

# Acting Chief Health Officer Advice to Minister for Health

## Advice relating to the making of Pandemic Orders as required by section 165AL of the *Public Health and Wellbeing Act 2008*

Date of advice: 07 April 2022

<b>HOW THE ACT INFORMS THIS ADVICE .....</b>	<b>6</b>
<b>THIS ADVICE IS BASED ON THE INFORMATION THAT IS AVAILABLE.....</b>	<b>7</b>
<i>Current situation in Victoria.....</i>	<i>7</i>
• Epidemiology .....	7
• Test results .....	7
• Genomics.....	8
• Vaccine uptake .....	8
• Health system pressure.....	8
• Community mobility and behaviours .....	9
<i>Summary of the evidence underpinning the health advice provided in relation to the declaration of a pandemic.....</i>	<i>9</i>
• Emerging evidence about Omicron and sub-lineages.....	10
• Vaccine effectiveness.....	10
• Treatments for COVID-19.....	11
• Modelling the impact of Omicron BA.2.....	12
<b>OVERVIEW OF NECESSARY OR APPROPRIATE PUBLIC HEALTH MEASURES.....</b>	<b>12</b>
<b>CONTINUED AND ADDITIONAL PUBLIC HEALTH AND SOCIAL MEASURES IN THE CONTEXT OF OMICRON.....</b>	<b>14</b>
<i>Face masks.....</i>	<i>14</i>
<i>COVIDSafe Plans.....</i>	<i>15</i>
<i>Management of cases, close contacts and social contacts .....</i>	<i>16</i>
• Testing requirements.....	16
• Quarantine requirements.....	16
• Social contacts.....	17
• Obligations for individuals to report or notify.....	17
• Obligations for workplaces and education facilities to notify.....	18
<i>Management of international arrivals.....</i>	<i>18</i>
<i>Cruise passenger vaccination and testing requirements .....</i>	<i>20</i>
<i>Worker vaccination requirements.....</i>	<i>21</i>
• Two-dose mandates for workforces .....	21
• Third-dose (booster) mandates for workforces .....	22

<i>Care facilities</i> .....	24
• Excluded persons.....	25
• Essential visitors to care facilities.....	25
<b>CONCLUSION</b> .....	<b>26</b>
<b>REFERENCES</b> .....	<b>28</b>

## Introduction and Summary of Advice

1. In response to the request from the Victorian Minister for Health (**the Minister**) made on 07 April 2022, set out below is my advice as Victoria's Acting Chief Health Officer, regarding whether the Minister should renew and revise the current Pandemic Orders (**Orders**) made pursuant to section 165AI of the *Public Health and Wellbeing Act 2008* (Vic) (**Act**) in relation to the coronavirus of 2019 (**COVID-19**).
2. In providing this advice, I am aware of the legislative context in which the Minister's request is made. Section 165AI of the Act empowers the Minister, at any time on or after the making of a pandemic declaration, to make any order that the Minister believes is reasonably necessary to protect public health. The Premier of Victoria has extended the Pandemic Declaration which enables the Minister to deploy legally enforceable measures as part of a focused public health response. Section 9 of the Act requires that the public health response be proportionate to the public health risk that the disease (in this case, COVID-19) poses. Section 10 of the Act requires that, wherever possible, I have regard to the benefits that accrue when there is collaboration between all levels of Government and industry, business, communities, and individuals.
3. This advice relates to the public health measures I advise be introduced or continue in Victoria at the current time. This advice supersedes all previous advice I have provided to the Minister (both written and verbal), as well as advice provided by the Chief Health Officer (both written and verbal) regarding the making of Pandemic Orders.
4. I am providing this advice with consideration to the increasing prevalence of the BA.2 Omicron sub-lineage in the Victorian community, which appears to be even more transmissible than the original Omicron variant of concern (**VOC**) (BA.1) (World Health Organization (a), 2022) (United Kingdom Health Security Agency (a), 2022), the forthcoming winter season and the greater movement and mixing of individuals locally and internationally. My advice also considers the likelihood of waning immunity to COVID-19 over time, both in those who have become infected and those who are vaccinated.
5. As the Chief Health Officer advised in his Advice to the Premier to extend the Pandemic Declaration, I have considered the increased risk of incursion and viral propagation due to community fatigue with public health measures and the pandemic more broadly. I have also considered the possibility of increasing cases of COVID-19 as winter approaches and there is a resultant change in community behaviour such as gathering indoors more frequently and for prolonged periods. As the Chief Health Officer advised in his Advice to the Premier to extend the Pandemic Declaration, these factors, alongside poorer indoor ventilation, typically increase transmission and the spread of respiratory diseases, not only from severe acute respiratory syndrome coronavirus 2 (**SARS-CoV-2**), but seasonal respiratory viruses, such as influenza, which compound the overall risk to population health. The current situation in Victoria necessitates continuation of and changes to some public health measures as outlined below to address the threat posed by COVID-19. It also warrants removal of some measures currently included in Orders.
6. The public health measures outlined in this advice include measures that should continue to be required or recommended. Measures not outlined below that have been included in Orders to date,

have either transitioned to guidance documents or I no longer advise because their ongoing application is no longer proportionate, necessary, or practical to address the current threat from COVID-19.

7. The priority for the COVID-19 response remains reducing morbidity and mortality and limiting the impact of COVID-19 on Victorians who are most at risk of serious illness, controlling chains of transmission, and reducing the strain on our health system, while maintaining the continued operation of essential services and sectors. It is therefore necessary and appropriate to continue some public health and social measures (**PHSMs**) to protect those most at risk and our health system.
8. The public health measures below remain proportionate, despite high vaccine coverage and the presence of variants (Omicron BA.1 and BA.2) with somewhat milder disease severity than the Delta VOC (United Kingdom Health Security Agency (b), 2022), to reduce the risk to Victorians (especially those who are most at risk of serious illness) and further pressure on our health system.
9. I acknowledge the increase in COVID-19 cases observed in recent weeks, which is likely due to a number of factors including the circulation of the more transmissible BA.2 sub-lineage and waning population level protection afforded from both COVID-19 vaccination and previous COVID-19 infection. This trend aligns with the experience reported internationally. I also note the forecasting which suggests Victoria is entering a period of rising case numbers which is likely to peak around mid-April, with hospitalisations peaking shortly thereafter. My advice below sets out the measures I consider appropriate and proportionate to the current epidemiology and forecasted impact of the BA.2 sub-lineage. It is open to the Minister, however, to consider the timing for implementing the measures set out below and the Minister may choose to draw on earlier advice or external information (for example, Australian Health Protection Principal Committee [**AHPPC**] statements) regarding current measures contained in the Orders as the epidemiology evolves.
10. The measures I continue to advise are as follows:
  - i. **continuing to educate the community** about the risks posed by COVID-19, and encouraging and empowering the public to utilise measures that will decrease the risk to themselves, their loved ones and the wider community including wearing a face mask in indoor settings (outside of private homes) and outdoors when unable to physically distance, maintaining up-to-date COVID-19 vaccination status, practising physical distancing and good hand and respiratory hygiene, avoiding sensitive settings and working and studying from home if unwell, optimising ventilation, and the use of rapid antigen (**RA**) testing where appropriate;
  - ii. **requiring face masks** in higher risk and sensitive indoor settings (with limited exceptions) with strong communications regarding the benefits of wearing masks;
  - iii. **facilitating access to testing** by using a combination of RA and polymerase chain reaction (**PCR**) testing to identify as many probable or confirmed cases in a timely manner;

- iv. **facilitating access to COVID-19 therapies** for those eligible to prevent severe illness;
- v. **promoting and facilitating vaccination**, particularly for third and fourth doses (boosters) where eligible and among populations at highest risk of adverse outcomes;
- vi. **requiring COVID-19 vaccination** for workers, including third doses (booster) for high-risk workforces;
- vii. **requiring COVIDSafe Plans** to support practising of COVIDSafe behaviours in workplaces with workers onsite, including facilitating working or studying from home in periods of high community transmission as an additional measure to reduce the risk of transmission at work where appropriate;
- viii. optimising **ventilation** in workplaces, venues and other indoor environments;
- ix. regularly reviewing **test, trace, isolate and quarantine (TTIQ) requirements** and making further changes to align with national guidelines if appropriate;
- x. reviewing and revising the management of **international arrivals**, including air passengers and crew, and maritime passengers and crew including cruise ship passengers;
- xi. **entry requirements** for visitors to care facilities to protect individuals who may be particularly susceptible to the negative impacts of COVID-19 infection, including severe disease and death.

11. I advise the Minister that early and consistent implementation of all these measures is the best strategy to limit further impacts from Omicron, including BA.2 and any new variants that emerge. These measures, if implemented as a suite, will help to limit the impacts to Victorian residents who are most at risk of serious illness, reduce effects on the health system and support the continuity of critical services. I advise several measures be retained in Orders, as outlined below. Other measures that remain strongly recommended, should be implemented via alternative mechanisms wherever possible such as through strong engagement or via another legal instrument if deemed necessary. This is part of a gradual shift to empower individuals, communities, and industry to play a greater role in the ongoing pandemic response.

12. In providing this advice, I acknowledge the Minister's obligation to weigh social, economic and operational considerations with public health outcomes, when deciding which public health measures are appropriate to implement and when they should be implemented. I note that the Minister will consider how each public health measure weighs upon Victorians' confidence in the administration of public health, and continued willingness to comply with government policy and public health measures more broadly.

13. In providing this advice, I have carefully considered the limits that the proposed measures place on human rights, and the objective of reducing serious risk to public health. Additionally, I have considered whether the proposed measures are the least restrictive reasonably available by which to achieve the public health objective, as required by the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**).

## How the Act informs this Advice

14. The Act provides that, once Victoria's Premier has made a Pandemic Declaration, (and noting that the Pandemic Declaration has been extended) the Minister may make any order that the Minister believes is reasonably necessary to protect public health.<sup>1</sup>

15. If the Minister is considering making pandemic orders, the Minister must consult with the Chief Health Officer and consider the Chief Health Officer's advice.<sup>2</sup> This is the advice provided by me in my capacity as Acting Chief Health Officer for the purpose of that provision.

16. The Minister has sought advice about:

- i. *the serious risk to public health posed by the disease specified in the pandemic declaration to which the proposed pandemic order relates; and*
- ii. *the public health measures that I consider are necessary or appropriate to address this risk.*

17. Section 3 of the Act defines the phrase "serious risk to public health" as:

*a material risk that substantial injury or prejudice to the health of human beings has occurred or may occur having regard to:*

- i. *the number of persons likely to be affected;*
- ii. *the location, immediacy, and seriousness of the threat to the health of persons;*
- iii. *the nature, scale and effects of the harm, illness or injury that may develop; and*
- iv. *the availability and effectiveness of any precaution, safeguard, treatment, or other measure to eliminate or reduce the risk to the health of human beings.*

18. I have taken the Act's definition of "serious risk to public health" into account when giving this advice.

19. I have also noted the Act's requirement that I have regard to:

- i. the need to ensure that decisions and actions taken in the administration of the Act should be proportionate to the public health risk that the public health risk (in this case, COVID-19) poses, and should not be undertaken in an arbitrary manner; and <sup>3</sup>
- ii. the benefits that accrue when there is "collaboration between all levels of Government and industry, business, communities and individuals".<sup>4</sup>

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<sup>1</sup> See section 165AI of the Act.

<sup>2</sup> See section 165AL of the Act.

<sup>3</sup> See section 4(3) and section 9 of the Act.

<sup>4</sup> See section 4(3) and section 10 of the Act.

## **This advice is based on the information that is available**

20. My advice is based on the relevant and reliable evidence available to me,<sup>5</sup> which I have reviewed and assessed to ensure that it is relevant and reliable. This advice is informed by the current COVID-19 context in Victoria and scientific evidence from local and international literature.
21. Evidence, particularly on the BA.2 Omicron sub-lineage continues to emerge, however as the Act indicates and requires,<sup>6</sup> a lack of full scientific certainty is not a reason for postponing measures to prevent or control the public health risks described below.

### *Current situation in Victoria*

#### Epidemiology

22. On 7 April 2022, there were 4,062 new cases confirmed on PCR and 8,252 probable cases detected from RA tests reported to the Victorian Department of Health in the previous 24 hours (Victorian Department of Health (a), 2022).
23. The 7-day rolling average of cases is increasing in Victoria. As of 7 April 2022, the 7-day rolling average was 10,267 people. This has increased from 9,569 cases the previous week (Victorian Department of Health (a), 2022).
24. As of 7 April 2022, Victoria has 63,024 active cases (confirmed and probable) and 283 cases in hospital. Of the patients who are currently hospitalised, there are seven active cases in intensive care units (ICUs), of which two are receiving ventilatory support. There are an additional five cleared cases in ICU (Victorian Department of Health (a), 2022).
25. In Victoria, there has been 1,354,194 total cases of COVID-19 and 2,770 total deaths since the beginning of the pandemic (Victorian Department of Health (a), 2022).

#### Test results

26. According to data from the week ending 5 April 2022, the proportion of PCR tests returning a positive result in Victoria is estimated at 18.5% (Victorian Department of Health (b), 2022). The test positivity rate for the preceding seven days was 18%, indicating that test positivity rate is increasing slightly (Victorian Department of Health (c), 2022). During September, October and November of 2021, the test positivity rate was roughly between 1.5% and 2.0% in Victoria. In addition, there will be some individuals not getting tested when unwell or because they are asymptomatic, some test results are false negative results, and it is probable that not every RA test is being reported to the Department of Health. In combination with the current test positivity rate, these factors indicate that current case numbers substantially underestimate the number of Victorians becoming infected on any given day.
27. As of 7 April 2022, there have cumulatively been 584,310 self-reported probable cases (Victorian Department of Health (a), 2022). RA tests cannot be easily monitored and therefore the denominator of total RA tests undertaken in the community is unavailable to draw additional inferences.

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<sup>5</sup> See section 4(3) and section 5 of the Act.

<sup>6</sup> See section 4(3) and section 6 of the Act.

28. The above information (paragraphs 26 and 27) demonstrates the high level of transmission currently in Victoria and suggests that there is an ongoing substantial proportion of undiagnosed COVID-19 cases in the community.

#### Genomics

29. Based on genomic surveillance data, BA.2 is now the dominant variant in Victoria. For the period between 22 and 28 March 2022, 88.8% of sequenced samples were BA.2 and 11.2% were BA.1. There were 125 samples sequenced during this period (Victorian Department of Health (b), 2022).

30. Victorian wastewater surveillance data collected between 16 and 29 March 2022 detected BA.2 in all 37 metropolitan and in 28 out of 29 regional wastewater catchment areas in Victoria indicating widespread transmission. BA.2 was detected as the dominant variant in 97% of the 37 metropolitan catchment areas and 90% of the 29 regional catchment areas (Victorian Department of Health (b), 2022).

31. Similarly, surveillance data indicates that BA.2 is now the dominant sub-lineage in Australia. For the period between 7 March to 21 March 2022 BA.2 was for the first time reported as the dominant sub-lineage in surveillance samples collected in Australia, including Victoria. BA.2 remains the dominant sub-lineage in Australia from surveillance samples collected 31 March to 4 April 2022. In contrast BA.1 was dominant for the period of 21 February 2022 to 7 March 2022 following the Omicron outbreak (CoVariants, 2022).

#### Vaccine uptake

32. As of 4 April 2022, 94.4% of eligible Victorians aged 12 years and over have received their second dose of a COVID-19 vaccine. For those aged 16 years and above, 65.3% have received a third dose (booster) vaccine. For those aged 70 years and above, 88% have received a third dose (booster) vaccine (Victorian Department of Health (d), 2022). Among individuals who were eligible for a third dose (booster) 70%, 75% and 89% received it within 4, 5 and 6 months of their primary course, respectively, as reported on 2 April 2022.

#### Health system pressure

33. The Victorian healthcare system faced additional and extraordinary pressure due to the Omicron outbreak. Hospital admissions surged and there were severe workforce shortages across the system including acute care, community care, aged care, and ambulance services. High demand and declining resource availability contributed to the Department of Health issuing a coordinated 'Pandemic Code Brown' triggering public hospitals to activate Code Brown plans on 19 January 2022 (Victorian Department of Health (e), 2022). The Pandemic Code Brown was stood down on 14 February 2022.

34. The direct and indirect impacts of COVID-19 continue to pressure the health system, with workforce availability a significant factor influencing capacity. While hospitalisations and ICU admissions related to COVID-19 had been gradually declining since 28 January 2022, hospitalisations and unplanned workforce absences have recently started to rise again.

35. The health system is very likely to encounter additional strain as the winter months approach due to a number of factors. This includes an increase of influenza infections and influenza-related



hospital admissions, increases in respiratory syncytial virus and other seasonal respiratory viruses that can increase hospitalisations in the winter months; other cold weather-related increases in cardiovascular and respiratory illness, alongside parallel demand due to BA.2 or another VOC that may emerge.

36. AHPPC has recently expressed concern about the upcoming winter season and the additional challenges that the health system may encounter due to the likely co-circulation of influenza and COVID-19 (Australian Health Protection Principal Committee (a), 2022). I have taken account of the AHPPC statement on winter season preparedness on 31 March 2022, which highlights that these challenges may be offset by increasing population level immunity from vaccination and natural infection and the availability of treatments which may mitigate against high hospital demand. AHPPC reinforced that the least restrictive PHSMs should be employed to support the health system to function. I have also taken account of AHPPC advice that adjusting measures such as quarantine requirements, that will contribute to greater transmission, may lead to additional health system disruptions at a time when cases are increasing or are at their peak. They advised that subsequent increases in case numbers would likely result in further disruptions to the functioning of the wider community.

#### Community mobility and behaviours

37. Movement within the community has increased following the reopening of international borders and the return to community activities once the peak of the recent Omicron wave appeared to have passed. In response to the risks of COVID-19 during the Omicron wave in early 2022, people self-modified their behaviours by limiting going out, travelling, and interacting with others (Victorian Department of Health (f), 2022).
38. Victorians are largely returning to usual activities following the Omicron wave. Recent self-reported data from the Behaviours and Attitudes Survey note that Victorians have increased their visits to hospitality venues, personal services, and shopping centres since January 2022 (Behavioural Insights Unit (a), 2022). More Victorians have also returned to work on-site during this time, although levels are very likely to remain below pre-pandemic level. Victorians' intentions to dine out both in their local area and the Melbourne central business district (**CBD**) are also increasing. Data from the recent Behaviours and Attitudes Survey has also indicated that always wearing a face mask indoors in a public space has declined significantly since the previous round of surveys, from 71% in February to 36% in March 2022 (Behavioural Insights Unit (b), 2022).
39. Furthermore, the resumption of cruise ships from 17 April 2022 (Department of Health, 2022) will contribute to greater mobility into and within Victoria.

#### *Summary of the evidence underpinning the health advice provided in relation to the declaration of a pandemic*

40. On 31 March 2022, the Chief Health Officer provided written advice to the Premier of Victoria that described his reasons for advising that COVID-19 continues to constitute a serious risk to public health in Victoria and that the Pandemic Declaration should be extended. This is summarised below from paragraphs 41 to 58.

41. SARS-CoV-2 is the virus that causes COVID-19 infection. SARS-CoV-2 is transmitted between people in multiple ways including airborne and respiratory droplets (Centers for Disease Control and Prevention (a), 2021).

#### Emerging evidence about Omicron and sub-lineages

42. Currently, Omicron is the dominant variant of COVID-19 circulating across the world (World Health Organization (a), 2022). The Omicron variant has multiple sub-lineages, including BA.1.1, BA.1, BA.2 and BA.3. The predominant sub-lineage globally is BA.1.1 (World Health Organization (a), 2022), however, the proportion of BA.2 cases is increasing globally (World Health Organization (b), 2022), with evidence indicating that in New South Wales (New South Wales Health (a), 2022) and Victoria (Victorian Department of Health (b), 2022) BA.2 is now the dominant sub-lineage.
43. Evidence about the Omicron sub-lineage BA.2 and the potential implications for individuals, the population and the health system is building. Initial evidence demonstrates that BA.2 has a moderate growth advantage over BA.1 (World Health Organization (a), 2022) (United Kingdom Health Security Agency (a), 2022). The growth advantage of BA.2 over other variants and sub-lineages translates to greater transmission, posing a significant risk due to the potential for a steep rise in infections and hospitalisations over the coming weeks, from a baseline of sustained community transmission.
44. From 9 January 2022, Victoria had been experiencing a downward trend in case numbers from a peak of 51,356 new cases on 8 January 2022 (Victorian Department of Health (g), 2022). However, since 15 March 2022 case numbers have been steadily rising again, as outlined in paragraph 26. A similar trend is occurring in New South Wales, with 24,115 positive cases recorded on the 23 March 2022 (New South Wales Health (b), 2022), following a previous peak of 91,928 daily infections on 12 January 2022 (New South Wales Health (c), 2022). Similarly, all other jurisdictions that experienced an Omicron wave in January are seeing a resurgence in case numbers. While caution should be exercised in interpreting changing case numbers, the increased proportion of cases identified as the more infectious BA.2 sub-lineage coupled with increasing case numbers represent a trend towards a national BA.2 wave.
45. The Omicron variant appears to be less severe than the Delta variant. Evidence from the UK indicates that people with Omicron have a lower risk of hospitalisation and death compared to cases with the Delta variant (United Kingdom Health Security Agency (b), 2022).
46. Evidence regarding the disease severity of BA.2 is still emerging; however, preliminary data suggests that infection with BA.2 does not result in a higher risk of hospitalisation than BA.1 (United Kingdom Health Security Agency (a), 2022). Even if less severe disease continues to be a feature of BA.2, it may still have a significant impact on our hospital system given the sheer number of cases that could result from a more transmissible variant, and particularly going into winter.

#### Vaccine effectiveness

47. Studies investigating the impact of COVID-19 vaccines against transmission and disease severity due to Omicron continue to emerge. Evidence to date indicates that vaccine effectiveness (**VE**) against infection, symptomatic disease and severe disease following the primary course of COVID-19 vaccines is lower for Omicron than other VOCs (World Health Organization (a), 2022).

48. Despite this, multiple studies on VE against Omicron demonstrate that protection against severe disease is preserved following a primary vaccine course compared to protection against infection and symptomatic disease (World Health Organization (a), 2022).
49. Evidence from the UK also suggests that although a primary course of the AstraZeneca, Pfizer or Moderna vaccine initially confers modest protection against symptomatic infection due to Omicron, immunity wanes over time (United Kingdom Health Security Agency (c), 2022). Protection against hospitalisation and mortality is relatively more preserved. A third dose (booster) increases the VE and provides greater protection from infection, symptomatic disease, hospitalisation and death. The VE against symptomatic infection has been reported as 60 to 75% at two to four weeks following a third dose (booster). The VE against hospitalisation after a third dose (booster) is approximately 90% for Pfizer and 90-95% for Moderna. Similarly, the VE against mortality is 95% two or more weeks following a third dose (booster) (United Kingdom Health Security Agency (c), 2022). This highlights the important role of receiving a third (booster) dose and being 'up-to-date' with vaccination to reduce the risk of severe morbidity and mortality, in accordance with recently updated Australian Technical Advisory Group on Immunisation (**ATAGI**) guidance (Australian Technical Advisory Group on Immunisation, 2022).
50. Amongst children aged 5 to 15 years, evidence from the USA indicates that receipt of two doses of Pfizer is moderately effective in preventing both asymptomatic and symptomatic infection with the Omicron variant (Fowlkes, 2022).
51. Data on the impact of COVID-19 vaccines in protecting against transmission of Omicron remains limited. However, as people who are vaccinated are less likely to acquire infection, COVID-19 vaccines may prevent some onward transmission, including due to Omicron. Preliminary evidence from a study among households in Denmark, indicates that a third dose (booster) may curb onward transmission of both BA.1 and BA.2 (Lyngse, 2022).
52. Preliminary data from the UK indicates that the VE against symptomatic disease following BA.1 and BA.2 infection is similar (United Kingdom Health Security Agency (c), 2022).

#### Breakthrough infection and reinfection

53. Preliminary studies have shown that the risk of reinfection (after infection with an earlier variant, such as Delta) is higher for Omicron compared to other variants (Sheikh, 2022) (United Kingdom Health Security Agency (d), 2022).
54. However, early evidence comparing BA.1 and BA.2 appears to indicate cross-immunity between the two is very high, where infection with either sub-lineage provides greater protection from the other (Chemaitelly, 2022) (Stegger, 2022). Such protection is estimated to remain for several weeks and national advice, via the Communicable Diseases Network Australia (**CDNA**), is that 12 weeks is a likely duration when protection from re-infection is substantial (Communicable Diseases Network Australia (a), 2022).

#### Treatments for COVID-19

55. In addition to COVID-19 vaccines, as outlined in greater detail in my recent advice to extend the Declaration of a Pandemic, there are other pharmaceutical interventions provisionally approved

for use in Australia by the Therapeutic Goods Administration (**TGA**) that can reduce the risk of negative health outcomes from COVID-19. These agents are currently reserved for select high-risk cohorts.

56. A recent study has indicated the potential for reduced effectiveness of a particular monoclonal antibody medication used in Australia (Sotrovimab) against the BA.2 sub-lineage (Takashita, 2022), reflecting the challenges and limitations of therapies against a virus that continues to evolve and mutate. Further studies are needed to better describe the impact of available COVID-19 therapeutic agents on BA.2.
57. Regardless of the availability of therapeutic agents to treat COVID-19 and need for further research on their effectiveness against VOCs, these agents do not replace the need for other critical preventative measures.

#### Modelling the impact of Omicron BA.2

58. Recent modelling by the Burnet Institute suggests that there will be an increase in COVID-19 infections and hospitalisations during March and April 2022. The early adoption of measures by individuals and employers - such as wearing face masks indoors at locations other than private residences and working from home where possible - may improve outcomes with fewer infections and less pressure placed on the health system. Conversely, reducing certain public health measures, including isolation and quarantine requirements, may adversely and significantly impact the trajectory and outcomes with a greater number of infections and strain on the health system (Burnet Institute, 2022).

#### **Overview of necessary or appropriate public health measures**

59. PHSMs are actions or interventions that aim to suppress transmission of COVID-19, such as TTIQ, ventilation, physical distancing, and use of face masks (World Health Organization (c), 2022). PHSMs have been a crucial component of local and international public health responses throughout the pandemic.
60. Although Victoria has achieved high vaccination coverage, and a substantial proportion of the population with a level of natural immunity from recent surging Omicron infections, the potential impacts of Omicron and the BA.2 sub-lineage discussed above mean that PHSMs continue to play a vital role by reducing the amount of contact between people and the risk of transmission during interactions, limiting further spread of COVID-19 and the potential impact on the health system.
61. In my advice below I detail advice regarding a specific subset of measures that should be retained or introduced in Orders at this time (paragraphs 68 - 138). These measures represent key controls that are proportionate to the level of risk the virus continues to pose to Victoria. I consider that the benefits provided by each of these measures outweigh or are at least equivalent to the potential burdens they impose.
62. As the Victorian public health response to COVID-19 continues to transition from Orders towards empowering individuals, communities, and industry to drive protective measures and behaviours, there are certain measures that I have not advised be introduced or retained in Orders in this

advice yet continue to be important in reducing the risk of COVID-19. These are outlined in paragraphs 63 to 67.

63. Community education, engagement, and COVIDSafe behaviours such as vaccination, mask wearing, physical distancing, respiratory and hand hygiene, staying home and getting tested when unwell remain key to an effective pandemic response in Victoria. Mask wearing remains particularly important in indoor public settings and outdoors when physical distancing cannot be maintained. Access to both RA and PCR testing should also be optimised to ensure cases can be rapidly identified and appropriate measures taken to reduce risk to others. Even if some of these measures no longer appear in Orders going forward, I advise that they be strongly encouraged by Government, individuals, communities, workplaces and industry in recognition of their ongoing important role in risk reduction, especially in the context of BA.2. It is the combined effect of these PHSMs, as well as those outlined below that will provide Victoria the greatest level of ongoing protection against the harms of COVID-19 at this phase of the pandemic.
64. As such I continue to advise the Minister that significant benefits will flow from publishing and updating materials, and enable Victorians to understand:
- i. what to do when one is experiencing symptoms;
  - ii. measures that employers can take to keep workplaces safe;
  - iii. measures that operators can take to keep venues open to the public safe;
  - iv. how to conduct public and private events as safely as possible; and
  - v. what Victorians can do to stay safe and help protect themselves and their loved ones for example, wearing masks, hand hygiene, monitoring and responding to symptoms, and getting vaccinated.
65. Of particular importance is the continuing role of community engagement to promote uptake of PHSMs, including up-to-date vaccination, especially in the lead up to winter. Accessible and culturally appropriate engagement and health promotion activities continue to play a key role in Victoria's pandemic response to meet the needs of the whole community. Engagement and health messaging should continue to be developed in partnership with primary health care providers, community health services, and community and faith-based leaders, including those from Aboriginal and Torres Strait Islander communities (Communicable Diseases Network Australia (b), 2020) and culturally and linguistically diverse communities. It is critical that tailored community engagement and communication strategies continue to promote vaccination, particularly third dose (booster) uptake where eligible. Strategies that engage, encourage, educate, and incentivise the community to achieve 'up-to-date' vaccination status should continue and be prioritised.
66. I also urge workplaces to use their discretion to facilitate work from home if practical at times of high community transmission as an additional measure to reduce the risk of transmission at work. Additionally, higher education should consider enabling students to study from home at times of high community prevalence of COVID-19, where practicable.
67. While some public health measures in place for visitors to hospitals are intended to remain in some form, including limitations on the number of visitors and entry requirements such as vaccination or

RA testing to help protect patients and staff, there are alternative mechanisms to Orders through which they can be implemented, for example, via health service policy and guidance materials to achieve the same intent. While I continue to advise that measures be implemented to reduce the risk posed by visitors to hospital settings, particularly at times of increased community transmission, in this phase of the pandemic there are suitable alternatives to Orders, which can allow health services to implement their own tailored entry requirements or restrictions for visitors that are proportionate, compassionate and provide the best level of protection for their staff and at-risk patient populations in their specific setting. Consultation with relevant parts of the Department indicate high confidence that proportionate measures will be implemented through health service guidance and local policy. This should include, importantly, allowing an appropriate number of visitors in end-of-life scenarios.

### **Continued and additional public health and social measures in the context of Omicron**

68. The Victorian public health strategy to manage the impacts of COVID-19 has included a suite of measures that range from less restrictive, such as engagement and health education, through to more restrictive measures, such as vaccination mandates. Interventions that are the least restrictive and achieve the same public health objective should continue to be utilised, prioritised and exhausted, prior to applying more restrictive measures, wherever possible.
69. The following measures are those I advise continue to be reflected in, or introduced to, Pandemic Orders. These remain crucial public health measures to address the evolving threat of BA.2, and in combination with the measures outlined in paragraphs 59 to 67 above, will continue to reduce the potential impact of the virus on individuals and the health system.

#### *Face masks*

70. Face masks remain an important public health measure even in the context of high population vaccination rates in Victoria. Face masks have a protective effect and can both protect healthy individuals (Chu, 2020) and reduce the risk of disease transmission from infected individuals. Moreover, masks are a cost-effective and cost-saving measure, especially considering increasing transmissibility of Omicron variants, decreased vaccine effectiveness due to waning immunity or escape variants and increased social interactions, particularly indoors, which will likely increase in the cooler months (Bartsch, 2022).
71. The Behaviours and Attitudes Survey continues to demonstrate that face masks have been widely adopted by most members of the community, with high uptake and compliance (Behavioural Insights Unit (a), 2022).
72. For these reasons, I advise that masks continue to be required for those aged eight years and over in higher-risk indoor settings. These settings include - but are not limited to – healthcare settings, care facilities, childcare and early childhood service centres, primary schools (excluding children prep to grade two), airports (excluding office spaces), public transport and retail and hospitality settings (workers only). Previous mask exceptions should continue to apply, particularly for those who have medical reasons not to wear a face mask.
73. Workers in retail and hospitality settings with public facing roles should continue to be required to wear masks as there are members of the community who are at risk of serious consequences

from COVID-19 accessing these settings, and a requirement to wear masks offers additional protection for those at-risk patrons, who can also choose to wear a mask themselves. While hospitality and retail patrons are more likely to only interact with members of their party, workers by necessity interact with multiple groups throughout the duration of their shift, increasing the risk of transmission among different groups of patrons.

74. Masks should continue to be required in primary school settings for children in grades three to six in the context of high levels of community transmission and lower rates of vaccination coverage in primary school aged children (31.5% of those aged 5 to 11 have received two doses) compared to other age cohorts within the Victorian community (94.4% of those aged 12 years and above have received two doses) (Victorian Department of Health (d), 2022).
75. Increasing evidence is demonstrating the benefits of mask wearing in schools. For example, a recent US multi-state-based study demonstrated a 72% reduction in secondary transmission in schools with universal masking compared to schools with optional mask policies (Boutzoukas, 2022). Similarly, another US-based study in Arizona found that schools without mask requirements were 3.5 times more likely to have COVID-19 outbreaks than schools that started the school year with mask requirements (Jehn M, 2021). While severe disease and death due to COVID-19 is rare in children, the long-term potential consequences of infection, including 'long COVID' are not well understood. This age group also continues to play a major role in disease transmission. With the commencement of term one school holidays on 9 April 2022, and as the epidemiological situation evolves, mask use in this setting will require ongoing review.
76. In addition, I advise that existing mask requirements for diagnosed persons, close contacts, or symptomatic persons awaiting the result of a COVID-19 test, remain in place where those individuals are leaving their premises. This is particularly important given the increased transmissibility of Omicron and BA.2.
77. As previously advised, early and consistent implementation of measures, such as face masks, is the best strategy to slow transmission and reduce the likelihood of more restrictive measures being required in the near future. I also continue to advise ongoing health promotion and education around the effectiveness of masks in the reduction of transmission risk. These measures may support individuals to feel empowered to make decisions on the circumstances in which they wear masks to reduce their own infection risk. Even when not required as part of Orders, masks should be strongly recommended, particularly in indoor settings and outdoor settings when unable to maintain physical distance from others such as at entry and exit points at large events.

#### *COVIDSafe Plans*

78. Throughout the pandemic, transmission of the virus has occurred in workplace settings due to the close contact between people, inadequate ventilation, and the use of shared facilities such as meeting rooms and lunchrooms. I advise that employers should continue to be required to maintain an up-to-date COVIDSafe Plan for each work premise where workers are onsite, to mitigate COVID-19 risk. As the COVID-19 response continues to transition from Orders towards empowering individuals and industry to utilise protective behaviours and measures, however, I advise that COVIDSafe Plan requirements should transition at the earliest reasonable juncture

from Orders and is implemented via alternative such as workplace requirements, guidance materials and strong engagement, to achieve the same intent.

#### *Management of cases, close contacts and social contacts*

79. I advise that the TTIQ strategy should continue to form a key pillar of the Victorian public health response to COVID-19. The TTIQ strategy aims to limit spread of COVID-19 by interrupting chains of transmission through rapid testing, contact tracing, quarantining exposed individuals and isolating people who have acquired infection.
80. As I have noted in the Chief Health Officer's advice to the Premier to extend the Pandemic Declaration, it is important for the TTIQ strategy to be flexible and adaptive to meet the changing epidemiology, evidence, and susceptibility of the population, as well as considering operational factors. This strategy remains an important measure to protect the Victorian population and these measures are outlined in Victorian guidelines and aligns with the current CDNA guidelines, which are supported by the AHPPC (Communicable Diseases Network Australia (a), 2022) (Australian Health Protection Principal Committee (b), 2021).

#### Testing requirements

81. Testing requirements for some cohorts remain necessary to support a rapid public health response. Individuals who have been exposed to a person with COVID-19 are at increased risk of acquiring infection and it is important to identify if they become infected early, to limit the spread of infection and limit exposure to others. Close contacts should continue to have mandatory testing requirements as they are the highest risk of acquiring COVID-19 due to the nature and duration of their exposure to a case. All other contacts (workplace or social) who are still at increased risk of infection, should be required to have a COVID-19 test if they develop symptoms.

#### Isolation requirements

82. To limit transmission of COVID-19 within the community, it is proportionate to continue to require isolation for persons who have COVID-19. Diagnosed cases (diagnosed via PCR) and probable cases (positive RA test) should be required to isolate for seven days to minimise onward transmission. This period aligns with current national CDNA guidelines (Communicable Diseases Network Australia (a), 2022), which were revised in January 2022 to incorporate the National Cabinet agreed COVID-19 Test and Isolation National Protocols (Department of Health (b), 2022). The changes occurred in response to the impact the previous requirements were having on the public health workforce, testing capacity and the community more broadly in the context of the high case burden across the state (Communicable Diseases Network Australia (a), 2022).

#### Quarantine requirements

83. Close contacts, also known as household and house-like contacts, are individuals who have spent four or more hours with a person with COVID-19 inside a private home, accommodation premises or care facility. Close contacts should continue to be required to quarantine for seven days. This close contact definition and period of quarantine also aligns with the current national CDNA guidelines and the National Cabinet agreed COVID-19 Test and Isolation National Protocols (Communicable Diseases Network Australia (a), 2022) (Department of Health (b), 2022). Individuals who have been exposed to the virus in these settings are at higher risk of acquiring



COVID-19 due to the prolonged or repeated interactions that occur within an enclosed space. Thus, retaining this requirement will interrupt chains of transmission and limit further spread within the community. To ensure prompt identification of COVID-19 infection, it is necessary for close contacts to continue to test on days one and six of their quarantine.

84. To align with recent changes in the CDNA guidelines (Communicable Diseases Network Australia (a), 2022), I advise that recovered confirmed or probable cases should not need to be tested or managed as a close contact within 12 weeks after being released from isolation. This advice reflects the substantial cross-immunity between BA.1 and BA.2 and the data on the very substantially reduced risk of re-infection in the weeks following infection. Individuals that are re-exposed to COVID-19 after this period, should continue to be subject to testing and quarantine requirement according to the contact definition they meet.
85. It is advised that the power to grant class exemption to close contact quarantine is retained, in consideration of the elevated and rising case numbers which may place increasing pressure on workforces' ability to provide essential goods and services to the Victorian community. Exemptions to allow certain workers to return to work during their quarantine period even if they are deemed a close contact helps to preserve the capacity of certain essential workforces and continues to be proportionate in the context of additional safeguards in place to mitigate transmission risk such as RA testing each day for five days, exclusion of symptomatic workers, and appropriate personal protective equipment (**PPE**).
86. In addition, I advise the Minister that local public health unit (**LHPU**) Directors and Medical Leads' powers are extended to grant temporary exemptions to close contacts and confirmed cases to vary the conditions of their self-isolation or quarantine period, for example, drive a dependent to school. LHPUs would be able to undertake a case-by-case assessment and grant temporary exemptions with the appropriate mitigation measures in place. LHPU powers were recently extended to allow them to vary isolation or quarantine periods as well as the location of self-quarantine or isolation, and I advise that these powers should be retained. This proposed amendment to the Orders would further support the management of close contacts and confirmed cases at a localised level.

#### Social contacts

87. Individuals who have been exposed to a person with COVID-19 in a workplace or social setting, but do not meet the definition of a close contact, are still at risk of acquiring COVID-19 infection. Social contacts who are symptomatic must undertake a COVID-19 test and self-quarantine until they receive a negative result, or for seven days after their test, whichever is sooner. Individuals without symptoms are strongly recommended to complete daily RA tests for five days following their exposure.

#### Obligations for individuals to report or notify

88. I consider that the requirement for a COVID-19 positive case to notify the Department of Health of a positive diagnosis, infectious period and isolation address to be reasonable as it empowers the Health Department to protect the health and safety of the community.

89. Location details such as the case's address informs the Department's understanding of the spread of the virus across the community, transmission pathways, risk areas, and the potential impact or incursion into sensitive settings, and further contributes towards data on secondary attack rates. It provides linkages into the Department's and community support programs such as the Household Engagement Program, COVID-19 Positive Pathway Program, and our Compliance and Enforcement Program.
90. There are numerous privacy protections that apply to information disclosed and held by the Department, education facilities and Service Victoria under the pandemic orders. The information is not shared outside of the scope and purpose of case, contact and outbreak management and only disclosed where necessary or required to be under law or direction.
91. The Privacy and Data Protection Act 2014 (Vic) and the Health Records Act 2001 (Vic) provide privacy protections. This is the primary legislation that regulates the information handling of personal and health information. The department manages information in accordance with the Information Privacy Principles and Health Privacy Principles that provide standards for information collection, storage, access, transmission, disclosure, use and disposal as prescribed within these Acts.
92. Individuals who are a confirmed or probable case should also continue to be required to inform their workplace or education facility that they have been diagnosed with COVID-19 if they attended the setting during their infectious period. This responsibility enables prompt de-identified information to be shared to alert individuals that they have been exposed to a positive case and should test for COVID-19 if they develop symptoms, to be initiated by the workplace or education facility. In addition, individuals who have COVID-19 should also be required to inform any other persons who may be a close contact or a social contact, to the extent the diagnosed person is able to reasonably identify and notify these persons. This will allow identification of potential new cases and prevent onward transmission.

#### Obligations for workplaces and education facilities to notify

93. It is necessary to require employers and educational facilities to provide a general notification to individuals (or parents, guardians and carers) that they may have been exposed to a positive case. This measure supports the recent shift in the pandemic response towards empowering and educating the general public and businesses to manage outbreaks and protect staff, students and the community.

#### *Management of international arrivals*

94. I advise that international arrivals via air and sea should continue to be subject to specific quarantine and testing requirements (albeit less than previous), as there is an ongoing risk of incursion of COVID-19 and emerging VOCs due to international travel. However, my advice below also takes into account the significant local threat of COVID-19 in Victoria.
95. The requirements for international arrivals have changed recently to reflect the shift in the Victorian epidemiological context over the past few months. In Victoria, despite high vaccination coverage there continues to be widespread community transmission of COVID-19, thus the relative risk posed by international arrivals is much less compared to earlier stages of the pandemic.

96. However, given inequitable access to COVID-19 vaccines internationally leading to varied vaccination coverage across the world (John Hopkins University and Medicine, 2022), there are many countries that remain largely unvaccinated and high levels of transmission continue to occur across the world. Consequently, there is an ongoing risk that new variants may emerge that are more virulent or better able to evade host immune responses and spread via international travel.
97. When referring to 'fully vaccinated' below, I am referring to having completed a primary course of a TGA-approved or recognised COVID-19 vaccine (usually two doses).
98. International arrivals via air and sea should be managed according to their vaccination status due to the different level of public health risk posed. As described in paragraph 51, some onward transmission from Omicron may be limited by vaccination against COVID-19. The following advice reflects this reduced risk profile. My advice regarding cruise ship passengers and crew is outlined separately in paragraphs 104 to 106.
99. Australian based international aircrew are currently required to complete a pre-departure COVID-19 test. I advise the Minister that this requirement be removed in the context of existing post-arrival testing requirements within Orders to mitigate against the risk of incursion and advice outlined in paragraphs 101 to 103. This advice aligns with recently announced removal of pre-departure testing obligations for all international arrivals as per current Commonwealth requirements on 17 April 2022 (Department of Health, 2022). Additionally, with high levels of community transmission, at this phase of the pandemic response, reducing incursion of new variants from overseas is no longer proportionate or realistic. Although there remains a risk of the introduction of new VOCs, such a risk would exist regardless. Other measures are in place to monitor (for example, recommendation of PCR over RA test) and manage this risk. I advise that if the Minister supports this change, that it is implemented at a time when all jurisdictions are aligned.
100. International air and sea arrivals (including all crew) who are fully vaccinated with a TGA approved or recognised vaccine or have a valid medical exemption to vaccination (and children less than 12 years old) should be strongly recommended to undertake a RA or PCR test within 24 hours of arrival. They should be required to undertake a COVID-19 test if they become symptomatic in the seven days following arrival. It is recommended for international arrivals that a PCR test is used over a RA test if easily accessible, and that they self-quarantine until a negative test result is received. If they receive a negative RA test result but are still symptomatic, they should have a PCR test.
101. I advise that international air and sea arrivals (including all crew) aged 12 years and over who are not fully vaccinated against COVID-19 ought be required to complete a RA or PCR test within 24 hours of arrival and complete seven days of self-quarantine at their home or other suitable voluntarily chosen locations, such as at a hotel. An additional COVID-19 test should be required if the person develops symptoms of COVID-19 during the seven days of quarantine. It is recommended that a PCR test is used over a RA test if easily accessible. Self-quarantine will prevent unvaccinated international arrivals from interacting with members of the community and reduce the risk of onward transmission within Victoria. As the epidemiological situation shifts, it is

now proportionate to transition from government-managed quarantine facilities to a self-quarantine model.

102. As previously advised by the Chief Health Officer, international arrivals who have a temporary or permanent medical contraindication to vaccination should be managed in the same manner as those who are fully vaccinated. It is not proportionate to place additional requirements on individuals who are unable to be vaccinated due to a medical contraindication.
103. For those aged 12-18 years, requirements should be determined by vaccination status as per paragraphs 98-102.

*Cruise passenger vaccination and testing requirements*

104. As the Commonwealth ban on international cruising will be lifted on 17 April 2022 (Department of Health, 2022), I advise that new measures are implemented to ensure the safe resumption of cruising.
105. I am aware that the Health Departments across Victoria, New South Wales and Queensland (Eastern Seaboard States) have been working together to achieve alignment on policy positions relating to the return of local and international cruising. There has also been close consultation with the cruise industry on the requirements that should apply to cruise operations.
106. The measures I advise be implemented in Victoria are based on agreed positions between Eastern Seaboard states, including but not limited to:
- i. All travellers will sign a statement provided by industry at time of booking acknowledging the health, travel and financial risks associated with cruising;
  - ii. All crew must be 'up-to-date' with COVID-19 vaccination (i.e. two doses of a TGA approved or recognised vaccine, plus a third dose (booster) when eligible). Medical exemptions to vaccination will not apply to crew;
  - iii. Industry will maintain a threshold of minimum 95% of all passengers on any cruise to be fully vaccinated with a COVID-19 vaccine, with children under 12 years and medically exempt included in the remaining 5%;
  - iv. Passengers will be required to have a PCR within 72 hours of boarding or a self-administered RA test within 24 hours of boarding;
  - v. Masks must be worn by passengers for embarkation and disembarkation and onboard indoors when physical distancing is not possible. Crew will wear masks while indoors;
  - vi. Cruise lines will refer to guidelines developed by the Centers for Disease Control (Centers for Disease Control and Prevention (b), 2022) for guidance in identifying and responding to an outbreak;
  - vii. It is strongly recommended that passengers on cruises of five days or longer have a COVID-19 test within three to five days after disembarking; and
  - viii. Further COVID safe measures for safe international cruising as agreed between the relevant East Seaboard States.

107. I consider these measures to be proportionate to the elevated risk of COVID-19 transmission and amplification among passengers and crew on cruise ships, given the close quarters shared by individuals, the number of large outbreaks that have occurred locally and internationally on cruise ships, and the difficulty in providing health services while at sea.

#### *Worker vaccination requirements*

108. Vaccination has been shown to reduce the risk of severe COVID-19 related outcomes such as hospitalisation and death (World Health Organization (a), 2022) (United Kingdom Health Security Agency (c), 2022). I have discussed the evidence on vaccination and Omicron above in paragraphs 47 to 52.

109. In providing advice on worker vaccination requirements, I have considered the current epidemiology of COVID-19 in Victoria, vaccination coverage and uptake of third dose (booster) vaccination, and population susceptibility of COVID-19 in the context of natural immunity and community transmission. I have also considered the shift in Victoria's pandemic response to individual and industry-led action, and the ongoing focus on protecting those most at risk of serious outcomes from COVID-19 and our healthcare system. In addition, I have considered the settings and environments, including workplaces, where an outbreak may be particularly detrimental, and the ongoing role of mandatory vaccination of workers.

110. As I discussed in paragraphs 63 to 65, it is important that less restrictive measures continue to be utilised to increase vaccination coverage. I advise tailored communication and engagement strategies continue to educate, incentivise, and encourage voluntary vaccine uptake among workers, and address any potential barriers to vaccination.

#### Two-dose mandates for workforces

111. Worker vaccination mandates served an important role at the time of their introduction. The requirement was proportionate to the epidemiology and level of immunity in the community at that time, and aimed to reduce transmission within workplaces, protect people at risk of adverse outcomes and ensure the ongoing provision of critical goods and services.

112. The Victorian COVID-19 response continues to transition towards empowering individuals and industry to play a larger role in protecting themselves, their loved ones and the wider community. At this stage of the COVID-19 response, public health measures are increasingly becoming the responsibility of individuals, employers and event organisers with less reliance on rules and regulations imposed by government. As part of this shift, I advise that vaccination mandates for patrons and some workforce requirements move away from Orders in a stepwise manner. As I have outlined in paragraph 32, the Victorian vaccination program has successfully achieved some of the highest two dose rates among adults seen worldwide. However, this appears to have reached a plateau, with negligible uptake in recent months as those Victorians who are yet to begin a primary course of COVID-19 vaccination by now appear highly unlikely to do so in the future. I have also described the evidence regarding VE following a primary vaccination course, especially within the context of onward transmission of Omicron, and how immunity levels wane over time. This waning immunity after two doses is the basis for the updated ATAGI advice on

what constitutes 'up-to-date' vaccination status against COVID-19 (Australian Technical Advisory Group on Immunisation, 2022).

113. With infrastructure to record and monitor workplace vaccination requirements being scaled-up across the state and as part of a broader stepwise approach being taken to vaccination requirements with a move away from Orders to an individual, industry and workplace approach based upon choice and responsibility, it is in my view appropriate to do the following:
- i. transition general worker vaccination requirements at the earliest reasonable juncture to being at the discretion of industry and individual workplaces, understanding the occupational health and safety obligations in these specific settings; and
  - ii. remove the existing two dose requirements from the Orders for patron visiting venues and premises open to the public.

Given Victoria's high two dose vaccination coverage, continuation of vaccine mandates for patrons to open premises is unlikely to materially increase uptake of vaccination in those who remain unvaccinated, and the negative consequences of social and community exclusion of unvaccinated patrons from these premises may now outweigh the previously recognised benefits. I continue, however, to recommend ongoing investment and targeted engagement in promoting vaccination of patrons, particularly 'up-to-date' vaccination, using the least restrictive means available.

114. It should also be noted that a proportion of the Victorian community will recently have recovered from COVID-19 infection and may have some natural immunity from this. The duration of natural immunity is, however, still the subject of ongoing research, and it is likely only applicable to a minority of the Victorian population at any one time.
115. In this context, it is open to the Minister to consider the continuation of the current requirement for all workers that leave their home for work to have at least received their primary course of vaccination (two doses), or a valid medical exemption to attend work onsite. As is currently the case, this obligation would not apply to general workers if it is not reasonably practicable for the individual to work at their ordinary place of residence.
116. To support this gradual change to reducing vaccination mandates, industry and employers will require sufficient lead time to assess their individual risk for employees, the measures and infrastructure available for protection against COVID-19 and introduce their own individualised vaccination policies to address the particular level of risk their workplace faces. Taking this approach is positive for the ongoing protection for public health in work settings (and for the members of the public who visit workplaces) and with this in mind I advise that it will be proportionate for this requirement to shift away from Orders; certainly within the next three months.

#### Third-dose (booster) mandates for workforces

117. I advise that a third dose (booster) requirement be retained in the workforces where they currently apply. As I have outlined in paragraph 51, evidence suggests that a third dose (booster) limits

onward transmission of Omicron and provides greater protection to workers from symptomatic illness, hospitalisation and death.

118. I advise this requirement should continue to apply to the workforces where they are currently required, including:

- i. Healthcare, disability and residential aged care workers who provide care to population groups at increased risk of adverse health outcomes from COVID-19 infection;
- ii. Education facility workers who are involved in essential learning and development of children;
- iii. Emergency services workers who are involved in providing critical operations and essential goods and services to the community; and
- iv. Workers in workplaces at increased risk of incursion, propagation, or downstream implications on the Victorian community, such as custodial, food processing and distribution, and – where operational - quarantine accommodation settings. These settings can also be regarded as having relatively greater criticality than many others.

119. These groups of workers have been included in the third dose (booster) mandate to date because they are those involved in the care of at-risk populations, are at higher occupational risk of COVID-19, are critical to maintaining emergency services or food supply chains, or are at higher risk of being involved in large workplace outbreaks because of the nature of their work environment.

120. Healthcare, disability and residential aged care workers provide care to individuals who are at greater risk of exposure to COVID-19 and severe adverse outcomes. These workforces provide essential care that may be in close physical proximity, with periods of repeated or prolonged exposure, increasing the risk of transmission to individuals most at risk. This also confers an occupational exposure risk to workers and this requirement will provide direct protection to staff.

121. Third dose (booster) requirements should be retained for education facility staff as this workforce mostly works in indoor settings alongside children with various abilities to physically distance or wear a mask and with relatively lower vaccination coverage in the children. As maintaining mask requirements among younger children can be varied, exemptions currently apply for children under eight years of age or in grade two or below. There are also mask requirement exceptions for individuals, such as education workers, where clear enunciation or visibility of their mouth is essential. Thus, staff who work in these environments are at an increased risk of exposure, especially considering the disproportionate number of new infections occurring in education settings. This measure will confer direct protection to education workers, reducing the risk of severe outcomes associated with their heightened risk of exposure to COVID-19 relative to other workforces and will also support the continuity of education and learning for their students. It may also limit onward transmission, particularly, as some children are unvaccinated or partially vaccinated.

122. Emergency services workers should also continue to be subject to the third dose (booster) mandate. This workforce directly interacts with members of the community and may work in situations where the ability to physically distance may be limited due to the nature of their role, increasing the risk of acquiring the virus. This requirement will protect workers and help limit potential disruptions in the provision of essential goods and services to the community due to COVID-19 infection.
123. Workforces that, by the nature of their work setting, have a high risk of viral amplification and rapid transmission between staff (for example, food processing and distribution) should at this time have third dose (booster) requirements retained to protect the staff working in these settings.
124. This worker vaccination requirement continues to be a proportionate measure as the potential benefits outweigh the potential harms. There is already strong industry support to protect Victorians at risk of serious outcomes and ensure that workforces at highest risk of incursion and amplification of COVID-19 infection have the opportunity to maximise the protection of their employees.
125. This requirement also aligns with updated ATAGI advice on what should be considered 'up-to-date' vaccination against COVID-19 (Australian Technical Advisory Group on Immunisation, 2022), will minimise the risk of incursion and help to protect individual workers who may be particularly susceptible to the negative impacts of COVID-19 infection, including severe illness and death.
126. Regardless of mandates, vaccination of workers remains an important safety measure, and I recommend that employers or operators continue to actively promote and encourage staff to maintain an 'up-to-date' vaccination status where eligible as per ATAGI guidelines, as many have already done, to reduce the risk to staff and any members of the public who may attend their workplace. High vaccination rates in the workplace may also minimise the impact of furloughing and its impacts on business continuity. Vaccination must also be seen in light of the legal occupational health and safety obligations that require employers to 'provide and maintain a working environment that is safe and free of risks to health, so far as is reasonably practicable' (WorkSafe Victoria, 2021).

#### *Care facilities*

127. Care facilities, including but not limited to, residential aged care facilities (**RACF**), disability residential services, alcohol and drug residential services and homelessness residential services, commonly house and care for members of the community who may be frail, immunocompromised or have significant comorbidities and complex care needs, making them particularly susceptible to the negative impacts of COVID-19 infection, including severe disease and death. As such, these facilities are sensitive settings requiring specific consideration.
128. Care facilities are a diverse group of facilities of differing sizes, resources, governance structures, and level of care provided to residents, and with significant diversity in their ability to implement infection control measures. For these reasons I advise that at this time visitor requirements for care facilities continue to be a requirement in Pandemic Orders, to ensure the upmost level of protection continues to be provided to residents, particularly as we approach winter, and noting



significant COVID-19 mortality in care facilities in Victoria (Victorian Department of Health (h), 2022).

129. In consideration of the above, and in the setting of high case numbers, I advise the Minister that visitor restrictions remain in place for care facilities to reduce opportunities for viral incursion, given the higher risk of transmission, amplification and consequence should incursion occur. Visitor restrictions include entry requirements, face mask requirements and pre-entry RA testing.
130. As there continues to be a high level of community transmission, RA tests are an appropriate asymptomatic screening tool to limit incursion of COVID-19 into care facilities. RA tests are a low impost measure that are quick to administer and return a result that has a high level of accuracy in excluding active infection.
131. I advise that visitors to care facilities should not be permitted to enter until they have a negative RA test at the facility on the day of attendance.
132. Although the supply of RA tests within the community has improved recently, I advise it is appropriate to retain current provisions that permit visitors to enter even when a RA test is unavailable and retaining the current exceptions to RA testing requirements.

#### Excluded persons

133. There are certain groups who are unable to enter a care facility including those who have had contact with a confirmed case in the last:
- i. Seven days immediately preceding entry if the person is fully vaccinated and is not a close contact and has not returned a negative PCR test; or
  - ii. 14 days immediately preceding entry if the person is not fully vaccinated or is a close contact and has not returned a negative PCR test.
134. I advise the Minister that this is amended to seven days immediately preceding entry if the person has been exposed to someone with COVID-19 (workplace, educational or social contact) and has not returned a negative PCR test, irrespective of vaccination status. This would align the current seven-day isolation and quarantine period for confirmed cases and close contacts.

#### Essential visitors to care facilities

135. In the event of an outbreak, I advise the Minister that essential visitors be permitted to enter care facilities. Essential visitors should include:
- i. Parents or guardians of the resident if they are aged under 18 years;
  - ii. Parent, guardian (including guardians appointed by the Victorian Civil and Administrative Tribunal), partner, carer, support or other named person of a resident who is aged 18 or over to provide emotional and social support;
  - iii. Persons providing care and/or support for a resident's immediate physical, cognitive, social or emotional wellbeing (including mental health support and support for people living with dementia);

- iv. Persons providing end of life support and visits;
- v. Nominated person in the case of a resident's mental illness or incapacity;
- vi. Persons providing learning and/or training to support a resident's care and/or discharge;
- vii. Interpreters or inform language support;
- viii. On-site attendance of contractors;
- ix. Aged and disability care advocates;
- x. Legal representatives of residents and persons with power of attorney for residents;
- xi. Volunteers in the Community Visitors Scheme.

136. Visitors included as part of this essential visitors list should be required to complete the same pre-entry requirements as visitors currently in scope, as outlined in paragraphs 129 to 132.

137. The impact of the COVID-19 pandemic on the residential care sector has been significant and has necessitated at times the restriction on visitation to care facilities to keep residents safe. However, as the pandemic response continues to shift from Orders to guidance-driven obligations, care facilities should be empowered to begin to look at what self-regulated, compassionate visitation will comprise at their facility.

138. Care facilities have faced some of the most challenging outbreak control scenarios throughout the pandemic. Ongoing concern has been expressed across the community that some care facilities have implemented overly restrictive visitation rules. An important balance must be achieved to ensure residents have vital personal, social, emotional and community support and connection when living in care facilities, whilst continuing to mitigate the risk of COVID-19 introduction and spread.

## **Conclusion**

139. In the context of the pandemic declaration recently being extended and the ongoing threat posed by COVID-19 and the Omicron BA.2 sub-lineage, my advice above details the public health measures I believe ought continue to be implemented, or introduced, in Victoria to reduce the risk to individuals, the community and our healthcare system. I have provided advice on public health measures that continue to be important for Victorians to practice – as individuals, patrons, workers, employers or operators and as a community. In addition, I have given specific advice regarding controls that I believe should be retained in Orders at the current time given their critical role in mitigating COVID-19 risks within the current epidemiological context.



**Professor Benjamin Cowie**

Victorian Acting Chief Health Officer

Dated this 7<sup>th</sup> day of April 2022

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