



COVID-19 Health guidance for remote Aboriginal communities of Western Australia

This is a live document and information in this document will be updated as required

Introduction

Aboriginal people are identified as a vulnerable group that may be disproportionately affected by COVID-19. Aboriginal communities situated in remote areas face particular challenges in their capacity to both protect their community from COVID-19 and respond to cases of infection or outbreaks that may occur in the community.

This document has been prepared to assist and guide organisations with COVID-19 planning for remote Aboriginal communities in WA. The focus of this document is on planning, and the decisions that will need to be made at the community level concerning COVID-19.

This document should be used in conjunction with the Western Australian Declaration State of Emergency and Public Health Emergency plans and directions. Government plans and directives in relation to COVID-19. As State directives may change as the situation requires, it is important to refer to the most current instructions, these can be found via the following link:<https://www.wa.gov.au/government/document-collections/coronavirus-covid-19-state-of-emergency-declarations>

This document acknowledges but does not address external risks related COVID-19 that may impact on remote Aboriginal communities, such as difficulties in ensuring continuous supplies of essential items throughout WA. These will need to be managed at a regional or state-wide across government level.

This guidance is primarily intended for those in the health sector including the WA Department of Health, Health Service Providers, Aboriginal Community Controlled Health Organisations (ACCHO), primary care providers, and public, private and non-profit providers of health services. The plan may also provide useful guidance to non-health sector agencies who will be involved in the response to the COVID-19 emergency or who are developing their own response plans.

This guidance has been prepared by a working group with membership from the Aboriginal Health Policy Directorate and Public Health Emergency Operations Centre (PHEOC) in the Department of Health, the WA Country Health Service (WACHS), Aboriginal Health Council of Western Australia (AHCWA) and Aboriginal Policy Coordination Unit, Department of Premier and Cabinet.

Background

Western Australia (WA) has remote Aboriginal communities situated primarily in the State's north and east. On average, Aboriginal people have significantly poorer health than the general population and, if exposed to COVID-19, may be more likely to have poorer outcomes than other Australians. Remote communities also face challenges with road access, housing, essential services (such as water, power and sewerage) and access to telecommunications.

Aboriginal and Torres Strait Islander (ATSI) advisory groups have been formed at both the national and state level to provide guidance on developing COVID-19 responses that support and provide advice regarding ATSI people as a vulnerable group. The Communicable Diseases Network Australia (CDNA) [National advice for public health units](#) contains recommendations on the development of strategies for ATSI communities¹. The key strategy recommendations are:

- **Shared decision-making and governance:** Throughout all phases, COVID-19 response work should be collaborative to ensure local community leaders are central to the response. Further risk reduction strategies and public health responses should be co-developed, and co-designed, enabling Aboriginal and Torres Strait Islander people to contribute and fully participate in shared decision-making.
- **Social and cultural determinants of health:** Public health strategies should be considered within the context of a holistic approach that prioritises the safety and well-being of individuals, families and communities while acknowledging the centrality of culture, and the addressing racism, intergenerational trauma and other social determinants of health.
- **Community control:** The Aboriginal Community Controlled Health Services (ACCHS) sector provides a comprehensive model of culturally safe care with structured support and governance systems. The network of ACCHS and peak bodies should be included in the response as a fundamental mechanism of collaboration, engagement and communication.
- **Appropriate communication:** Messages should be strengths-based and encompass Aboriginal ways of living, including family-centred approaches during both prevention and control phases. They should address factors that may contribute to risk such as social and cultural determinants of health, including living arrangements and accessibility to services. Include communication in languages and the use of Aboriginal interpreters as required in liaison with Aboriginal workers, Aboriginal Health Practitioners and Regional Aboriginal Health Consultants.
- **Flexible and responsive models of care:** Consider flexible health service delivery and healthcare models (e.g. proportionate testing, pandemic assessment centres, flexible ACCHSs clinic hours/location with additional staffing, and home visits). Consider employing the use of point of care tests, where available, to help determine whether COVID-19 is implicated in presentations in the community.
- **Isolation and quarantine:** Families should feel empowered and be part of decision-making around quarantine. This can be achieved through exploring with families what social isolation, social distancing and quarantine looks like, working through how it might impact on the family and their way of living, and identifying ways around

¹ <https://www1.health.gov.au/internet/main/publishinsecg.nsf/Content/cdna-song-novel-coronavirus.htm>

it. Family members will want to visit unwell people in hospital. It should be made clear that there are other ways to maintain communication with sick family members while they are in isolation or hospital, and that communication can be maintained with families in lieu of gatherings (e.g. staying socially connected through the internet and video calling).

Governance

Under the State Hazard Plan - Human Biosecurity, the State Health Epidemic Controller (SHEC) is responsible for coordinating responses to a human epidemic such as COVID-19 at the State level. This is performed in a two-pronged approach as described in the Infectious Diseases Emergency Management Plan (IDEMP), which is activated in parallel with the State Hazard Plan– Human Biosecurity to manage a human epidemic emergency.

While the State Hazard Plan– Human Biosecurity outlines multi-agency responses to an infectious disease emergency in WA, the IDEMP is a health-specific infectious disease emergency response plan.

The Public Health Emergency Operations Centre (PHEOC) has been established to coordinate the public health response to infectious diseases at the State-level.

Refer to **Appendix 1. Governance Structures**, for further information on the hierarchy of responsibility and decision making.

Emergency response structures

Public health

Under the State Hazard Plan – Human Biosecurity, Regional Human Epidemic Coordination Centres (HECCs) are responsible for coordination and implementation of public health responses to a human epidemic such as COVID-19 at the local level and are under the control of the PHEOC. Regional HECCs may be established at regional public health units as required and are responsible for disease surveillance, data management and public health management of an infected person or their contacts.

Regional Public Health Units should be contacted for advice on cases, potential cases, contacts, investigative procedures and transport of pathology.

Regional Health Service Provider

The Regional Health Disaster Coordinator (RHDC) will establish Regional Emergency Operations Centres (REOCs) to implement epidemic control strategies as directed by the SHEC. Local Emergency Operations Centres (LEOCs) will be established to provide the local health response. REOCs are responsible for the provision of triage/isolation/treatment facilities for infected persons in public hospitals and ambulatory care settings.

Department of Communities

Under the State Hazard Plan – Human Biosecurity, the Department of Communities will assist people under self isolation and home quarantine as well as their dependents.

COVID-19 planning for remote Aboriginal communities

It is recognized that the high prevalence of co-morbidities, and distance from tertiary health care, means that residents of WA's remote communities should be considered vulnerable to COVID-19 outbreaks based on rates of both morbidity and mortality found from previous outbreak situations. At each stage of planning, meaningful community consultation with relevant local community stakeholders, such as local council and ACCHS, is essential.

The importance of family and culture in remote communities needs to be considered when implementing plans in response to COVID-19. Limitations of local resources and infrastructure will influence how plans are developed and implemented in individual communities.

All remote Aboriginal communities in WA are advised to develop a COVID-19 plan to ensure that:

- communities are prepared for COVID-19
- prevention activities are occurring to minimise the risk of COVID-19 infections occurring in communities
- there is an effective response to individual cases and outbreaks of COVID-19 infection.

Recovery activities will also need to occur in the future, but these are not addressed specifically in this guidance document.

Some of the important areas that should be addressed in the community-level COVID-19 plans are:

1. The leadership or coordination structure for planning and responding to COVID-19 in the community.
2. Health promotion activities to be developed in English and local Aboriginal languages.
3. Identifying and obtaining supplies that may be required.
4. Policies on entry restrictions to the community.
5. A plan for identifying and isolating someone who is a suspect case of COVID-19.
6. A plan for managing someone who is a confirmed case of COVID-19.
7. A plan, including disposition, for evacuating a person with suspected or confirmed COVID-19 for medical reasons.
8. A plan for transporting and housing someone who has mild symptoms and is a suspected or confirmed case of COVID-19 and needs to be moved from the community for the purpose of isolation.
9. A plan for housing close contacts of a suspected or confirmed case who cannot remain in their own household.
10. A plan for responding to an outbreak of COVID-19 in the community.
11. A workforce plan to ensure continuity for key staffing roles in Aboriginal communities.
12. A plan for conducting funerals and burials that recognises the most current advice concerning social distancing, limits on the numbers of people within both in-door

and out-door gatherings. This plan should be sensitive to cultural protocols on viewing deceased persons.

13. A plan for temporary accommodation for members in transient situations in communities.
14. A plan for telehealth services to be delivered for medical conditions and chronic diseases.

Recommendations

The following recommendations have been developed to guide the preparedness, prevention and response stages to COVID-19 in remote Aboriginal communities.

1. Response planning and structure

Each remote Aboriginal community should have a clear coordination structure for planning and leading the response to COVID-19.

2. Health promotion

Preventive health advice should start early in remote communities and continue at each stage of the response. This includes messaging around hand washing and cough etiquette. Social distancing, social isolation and quarantining should be promoted and explained through specific education materials. Health services should work with communities to develop culturally appropriate methods of disseminating this advice so that all community members have knowledge of actions and resources such as hand sanitiser and soap to prevent or reduce the spread of COVID-19 infections. Health promotion resources can be found via the following link: https://ww2.health.wa.gov.au/Articles/A_E/Coronavirus

3. Additional supplies and resources needed

Additional supplies or resources may be needed in the community to respond to COVID-19. These could include additional cleaning materials, additional products to support hygiene, and supplies to support individuals or the community in a period of isolation.

4. Entry restrictions

On the 21 March 2020, the State Government released a set of binding new directions to protect the health and wellbeing of people living in remote communities in response to COVID-19².

The directions will apply to each remote community within the state and prevent persons entering without approved purpose. Directions may change as the situation requires, please check for the most current directions via the following link: <https://www.wa.gov.au/remot-aboriginal-communities-directions> .

Whatever the circumstances, the following people should be advised not to enter Aboriginal communities in order to prevent the introduction and spread of COVID-19 into remote Aboriginal communities:

- Those who have returned from overseas or interstate (in the last 14 days and have been advised to remain in quarantine. When the quarantine period has been completed (14 days since last leaving the high-risk country) and the person remains

² <https://www.wa.gov.au/government/publications/remot-aboriginal-communities-directions>

well, they may enter the remote community (subject to the Aboriginal Remote Communities Directions).

- Those who have been identified as a 'close contact' with a confirmed case of COVID-19 by public health officials until 14-days after their exposure, when, if they are well, they may enter their community (subject to the Aboriginal Remote Communities Directions).
- Those displaying symptoms of COVID-19, which can be the same as many other respiratory infections e.g. fever, cough, sore throat, tiredness and/or shortness of breath.

The workforce providing essential services travelling in and out of the community should be aware that overseas, interstate and regional travel may affect their ability to enter a remote Aboriginal community.

Aboriginal communities may decide to apply more restrictive criteria regarding entry into the community, such as excluding a person who has respiratory symptoms, or restricting all entry. Ensure government policy regarding remote community restrictions are always adhered to.

5. Management of people who develop symptoms of a respiratory infection in an Aboriginal community and may be suspect COVID-19 cases

Communities need to have a plan of how to manage a suspect COVID-19 case and this should be consistent with the Communicable Diseases Network Australia National Guidelines for Public Health Service³ concerning the management of suspected or confirmed cases in remote communities. When isolation in the community is not possible or in the best interests of the community, there should be a clear plan for transporting the suspect case to where they can be tested and isolated, including a clear pathway on the provision of support in order to maintain isolation.

a. General considerations for home quarantine or isolation

Home quarantine, or isolation, are effective measures that minimize the spread of COVID-19. The barriers to effective home quarantine or isolation measures in communities in which overcrowding exists are recognized.

Communities are encouraged to work within their constraints to effectively isolate people who have been diagnosed with COVID-19, their close contacts and people who are suspected cases, until COVID-19 has been excluded.

Suggested ways this could be achieved include:

- encouraging communities to identify culturally appropriate social distancing measures using a strengths-based approach
- engaging with the Department of Communities to identify WA Government assets such as non-residential community buildings that may be utilised for isolation purposes
- provision of essential material requirements if household preparations prove inadequate - these would include food for preparation; prescribed medications; essential commodities e.g. disposable nappies, hygiene requirements, etc. NOTE:

³ <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

as delivery would be by well population, protocols regarding social distancing should be established

- monitoring of the household situation, initially through social contact via telephone - this may be a non-clinical person telephoning daily to ask questions according to a protocol regarding material needs, emotional status, and any worsening of symptoms. The protocol should state escalation protocol if a worsening of symptoms is identified
- contact via telephone by a health professional, if social contact identifies worsening of symptoms - clients without telephone may need home visits, with sufficient distance maintained by contact person i.e. speak to household through window or from gate and a plan for donning of Personal Protective Equipment where face-to-face contact is required
- selectively quarantining at-risk individuals within the community to protect them from the virus e.g. the elderly.

All of these would need to occur in a culturally acceptable way that recognizes the importance of cultural and family relationships.

b. Managing suspect cases

People who develop symptoms of a respiratory infection, e.g. fever, cough, sore throat or shortness of breath, should follow standard precautions to prevent the spread of respiratory infections until symptoms have resolved⁴. If this person is a Health Care Worker (HCW) and they satisfy the criteria for testing for COVID-19 they should get tested and go into isolation until COVID-19 has been excluded.

The identification of someone who could be considered a suspect case of COVID-19 is likely to change as the COVID-19 outbreak progresses.

If COVID-19 is suspected, and meets the case definition for a suspect COVID-19 case⁵, the following should occur:

- A health assessment should be carried out, during which droplet and contact precautions should also be used, and a surgical mask should be used by the patient during assessment.
- Where a person is suspected of having severe COVID-19, disease airborne precautions, including N95/P2 mask, must be worn by the HCW.
- In some instances, it may be possible to collect swab specimens for testing for COVID-19 and other respiratory viruses, while in the community or at a nearby town's medical facility, provided this can be done using appropriate precautions and there is a mechanism to transport specimens to Perth within a reasonable timeframe.
- Where the suspect case requires medical evacuation, specimens can be coordinated for collection at the receiving hospital.
- If COVID-19 is suspected, the local Public Health Unit⁶ will be able to provide further advice.

⁴ <https://www.health.gov.au/resources/publications/coronavirus-covid-19-print-ads-simple-steps-to-stop-the-spread>

⁵ <https://www1.health.gov.au/innet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

⁶ https://www.healthywa.wa.gov.au/Articles/A_E/Contact-details-for-population-public-health-units

If the person is assessed as being medically well enough to remain in the community and this is in line with the current CDNA national guidelines⁷, the following is recommended whilst they are symptomatic and/or awaiting test results for COVID-19 and/or other viruses:

- Self-isolation by eating and sleeping alone in their own bedroom and not sharing bathroom facilities.
- A building in the community could be designated for this, such as a community centre, an office or another suitable building.
- The person who is undergoing testing should avoid being with other people, particularly indoors, e.g. office, meeting room or dining room, motor vehicle, or any other enclosed spaces. If this is unavoidable, the person should wear a surgical mask and should follow the latest social distancing advice, i.e. remain at least 2 meters from other people.
- Take extra care to practise good hand and sneeze/cough hygiene.
- Environmental cleaning and disinfection should be undertaken of rooms used by the person.

6. Managing a confirmed case of COVID-19

Some cases may be able to be managed in communities if there are appropriate facilities and support to do so. Follow directions regarding suitability for community isolation as set out in the CDNA National Guidelines⁸. Contact via phone or alternate method must be made daily by a delegated worker to monitor the health and wellbeing of the case.

7. Management of people with suspected or confirmed COVID-19 who require transfer to a medical facility

Repatriation of people who develop symptoms consistent with the case definition for a COVID-19 respiratory infection and require medical attention not available in the community will need to be transported out of the community. Communities should have a plan for vehicles, drivers and infection control where transport is via road and not conducted by St John's Ambulance or hospital ambulance services (these services will follow their own protocols).

Where transfer is warranted, clear communication that the transport involves a case or suspected case of COVID-19 should be made to the hospital and retrieval services.

8. Management of workforce

It is recognized that workforce constraints are a significant issue in remote WA.

During times of COVID-19 activity, communities should ensure that the workforce are aware to:

- be alert for symptoms
- exclude themselves from work immediately if they develop a respiratory illness and report the illness to their supervisor
- if symptomatic, be assessed and tested for COVID-19

⁷ <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

⁸ <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

- immediately exclude themselves from work while unwell. It is recommended that HCWs should stay off work until they fulfil criteria for clearance as outlined in the CDNA national guideline, section 3⁹. HCWs who are unwell but do not meet criteria for a suspected case and/or testing of COVID-19, should remain off work until they are well according to usual infection control exclusion policies.

Communities will also need to plan for workforce continuity if the existing workforce is affected by quarantine or isolation requirements.

9. Conducting funerals and burials

Gathering for funerals will present a challenging situation for Aboriginal communities. Traditional funerals attended by people from outside the community are a risk for the introduction of COVID-19 to communities, and groups of people may be inconsistent with national advice regarding public gatherings¹⁰. Careful consideration and planning will need to occur within communities to consider culturally appropriate funeral ceremonies.

Acknowledgements

Materials developed by the Northern Territory government and the AHCWA have been used as resources in the development of this guidance.

Key Contacts

Coronavirus Health Information Hotline

1800 020 080

Public Health Emergency Operations Centre

Tel No: 9222 0221

Email: pheoc@health.wa.gov.au

⁹ <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

¹⁰ <https://www.health.gov.au/resources/publications/coronavirus-covid-19-advice-for-organising-public-gatherings>

WA Public Health Units

Metro 9222 8588 / 1300 MCDCWA (1300623292)	Kimberley 9194 1630	South West 9781 2359
Goldfields 9080 8200	Midwest 9956 1985	Wheatbelt 9690 1720
Great Southern 9842 7500	Pilbara 9174 1660	After hours/on call 9328 0553

Appendix 1. Governance Structures

Under the State Hazard Plan - Human Biosecurity, the State Health Epidemic Controller (SHEC) is responsible for coordinating responses to a human epidemic such as COVID-19 at the State level. This is performed in a two-pronged approach as described in the Infectious Diseases Emergency Management Plan (IDEMP), which is activated in parallel with the State Hazard Plan– Human Biosecurity to manage a human epidemic emergency. While the State Hazard Plan– Human Biosecurity outlines multi-agency responses to an infectious disease emergency in WA, the IDEMP is a health-specific infectious disease emergency response plan.

The Public Health Emergency Operations Centre (PHEOC) is established at the Communicable Disease Control Directorate (CDCD) within the Department of Health and is coordinated by the Director CDCD, who also acts as the Chief Human Biosecurity Officer for WA. The PHEOC coordinates the public health response to infectious diseases at the State-level.

The Director General's delegate, via the State Health Incident Coordination Centre (SHICC), coordinates hospital and clinical health services, and non-government health sector responses by activating continuity strategies to maintain the integrity of health system service delivery, overseeing logistical requests, and disseminating information to internal and external stakeholders. Regional Directors at the regional Health Service Provider (HSP) level (i.e. WACHS), or their delegate, are the Regional Health Disaster Coordinators (RHDCs) in regional areas responsible for managing the respiratory infectious disease emergency response and recovery.

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