VICTORIAN multicultural commission
strengthening our community

Victorian Multicultural Commission's submission to *The Inquiry into the Victorian government's covid-19 contact tracing system and testing regime*

The Victorian Multicultural Commission (VMC) welcomes the opportunity to respond to the Legal and Social Services Committee's Inquiry into the Victorian Government's COVID-19 contract tracing system and testing regime.

The VMC is an independent statutory body, established in 1983 and constituted under the *Multicultural Victoria Act 2011*. Its primary roles include:

- engaging and consulting Victoria's multicultural communities;
- acting as a conduit between Victoria's multicultural communities and government; and
- providing advice to government departments and agencies on policies and programs.

The global COVID-19 pandemic has certainly challenged the community, the public health and other service responses and had an enormous impact on us all affecting our health, livelihoods, job and financial security as well as mental health and wellbeing.

There are several critical factors that underpin the VMC's submission:

- Victoria is one of the most culturally, linguistically and religiously diverse societies in the world.
- Our diversity is increasing and has delivered social, cultural and economic benefits.
- With any social or economic objective, there are opportunities and challenges – COVID-19 has been an exemplar in presenting both the challenges and opportunities; noting that the pandemic, in many instances, exacerbated and brought to the fore pre-existing issues but has also provided an opportunity to proactively and systematically address them.

The VMC took an unprecedented and proactive approach in supporting Victoria's multicultural communities since the pandemic's impact commenced earlier in the year, but particularly during the second wave.

As the pandemic unfolded, the VMC conducted extensive consultations with multicultural and faith communities. These included consultations with or through:

- the VMC's Regional Advisory Councils;
- the Multifaith Advisory Group;
- -specific community organisations;
- young people from multicultural communities;
- members of the LGBTIQ multicultural community;
- people with disabilities or those working with people with disabilities from multicultural communities;
- multicultural business community and chambers of commerce; and
- key stakeholders to learn about the complexities of intersectionality.

As a conduit between Victoria's multicultural communities and government, the VMC ensured that the key issues identified through these various channels and consultations informed the guidance,

practical advice and support that was provided to relevant government agencies, which led to influencing policy and systems responses.

The VMC also cochaired purpose specific and time limited Working Group established to assist the DHHS, residents and communities and provided support to the public housing estate residents in North Melbourne and Flemington during the lockdown implemented on 4 July in response to the concerning level of COVID-19 cases. Community volunteers were also mobilised at both sites to assist Department of Health and Human Services (DHHS) staff with doorknocking for welfare checks and testing, translating and disseminating critical information in community languages and encouraging residents to get tested and comply with quarantine restrictions.

Key observations and feedback received from communities pertaining to COVID-19 contract tracing and testing included the following, noting that improvements occurred over time.

1. Given our cultural, religious and linguistic diversity, the importance of in-language resources and information being packaged and readily available in various forms (visual, audio, print etc) is not to be underestimated. The VMC acknowledges that the Victorian Government did produce a higher number of translated materials (more than 50 community languages) compared to other states and territories and that communication systems improved over time. Clearer messaging around notions of isolation and quarantining strengthened community understanding of these terms and gave families the opportunity to understand implications of work, home-schooling and running of day to day duties. This was a critical factor in better supporting multicultural communities navigate contact tracing, testing processes and quarantine requirements.

2. Many members of the multicultural communities source in-language news and information from overseas media, including from their country of origin, which at times was inconsistent to Victorian Government messaging and context. This reinforces the need for up-to-date information being provided regularly through trusted sources.

3. The VMC provided advice to government departments on utilising existing trusted community leaders and representatives as part of community engagement strategies to improve information dissemination and increase community confidence. The VMC provided the opportunity for senior health officials and government representatives to present at community consultations and answer related queries. These consultations proved positive for both community and government.

4. Overarching difficulties in managing contract tracing and testing regime at the beginning improved over time, particularly regarding community engagement strategies employed for diverse cohorts. The nature of initial community engagement and mutual understanding between DHHS and communities proved challenging to facilitate important conversations and provide instructions on how to manage processes. This also extends to the adequacy of disclosure of close contacts or their movements. The VMC, community representatives and residents played an important role in assisting to refine messaging and communications systems and encourage that the learning be set as the benchmark for future community engagement strategies.

5. Bi-cultural workers employed in contact tracing teams helped formulate a public health response and to educate communities about the importance of the contact tracing process.

6. Concerns were expressed by some community representatives that close contacts were not contacted within the period of time that was indicated leading to fear and concern amongst community that some may unknowingly spread the virus.

7. Improvements in the faster release of test results reduced stress of staying in isolation and helped with fast contact tracing.

8. The centralised nature of the contract tracing reduced its ability to connect with constituents at a local grassroots level.

9. Concerns and barriers to testing included stigma around testing, initial delay in receiving test results (though this improved significantly over time), need for clearer and simpler translated information/resources and misinformation that was spreading through other mediums such as social media.

10. Concerns around receiving contact tracing calls or positive infection confirmation calls from No Caller ID numbers meant that some community members wouldn't answer or return messages from DHHS.

11. Better utilisation of interpreter services would have better supported cohorts with low-level English proficiency. The dedicated COVID-19 Hotline which included interpreting service provisions required a good command of the English language to access in the first instance and for many members this was beyond their English language level. This meant they were not able to sufficiently access information relating to testing processes or necessary information needed to support their compliance.

12. Importance of collating diversity data not only for those testing positive but those who have come forward for testing. Birthplace and language spoken at home data is now being collated.

13. Family dynamics, family size and definition of what constitutes a family differs amongst the multicultural communities. As such, the timeliness of wrap around supports available may prevent a large family with multiple positive cases determine suitable means of isolation and quarantine, as well as managing younger family members and their schooling and other activities. Greater understanding and flexibility is required around individual family needs as opposed to some of the mainstream approaches that have been adopted.

14. Many temporary visa holders and for those in precarious working conditions had feared job loss or reprisal should they test positive to COVID-19, with some continuing to work with symptoms. The Victorian Government's Coronavirus Test and Worker Support Payment schemes did provide financial relief and encouraged community members to come forward and get tested.

15. Managing initial quarantine expectations for international students and temporary visa holders in shared accommodation and available supports proved difficult - this was addressed appropriately at a later stage.

16. Housing estate resident quarantine processes and available wrap-around supports were not effective in catering for larger families. It would have been more appropriate for DHHS Case Managers to directly manage their clients and provide communications and access to information and supports.

Key recommendations:

The VMC acknowledges that a number of the following recommendations are being addressed by the DHHS, with the support of the Culturally and Linguistically Diverse Task Force (CALD Task Force). The VMC is also assisting in the community engagement aspects in ensuring the voice of communities are included in the design and implementation of some of these recommendations.

1. Adopt a geographic based approach to contact tracing and testing, including:
   1.1. More localised community engagement, leveraging community and organisations, local governments and service providers including ethno-specific, multicultural service providers; and
   1.2. Strengthening community engagement by departments and agencies.

2. Support a case management approach to positive COVID-19 cases. This approach could:
   2.1 Leverage existing trusted relationships with GPs to support initially and ongoing engagement;
   2.2 Leverage existing trusted relationships with community or faith representatives to support engagement around isolation and quarantine processes, provide advice on wrap around services and address concerns regarding cultural needs (food, faith practices, stigmatism etc);
   2.3 Employ bicultural/diverse workforce to support the planning and implementation of contract tracing and testing processes;
   2.4 Engage multicultural service providers in the implementation of contact tracing and testing activities; and
   2.5 Where relevant, appropriate training and provision of PPE materials should be provided.

3. Greater coordination within government services to manage communities that are spread across different geographic locations and who require different services across government departments. This could include:
   3.1 Targeted and client-focussed strategies through interdepartmental community liaisons who have knowledge of the communities and systems to better respond to needs or timely referral to appropriate support services;
   3.2 Ensure appropriate oversight of the deliverables of the interdepartmental community liaisons and that they are supported timely and adequately.
   3.3 Better utilisation of existing staff with cultural and linguistic skills within the VPS to liaise with communities (noting this does not replace the need to use of accredited interpreters and that a whole-of-government workforce diversity as a long-term strategy should be considered); and
   3.4 Identify community leaders who have cultural understanding, intercultural and multifaith knowledge to support and inform communities.

4. Strengthen communication using multiple means, modes and channels, including:
   4.1 Flexibility in the availability and delivery of supports to communities, develop and deliver public health information to hard to reach members, and keep them updated and informed;
   4.2 Leveraging trusted people in communities to deliver, endorse, reinforce key messages;
   4.3 Leveraging different multicultural media networks, both formally (e.g. SBS, 3ZZZ, NEMBC, and Channel 31) or informally (via community, youth, faith-based organisations who have their own “followings” via social media, online chats, online newsletter databases etc); and
   4.4 Communication should take a layered approach including to broader networks and or targeted networks, cultural groups across geographic, demographic or faith settings;
   4.5 Having mechanisms to be able to respond swiftly to community concerns and requests.

5. Improving efforts to respond to misinformation, provide clarity and build trust. This could be achieved by:
   5.1 Greater access to senior public health officials at community meetings and gatherings;
   5.2 Improving the utilisation of agencies including ethno-specific or multicultural service providers which have existing community engagement infrastructures and networks;
   5.3 Strengthening relationships with community organisations, faith leaders and ethnic media who have influence, reach and are trusted by their communities; and
   5.4 Allowing for continuous improvement and feedback via clear departmental escalation points to address issues in an appropriate and timely manner.

6. Improving the collection of diversity data to better inform targeted communication for underrepresented cohorts.

7. Greater leverage of agencies, statutory bodies, peak bodies organisations and multifaith organisations who have knowledge, expertise in community engagement infrastructures and networks to assist.