or more cases, which should recognise the key role that Aboriginal and Torres Strait Islander health based organisations, including ACCHOs, will play in this.

An outbreak may provide an opportunity to provide targeted vaccination to individuals who have previously not had access to vaccination or have been reluctant to get vaccinated. Increased vaccination uptake will require effective communication from local health services and community leaders, including one-on-one conversations, to provide reassurance to individuals and address vaccine hesitancy.

5. Surveillance for COVID-19

As indicated by the modelling results presented above, high community vaccination rates are an effective way to reduce transmission and disease impacts in an outbreak. Even in the context of vaccination, the modelling also indicates that, due to its high transmissibility, significant pre-symptomatic transmission and short serial interval, early detection of a case of COVID-19 is imperative to contain transmission. Early detection of a case relies on symptomatic individuals seeking health care soon after symptom onset, appropriate recognition and testing of possible cases,

and rapid laboratory turn around. Early detection can be supported by high testing rates for symptomatic individuals, serial testing of high-risk asymptomatic individuals and sewage surveillance.

Testing all people with a compatible illness is a key component of surveillance for COVID-19 in a low COVID-19 case load environment. Maintenance of high testing rates for symptomatic individuals will remain key to early detection of cases and outbreaks in remote communities. Current enhanced testing protocols recommended in the CDNA SoNG encourage testing of all people with fever, loss of smell or loss of taste or symptoms of acute respiratory infection (ARI), and those presenting with other symptoms (such as sudden onset fatigue) where there is high suspicion of COVID-19. Given the potential for relatively mild illness in some people (particularly children and young people and those who have been vaccinated), it is important to have clear messaging to the community about the need to present for testing with any fever or respiratory illness, however mild, and even if they are vaccinated.

Strategies to encourage presentation for COVID-19 testing should also consider potential barriers to presentation and address these wherever possible. These barriers include the fear of having to isolate if they test positive, distrust of government and generational trauma. Flexible models, including offering testing at peoples' homes and point-of-care testing may address some of these barriers. It is also important that frontline health care workers are skilled in recognising those who meet testing criteria. Auditing the proportion of presentations eligible for SARS-CoV-2 testing against the number of tests done at a clinic is a useful adjunct, where feasible, to encourage and sustain high levels of surveillance.

Rapid antigen testing may be used to enhance surveillance through the testing of asymptomatic high-risk individuals. This may include testing of health staff or patients who have recently arrived from outside of the community prior to entry into healthcare facilities.

Sewage detection may also support early identification of cases within a community.

High rates of testing, including consideration of serial testing of high-risk asymptomatic individuals should be implemented when there are active outbreaks in surrounding towns, and when there is positive sewage detection.

5.1. Definition of a suspect case

The suspect case definition should follow the national case definition as outlined in the COVID-19 SoNG and relevant jurisdictional case definitions.

While not covered in the suspect case definition, a particular aspect of some communities is that they may be relatively 'closed' and so less likely to have introduction of disease. In this situation, consideration should be given to whether someone who presents with a clinically compatible illness who has not recently been outside of the community, but is a contact of someone who has been outside of the community, may also have a higher pre-test probability of disease and whether some aspects of a 'suspect case response' (see below) should also be considered for this person.

5.2. Testing technologies and application in remote areas

Many rural and remote communities face long turnaround times for traditional laboratory testing. Some rural and remote communities will have access to (RT-PCR) point of care testing (POCT) for SARS-CoV-2 (e.g. using GeneXpert, BioFire, FilmArray devices). In addition, rapid antigen testing will likely become more widely available as a tool to enhance surveillance and provide an added layer of protection to high risk settings, such as healthcare facilities. The role of rapid antigen testing within these settings may differ in each jurisdiction.

At times, when there is a large volume of testing it may be more efficient to move the samples to a large-scale testing platform, rather than running a large volume of samples through a POCT device.

Where point-of-care testing devices are on site, only appropriately trained laboratory or point-of-care operators should operate the devices with compliance to all standard operating procedures and regulatory requirements to ensure the analytical performance of the test and safety of the operator. In preparation for an outbreak, POC Testing Program, lab and public health stakeholders should:

- confirm roles and responsibilities
- review prioritisation of swabs for POC testing
- define alternative testing pathways (local/ regional/ central)
- consider options to enhance POC testing (including training additional staff if available)
- consider RAT availability and appropriate use
- confirm communication pathways to ensure public health action
- consider deployable lab capacity options.

This information should be regularly communicated to health services.

If there is not access to POCT, or the capacity of these machines to process tests within 24 hours will be exceeded, options for quicker turnaround of 'low risk' samples (that is samples which have a low positive predictive value such as those taken under enhanced testing guidelines where the individual has no epidemiological risk factors for disease) include:

1. Setting up specific regular transporting of swabs using e.g. drivers or regular charter flights who can service several communities on each run.
2. Working with labs to prioritise tests arriving from rural/remote centres for urgent processing on arrival to the lab, particularly samples from healthcare workers from remote/rural clinics, given the limited capacity of many remote clinics to cope with staff shortages.

Clinics should aim for no more than 48 hours turnaround time from tests taken to results returned.

When an **urgent result** is required on the test for a suspect case, or other result deemed clinically urgent and there is no access to POCT on site, rapid antigen testing may be utilised to provide a more rapid, albeit, less sensitive result. Rapid antigen testing is useful to allow earlier identification of cases where there is a high pre-test probability, such as where the individual has epidemiological risk factors for disease. The lower sensitivity of rapid antigen testing compared with PCR testing means that rapid antigen testing is not generally recommended for widespread use in low prevalence environments. All positive rapid antigen test results, as well as negative results where the individual is a suspected case or close contact, should be confirmed using PCR testing. In this case, or in instances where retesting on an alternative platform is required, clinics should consider urgent transfer of a swab(s) to a standard laboratory or site where POCT is available, via road or commercial/charter flight. (This is available through Commonwealth funded Royal Flying Doctor Service (RFDS) services for COVID-19).

6. Response to COVID-19 in the community

When it is possible that there are COVID-19 case(s) in the community, due to positive sewage detects or an individual who has been exposed to COVID-19 (either as a close contact or in another community with a COVID-19 outbreak) presenting with symptoms to a clinic, this should precipitate an assessment of the likelihood of a COVID-19 outbreak to determine what actions should be taken at this point. This should include a risk assessment of the potential impact that a COVID-19 outbreak may have on the community, which will be informed by the vaccination rate of the community and the availability of healthcare and other essential services. The organisations involved in this process will differ by jurisdiction, community and the

emergency management structures in place (see local and jurisdictional plans for detail) but should involve a discussion between clinic staff and some or all of the following:

- management structures within the clinical organisation;
- the local public health unit (and/or jurisdictional communicable diseases unit); and
- jurisdictional emergency operations centre.

Discussions may also be required to prepare for the possible need for a surge workforce, including to provide medical care, essential services, social support to the community and enhanced provision of COVID-19 vaccination, and to organise timely access to COVID-19 treatments.

Consideration should be given to storing POCT machines and COVID-19 response kits in strategic locations in regions with low vaccination rates to enable the rapid deployment into communities with possible COVID-19 cases. These response kits may include POCT machines, vaccines, Rapid Antigen Tests, COVID treatment options and PPE.

If an individual presents with suspected COVID-19, the next steps will be influenced by the rapidity with which test results are likely to be available, and particularly whether POCT or rapid antigen testing is available.

When there is a **high suspicion the individual will become a confirmed case** consideration should be given to **immediate contact tracing and follow up of contacts**, including isolation of the suspect case and quarantine of their contacts as soon as practicably possible. This may include consideration of early evacuation (see below).

If there is **low suspicion that the individual will become a confirmed case**, the suspected case should be isolated while waiting for test results and consideration given to contact tracing if resources allow this. An individual's vaccination status can impact whether or not a suspected case will become a confirmed case.

Note that appropriate PPE and other infection control procedures should be used by clinic staff and the suspect case during clinical management and contact tracing.

6.1. Evacuation of confirmed cases and quarantine of contacts

Early isolation of confirmed cases is ideal to limit disease transmission. If appropriate, as informed by a risk assessment and specific circumstances for the community, early evacuation of cases (defined as relocation from the community to an appropriate place outside of the community via an appropriate transport service) may be used as a method of management to:

- prevent onward transmission;
- optimise clinical outcomes; and
- take the burden of follow up away from over-stretched primary care clinics.

Engagement and agreement with community regarding the use of either evacuation or isolation within community to prevent transmission needs to occur through COVID outbreak management planning. Evacuation is a sensitive issue, with some individuals not wishing to leave country or where past trauma due to forced separation of family can resurface. If there is reluctance to evacuate from community, planning should include how cases will be isolated within community and what supports (including infrastructure and social supports) may be required to ensure safe isolation.

A detailed case interview will be required to identify contacts. This should be undertaken by the local ACCHO or health service staff (where available), with remote support from PHU or jurisdictional centres¹. The definition of close contacts used in the CDNA SoNG for COVID-19

¹ Online resources for contact tracing in remote communities, specific for Aboriginal and Torres Strait Islander peoples can be found here: <https://covid-19training.gov.au/>

should be used to determine who is a close contact. This will usually include all others who live in the household where the case usually resides and may also include those in other households where the case has spent time.²

Prompt contact tracing and quarantine of close contacts is imperative. The local clinic may be utilised to provide culturally safe contact tracing support, as well as identifying extra assistance that may be required by cases and their contacts. The local clinic or other Aboriginal health professionals can be critical in identifying additional supports which may be required for certain social and cultural considerations. Depending on local arrangements and preferences, close contacts, such as household members of the case, may undertake quarantine in appropriate accommodation in the community or may be evacuated to accommodation outside of the community.

For confirmed cases with no clear epidemiological link (e.g. the case has not arrived from an area of high transmission in the past 14 days and has no known contacts with COVID-19), consideration should be given to **upstream contact tracing** to identify other potential chains of transmission. Each of these should also be followed up with the aim of identifying and breaking all chains of transmission within the community. Note that upstream contact tracing may not be feasible and may be of less importance in disease control if whole of community testing and/or movement restrictions are implemented (see 10.2 below).

6.2. Considerations for cases and contacts remaining in community

Where evacuation of suspected and confirmed cases is not possible or appropriate, public health and primary health care staff (especially First Nations staff) must collaborate regarding public health management of suspected and confirmed cases and their contacts on a case by case basis, incorporating their knowledge of the likelihood of any suspect case being confirmed, individuals and community involved, local processes and available resources. Questions that can be used to guide this process can be found in [Appendix 2: Key considerations to guide the decision to evacuate suspect and confirmed cases and their close contacts](#).

Appropriate and adequate supports should be provided to enable the case to isolate and their contacts to quarantine in the community. This will require wrap-around supports, including for essential services, and may require provision of appropriate accommodation in the community, including repurposed buildings and/or motor homes. See [Appendix 3: requirements for isolation in the community](#) and 'considerations for cases and contacts remaining in community' below. See also [Appendix 4: Algorithm for decision making](#).

The PHU is responsible for coordinating the public health follow up of the case and their close contacts, although this may be managed in conjunction with the local clinic. Follow up of contacts clinical needs should include regular monitoring for symptoms and wellbeing checks – this may be performed by clinical services. It is recommended to test asymptomatic contacts, with the aim of early identification and isolation of pre-symptomatic and asymptomatic individuals. If there is no access to POCT, or there is excess demand, consider sending samples from household or close contacts to the laboratory, where the turn-around time of the result would not change public health action.

The senior doctor of the primary health care service (or other relevant senior clinician) is responsible for the clinical management of the case whilst they remain in community, including monitoring the need for potential evacuation should there be a clinical need. This may be coordinated through a care in the community or a hospital in the home type approach. There should be a low threshold for evacuating a patient for medical reasons, including people who

² The modelling conducted by the Kirby Institute found that quarantine was most effective in limiting the total number of cases if it was applied to all members of extended households where a case had spent time in the 2 days before becoming unwell.

require minimal amounts of oxygen support (limited community supply and/or possibility of rapid deterioration).

The clinic should organise for timely delivery of COVID-19 treatments for cases with mild symptoms who are at high risk of severe disease ([Therapeutic Goods Administration information COVID-19 treatments](#)). The clinics should be assisted in gaining access to these medications by the jurisdiction (via RFDS). External workforce should be under the direction of the local service and be supported by local Aboriginal and Torres Strait Islander staff to ensure cultural safety wherever possible. The need for isolation /quarantine should be stressed at each encounter with the case and contacts, and they should be supported to follow restrictions as much as possible. This should include relevant information, provision of health care (including PPE), food, essential goods and services, and social and financial support.

If cases and their contacts choose not to evacuate and there are **no** appropriate facilities for isolation, and they are unable to comply with restrictions that would limit opportunities for transmission, careful discussion between local health services and the relevant PHU will be required. These discussions should include how to reduce potential transmission risk within the community whilst maintaining the safety and confidentiality of the case and their contacts as much as possible.

6.3. Other community actions in response to one or more cases

Based on the high likelihood of rapid transmission and undetected cases when the first case is detected (supported by modelling – see above), best practice is generally to enact an outbreak type response on notification of a single case of COVID. -In addition, a positive sewage detection should lead to an increase in outbreak response preparations. In some cases, a significant community exposure may also require an outbreak type response (e.g. a non-resident who attends Sorry Business whilst infectious). Public health judgement will always be needed to determine the magnitude of initial response; for example there will be lower risk of significant transmission prior to detection if a case has developed symptoms within a short timeframe from returning from an area of high transmission, is tested and quarantined early and has had minimal contact with community members during their infectious period compared with a case who has not travelled outside the community and presents late in their illness and/or has multiple close contacts. In addition, the vaccination rate in the community will strongly influence the magnitude of the response, due to the positive effects of vaccination including reduction in transmission and adverse health outcomes.

The response to one or more cases in the community should be outlined in the community plan and agreed to by the community prior to a case occurring. Actions that should be considered in the plan include:

- Active surveillance for COVID-19 symptoms across the whole community, with people encouraged and supported to report symptoms and get tested as soon as possible;
- Offering relocation to particularly vulnerable elderly or sick people from the community;
- Stepping up health promotion activities and community messaging around preventative actions around COVID-19, particularly vaccination;
- Planning support for households who may need to isolate, including provision of food and other essential goods and services;
- Restricting movement within and outside of the community (see 10.2.1 below);
- Confining all community members to their house and yards for an initial period to determine how much community spread has occurred prior to detection of the index case, or for longer if this is deemed necessary; and
- Multiple rounds of testing for COVID-19 including for asymptomatic community members to allow early identification and isolation of cases.

It should be noted that any approach which involves restriction of movement within or outside of the community will require well developed plans for mobile delivery of health services including social and emotional wellbeing and addiction services, delivery of food, communications and other essential services to people to their houses.

As of October 2021, there has been a slow uptake of COVID-19 vaccination in many remote communities for a variety of reasons. Any outbreak response should also support an increase in COVID-19 vaccinations in response to potential surge in demand for vaccination within the community. This may require utilisation of external teams such as jurisdictional teams or AUSMAT, Australian Defence Force, the RFDS as well as commercial options.

6.4. Restricting movement to and from the community

Determinations under relevant jurisdictional legislation may allow for movement restrictions into designated areas. Imposition of movement restrictions should be informed by the outcomes of a risk assessment of the impact of a COVID-19 outbreak in the community, and at the agreement and request of the relevant community. Communities with high vaccination rates and good access to healthcare services are less likely to require extensive restrictions than communities with lower vaccination rates and less access to healthcare services. These restrictions should be well understood for each community by all health staff and public health services.

If movement restrictions are implemented, residents should be supported to not leave the community where a case has been detected until the quarantine period of the case's contacts is over so as to reduce the risk of spreading COVID-19 to other communities. To reduce strain on essential services and individual risk, entry into the community should also be limited. The length of time that movement restrictions are imposed should be guided by the CDNA SoNG.

Experience from the 2021 Delta variant outbreak in western and far western NSW indicates that locking down remote communities causes significant difficulties to those communities, including isolation from essential services and family and social supports. If movement restrictions are imposed, consideration should be given to broadening the restricted zone to regional areas, rather than single communities with support provided to encourage residents to remain in their local community.

A broader restriction zone may be considered in certain circumstances, such as where vaccination rates are adequate, to allow individuals in remote communities to access essential services outside their community. The broadened scope of this zone should be as specific as possible to ensure surrounding communities are also protected. This will require enhanced public health support for more broad contact tracing, surge vaccination clinics in anticipation of further cases in the region, and additional provision of essential services.

If the community is experiencing an isolated outbreak and there is no community transmission in surrounding areas or the regional centre, and vaccination rates in the region are not adequate, with the support of the community it would be highly desirable to restrict movement to limit further spread. Risk from movement between communities would be increased if vaccination rates in the region are low, if there is limited access to healthcare or food and reduced access to surge workforce.

Where nearby communities within the potential restricted zone remain unaffected but have low vaccination rates, consideration should be given, in consultation with community leaders, to closing these communities and offering enhanced vaccination services.

6.5. Relocation of vulnerable people from community

'High-risk', or vulnerable people (defined as at higher risk of severe disease and death) have been defined by the Australian Health Protection Principal Committee (AHPPC). Australian and international data show that increasing age is the strongest independent risk factor, with the worst outcomes seen in those over 70 years old, followed by people with chronic diseases.

Current evidence suggests the risk of severe disease is higher in Aboriginal and Torres Strait Islander people due to the high proportion of people living with chronic disease. The current evidence shows that children with COVID-19 generally experience mild disease. However, Aboriginal and Torres Strait Islander children have high rates of chronic disease, including rheumatic heart disease and chronic lung disease, which increases their risk of more severe illness with COVID-19. Ongoing data collection and analysis is important to better determine risk of severe outcomes among all Aboriginal and Torres Strait Islander people.

COVID-19 vaccination is very effective at preventing more severe illness from COVID-19. The outcomes of modelling, outlined above, supported the significant benefits of vaccination for reducing the disease burden of COVID-19. However, COVID-19 vaccination rates in remote Australian communities is below the national rates of vaccination. Vulnerable people in these communities therefore remain at high risk of illness and death from COVID-19.

When a case of COVID-19 has been confirmed in a community, consideration should be given by clinical staff in consultation with other relevant agencies (including the local PHU), to offering those at 'high risk' of hospitalisation/death from COVID-19 relocation to an area where they have reduced risk of transmission. However, they would need to be in quarantine and obtain exit testing according to jurisdictional guidance and immunisation status. In addition, these individuals, and their families, should be offered COVID-19 vaccination, if they are not yet vaccinated.

Key considerations in this decision to offer relocation to vulnerable groups will be:

- Whether transmission is likely to be occurring in the community;
- Whether individuals in these vulnerable groups are vaccinated;
- Vaccination rate in the community;
- Availability of appropriate accommodation for relocation including access to health services and social support for people relocating;
- Availability of appropriate transport for relocation;
- Availability in the community of appropriate healthcare services and access to COVID-19 treatment to reduce the risk of progression to severe illness in high-risk individuals; and
- Acceptability of alternate site to the community.

6.6. Reactive vaccination

The outbreak response should include planning for reactive COVID-19 vaccination in the community. This may require support from external teams such as AUSMAT, the ADF and the RFDS. Modelling indicates that reactive vaccination is very effective in under-vaccinated communities at reducing the rates of severe disease and adverse outcomes from COVID-19 where other measures are also instituted to slow progression of the outbreak.

Preparation for COVID-19 outbreaks should include protocols to assist with increased vaccination provision prior to, and in the early stages of, the outbreak. This planning should be done in conjunction with public health units and with state or Commonwealth assistance, as appropriate.

Where there are areas of the community who may have been vaccinated early in the roll-out, deployment of booster vaccination should be considered.

6.7. Potential cessation of evacuating cases (with or without contacts) in the event of widespread community transmission

With agreement from the community, evacuation of cases and their contacts should continue whilst there is thought to be benefit to the community in preventing onwards transmission. Even in the event of widespread community transmission removing infectious cases (and potentially close household contacts) to appropriate isolation facilities to prevent spread within communities is still recommended if supported by community and household members. The benefits of

transferring high-risk cases to regions with appropriate intensive care facilities will also remain. However, in the event of widespread community transmission with multiple cases, it may no longer be feasible to evacuate all cases and contacts. The decision to cease evacuation of cases (plus or minus contacts) should involve a discussion between the community health service and the relevant public health unit or jurisdictional communicable diseases unit, the jurisdictional health emergency operations centre, local health authority CEO or delegate, and the peak Aboriginal and Torres Strait Islander health organisation in the jurisdiction (noting that organisational structures will differ by jurisdiction). This decision should be documented in writing and forwarded to all relevant departments and organisations. The community should be informed as this will explain the changes that will be visible to the community from previous practice.

Where there is no longer evacuation occurring for public health reasons, every effort should still be made to work with local community staff members and residents to:

- Contact trace all cases and encourage and support cases and their contacts to isolate and quarantine AND
- Monitor and test contacts for disease AND
- Enhance movement restrictions for the community AND
- Encourage social distancing, cough etiquette, hand hygiene, use of face masks AND
- Continue the vaccination program.

Evacuation of cases for clinical reasons would continue, as guided by the case's clinical presentation and the capacity of the community health service to monitor, treat and support the person in community. Early evacuation of cases who are at high risk of severe disease should be considered.

7. Coordination of evacuation for suspect and confirmed cases and their close contacts

When the decision is made to evacuate a suspect or confirmed case, either for clinical or public health reasons, the evacuation category should be discussed with local evacuation services by the attending senior medical practitioner.

If the person is stable, and for asymptomatic contacts, evacuation by road (with driver trained in infection control, wearing appropriate protection and with adequate ventilation in the vehicle) or on charter plane (appropriately set up) could be considered over medical retrieval. Clinical criteria to determine the safety of road or charter evacuation will be made based on the expertise of the treating clinician in conjunction with the receiving service and the retrieval service. The Commonwealth has provided additional funding to aeromedical services in rural and remote Australia to evacuate suspect, probable and confirmed cases of COVID-19 and their contacts from remote Aboriginal and Torres Strait Islander communities for clinical and public health reasons. See <https://www.health.gov.au/resources/publications/coronavirus-covid-19-early-aero-medical-evacuation-of-covid-19-cases-and-contacts-from-remote-communities> for further information including how evacuations may be co-ordinated and key considerations for transport.

7.1. Return home of confirmed and suspected cases and their contacts

Cases who are evacuated and are subsequently medically cleared for release from isolation should be assisted in their return home. Close contacts of a confirmed case should be offered relocation back home once their period of quarantine has ended. Close contacts of a suspected case should be offered relocation back home once COVID-19 testing confirms the suspect case is negative.

Arrangements for returning home should be developed by local health authorities and the community health service.

Depending on jurisdictional legislation, returned cases and their contacts may need to remain outside of community for a period of time so that entry requirements are met.

In some instances, a case or contacts of a case may request to return home whilst they are still infectious/undergoing quarantine. Public health and primary health care staff (especially First Nations staff) must collaborate regarding the return of confirmed cases on a case by case basis, incorporating their knowledge of the individuals and community involved, local processes and available resources and supported by evidence of likely duration of transmissibility for the particular variant involved. Arrangements for returning home should be developed by local health authorities and the community including appropriate isolation and quarantine facilities.

Appendix 1: Guidance for the rational use of Point-of-Care Testing in primary care

Purpose

This document is intended for use by primary care services in rural and remote Australia who have access to point of care testing (POCT) for SARS-CoV-2 (the virus causing COVID-19). This document provides guidance for rational use of POC tests in the context of potentially limited cartridge supply. **It is important to note that decisions on the appropriateness of testing and use of POC test versus conventional laboratory PCR will ultimately need to be made at the service level and should be guided by clinical judgement.**

This document should be read in conjunction with:

- Aboriginal and Torres Strait Islander COVID-19 Point-of-care (POC) Testing Program Guidelines, and standard operating procedures
- CDNA [COVID-19 Series of National Guidelines](#)
- CDNA [National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19](#)
- Relevant jurisdictional guidelines for COVID-19
- CDNA/PHLN Testing Framework for COVID-19 in Australia

Background

Importance of early diagnosis in Aboriginal and Torres Strait Islander communities: A case of COVID-19 in an Aboriginal and Torres Strait Islander community has the potential to rapidly cause an outbreak which may have high levels of mortality and morbidity. Because of this, **early identification and isolation of first cases achieved through adequate surveillance (enhanced testing and identification and testing of suspect cases), and minimising time to results is important to reduce** transmission and allow possible containment of an outbreak. POC testing will help to facilitate quicker turn-around times for tests and therefore quicker public health response.

Who should be tested for COVID-19? Clinicians should follow testing criteria outlined in **jurisdictional guidelines or the COVID-19 SoNG** regarding when it is appropriate to test for COVID-19. This will include those that meet **suspect and probable case definitions** and those that meet **enhanced testing criteria**.

Recognising and proactively offering COVID-19 testing to presentations consistent with possible COVID-19 disease, is a key element of early detection of disease in remote areas. Reduction in border restrictions may increase risk of cases occurring in remote areas and so should be accompanied by an increase in surveillance with rapid turnaround times.

Cartridge Prioritisation

The TGA-approved GeneXpert Xpress SARS-CoV-2 test for use on the Xpert platform (Cepheid) enables the rapid molecular detection of SARS-CoV-2 infection at the point-of-care. However, there is a limited global supply of COVID-19 cartridges to operate the GeneXpert platforms and throughput is limited (upper limit of ~30 tests per day on a 4 module device which may be reduced if there are positive results.) Note that there are other TGA approved POCT platforms now available (Biofire, Liat, FilmArray). Therefore, there may be occasions or situations where supply does not meet demand, and if so, POC testing should be used for cases where this will provide clinical or public health advantage, compared with usual laboratory-based testing.

Below are recommendations for individuals to be prioritised for POCT. However these are guidelines only and ultimately decisions on prioritisation of POC testing should be made

based on clinical judgement, in discussion with a senior medical officer and/or Public Health Unit where necessary.

Consider prioritisation of the following groups:

- Individuals meeting the suspect or probable case definition for COVID-19 (as defined in jurisdictional guidelines or the COVID-19 SoNG:
 - Note that this includes clinical AND epidemiological criteria
- **Aboriginal and Torres Strait Islander people who meet the criteria for enhanced testing (e.g. respiratory symptoms, or unexplained fever or history of fever) and where delays in testing or longer periods of self-isolation places others at higher risk of transmission (e.g. due to overcrowded or inadequate housing).** Within this category, the following could be considered as priorities:
 - Individuals who are likely to leave the community prior to a result becoming available
 - Individuals who are likely to have or have had multiple contacts e.g. where an individual is intending to attend a mass gathering before a result will be available and would be at risk of not following guidance to self-isolate
 - Individuals who are likely to have major barriers to **any** kind of self-isolation (e.g. where there are no alternative accommodation options, those who have unstable housing, or those who have difficulty following directions due to barriers in understanding)
 - Individuals who need a negative result in order to attend medical appointments e.g. surgery or specialist appointments
 - Health workers, to ensure critical health staff can maintain maximum staff capacity to provide health care and ongoing testing capabilities.
- **Non-Indigenous residents and visitors to Aboriginal and Torres Strait Islander communities, who meet criteria for enhanced testing and have had direct contact with community members in the 14 days prior to onset of illness (that may have resulted in disease transmission), or will need to have direct contact with community members as part of their role, where waiting for a conventional PCR test could lead to risk of service failure.**

Note that:

- When making local decisions, it is acknowledged that services may consider reserving cartridges (approximately 100) to allow for testing within the first 24-48 hours of a confirmed COVID-19 case or outbreak. This could occur if the capacity to test close contacts and community members is identified, planned for within the outbreak management plan, and should articulate with the relevant jurisdictional COVID-19 remote outbreak plan
- To best understand issues faced by Aboriginal and Torres Strait Islander people being tested, non-Indigenous staff should consult with Aboriginal and Torres Strait Islander colleagues.

Appendix 2: Key considerations to guide the decision to evacuate suspect and confirmed cases and their close contacts

Key consideration	Rationale
<p><i>(Suspect cases only)</i></p> <p>What will be the time delay until results are received and is there a suitable location for isolation of the case and quarantine of their contacts which can be used in the short term?</p>	<p>Even if longer term isolation in the community is not possible, it may be feasible to isolate a case and their close contacts in temporary accommodation until test results are received if this will be a relatively short period e.g. 24-48 hours.</p>
<p><i>(Suspect cases only)</i></p> <p>Does the potential benefit to the community of early evacuation of a suspect case (with or without their contacts) outweigh the risks of evacuating a case and their contacts, when the true status of the case is unknown?</p>	<p>Evacuation of a suspect case that proves to be unnecessary has significant implications for the suspect case and their contacts with regards to increasing their risk of disease (via transport and being in an area of higher transmission) and a prolonged absence from their community. This must be balanced against the potential community protection.</p> <p>If a suspect case presents immediately after onset of symptoms, then given the median incubation period it may be feasible to wait for confirmation of diagnosis before considering evacuation of contacts, however every attempt should be made to keep contacts isolated within this time frame.</p>
<p>Where is it likely the case acquired disease?</p>	<p>A case who has returned to the community within 14 days of developing symptoms is more likely to be an imported case. This lowers the probability of community transmission and provides a stronger rationale for early evacuation.</p>
<p>For how long has the case been symptomatic and what has their activity been during this time?</p>	<p>If the case has been symptomatic for some time (e.g. 3 days) and has had multiple contacts during this time, there is high likelihood of transmission having already occurred.</p>
<p>Are the case and their contacts likely to adhere to isolation and quarantine?</p>	<p>The case and their contacts need to have a high degree of understanding of the issue and why it is important to isolate and quarantine. They also need adequate support to help them to safely isolate and quarantine. Where a case and/or their close contacts are unlikely to adhere to medical recommendations around the need for self-isolation and quarantine in community, medical evacuation should be strongly encouraged.</p>

Key consideration	Rationale
Can the case have mild illness, and not be at high risk of a poor outcome?	Current evidence suggests that clinical deterioration generally occurs within 5-10 days of onset of symptoms. For cases at particularly high risk particularly where they are unvaccinated, no access to disease-modifying treatments and/or limited access to medical retrieval, there may be a preference for early evacuation.
Does the case and their close contacts wish to remain in the community?	It is important to explain why evacuation benefits the case and the community. Answer questions and offer evacuation even if clinically the person does not meet the conventional threshold for evacuation. A support person should also be made available to anyone evacuated.
Does the case have carer responsibilities?	Wrap-around supports should be provided to the case's entire household to safely isolate and quarantine.
What is the community's preference?	This should include consideration of potential disharmony if cases and their contacts are not evacuated.
Is there suitable accommodation for the case to isolate in community?	For a case to isolate in community, suitable accommodation must be available to ensure the patient is isolated in a house on their own or meets the minimum standards as specified by the WHO; if there is no suitable accommodation in community, early evacuation should be recommended.
Are there suitable supports available for the case to self-isolate?	Including provision of food and essential goods, social and financial supports, regular health needs, cultural supports).
Does the clinic have capacity to safely monitor the case for signs of deterioration, and contacts for signs of developing disease?	If capacity to do this is limited (e.g. clinic staff are sick) then early evacuation should be considered.
Is the case able to be medically evacuated safely in the case of medical deterioration?	If there are restrictions on accessing timely medical evacuation, then early evacuation should be considered.
Is there suitable accommodation available for evacuated case(s) and their contacts in the evacuation location?	Cases should be admitted to hospital or offered safe accommodation (single room with ensuite). Contacts should also be offered safe accommodation. The facility needs to be able to provide close clinical monitoring as well as social and cultural support.

Key consideration	Rationale
Are there suitable supports available for cases and contacts in the evacuation location?	Supports must be available in regional isolation centres to ensure that cases and contacts are in culturally appropriate and safe environments that maximise the likelihood of the isolation and quarantine period being observed.
What are the vaccination rates in the community?	COVID-19 vaccination reduces transmission of disease and is very effective at preventing serious illness and death from COVID-19. Modelling has shown that evacuation of cases and contacts continues to be beneficial in reducing prevalence and length of an outbreak in highly vaccinated communities.
Does the community have access to disease-modifying treatments for COVID-19?	There is evidence that some new treatments, if given early in the course of the disease, can reduce the risk of progression to severe illness from COVID-19 in vulnerable individuals.

Appendix 3: Requirements for safe isolation and quarantine in community

While evacuation of confirmed and early suspected cases is strongly recommended, plans must also be developed for isolation and quarantine in the community. This is to have systems in place in the event retrieval is not possible, either for initial cases or if community transmission becomes sustained. Due to the high prevalence of overcrowding and homes with faulty facilities for cleaning and personal hygiene, the community, health service, public health and other relevant organisations must together design options for isolation and quarantine outside of the household to protect the community. These should be articulated in the co-designed community local action plan. These options may require urgent erection of accommodation options with additional efforts to ensure failsafe arrangements for water, sanitation, power, food and other essential goods and access to medications.

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

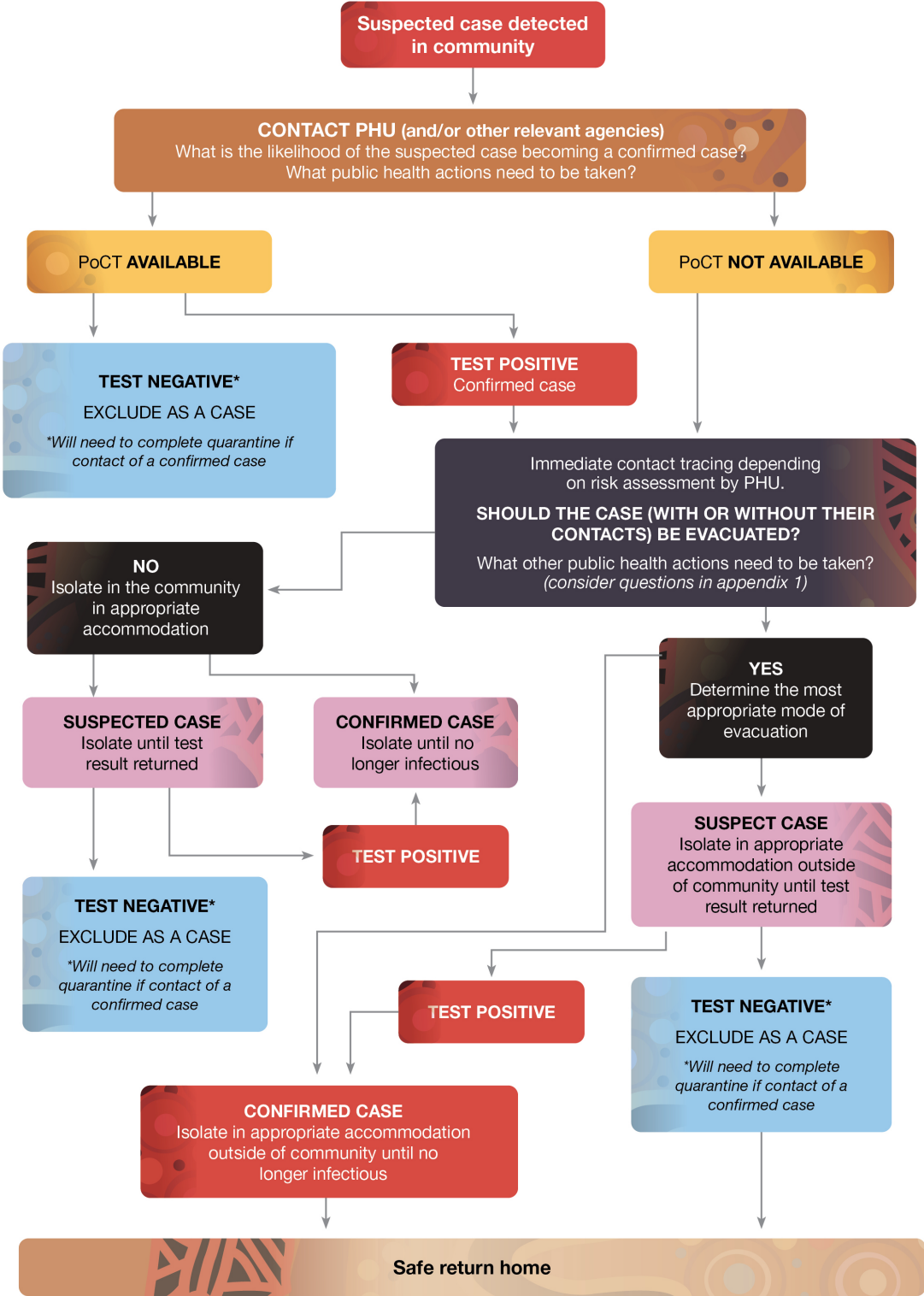
Separate facilities should be designated for confirmed and suspect cases and their close contacts (keeping these groups separate) where home facilities are inappropriate to allow for adequate separation of cases and contacts.

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 4m². 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 4: Decision making algorithm for suspect and confirmed cases



Note that this is a simplified diagram and decisions around public health action, including confirmatory testing of those who test negative and positive and other public health actions, should involve consultation between the health service and the relevant PHU/CDC (and/or other relevant jurisdictional agencies), other community controlled services where relevant, and where ever possible and pertinent, the individual and their community. Updated 29 October, 2021.

Appendix 5: Indigenous Liaison Support Team overview

Goal

To aid in efforts to support the COVID-19 response and vaccination as it relates to Aboriginal and Torres Strait Islander people, and Aboriginal communities in the western and far west NSW regions.

Overview

Embedded between the Regional Operational Command and the AUSMAT deployment teams, the Indigenous Liaison Support Team (ILST) would coordinate with the various Aboriginal and Torres Strait Islander leaders, organisations, including Government and non-Government, and ensure local leadership and the cultural leadership is engaged and informed. They would also link into the National Indigenous Australians Agency (NIAA), and state and territory counterparts, in terms of facilitating stakeholder contacts and draw on their staff to guide engagement with the various Aboriginal and Torres Strait Islander organisations.

ILST Methodology

Over the period of deployment, the ILST observed and developed models for effective community engagement and vaccine delivery for Aboriginal and Torres Strait Islander communities which may be useful for future deployments. These models, involving AUSMAT and ILST, proved successful in delivering vaccines in a culturally safe and effective manner. Over the three weeks, 1,927 vaccines were delivered in rural and remote communities allowing access for many who may not otherwise have had the chance to be vaccinated.

Minimum skills for ILST team-members

The following minimum skillsets would be required of a team undertaking this work in future.

- Identify as Aboriginal and/or Torres Strait Islander and feel strong in their own Indigenous identity;
- Have a depth of knowledge about how to engage with Aboriginal and Torres Strait Islander individuals, Communities, and leaders;
- Have excellent communications skills, including the ability to communicate in a culturally appropriate manner with Aboriginal and Torres Strait Islander individuals and Communities, as well as with other stakeholders and health and emergency personnel, in highly dynamic situations;
- Excellent negotiating skills and ability to create a culturally safe environment for Aboriginal and Torres Strait Islander people to learn about COVID-19 and associated vaccines and consent issues;
- Able to be adaptable and flexible, and to problem solve in a rapidly changing environment; and
- Have a basic understanding of public health principles, epidemiology and the ability to interpret and use data for decision making in the COVID-19 situation.