

Acceptability of an asymptomatic COVID-19 screening program for schools in Victoria, Australia: a qualitative study with caregivers from priority populations

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Key points

- This study explores the views of priority populations on an asymptomatic COVID-19 rapid antigen test (RAT) screening program implemented in Victorian schools during the pandemic
- Culturally and linguistically diverse families were compliant with screening, however, in-language resources were limited
- Aboriginal or Torres Strait Islander families tested children less regularly and received information from their community, rather than the school

Abstract

Background: An asymptomatic COVID-19 rapid antigen testing (RAT) screening program was implemented in Victorian schools in January 2022, to support keeping schools open throughout the pandemic. This study explored compliance with the program among caregivers from priority populations in Victorian mainstream and specialist schools.

Methods: We conducted semi-structured interviews between 7–31 March 2022 with caregivers of school-aged children participating in the RAT program in Victoria. Participants were asked about awareness, acceptability, compliance, frequency, and barriers to testing. Recordings were transcribed and deductively analysed using a framework approach.

Results: Fifty caregivers participated. They expressed confusion about the 'recommended' program, assuming it was mandatory. Caregivers wanted notification from schools of positive cases to increase motivation for compliance. Culturally and linguistically diverse (CALD) families were compliant; however, in-language resources were limited. Aboriginal or Torres Strait Islander (Koori) families tested less regularly and received information from their community rather than school. Caregivers of children living with disabilities reported behavioural challenges to testing, resulting in distress or non-compliance, and received non-specific information for their children.

Conclusions: To increase engagement with future surveillance programs, caregivers need clarity about optionality, conducting tests, reporting results, and timely notification of cases. Requirements unique to each priority population include: accurate in-language information for CALD caregivers, community-led communication for Koori caregivers, tailored information, less testing, and flexibility for caregivers of children living with a disability. Keeping

Key points (continued)

- Caregivers of children living with disabilities reported behavioural challenges to testing and were provided non-specific information for their children.

schools open and having tailored strategies to ensure equitable access for priority populations are essential for future pandemic management.

Introduction

As Australia pursued a goal of zero community SARS-CoV-2 transmission in 2020–21, the state of Victoria experienced restrictions, and children had lengthy periods of at-home online learning due to lockdowns and school closures. Coronavirus disease 2019 (COVID-19) outbreaks in schools were managed by closure followed by a 14-day quarantine for all close contacts and their households – measures that successfully reduced the size of outbreaks.¹ However, as the psychosocial impacts of school closures on children became evident, keeping schools open became a national priority.²

The asymptomatic COVID-19 rapid antigen test (RAT) screening program was implemented in several Australian jurisdictions in January 2022 to identify asymptomatic cases who might unknowingly spread the virus within schools.³ The Victorian Government's 'back to school' plan included the RAT program in primary (kindergarten – year/grade 6) and secondary (year/grade 7–12) schools.⁴ The program applied to mainstream and specialist schools, which are attended by 12% of young people living with a disability.⁵ Staff and students were recommended to take tests at home in the morning. Those in mainstream schools were recommended to test twice weekly, while those in specialist schools were recommended to test daily for five days (Monday to Friday), due to the higher risk of poor COVID-19 outcomes for these students.⁶ Packets of nasal swab tests – which were deemed more accurate than saliva tests – were provided by the Government free of charge and available for collection at schools.⁷ Students and staff were required to report positive results to the school and the Victorian Department of Health. Positive cases were required to isolate at home for 14 days, which was then reduced to 7 days. Participation in the program was recommended, but it was not mandated. The program aimed to facilitate early detection of COVID-19 cases in education settings to minimise transmission, maximise face-to-face teaching, reduce health system impact and protect vulnerable staff and students.

The pandemic and public health measures disproportionately impacted priority populations in Victoria.^{8–10} These populations included children living with a disability, children from culturally and linguistically diverse (CALD) backgrounds, and children from Aboriginal or Torres Strait Islander communities. The Victorian Department of Health commissioned

this study to explore awareness, acceptability and compliance with the program and frequency of child testing among parents and guardians (hereafter referred to as 'caregivers') of school-aged children from priority populations in Victorian mainstream and specialist schools.

Methods

Study design

We conducted individual and group qualitative interviews with caregivers of school-aged children from priority populations who participated in the RAT program in Victoria, Australia.

We applied a descriptive phenomenological approach within a constructivist-interpretivist research paradigm to explore caregiver experiences.¹¹ This study is reported according to the Consolidated Criteria for Reporting Qualitative Research checklist.¹² Reflexivity was applied.¹¹

Participant recruitment

The Victorian Department of Education and Training (DET) project partners identified schools and community groups who were less likely to respond to a RAT evaluation survey sent by DET and the Department of Health between February and March 2022, due to health, literacy, or cultural barriers. The DET partners approached school principals or community liaison officers to introduce the project and ascertain their willingness to recruit caregivers.

School staff or community liaison officers contacted caregivers by phone, email, or in person and provided a list of interested caregivers to us. Participants were eligible if they were caregivers of a child who participated in the school RAT program in Victoria and if their child was either living with a disability, from a CALD background or identified as Aboriginal or Torres Strait Islander.

Our study team and DET called or emailed caregivers, discussed the study and obtained written informed consent. A suitable time was arranged for a group interview, and individual interviews were offered if needed. If participants did not speak English, community liaison officers facilitated the consent discussion and translated consent forms were provided. As this work aimed to support Victorian Government decisions regarding the ongoing use of the RAT screening program, recruitment was pragmatically limited to a 4-week period.

We aimed to recruit as many participants as possible during that time.

Data collection

Four researchers (FJ, IO, JK, JT, all female and experienced in qualitative interviewing) conducted interviews using the Zoom online video platform between 7 and 31 March 2022.¹³ Interpreting services were used where required, and a cultural safety officer was present, such as a community liaison officer or staff member. Interviews followed a semi-structured guide asking about program awareness, acceptability, and frequency of child testing, which was adapted with consensus over time. Audio recordings were transcribed verbatim by OutScribe.¹⁴

Data analysis

Two researchers (FJ, IO) read and coded transcripts using a deductive framework analysis approach using key topics from the interview guide and NVivo.^{15,16} FJ and IO initially coded the same two transcripts, then decided on a coding framework with IO, JK, JT, and MD. Two authors (FJ, IO) conducted the analysis, which was discussed with JK, JT, and MD for consensus.

Ethics and funding

The study received ethical approval from the Royal Children's Hospital Human Research Ethics Committee (HREC 70355) and approval from the Department of Education Research in Schools and Early Childhood Settings (RISEC 2021_004353). Written informed consent was obtained from participants prior to participation.

This research was funded by the Victorian Department of Health. The funder had no role in study design, data collection, analysis, or in the decision to submit the manuscript for publication. The funder approved the study design and conduct to ensure it supported the aims of the Department of Health.

Results

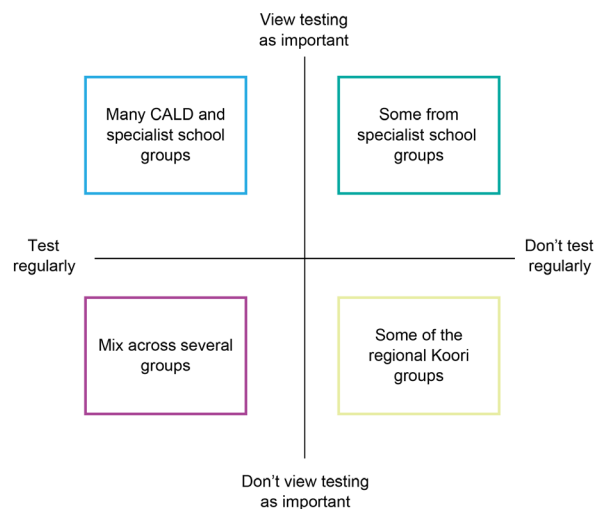
Participants

We conducted eight group and seven individual interviews with a total of 50 caregivers (CALD $n = 21$, specialist schools $n = 19$, Aboriginal and Torres Strait Islander $n = 10$). The CALD caregivers were from Arabic-African and Chinese language communities. The Aboriginal and Torres Strait Islander caregivers, self-identified and hereafter referred to as 'Koori', were from Melbourne or regional Victoria. Specialist schools included two special development schools in regional Victoria and one autism-specific school in Melbourne. Group interviews were 40–80 minutes, and individual interviews were 15–65 minutes in duration.

Key findings

Each group's views on the importance and frequency of testing are shown in Figure 1.

Figure 1. Caregivers' views on the importance of testing and testing frequency, by priority group



CALD = Culturally and linguistically diverse; Koori = Name of self-identification provided by Aboriginal and Torres Strait Islander caregiver participants.

Awareness of the program

Caregivers knew what was expected of them in the RAT screening program. Initially, caregivers heard about it through television and radio, and Koori caregivers heard from their community. Before the start of the school year, most received information about the program from the school through emails, texts, newsletters and apps. Some CALD caregivers were provided translated materials, others could not find translated information, and some relied on children to translate information.

Most caregivers thought testing was mandatory and expressed confusion around the word 'recommended'. One Koori caregiver was disappointed when their school took an 'opt in' approach. Most were relieved when informed testing was not mandatory, especially specialist school caregivers who struggled to do five tests with children weekly.

"When I rang the school, I was reminded that it was not mandatory...so then when it was like recommended, the pressure was off a little bit."
(Specialist school caregiver)

Inconsistent information led to confusion and challenges with compliance. Caregivers relied on instructions that came with the RAT kit, and a small number were given instructions from the school. Two Koori caregivers reported not receiving instructions on

how to perform the test. Specialist school caregivers advocated for tailored resources and “visual cues” and were frustrated with the lack of specific guidelines.

“They’d go, ‘oh yep, no worries. Special needs kids, here you go. Take the test.’ Um, we are classified as a special needs school for a reason. We’re not mainstream.” (Specialist school caregiver)

No participants indicated an inability to access tests, except at the start of the school year when supplies were limited, and some bought their own. Afterwards, caregivers received ample kits, which was helpful for testing other family members or when isolating. Initially, caregivers collected tests from school, and later on, schools placed the kits in students’ bags. Older children collected tests from the office. This made some students uncomfortable,

“Koori kids don’t go to the office. What they remember with an office is being in trouble.” (Koori caregiver).

Testing frequency

Caregivers from CALD groups were concerned about the rapid increase in COVID-19 cases, saw testing as vital to keep the community safe, and were compliant with testing their children,

“Complaint or not, allergy or sensitivity or not, I still do it twice a week. I tell them [children] that’s the regulations you know.” (CALD caregiver).

Most participants tested less frequently over time. Reasons included lack of time, forgetting recent positive results, or not viewing testing as important. Those who tested infrequently would test their child if they were symptomatic, if they were attending an event, if their child prompted it, or if there was a positive case in the classroom. Caregivers from specialist schools said testing five times each week was not feasible, as many faced physical and behavioural challenges while testing their children. Some chose not to test but to keep their child home if symptomatic; others would test siblings or themselves instead.

Participants initially tested in the morning before school as recommended but eventually tested in the evening. Difficulties testing in the morning were due to having multiple children, a busy morning routine, and not upsetting their child before school. Caregivers from specialist schools responded to their child’s mood to determine when to test.

Acceptability to children

Caregivers reported that older children didn’t mind the tests and did them themselves. Younger children found them uncomfortable or complained about an itchy nose, a bloody nose, or sneezing fits. Caregivers preferred testing younger children themselves to ensure they were

performed correctly. Some made the experience into a game, and one CALD caregiver treated the test “as a science experiment” by following the procedure diligently.

Caregivers of children with disabilities described the difficulties the tests had caused their children, including reacting physically due to hypersensitivity or behavioural triggers. Some caregivers had to restrain their child physically; others reported bloody noses or swabs broken inside the nose, which was distressing for the caregiver and child.

“Every time I would have to pin her down and she’d scream... and she’d have a bloody nose every single time.” (Specialist school caregiver).

One specialist school caregiver said doing the RAT on their child would make them “more prone to having behaviours of concern”. Meanwhile, another participant with a non-verbal child said the process was straightforward as the child was familiar with this type of intervention. Most children with disabilities did not fully comprehend why the tests were being performed beyond a basic understanding that they were related to COVID-19.

Those who purchased saliva RAT tests felt they were easier to perform and less invasive than nasal tests, especially for younger children and children with disabilities. Most caregivers from specialist schools were not aware of the saliva testing option and were frustrated to discover this during the group interview, considering the distress they had put their children through. Most caregivers from specialist schools concurred with one caregiver’s comment that there was “not a hope in hell” of managing nasal RAT tests, and in many cases, their child would not tolerate saliva tests either.

Acceptability to caregivers

Caregivers were supportive of the program as it increased their confidence to send their child to school, kept the community safe, and reduced school closures. Caregivers from specialist schools would not have felt comfortable sending their children to school without the program, given their children were at higher risk of poor COVID-19 outcomes. However, those from specialist schools wanted less frequent testing or only when symptomatic. Caregivers said the program made it easier to test multiple children within a household without having to go to a testing site.

Caregivers from specialist schools were concerned about long-term impacts, such as accessing medical treatments in future, if their child experienced distress from the RAT.

“Is she going to then have an aversion to anything... going to doctors, going to hospitals, getting other tests done...?” (Specialist school caregiver)

Some caregivers complied because “*that’s the regulations*” (CALD caregiver). Some were uncertain about the accuracy, “*I’m scared the result isn’t 100% correct.*” (CALD caregiver), making them wonder whether the RATs were worth doing. Some didn’t see the point in testing, especially if the child already had COVID-19, “*If we get it, we get it*” (Koori caregiver). Some Koori caregivers expressed they wanted to stop focusing on COVID-19, with many facing bigger issues such as racism and bullying. There was some distrust in the government among the Koori group:

“They still kept the floodgates open, now you don’t have to wear masks. So it kind of sort of like says to us as a community, did the government get it wrong?” (Koori caregiver)

Awareness of reporting results and isolation requirements

Positive results were to be reported to the school and Department of Health; however, most participants were only aware they needed to report to the school, and some were confused about how to do it. Reporting was done by phone or app. Most felt supported by their school if their child tested positive.

Caregivers in mainstream schools wanted to know about COVID-19 cases to reassure them that families

were compliant with testing and the school was responding.

“I haven’t got any information about positive cases at my kid’s school.” (CALD caregiver).

Caregivers from specialist schools were happy with the information provided, including details of the year level or room number of a COVID-19 case. Alternatively, one asked the school to stop sending emails due to communication overload.

Although most caregivers had adequate information about isolation, some were confused about the requirements and how to manage household members. Caregivers from specialist schools reported that isolation information from the school was generic and did not cater to their child’s needs.

“...it was miscommunicated, at first I was told he could come back to school and then I received another call saying he couldn’t...”(Specialist school caregiver)

Recommendations

The key findings and recommendations for each of the three priority populations are summarised in Table 1.

Table 1. Key findings and recommendations for an asymptomatic rapid antigen test surveillance program in schools, by priority group

CALD group	Koori group	Specialist school group
Findings		
<ul style="list-style-type: none"> Compliant with testing, even if child refused Motivated to follow guidelines In-language resources were limited Concerns about test accuracy 	<ul style="list-style-type: none"> Did not test regularly Received information from community, not school Distrust in government decisions and program Formalities (e.g. retrieving tests from school office) made children uncomfortable More important issues drew focus (e.g. racism, bullying) 	<ul style="list-style-type: none"> Supportive of the program Physical and behavioural challenges meant testing five days a week was not possible Information not always relevant Adapted for their child’s needs (e.g. only tested when symptomatic, tested siblings, not testing and keeping child home if unwell) Those who knew about saliva tests preferred them
Recommendations for future surveillance programs		
<ul style="list-style-type: none"> Provide up-to-date, in-language information about: the program, how to test, reporting of results 	<ul style="list-style-type: none"> Provide flexibility Consider broader needs Community-led information delivery (e.g. community liaisons) 	<ul style="list-style-type: none"> Provide flexibility Provide saliva options for specimen collection Provide tailored information relevant to the child’s needs, about how to perform the test (use imagery)

CALD = culturally and linguistically diverse; Koori = Name of self-identification provided by Aboriginal and Torres Strait Islander caregiver participants.

Discussion

This is the first qualitative study on caregiver experiences of the school COVID-19 RAT screening program within priority populations in Victoria. As the psychosocial impacts of school closures on children became evident, keeping children in schools became a high priority, and the RAT program facilitated this. Similar RAT screening programs internationally showed success in the early identification of COVID-19 cases and, therefore, reduced disruption to students in schools, with the most common barrier to testing being the perceived benefit of screening compared to the burden of testing.¹⁷⁻¹⁹ The urgent rollout of the program in Victoria in February 2022, during the Omicron wave of the COVID-19 pandemic, meant it was not initially tailored to the needs of priority populations, although this improved over time. Overall, caregivers desired clarity that the program was only 'recommended' and not mandatory, as most assumed, which resulted in challenges and distress. Caregivers also wanted schools to communicate positive COVID-19 cases clearly, as this increased motivation to be compliant with RAT screening. CALD families were compliant with testing; however, the availability of in-language resources was limited. Koori families often did not test regularly and received their information from their community, not the school. Caregivers with children living with disabilities had unique challenges with testing that were often physical or related to accessing irrelevant information.

CALD families were highly compliant and motivated to follow government guidelines but lacked correct, up-to-date translated information. Comparable unpublished findings were reported in the survey conducted by the Victorian Department of Health, which found that 70% of CALD households took all recommended COVID-19 RAT tests, compared to 53% of non-CALD households.²⁰ Similar behaviours were identified throughout the pandemic in Victoria, with CALD families reportedly highly motivated to adhere to pandemic precautions, with non-compliance typically due to extrinsic factors such as lack of access, opportunity, or in-language information.^{21,22} These findings are not unexpected, as trends of high motivation to comply with both health and government recommendations, despite facing barriers with access and language, are observed nationally and internationally among CALD households.²² For ongoing, effective engagement with this group to encourage compliance with future pandemic measures or other health recommendations, such as immunisation, it is critical to ensure detailed, up-to-date, in-language information is available.

Doubt in government decisions meant there was some distrust in the program's purpose among caregivers from Koori groups. These families were often dealing with other issues, such as experiences with racism and bullying. The ongoing impact of colonisation is important to consider when recognising the social determinants of health for

this population, as program formalities, mandates, and strict procedures may reinstate poor practices unsuitable for engaging with this group. Program flexibility, co-design, and consideration of broader needs are important for Koori families and will continue to be a crucial element of any future health initiative. Similar recommendations have been made in previous programs that work with Aboriginal and Torres Strait Islander populations in Australia.^{23,24} Communication about the RAT program within this group occurred primarily through other community members, as was the case throughout the pandemic.²⁵ Community-led information delivery, such as with community liaison officers, should continue to be used going forward and should be included in program planning.^{26,27}

Caregivers of children living with disabilities were supportive and engaged with the RAT program, however, they faced more behavioural challenges and distress in complying with testing children five days a week. The Department of Health survey also found low compliance in specialist schools compared to mainstream schools (43% compared to 72-74%).²⁰ Given children living with disabilities are known to have or be at risk of developing procedural anxiety, relevant programs should cater to this group by providing additional support or guidance to optimise compliance. This could include testing only when a child is symptomatic or giving the option not to test and to keep the child at home. A study in the US offered flexibility in their program, with options for in-home or in-school testing, nasopharyngeal or saliva collection, and a requirement of only up to two tests per week.¹⁸ They had high compliance with the program but had challenges with caregiver engagement and eventual testing hesitancy due to variability in the testing strategy. In our study, saliva tests were preferred to nasal tests by those who knew about them, suggesting offering this option to children living with a disability and young children in future programs may increase testing engagement.⁷ While the acceptability of nasal swabs in children has been well documented, there is variability in the acceptability of saliva as a method of specimen collection in children with disabilities and young children, with some caregivers preferring the nasal swab due to collection difficulties and time taken.²⁸ Any consideration of saliva or nasal testing should weigh the acceptability and benefits of collection and the accuracy of results. Lastly, tailoring information on how to conduct the test is needed, with some caregivers recommending instructions using imagery would be effective for their children, as has been previously described with other interventions.^{29,30}

A limitation of this study is that participants were nominated by school community liaison officers or principals and were, therefore, likely engaged in school activities and compliant with the program. There was limited participation from Koori groups. While the voices of those from priority groups have been incorporated, they are not representative of other caregivers in their child's community group.

Conclusion

This is the first study to provide views of caregivers from priority populations on the adherence, useability, and acceptability of the asymptomatic RAT surveillance program implemented in Victorian mainstream and specialist schools in 2022. To increase compliance in future, clarity is needed for all caregivers to ensure they understand the non-mandatory nature of the program, how to conduct RATs on children and how to report results. Timely notification of COVID-19 cases in schools motivates caregivers to comply with screening. If the program is conducted again, there are requirements unique to each group that would maximise compliance, including accurate in-language information for CALD caregivers, community-led communication for Koori caregivers, and visual, tailored information, and leniency within the program's requirements for caregivers for children with a disability. Keeping schools open should remain a key focus during future pandemics, and tailored strategies to ensure equitable access for priority populations are essential.

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Peer review and provenance

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Competing interests

MD received funding from the Victorian Department of Health for this and other projects. MD was seconded to the Victorian Department of Health from October 2021 to February 2022.

JT received funding from GlaxoSmithKline for investigator-led research.

All other authors declare no competing interests.

Author contributions

MD designed the study with IO, FJ, JK, and JT. FJ, IO, and JT contributed to data collection. IO and FJ contributed to the data analysis and manuscript writing.

All authors were involved in the interpretation of data and critical revision of the manuscript.

References

1. Ryan K, Snow K, Danchin M, Mulholland K, Goldfeld S, Russell F. SARS-CoV-2 infections and public health responses in schools and early childhood education and care centres in Victoria, Australia: an observational study. *Lancet Reg Health West Pac*. 2022;19:100369.
2. Goldfeld S, O'Connor E, Sung V, Roberts G, Wake M, West S, et al. Potential indirect impacts of the COVID-19 pandemic on children: a narrative review using a community child health lens. *Med J Aust*. 2022;216(7):364–72.
3. Abey Suriya RG, Sacks-Davis R, Heath K, Delpont D, Russell FM, Danchin M, et al. Keeping kids in school: modelling school-based testing and quarantine strategies during the COVID-19 pandemic in Australia. *Front Public Health*. 2023;11:1150810.
4. Victorian Government. Keeping education open and safe in 2022. Victoria: Victorian Government; 2022 [cited 2023 Jul 28]. Available from: www.premier.vic.gov.au/keeping-education-open-and-safe-2022
5. Australian Institute of Health and Welfare. People with disability in Australia. Canberra, ACT Australian Government; 2022 [cited 2023 Aug 23]. Available from: www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/education-and-skills/engagement-in-education
6. Grace R, McMillan A. What are the new rules for Victorian students returning to school? *The Age*. Victoria; Nine Entertainment; 2022 Jan 23 [cited 2024 May 16]. Available from: www.theage.com.au/national/victoria/what-are-the-new-rules-for-victorian-students-returning-to-school-20220123-p59qhk.html
7. Schuit E, Venekamp RP, Veldhuijzen IK, van den Bijllaardt W, Pas SD, Stohr JJM, et al. Head-to-head comparison of the accuracy of saliva and nasal rapid antigen SARS-CoV-2 self-testing: cross-sectional study. *BMC Med*. 2022;20(1):406.
8. Jesus TS, Bhattacharjya S, Papadimitriou C, Bogdanova Y, Bentley J, Arango-Lasprilla JC, et al. Lockdown-related disparities experienced by people with disabilities during the first wave of the COVID-19 pandemic: scoping review with thematic analysis. *Int J Environ Res Public Health*. 2021;18(12):6178.
9. Dudgeon P, Alexi J, Derry K, Brideson T, Calma T, Darwin L, et al. Mental health and well-being of Aboriginal and Torres Strait Islander peoples in Australia during COVID-19. *Aust J Soc Issues*. 2021;56(4):485–502.
10. Muscat DM, Ayre J, Mac O, Batcup C, Cvejic E, Pickles K, et al. Psychological, social and financial impacts of COVID-19 on culturally and linguistically diverse communities in Sydney, Australia. *BMJ Open*. 2022;12(5):e058323.

11. Liamputtong P. Methodological frameworks and sampling in qualitative research. In: *Qualitative Research Methods*. 4th ed. England: Oxford University Press; 2013. p. 5–22.
12. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–57.
13. Zoom Video Communications. Zoom. United States: Zoom Video Communications Inc; 2021 [cited 2021 Mar 16]. Available from: zoom.us/
14. OutScribe. OutScribe Australian Transcription Services. Australia: OutScribe Pty Limited; 2021 [cited 2021 Mar 12]. Available from: www.outscribetranscription.com.au/
15. Clarke V, Braun V, Hayfield N. Thematic analysis. In J. Smith (Ed). *Qualitative psychology: a practical guide to research methods*. pp 222–48. London: Sage Publications Ltd; 2015.
16. QSR International. NVivo qualitative data analysis software. Australia: QSR International Pty Ltd; 2018 [cited 2021 Mar 12]. Available from: www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home
17. Haroz EE, Kalb LG, Newland JG, Goldman JL, Mast DK, Ko LK, et al. Implementation of school-based COVID-19 testing programs in underserved populations. *Pediatrics*. 2022;149(12 Suppl 2):e2021054268G.
18. Gemmell M, Sherby MR, Walsh TJ, Kalb LG, Johnson SB, Collier RJ, et al. Recommendations for SARS-CoV-2 testing in children with disabilities and medical complexity. *Pediatrics*. 2023;152(Suppl 1):e2022060352G.
19. Goldenfeld M, Cohen C, Gilboa M, Pessach IM, Mehnick B, Tal I, et al. Rapid antigen tests for safe school opening in the COVID-19 pandemic era. *Pediatr Infect Dis J*. 2022;41(8):e312–17.
20. Victorian Department of Health. COVID-19 screening in schools. Weekly data to evaluate the uptake, effectiveness and acceptability of RATs: Report #6. Week 22–27 March 2022. Unpublished data provided to authors by Department of Health.
21. Qi L. Translation as crisis (mis) communication for culturally and linguistically diverse communities: the case of Australia during the COVID-19 pandemic. *Translation Spaces*. 2023;12(1):97–123.
22. Khatri RB, Assefa Y. Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. *BMC Public Health*. 2022;22(1):880.
23. Busija L, Cinelli R, Toombs MR, Easton C, Hampton R, Holdsworth K, et al. The role of elders in the wellbeing of a contemporary Australian Indigenous community. *The Gerontologist*. 2020;60(3):513–24.
24. Fehring E, Ferguson M, Brown C, Murtha K, Laws C, Cuthbert K, et al. Supporting healthy drink choices in remote Aboriginal and Torres Strait Islander communities: a community-ed supportive environment approach. *Aust N Z J Public Health*. 2019;43(6):551–7.
25. Kerrigan V, Lee AM, Ralph AP, Lawton PD. Stay strong: Aboriginal leaders deliver COVID-19 health messages. *Health Promot J Austr*. 2021;32(Suppl 1):203–04.
26. Holly S, Ben H-R, Kinza M, Pippa M. Communication and engagement of community members from ethnic minorities during COVID-19: a scoping review. *BMJ Open*. 2023;13(6):e069552.
27. Brynne G, Rawlance N, Adalbert T, Vergil de C, Elizabeth M, Alpha AD, et al. Community engagement for COVID-19 prevention and control: a rapid evidence synthesis. *BMJ Glob Health*. 2020;5(10):e003188.
28. Tosif S, Lee L, Nguyen J, McMinn A, Selman C, Grobler AC, et al. Stick with the nose... Saliva rapid antigen testing is not a viable method for testing children under 5 years old. *J Paediatr Child Health*. 2023;59(2):258–63.
29. Toseeb U, Asbury K, Code A, Fox L, Deniz E. Supporting families with children with special educational needs and disabilities during COVID-19. UK: The University of York; 2020 [cited 2024 May 16]. Available from: osf.io/preprints/psyarxiv/tm69k
30. Flores AL, Holt S, Lynch MM, Squiers L, Walker K, Ligon J. Tips for health care providers on talking with patients who have intellectual and developmental disabilities about COVID-19. *J Commun Healthc*. 2022;15(4):324–8.