



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

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Introduction

Aboriginal people are identified as a vulnerable group that may be disproportionately affected by COVID-19. Aboriginal communities situated in remote areas face 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 Western Australia (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 Australia Declaration of State of Emergency and Public Health Emergency plans and directions. As State directions 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/covid-19-state-of-emergency-declarations>.

This document acknowledges but does not address external risks related to 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 level across government.

This guidance is primarily intended for those in the health sector including the WA Department of Health, Health Service Providers, Aboriginal Community Controlled Health Services (ACCHS), primary care providers, and other public, private and not-for-profit providers of health services. The document 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 Engagement Unit, Department of Premier and Cabinet.

Community engagement

WA has remote Aboriginal communities situated primarily in the State's north and east. On average, Aboriginal people have significantly poorer health outcomes 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 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 Aboriginal and Torres Strait Islander people as a vulnerable group.

The Communicable Diseases Network Australia (CDNA) have developed the [*Coronavirus Disease 2019 Series of National Guidelines for Public Health Units*](#)¹ (COVID-19 SoNG) and the [*CDNA National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19*](#)² (CDNA Guidance for remote Aboriginal communities), to assist in the development of strategies for Aboriginal communities.

Key strategy recommendations include:

- **Shared decision-making and governance:** Throughout all phases, COVID-19 responses 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 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 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 the prevention, response and recovery phases of a pandemic. Messages should address factors that may contribute to risk, for instance, living arrangements and accessibility to services. Additionally, when required, messages should be customised to the cultural needs of the various regions/groups and translated into local languages, and/or delivered through Aboriginal interpreters in liaison with Aboriginal workers and Aboriginal Health Workers.
- **Flexible and responsive models of care:** Consider flexible health service delivery and healthcare models (e.g. proportionate testing, bringing in external mobile services, flexible ACCHS clinic hours/location with additional staffing, and home visits). Consider employing the use of COVID-19 Point of Care Testing (PoCT), where available.
- **Isolation and quarantine:** Families should feel empowered and be part of decision-making around isolation and quarantine. This can be achieved through explaining and exploring with families what social isolation, physical distancing and quarantine looks like. Work through how it might affect the family and their way of living, and identifying ways to minimise any impacts. While family members may want to visit unwell people in hospital, it should be clearly explained that there are alternate ways to maintain communication with sick family members when they are in isolation or hospital. Importantly, it should be stressed that communication can be maintained with families in lieu of gatherings through other means such as the internet and video calling.

¹[https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/\\$File/COVID-19-SoNG-v3.8.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/COVID-19-SoNG-v3.8.pdf)

² <https://www.health.gov.au/resources/publications/cdna-national-guidance-for-remote-aboriginal-and-torres-strait-islander-communities-for-covid-19>

Governance structure and roles and responsibilities

1. Legislative and Policy context

The Controlling Agency is the agency with responsibility, either through legislation other than the *Emergency Management Act 2005 (WA)* ('[EM Act](#)'), or by agreement between a Hazard Management Agency (HMA) and one or more agencies, to control the response activities to an incident, as specified in the appropriate [State Hazard Plans \(Westplans\)](#). In most instances, when an incident escalates to become an emergency, the Controlling Agency and the HMA are the same agency.

Under the [EM Act](#), the State Human Epidemic Coordinator (SHEC), Department of Health, is the designated HMA responsible for a human epidemic.

An Incident Controller has been appointed. The Incident Controller requests other supporting agencies to assist in the response to COVID-19 as required.

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

2. State Health Incident Coordination Centre (SHICC)

The State Health Incident Coordination Centre (SHICC) addresses strategic management of an incident/disaster as well as facilitating management of state-wide events. During an infectious disease emergency, hospital, clinical health service, and non-public health sector responses will be coordinated by the SHICC, in conjunction with the SHEC.

3. Public Health Emergency Operations Centre (PHEOC)

The Public Health Emergency Operations Centre (PHEOC) responsible for coordinating the state-wide public health response to an infectious disease emergency which includes, but is not limited to, disease surveillance, data management, and public health management of infected persons and their contacts.

4. Public Health Units (PHU)

For the purposes of COVID-19 the WACHS Regional [Public Health Units](#)³ (PHUs) are considered to be part of PHEOC. The WACHS PHUs are involved in the coordination and implementation of public health responses to COVID-19 at the local level. Activities of PHU's include disease surveillance, data management and public health management of infected persons and their contacts.

WACHS may deploy an Outbreak Management Team (OMT), which will include public health staff, to provide a local operational response.

5. WA Country Health Service (WACHS)

WACHS provides, accessible health services including hospitals, health services and nursing posts to people from large regional centres to those in small remote communities.

Refer to **Appendix 2. WACHS Network Map**, for further information on the regions and their interrelationships with services.

³ https://www.healthywa.wa.gov.au/Articles/A_E/Contact-details-for-population-public-health-units

5.1 Emergency Operations Centre (EOC) and Regional Emergency Operations Centre (REOC)

WACHS has established an Emergency Operations Centre (EOC) to coordinate the operational response across the seven regions. Each region has a Regional Emergency Operations Centre (REOC) which coordinates the clinical services and public health response under the oversight of PHEOC and the Incident Controller.

5.2 Operational Area Support Groups (OASGs)

Operational Area Support Groups (OASG) are responsible for the provision of triage/isolation/treatment facilities for infected persons in public hospitals and ambulatory care settings. Each OASG is made up of multiple agencies (including ACCHS) and provides strategic support during a response.

The OASG and REOC will provide support and coordination for the management of the outbreak in collaboration with the local ACCHS and are overseen by the EOC.

6. Aboriginal Community Controlled Health Services (ACCHS)

ACCHS are the principal health agencies in Aboriginal remote communities and under the advice of PHUs will often lead in the assessment, care and management of suspected, probable and confirmed COVID-19 cases. Key roles and responsibilities include:

- Assess and organise testing for suspect and probable cases.
- Care and management of confirmed COVID-19 cases, including arrangements for emergency evacuation and transport if required.
- Assist with identification and management of close contacts.
- Liaise with other stakeholders (WACHS, PHUs, Department of Communities, etc.) regarding the coordination of primary health care and social and emotional wellbeing support for people isolating or in quarantine.
- Communicate with community, including helping to reduce fear and panic.

ACCHS also undertake targeted health and hygiene promotion activity to reduce the risk of transmission to and within remote Aboriginal communities. This may include the production and promotion of education resources, community wide communications through media, and presence on advisory groups at commonwealth, state and regional levels to help reduce the spread of COVID-19.

7. Department of Communities

Under the State Emergency Welfare Plan, the Department of Communities will assist people who are affected by COVID-19 with emergency accommodation and welfare needs.

COVID-19 planning for remote Aboriginal communities

The high prevalence of co-morbidities and distance from tertiary health care means that residents of WA's remote Aboriginal 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 Aboriginal communities needs to be considered when implementing plans in response to COVID-19.

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 including Personal Protection Equipment (PPE)
4. Policies on entry restrictions to the community
5. A plan for identifying and managing someone who is a suspect or probable 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, probable or confirmed COVID-19 for medical reasons
8. A plan for transporting and housing someone who is confirmed COVID-19 and needs to be moved from the community for isolation
9. Environmental cleaning and disinfection of rooms used by confirmed cases
10. A plan for quarantining close contacts of a confirmed COVID-19
11. A plan for responding to an outbreak of COVID-19 in the community
12. A workforce plan to ensure continuity for key staffing roles in Aboriginal communities
13. 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
14. A plan for temporary accommodation for vulnerable community members and members in transient situations in communities
15. A plan for telehealth services to be delivered for medical conditions and chronic diseases.

Refer to **Appendix 3. COVID-19 Remote Aboriginal Communities Public Health Planning survey**, for further considerations in planning for a response to COVID-19 in a remote Aboriginal Community.

Recommendations

The following recommendations have been developed to guide the preparedness, prevention and response stages to COVID-19 in remote Aboriginal communities. It is recognised that there is a lot of diversity across remote Aboriginal communities that may influence their approach.

1. Response planning and structure

Each remote Aboriginal community should have a clear coordination structure for planning and leading the response to COVID-19. The Department of Communities has led a pandemic planning process for remote Aboriginal communities. As a result, Local Pandemic Action Plans have been developed for most communities outlining their prevention and preparedness for COVID-19. These guidelines should be used to help inform the Local Pandemic Action Plans.

2. Health promotion

Preventive health advice should start early in remote communities and continue at each stage of the response. Remote Aboriginal communities should be empowered to protect themselves against COVID-19 through tailored health education materials that address and explain:

- Presenting early to the clinic (phone ahead) if developing fever and/or respiratory symptoms
- Hand hygiene
- Cough etiquette
- Physical distancing
- Isolation and quarantining
- Staying at home when unwell except to seek medical care
- Environmental cleaning.

Health promotion messages should be disseminated, promoted and explained to community members through culturally appropriate and specific education materials and methods.

Health promotion resources can be found via the following links:

- https://ww2.health.wa.gov.au/sitecore/content/Healthy-WA/Articles/A_E/Coronavirus/Coronavirus-information-for-Aboriginal-people
- <https://www.health.gov.au/resources/collections/coronavirus-covid-19-resources-for-aboriginal-and-torres-strait-islander-people-and-remote-communities>

3. Staff education and training

Education for health staff is vital to inform their behaviour and help manage the potential of transmission of COVID-19.

Health services should identify roles and responsibilities concerning staff education and training. Prompt and clear information needs to be provided to health staff regarding transmission including:

- Signs and symptoms of coronavirus (COVID-19) illness
- Early identification and testing of respiratory illness
- Hand hygiene
- Standard precautions, transmission-based precautions (contact, droplet, airborne)
- Appropriate use of PPE, including donning and doffing
- Biohazard waste management
- Decontamination and cleaning of clinical areas and equipment
- Quarantine and isolation protocols
- Medical evacuation protocols
- Notifiable disease reporting.

Online training modules for Hand Hygiene, COVID-19 infection prevention and control and PPE are available. All staff should undergo regular refresher training to ensure they are aware of the most current information and recommendations regarding COVID-19 prevention and control measures.

Staff should be educated, and supported, to exclude themselves from work and get tested when they have fever and/or an acute respiratory infection and to notify their employer if they have been confirmed to have COVID-19.

4. Additional supplies and resources needed

Additional supplies or resources may be needed in the community to respond to COVID-19. Facilities should ensure that they hold adequate stock levels of all consumable materials required during an outbreak, including:

- PPE (gloves, gowns, masks, eyewear)
- Hand hygiene products (alcohol-based hand rub, liquid soap, hand towel)
- Cleaning supplies (detergent and disinfectant products)
- Supplies to support individuals or the community in a period of isolation or quarantine
- Testing diagnostic materials (swabs).

5. Preventing the introduction of COVID-19 to communities

Avoiding exposure to a person with COVID-19 infection is the single most important measure for preventing COVID-19 in a remote Aboriginal community. Processes should be in place to help prevent the introduction of COVID-19 to remote communities, including the restricting the movement of visitors into and out of communities and limiting contact between members of the community and essential services workers.

5.1 Entry restrictions

Under the state of emergency, the State Government implemented the Remote Aboriginal Communities Directions, to prevent the spread of COVID-19 to remote Aboriginal communities and protect vulnerable Aboriginal people. On 4 June 2020 the State Government revoked the Remote Aboriginal Communities Directions No. 2 and released a set of new binding directions, the Remote Aboriginal Communities Directions No. 3.

The Remote Aboriginal Communities Directions No. 3. apply to each remote Aboriginal community within the State and put restrictions on persons entering and passing through communities.

Details of the directions can be found via the following link:

<https://www.wa.gov.au/government/publications/remote-aboriginal-communities-directions-no-3> .

Whatever the circumstances, the following people should be advised not to enter 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) and the person remains well, they may enter the community (subject to the Remote Aboriginal Communities Directions).

- Those who have been identified as a 'close contact' with a confirmed case of COVID-19 by PHEOC. When the quarantine period has been completed (14 days) and the person remains well, they may enter the community (subject to the Remote Aboriginal Communities Directions).
- Those displaying symptoms of COVID-19 e.g. fever, cough, sore throat, tiredness and/or shortness of breath, loss of taste or loss of smell should seek medical advice before entering a community.

5.2 Exposure prevention

Exposure prevention actions that remote communities can undertake include:

- Practicing good hand hygiene, cough etiquette, physical distancing and environmental cleaning.
- Staying at home when unwell except to seek medical care.
- Presenting early to the clinic (phone ahead) if developing fever and/or respiratory symptoms.
- Monitoring of residents for fever or acute respiratory symptoms.
- Healthcare personnel should keep up to date with most current Commonwealth Department of Health and State Government public health information to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness ([COVID-19 Information for health professionals](#)).
- Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately for all individuals interacting with suspect or confirmed cases.
- Ensure correct use of PPE.
- Notify facilities and transport service providers prior to transferring a resident with an acute respiratory illness, including suspected, probable or confirmed COVID-19.
- When PoCT is conducted, notify any confirmed COVID-19 cases in residents and employees to the relevant jurisdictional PHU authority (see **Key Contacts**).
- If there is transmission of COVID-19 in the community, it might be an option to selectively quarantine at-risk individuals within the community to protect them from the virus e.g. the elderly.
- If there is transmission of COVID-19 in the community, in addition to implementing the precautions described in these guidelines, communities should consult with relevant jurisdictional PHU authority for additional guidance (see **Key Contracts**).

6. Management of suspect, probable and confirmed COVID-19 cases

Communities need to have a plan that sets out how they will respond to and manage a suspected, probable and confirmed COVID-19 case as defined in the COVID-19 SoNG¹. Community planning should be done in consultation with community members, local ACCHSs, PHUs and be consistent with the CDNA Guidance for remote Aboriginal communities².

Limitations of local resources and infrastructure will influence how a community responds to suspect, probable and confirmed COVID-19 cases. Some of the key considerations include but are not limited to:

- **Clinical condition:** The first consideration should be the clinical condition and medical needs of people and whether they require emergency medical evacuation.
- **Health services:** Is the community supported by a local health clinic? What staff does the clinic host, and what capacity does it have to respond to COVID-19, as well as

continuing to respond to daily primary health care priorities (business as usual) for the community?

- **Testing capability:** Does the community has access to COVID-19 PoCT? If testing is not available within the community consider the distance, time it would take and methods available to transport either a person out of community to be tested, or, to collect and transport swab specimens for testing.
- **Road distance to a hospital and access to an airstrip:** Consider the road access, distance and time it would take to evacuate a person by car to a regional hub with adequate hospital facility, and/or and whether the community has access to an operational airstrip. This will inform what options are available and preferred if a person requires evacuation out of the community. This consideration becomes more significant in the event of flooding blocking road access during the wet season.
- **Isolation and quarantine capability:** Assess whether the community has appropriate facilities, infrastructure and support services to facilitate and maintain on-site isolation or quarantine.
- **Communications arrangements:** What telecommunications and internet access does the community have?

6.1 Suspect or probable COVID-19 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 COVID-19 is suspected or probable, meeting the case definitions, 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 Healthcare practitioner.
- Where PoCT is available the person should be tested and isolated while waiting for the results. In some instances where a nearby community has PoCT it may be an option to transport the person to be tested, provided this can be done using appropriate precautions.
- Where PoCT is not available, it may be possible to collect and transport either the person, or swab specimens, for testing for COVID-19 and other respiratory viruses. This is provided it can be done using appropriate precautions and there is a mechanism to transport specimens to a testing laboratory within a reasonable timeframe. Transport options include; private vehicle, ambulance, clinic vehicle or the Royal Flying Doctors Service (RFDS).
- Where the suspect or probable case requires immediate medical evacuation, specimens can be coordinated for collection at the receiving hospital.
- Where the person is being transported there needs to be clear communication that the transport involves a suspected or probable case of COVID-19.
- The local PHU 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>

If the person is assessed as being medically well enough to remain in the community while awaiting test results for COVID-19, it is recommended that:

- The person takes extra care to practise good hand and sneeze/cough hygiene.
- The person is isolated in a room in the clinic or a building in the community designated for this.

OR

- The person stays in their home and avoids being around other people. If this is not possible, the person should wear a surgical mask and follow the latest physical distancing advice.

6.2 Managing COVID-19 in community

Self-isolation and quarantining is an effective measure to minimize the spread of COVID-19 and this may be managed in communities if there are appropriate facilities and support to do so. People who have been diagnosed with COVID-19, and their close contacts, will be required to isolate or quarantine until COVID-19 has been excluded.

It is recognised that in many remote Aboriginal communities there are barriers to effective isolation including overcrowding. The directions regarding suitability for community isolation as set out in the CDNA Guidance for remote Aboriginal communities² should be followed.

General considerations for community/home isolation and quarantine

Communities are encouraged to work within their constraints to ensure that people can effectively isolate or quarantine. Suggested ways this could be achieved include:

- Encourage communities to identify culturally appropriate physical distancing measures using a strengths-based approach.
- Engage with the Department of Communities to identify WA Government assets such as non-residential community buildings or other accommodation that may be utilised for isolation purposes.
- Ensure provision of essential material requirements if needed. These would include food; prescribed medications; essential commodities e.g. disposable nappies, hygiene requirements, etc. NOTE: as delivery would be by a well population, infection control protocols should be established.
- Establish monitoring of the household situation, initially via telephone. This may be done by a non-clinical person telephoning daily to ask questions according to a protocol regarding material needs and emotional status.
- Contact via telephone by a health professional to identify any worsening of symptoms and/or other health concerns. Clients without a telephone may need home visits with sufficient distance maintained by the clinician i.e. speak to household through window or from gate or use PPE where face-to-face contact is required.
- Establish pathways for other health and welfare services that may be required while in isolation or quarantine, for example the provision of regular treatments for a chronic disease.

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

6.3 Removal and management of COVID-19 out of community

When isolation or quarantining in the community is not possible or in the best interests of the individuals or the community, there should be a clear plan for transporting and isolating or quarantining people out of the community.

Where a person who is COVID-19 positive requires hospitalisation and has dependents, alternative care arrangements with family or friends is the best option. Provisions should be provided to support this.

Transport out of community

Where a transfer is occurring, clear communication that the transport involves a suspected, probable or confirmed case of COVID-19 should be made to the transport service and receiving health services. Transport options include road transport via ambulance, medical clinic vehicle, personal or community vehicle, or air transport via the RFDS or a chartered flight.

Where transport is not conducted by St John's Ambulance, a hospital ambulance service or RFDS (these services will follow their own protocols), infection control protocols should be implemented to ensure the safety of the driver and any other passengers. These include the use of PPE, having the suspected, probable or confirmed case sitting as far from others as possible, and decontamination cleaning of the vehicle after transport is completed.

Isolation and quarantining out of community

Where the person is well enough not to be in hospital, isolation out of community in suitable accommodation will need to be arranged. Under the State Hazard Plan – Human Biosecurity, the Department of Communities will assist with emergency accommodation and welfare, if a person and their dependents are required to self-isolate or quarantine.

Cultural consideration should be given to the type of accommodation, e.g. ensuring access to an outdoor area. Where a person has dependents and decides that alternative care arrangements with family or friends is best, then provisions should be provided to support this decision.

To support safe and successful isolation, a multi-agency approach should be adopted involving PHU, the Department of Communities, Aboriginal Community Controlled Health Services, WA Police, and if required, additional health or welfare services (e.g. regular health treatments, aged care, disabilities and/or mental health services). To ensure that people can effectively isolate the following should occur:

- Provision of essential material requirements needed including food for preparation; prescribed medications; essential commodities. Infection control protocols should be in place to ensure the safety of any people delivering items.
- The Australian Red Cross (contracted by the SWICC) will telephone daily to monitor the persons emotional status. If any issues are detected an escalation protocol will be followed.
- Contact via telephone by a health professional to identify any worsening of symptoms and/or other health concerns. Clients without a telephone or who require more direct medical attention may need a face-to-face visit, ensuring infection control protocols are taken by the health professional.
- Support health and welfare services should be made available if required to ensure isolation is safe and maintained.

7. Contact tracing

For the purposes of contact tracing, cases are considered to be infectious from 48 hours prior to onset of symptoms. PHEOC will lead the process of contact tracing within communities, but the process will require assistance from community members and/or local health clinic staff. In most situations, PHU staff will be able to conduct contract tracing via phone or telehealth but sometimes it may be required that PHU staff come to the community. Either of these methods will require community assistance and corporation.

Under the advice of PHU and in collaboration with community members, it must be decided if close contracts will quarantine in the community or be moved out of the community. The same considerations outlined previously regarding isolation in community should also be considered when deciding the suitability of people quarantining in community.

Upon advice from PHEOC, further testing for COVID-19 of asymptomatic people may be arranged (with support from WACHS PHU).

8. Management of workforce capacity

It is recognised 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:
 - It is recommended that Health care workers (HCWs) should stay off work until they fulfil criteria for clearance as outlined in the COVID-19 SoNG¹.
 - 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.

If they are in a medically vulnerable group, they should be provided with advice regarding not working with COVID-19 cases.

Communities will also need to plan for workforce continuity if the existing workforce is affected by quarantine or isolation requirements. Escalation protocol utilising regional WACHS and ACCHS plans should be in place for when a surge in workforce is required.

9. Conducting funerals and sorry business

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 when organising funerals communities should follow the advice in the [Guide for Funerals and Sorry Business during the coronavirus pandemic](#)⁵. Careful consideration and planning will need to occur within communities to consider culturally appropriate funeral ceremonies.

⁵ <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Infectious-disease/COVID19/COVID19-Funerals-and-Sorry-Business.pdf>

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

For health information/advice related to COVID-19 or assistance with emergency accommodation and welfare.

Public Health Emergency Operations Centre

Tel No: 1300 316 555 (08:00 – 17:00) Email: pheoc@health.wa.gov.au

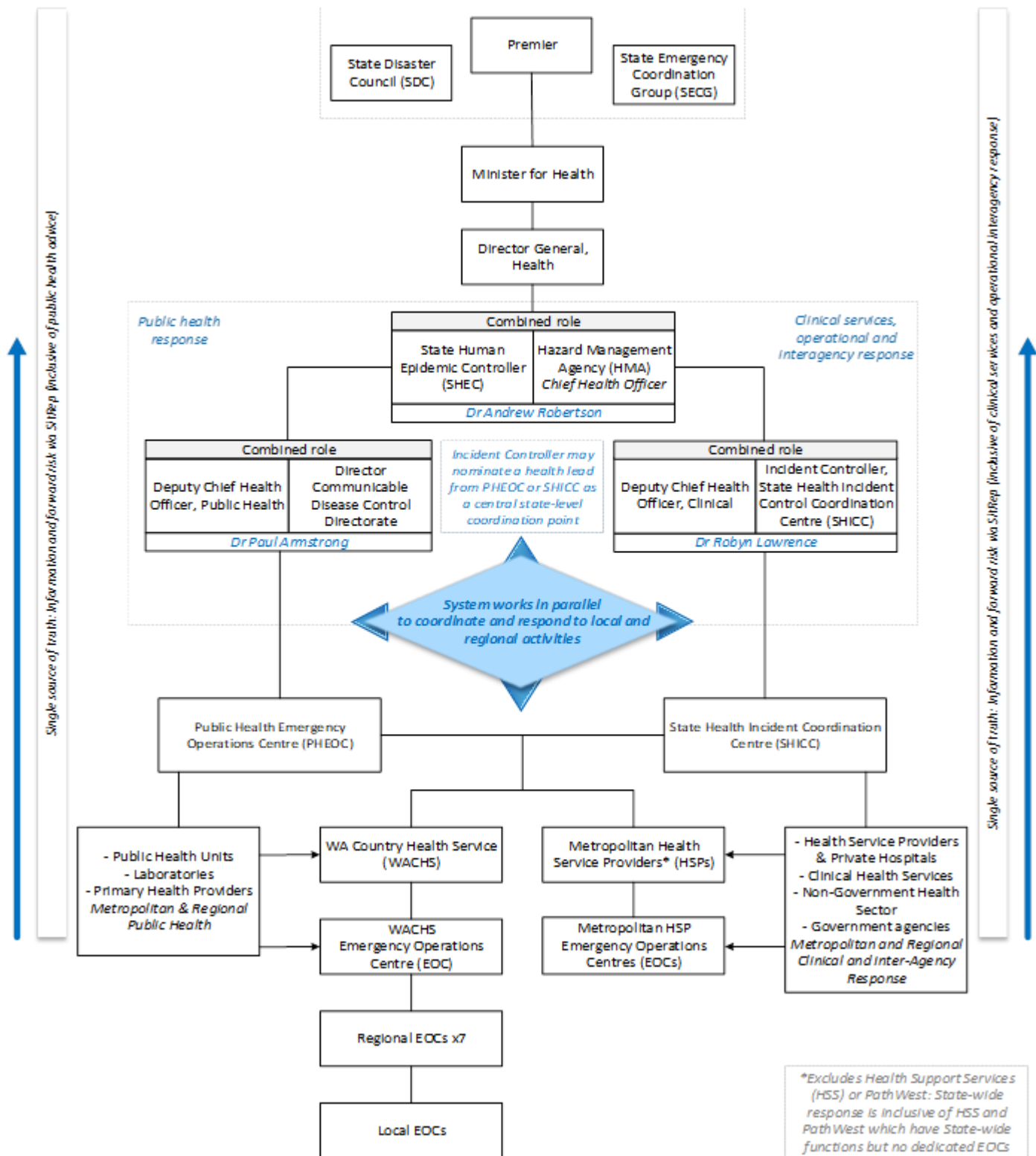
If you are seeking information regarding PPE, infection control isolation and other matters of a public health nature.

WA Public Health Units

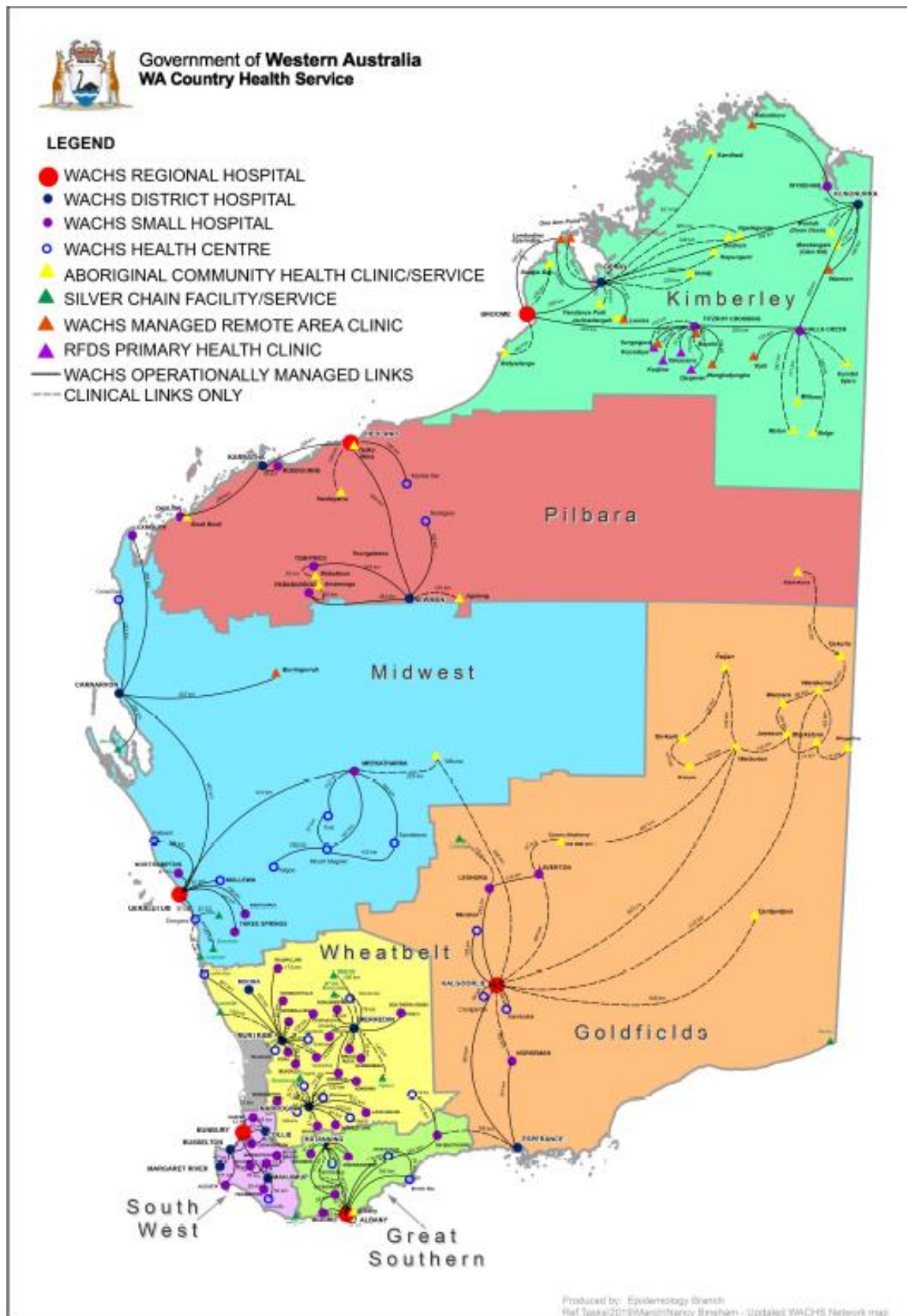
Public and population health contracts can be found via the following link: [Contact details for population/public health units.](#)

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



Appendix 2. WACHS network map



Appendix 3. COVID-19 Remote Aboriginal Communities Public Health Planning survey

The following information will be collected via an online survey tool, through a coordinated approach engaging; regional Operational Area Support Group; the Department of Communities; community clinic staff and; local community leaders.

GENERAL INFORMATION	
Site or community name	
Region	Goldfields <input type="checkbox"/> Midwest <input type="checkbox"/> Pilbara <input type="checkbox"/> Kimberley <input type="checkbox"/>
In the event of a case of COVID in the community who within the community should be contacted?	
ACCESS	
What telecommunication access is available in the community? <i>select all options that are relevant</i>	Landline <input type="checkbox"/> Mobile phone coverage <input type="checkbox"/> Satellite phone coverage <input type="checkbox"/> Internet <input type="checkbox"/>
What languages are spoken in the community?	
Does the community have an airstrip?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes: Is there lighting to allow flights at night? Is the airstrip functional when there is/has been heavy rain? Are there any other constraints that impact the functionality of the airstrip?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Max capacity:

What is the capacity (number of people) of the largest plane that can land?	
What is the nearest town with a hospital? What is the road distance to that town? Estimated travel time (in good weather and road conditions)? Estimated travel time (in bad weather and road conditions)?	
Is the road sealed?	Yes, completely <input type="checkbox"/> Yes, partially <input type="checkbox"/> No <input type="checkbox"/>
HEALTH SERVICES	
Where is the nearest health clinic? What is the name of the clinic? What is the contact number of the clinic?	On community <input type="checkbox"/> Other:
Name of health service provider	
Type of health service provider	Aboriginal Community Controlled Health Service <input type="checkbox"/> WA Country Health Service <input type="checkbox"/> Royal Flying Doctor Service clinic <input type="checkbox"/> Other:
How many staff does the clinic have who live in the community?	Doctor: Nurse: Other health workers:
How many staff provide a regular visiting health service to the community?	Doctor: Nurse: Other health workers:
How frequently do visiting staff come to the community?	Weekly <input type="checkbox"/>

	Fortnightly <input type="checkbox"/> Monthly <input type="checkbox"/> Other:
What service is use after hours? What is it contact number?	
TESTING	
Nearest Point of Care Testing (PoCT)?	On community <input type="checkbox"/> <i>Go to next section</i> Other:
If on community, does the community have short-term (< 24 hours) isolation capabilities, with access to private toilet, while patients await test results? How many people could isolate separately at once?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If there is no PoCT available on community, what is the preferred testing approach?	Suspect or probable cases evacuated from the community to get tested <input type="checkbox"/> Swab specimen taken and transported to testing facility <input type="checkbox"/>
Does the PoCT clinic have short-term (< 24 hours) isolation capabilities, with access to private toilet, while patients await test results? How many people could isolate separately at once?	Yes <input type="checkbox"/> No <input type="checkbox"/>
SUPPLIES	
Has your community have a supply of masks and gloves?	Yes <input type="checkbox"/> No <input type="checkbox"/>
ISOLATION AND MANAGEMENT IN COMMUNITY	
Has suitable* accommodation for suspected, probable, confirmed cases or close contracts been identified in the community?	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Go to next section</i>

<p>Have accommodation that is suitable for an individual?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
<p>What facilities does the individual accommodation have? <i>select all options that are relevant</i></p>	<p>Bed <input type="checkbox"/></p> <p>Telephone access <input type="checkbox"/></p> <p>Internet or TV <input type="checkbox"/></p> <p>Kitchen facilities <input type="checkbox"/></p> <p>Private bathroom <input type="checkbox"/></p> <p>Private toilet <input type="checkbox"/></p> <p>Shared bathroom <input type="checkbox"/></p> <p>Shared toilet <input type="checkbox"/></p> <p>Open windows <input type="checkbox"/></p> <p>Contained outside space <input type="checkbox"/></p>
<p>Have accommodation that is suitable for a household or a group?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
<p>What facilities does the group accommodation have? <i>select all options that are relevant</i></p>	<p>Bed <input type="checkbox"/></p> <p>Telephone access <input type="checkbox"/></p> <p>Internet or TV <input type="checkbox"/></p> <p>Kitchen facilities <input type="checkbox"/></p> <p>Private bathroom <input type="checkbox"/></p> <p>Private toilet <input type="checkbox"/></p> <p>Shared bathroom <input type="checkbox"/></p> <p>Shared toilet <input type="checkbox"/></p> <p>Open windows <input type="checkbox"/></p> <p>Contained outside space <input type="checkbox"/></p>
<p>How many people could be accommodated to isolated separately in community at the same time?</p>	
<p>Who is responsible for organising accommodation in the community?</p>	<p>Name:</p> <p>Phone number/s:</p>
<p>Who would conduct daily checks on people in isolation?</p>	

Who would provide healthcare for people in isolation?	
Have broader welfare plans, such as food and hygiene, been made for people in accommodation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Would security be used to manage accommodation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, who would provide the security?	Name: Phone number/s:
Are relevant personnel (including security and staff who provide daily checks, healthcare or other services to those in isolation) trained in the use of PPE?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>IMPORTANT: If the above considerations can not be addressed it is recommended that the decision to have people isolate or quarantine in community be reassessed.</i>	
ISOLATION AND MANAGEMENT OUT OF COMMUNITY	
What is the nearest regional hospital identified for COVID-19 cases?	
Would a suspect, probable or confirmed case be transferred from the community for isolation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, to where?	Location: Name of accommodation: Distance from community:
Would close contacts of a confirmed/probable case be transferred from the community for quarantine?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, to where?	Location: Name of accommodation: Distance from community:
Would vulnerable community members (e.g. elders, those with chronic conditions) be transferred from the community for isolation?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If yes, to where?	Location: Name of accommodation: Distance from community:
Who is responsible for organising accommodation outside of the community?	Name: Phone number/s:
TRANSPORT	
Which of the following transport is available to transfer people from community? <i>e.g. for isolation, testing or health reasons</i> <i>select all options that are relevant</i>	Ambulance <input type="checkbox"/> Clinic vehicle <input type="checkbox"/> Personal vehicle <input type="checkbox"/> Community vehicle <input type="checkbox"/> RFDS <input type="checkbox"/> Other:
What transport provider would be used?	Name: Phone number/s: