

# COVID Screening in Schools

Weekly data to evaluate the uptake, effectiveness and acceptability of RATs

Report # 6  
Final Term 1 Report

1 April 2022

# Background

The COVID-19 rapid antigen testing (RAT) screening program is in place for staff and students, across schools and early childhood education & care (ECEC) in Victoria. The objectives of the screening program are to detect COVID-19 cases in education settings early through RAT screening to:

1. Minimise transmission in schools and Early Childhood Education and Care settings across staff and students to reduce epidemic growth and health system impact.
2. Reduce days of lost learning in school.
3. Protect vulnerable staff and students.

28(1)(d) RAT screening will be monitored, and the public health advice will be reviewed based on epidemiology.

Triggers to review the program include screening being of reduced epidemiological benefit due to reducing community prevalence; reduced community confidence (identified through low compliance); increased concerns of false positive RAT results; and RAT supply and/or prioritisation. As of 18 March, recovered cases do not need to participate in screening or surveillance testing, as per the Quarantine Isolation and Testing Order 2022 (No. 6), which could impact on future compliance statistics.

**The purpose of the evaluation** is to; assess the implementation (RAT distribution, uptake), acceptability and effectiveness (screening yield, case and outbreak trends) of the RAT surveillance program in Victorian education settings, to inform decisions for ongoing implementation.

The evaluation involves mixed methods design using programmatic data available from DET, DH epi data, data from a weekly staff and student surveys and focus group discussions targeting priority population groups including culturally and linguistically diverse, indigenous, rural and disability.

**This is the final report for term 1, bringing together longitudinal trends since 31 January 2022, as observed through epidemiology, survey responses and focus groups.**

**Note:**

- **RAT screening commenced in primary and secondary schools on 31 January 2022.**
- **RAT distribution to ECEC locations commenced incrementally from 14 February and scaled to full distribution by 7 March. To enable services and families adequate time to participate in the screening program, ECEC providers, services staff and families have been surveyed from 8 March.**

# Term 1 Summary (Epidemiology)

**Since the beginning of Term 1 – 154,169 cases have been reported in children aged 0-18 years (reported to DH).**

18,950 case notifications in children were received in the past week (21 – 28 March). 80% were identified via a Rapid Antigen test ('probable' cases), of which 81% reported symptoms at the time of testing.

**Cases in children declined from the first week of term 1 to week 6 (28% decrease); however, increased 14.3% from week 6 to 8 (most recent reporting week)**

In this same period, cases in adults 19+ years declined 41.1% from week 1 to 6 but have increased 59% from week 6 to 8. This increase in cases is due to the epidemic surge from the Omicron BA.2 sub-lineage, which is anticipated to peak in mid April.

**Case notification rates in school-aged children (5-18 years) remain higher than the adult population and children aged 0-4 years.**

Children aged 12-18 years continue to report the highest case rate per population (seven-day average of 23.7 per 10,000 as of 28 March), higher than primary-aged children (seven-day average of 18.9 per 10,000). The case rate in children 0-4 years (seven-day average of 8.9 per 10,000) is lower than the adult population (19 years and over) (seven-day average of 12.3 per 10,000), but both have increased in the past two weeks.

Despite increasing case numbers in children, the proportion of total cases that children comprise has remained at proportions similar to the previous week, having declined from earlier in the term. This reflects the increase in cases reported in adults in this period. However, the proportion of cases in children overrepresent their population proportion.

From 21 – 28 March, 36.2% of all cases were reported in children aged 0-18 years: 0-4 years 5.2%, 5-11 years 15.7%, and 12-18 years 15.3%.

**From 18 February when the DH RAT notification form asked if the test was part of the education screening program, the median daily proportion of RAT cases indicating the test was part of an education screening program was 51% (range 36 – 58) for 5-11 years and 46% (range 32 – 56) for 12-18 years age groups.**

# Term 1 Summary (Survey)

**The proportion of children (surveyed via parents) who reported they took the recommended number of tests (2 for ECEC, Primary and Secondary, 5 for Specialist) declined from 75% in the first survey, to 60% in the final survey.**

## Over the survey period:

- Compliance was 54% in ECEC, 72% in primary schools, 74% in secondary schools and 43% in specialist schools.
- In schools, the most common reasons for not completing the recommended number of RATs were that parents didn't want to perform frequent RATs on their children, closely followed by the child having had COVID-19 in the last 30 days.
- In ECEC, the most common reasons for not completing the recommended number of RATs were that parents found it too difficult to perform the RAT on their child (e.g., caused distress) or their child did not want to, followed by not wanting to perform frequent RATs on their child.
- In schools and ECECs, the most common motivations for taking the recommended number of RATs were wanting to follow the recommendations of DET and DH to test.
- 86% of school parents and 84% of ECEC parents surveyed said they reported the results to DH via the online self reporting tool
- 96% of school parents and 75% of ECEC parents surveyed said they reported the results to the education setting.

**5% of school students surveyed tested positive, of these:** 7% were asymptomatic and not a close contact, 69% were symptomatic, 38% were a close contact, noting some children were both.

**4% of ECEC students surveyed tested positive, of these:** 6% were asymptomatic and not a close contact, 48% were symptomatic, 29% were a close contact, noting some children may have been both.

**The proportion of school and ECEC staff who reported they took the recommended number of RATs declined from 76% in the first survey, to 70% in the final survey.**

- For ECEC and school staff, the most common reasons for not testing were 'Other' (usually that they worked part time), and that they forgot.

**3% of school and ECEC staff surveyed tested positive, of these:** 12% were asymptomatic and not a close contact.

**73% of school principals and ECEC providers reported all staff and children collected their RATs.**

*Note the dates for each survey round; Round 1 (16-20 February), Round 2 (22-27 February), Round 3 (1-6 March), Round 4 (8-14 March), Round 5 (16-20 March), Round 6 (22-27 March).*

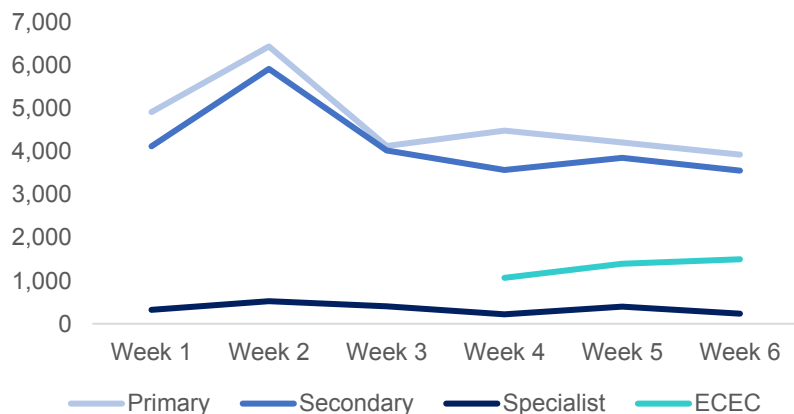
# Term 1 Summary (Survey) – Response Rate



## Parents

**45,535 responses**

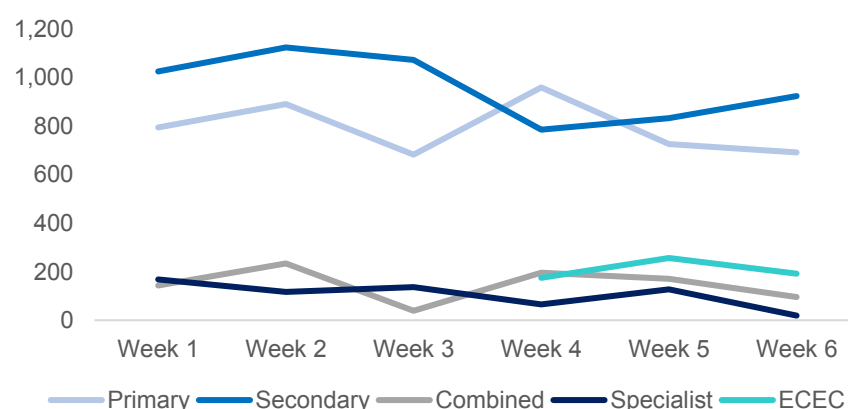
- 4,053 ECEC
- 28,242 primary
- 25,427 secondary
- 2,422 specialist



## Teachers

**12,732 responses**

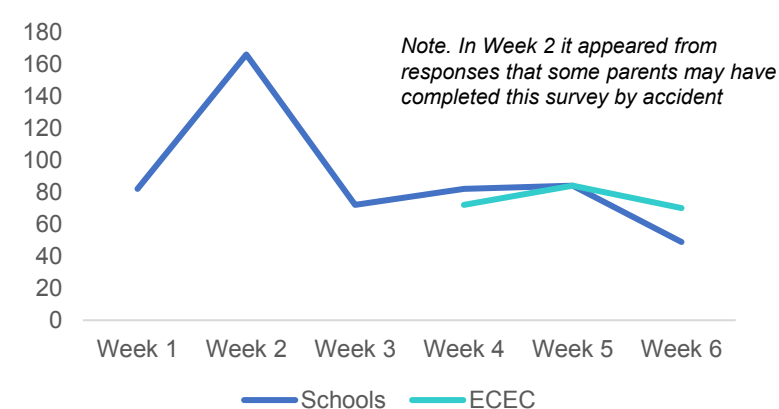
- 643 ECEC
- 4,176 primary
- 5,765 secondary
- 871 combined
- 647 specialist



## Principals & Providers

**809 responses**

- 226 ECEC
- 333 primary
- 105 secondary
- 30 combined
- 23 specialist



Overall, parent responses account for at least 9% of the total sample of school students eligible to be surveyed. Parent responses for ECEC is estimated to be at least 4%, which is the number of survey responses as a proportion of all children attending ECECs that were invited to participate in the survey. A response rate <10% (generic benchmark) is generally considered low, however, we are unable to determine the exact percentage of parents who completed the survey after receiving it, as we don't know how many schools or ECEC distributed the survey. The true response rate (surveys completed of those who received the link) is expected to be higher. A staff response rate has not been able to be estimated. Responses from principals equate to 29% of schools sampled, and 11% of ECEC services sampled.

# DH data

## Case Notifications & Trends

as at 29 March 2022

# Weekly case detection in children (0-18 years)

## Reported to DH by test type

Age group (years)	Test type	Week 1 6 Feb	Week 2 13 Feb	Week 3 20 Feb	Week 4 27 Feb	Week 5 6 Mar	Week 6 13 Mar	Week 7 20 Mar	Week 8 27 Mar	Total
0-4	PCR	1785 (37%)	1383 (33%)	1021 (32%)	733 (33%)	454 (29%)	468 (29%)	561 (28%)	706 (28%)	7111 (32%)
	RAT	3087 (63%)	2795 (67%)	2127 (68%)	1514 (67%)	1115 (71%)	1172 (71%)	1459 (72%)	1803 (72%)	15072 (68%)
	<b>Total</b>	<b>4872</b>	<b>4178</b>	<b>3148</b>	<b>2247</b>	<b>1569</b>	<b>1640</b>	<b>2020</b>	<b>2509</b>	<b>22183</b>
5-11	PCR	2469 (25%)	2370 (23%)	2140 (23%)	1855 (23%)	1535 (22%)	1433 (21%)	1463 (18%)	1438 (19%)	14703 (22%)
	RAT	7451 (75%)	8041 (77%)	7357 (77%)	6050 (77%)	5421 (78%)	5280 (79%)	6455 (82%)	6219 (81%)	52274 (78%)
	<b>Total</b>	<b>9920</b>	<b>10411</b>	<b>9497</b>	<b>7905</b>	<b>6956</b>	<b>6713</b>	<b>7918</b>	<b>7657</b>	<b>66977</b>
12-18	PCR	2126 (26%)	1743 (22%)	1590 (22%)	1481 (21%)	1742 (20%)	1814 (22%)	1597 (18%)	1647 (19%)	13740 (21%)
	RAT	6141 (74%)	6083 (78%)	5643 (78%)	5641 (79%)	6942 (80%)	6406 (78%)	7276 (82%)	7137 (81%)	51269 (79%)
	<b>Total</b>	<b>8267</b>	<b>7826</b>	<b>7233</b>	<b>7122</b>	<b>8684</b>	<b>8220</b>	<b>8873</b>	<b>8784</b>	<b>65009</b>
Total 0-18	PCR	6380 (28%)	5496 (25%)	4751 (24%)	4069 (24%)	3731 (22%)	3715 (22%)	3621 (19%)	3791 (20%)	35554 (23%)
	RAT	16679 (72%)	16919 (75%)	15127 (76%)	13205 (76%)	13478 (78%)	12858 (78%)	15190 (81%)	15159 (80%)	118615 (77%)
	<b>Total</b>	<b>23059</b>	<b>22415</b>	<b>19878</b>	<b>17274</b>	<b>17209</b>	<b>16573</b>	<b>18811</b>	<b>18950</b>	<b>154169</b>

Dates are the week ending on a Sunday.

- Since the beginning of term 1 – 154,169 cases have been reported in children aged 0-18 years (reported to DH).
- Total cases in children (0-18 years) declined 25% from the first week of term to week 4, then remained consistent in weeks 5 and 6. Cases rose to 18,811 in week 7 (13.8% increase from week 6) and have remained consistent for the current reporting week (week 8).
  - From week 7 to 8, cases in the 0-4 age group increased 24% (the same percentage increase from week 6 to 7).
  - After decreasing case reports in the 5-11 years age group, cases increased in week 6 and remained consistent in the past two reporting weeks (3% decrease from week 7 to 8).
  - Whilst, cases in secondary-aged children (12-18 years) have remained consistent across the term, the most recent week saw the second highest weekly cases notified for this age group this term (1% decrease from the highest number in week 7).
- In the most recent reporting week, 80% of all positive cases were detected via Rapid Antigen Test (RAT).
- From the first week of term to the most recent week, the proportion of positive cases reported via RATs has increased 8 percentage points (a 1 point decrease from the previous reporting week).
  - This rise has been most pronounced in the 0-4 age group with an overall increase of 9 percentage points. With increased access to RATs as part of the ECEC screening program from week 5, the increased access to may reasonably explain part of the trend to proportionally more RAT reports than PCR. However, it should be noted that reported cases, from both PCR and RAT, have decreased over the study period.

# Weekly cases reported via Rapid Antigen Tests in children (0-18)

Reported to DH by Rapid Antigen Test and symptoms

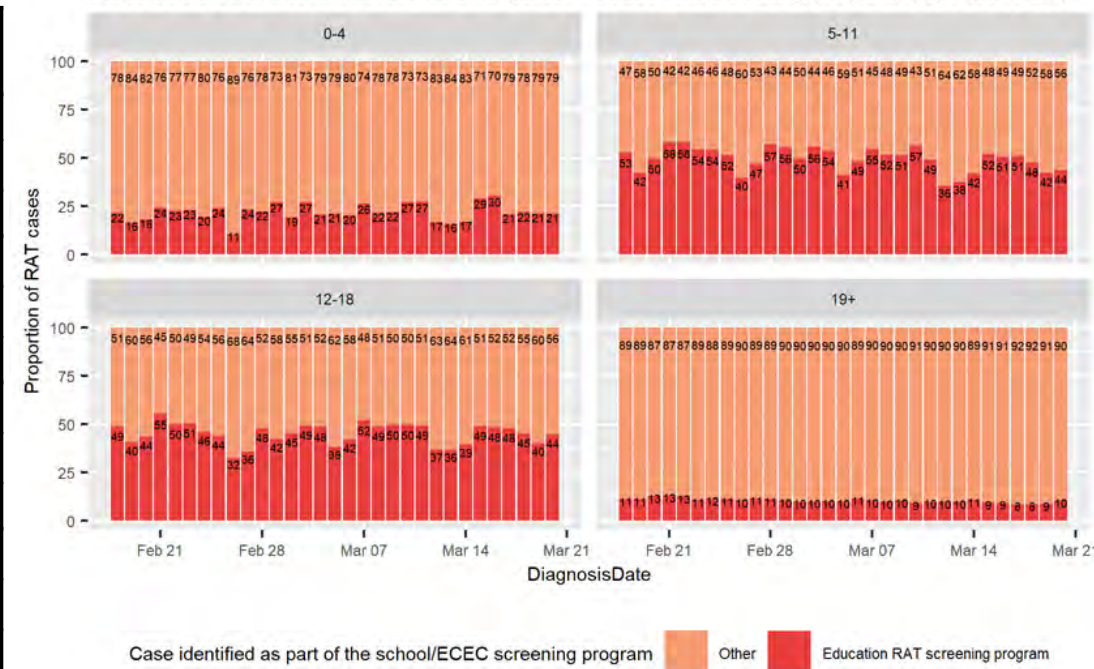
**Weekly probable cases in children by symptomatic or asymptomatic at testing, term 1 2022.**

Dates are the week ending on a Sunday.

Age group (years)	SX at testing	Week 1 6 Feb	Week 2 13 Feb	Week 3 20 Feb	Week 4 27 Feb	Week 5 6 Mar	Week 6 13 Mar	Week 7 20 Mar	Week 8 27 Mar
0-4	ASX	712 (23%)	622 (22%)	448 (21%)	307 (20%)	262 (23%)	252 (22%)	332 (23%)	371 (21%)
	SX	2375 (77%)	2173 (78%)	1679 (79%)	1207 (80%)	853 (77%)	920 (78%)	1127 (77%)	1432 (79%)
	<b>Total</b>	<b>3087</b>	<b>2795</b>	<b>2127</b>	<b>1514</b>	<b>1115</b>	<b>1172</b>	<b>1459</b>	<b>1803</b>
5-11	ASX	2139 (29%)	1906 (24%)	1594 (22%)	1232 (20%)	1132 (21%)	1036 (20%)	1250 (19%)	1386 (22%)
	SX	5312 (71%)	6135 (76%)	5763 (78%)	4818 (80%)	4289 (79%)	4244 (80%)	5205 (81%)	4833 (78%)
	<b>Total</b>	<b>7451</b>	<b>8041</b>	<b>7357</b>	<b>6050</b>	<b>5421</b>	<b>5280</b>	<b>6455</b>	<b>6219</b>
12-18	ASX	1292 (21%)	1133 (19%)	1032 (18%)	883 (16%)	1126 (16%)	1026 (16%)	1117 (15%)	1152 (16%)
	SX	4849 (79%)	4950 (81%)	4611 (82%)	4758 (84%)	5816 (84%)	5380 (84%)	6159 (85%)	5985 (84%)
	<b>Total</b>	<b>6141</b>	<b>6083</b>	<b>5643</b>	<b>5641</b>	<b>6942</b>	<b>6406</b>	<b>7276</b>	<b>7137</b>
Total 0-18	ASX	4143 (25%)	3661 (22%)	3074 (20%)	2422 (18%)	2520 (19%)	2314 (18%)	2699 (18%)	2909 (19%)
	SX	12536 (75%)	13258 (78%)	12053 (80%)	10783 (82%)	10958 (81%)	10544 (82%)	12491 (82%)	12250 (81%)
	<b>Total</b>	<b>16679</b>	<b>16919</b>	<b>15127</b>	<b>13205</b>	<b>13478</b>	<b>12858</b>	<b>15190</b>	<b>15159</b>

ASX-asymptomatic at testing, SX-symptomatic at testing

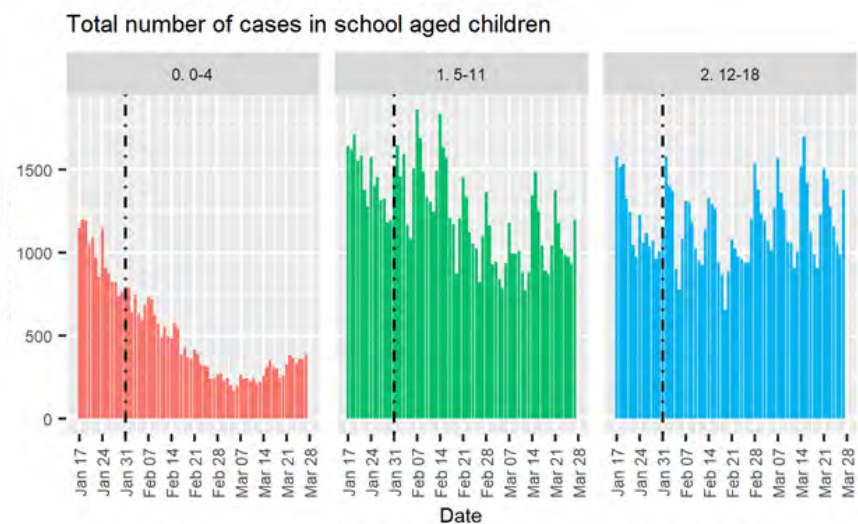
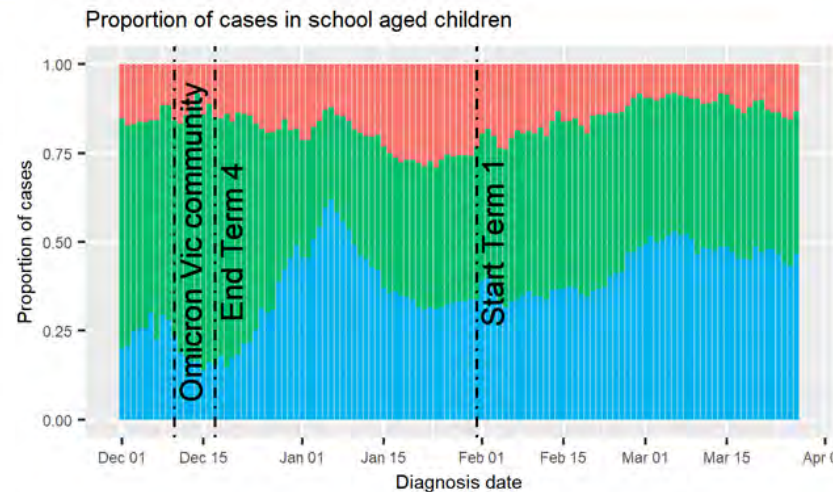
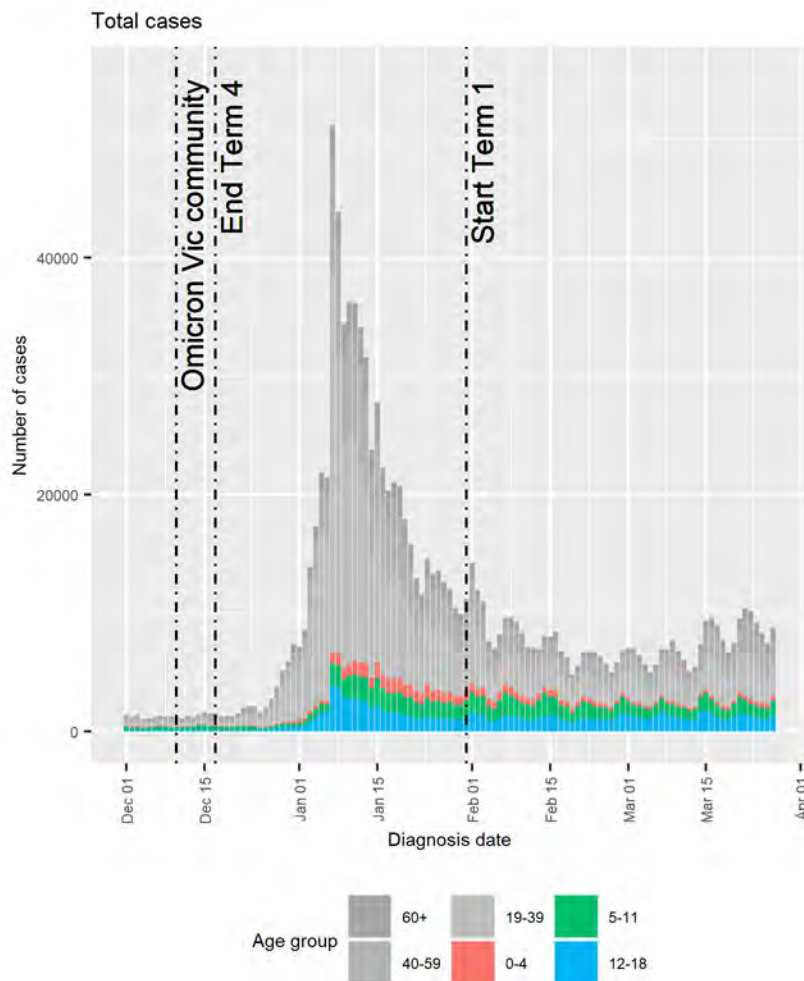
Proportion of RAT cases self-identified as 'part of an education screening program' (reported to DH)



- Across all child cases diagnosed by RATs, those reporting symptoms at testing has increased by 6 percentage points from week 1 to week 8 (1 point decrease from week 7). 81% of cases reported last week indicated they were displaying symptoms when they took their RAT.
  - Children aged 5-11 years had a 3 percentage point decrease in the proportion with symptoms at testing in the past two weeks, whilst the 12-18 age group also had a 1 point decrease, and the ECEC age group displayed a 2 point increase.
- From February 17, a question was added to the DH RAT notification form asking: "Did you complete the RAT as part of an education (school or early childhood) screening program?" Among school-aged children, the median proportion of daily reported cases indicating the test was part of the education screening program was 51% (range 36 – 58) in the 5-11 years age group, and 46% (range 32 – 55) in the 12-18 years age group. This has remained relatively stable since the question was added.

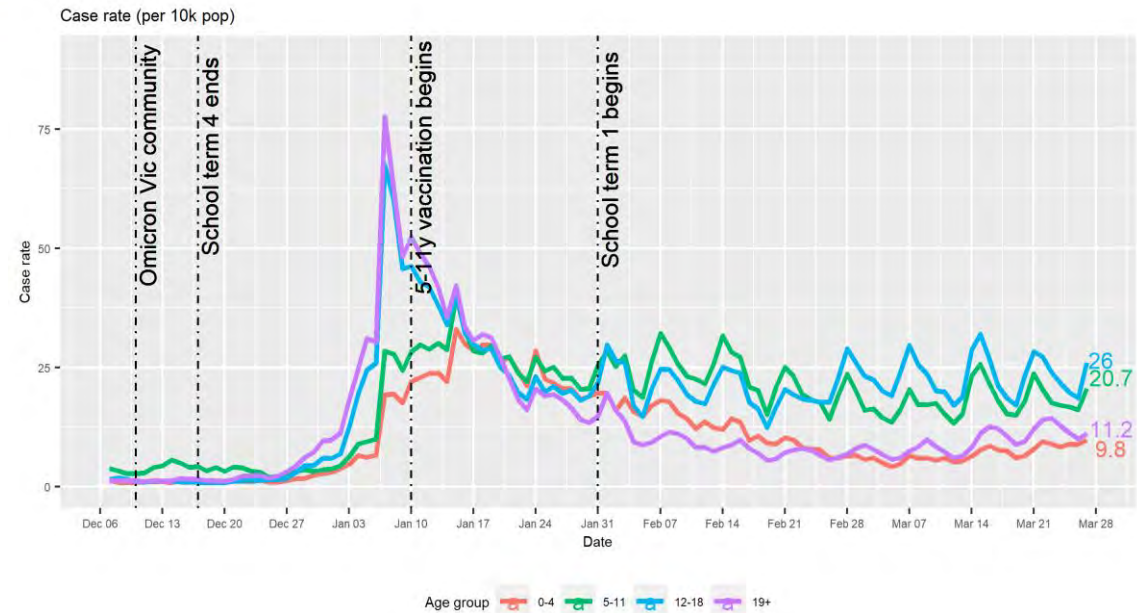


# Overall trends in children (0-18 years) from Dec 2021



- Cases in school-aged children (5-18 years) declined from the epidemic peak in early January; however, cases declined at a slower rate than in non-school-aged children.
- With the increasing predominance of the Omicron BA.2 lineage, cases in the general population have begun to increase in the past two weeks, as have cases in children.
- The 12-18 years age group comprised the largest proportion of the total child cases reported from week 4 of term. In the first week of term, 36% of child cases were in this age group, increasing to 41% in the fourth week, further increasing to 50% in week 5 and 6 before decreasing slightly to 46% in week 8. This age group comprises 35% of the child population.
- As reported cases in 5-11-year-olds declined over term, the proportion of cases this age group comprised has declined from the peak of 48% in week 3 to remaining steady at approximately 40% from weeks 5 to 8. These children make up 38% of the child population.
- Case in children 0-4 years declined steadily this term to week 5, though began to increase from week 6. These children comprised 21% of reported child cases in the first week of term, declining to 9% in the fifth, but increased again to 13% in the eighth, despite comprising 27% of child population.

# Children as a proportion of total cases and rates

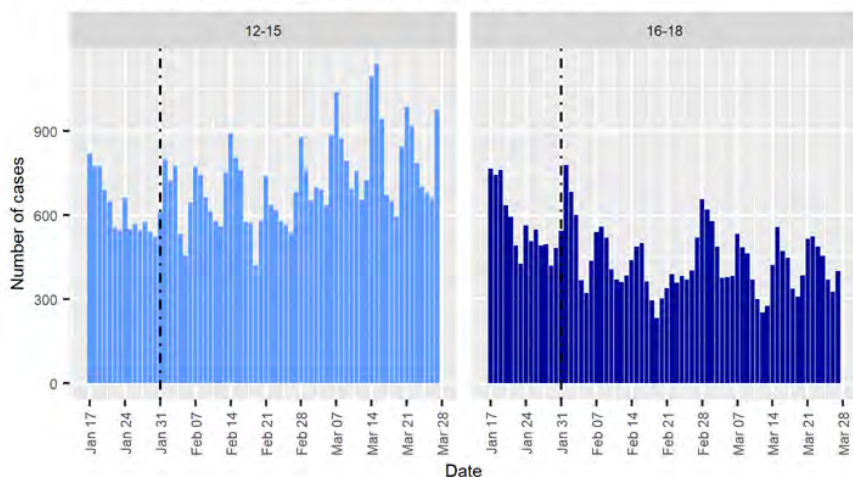


- School-aged children remain a cohort that has a significantly higher case rate than the adult population, and therefore comprise a large proportion (36.2%) of the total cases in Victoria.
- Whilst the case rate (per 10,000 population) was similar for all age groups (including 19+ years age group) in mid-January, the rates diverged as school resumed. As at 28 March, adults 19 years and older and children 0-4 years have the lowest case rates, but have an increasing trend (11.2 and 9.8 per 10,000, respectively). Children aged 5-11 years had the highest case rate during term 1 until the fourth week of term where the 12-18 age group became the cohort with the highest case rate, a trend which has been maintained.
- Both the 5-11 and 12-18 years age groups increased as a proportion of total cases in the opening weeks of term 1. However, the proportion of cases reported in 5-11-year-olds declined from week 4 to a seven-day rolling average of 12.1% by the end of the most recent week (this group comprises 8.6% of the population). Conversely, a steep increase in the proportion of total cases reported in 12-18-year-olds was observed in week 4 before declining in week 6 and 7 to a seven-day rolling average of 13.8% of reported cases in the state in week 8, despite comprising 7.9% of the population.
- Some considerations:
  - Case detection relative to the general population in children may have increased with the return to school and commencement of the RAT screening program.
  - There are differences in vaccination coverage: as of 28 March, 58% of 5-11-year-olds have received a first dose, whereas >94% of children over 12 years have had a second dose. 38% of 16-18-year-olds have received a third dose.
  - As of 25 February, face masks are not mandatory in secondary school settings.

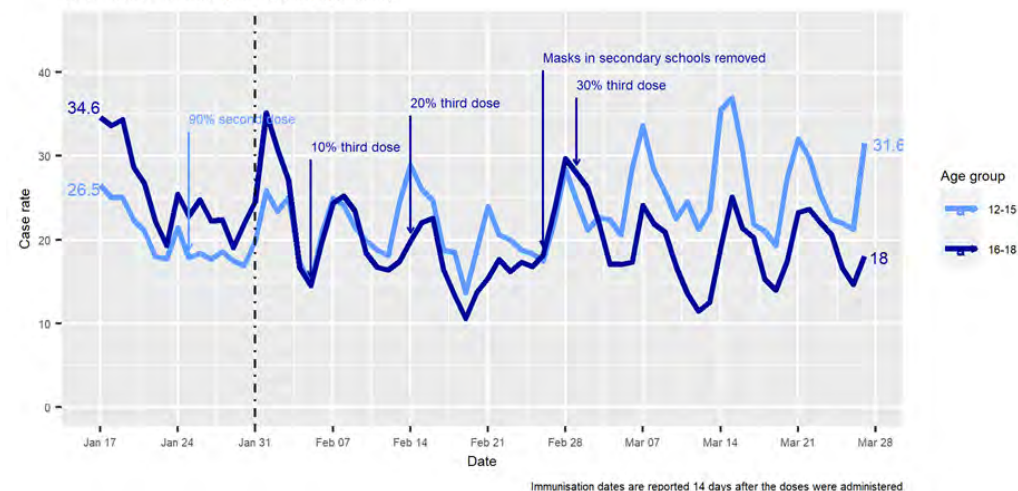


# COVID-19 cases in 12–18 year-olds

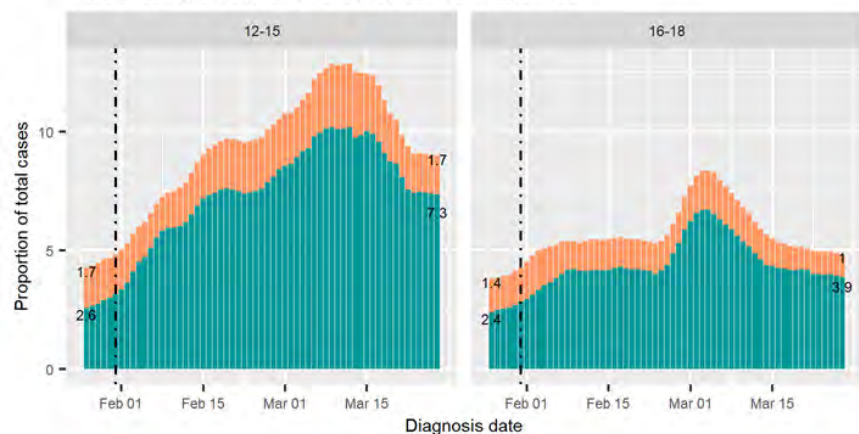
Total number of cases in secondary school aged children



Case notification rate (per 10,000 population)



Child cases (12-18 years) as a proportion of total cases

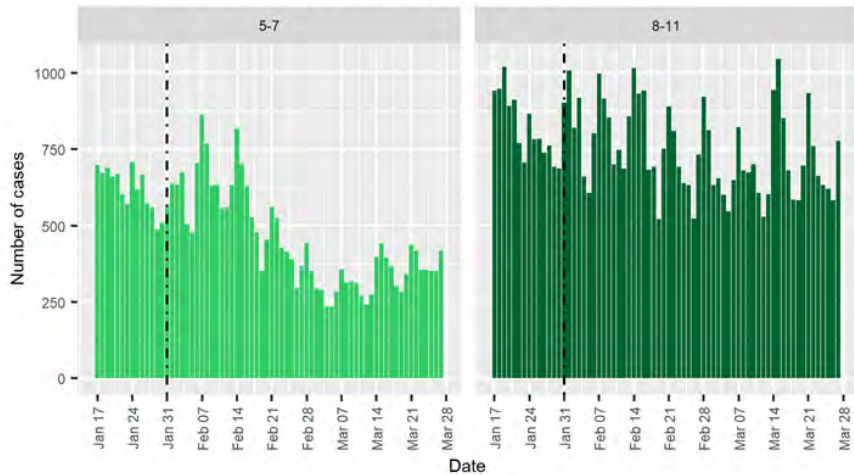


- Total cases in the 12-15 years age sub-group have increased across term 1. As a proportion of total cases, this age group comprised 9% of total cases in the previous reporting week (4.6% of the total population are in this age group). However, although 12-15 years cases increased, their population share has decreased in recent weeks as cases in the general population increased.
- Cases in children aged 16-18 years declined to 4.9% of the total population cases (3.3% of the population) after a peak in weeks 4/5.
- Whilst the 16-18 years age group had higher rates than 12-15-year-olds in January and the first few days of term 1, the rates became similar before the upper secondary aged group began to decline. However, in the fourth/fifth week of term, the 16-18 group had a large increase in cases. 18-year-olds are a transition age; some will be in their final year of school whilst others are beginning university or other activities. The rapid increase in 16-18 years cases was mainly due to large increases in cases reported in 18-year-olds. This observation occurred during the orientation week of university where this age group often socialise more widely, and may, in part, explain the increase. In the past three weeks, the case rate in this older age group has once again remained below the 12-15 age group rate.
- Some additional considerations:
  - Masks were no longer mandatory from week 5 in secondary schools

Test type: PCR, Rapid Antigen Test  
FOI ASSESSMENT DATA -

# COVID-19 cases in 5–11 year-olds

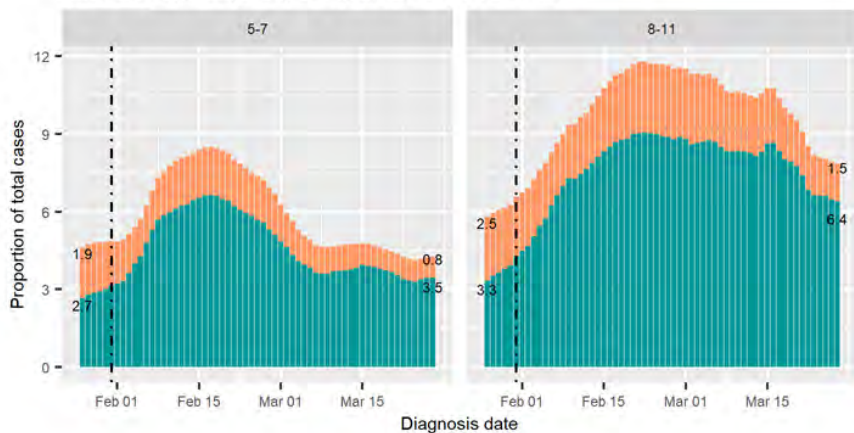
Total number of cases in primary school aged children



Case rate (per 10k pop)



Child cases (5-11 years) as a proportion of total cases



- Cases in children in lower primary school (5-7 years) have declined since the third week of term with a small increase in the past two weeks. Cases in 8-11-year-olds in upper primary school have remained consistent across the weeks.
- As a proportion of total cases in Victoria, the 5-7 years age group increased to week 3 but has since declined to 4.3% of total cases in the last reporting week (these children comprise 3.8% of the population). The 8-11 years age group also increased as a proportion of total cases in the first 3 weeks but has plateaued, with 7.9% of cases in this age group last week, overrepresenting their population proportion (4.9%).
- Some considerations:
  - The timing of vaccination milestones in primary aged children are similar between the subgroups, apart from the longer time to 50% immunisation in 5-7 years age group. Currently, 52.8% of 5-7-year-olds and 61.4% of 8-11-year-olds have received their first dose.
  - Face masks remained mandatory indoors for students in grade 3 to 6 (~8-11 years) and in staff in schools and ECEC (with some exceptions).

# RAT Performance with PCR confirmation

From 3 March, in consultation with DH, DET recommended a confirmatory PCR was sought for all positive RATs (excluding those who are close contacts) in children tested via the schools and ECECs screening, including independent and catholic schools. This was due to concerns regarding the false positive rate in RATs when prevalence reduces.

Test tracker was used to assess the results of children who had a positive RAT and presented for PCR (42% of PCR tests in 0-18 year-olds have a test tracker record). Between 3 March and 27 March, just over 4K people between 0-18 years are recorded as having a confirmatory PCR within 72 hours following a positive RAT.

It is important to note that this is real-world data and does not have the systematic sampling of a diagnostic accuracy study. The direction of the bias is likely to overestimate false positives. No real change to PCR demand has been noted during this time period.

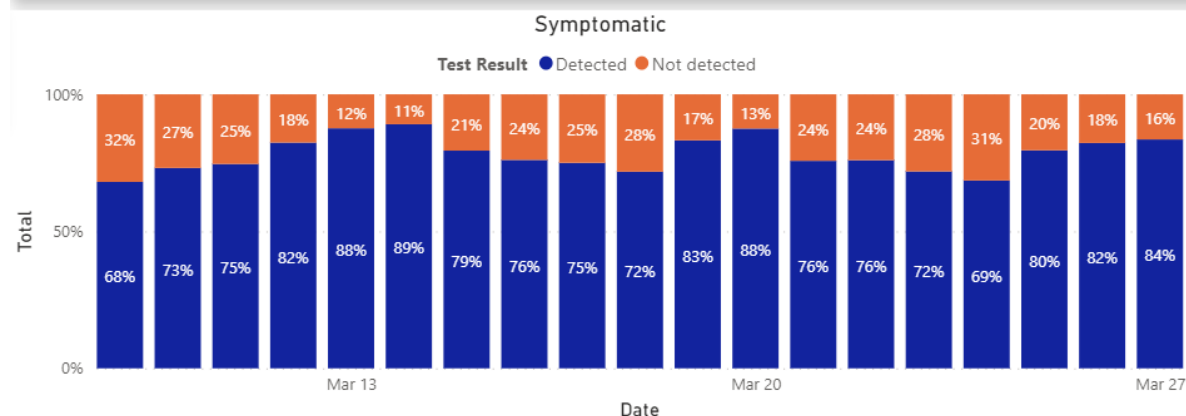
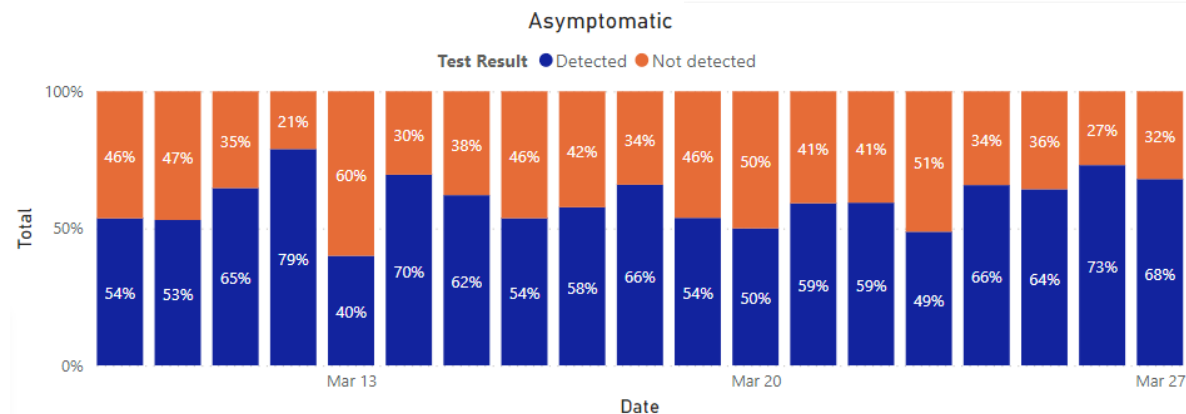
Overall, the positive predictive value was 74.8% (74.8% of positive RATs were confirmed cases) and 25.2% did not have COVID-19 detected by PCR following their positive RAT. There was no significant difference between overall PPV in the adult (19+ years) population (n=9,506), with 78.3% records of a positive RAT followed by a PCR with COVID-19 detected.

The PPV increases in symptomatic cases to 77.9% (n=3,396) whilst 59.4% of cases with a prior positive RAT and reporting no symptoms at PCR testing had a detected PCR result (a small sample size of 692 for this cohort means this interpretation should be treated with caution). Compared to the adult sample, 49.1% RAT positive and PCR detected cases were asymptomatic at PCR testing (n=1,208), and 82.5% of adults with a positive RAT had COVID detected in their PCR when symptomatic at testing (n=8,298).

Interestingly, there was not a notable difference in this cohort between household and non-household contacts. 74.3% of those who had a positive RAT and were non-household contacts had a positive PCR (n=3,048), compared to 79.1% of those who had a positive RAT, were household contacts and had COVID detected by PCR (n=1,040). Compared to the adult population, 80.1% of non-household contacts with positive RATs had COVID detected by PCR (n=2,239) and 77.7% of non-household contacts with positive RATs had COVID detected by PCR (n=7,267)

Test Result	Asymptomatic	Symptomatic	Total
Detected	411	2,646	3,057
Not detected	281	750	1,031
<b>Total</b>	<b>692</b>	<b>3,396</b>	<b>4,088</b>

Test Result	Household Contact	Non-Household Contact	Total
Detected	791	2,266	3,057
Not detected	249	782	1,031
<b>Total</b>	<b>1,040</b>	<b>3,048</b>	<b>4,088</b>



Exemption graphics and tables above are for 0-18 year population. NB: Blank = no record available (likely lab result not linked to RAT or PCR record not yet received).

# DET data

## RAT Distribution & Case Notifications

as at 28 March 2022

# RAT Distribution

## Number of students in education settings

Sector	Number of students (only) by Education Setting Type						
	Specialist	Primary	Primary / Secondary	Secondary	ECE	Other	Total
Government	13,239	353,878	58,042	221,634		1,252	648,045
Independent	2,032	4,221	145,051	3,204			154,508
Catholic	756	107,243	13,347	90,349			211,695
ECEC							
Grand Total	16,027	465,342	216,440	315,187		1,252	1,014,248

Number of RATs across all tranches as at **7th Mar 2022**. Supply remains adequate.

Sector	Number of RATs distributed by Education Setting Type						
	Specialist	Primary	Primary / Secondary	Secondary	ECEC	Other	Total
Government	422,775	4,125,220	688,430	2,532,865		4,840	7,769,290
Independent	58,610	51,660	1,817,630	38,235			1,970,975
Catholic	21,870	1,262,045	157,865	1,039,550			2,481,330
ECEC					894,190		894,190
Grand Total	503,255	5,438,925	2,663,925	3,610,650	894,190	4,840	13,115,785



# Cases by school type reported to DET

	Week 1 (ending 6 Feb)	Week 2 (ending 13 Feb)	Week 3 (ending 20 Feb)	Week 4 (ending 27 Feb)	Week 5 (ending 6 Mar)	Week 6 (ending 13 Mar)	Week 7 (ending 20 Mar)	Week 8 (ending 28 Mar)	Total
<b>Number of new COVID cases (students)</b>	<b>5,644</b>	<b>11,976</b>	<b>13,963</b>	<b>11,367</b>	<b>10,663</b>	<b>10,351</b>	<b>11,294</b>	<b>11,058</b>	<b>86,316</b>
Govt Primary Schools	2,989	5,774	5,542	4,702	3,761	3,495	4,015	3,967	34,245
Govt Secondary Schools	1,375	2,403	2,621	2,119	2,332	2,466	2,645	2,874	18,835
Govt Primary-Secondary Combined Schools	232	503	825	490	397	415	543	560	3,965
Govt Specialist Schools	86	190	173	138	108	91	113	114	1013
Catholic Schools	^	1,054	3,221	2,326	2,647	2,519	2,584	2,552	16,903
Independent/Private Schools	962	2,052	1,581	1,592	1,418	1,365	1,394	991	11,355
<b>Number of new COVID cases (school staff)</b>	<b>935</b>	<b>1,261</b>	<b>1,191</b>	<b>1,102</b>	<b>903</b>	<b>1,060</b>	<b>1,238</b>	<b>1,390</b>	<b>9,080</b>
Primary Schools	403	411	394	375	333	314	367	413	3,010
Secondary Schools	229	253	200	183	210	214	293	353	1935
Primary-Secondary Combined Schools	78	99	60	72	55	56	72	87	579
Specialist Schools	90	104	88	81	56	48	65	83	615
Catholic Schools	^	129	270	230	249	278	247	290	1693
Independent/Private Schools	135	265	179	161	171	150	194	164	1248

## Notes:

- Government schools - weekly figures are from Monday to Sunday each week, with 4pm cut-off each day. Cases submitted after 4pm are counted against the next day.
- The Specialist school category includes Camp and Language schools (6 in total). Source: VicEd COVID Tool
- Data by Catholic and Independent/Private schools reported weekly to DH with a cut off of 5pm Friday. Any cases lodged after the deadline will be included in next week's reporting.
- ^ Individual cases not provided/not complete

# Survey Analysis

Week 6 Results: 22-27 March 2022

# Survey sample and response – Week 6



## Parents

6,827 responses

(1,494 ECEC, 3,918 primary, 3,553 secondary, 232 specialist)\*

### Demographics:

- These responses account for at least 6% of the total sample of school students eligible to be surveyed compared to 7% last round, and 4% of ECEC enrolments (same as last round).
- 76 (1%) identify as Aboriginal and/or Torres Strait Islander.
- 47% CALD and 53% not-CALD (this is a measure of non-English speaking country of birth or English not spoken at home - 83% said main language spoke at home was English).
- 53% metro, 5% cities and major regional centres (regional), 20% other regional areas (rural), and 22% didn't give postcode.
- 7% most disadvantaged quintile, 9% 2nd most, 18% middle, 17% 2nd most advantaged, and 27% most advantaged (again 22% didn't give postcode).



## Teachers

1,921 responses

(10% ECEC, 36% primary, 48% secondary, 5% combined, and 1% specialist)\*

### Demographics:

- We do not have access to school staff numbers so are unable to calculate response rate.
- 17 (1%) identify as Aboriginal and/or Torres Strait Islander.
- 93% main language spoken at home was English (other 7% coded as CALD).
- 59% metro, 6% regional, 24% rural and 11% didn't give postcode.
- 7% most disadvantaged quintile, 13% 2nd most, 17% middle, 24% 2nd most advantaged, and 28% most advantaged (11% didn't give postcode).



## Principals & Providers

133 responses

(70 ECEC and 49 schools)\*

These responses equate to 17% of schools sampled and 11% of ECEC services.

- Survey released midday 22 March, results taken as at 28 March (8am)
- Government/non-Government and ECEC/primary/secondary/combined/ specialist schools
- 1688 schools sampled in the 6 rounds of the survey. The survey was sent to 282 schools in rounds 1, 5 and 6, 281 schools in rounds 2 and 3, and 280 schools in round 4 (randomly selected within sample).

\* Split of respondents may not add to 100% as answering this demographic question was not compulsory, and parents/staff could select more than one setting.

Note: We have not calculated completion rate for this round.

Assessment Date: December 2022.

Exemptions applied (if any):

# Parent and guardian survey

Note: In this round, the full set of questions was only asked of ECEC parents. Where questions were also asked of school parents we have noted this, otherwise responses only relate to ECEC settings. Parent and guardians could answer for more than one setting if they have children in each.

# Parent and guardian survey

## Almost all ECEC parents had access to enough RATs to test all their children

**86% of parents from ECEC services reported having access to enough RATs to test their children in the last week** (82% last round).

Proportion of these respondents who reported they had access to enough tests:

- 87% of CALD parents, 85% non-CALD parents.
- 89% of parents in metro areas, 88% in regional centres, and 83% of parents in other regional areas.\*
- Access across SEIFA quintiles was lower in the second most disadvantaged quintile (81%), with all others between 85-89%.

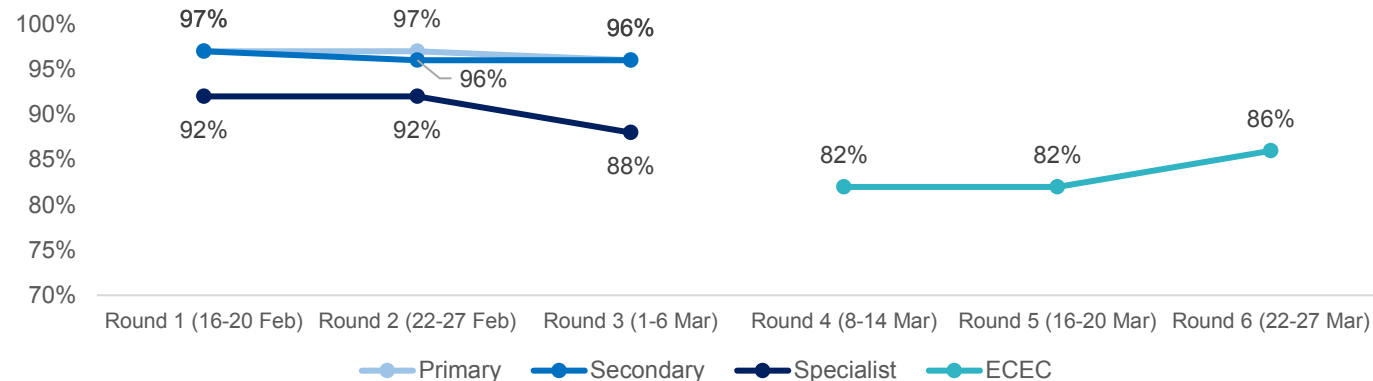
**The most common reasons for not having access to enough RATs was that the ECEC service did not have enough RATs** (48%, compared with 52% last round), then 'Did not collect the RATs from the ECEC' (47% compared with 45% last round). Only 6% 'Used RATs for other purposes' (compared with 4% last round).

CALD parents were more likely to say their ECEC did not have enough RATs (53% vs 41%) and less likely to say they did not collect their RATs (30% vs 54%).

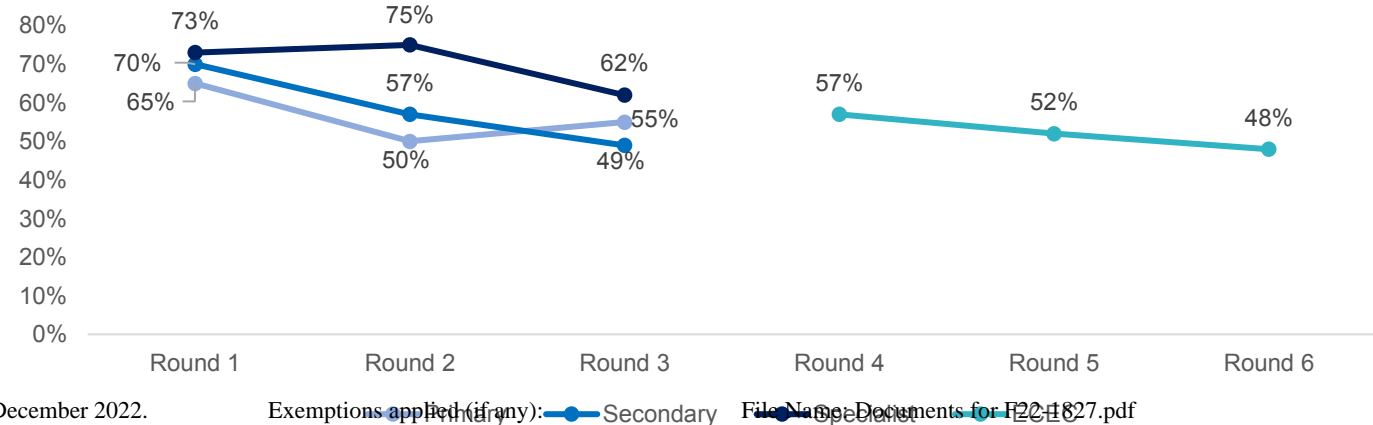
\* For this survey we have taken the table of postcodes from the Department of Home Affairs website and classified those that correspond to 'Cities and Major Regional Centres' as Regional, and those classified as 'Regional Centres and other regional areas' as Rural: [Designated regional area postcodes \(homeaffairs.gov.au\)](https://www.homeaffairs.gov.au/postcodes)

\*\* Due to the small sample of specialist schools, these results should be interpreted with caution.

**Figure 1. Proportion of parents who reported having enough RATs to test their child last week\*\***



**Figure 2. Of those who didn't have enough RATs, the proportion reporting that the school/ECEC did not have enough RATs\*\***



# Parent and guardian survey

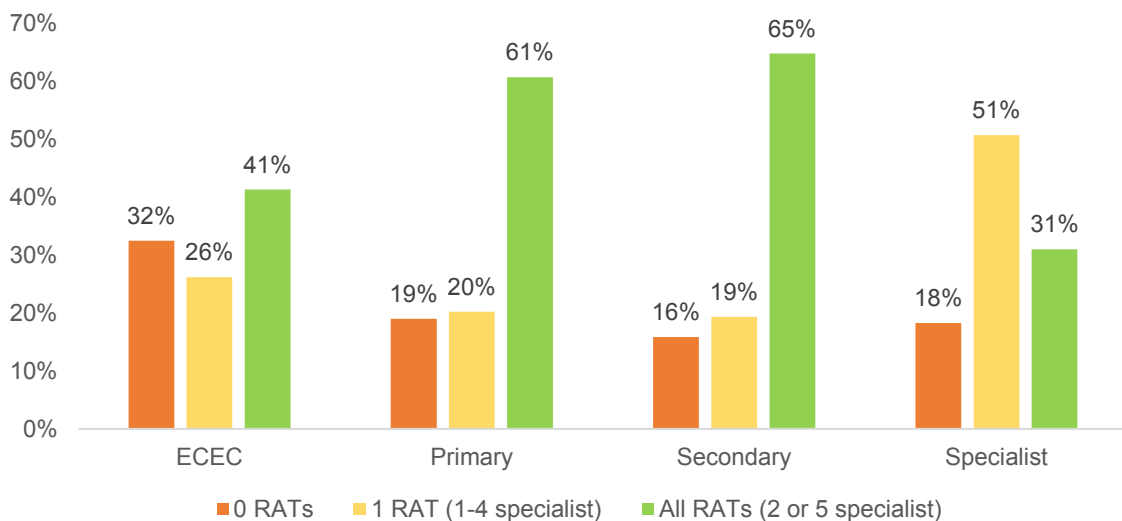
The proportion of children who take the recommended number of RATs has declined slightly, but is still high.

Last week, **60% of children took the recommended number of tests** (2 for ECEC, Primary and Secondary, 5 for Specialist), compared with 63% last round. A further 21% took some but not the recommended amount (20% last round).

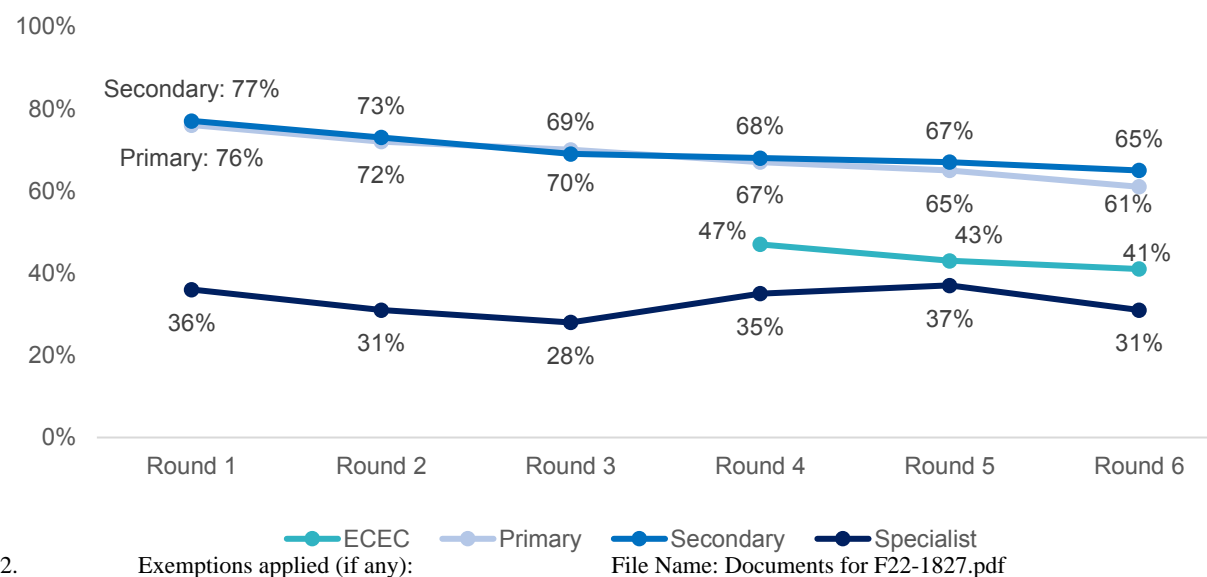
**61% of households had all their children take the recommended number of tests:**

- 70% of CALD households (67% last round), 53% of non-CALD households (57% last round) took all recommended tests.
- 59% of households in metropolitan Melbourne (60% last round), 53% for regional (57% last round), 50% for rural households (58% last round). 75% of those who did not give a postcode took the recommended number of RATs.
- Those in the second most disadvantaged quintile (50%) were slightly less likely to take all their tests compared with other quintiles (56-61%).

**Figure 3. Number of tests taken per child last week, by educational setting**



**Figure 4. Number of children who did all recommended tests each week, by educational setting**



# Parent and guardian survey

Difficulty testing their child and not wanting to perform frequent tests on their child were the most common reasons why ECEC parents did not test their children, while many also only test when their child is symptomatic

41% of ECEC children took all tests, however, removing those who did not have enough RATs or who didn't use them as their child had COVID-19 or was isolating/didn't attend, compliance with testing rises to 46%.

Overall, among ECEC parents the most common reasons why the recommended number of RATs were not taken were:

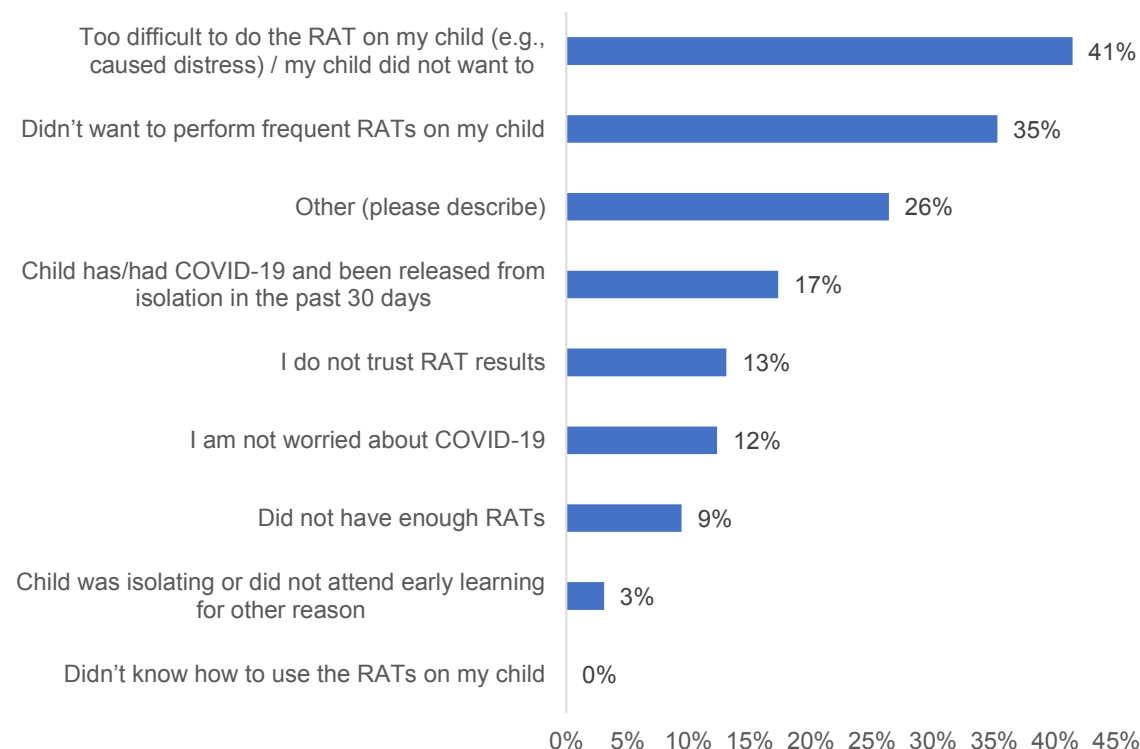
- Too difficult to do the RAT on their child (e.g., caused distress) (41%, same as last round).
- Didn't want to perform frequent RATs on their child (35%, compared to 29% last round),
- 'Other' responses (26%, compared with 33% last round).

Consistent with previous rounds of the survey in schools, **most 'other' responses from this round (137 responses) and the last round were that they didn't test their child as they were not showing symptoms.** Others reported that they didn't have RATs to test or that they preferred saliva tests, while some said their child only attends early learning services one to two days, so they did not take more than one RAT. Child anxiety or distress with testing was also mentioned.

The most common motivations for taking the recommended number of RATs among ECEC parents were:

- Wanting to follow the recommendations of DET and DH to test the child (64%, compared with 66% last round),
- To make early learning safer (55%, compared to 54% last round)
- Because they are comfortable testing their child (53%, compared with 52% last round).

**Figure 5. Reasons for not taking recommended number of RATs for ECEC parents (n=519)**



# Parent and guardian survey

Of the 6% of students who tested positive, 6% were asymptomatic at the time of testing and not a close contact

Last week, 6% (n=557) of students tested positive (5% last round), of these:

- 6% (n=31) were asymptomatic at the time of testing and not a close contact (same as last round).
- 67% (n=374) were symptomatic (70% last round)
- 41% (n=231) were a close contact (36% last round) – Note some children were both symptomatic and a close contact.

No. of children*	Primary	Secondary	Specialist	ECEC
Asymptomatic and not close contact	15 (7%)	14 (5%)	0 (-)	2 (6%)
Symptomatic	142 (65%)	220 (72%)	1 (50%)	11 (32%)
Close contact	102 (47%)	112 (37%)	2 (100%)	15 (44%)

No. of children	CALD	Non-CALD
Positive test on any child	5%	7%
Child(ren) were asymptomatic at time of test and not a close contact	7%	5%

\* Columns may not add to 100% as children could be both symptomatic and a close contact. For ECEC, it appears not all parents answered whether their child was symptomatic or a close contact so these sum to less than 100%.

^ Note that sample size of children attending specialist schools who tested positive to COVID-19 in any week is small (<30), interpret with caution. In this round only 2 children at specialist schools surveyed tested positive over the 3 week period.

Figure 6. Positivity rate over time, by school phase^

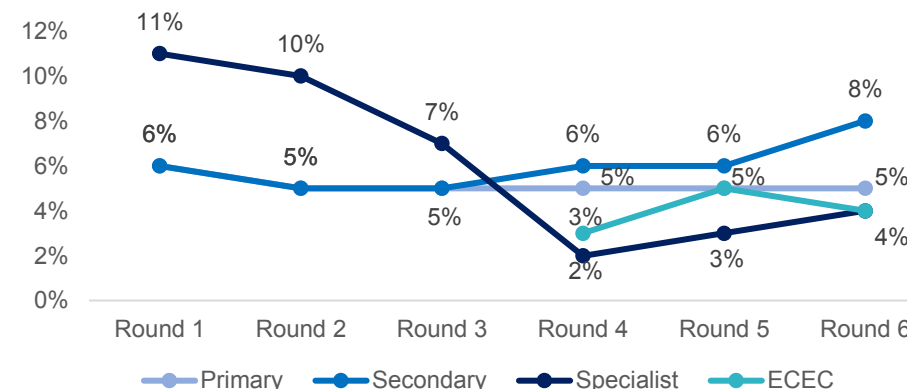
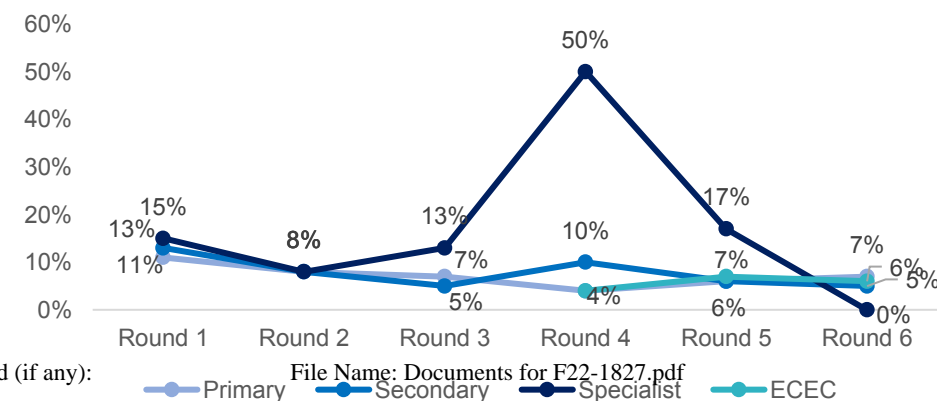


Figure 7. Percentage of positive cases that were asymptomatic and not close contacts over time^



Exemptions applied (if any):

File Name: Documents for F22-1827.pdf



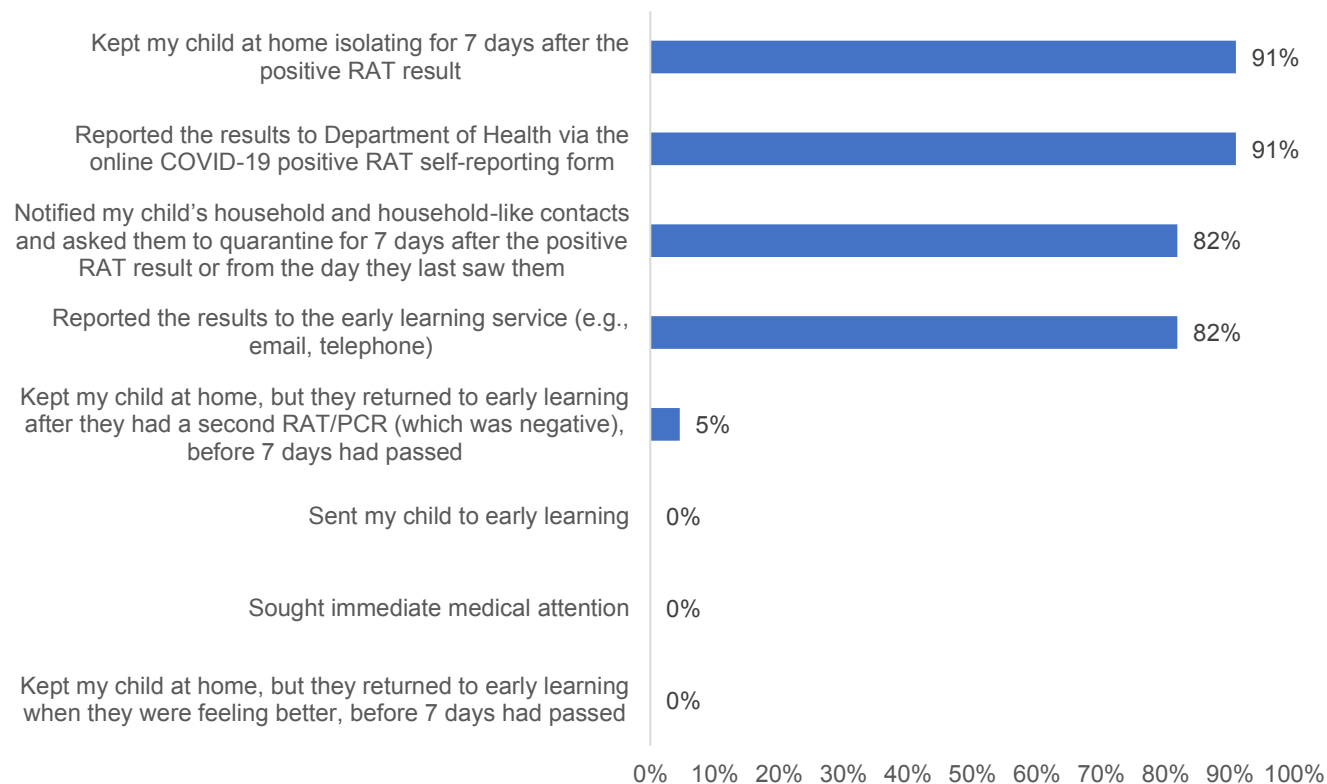
# Parent and guardian survey

Most parents in our sample reported the results to DH and the ECEC service

**91% of ECEC parents reported the results to DH via the online self reporting tool (78% last round), while 82% reported the results to the ECEC service (78% last round) - note there is no DET online reporting tool for ECEC services.**

- 91% of parents reported keeping their child home for 7 days (85% last round).
- One parent (5%) said they kept their child home for less than 7 days sending their child to ECEC after a subsequent negative test (4% last round).
- Note parents may have selected more than one option to reflect a different action for different children, or that the child both tested negative and felt better, which is why they went back to school.

**Figure 8. What ECEC parents did after receiving a positive RAT test on one or more of their children (n=22)**



Note: Data for what parents/households did after a positive RAT was returned reflect what that single household did, rather than what happened for each positive case.

# Parent and guardian survey

Majority of parents support the program, and there has been little change over the last 3 weeks.

% Agree or strongly agree	Round 1	Round 2	Round 3	Round 4*	Round 5*	Round 6*
I understood how to administer a RAT on my child	96%	97%	97%	97%	96%	<b>96%</b>
I am confident that the RATs were completed correctly	89%	90%	89%	84%	78%	<b>80%</b>
There was enough information available to help me administer the RATs on my child	95%	95%	96%	92%	90%	<b>91%</b>
Overall, the RATs are easy to do	88%	89%	89%	76%	75%	<b>72%</b>
I understand what to do if my child returns a positive or negative RAT result	96%	96%	97%	97%	96%	<b>94%</b>
Doing multiple weekly tests will help make schools/early learning services safer	83%	82%	80%	82%	76%	<b>74%</b>
Doing multiple weekly tests will help keep children in face-to-face learning	83%	82%	81%	80%	73%	<b>73%</b>
Regular testing will help reduce the spread of COVID-19 in our community	83%	83%	82%	83%	79%	<b>77%</b>
I am happy for my child to participate in the school RAT screening program	84%	84%	83%	78%	72%	<b>70%</b>
I would be able and willing to continue the testing if advised to do so	86%	86%	85%	82%	79%	<b>76%</b>

\*These rounds reflects answers from ECEC parents, whereas previous rounds were asked of school parents.

# Parent and guardian survey

## Qualitative snapshot of themes

### **“Do you have any feedback on how the program could be improved” (1,654 responses)**

- Some volunteered positive feedback or reported no issues, with many wanting the program to continue.
- More access to saliva RATs remains one of the most common pieces of feedback, as well as more RATs in general given supply issues.
- Some asked for only symptomatic testing, while others said testing should be made compulsory/a requirement to attend school given concerns around compliance.
- One suggested there should be designated days for testing, with reminders sent to prompt parents/students to test.

# Staff survey

Note: In this round, the full set of questions was only asked of ECEC staff. Where questions were also asked of school staff we have noted this, otherwise responses only relate to ECEC settings.

# Staff survey

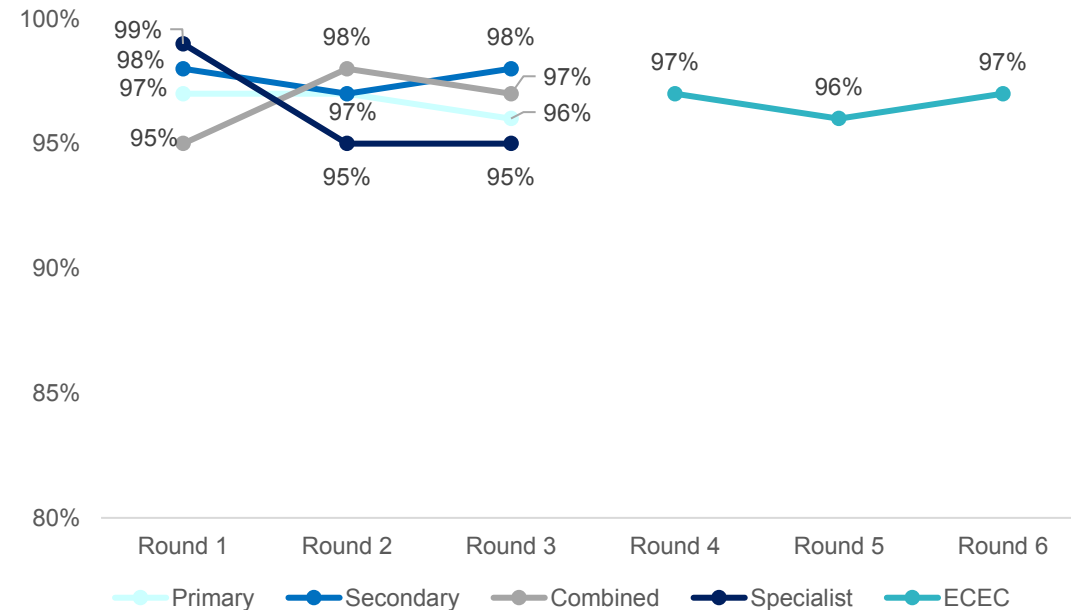
## Almost all staff had access to enough RATs to test themselves last week

Last week, 97% of ECEC staff reported having access to enough RATs to test themselves, compared with 96% last round:

- 100% of CALD staff had enough RATs compared with 97% of non-CALD staff.\*
- Access to RATs was lower in regional areas (91%) compared with metro (97%) and rural (98%)
- Across SEIFA quintiles, those in the 2<sup>nd</sup> most advantaged quintile were least likely to have access to enough RATs (91%) compared to all other quintiles (97-100%).

Consistent with last round, the most common reason for not having enough RATs was that they didn't collect them (3/5), followed by the ECEC service not having enough (2/5). No ECEC staff reported using the RATs for other purposes.\*\*

Figure 9. Had enough RATs last week, by education setting



\* Interpret this breakdown with caution as only 12 CALD staff responded to this question.

\*\* Too few respondents did not have enough RATs, so we cannot do demographic breakdowns for this question.

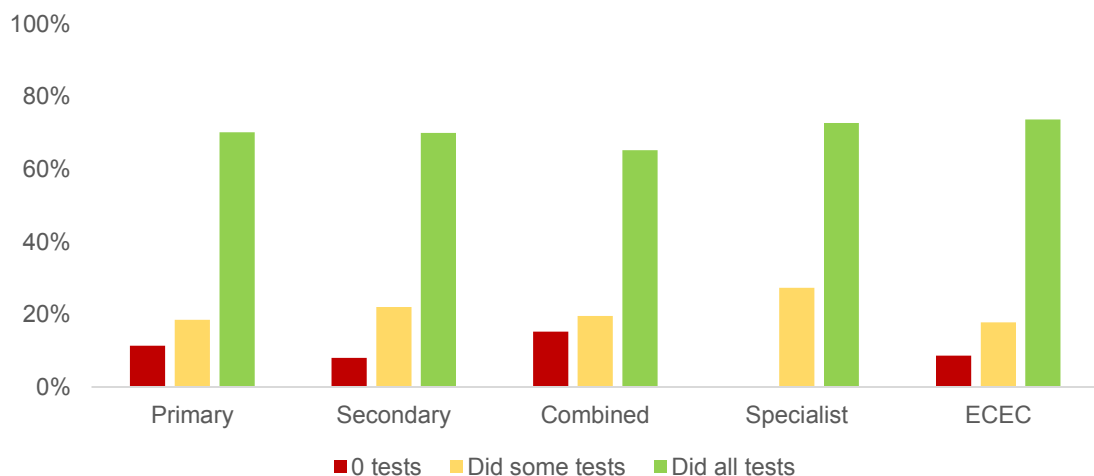
# Staff survey

70% of staff reported they took the recommended number of RATs

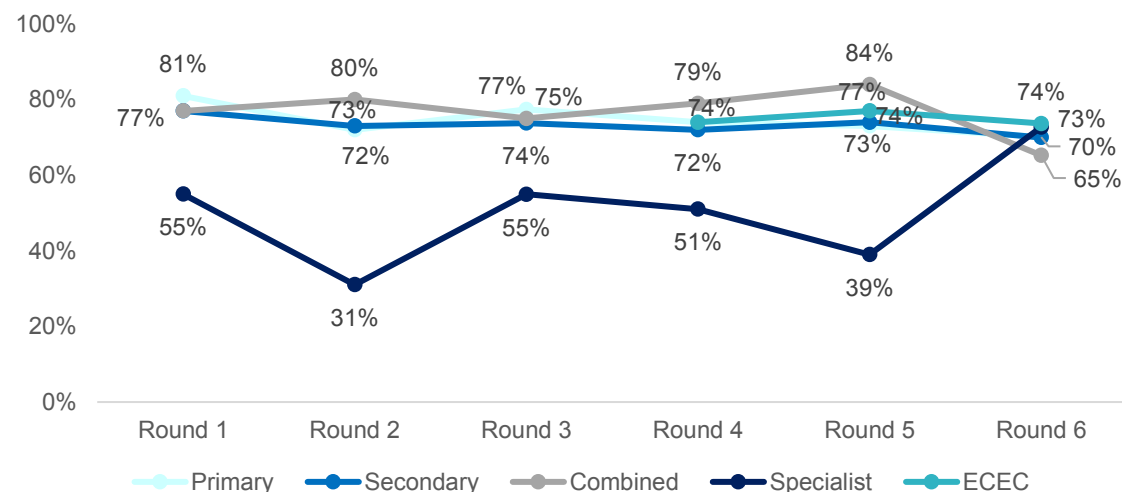
Last week, 70% of staff across ECEC and school settings reported they took the recommended number of tests (71% last round). A further 20% took some but not all tests (compared with 17% last round).

- 72% CALD staff did all their tests (73% last round) and 69% non-CALD staff (71% last round).
- The proportion of people who took all RATs was similar across metro, regional and rural areas. Among those who didn't provide a postcode however, only 50% took all the recommended number of tests.
- Those in the most disadvantaged SEIFA quintile were more likely to take all their tests (77%), compared with 69-73% across all other areas.

**Figure 10. Number of tests taken, by education setting**



**Figure 11. Number of staff who took all recommended tests, over time**



# Staff survey

## Having COVID-19 and forgetting to take it were the most common barriers to testing

### The most common reasons why the recommended RATs were not completed for ECEC staff were:

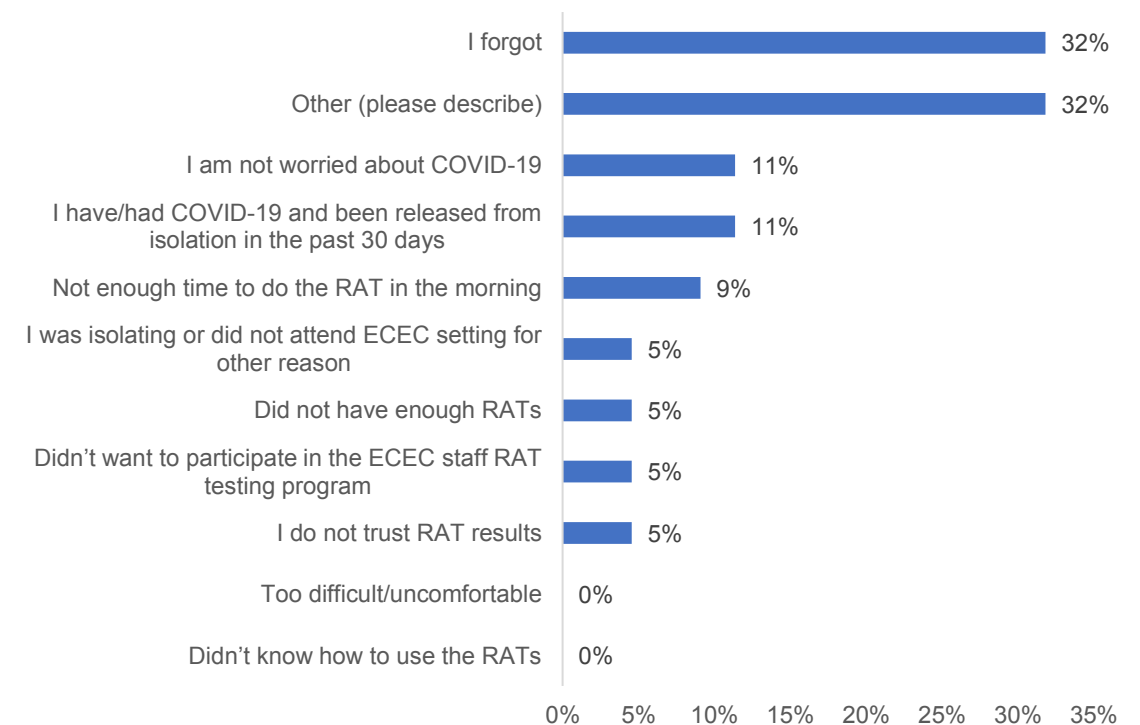
- Other (32%, compared to 31% last round). Consistent with last round, the most common 'other' responses (*14 free text responses*) were that they worked part time so did not need to do as many (about half). Some did not test as they did not have symptoms (3/14) or because they were not a close contact (1/14).
- Forgetting to take it (32%, compared with 27% last round)
- Having COVID-19 (11%, compared with 18% last round) and not being worried about COVID (11%).

*While the order and exact percentages may change, these three reasons have been the top three across all rounds of the survey – except for not being worried about COVID which tied for 3<sup>rd</sup> place this round.*

### 83% of staff intend to test next week (84% the last three rounds).

- CALD staff were slightly more likely to say they would test next week (88%) compared with non-CALD staff (82%). In previous rounds, CALD staff were 6-11 percentage points more likely to indicate they would test next week than non-CALD staff, except last round where they were similar.

**Figure 12. Reasons for not taking the recommended number of RATs (ECEC only)**



# Staff survey

Of the 4% of staff who tested positive, the proportion who were asymptomatic and not a close contact has stabilised after declining over the last few rounds, and most reported the results to DH and DET

**Last week, 4% of staff across ECEC and schools tested positive (same as last round):**

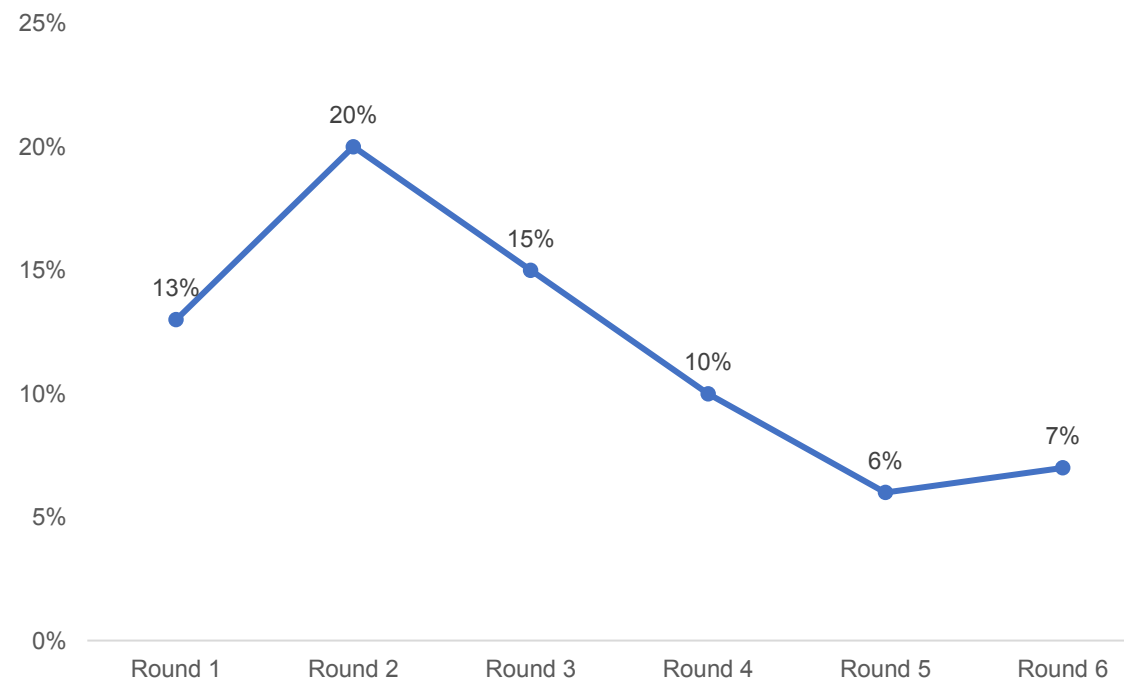
- 2% in ECEC (same as last round), 4% in primary (3% last round), 4% in secondary (3% last round), 0% in combined (3% last round), and 9% in specialist (2% last round).
- 5% of CALD (2% last round) and 3% of non-CALD staff (same as last round) tested positive.\*
- More positive results were reported in rural areas (3%, same as last round) and metro (4%, compared with 2% last round), than in regional areas (0, compared with 1% last round).
- The positivity rate across SEIFA quintiles was 4% in the most advantaged and 2 most disadvantaged quintiles, while it was lower in the middle (2%) and 2<sup>nd</sup> most advantaged (3%) quintiles.

**Of the staff who tested positive, 7% were asymptomatic at the time of testing and not a close contact (6% last round).**

**Of the staff in ECEC settings, all (3/3) said they reported the results to DH via the online self reporting tool (same as last round) while 2/3 reported the results to their employer (compared with 3/4 last round).\***

- All said they isolated for 7 days (same as last round).

**Figure 13. Percent of positive cases that were asymptomatic and not a close contact (all staff)**



\*Note: Given the small sample size of CALD and ECEC positive results (<10), these results should be interpreted with caution.



# Staff survey

## Staff overwhelmingly know what to do and support the program

% Agree or strongly agree	Round 1	Round 2	Round 3	Round 4*	Round 5*	Round 6*
I understood what I needed to do to complete a RAT	98%	97%	97%	97%	98%	<b>99%</b>
I am confident that I completed the RATs correctly	95%	93%	95%	94%	97%	<b>96%</b>
There was enough information available to help me do the RAT	96%	95%	96%	97%	96%	<b>98%</b>
Overall, the RATs are easy to do	94%	94%	95%	94%	96%	<b>97%</b>
I understand what to do if I return a positive or negative RAT result <i>This round all free text responses indicated that respondents knew what to do.</i>	96%	95%	95%	97%	96%	<b>98%</b>
Doing multiple weekly tests will help make schools services safer	88%	86%	85%	87%	89%	<b>86%</b>
Doing multiple weekly tests will help to prevent school service closures	84%	82%	82%	87%	84%	<b>88%</b>
Regular testing will help reduce the spread of COVID-19 in our community	88%	87%	88%	87%	87%	<b>88%</b>
I am happy to participate in the school RAT screening program	87%	88%	89%	84%	78%	<b>84%</b>
I would be able and willing to continue the testing if advised to do so	92%	91%	92%	92%	90%	<b>93%</b>
Testing helped me manage my COVID-19 risk more effectively <i>Reasons for disagree/strongly disagree: others are not testing or showing up symptomatic or not believing RATs are accurate, while other responses indicated they thought testing helped.</i>	80%	80%	81%	82%	85%	<b>82%</b>

\* These rounds only include ECEC responses, whereas previous rounds reflect school staff responses

# Staff survey

## Qualitative snapshot of themes

### **“Do you have any feedback on how the program could be improved” (754 responses)**

- The most common responses were positive, or staff asking that the program be continued.
- However, the next most common responses were that there should be less testing/only symptomatic testing, or more accurate alternatives used (e.g., PCR).
- Some requested more RATs or noted delayed deliveries, while others requested saliva tests.
- A few respondents said testing should be mandatory or monitored, while others said data should be collected on family compliance.

# Principal and Provider survey

Note. Any breakdowns of this by school type or area should be interpreted with caution, given the small sample size. We have presented number of respondents alongside or instead of percentages to convey the fact these breakdowns may not be generalisable.

# Principal and Provider survey

There appears to have been a drop in the number of schools (not ECECs) who received enough RATs last week

**Last week, 87% of schools and ECEC services (111/127 responses) reported receiving enough RATs to allow all staff and children to complete tests (81% last round):**

- 87% primary (27/31), 100% secondary (12/12), 80% combined (4/5), 100% specialist (1/1), and 87% ECEC (61/70)
- 90% Government (36/40), 100% Catholic (5/5), 75% independent (3/4)
- 96% metro (77/80), 74% regional (17/23), 64% rural (9/14)

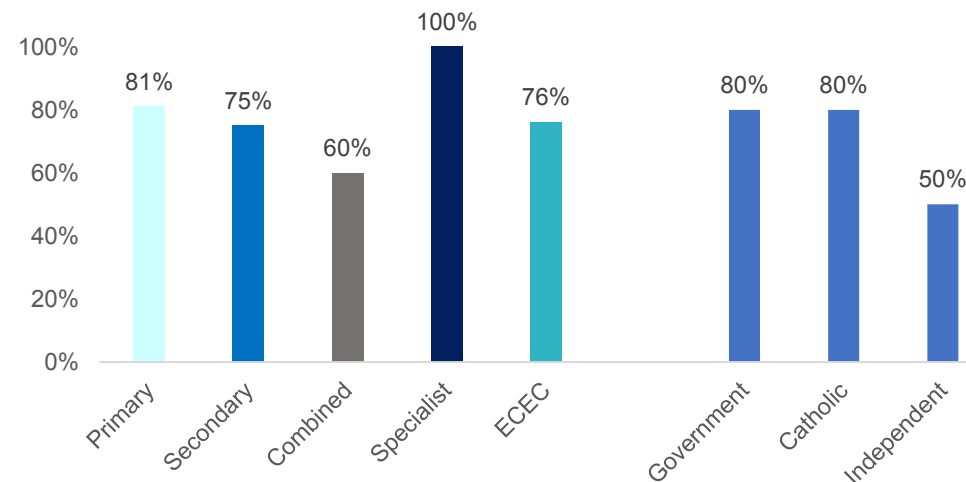
**Last week, 77% of schools and ECEC reported all staff and children getting their RATs, up from 70% last round.**

**Among those who said not everyone received their RATs, the most common issues preventing staff and children from getting their RATs:**

- The school/ECEC service did not receive enough RATs (10/14 respondents)
- The person was away (2/14) or did not collect them (3/14)
- Other (4/14) – most related to delivery issues/lack of stock, while a couple said it was hard or costly to distribute them (e.g., cannot post them out to everyone).

\*Note: Given the small sample size of Independent and Catholic schools (<10), these results should be interpreted with caution.

**Figure 14. Percentage of schools where all staff and students collected their RATs, according to the principal or provider\***



**Note:** Due to small sample sizes for these breakdowns, these results should be seen as indicative only and not fully representative of the actual breakdown by sector/area. We had 133 people fill in parts of the survey, but not everyone answered all questions or provided demographic details, so total N can change for each answer.

Too few respondents reported not everyone getting their RATs, so we cannot provide demographic breakdowns for this question. Responses do not sum to 100% as respondents could select multiple responses.

# Principal and Provider survey

## Information and guidance

What information or guidance (if any) have you used to support successful testing at your school/ECEC? (Select all that apply)	Primary	Secondary	Combined*	Specialist*	ECEC
Provided guidance on how to take a RAT properly	42%	50%	60%	100%	46%
Notified staff/parents/children about program via email or letter	100%	100%	100%	100%	94%
Provided guidance on what to do if you test positive	84%	92%	100%	100%	71%
Forwarded guidance from government on the RAT program to staff/parents/children	81%	83%	80%	100%	74%
Held information sessions for staff/parents/children	6%	0	20%	0	4%
Reminded children during the week to complete a RAT	35%	75%	80%	100%	19%
Other: <i>the modes of disseminating information included notifying parents/children via newsletter, speaking to students in class, speaking to parents directly at the school/ECEC gate or when handing our RATs.</i>	3%	8%	20%	0	7%

Note: Principals and providers could select multiple options. Percentage refers to the % of schools that said they provided that type of information.

\* Results for these sectors should be interpreted with caution as sample size is small (<10 respondents)

# Principal and Provider survey

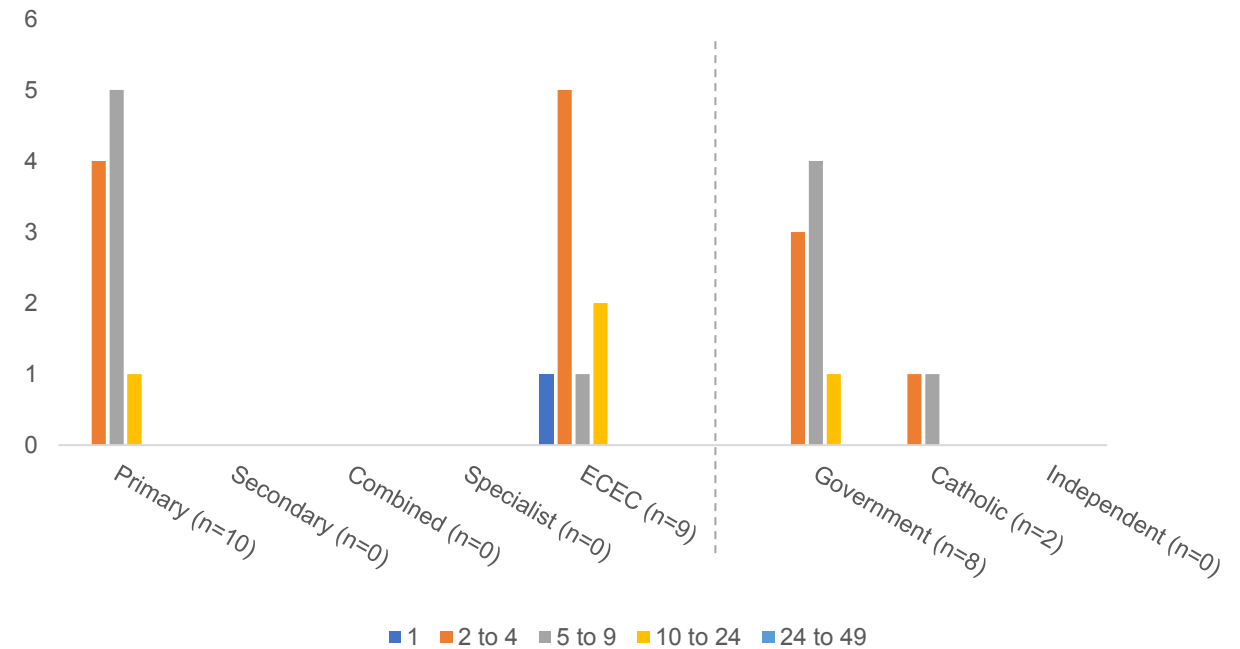
## Complaints

Last week, two ECECs that responded to this question said they received at least one complaint from *staff* about taking RATs (around 2% of respondents). This included 1 ECEC service that received 5-9 complaints from staff, and 1 that received 2-4 complaints.

Conversely, 16% of schools and ECECs (19) received at least one complaint from *parents and children* about taking RATs. Of these:

- 5% received only 1 complaint
- 47% received 2-4 complaints
- 32% received between 5-9 complaints
- 16% received 10-14 complaints

**Figure 15. Number of schools/ECECs reporting parent and child complaints by education setting (number of complaints)**



# Principal and Provider survey

## Attitudes

% Agree or strongly agree	Round 1	Round 2	Round 3	Round 4*	Round 5*	Round 6*
This program was easy to implement at my school/ECEC service	90%	84%	84%	83%	85%	<b>84%</b>
I was satisfied with the guidance I received to support staff and children to test accurately at my school/ECEC service	91%	89%	91%	84%	90%	<b>88%</b>
The communication and support from government to implement the program was helpful	94%	88%	87%	81%	87%	<b>86%</b>
I am confident staff and children are completing the RATs correctly	68%	71%	67%	64%	69%	<b>67%</b>
Testing has helped my school/ECEC service stay open and manage COVID-19	83%	87%	88%	73%	76%	<b>82%</b>
I support the program of testing at my school/ECEC service	94%	90%	93%	90%	90%	<b>94%</b>
This school/ECEC service would be able and willing to continue the testing program if advised to do so	99%	89%	93%	88%	88%	<b>93%</b>

\* These rounds include ECEC and school responses, whereas previous rounds reflect only school responses.

# Principal and Provider survey

## Qualitative snapshot of themes

### **“Were there any other issues regarding the implementation of the program you would like to raise?” (78 responses)**

- Having insufficient stock due to late or staggered arrivals remain the most cited issues.
- Stock arriving after hours (e.g., Saturdays) when staff were not around to collect the delivery is also a common concern.
- Families not collecting them was cited by some as an issue, while others said families were only testing symptomatic children.
- Some also commented on communications problems with DET or wanting more guidance they could also pass onto parents.
- Many principals and providers also mentioned the administrative burden of the program (e.g., time and effort to distribute RATs, or finding somewhere to store them).

### **“Do you have any other feedback on the program that may help us improve it that you would like to share?” (54 responses)**

- Many volunteered positive feedback about the program.
- Improving RAT delivery (timeliness and advance notice)
- Some mentioned that they now have surplus RATs as fewer are collected or used, so they don't need as many delivered.
- One mentioned wanting improved storage in the school/ECEC, and support to distribute RATs.
- Some mentioned wanting strategies to maintain compliance and encourage participation, while others wanted support with communications and public health messaging.



Pages 41 through 45 redacted for the following reasons:

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35(1)(a)

# Behaviours and Attitudes Survey

Survey ran 17-22 March.

Sample of 1,300 Victorians, representative by age and gender with a metro/regional split of respondents and approximately 25% of CALD background, completed online and in English only.

# Initial key themes relevant to Education RAT Screening

## Vaccination

For this round, we asked the questions to parents of two specific age groups within the 5-11 year old cohort. Parent respondents were evenly spread between males and females.

### Children aged 5-7 years old

- Of those yet to be vaccinated (34%), 6% say they will vaccinate their child, 13% are hesitant and 16% say they won't vaccinate their child.
- Safety was the key barrier for parents of 5-7yo children (35%) followed by not knowing whether the COVID-19 vaccine would be effective for their child (16%).

### Children 8-11 years old

- Of those yet to be vaccinated (30%), 7% say they will vaccinate their child, 11% are hesitant and 12% say they won't vaccinate their child.
- For this cohort, 28% of parents were concerned about safety and 18% concerned about efficacy.

## Perceptions of the rules and thinking about COVID

- 52% of respondents believe the rules are about right, with 24% believing the current rules are too strict and the same proportion believing they are too relaxed.
- 45% of respondents said they always or often think about COVID. A further 38% say they sometimes think about COVID, with 18% saying they sometimes or rarely do so.

**Situation:**

Mask wearing requirement remains in place for all workers, visitors and students in Grade 3 to 6 while in indoor spaces of primary schools. The ongoing use of this requirement as Victoria enters Term 2 of the academic calendar has been reviewed, in the overall context of the COVID-19 Response.

**Assessment:**

- Masks are a safe, effective and low-impost public health measure that reduces both the risk of an infectious person transmitting to others and the risk of a susceptible uninfected person from acquiring infection. They have been widely adopted by the Victorian community, including children and will continue to play an important role in the pandemic response.
- Victoria has been experiencing elevated rates of community transmission since 1 December 2021 driven by the Omicron variant of concern. Case numbers have increased in recent weeks with a projected surge expected in mid April, based on the dissemination of the newly emerged BA.2 subvariant, which demonstrates a growth advantage over other Omicron subvariants.
- However, research suggests that the young population including school-age children are at lower risk of experiencing poor health outcomes from COVID-19, even in the case of Omicron. In Victoria between 28 February to 3 April 2022 during Term 1 the 0-19 age group accounted for 34.2% of total cases but constituted a lower proportion of hospitalisations at 14.8%, reassuringly with only 1 case of ICU admission and no deaths.
- At this stage of the pandemic, individuals and organisations are taking increasing responsibilities to promote COVID-safe behaviours and implement protective measures. This has been exemplified in schools through the combined use of:
  - COVID-19 screening program which trialled voluntary rapid antigen (RA) testing to detect cases early cases in students and staff. Recent reporting outlined that of those participating, 5% ECEC and 4% of primary school children tested positive while 3% ECEC and primary school staff tested positive. Survey data suggests relatively high but down trending compliance over time;
  - Improved ventilation through both natural and mechanical processes;
  - School operations guides, updated in consultation with the Department of Health to ensure they contain the most current public health advice;
  - Ongoing use of appropriate public health and social measures, such as hygiene and physical distancing, in line with current Department of Health advice.

**Recommendation:**

- In keeping with changes in public health requirements in other settings of comparable risk and the overall shift in the pandemic response, the use of masks remain important but should be **phased to a recommendation** for school settings. This also is in keeping with current advice on recommended mask use such as when physical distancing cannot be maintained.

- It is also possible for individual education facilities to enforce the use of masks through internal policies as demonstrated in certain secondary schools and should be supported to implement such measures.
- Face masks remain strongly recommended where physical distancing cannot be maintained.

### Background:

- As of 25 February 2022, face mask requirements in lower risk indoor settings were eased in response to reducing community transmission in Victoria, including in secondary schools.
- Secondary school settings were considered lower risk settings at this time, due to the higher vaccination rates of 12–18 year olds, mandatory vaccination requirements for all staff and visitors who attend onsite and implementation of other COVIDSafe measures.
- Under the current *Pandemic Movement and Gathering Order, No. 4*:
  - face coverings must be carried at all times by a person aged 8 years and above, with limited exceptions.
  - face coverings are mandatory for a person aged 8 years and above in the following settings:
    - on public transport, in taxis/rideshare services or in tourism vehicles
    - indoors at an airport and while inside an aircraft
    - while visiting a hospital or care facility
    - indoor space that is a publicly accessible area in a healthcare premises
    - workers, visitors, and students in Grade 3 to 6 in an indoor space at a primary school (including outside school hours services at a primary school)
    - workers and visitors in an indoor space at a childcare or an early childhood service centre
    - workers in an indoor space that is a publicly accessible area of a:
      - court or justice centre
      - retail premises or food and drink premises (including food courts)
      - an event with more than 30,000 patrons in attendance
      - workers performing a resident-facing role in an indoor space at a care facility, including when not interacting with residents
      - workers in an indoor space at a prison, police gaol, remand centre, youth residential centre, youth justice centre or post-sentence facility
      - after being tested for COVID-19 and awaiting results, other than as part of surveillance testing
      - if the person is a diagnosed person, probable case or close contact, and is leaving the premises for a permitted reason.

Pages 50 through 74 redacted for the following reasons:

- 
- 35(1)(a)
- 35(1)(a), 28(1)(d)
- 35(1)(a), 33(1)
- 35(1)(a), 35(1)(b)
- 35(1)(a), 35(1)(b), 33(1)

# COVID-19 Screening in Schools

Report #7  
0-18 years

Week ending 8 May 2022

# Background

The COVID-19 rapid antigen testing (RAT) screening program is in place for staff and students, across schools and early childhood education & care (ECEC) in Victoria. The objectives of the screening program are to detect COVID-19 cases in education settings early through RAT screening to:

1. Minimise transmission in schools and ECEC settings across staff and students to reduce epidemic growth and health system impact.
2. Reduce days of lost learning in school.
3. Protect vulnerable staff and students.

28(1)(d) RAT screening will be monitored, and the public health advice will be reviewed based on epidemiology.

Triggers to review the program include screening being of reduced epidemiological benefit due to reducing community prevalence; reduced community confidence (identified through low compliance); increased concerns of false positive RAT results and children being precluded from school unnecessarily; and RAT supply and/or prioritisation.

As of 18 March, recovered cases do not need to participate in screening or surveillance testing, as per the Quarantine Isolation and Testing Order 2022 (No. 6), which could impact on future compliance statistics.

**The purpose of the evaluation** is to; assess the implementation (RAT distribution, uptake), acceptability and effectiveness (screening yield, case and outbreak trends) of the RAT surveillance program in Victorian education settings in term 1, 2022, to inform decisions for ongoing implementation.

The evaluation involves mixed methods design using programmatic data available from DET, DH epi data, data from a weekly staff and student surveys and focus group discussions targeting priority population groups including culturally and linguistically diverse, indigenous, rural and disability.

The weekly report summarises data from; case notifications to DH and DET and survey respondents.

**Note:**

- **RAT screening commenced in primary and secondary schools on 31 January 2022.**
- **RAT distribution to ECEC locations commenced incrementally from 14 February and scaled to full distribution by 7 March. To enable services and families adequate time to participate in the screening program, ECEC providers, services staff and families have been surveyed from 8 March.**



# Epidemiology Summary

In the past 14 weeks (10 weeks of term 1, two weeks of school holidays and two weeks of term 2) 243,063 cases were reported in children aged 0-18 years (reported to DH).

17,064 case notifications in children were received in the past week (2–8 May, second week of term 2), a 38% increase from the previous week. 82% of cases were identified via Rapid Antigen Test ('probable' cases), of which 83% reported symptoms at the time of testing.

From 2–8 May, 24.4% of all cases were reported in children aged 0-18 years: 0-4 years 5.4%, 5-11 years 9.2%, and 12-18 years 9.8%.

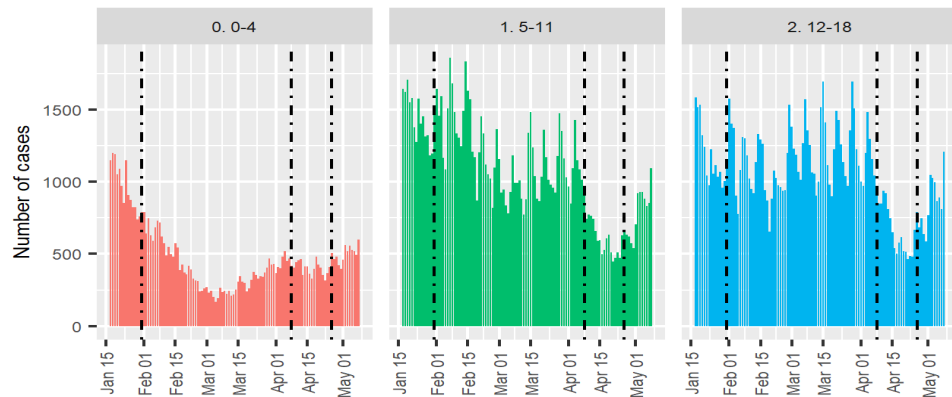
Following a significant decline among child cases over the school holidays, cases in children have increased since the beginning of term 2 (Figure a). However, case numbers in the first 2 weeks of term 2 remained below the weekly average observed in term 1 (19,127 cases per week average).

Cases in adults 19+ years remained relatively stable since the latter part of term 1. Cases in adults increased slightly by 3% during the second week of term 2.

Deviating from trends seen over the school holidays and into the first week of the school term, case notification rates in school aged children (5-18 years) are now, once again, higher than that of the adult population (Figure b). Children aged 12-18 has the highest case rate per population in the past week with a seven-day average of 18.4 per 10,000, followed by the 5–11-year age group (seven-day average of 15.9 per 10,000). Adults aged 19+ had an average case rate of 13.4 per 10,000 over the past week, whilst children aged 0-4 years showed the lowest case rate (seven-day average of 13.4 per 10,000).

From 18 February when the DH RAT notification form asked if the test was part of the education screening program, the median daily proportion of RAT positive cases (0-18 years) indicating the test was part of an education screening program was 41.9% (range 10.5-57.8%) during term 1. The daily proportion indicating the test was part of the program has declined to 39.4% in the second week of term 2 (range 16.3-58.7)

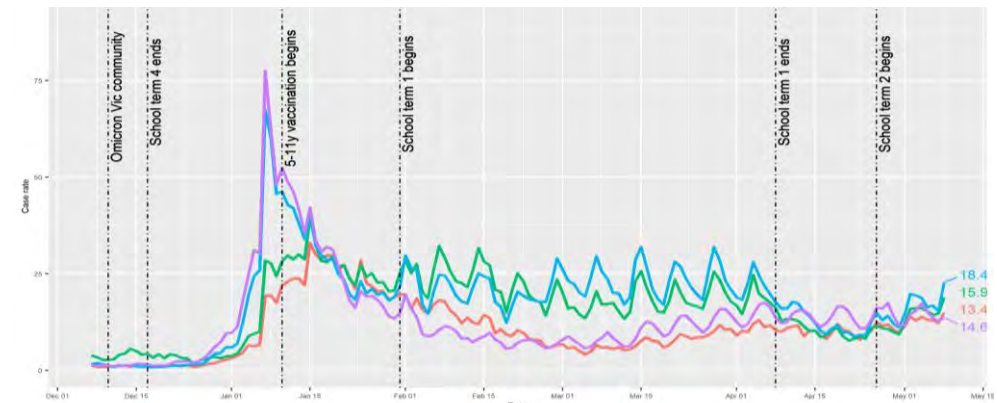
Figure a. Total number of cases in school-aged children by age group



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Assessment Date: December 2022.

Figure b. Case rate per 10,000 population by age group



Exemptions applied (if any):

File Name: Documents for F22-1827.pdf

# Survey Summary

A one-off survey was distributed to schools and ECEC at 9am on 2 May 2022. It was closed at 11am on 9 May and 14,077 responses were received.

**47% of children (surveyed via parents) reported they took the recommended number of tests (2 for ECEC, Primary and Secondary, and 5 for Specialist), with a further 24% taking some, but not all.**

- The reduced compliance may be a result of the survey timeframe which asked about testing in the first week of Term 2, which was a 4-day school week.
- The compliance decreased in all educational setting from the last round of the survey (term 1, week 8).
  - ECEC: 36% compared to 41% last round
  - Primary: 47% compared to 61% last round
  - Secondary: 52% compared to 65% last round
  - Specialist: 28% compared to 31% last round
- The proportion of children who reported taking no RATs increased from the last round; 36% (32% last round) in ECEC, and between 24-29% (16-19% last round) in Primary, Secondary and Specialist schools.
- The most common reasons for not completing the recommended number of RATs were that; the child has/had COVID-19 in the last 12 weeks (30%), parents didn't want to perform frequent RATs on their child (21%), and 'other' (20%, of which the majority related to only testing children when they were symptomatic).
- This round, compliance was higher in CALD households and in metropolitan Melbourne.

Parent responses account for at least 9% of the total sample of school students eligible to be surveyed. Parent responses for ECEC is estimated to be at least 3.5%, which is the number of survey responses as a proportion of all children attending ECECs that were invited to participate in the survey. A response rate <10% (generic benchmark) is generally considered low, however, we are unable to determine the exact percentage of parents who completed the survey after receiving it, as we don't know how many schools or ECEC distributed the survey. The true response rate (surveys completed of those who received the link) is expected to be higher.

The SEIFA quintiles of the survey respondents compared to the general Victorian population showed that survey respondents are more likely to be in the more advantaged groups; 54% of parents with known postcodes were in the top two more advantaged quintiles (compared to around 40% of the general population). However, a disproportionately high number of schools and ECEC in more advantaged postcodes may have been sampled in this survey round, so we are unable to make any concrete observations of SEIFA representativeness.

# DH data

## Case Notifications & Trends

as at 9 May 2022

# Weekly notified cases in children (0-18 years)

Reported to DH by test type (confirmed and probable). Dates are the week ending on a Sunday.

Age group (years)	Test Type	Week (ending Sunday)														Total
		Week 1 6 Feb	Week 2 13 Feb	Week 3 20 Feb	Week 4 27 Feb	Week 5 6 Mar	Week 6 13 Mar	Week 7 20 Mar	Week 8 27 Mar	Week 9 3 Apr	Week 10 10 Apr	School Hols Wk 1 17 Apr	School Hols Wk 2 24 Apr	Week 1 1 May	Week 2 8 May	
0-4	PCR	1785 (37%)	1381 (33%)	1016 (32%)	732 (33%)	454 (29%)	465 (28%)	559 (28%)	696 (29%)	840 (29%)	961 (30%)	863 (31%)	813 (30%)	783 (25%)	908 (24%)	<b>12256 (30%)</b>
	RAT	3086 (63%)	2796 (67%)	2129 (68%)	1516 (67%)	1114 (71%)	1172 (72%)	1452 (72%)	1744 (71%)	2067 (71%)	2224 (70%)	1926 (69%)	1933 (70%)	2356 (75%)	2867 (76%)	<b>28382 (70%)</b>
	<b>Total</b>	<b>4871</b>	<b>4177</b>	<b>3145</b>	<b>2248</b>	<b>1568</b>	<b>1637</b>	<b>2011</b>	<b>2440</b>	<b>2907</b>	<b>3185</b>	<b>2789</b>	<b>2746</b>	<b>3139</b>	<b>3775</b>	<b>40638</b>
5-11	PCR	2469 (25%)	2365 (23%)	2135 (23%)	1853 (23%)	1528 (22%)	1429 (21%)	1448 (18%)	1394 (18%)	1594 (20%)	1457 (20%)	954 (22%)	709 (19%)	773 (18%)	1009 (16%)	<b>21117 (21%)</b>
	RAT	7453 (75%)	8040 (77%)	7353 (77%)	6050 (77%)	5420 (78%)	5281 (79%)	6438 (82%)	6191 (82%)	6336 (80%)	5664 (80%)	3425 (78%)	2947 (81%)	3598 (82%)	5432 (84%)	<b>79628 (79%)</b>
	<b>Total</b>	<b>9922</b>	<b>10405</b>	<b>9488</b>	<b>7903</b>	<b>6948</b>	<b>6710</b>	<b>7886</b>	<b>7585</b>	<b>7930</b>	<b>7121</b>	<b>4379</b>	<b>3656</b>	<b>4371</b>	<b>6441</b>	<b>100745</b>
12-18	PCR	2124 (26%)	1736 (22%)	1588 (22%)	1480 (21%)	1740 (20%)	1812 (22%)	1588 (18%)	1600 (18%)	1681 (19%)	1466 (19%)	1091 (21%)	685 (19%)	795 (16%)	1101 (16%)	<b>20487 (20%)</b>
	RAT	6143 (74%)	6085 (78%)	5645 (78%)	5641 (79%)	6941 (80%)	6393 (78%)	7260 (82%)	7082 (82%)	7029 (81%)	6147 (81%)	4015 (79%)	2971 (81%)	4094 (84%)	5747 (84%)	<b>81193 (80%)</b>
	<b>Total</b>	<b>8267</b>	<b>7821</b>	<b>7233</b>	<b>7121</b>	<b>8681</b>	<b>8205</b>	<b>8848</b>	<b>8682</b>	<b>8710</b>	<b>7613</b>	<b>5106</b>	<b>3656</b>	<b>4889</b>	<b>6848</b>	<b>101680</b>
0-18	PCR	6378 (28%)	5482 (24%)	4739 (24%)	4065 (24%)	3722 (22%)	3706 (22%)	3595 (19%)	3690 (20%)	4115 (21%)	3884 (22%)	2908 (24%)	2207 (22%)	2351 (19%)	3018 (18%)	<b>53860 (22%)</b>
	RAT	16682 (72%)	16921 (76%)	15127 (76%)	13207 (76%)	13475 (78%)	12846 (78%)	15150 (81%)	15017 (80%)	15432 (79%)	14035 (78%)	9366 (76%)	7851 (78%)	10048 (81%)	14046 (82%)	<b>189203 (78%)</b>
	<b>Total</b>	<b>23060</b>	<b>22403</b>	<b>19866</b>	<b>17272</b>	<b>17197</b>	<b>16552</b>	<b>18745</b>	<b>18707</b>	<b>19547</b>	<b>17919</b>	<b>12274</b>	<b>10058</b>	<b>12399</b>	<b>17064</b>	<b>243063</b>

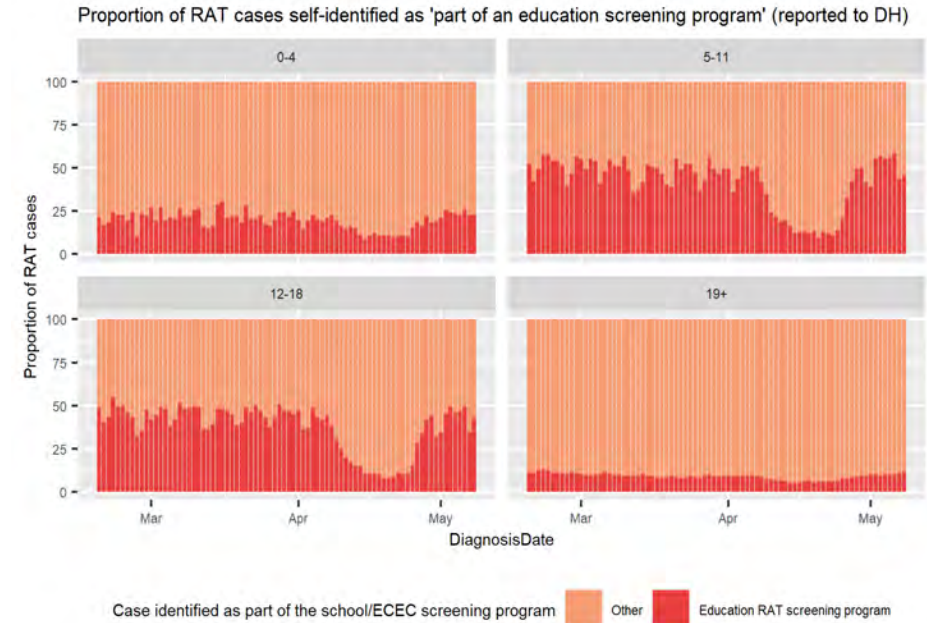
- Since the beginning of term 1 to the end of the second week of term 2 (8 May) 243,063 cases have been reported in children aged 0-18 years (reported to DH).
- In term 1, total cases in children (0-18 years) declined 28% from the first week of term to week 6, but then increased 18% to week 9, before declining slightly from week 9 to 10 by 8%. The school holidays saw a significant decrease in child cases, declining 44% over the from week 10 to week 2 of school holidays.
- Over the 2 weeks since the commencement of term 2, child cases have increased 70% since the end of the school holidays.
- In the second week of term 2, there were 17,064 child cases reported. This remains below the weekly average observed in term 2 (average of 19,127 cases per week).
- Case numbers in each age group have continued to increase since the start of term 2:
  - Cases in the 0-4 age group steadily increased throughout the latter half of term 1 (from week 6-10), before declining over the school holidays. Cases in this age group increased by 20% during the second week of term 2 compared to the first week, with case numbers at the same level recorded in term 1, week 10.
  - After peaking at the beginning of term 1, case numbers in the 5-11 years age group steadily declined before increasing slightly towards the latter end of the term. Since the commencement of term 2, cases have increased by 76%. However, in the second week of term 2, case numbers remained below the weekly average of term 1 for this age group (average of 8,190 cases per week).
  - Whilst cases in secondary aged children (12-18 years) remained fairly consistent throughout term 1, cases declined by 52% over the 2 weeks of school holidays compared to week 10. Since the start of term 2, cases have increased by 87%, but numbers remained below the weekly average reported in term 1 (average of 8,118 cases per week).
- In the most recent reporting week, 82% of all positive cases in children were detected via Rapid Antigen Test (RAT). This is slightly higher than the proportion identified throughout the latter part of term 1.

# Weekly cases notified via Rapid Antigen Tests in children (0-18 years)

Reported by symptoms at testing

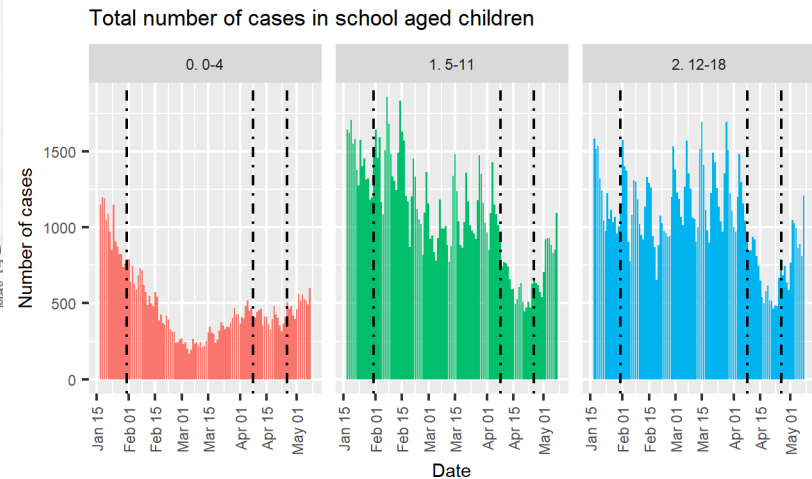
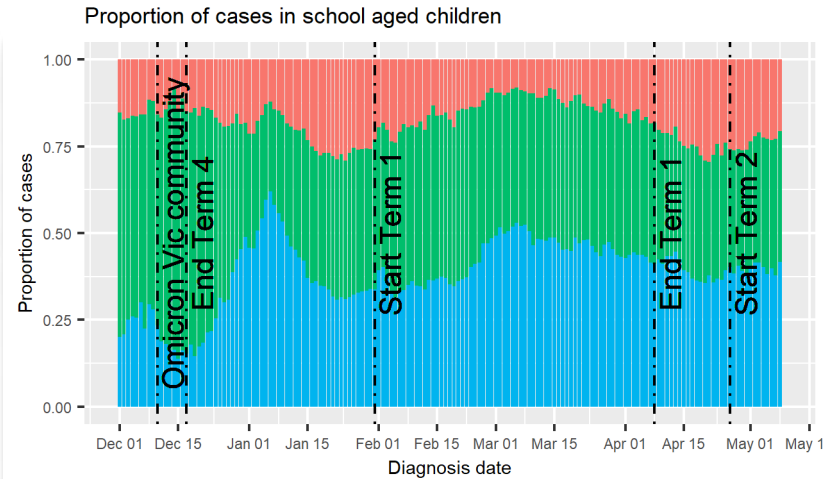
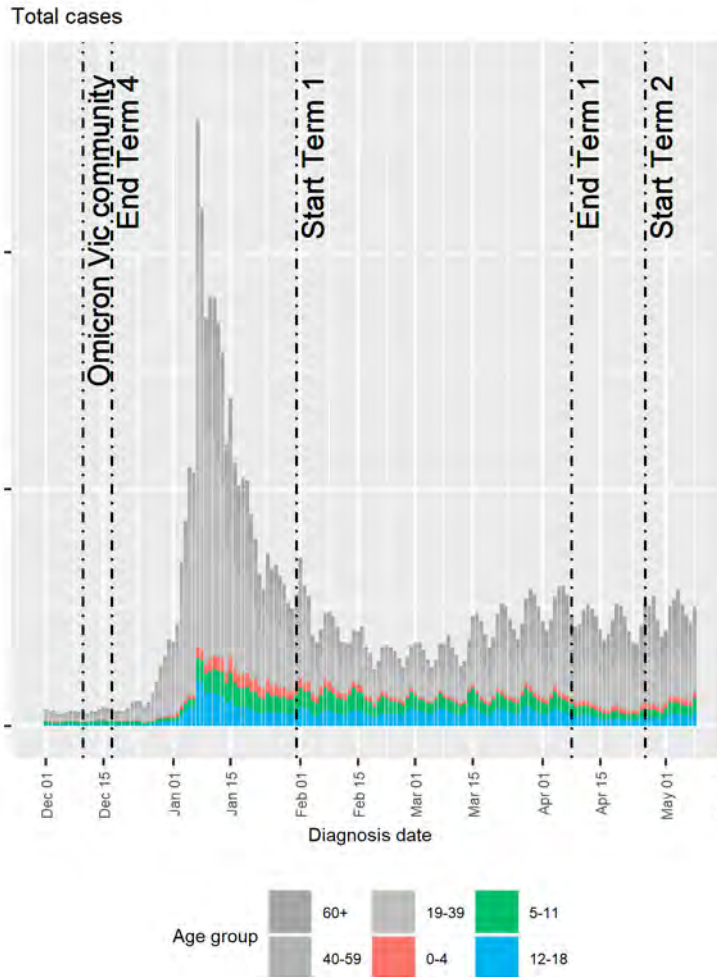
**Weekly probable cases in children by symptomatic or asymptomatic at testing, from term 1 2022. Dates are the week ending on a Sunday. ASX-asymptomatic at testing, SX-symptomatic at testing**

Age	SX at testing	Week 1 6 Feb	Week 2 13 Feb	Week 3 20 Feb	Week 4 27 Feb	Week 5 6 Mar	Week 6 13 Mar	Week 7 20 Mar	Week 8 27 Mar	Week 9 3 Apr	Week 10 10 Apr	Hols Wk 1 17 Apr	Hols Wk 1 24 Apr	Week 1 1 May	Week 2 8 May
0-4	ASX	712 (23%)	623 (22%)	448 (21%)	307 (20%)	261 (23%)	252 (22%)	331 (23%)	355 (20%)	415 (20%)	411 (18%)	343 (18%)	350 (18%)	416 (18%)	474 (17%)
	SX	2374 (77%)	2173 (78%)	1681 (79%)	1209 (80%)	853 (77%)	920 (78%)	1121 (77%)	1389 (80%)	1652 (80%)	1813 (82%)	1583 (82%)	1583 (82%)	1940 (82%)	2393 (83%)
	<b>Total</b>	<b>3086</b>	<b>2796</b>	<b>2129</b>	<b>1516</b>	<b>1114</b>	<b>1172</b>	<b>1452</b>	<b>1744</b>	<b>2067</b>	<b>2224</b>	<b>1926</b>	<b>1933</b>	<b>2356</b>	<b>2867</b>
5-11	ASX	2139 (29%)	1906 (24%)	1593 (22%)	1234 (20%)	1133 (21%)	1038 (20%)	1247 (19%)	1366 (22%)	1451 (23%)	1264 (22%)	660 (19%)	615 (21%)	784 (22%)	1145 (21%)
	SX	5314 (71%)	6134 (76%)	5760 (78%)	4816 (80%)	4287 (79%)	4243 (80%)	5191 (81%)	4825 (78%)	4885 (77%)	4400 (78%)	2765 (81%)	2332 (79%)	2814 (78%)	4287 (79%)
	<b>Total</b>	<b>7453</b>	<b>8040</b>	<b>7353</b>	<b>6050</b>	<b>5420</b>	<b>5281</b>	<b>6438</b>	<b>6191</b>	<b>6336</b>	<b>5664</b>	<b>3425</b>	<b>2947</b>	<b>3598</b>	<b>5432</b>
12-18	ASX	1293 (21%)	1134 (19%)	1032 (18%)	883 (16%)	1126 (16%)	1026 (16%)	1120 (15%)	1136 (16%)	1089 (15%)	929 (15%)	530 (13%)	398 (13%)	587 (14%)	824 (14%)
	SX	4850 (79%)	4951 (81%)	4613 (82%)	4758 (84%)	5815 (84%)	5367 (84%)	6140 (85%)	5946 (84%)	5940 (85%)	5218 (85%)	3485 (87%)	2573 (87%)	3507 (86%)	4923 (86%)
	<b>Total</b>	<b>6143</b>	<b>6085</b>	<b>5645</b>	<b>5641</b>	<b>6941</b>	<b>6393</b>	<b>7260</b>	<b>7082</b>	<b>7029</b>	<b>6147</b>	<b>4015</b>	<b>2971</b>	<b>4094</b>	<b>5747</b>
Total 0-18	ASX	4144 (25%)	3663 (22%)	3073 (20%)	2424 (18%)	2520 (19%)	2316 (18%)	2698 (18%)	2857 (19%)	2955 (19%)	2604 (19%)	1533 (16%)	1363 (17%)	1787 (18%)	2443 (17%)
	SX	12538 (75%)	13258 (78%)	12054 (80%)	10783 (82%)	10955 (81%)	10530 (82%)	12452 (82%)	12160 (81%)	12477 (81%)	11431 (81%)	7833 (84%)	6488 (83%)	8261 (82%)	11603 (83%)
	<b>Total</b>	<b>16682</b>	<b>16921</b>	<b>15127</b>	<b>13207</b>	<b>13475</b>	<b>12846</b>	<b>15150</b>	<b>15017</b>	<b>15432</b>	<b>14035</b>	<b>9366</b>	<b>7851</b>	<b>10048</b>	<b>14046</b>



- From week 3 of term 1, the proportion of child cases reporting symptoms at the time of RA testing remained relatively stable for the rest of term 1, between 80 and 82%. Over the course of the school holidays, the proportion of cases displaying symptoms at the time of RAT diagnosis was slightly higher than the proportion symptomatic at time of RAT testing in any week of term 1 (84% symptomatic in week 1 and 83% in week 2 of the school holidays).
- During the second week of term 2, 83% of all child cases reported symptoms at the time of RAT diagnosis. The proportion of children in each age group reporting symptoms at the time of RA testing remained fairly similar in the second week of term 2 compared to the school holidays and the latter part of term 1.
- From February 18, a question was added to the DH RAT notification form asking: "Did you complete the RAT as part of an education (school or early childhood) screening program?"
  - In term 1 (to Friday 8 April), among school-aged children the median proportion of daily cases indicating the test was part of the education screening program was 50% (range 36–58) in the 5-11 years age group, and 46% (range 32–55) in the 12-18 years age group. Overall, for 0-18 year-olds, a daily median of 42% (range 11–58) of cases reported stated being part of the education screening program.
  - Since term 1 ended, the proportion of RAT cases stating they were completed as part of the education screening program declined.
  - Over the first 2 weeks of term 2, a median of 39% (range 16–59) of daily cases reported being part of the screening program in education settings.

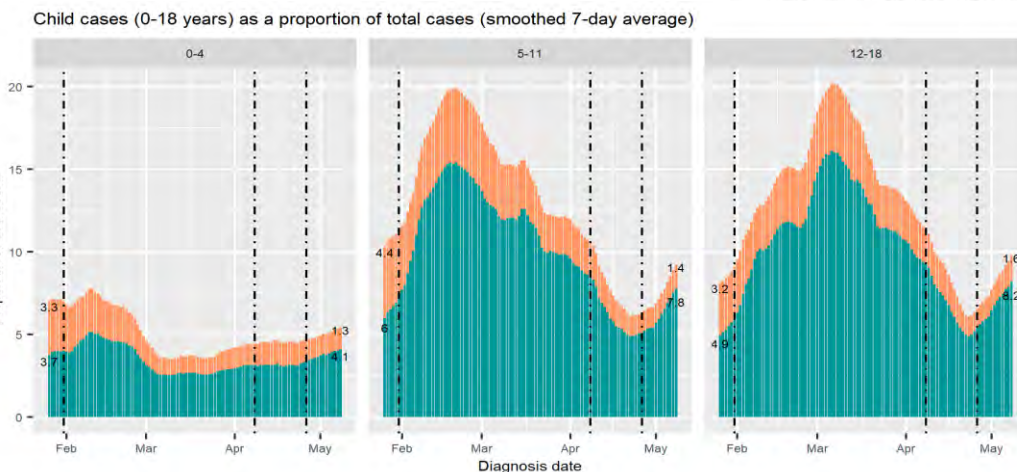
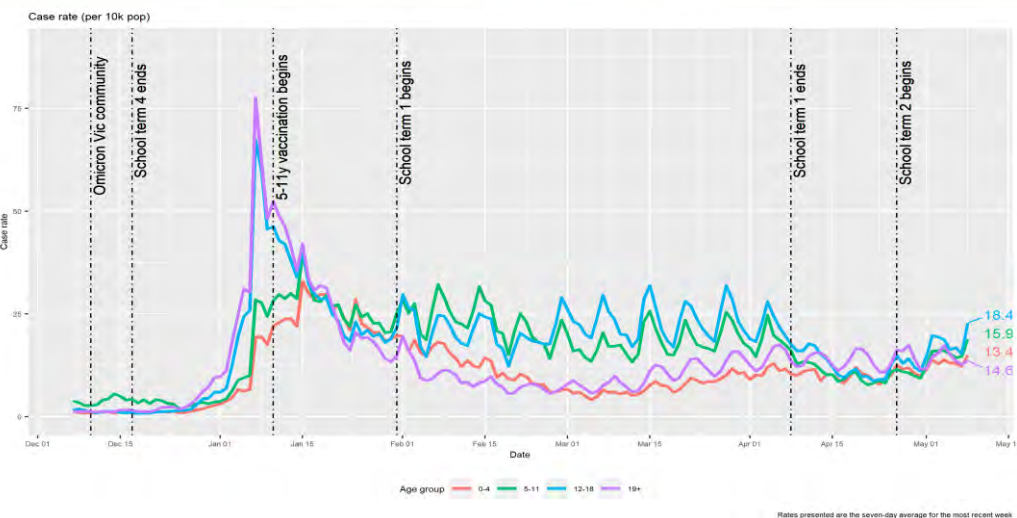
# Daily reported cases in children, by age group



- Cases in school-aged children (5-18 years) declined from the epidemic peak in early January; however, cases declined at a slower rate than in non-school-aged children in term 1.
- With the increasing predominance of the Omicron BA.2 lineage, cases in the general population increased in the latter part of term 1, declined slightly over the school holidays, and have once again increased with the start of term 2.
- In the school holidays, cases in both primary (5-11 years) and secondary (12-18 years) aged children were at the lowest point since early January 2022.
- The commencement of term 2 has seen an increase of cases in all child age groups.
- The 12-18 year age group comprised the largest proportion of child cases throughout the latter half of term 1. This trend has continued into term 2, with 40% of all child cases within this age bracket, however this is still lower than the proportion reported throughout most of term 1. This age group comprises 35% of the child population.
- As reported, cases in 5-11-year-olds declined steadily throughout term 1 since the peak proportion of 48% seen in week 3. Following a further decline in the first week of term 2, the proportion of child cases within this age group has once again increased to 38% in week 2 of this term, but remains lower than the proportion reported throughout all of term 1. These children make up 38% of the child population.
- The proportion of cases in children 0-4 years declined steadily from the start of term 1 to week 5, then consistently increased from week 6 (in line with the full rollout of the RAT screening program in ECEC) to the end of the school holidays. The commencement of term 2 saw a decline in the proportion of cases within this age group, with 22% of all child cases in the second week of term 2 aged 0-4 years. This children make up 27% of the child population. This decrease may be due to the relative increase in older child cases in line with the start of the school term.

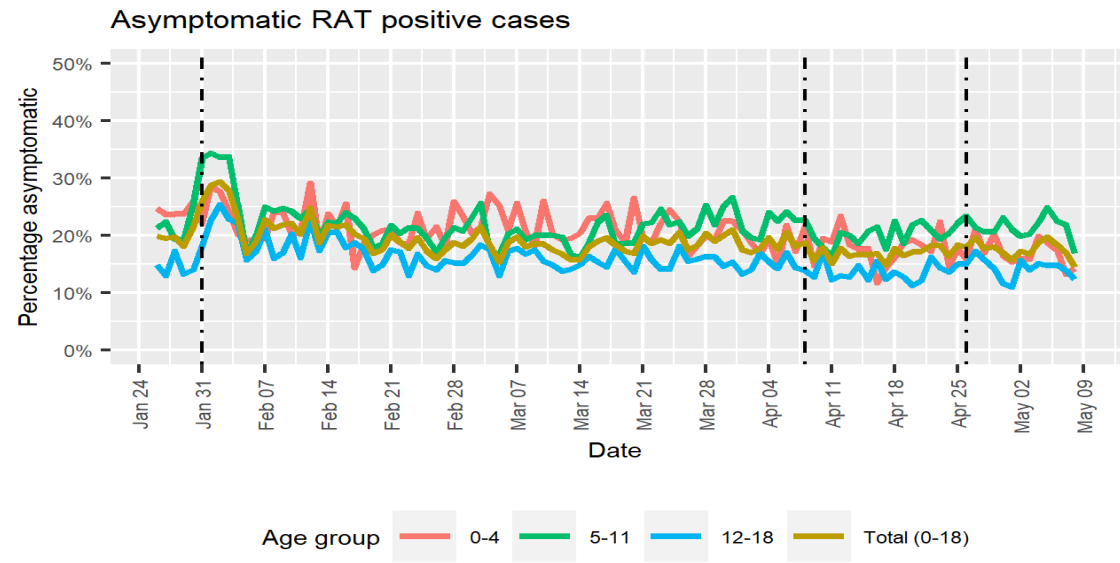
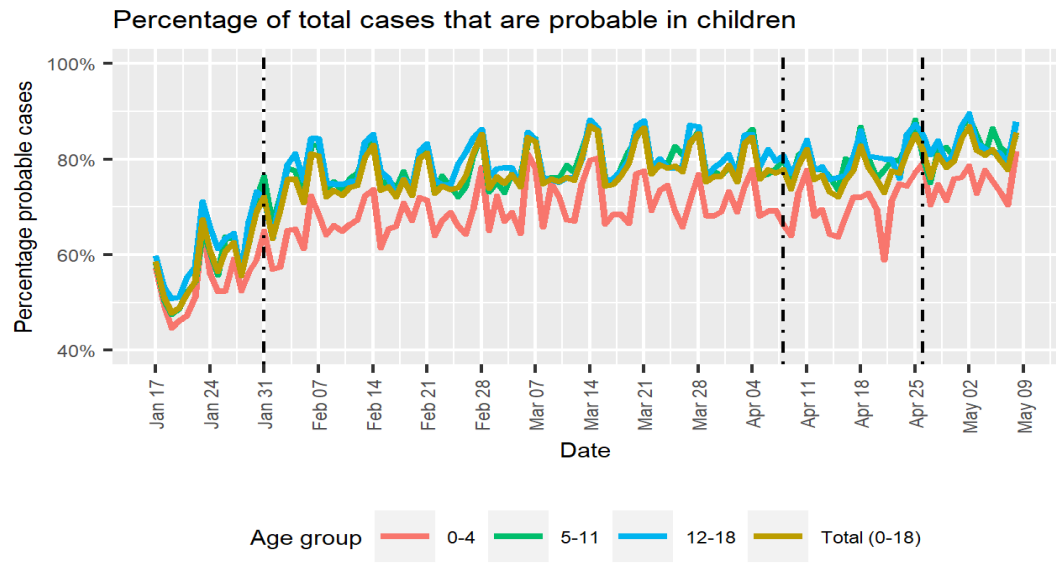
Notes: Total cases, probable and confirmed COVID-19 cases includes age groups 0-4, 5-11, 12-18, 19-39, 40-59, 60+. Includes total cases (confirmed and probable) from 1 Dec 2021 to 15 May 2022. Exemptions applied (if any):

# Case rate (per 10,000 population) by age group



- School-aged children remained a cohort with a higher case rate than the adult population in term 1 however, with the impact of Omicron BA.2, cases in the adult population (and to a lesser extent the under school-aged children) increased since the middle of term 1. Throughout the school holidays and in to the first week of term 2, the case rate in the adult population overtook that of all child age groups.
- With the commencement of term 2, case rates in both primary and secondary aged children have once again increased above that of the adult population aged 19+ (seven day average rate of 14.6% per 10,000). Children in the 12-18 year age group have the highest case rate with a seven day average rate of 18.4 per 10,000 population, which is a similar rate to what was seen in the earlier weeks of term 1, before an increase was observed at week 4. The case rate in the 5-11 year age group has also continued to increase, reaching a seven day average rate of 15.9 per 10,000 population in the second week of term 2. The case rate is lowest in the 0-4 age group (seven day average rate of 13.4 per 10,000).
- The proportion of reported cases that children comprised decreased in term 1 and the school holidays as adult cases increased; however, the start of term 2 saw an increase in the proportion of child cases. 24.4% of the total cases in Victoria in the past week were in children 0-18 years (children comprise 22.5% of the population).
- In the opening weeks of term 1 both the 5-11 and 12-18 years age groups increased as a proportion of total cases. However, in the 5-11 years age group the proportion of cases reported declined from week 4 to the end of the school holidays. The commencement of term 2 saw an increase to a weekly proportion of 9.2% in week 2 (this group comprises 8.6% of the population). In the 12-18 age group, the increase in the proportion of cases reported steepened in week 4 of term 1 before declining from week 6. Similar to the primary aged children, the proportion of cases increased with the start of term 2, to 9.8% (12-18s comprise 7.9% of the population). Conversely, cases in the 0-4 years group declined in the first four weeks of term 1, plateauing for a period, before a steady but minimal increase to 5.4% of cases in the second week of term 2 (these children comprise 6.0% of the population).
- Some considerations:
  - Case detection relative to the general population in children may be elevated during school term time with the return to school and the RAT screening program.
  - There are differences in vaccination coverage: as of 29 April, 59% of 5-11-year-olds have received a first dose, whereas >94% of children over 12 years have had a second dose. 42.6% of 16-18-year-olds have received a third dose.
  - From 25 February, face masks were no longer mandatory in secondary school settings. From the beginning of term 2, face masks were no longer mandatory in ECEC or schools.

# COVID-19 cases in children by RAT detection



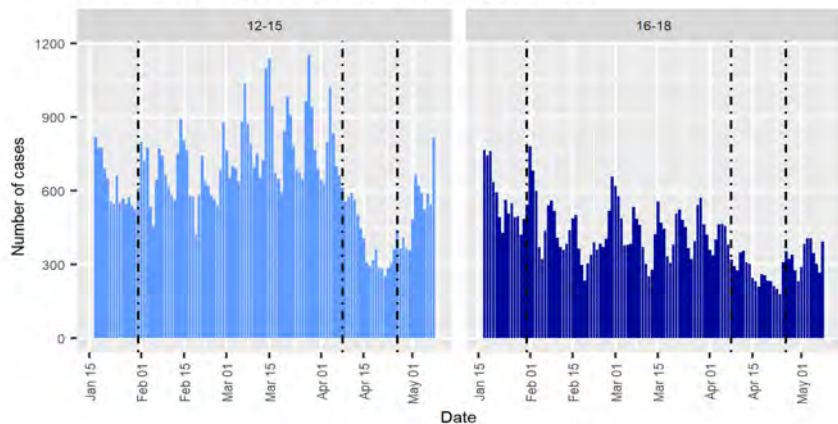
- The percentage of cases that were identified via RAT (probable cases) increased with the commencement of the screening program in the first week of term, and has remained consistent across the subsequent weeks; between 70% and 85% of daily reported cases in school-aged children were identified via RAT. Children aged 0-4 years have had a consistently lower proportion of cases identified by RAT than older children. ECEC students joined the screening program later than school students; however, this group continued to maintain a lower proportion of cases identified via RAT even after the screening program commenced. This is possibly owing to a smaller proportion of this age group having access to RATs or are recommended to seek PCR testing due to age (RATs are not recommended to those aged <2 years and not all 2-4 year-olds attend ECEC settings).
- The proportion of cases identified by RAT displays a cyclical weekly pattern with the highest proportions of reported tests being RATs on Sunday and Monday. This likely reflects the strategy of the RAT screening program in schools where schools recommended one test taken at the beginning of the week and the other mid-week, or as necessary. Despite school holidays commencing on 9 April, this cyclical pattern can still be observed over duration of the 2 week holiday period
- The proportion of cases identified by RAT that were asymptomatic at testing has remained fairly consistent across term 1 and across age groups, with approximately 20% of cases reporting no symptoms at testing. This number declined slightly to approximately 17.5% over the school holidays, and remained stable into the first 2 weeks of term 2

Notes: Dates from 17 Jan 2022 to 7 weeks before term 1 began to report on date. Includes ages 0-18. Symptomatic and asymptomatic cases data included from 26 Jan onward because prior to this date, the sample population of this field was not complete. For ASSH Summary Data Page 8 of 15. Accessed Date: December 2022. Exemptions applied if any.

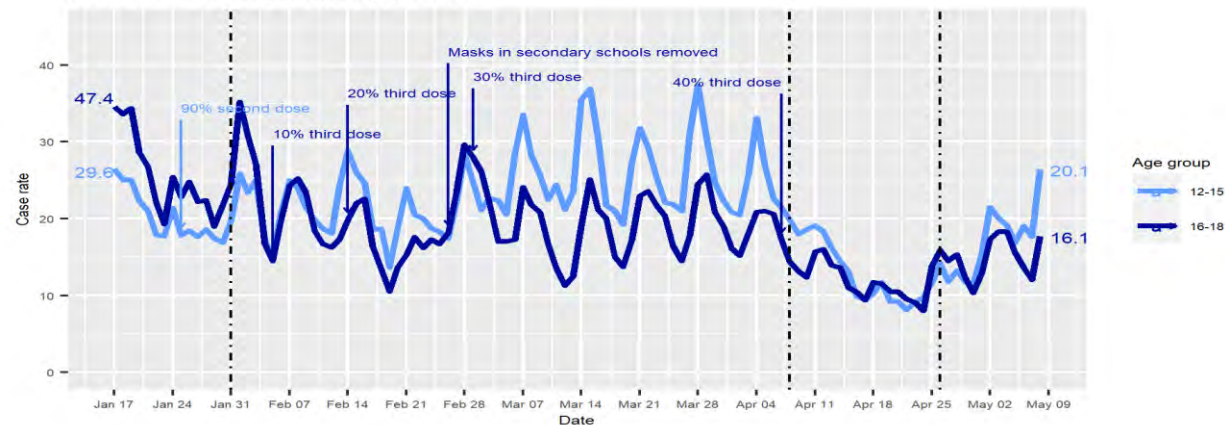


# COVID-19 cases in 12–18 year-olds

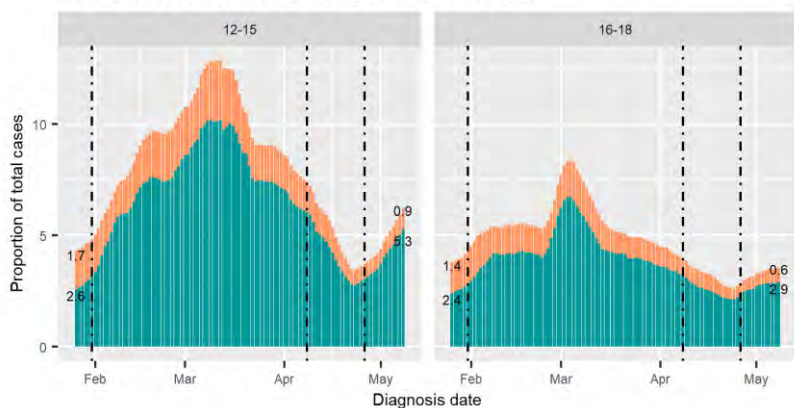
Total number of cases in secondary school aged children



Case notification rate (per 10,000 population)



Child cases (12-18 years) as a proportion of total cases

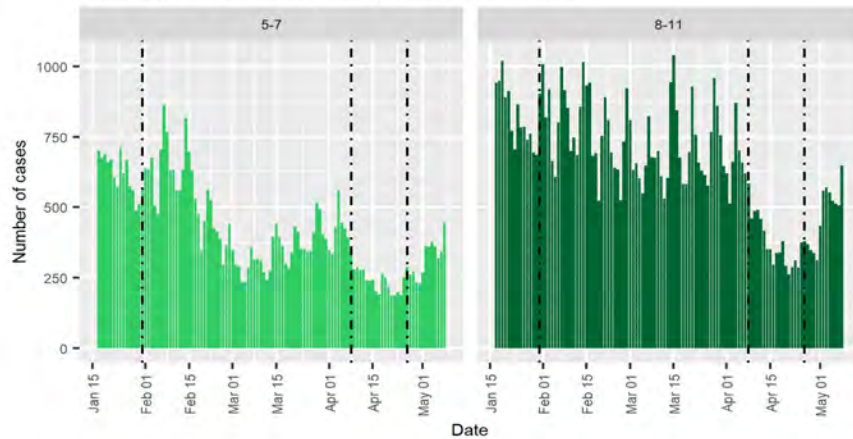


Test type ■ PCR ■ Rapid Antigen Test

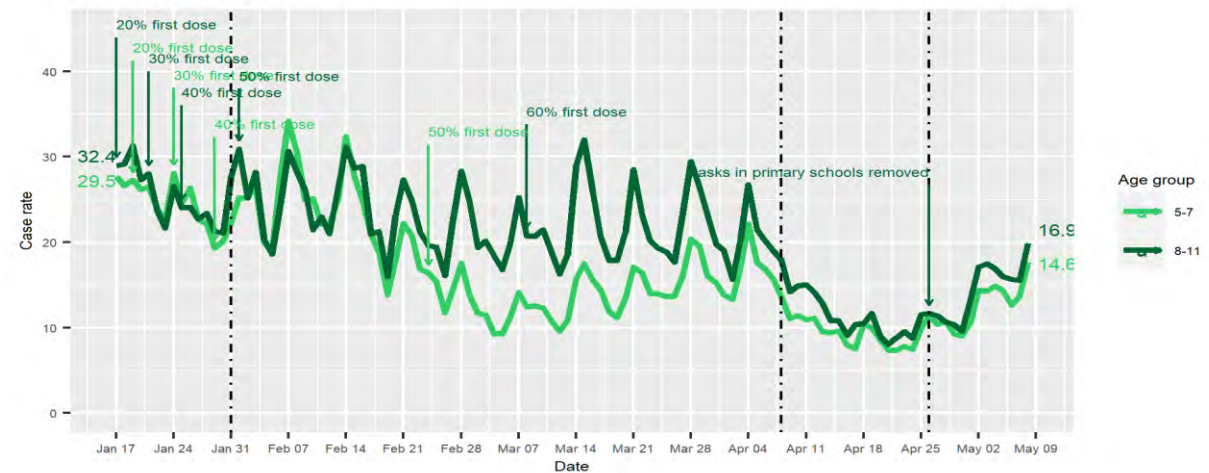
- Total cases in the 12-15 years sub-group increased across term 1 and were reported at higher rates than the 16-18 population.
- Although cases aged 12-15 increased across term 1, their population share decreased in the latter weeks of the term as cases in the general population started to increase. The school holidays saw a rapid decline in cases in lower secondary school-aged children, followed by a significant increase with the commencement of term 2. This age group comprised 6.2% of total cases in the previous reporting week (4.6% of the population are in this group).
- Following a peak in weeks 4/5 of term 1, cases in adolescents aged 16-18 years gradually declined over the remainder of the term and throughout the school holidays. The start of term 2 saw an increase in the proportion of cases, with 3.5% of all cases reported last week within this age bracket (3.3% of the population).
- For the majority of term 1, the 12-15 years age group had a higher case rate per population than the 16-18 age group. In the school holidays the rates became similar (especially in the second week). From the start of term 2, the case notification rate in both the 12-15 year and 16-18 year sub-groups has increased.
- Some additional considerations:
  - Masks were no longer mandatory from week 5 of term 1 in secondary schools.
  - 16-18 year-olds are eligible for a third dose vaccination (42.6% triple vaccinated)
  - There may be differences in social interactions and mixing patterns, therefore differing transmission risk between these groups

# COVID-19 cases in 5–11 year-olds

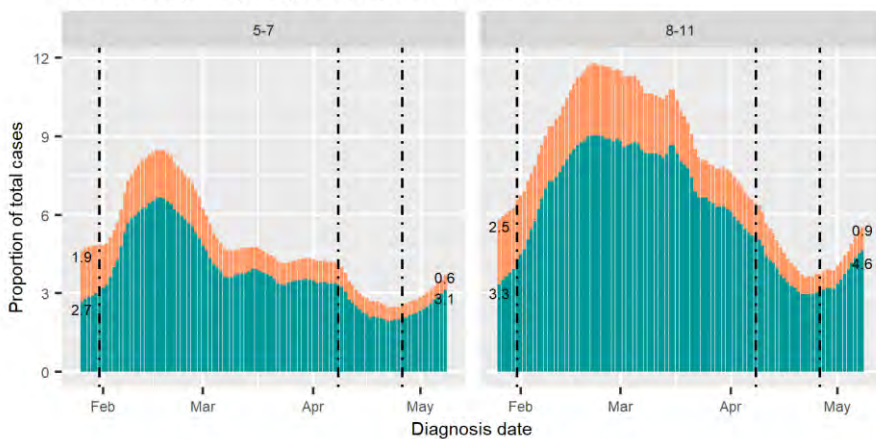
Total number of cases in primary school aged children



Case rate (per 10k pop)



Child cases (5-11 years) as a proportion of total cases



Test type ■ PCR ■ Rapid Antigen Test

- Cases in children in lower primary school (5-7 years) declined from the third week of term 1 but increased in the last five weeks of term. Cases in 8-11-year-olds in upper primary school remained more consistent across term 1. The school holidays saw a step decline in cases in all primary school aged children to similar rates per population, but a significant increase has been observed in the first 2 weeks of term 2.
- As a proportion of total cases in Victoria, the 5-7 years age group increased to week 3 of term 1 but has since declined to 3.7% of total cases in the last reporting week (these children comprise 3.8% of the population). The 8-11 years age group also increased as a proportion of total cases in the first 3 weeks of term 1 but decreased more steadily than in the younger ages. Following the start of term 2, 5.5% of all cases were aged 8-11 years (these children comprise 4.9% of the population).
- Some additional considerations:
  - The timing of vaccination milestones in primary aged children are similar between the subgroups, apart from the longer time to 50% vaccination coverage in 5-7 years age group. As of 7 May 2022 (week 2 of term 2), 54.7% of 5-7-year-olds and 62.7% of 8-11-year-olds have received their first dose.
  - Face masks remained mandatory indoors for students in grade 3 to 6 (~8-11 years) and in staff in schools and ECEC in term 1 (some exceptions). From the first day of term 2, face masks were no longer mandatory in schools/ECEC settings.

# Term 1 2022 Overview

## Summary

In the ten weeks of term 1 2022 (Monday 31 January to Friday 8 April), 187,226 cases were reported (to DH) in children aged 0-18 years. Children were overrepresented as a proportion of total cases in Victoria in term 1: despite comprising 22.5% of the Victorian population, 34% of the total cases reported in this period were in children 0-18 years (29% in school-aged children 5-18 years).

## Case trends

From the epidemic peak in early January, cases in children continued to decline as school resumed; however, cases declined in school-aged children at a slower rate than adults and non-school-aged children. Across the entire term, the week with the highest case notifications aged 0-18 years was week 1 (n=23,060), followed by week 2 (n=22,403). The lowest number of weekly case notifications was in week 6 (n=16,553).

From the highest notifications in the first week of term to the lowest in the sixth, cases in children declined 28%. Whilst cases declined, the proportion of the total cases that school-aged children comprised increased in the opening weeks of term as cases in adults and non-school-aged children continued to decrease at faster rates. In this period the highest case notification rate per population age group as observed in the primary aged cohort (5-11 years) until week 4 when secondary aged children (12-18 years) became the group with the highest case rate, a trend which remained for the rest of term.

As total cases in Victoria declined, pandemic restrictions were further loosened. The mask mandate for most settings was removed from 11:59pm 25 February (from week 5 of term), including for secondary schools (masks in Grades 3-6 students and primary school/ECEC staff remained mandatory for the rest of term).

From the lowest weekly case notification in week 6, cases in children began to increase (an 18% case increase to week 9, n=19,556 cases). This coincided with the increasing prevalence of the Omicron BA.2 lineage and a case increase in the general population. However, as the case increase in children was smaller in comparison to the adult population, the share of total case that children comprised continued to decline in the latter period of term 1.

In the final week of term 1, cases declined 8% from week 9 to 10 (n=17,921 in week 10). By the end of term 1, the weekly case notification rates in adults, and to a lesser extent 0-4-year-olds, had increased to levels close to school-aged children.

## Vaccination

By the end of term 1 58.3% of 5-11 year-olds had received a first vaccination, and 34.3% had received two doses. Over 95% of children aged 12-18 had received a second vaccine dose by the end of term 1, and 40.3% of those aged 16-18 who were eligible for a third dose had received theirs by the end of term.

# April school holidays 2022 Overview

## Summary

In the two weeks of April school holidays (9 to 25 April), 28107 cases were reported (to DH) in children aged 0-18 years. Children were no longer overrepresented as a proportion of total cases in Victoria in this period with 19% of the total cases reported in the school holidays being children 0-18 years (children comprise 22.6% of the Victorian population).

## Case trends

From the last week of school term 1 to the first week of the holidays, cases in children declined 31%. Whilst cases in school-aged children declined significantly (29% in children 5-11 years and 33% in those aged 12-18 years), cases in children 0-4 years declined only 12%.

In the second week of the holidays, cases further declined 17% from the first week. Across these two weeks the number of cases in non-school-aged children (0-4 years) did not change whilst in children 5-11 years cases further declined 16% and in children 12-18 years cases declined an additional 28%. The second week of the school holidays saw the lowest reported weekly case numbers since school resumed in 2022 with 10,182 cases reported. For primary and secondary school-aged children, cases in these age groups were the lowest reported since school began; however, children 0-4 years had reported lower weekly case numbers in weeks 5, 6, and 7 in term 1.

In the school holidays the case notification rate in adults (19+ years) overtook that of the rates observed in school-aged children age groups for the first time since mid-January. Notification rates were considerably more similar in the school holidays than they had been for most of term 1. In all child age groups, the rates were very similar, especially in the second week of the holidays, contrasting what was observed in school term 1.

The RAT screening program in education settings during school term may have impacted case ascertainment; this may mean the term 1 period (where twice-weekly RAT testing was recommended) may not be directly comparable to the school holiday period.

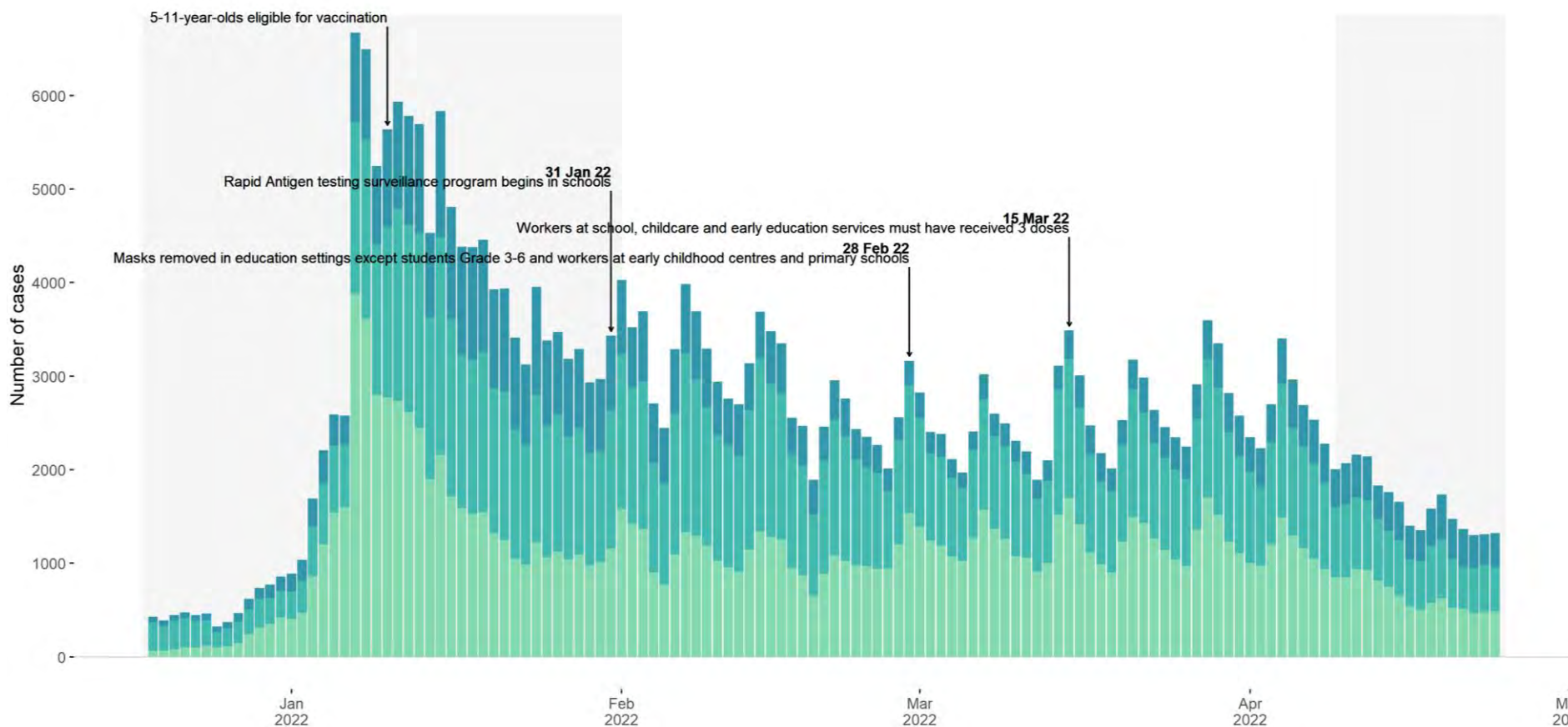
## Vaccination

Vaccination coverage increased marginally from the end of term 1 to the end of the school holidays. By the end of the April holidays, 59% of 5-11 year-olds had received a first vaccination, and 39.7% had received two doses. Over 95% of children aged 12-18 had received a second vaccine dose by the end of the holidays, and 42.6% of those aged 16-18 who were eligible for a third dose had received theirs by this time.

# Term 1 and school holidays 2022 Overview

**Daily reported cases in children (by age group) from the 2021/22 summer holidays to the end of April school holidays 2022 (18 December 2021 to 25 April 2022).**

Shaded grey periods are school holidays. Significant public health changes for this population are noted on the figure.



Cases in children declined at the start of term 1 but increased from mid-term in each age-group (0-4, 5-11, 12-18 years), coinciding with the increase in cases in the general population as part of the Omicron BA.2 surge.

In the school holidays, cases considerably declined to the lowest reports since December 2021.

In children:

- The majority of cases are detected via RAT (77% in term 1, 78% in April holidays).
- The majority of cases detected by RAT were symptomatic at testing (80% in term 1, 83% in April holidays).

# Survey Analysis

## Parents & Guardians

Results: 2-9 May 2022

# Survey sample and response – Term 2



## Parents

**14,077 responses**

**(3,721 ECEC, 9,703 primary, 5,334 secondary, 631 specialist)\***

### Demographics:

- These responses account for at least 9% of the total sample of school students eligible to be surveyed compared to 6% last round, and 3.5% of ECEC enrolments (4% last round).
- 157 (1%) identify as Aboriginal and/or Torres Strait Islander.
- 45% CALD and 55% not-CALD (this is a measure of non-English speaking country of birth or English not spoken at home - 83% said main language spoke at home was English).
- 58% metro, 3% cities and major regional centres (regional), 20% other regional areas (rural), and 20% didn't give postcode.
- 6% most disadvantaged quintile, 8% 2nd most, 13% middle, 22% 2nd most advantaged, and 32% most advantaged (again 20% didn't give postcode).

- Survey released 9am 2 May, results taken as at 11am 9 May
- Government/non-Government and ECEC/primary/secondary/combined/specialist schools
- 900 schools and 897 ECEC providers (1966 ECEC services in total) sampled this round, chosen randomly from the total population.

\* Split of respondents may not add to 100% as answering this demographic question was not compulsory, and parents/staff could select more than one educational setting.  
Note: We have not calculated completion rate for this round.

# Parent and guardian survey

The proportion of children who take the recommended number of RATs has declined since Term 1, with just under half now taking the recommended number of RATs.

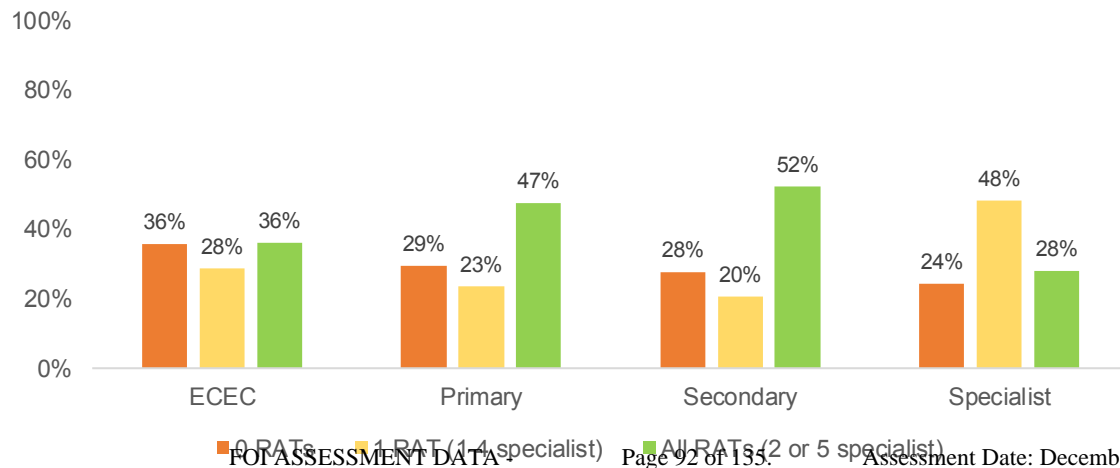
Last week, **47% of children took the recommended number of tests** (2 for ECEC, Primary and Secondary, and 5 for Specialist), compared with 60% at the end of Term 1.

- A further 24% took some but not the recommended amount (21% at the end of Term 1).
- The proportion of children who reported taking no RATs increased from the last round; 36% (32% last round) in ECEC, 29% (19% last round) in Primary, 28% (16% last round) in Secondary and 24% (18% last round) in Specialist schools.

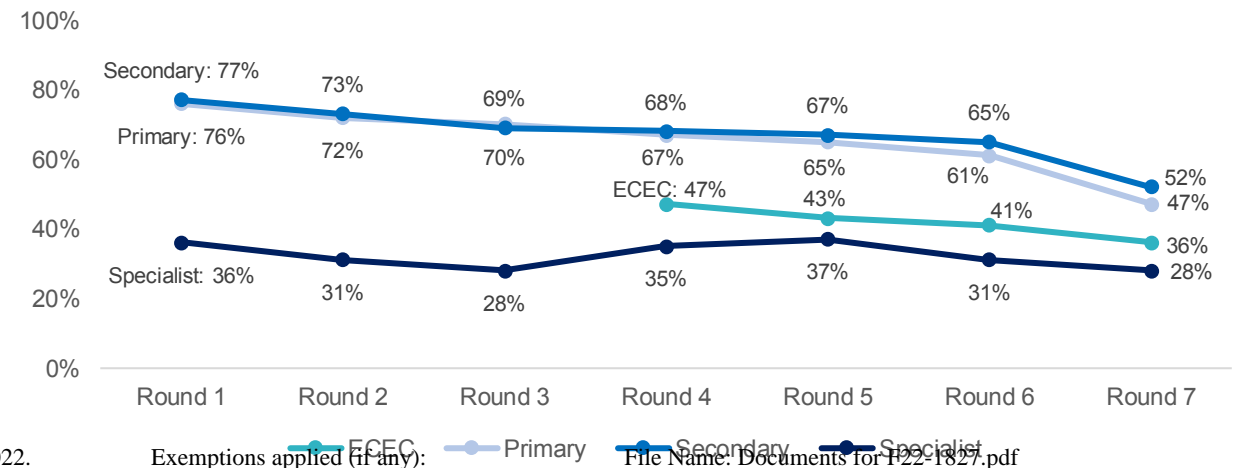
49% of households reported that all their children took the recommended number of tests:

- 59% of CALD households (70% last round), 40% of non-CALD households (53% last round) took all recommended tests.
- 46% of households in metropolitan Melbourne (59% last round), 35% for regional (53% last round), 42% for rural households (50% last round). 64% of those who did not give a postcode took the recommended number of RATs.
- Those in the most advantaged quintile (43%) were slightly less likely to take all their tests compared with other quintiles, while those in the least advantaged quintile were most likely to take all the recommended number of tests (50%). The other quintiles were 45-47%

**Figure 1. Number of tests taken per child last week, by educational setting**



**Figure 2. Number of children who did all recommended tests each week, by educational setting**





# Parent and guardian survey

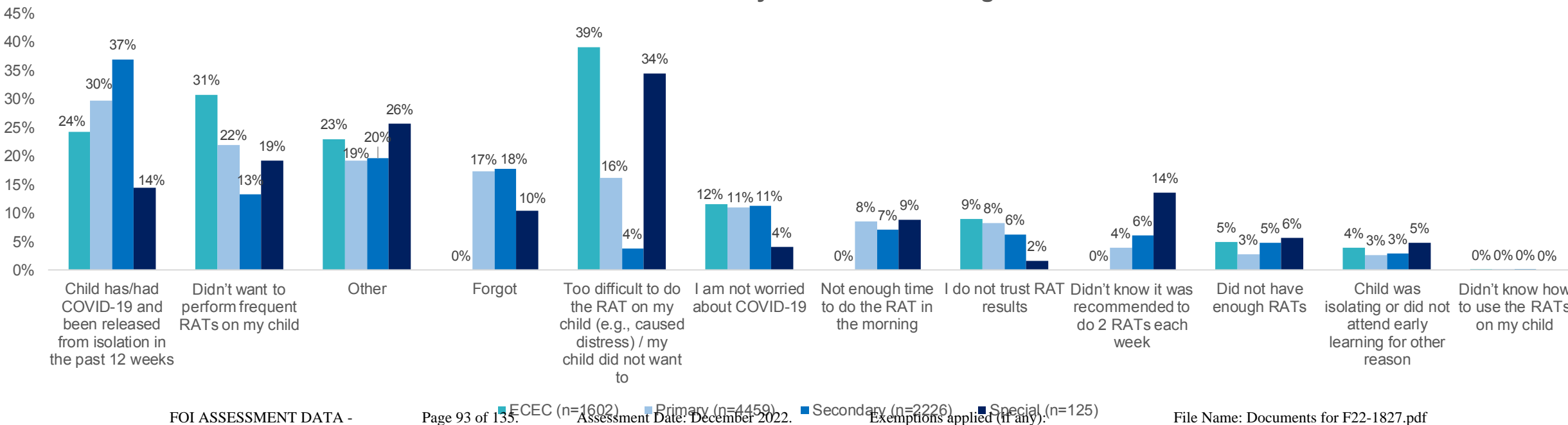
Their child having/had COVID-19 was the most common reason why the recommended number of RATs were not taken (30%) followed by not wanting to perform frequent RATs on their child (21%)

Overall, among ECEC and school parents the most common reasons why the recommended number of RATs were not taken were:

- Child has/had COVID-19 and been released from isolation in the past 12 weeks (30%, not previously in the top three reasons in Term 1 surveys).
- Didn't want to perform frequent RATs on their child (21%, compared to 35% last round),
- 'Other' responses (20%, compared with 26% last round).

**One of the most common 'other' responses from this round (1686 responses) was that they didn't test their child as they were not showing symptoms.** Others reported that they didn't have RATs to test or that they preferred saliva tests, with some saying doing nasal swabs frequently gives their child a bloody nose. Due to the timing of this survey, many also said they didn't do all the tests as it overlapped with school holidays, or their child attends ECEC part time.

**Figure 3. Reasons for not taking recommended number of RATs by educational setting**



# Mask wearing in schools

Survey of parents/guardians of Primary and Secondary school children to assess the uptake of the recommendation to wear face masks in schools and identify barriers and enablers

Report #1

27 July 2022

**OFFICIAL**

# Background and study design

Face masks were recommended to be worn by Victorian children aged eight and over when at school from Monday 18 July 2022 in a joint statement by the Department of Education and Training (DET), Independent Schools Victoria, and the Catholic Education Commission of Victoria.

**Objective:** To assess the uptake of the recommendation to wear face masks in Victorian school children and identify barriers and enablers to inform policy and implementation.

**Methods:** A survey was sent to an indicative sample of Victorian schools (N=250) including government, catholic and independent primary, secondary and specialist schools. Schools from areas with high levels of students from CALD backgrounds and lower SEIFA indexes (more disadvantaged) were oversampled. The survey was distributed to school principals/providers to send on to parents/guardians of enrolled students from 11:18am on Tuesday 19 July 2022. The survey was available in English and six other languages (Chinese, Vietnamese, Arabic, Persian, Dari, and Turkish).

**Evaluation:** Survey responses of parents/guardians on mask wearing attitudes and behaviours of themselves and students in a sample of Victorian schools were collected and analysed. The study period includes 11:18am Tuesday 19 July to 11:59pm Sunday 24 July 2022. Some responses were 'incomplete' at the cut-off time; however, responses that had filled in the main data collection section were included in the final dataset. Results were stratified by school type, socio-economic status, culturally and linguistically diverse (CALD) status, and metropolitan v regional location. All meaningful differences (statistically significant) observed between strata are presented in the report.

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# Summary

**Survey of 250 schools from July 19-24, 2022:** Response rate 7-14%

- 7,889 responses: 3,286 Primary P-2 (42%), 4,632 Primary 3-6 (59%), 3,617 Secondary (46%), 242 Specialist (3.1%)

**26% of respondents asked their child/ren to wear a mask when at school (29% of those Grade 3 and above for whom masks are strongly recommended).**

- Parents/guardians who were from culturally and linguistically diverse (CALD) backgrounds or from metropolitan areas were more likely to have asked their child/ren to wear masks when at school.

The most common reasons parents/guardians asked their child/ren to wear a mask at school were 'masks are effective at preventing child/ren from contracting COVID' (78%), 'wearing a mask is a small inconvenience for a large benefit' (71%), and 'everyone in schools should be wearing masks to stop the spread of COVID' (63%).

The most common reasons parents/guardians did not ask their children to wear a mask at school were 'masks interfere with school activities such as learning (65%), 'masks are uncomfortable and students shouldn't have to wear them' (61%), and 'my child doesn't want to wear a mask' (55%).

**Overall, 70% of respondents selected that, to the best of their knowledge, their child did not wear a mask when at school (66% of students in Grade 3 and above), noting that most respondents did not ask their child/ren to.** However, of students who were asked by their parent/guardian to wear a mask at school, respondents reported that most (53%) wore a mask every day, with a further 21% wearing a mask some days a week.

- Both CALD and metropolitan parents/guardians were more likely to report that their child wears a mask at school.

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# Survey sample and responses

## Sample

250 schools; 114,151 enrolments

- Sector: 184 Government (74.6%), 44 Catholic (17.6%), 22 Independent (8.8%)
- Type: 166 Primary (66%), 39 Secondary (14%), 29 Combined (12%), 19 Specialist (8%)

## Responses

7,889 responses\*: 3,286 Primary P-2 (42%), 4,632 Primary 3-6 (59%), 3,617 Secondary (46%), 242 Specialist (3.1%)

\*Parents/guardians could respond for more than one school type if they have children in multiple categories (3,579 – 45% – responded for >1 type)

Total children responded for\*^: 15,828 (3,822 Primary P-2 (24%), 6,363 Primary 3-6 (40%), 5,381 Secondary (34%), 262 Specialist (1.6%)

^Responses that reported >8 children per school type per household were considered implausible; responses were kept for 1 child (median per school type)

Response rate# = 7% – 14%

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# Response rate methodology is described in the Appendix

# Demographics of parent/guardian respondents

## Demographics of parent/guardian respondents

*These questions were optional*

- 1.8% Indigenous (8.7% did not respond; 3.4% 'prefer not to respond')
- 12% CALD i.e. language spoken at home not English (16% did not respond)
  - The most common languages spoken at home after English were 'Other' (4.8% of respondents), Mandarin (1.6%), Hindi (0.5%), Punjabi (0.5%), Tagalog (0.5%), Urdu (0.5%), Arabic (0.5%), and Vietnamese (0.5%).
- 62% of respondents stated all parents/guardians were born in Australia only (both if two parent/guardian household or one if single parent/guardian household), 14% of respondents stated all parents/guardians were born overseas only (both if two parent/guardian household or one if single parent/guardian household), and 12% of parents/guardians of two parent/guardian households stated one parent/guardian was in each of overseas and Australia. (12% did not respond)
- 59% metropolitan, 25% regional/rural (15% did not provide postcode)
- Socio-economic status (Index of Relative Socio-economic Advantage and Disadvantage; IRSAD): fewer responses were collected in lower IRSAD quintiles (those more disadvantaged)

IRSAD quintile	1 (Most disadvantaged)	2	3	4	5 (Least disadvantaged)	NA / postcode not provided
<b>N (%)</b>	657 (8.3%)	970 (12%)	1,512 (19%)	1,977 (25%)	1,568 (20%)	1,205 (15%)

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# Most parents/guardians did not ask their child/ren to wear a mask when at school

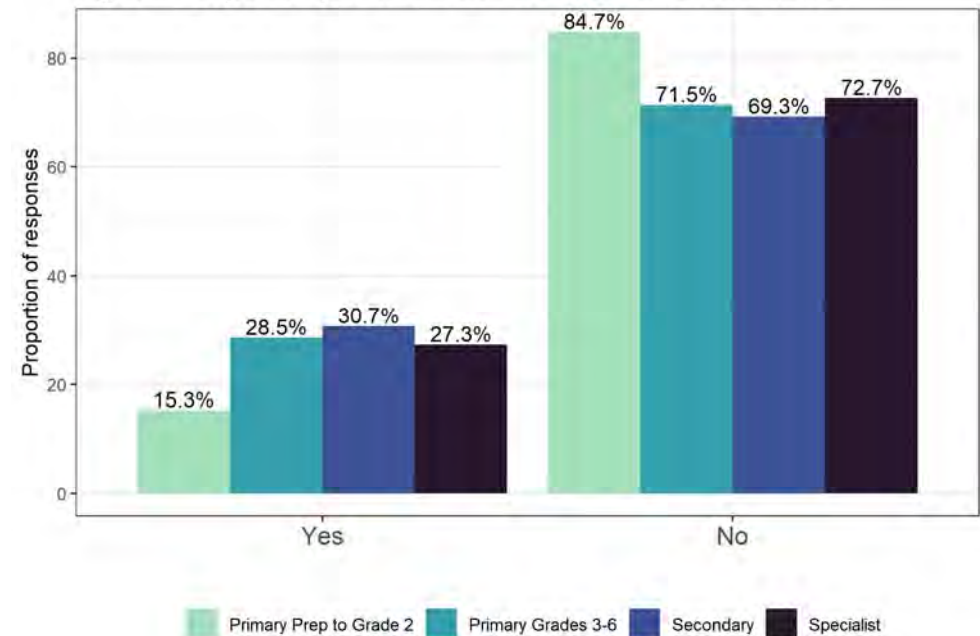
**26% of parents/guardian respondents asked their child/ren to wear a mask when at school.**

When restricted to parents/guardians of students Grade 3 and above (for whom masks are strongly encouraged), 29% of respondents asked their child/ren to wear a mask.

Similar proportions of responses by parents/guardians of Primary Grade 3-6, Secondary, and Specialist school students asked their child/ren to wear a mask (Figure 1).

- Parent/guardian respondents who had Prep to Grade 2 as well as older children mostly asked all their children to either wear masks or not; however, some did not ask their Prep-2 children to wear a mask whilst asking their Grade 3-6 or Secondary children to wear them (7% and 10%, respectively).
- A higher proportion of CALD parents/guardians asked their child/ren to wear masks (56%) compared to non-CALD parents (22%). (15% missing)
- Parents/guardians in metropolitan areas were more likely to ask their child/ren to wear a mask (31%) than those in regional areas (22%). (15% missing postcode)
- The proportion of parents/guardians asking their child/ren to wear a mask was similar across IRSAD quintiles (26% of the lowest – most disadvantaged – quintile, 27% quintile 2, 26% quintile 3, 29% quintile 4, and 29% of the least disadvantaged quintile). (15% missing postcode)

Figure 1. Do you ask your child/ren to wear a mask when at school?



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# The most common reasons parents/guardians asked their child/ren to wear a mask was believing them to be effective and a small inconvenience

The most common reasons parents/guardian respondents selected for asking their child/ren to wear a mask when at school were: ‘masks are effective at preventing child/ren from contracting COVID’ (78%); ‘wearing a mask is a small inconvenience for a large benefit’ (71%); and ‘everyone in schools should be wearing masks to stop the spread of COVID’ (63%).

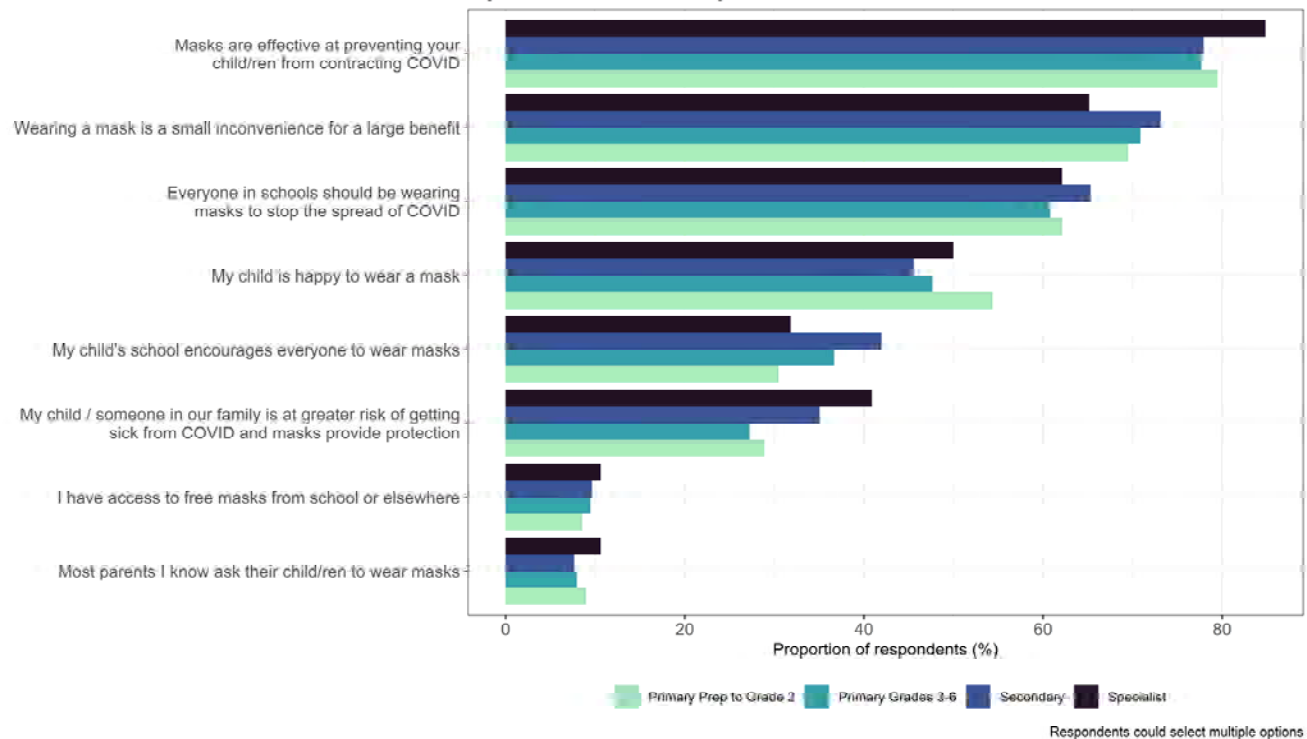
48% of respondents said their child was happy to wear a mask.

38% of respondents said that their child’s school encourages everyone to wear masks; this was highest in Secondary schools and lowest in Specialist schools.

31% of respondents selected ‘my child/someone in our family is at greater risk from getting sick from COVID’ (higher for Specialist school respondents)

Few parents/guardians selected the reasons including: ‘I have access to free masks from school or elsewhere’ (9.4%), and ‘most parents I know ask their child/ren to wear masks’ (8.1%).

Figure 2. Reasons for asking their child/ren to wear a mask



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## Some reasons differed by demographics

CALD parents/guardians were more likely than non-CALD parents/guardians to select 'everyone in schools should be wearing masks to stop the spread of COVID' (20% v 17%) and 'most parents I know ask their child/ren to wear masks' (4.2% v 1.6%). They were less likely to choose 'my child's school encourages everyone to wear a mask' (8.9% v 11%) and 'wearing a mask is a small inconvenience for a large benefit' (19% v 22%).

Parent/guardian respondents in the lowest IRSAD quintile (most disadvantaged) were more likely to say a reason for asking their child/ren to wear a mask at school is that they 'have access to free masks at school or elsewhere' (4.9% v 2.5% least disadvantaged). They were also more likely to select that 'most parents I know ask their child/ren to wear masks' (4.0% v 1.9% least disadvantaged).

Reasons selected in metropolitan and regional areas were largely similar; however, parents/guardians in regional areas were less likely to select 'most parents I know ask their child/ren to wear masks' (1.1% regional v 2.7% metropolitan) and respondents in regional areas were more likely to say they 'have access to free masks from school or elsewhere' (3.7% regional v 2.3% metropolitan).

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# The top reasons parents/guardians did not ask their child/ren to wear a mask were they interfere with school activities and are uncomfortable

The most common reasons parents/guardian respondents selected for not asking their child/ren to wear a mask when at school were: ‘masks interfere with school activities such as learning (65%); and ‘masks are uncomfortable and students shouldn’t have to wear them’ (61%).

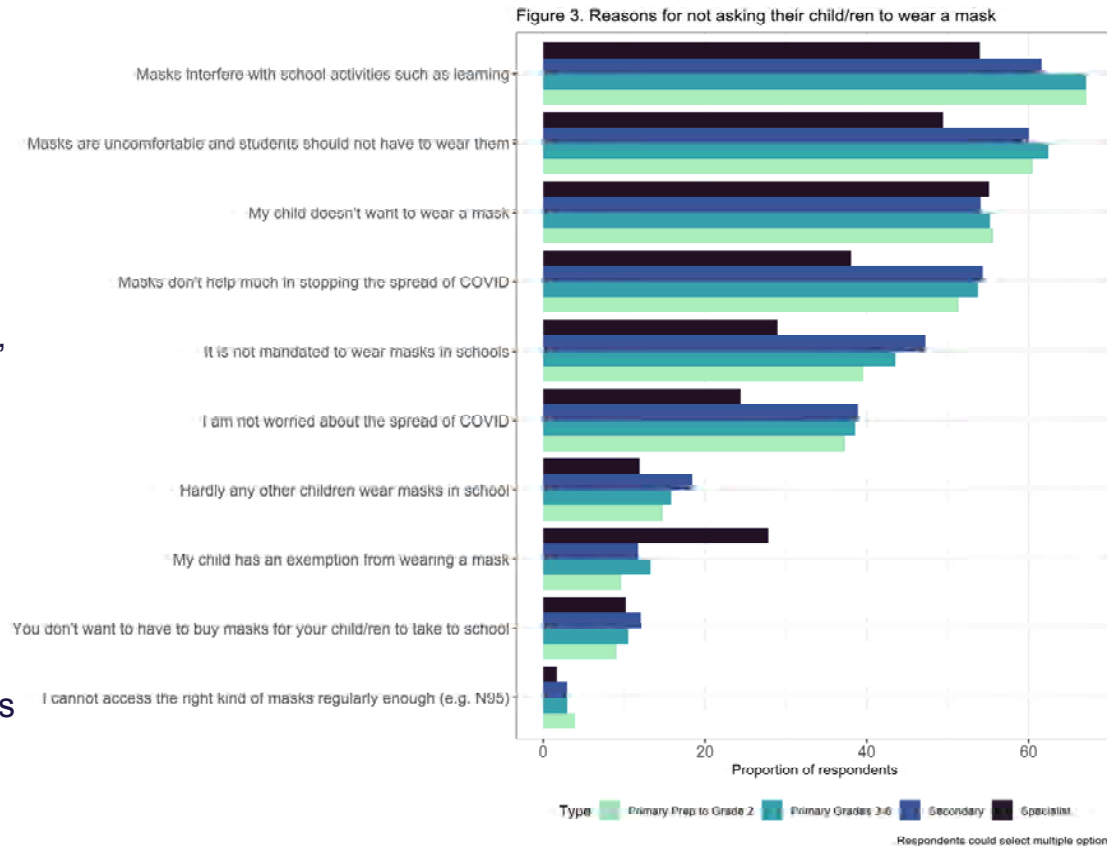
55% of respondents stated that their ‘child doesn’t want to wear a mask’.

53% of respondents selected that ‘masks don’t help much in stopping the spread of COVID’.

43% selected the reason ‘it is not mandated to wear masks in schools’, and 38% said that they ‘were not worried about the spread of COVID’.

Fewer parents/guardians selected the reasons including: ‘hardly any other children wear masks in schools’ (16%), ‘my child has an exemption from wearing a mask’ (12%; this was highest in responses for Specialist schools – 28%).

Small proportions of respondents selected reasons including not wanting to have to buy masks (11%) and very few stated lack of access as a reason for not asking their child/ren to wear a mask (3.3%).



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## Some reasons differed by demographics

CALD parents/guardians were more likely to say they cannot access to right kinds of masks regularly as a reason for not asking their children to wear masks at school (2.1% v 0.9%). They were also more likely to say 'it is not mandated to wear masks in schools' (16% v 12%) and 'hardly any other children wear masks in schools' (7.5% v 4.5%). However, CALD parents/guardians were less likely to state that they weren't worried about the spread of COVID (8.3% v 11%).

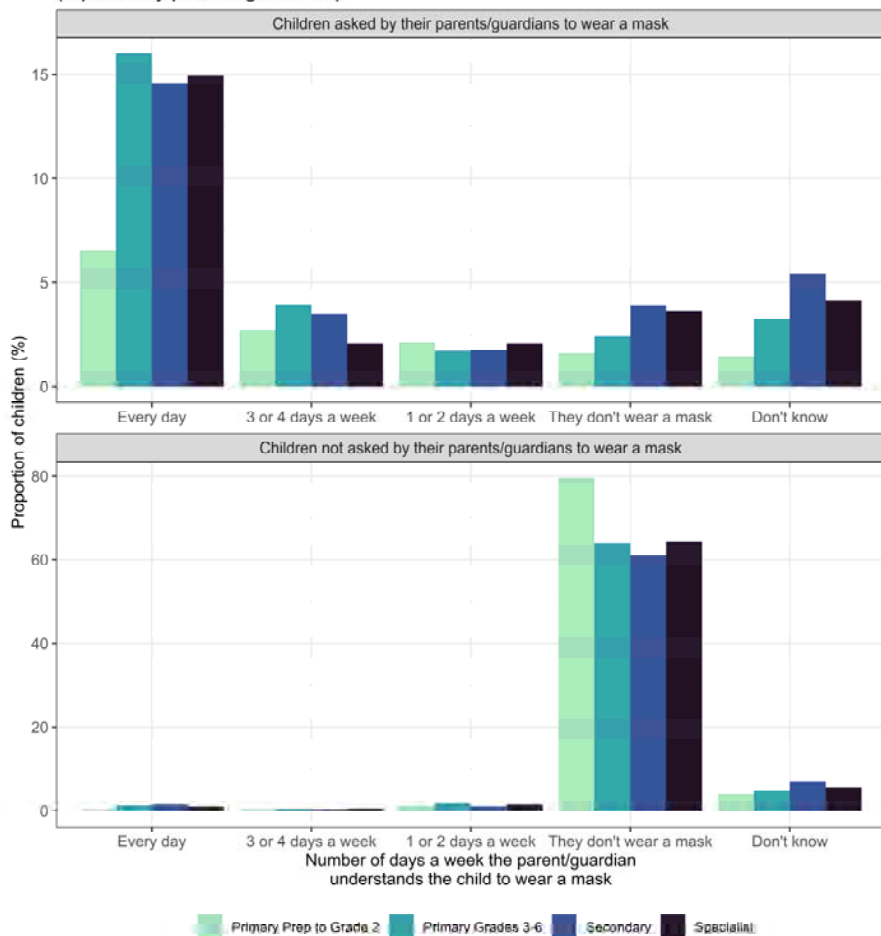
Parents/guardians in regional areas were more likely to select 'it is not mandated to wear masks in schools' than metropolitan respondents (14% v 12%).

No meaningful differences for reasons parents/guardians did not ask their child/ren to wear a mask were observed across SEIFA quintiles in this sample.

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# Most parents/guardians think their child/ren do not wear a mask when at school; however, of those that did ask, most believe masks were worn every day.

Proportion of children who wear/do not wear a mask at school (reported by parents/guardians)



Overall, 70% of respondents selected that, to the best of their knowledge, their child/ren did not wear a mask when at school. When restricted to students recommended to wear a mask (Grade 3 and above), 66% reported to not wear a mask.

89% of students whose parents did not ask them to wear a mask at school were reported to not wear a mask at all when at school.

Of students whose parents/guardians asked them to wear a mask when at school:

- Most (53%) stated their child wore their mask every day at school (54% not including Prep to Grade 2 students).
- Some selected that their children wore a mask part-time (either 3 or 4 days a week, 14% or 1 or 2 days a week, 7.4%).
- 11% stated that they did not think their child wore a mask at all at school.

Many parents did not know their child's mask wearing behaviour when at school (14% of those who asked their child to wear a mask and 7% of those who did not ask).

CALD parents/guardians were more likely to state their child wears a mask at school.

Parents/guardians in metropolitan areas were more likely than those in regional areas to say their child wears a mask.

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# Appendix

Language the survey was completed in:	English	Chinese	Vietnamese	Arabic	Persian	Turkish	Dari
	7,822	53	5	4	3	2	0

**Median survey response time:** 2 minutes 23 seconds

**Survey data collection over time:** Most surveys were completed on the day of release (56%) or the second day (34%).

**Response rate calculations:** Lower estimate is the total number of responses / number of enrolments in the sample. Upper estimate is the total number of children included in responses / number of enrolments in the sample (some families may have children in other schools that they also responded for).

**Socio-economic status** based on Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) utilises 2016 census data from the Australian Bureau of Statistics (ABS) [2033.0.55.001 - Census of Population and Housing: Socio-Economic Indexes for Areas \(SEIFA\), Australia, 2016 \(abs.gov.au\)](#) matched to postcodes entered by respondents.

**Metropolitan and regional/rural location** is based on Department of Health designation of postcodes used in COVID-19 Response reporting, matched to postcodes entered by respondents.

**Statistical significance:** Differences in proportions of responses by school type, CALD status, IRSAD, and metropolitan v regional location presented in this report are statistically significant. Non-statistically significant results are not presented.

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## Evidence Review: Face mask effectiveness and uptake

08 August 2022

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### **Situation:**

Following a request from the Acting Chief Health Officer a review of current evidence in relation to the utility of mask mandates in the current Victorian context was conducted. Victorian specific evidence, behavioural insights data and international evidence have been summarised below.

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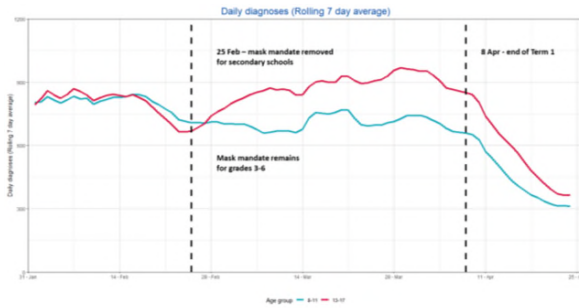
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Not Relevant

- Following the removal of mask mandates for secondary school students in Victoria on 25 February 2022 a significant increase in cases in this cohort was observed. Cases in grade 3-6 students who continued to have a mask mandate in place for this period remained stable. Modelling conducted to analyse the impacts of mask wearing on these school students demonstrated that the removal of masks in secondary schools increased the risk of COVID-19 by approximately 23% and resulted in an additional 8,000 infections during the 5-week period from 25 February to 31 March 2022 (Department of Health, 2022).

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*Figure. Divergence of case numbers between school student cohorts with mask mandate in place versus mask mandate removed.*

**Victorians' behaviours and views on mask wearing**

Not Relevant

- o In the summer of 2021 and 2022, a rapid survey was conducted to explore the perspectives of parents about children returning to school. There were 44% of parents of primary school children aged 8 years and older who believed children were wearing masks 'always' or 'most of the time'. A further 44% of parents believed children were wearing masks 'sometimes' (Burnet Institute ,

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2022). When the survey was undertaken in March 2022, two key barriers to primary school aged children wearing masks at school were the hot weather and that their children were uncomfortable.

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## References

- Adriana Milazzo, L. G. (2022). The impact of non-pharmaceutical interventions on COVID-19 cases in South Australia and Victoria. *Australian and New Zealand Journal of Public Health*.
- Burnet Institute . (2022). *The optimise study: a rapid survey examining concerns about children returning to school in 2022 April 2022 special report* . Melbourne : Burnet Institute .
- Burnet Institute (a). (2021). *COVID-19 attitudes, resilience and epidemiology report 4*. Melbourne: Burnet Institute.
- Burnet Institute (b). (2021). *The optimise study: social networks and mixing patterns April 2021 report 5*. Melbourne: Burnet Institute.
- Department of Health. (2022). *Modelling and Analytics Weekly Update 28 April 2022*. Victoria.
- James M. Trauer, M. J. (2021). *Understanding how Victoria, Australia gained control of its second COVID-19 wave*. Melbourne: Nature.
- Nick Scott, A. S. (2021). The introduction of a mandatory mask policy was associated with significantly reduced COVID-19 cases in a major metropolitan city. *PLOS One*.

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**FOI Unit Health (HEALTH)**

**From:** Daniel West (Health)  
**Sent:** Thursday, 14 April 2022 3:53 PM  
**To:** Euan Wallace (Health); Brett Sutton (Health); **Not Relevant** Ben Cowie (Health); Suman Majumdar (Health); David Lister (Health); Kym Arthur (Health); Robert Kennedy (Health)  
**Cc:** **Not Relevant** Andres Hernandez (Health); **Not Relevant**; Kate Matson (Health); **Not Relevant**  
**Subject:** RE: OFFICIAL - Sensitive: State Controller meeting action

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Hi team,

**Not Relevant**

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With quasi experimental analysis like difference-in-difference the coefficients are generally described as the effect of treatment **on the treated**. In plain English this means they are the effect of treatment (removing masks in schools) on those effected by the treatment (secondary students). These coefficients are not "externally consistent" in that they **cannot be applied to the wider population** (without additional strong assumptions) however they have strong "internal consistency" i.e. they can be inferred as causal on the treatment group (subject to assumptions).

- The above applies to all coefficients included in the difference-in-difference model
- For example, if we include vaccination status as a control variable, the effect of vaccination:
  - would not be causal (it is just a correlation)
  - would only be the effect of vaccination on the groups in the study (school students: primary + secondary).
- The **direction** (not magnitude) of control variables can be extrapolated to the wider population (within reason). For example, if the model suggests that vaccination reduces transmission in secondary schools (which is consistent with the wider literature that vaccination reduces transmission) it can add to the existing body of evidence that suggests that vaccination reduces transmission.
- While the direction of control variables is sound (if supported by existing literature), the magnitude of the effect may be confounded. For example, if we ran the model during a period of time with low covid transmission the effect of vaccination could be smaller than a similar model that was run during a period of high transmission (e.g. early Jan). As a result, the coefficients of control variables are unlikely to be reproducible in other models.

Additionally, if the treatment variable (removing masks) affects the two groups differently, bias may be introduced into the model. For example, if primary school students "play" closer together than secondary school students, and there is a **non-linear relationship** between masks, proximity and the chance of getting COVID (masks become exponentially more/less effective the closer/further you are to someone) the model may over or underestimate the effects of masks. The trust in your results (after acknowledging the presence of this confounding variable) may depend on:

1. Your intuition on how much of an effect this confounder will have
2. The magnitude of the effect of masks on transmission in the original model.

For example, removing masks was found to increase transmission by approximately 23% and had a very small standard deviation. As a result, we can be quite confident that, even if the confounding variable had an effect it would be extremely unlikely to change the sign of the coefficient from negative to positive. However, it could change the magnitude of the result from 23% to 20% or 26% (as an example) depending on which direction the confounding variable will affect the results.

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Not Relevant

Kind regards,

**Dan West**

Director – Modelling and Analytics  
DIME - Intelligence, Case Contact and Outbreak Management (ICCOM)

Department of Health  
t. [Redacted] e. [daniel.west@health.vic.gov.au](mailto:daniel.west@health.vic.gov.au)  
[www.health.vic.gov.au](http://www.health.vic.gov.au)

OFFICIAL: Sensitive

**From:** Daniel West (Health)  
**Sent:** 8 April 2022 4:55 PM  
**To:** Kym Arthur (Health) <Kym.Arthur@health.vic.gov.au> [Redacted]  
[Redacted]; Kate Matson (Health) <kate.matson@health.vic.gov.au>; Andres Hernandez (Health) <andres.hernandez@health.vic.gov.au>; [Redacted] Suman Majumdar (Health) <suman.majumdar@health.vic.gov.au>; [Redacted]  
**Cc:** [Redacted] Public Health Intelligence <publichealth.intelligence@dhhs.vic.gov.au>; [Redacted] 33(1)  
[Redacted] Robert Kennedy (DFFH) <Robert.Kennedy@dffh.vic.gov.au> [Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  
[Redacted] GAPI.DIME (HEALTH) <GAPI.DIME@health.vic.gov.au>; [Redacted]  
[Redacted]

**Subject:** RE: OFFICIAL - Sensitive: State Controller meeting action

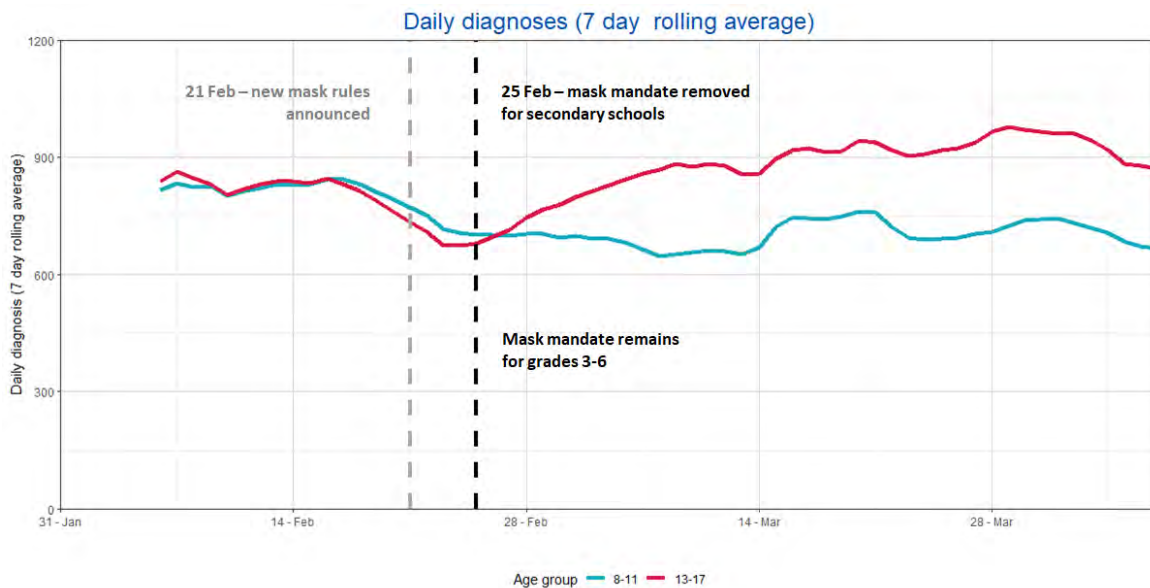
Hi Team,

Attached is analysis of Victorian data on school aged cases which highlights the period at which mask rules were removed for Secondary school, thanks go to [Redacted] and [Redacted] for this impressive work.

Thanks to @GAPI.DIME (HEALTH), I have also attached an annotated bibliography on a few recent papers which shows the reduction in transmission through mask wearing in schools.

**Analysis key messages:**

- For the best comparator group, persons aged 8-11 in Victoria were chosen. This group has been required to wear masks for the duration of term 1.
- It is clearly visible on a time series that infections in the 13-17 age group were significantly higher than those aged 8-11 after masks requirements were removed. Before this time the two groups are very similar.
- Difference in difference regression models the attributable change from the mask removal at 23%. This means that **secondary students were 23% more likely to catch COVID** after the removal of the mask mandate.



#### International evidence key messages:

- In a study led by Duke University in the United States, Boutzoukas *et al* aimed to estimate the impact of masking practices on secondary transmission in a cohort of “K-12” schools, serving students ranging from kindergarten through to grade 12 (ages 5-18 years).
  - **Universal masking was associated with an 87% reduction in predicted secondary transmission rates when compared with optional masking districts.**
  - **This study is of low to moderate quality.** Limitations include its observational nature, small number of potential confounders included in the analysis, and the small sample size: only 61 out of more than 13,800 public school districts in the United States, from 9 states, both responded to an invitation email and met inclusion criteria.
- Murray et al assessed the association in the US between masking of children  $\geq 2$  years and childcare closures due to COVID-19. This was a yearlong prospective longitudinal electronic survey conducted between 22 May to 08 June 2022.
  - Multivariable analysis (which included COVID-19 prevalence between the two time points) found that early adoption of child masking at baseline **was associated with a 13% lower risk of subsequent COVID-19 closure at follow-up compared with programs not practicing child masking**
  - **A survey** providing limited evidence of the benefits of masks in early childhood education and care
- Public Health Ontario Library Services conducted a rapid review to explore the influence of mask-wearing as a public health strategy to minimise the transmission of SARS-CoV-2 and incidence of COVID-19 in children. Three primary areas were examined: associations between children wearing masks and COVID-19 incidence; mask-wearing behaviours in children; and potential negative impacts of mask-wearing in children. Peer-reviewed and non-peer-reviewed studies that described mask-wearing in children and were published in English between 1 January 2020 – 10 January 2022 were included in the rapid review. A total of 88 references are cited.
  - Twenty-three primary studies included found that **school mask mandates were associated with a lower incidence of COVID-19 in indoor school and childcare settings.** However, many schools employed a layered COVID-19 response that utilised other public health and social measures extending beyond mask mandates, thus it is difficult to quantify the effectiveness of mask-wearing alone as a COVID-19 containment and prevention strategy.
  - Given the nature of a rapid evidence review conducted by a government organisation this study provides **high quality evidence** that the use of face masks is associated with reduced transmission of



SARS-CoV-2 and COVID-19 infection in children. However, these studies were performed before the emergence of the Omicron variant and few studies reported on the type of masks used.

Please let me know if you have any questions.

Kind regards,

**Dan West**

Director – Modelling and Analytics  
DIME - Intelligence, Case Contact and Outbreak Management (ICCOM)

Department of Health

t. (03) Not Relevant | e. [daniel.west@health.vic.gov.au](mailto:daniel.west@health.vic.gov.au)  
[www.health.vic.gov.au](http://www.health.vic.gov.au)

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**From:** [Redacted] Not Relevant  
**Sent:** Monday, 28 March 2022 11:31 AM  
**To:** Robert Kennedy (DFFH) <[Robert.Kennedy@dffh.vic.gov.au](mailto:Robert.Kennedy@dffh.vic.gov.au)>; Andres Hernandez (Health) <[andres.hernandez@health.vic.gov.au](mailto:andres.hernandez@health.vic.gov.au)>; Public Health Intelligence <[publichealth.intelligence@dhhs.vic.gov.au](mailto:publichealth.intelligence@dhhs.vic.gov.au)> Not Relevant  
[Redacted] Not Relevant  
**Cc:** Nick Haslett (Health) <[nick.haslett@health.vic.gov.au](mailto:nick.haslett@health.vic.gov.au)>; David Menon (Health)

Not Relevant

**Subject:** RE: OFFICIAL - Sensitive: State Controller meeting action

Hi everyone,

Please find below (and attached) some figures and a table for this request with the mask rules.

If there are any further breakdowns required, I am happy to add.

### **Cases reported to DH in secondary school-aged children (term 1, 2022)**

#### Term 1 2022 mask requirements:

##### Secondary schools

- Mask mandate removed 11:59pm 25/02/2022 (Friday), therefore not required from week 5 of term

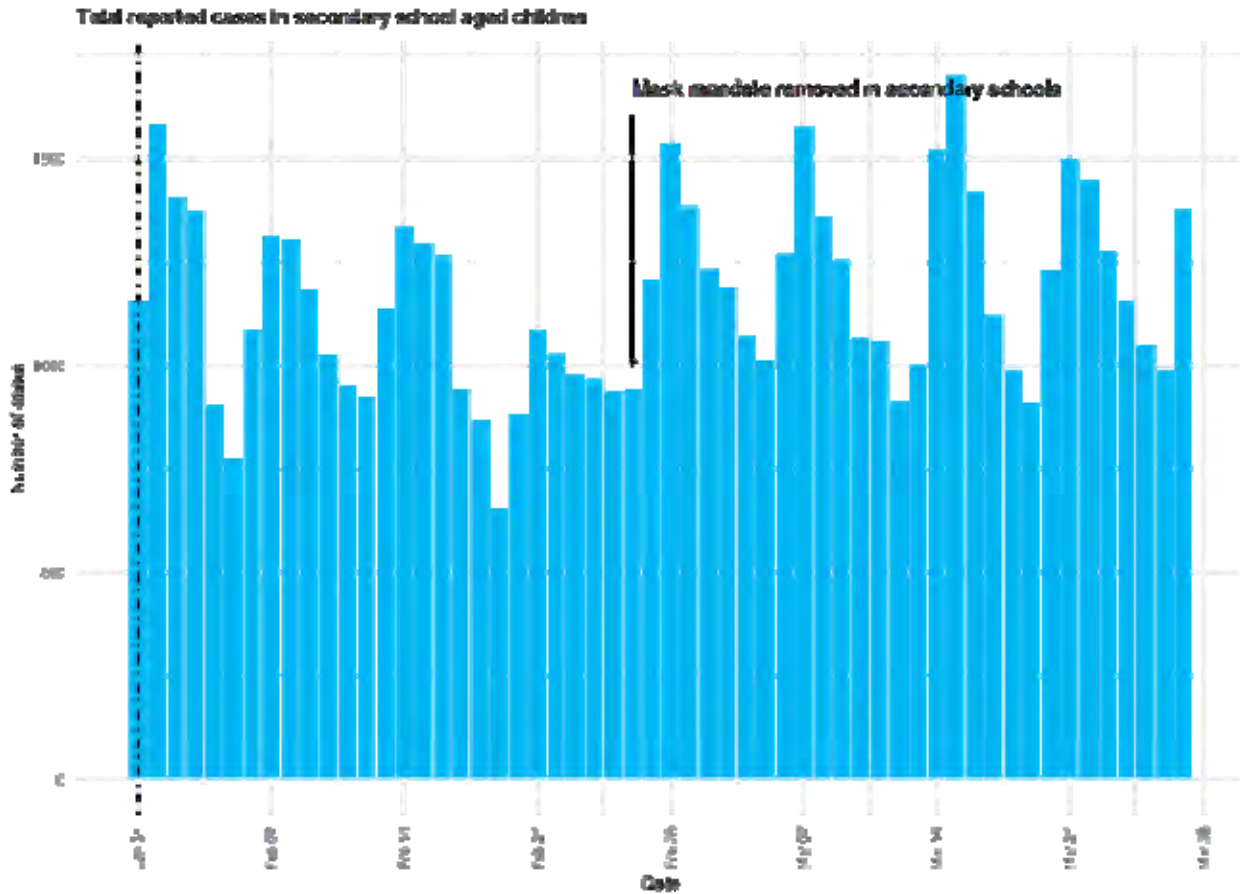
##### Primary schools – no change to mask requirements in term 1

- Prep-2: no mask mandate
- Grades 3-6: mask mandate remains for “workers, visitors, and students in Grade 3 to 6 in an indoor space at a primary school (including outside school hours services at a primary school)”

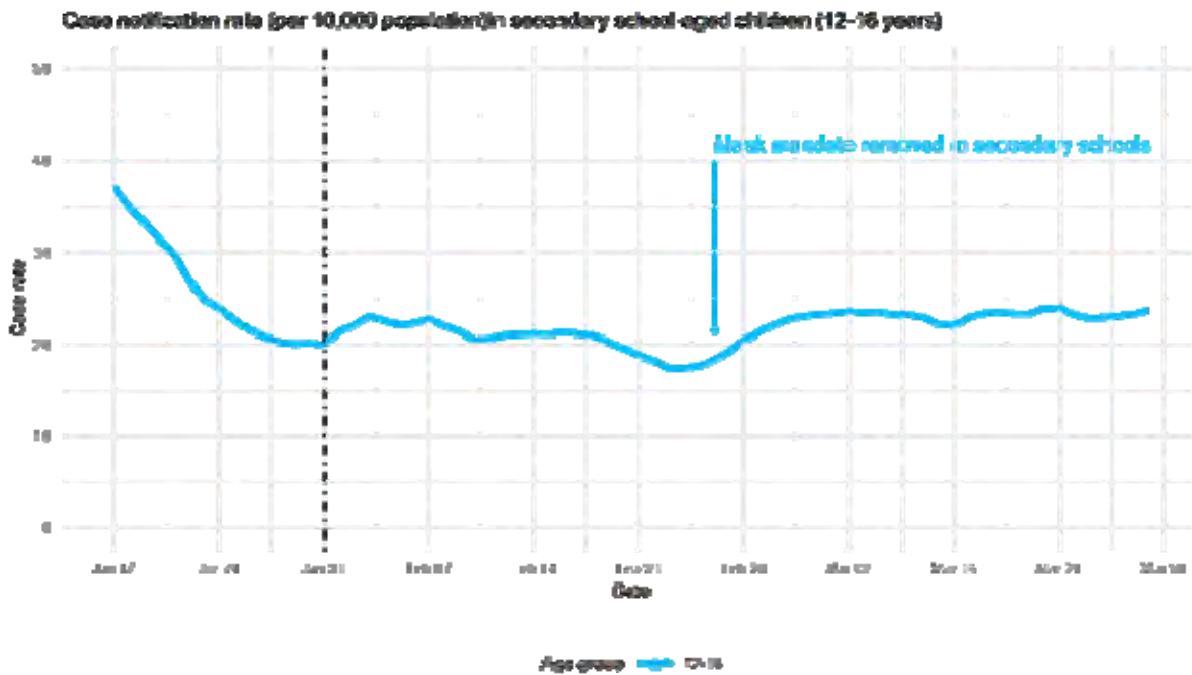
#### Some further considerations:

- Children 16-18 years are eligible for a third dose vaccination. As of 28 March, 34.7% of this age group have received a third dose >2 weeks ago.
- 18-year-olds are a transition year; some are at secondary school whilst others are at university. A large increase in cases aged 18 was observed in week 5 (coinciding with university orientation week).
- Cases in the general population have trended upwards in the past two weeks with the BA.2 variant increasing in prevalence.

### **Cases reported in secondary school-aged children (12-18 years) since the beginning of term 1 (31 January).**



Case notification rate (seven day rolling average) in secondary school-aged children (12-18 years) per 10,000 population.



**Weekly case notifications in secondary school-aged children (12-18 years).** The mask mandate was removed in secondary schools from week 5 (school week commencing 28 February). 16–18-year-olds are eligible for a third vaccine. (As of 28 March, 34.7% of this age group have received a third dose >2 weeks ago).

Age group	31 Jan - 6 Feb	7 - 13 Feb	14 - 20 Feb	21 - 27 Feb	28 Feb - 6 Mar	7 - 13 Mar	14 - 20 Mar	21 - 27 Mar
	Mask mandate in place				Mask mandate removed			
12-15	4534	4683	4608	4357	5203	5536	5941	5705

16-18	3733	3143	2625	2765	3481	2684	2932	3079
<b>Total 12-18</b>	<b>8267</b>	<b>7826</b>	<b>7233</b>	<b>7122</b>	<b>8684</b>	<b>8220</b>	<b>8873</b>	<b>8784</b>

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Not Relevant Data, Intelligence, Modelling and Epidemiology  
 System Support and Improvement (SSI), COVID-19 Response  
 Department of Health

e. Not Relevant | w. [www.dhhs.vic.gov.au](http://www.dhhs.vic.gov.au)

*We acknowledge the traditional Aboriginal owners of country throughout Victoria and pay our respect to them, their culture and their Elders past, present and future.*



Department  
of Health

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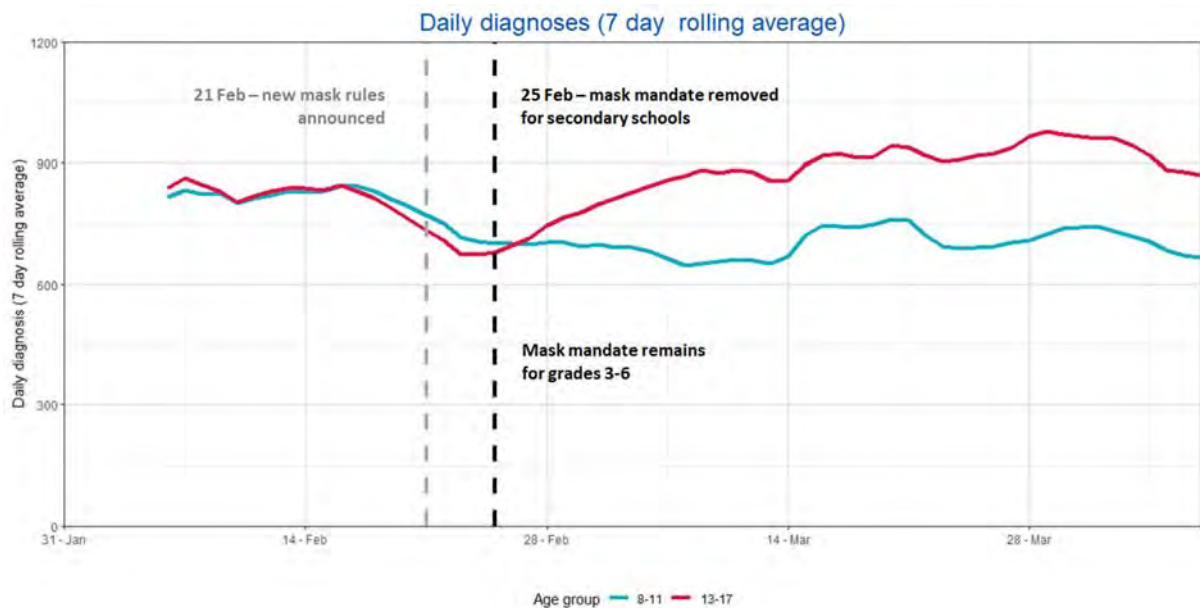
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## Analysis of Victorian data:

### Background

- On 21 February it was announced that masks would no longer be mandatory in secondary school students beginning 25 February.
  - Mask mandates remained in place for children in grades 3 to 6.
- We sought to analyse the effect of school mask-wearing policies in reducing transmission of COVID-19 by comparing diagnoses between secondary school students (ages 13-17) and grades 3 to 6 (ages 8-11) before and after changes in school mask policy.
- **The comparison between these two cohorts approximates the effect of mask-wearing in schools.**



- Diagnoses for secondary school students can be seen to accelerate shortly following the change in school mask policy on 25 February, while the rate for grades 3-6 students (who continued wearing masks) remained stable.
- Prior to the change in school mask policy, these two groups showed no significant differences.
- Given the time period in which these changes occurred, it is unlikely that factors such as vaccination rate are able account for a significant portion of the observed difference.
- Due to limited information on whether a diagnosed individual was attending primary or secondary school, age was used as a proxy.
  - Children aged 12 were excluded due to the possibility that they were attending either primary or secondary school and hence be subject to different rules.
  - Similarly, people aged 18 were excluded due to the possibility they were no longer attending secondary school.

### Difference in difference model:

#### Overview:

In addition to the graphical comparison, the effect of the mask mandate removal on transmission in Victoria was modelled using the 'difference-in-difference' technique (DID). DID is a quasi-experimental design that makes use of longitudinal data from a treatment (secondary schools) and a



control (primary students) group to estimate the effect of an intervention (mask mandate removal). This method was chosen because it can minimise the confounding effects of differences between cohorts (such as vaccination status) and population level trends (such as rising cases) and is a popular method for extracting causal effects (subject to assumptions).

**Key results:**

- Secondary students were **23% more likely to catch COVID after the removal of the mask mandate** (conditional on their vaccination status). This translates to approx. 8,000 additional cases which are modelled to have occurred due to the removal of the mask requirements.
- Students with 1 dose of vaccine were 8% less likely to catch COVID
- Students with 2 doses of vaccine were 60% less likely to catch COVID
- Students with 3 doses of vaccine were 67% less likely to catch COVID

In the table below, column 2 (the odds ratio) reports how much more or less likely an individual is to catch COVID relative to their vaccination/mask status.

VARIABLES	(1) Logit coefficient	(2) Odds ratio
COVID		
1 dose	-0.0843*** (0.00304)	0.919*** (0.00280)
2 doses	-0.909*** (0.00397)	0.403*** (0.00160)
3 doses	-1.106*** (0.00746)	0.331*** (0.00247)
<b>Mask removal</b>	<b>0.207***</b> <b>(0.00453)</b>	<b>1.229***</b> <b>(0.00557)</b>
Constant	-3.858*** (0.00279)	0.0211*** (5.90e-05)
Observations	46,571,030	46,571,030

Standard errors in parentheses  
 \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Method:**

Equation 1 below describes the regression specification of the logistic difference-in-difference model<sup>1</sup>

$$\text{logit}(\text{Pr}(\text{COVID}|\text{time}, \text{treatment})) = \alpha_0 \text{time} + \alpha_1 \text{treatment} + \alpha_2 \text{time} * \text{treatment} + \text{BX}_i \quad (1)$$

**Assumptions:**

Individuals are infected with COVID for 7 days after their diagnosis date and individuals become vaccinated 14 days after their dose is administered.

<sup>1</sup> Where COVID (0,1) represents COVID status, time (0,1) represents the period before and after 25 Feb respectively, treatment (0,1) represents membership of the control (8-11) and treatment (13-17) groups respectively and X is a vector of covariates (vaccination status – dose numbers 1, 2, 3).

## School Masking Policies and Secondary SARS-CoV-2 Transmission – an annotated bibliography of three papers

### Boutzoukas

**Boutzoukas, A. E, Zimmerman, K. O., Inkelas, M., Brookhart, M. A, Benjamin D. K., Butteris S., et al. School Masking Policies and Secondary SARS-CoV-2 Transmission. *Pediatrics* 2022. doi: 10.1542/peds.2022-057787**

This is a **PREPUBLICATION** paper, which has been accepted for publication after peer review, but which may still contain errors in facts, figures, and statements.

[Boutzoukas](#) *et al* has 22 authors from a variety of US University Medical and Public Health Schools and Institutes including Duke University, UCLA, University of Wisconsin.

In a study led by Duke University in the United States, Boutzoukas *et al* aimed The aim of this research was to estimate the impact of masking practices on secondary transmission in a cohort of “K-12” schools, serving students ranging from kindergarten for ages 5 – 17 years old through to grade 12 for ages 17 – 18 years). An observational study was conducted over a period of four and a half months, from 26/7/21 to 13/12/21, with schools reporting weekly counts of primary and secondary cases and quarantines for staff and students. 61 districts (i.e., late summer to early winter). Included were 9 states with 61 districts, and 1,112,899 students and 157,069 staff in attendance, reporting 40,601 primary and 3,085 secondary infections. The number of schools was not reported.

Key findings were that districts that required full masking had lower predicted secondary infections per primary infection than districts with optional masking policies. The relative rate of secondary transmission in optionally masked districts was **3.6** times the rate of secondary transmission in universally masked districts. **Universal masking was associated with an approximate 72% reduction in secondary transmission compared to districts with optional masking.** When adjusted for district size and weeks of data reported, **districts with optional masking were found to have 7.6 times the predicted rate of secondary transmission compared with universally masked districts.** Alternatively, universal masking was associated with an 87% reduction in predicted secondary transmission rates when compared with optional masking districts.

**This study is of low to moderate quality.** Limitations include its observational nature, small number of potential confounders included in the analysis, and the small sample size: only 61 out of more than 13,800 public school districts in the United States, from 9 states, both responded to an invitation email and met inclusion criteria. Data was collected during a time in which **Delta was the predominant variant**, ceasing when Omicron cases began to surge. Generalisations should therefore not be made to variants other than Delta.

### Murray – Childcare

[Murray](#) TS, Malik AA, Shafiq M, et al. Association of Child Masking With COVID-19-Related Closures in US Childcare Programs. *JAMA Netw Open*. Jan 4 2022;5(1):e2141227. doi:10.1001/jamanetworkopen.2021.41227

Murray et al has 15 authors from Yale university – various medical nursing and global health schools – and Columbia University Department of Epidemiology.

The study was a longitudinal electronic **survey of childcare providers**, which included paid childcare provided in a home and that provided in a childcare centre. It was conducted between 22 May to 8 June 8, 2020 (baseline), and again 26 May to 23 June 2021 (follow-up). Of the 19,114 participants providing care at baseline, 16,630 consented to follow up, and only 7,716 (46.4% of those consenting) responded to the follow up survey of whom 6,654 (40% of the baseline cohort) were eligible to participate.

The exposure variable was initially defined as all children (2 years and older) wearing a mask or facial covering at baseline (April 2020) and follow up. Covariates included infection mitigation strategies such as screening for temperature and symptoms, outside drop-off and pickup, and maintaining 6 ft between child seats and cots. The outcome of interest was whether the program had ever experienced a COVID-19–related closure because of a suspected child or staff case of COVID-19. There were 22,210 children aged  $\geq 2$  years (66.4% of the children), 18,695 were aged 3-5, and 8515 (20.8%) were  $\geq 6$  years. Child masking increased from 572 **programs** (8.6%) at baseline to 2060 programs (32.7%) 1 year later, with 408 programs (6.1%) masking at both time points. Staff masking also increased from 31.9% at baseline to 64.4% at follow up. [It is not clear if all children aged  $\geq 2$  years in a program were required to mask and there was no questioning of when the masking had begun for those who were only masked at the follow up.]

Multivariable analysis (which included COVID-19 prevalence between the two time points) found that **early adoption** of child masking at baseline was associated with a 13% lower risk of subsequent COVID-19 closure at follow-up compared with programs not practicing child masking. In the multivariable model in which combined child and adult masking was assessed as the exposure variable, **the aRR for both adult and child masking compared with neither child nor staff masking at baseline was 0.85 (95%CI 0.76-0.97; P = .01) and for masking at both time points was 0.87 (95%CI, 0.75-1.01; P = .06). Masking only by adults or children was not statistically significant at any stage.**

This survey has inherent **limitations**: the limited response rate of 46.4% of those who consented to follow up, or 40% of the original cohort; those participating may have differed from providers who did not consent to participate; it is not stated how many providers were approached. There may have been respondent bias as there was no independent confirmation of status; unknown dates of when masking started for those who masked at follow up but not baseline; and whether all staff or children aged  $\geq 2$  years in a program were required to mask. The types of masks were not ascertained nor completeness of wearing – for instance, which happened during meals? It is not stated whether the providers who introduced masking did so in response to a closure. There was no difference in outcomes for the providers who had masked at the beginning of the survey and at follow up.

**Summary: a low-quality survey providing limited evidence of the benefits of masks in early childhood education and care.**

Public Health Ontario

**Public Health Ontario. *Mask-wearing in Children and COVID-19...What We Know So Far.* 2022. 17 February 2022.**

Public Health Ontario Library Services conducted a **rapid review** to explore the influence of mask-wearing as a public health strategy to minimise the transmission of SARS-CoV-2 and incidence of COVID-19 in children. Three primary areas were examined: associations between children wearing masks and COVID-19 incidence; mask-wearing behaviours in children; and potential negative impacts of mask-wearing in children. Peer-reviewed and non-peer-reviewed studies that described

mask-wearing in children and were published in English between 1 January 2020 – 10 January 2022 were included in the rapid review. A total of 88 references are cited, of which 9 relate to local Ontario restrictions, the rest are from published literature (6 are preprints) and reports such as from the UK HSA.

Twenty-three primary studies included found that **school mask mandates were associated with a lower incidence of COVID-19 in indoor school and childcare settings**. However, many schools employed a layered COVID-19 response that utilised other public health and social measures extending beyond mask mandates, thus it is difficult to quantify the effectiveness of mask-wearing alone as a COVID-19 containment and prevention strategy. The review included ten primary studies that focused on mask-wearing in outdoor, extra-curricular, and sports settings, reporting that for most of these settings, mask-wearing was associated with reduced SARS-CoV-2 transmission and infection. **Evidence supporting the impact of mask-wearing in children was inclusive or lacking robustness for mask-wearing at school camps and when playing outdoor, non-contact sport.**

It was reported that children's **adherence** to mask-wearing policies was moderate to high, being higher in schools than in community settings, and increasing with age. Further, ethnic background was reported to play a role in adherence to mask mandate policies, being typically higher among Hispanic and Black children than in those from white families. Factors associated with decreased mask use included reporting discomfort of face masks, reporting that masks were unattractive to wear, perceived low risk of infection, and negative attitudes towards mask use. Additional factors included pre-existing conditions (such as allergies, skin sensitivity, asthma, etc.), societal norms, and perceived control.

There was minimal evidence of adverse outcomes associated with mask mandates in children. Studies assessing impact of paediatric mask-wearing on respiratory function (3 studies/95 children) found no evidence of impaired respiratory function in children wearing masks however did note individual subjective complaints including breathing discomfort or difficulty. Three studies indicated self-reported psychological distress associated with mask use in children while two others reported higher rates of self-reported anxiety in children who did not wear masks. The review concluded there was no evidence of impact on mask wearing on children's communication or cognitive function. Four studies found that mask-wearing in children was associated with dermatological outcomes such as acne, rashes, and other allergy symptoms around the mouth area, however these studies lacked control groups or had small samples sizes which limited the validity of reported findings. Three survey-based studies reported no relationship between mask-wearing in children and dermatoses.

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Given the nature of a rapid evidence review conducted by a government organisation **this study provides high quality evidence that the use of face masks is associated with reduced transmission of SARS-CoV-2 and COVID-19 infection in children.** However, these studies were performed **before the emergence of the Omicron variant and few studies reported on the type of masks used.**