Review of COVID-19 Communications in Victoria

Independent Pandemic Management Advisory Committee

September 2022

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Message from the Chair

In the government's pursuit of aggressive suppression of COVID-19, Victorians have experienced some of the greatest and most harsh restrictions imposed not only across Australia but the world. Subsequently, the Victorian government's obligation to effectively communicate the requirements across the state's diverse community was much greater. Given the far-reaching impacts of pandemic orders on the Victorian community, the Independent Pandemic Management Advisory Committee (IPMAC) has initiated this review of COVID-19 Communications in Victoria. The Committee is of the view that it is in the public interest, will have a collective impact and it can bring a meaningful, independent, and holistic perspective to inform pandemic communications moving forward. IPMAC is cognisant that this report is being produced in the third year of the pandemic and that during the period of this review much fewer pandemic orders have been made.

The importance of the Victorian Government's communications approach to pandemic orders cannot be understated. COVID-19 demanded a higher level of sophistication from the Victorian Government in terms of communication. It necessitated a rapid transition from planned policy related press releases, with further information available for individuals to access themselves, to crisis communication for all Victorians including highly targeted campaigns to priority groups. Pandemic communication required communicating with each and every Victoria across a diverse community. If anyone was left behind, everyone was at risk. The benchmark was high – if communications were to fail all other interventions put in place are at risk. It also required consideration of the misalignment in language and policy across jurisdictions and how to minimise confusion.

Pandemic orders are complex to communicate but the high level of compliance demonstrated they were well understood. The Committee would like to acknowledge the significant contribution of, and sacrifices made by the many thousands of individuals who worked tirelessly across government and other agencies during challenging times to ensure Victorians were aware of their obligations and to support them more broadly throughout the pandemic.

IPMAC would also like to thank the Department of Health and other government departments for supporting the Committee through the provision of a substantial volume of information to inform this review. It was disappointing however, that the Department of Premier and Cabinet did not make available the Behaviours and Attitudes Survey results. IPMAC made a formal request to the Secretary of the Department of Premier and Cabinet for specific information from the Behaviours and Attitudes Survey to understand how this data has been used in the development and refinement of government COVID-19 communications, any insights it could provide on how people receive information, if communications have changed the level of knowledge, attitudes and behaviours/practice and any other information relevant to the assessment of the Government's communication approach. IPMAC also requested information collected and analysed by the Department of Premier and Cabinet Business Insights Unit on digital activity relating to emerging issues and the sentiment, expectations and needs of Victorians.

In response, the Department of Premier and Cabinet advised that it "…is not able to release the data at this stage as the information is commercial in confidence as it utilises proprietary methodology and data and has supported Cabinet considerations". The Committee is of the view that given the expenditure of public funds, consistent with other jurisdictions for transparency and in the public interest, this information should be made public. The Department of Premier and Cabinet has previously published case studies on the behavioural insights work they have undertaken, including one on boosting Human Papillomavirus vaccination rates in 2019. Unlike other jurisdictions, there is nothing in the public realm on how the work of the Department of Premier

and Cabinet's Behavioural Insights unit has informed Victoria's COVID-19 Response or how it can assist other policy makers and organisations.

IPMAC is of the understanding that the COVID-19 related Behaviours and Attitudes Surveys are undertaken regularly and results are distributed across government to inform policy and program development. This information would have provided valuable insights into human behaviour for IPMAC to further inform the assessment of pandemic communications against best practice. IPMAC notes that findings from the Behaviours and Attitudes Survey have been used to inform the Chief Health Officer's advice to the Minister for Health in relation to the pandemic orders decision making process which is published on the Department of Health website. This is one of the safeguards introduced through the new pandemic management legislative framework that came into effect on 15 December 2021 to increase transparency and accountability in the exercise of the Minister's powers to make pandemic orders.

> "Face mask requirements are low impost measures that, according to Victorian population surveys on COVID-19 related behaviours and attitudes, are widely adopted by most members of the community (Department of Premier and Cabinet Victoria, 2021)."[1]

> "I have considered a consistent one-size-fits-all approach to vaccination mandates for all workforces and even for the general community but, at this time, I do not consider this to be a proportionate response for reasons including that I consider that the risks to the community – and the preliminary Victorians are voluntarily accessing booster doses at high numbers, and this willingness was further evidenced by behavioural insights data from the Department of Premier and Cabinet which has indicated that over 80% of respondents were willing to undertake a booster dose."[2]

> "Data from the recent Behaviours and Attitudes Survey has also indicated that always wearing a face mask indoors in a public space has declined significantly since the previous round of surveys, from 71% in February to 36% in March 2022."[3]

IPMAC considers it unacceptable that as an expert advisory Committee appointed by the Minister for Health with legislated functions, the Department of Justice and Community Safety did not respond to correspondence or requests for information from the Committee. This is particularly concerning given the responsibilities of this department in supporting the Attorney-General's portfolio as First Law Officer of the State. The Department of Justice and Community Safety is also responsible for other portfolios critical to the Victorian Government's COVID-19 response and this review including COVID-19 Quarantine Victoria, Victoria Police, Emergency Management Victoria, the State Control Centre which supported emergency coordination of the pandemic and WorkSafe.

The pandemic is not over. Well-resourced communications are even more critical going forward with the Minister for Health citing advice of the Acting Chief Health Officer in her 12 July Statement of Reasons to transition to a model that encourages a shared community responsibility through education, communication and engagement, the criticality of community goodwill and social

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1   Department of Health, *Chief Health Officer Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

2   Department of Health, *Acting Chief Health Officer Advice to Minister for Health (10 January 2022)*, 2022, Victorian Government.

3   Department of Health, *Acting Chief Health Officer Advice to Minister for Health (7 April 2022)*, 2022, Victorian Government.

acceptance to underpin compliance with restrictions, and that there is growing fatigue in the Victorian population with COVID-19 and COVID-19 response measures.[4]

IPMAC is of the view that this significant shift has not been supported with alternative clear and easy to access information to enable individuals and industry to take on a greater role in protecting themselves and their workforces. IPMAC heard at the Communications Roundtable convened by the Committee on 16 June 2022 with participation from communications experts across government and academia that resourcing was no longer available for the communications efforts required for effective engagement and ensuring nobody was left behind. On 1 July 2022, the Department of Health's dedicated COVID-19 Response was dismantled with the COVID-19 workforce reduced from more than 1500 people to 260 positions.[5]

With the onset of COVID-19, pandemic communications became a critical activity across government that required a significant growth in resourcing. It is imperative that a sufficient capability be maintained to communicate what is required in this pandemic and for any future pandemics. Individuals need information on managing public health risks to be able to make informed decisions about safe behaviours and facilitate behaviour change. Priority populations and the more vulnerable cohorts most at risk need to be able to continue to access information to positively guide health behaviours and link them to the services available.

Penny Armytage AM
Chair

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4   Department of Health, *Statement of Reasons (12 July 2022)*, 2022, Victorian Government.

5   Le Grand C. Pandemic response shrinks as COVID-19 pressure builds, 4 June 2022, The Age webpage <https://www.theage.com.au/politics/victoria/pandemic-response-shrinks-as-covid-19-pressure-builds-20220601-p5aq60.html>.

Acronyms and Abbreviations

Acronym	Explanation
ABS	Australian Bureau of Statistics
ACCHOs	Aboriginal Controlled Community Health Organisations
AHD	Aboriginal Health Division
AHPPC	Australian Health Protection Principal Committee
ATAGI	Australian Technical Advisory Group on Immunisation
BAS	Behaviours and Attitudes Survey
BETA	Behavioural Economics Team of the Australian Government
BI	Behavioural Insights
CALD	Culturally and Linguistically Diverse
CDC	Centers for Disease Control and Prevention (US)
CEO	Chief Executive Officer
CERC	Crisis and Emergency Risk Communications
CHO	Chief Health Officer (Victoria)
CQV	COVID-19 Quarantine Victoria
DELWP	Department of Environment, Land, Water and Planning (Victorian)
DET	Department of Education (Victorian)
DFFH	Department of Families, Fairness and Housing (Victorian)
DH	Department of Health (Victorian)
DJCS	Department of Justice and Community Safety (Victorian)
DJPR	Department of Jobs, Precincts and Regions (Victorian)
DoT	Department of Transport (Victorian)
DPC	Department of Premier and Cabinet (Victorian)

Acronym	Explanation
ECE	Early Childhood Education
eDM	Electronic Direct Messages
FAQs	Frequently Asked Questions
FECCA	Federation of Ethnic Communities Councils in Australia
ICU	Intensive Care Unit
IPMAC	Independent Pandemic Management Advisory Committee
IRSD	Index of Relative Socio-economic Disadvantage
IVF	In Vitro Fertilisation
LGA	Local Government Area
LPHU	Local Public Health Unit
MNS	Multilingual News Service
MRC	Migrant Resource Centre
NEMBC	National Ethnic and Multicultural Broadcasters' Council
NGOs	Non-Government Organisations
PCR	Polymerase Chain Reaction
PDAOC	Pandemic Declaration Accountability and Oversight Committee
PHW Act	Public Health and Wellbeing Act 2008
PRMC	Priority Response to Multicultural Communities
RAT	Rapid Antigen Test
RCCE	Risk Communication and Community Engagement
SEIFA	Socio-economic Indexes for Areas
TAC	Transport Accident Commission (Victorian)
VACCA	Victorian Aboriginal Child Care Agency

Acronym	Explanation
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Victorian Aboriginal Health Service
WHO	World Health Organization
VMC	Victorian Multicultural Commission

IPMAC Membership

Penny Armytage AM (Chair)

- Former Chair of the Royal Commission into Victoria's Mental Health system and former Secretary of the Victorian Department of Justice
- KPMG Partner and Special Advisor 2012 -2019

Paris Aristotle AO

- CEO of Victorian Foundation for Survivors of Torture and currently the Chair of the Refugee and Migrant Services Council

Pip Carew

- Health sector professional with 20 years of experience in clinical nursing and union representation

Assoc. Prof. Joseph Doyle

- Infectious diseases physician and public health physician

Belinda Duarte

- Cultural education and training leader and CEO of Culture Is Life

Dr Peter Harcourt OAM

- Sport and exercise physician and Chair of International Cricket Council (ICC) Medical Advisory Committee

Michael Graham

- CEO of the Victorian Aboriginal Health Service and Acting Chair of VACCHO.

Rabea Khan

- Barrister, previously a lawyer with Office of Public Prosecutions, IBAC and the Victorian Aboriginal Legal Service

Vivienne Nguyen AM

- Chairperson of the Victorian Multicultural Commission

Dr Amanda Rojek

- Clinical Research Fellow, Pandemic Sciences Institute, University of Oxford

Mark Stone AM

- Former CEO of Victorian Chamber of Commerce and Industry

Dr Helen Szoke AO

- Former Victorian Equal Opportunity and Human Rights Commissioner, and member of Advisory Boards for the Royal College of Surgeons and the Royal College of Australia and New Zealand Obstetrics and Gynaecology

Executive Summary

The COVID-19 pandemic changed the communications ask of the Victorian Government. Nobody could be left behind. One group being vulnerable meant that everyone else is vulnerable. Previously government expected people to come looking for the information they needed. During the pandemic government had to go to the people. This required a rapid alignment and mobilisation of communications functions across government underpinned by collaboration, innovation and agility.

Collaboration across government, supported by clear processes and structures facilitated alignment in consistent messaging through multi-layered communications. A broad range of communication and engagement activities were undertaken by government informed by consistent messaging that was tailored for different sectors and priority cohorts. Information was distributed through government networks using existing channels and a diversity of new mechanisms. The different relationships of respective departments were made available and utilised across government to maximise reach. Human intelligence was shared to target interventions to populations and places most in need. In addition to large scale communications campaigns, the government was positioned to, and facilitated, innovative and agile targeted interventions across communities and the state.

Significant effort was made across government to ensure the timely provision of consistent and relevant information that maximised reach utilising a diversity of methods and platforms. Due to the dynamic nature of the pandemic and the need to ensure accuracy, there were at times delays in government departments receiving a single, reliable, up to date source to develop tailored messaging on pandemic order changes for distribution through their networks to the target audience. Effective measures were put in place where possible to mitigate this. These should be embedded in future pandemic responses.

Coordinated and planned stakeholder engagement where regular feedback was encouraged and collected enabled ongoing and future messaging to be tailored to the audience and address any gaps identified.

The pandemic highlighted the limited reach of traditional public health messaging and the need for specific and targeted communications initiatives to reach different cohorts in the community. This required the Victorian Government to "let go" to a certain extent and empower trusted individuals and organisations to deliver accurate information. Where this was done effectively, capacity was expanded through trusting others to communicate messages to their own networks and communities and the timeliness of delivery improved. It was still important for those delivering the message to be able to validate messages by being able to say the message came from the Victorian Government (Department of Health). This model should be sustained moving forward.

Organisations were enabled and empowered to share information through platforms communities were already using and implement tailored communications to meet local needs which facilitated culturally appropriate and timely messaging. Programs should be co-designed and led by community wherever possible. Approaches led by community are representative of and engage the diversity within them. Methods of communication must be varied to meet the diverse needs of community members including written and non-written formats. Diversity is important between communities but also within them in terms of varying levels of literacy.

Use of trusted voices in message delivery gave credibility to the message and was important to counteract misinformation. Trusted voices such as faith and community leaders, local elders and influencers were as important as medical professionals when sharing information with their communities. Future planning for emergency communications and ongoing public health communications should include the ability to support resources, both individuals (including trusted sources) and organisations who have a voice in the community and media, by providing them the messaging and answers they need, in a timely manner, to assist in message amplification.

COVID-19 press conferences played a vital role in helping Victorians make sense of what was occurring across Victoria during uncertain times. They were an important vehicle for providing timely and informative contextual credible information. Participants demonstrated empathy, acknowledging the impacts, challenges and what people were feeling. The absence of regular communication and engagement with Victorians from the government and trusted experts since the end of October 2021 – when daily press conferences ceased – has likely contributed to the uncertainty around COVID-19 and the government's response to COVID-19 in the future. Misinformation starts to take hold in the absence of more authoritative advice. Without clear messaging and expert advice from the government, the media turn to people in the community who have an opinion.

Meaningful relationships were established over the course of the pandemic which engendered trust. Ongoing investment in this engagement is critical to ensure effective networks can be quickly leveraged when required. This should be embedded in departments and agencies whose role it is to ensure critical coordination of communication and engagement.

While large scale advertising campaigns remain important, the diversity of Victoria's community should be represented in these campaigns. Effective tailored and targeted communication relies on data and analysis, insights, and ongoing engagement requiring a sustained focus and investment by government.

Pandemic behaviour change campaigns and public health promotion must be evidence based. Systems to capture relevant data to inform communications process were established and refined throughout the pandemic, building on strong systems already in place. Accurate and accessible demographic data remains an important investment by government to ensure ongoing tailored communication and engagement strategies.

Advertising campaigns were informed by behaviour change theory, but this had to be done quickly in line with campaign delivery in other emergency settings such as bushfires. The notable difference being the length and complexity of messaging required to support the COVID-19 response. As more evidence about COVID-19 has become available since the pandemic began, and with the gradual shift to individual responsibility, there is an opportunity to undertake a more comprehensive campaign development process and ensure behaviour change theory and practice is central to the development of all pandemic communications. Behavioural and business insights produced by the Department of Premier and Cabinet should be publicly available and accessible outside government to inform the work of all agencies with a shared responsibility for enhancing the public health outcomes for Victorians.

Communications need to continue to reach Victoria's diverse community through proven targeted communications initiatives that recognise how audiences receive information differently. Priority populations and the more vulnerable cohorts most at risk need to be able to continue to access information to positively guide health behaviours and link them to services available. The Committee was made aware that communications with older Victorians and young people under 25 could have been a greater focus. There is a need to ensure communications are inclusive moving forward.

Communication is increasingly important with the model of shared responsibility. Individuals need information on managing risks related to COVID-19 to make informed decisions about safe behaviours and access appropriate support and services. Maintaining this collaboration and alignment of communications functions across government and sustained resourcing is critical to support behaviour change and health promotion programs for the whole community. With the lessons learnt, it is also imperative to ensure that the required communications functions are ready to be stood up during future waves and in the event of a vaccine resistant variant.

Recommendations

Sustain and resource COVID-19 Communications

Recommendation 1

IPMAC recommends that the Victorian Government Department of Health Public Health Division plan for the duration of the pandemic:

•   to sustain and resource the collaborative and aligned COVID-19 communications functions across government to support behaviour change and health promotion programs for the whole community and the more vulnerable cohorts most at risk to continue to access information to positively guide health behaviours and the services available.

Targeted communication plans to address those most at risk

Recommendation 2

IPMAC recommends that the Victorian Government Department of Health Public Health Division:

•   utilise data and analytics to inform the development of tailored and targeted communication and engagement plans to address places and populations most vulnerable to outbreaks in future pandemic communications.

COVID-19 Health literacy program

Recommendation 3

IPMAC recommends that the Victorian Government Department of Health:

•   identify, support, and build capacity for health literacy in Victorian government agencies and specialist organisations with overall responsibility for the program, recognising the shift to individual responsibility and the continuing evolution of the pandemic.

Pandemic Communications Plan

Recommendation 4

IPMAC recommends that the Victorian Government Department of Health:

- develop a plan for future pandemic communications informed by the lessons learned that incorporates a framework for the structure and networks that would be stood up and the lead agency responsible that considers:
  - A model to empower trusted individuals and organisations to deliver accurate information.
  - Enabling and empowering communities to codesign and lead communications.
  - Embedding ongoing engagement that has engendered trust across government and how this can be quickly leveraged when required.
  - Innovative and agile interventions that target populations and places most in need and maximise reach.

Investment in the evidence-base

Recommendation 5

IPMAC recommends that the Victorian Government:

- continue to invest in data and analytics and make this publicly available to inform public policy and the work of all agencies with a shared responsibility for enhancing the public health outcomes for Victorians.

Transparency

Recommendation 6

IPMAC recommends that the Victorian Government:

- make behavioural and business insights collected by the Department of Premier and Cabinet publicly available for transparency and public confidence and to inform public policy, or
- provide the capacity in the Department of Health.

1.   Independent Pandemic Management Advisory Committee (IPMAC)

The primary role of the Independent Pandemic Management Advisory Committee (IPMAC) is to provide advice to the Minister for Health on the exercise of powers under Part 8A of the *Public Health and Wellbeing Act 2008* (PHW Act). As an independent advisory committee, IPMAC can review, provide advice and make non-binding recommendations to the Minister for Health on the exercise of the powers under Part 8A of the PHW Act. The provision of this advice can be on its own initiative or on request by the Minister.

Under the PHW Act, the Pandemic Declaration Accountability and Oversight Committee (PDAOC) must request and consider the advice of IPMAC before it can recommend that a pandemic order, or an instrument that extends, varies or revokes a pandemic order, be disallowed in whole or in part. PDAOC is a joint investigatory committee of the Parliament of Victoria that reviews the pandemic orders and other instruments made by the Minister for Health to ensure they are compatible with the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006.*

As required by section 165CE(4) of the PHW Act, IPMAC as a group must as far as reasonably practicable have skills, knowledge and experience to encompass all of the following matters: public health; infectious diseases; primary care; emergency; critical care; law; human rights; the interests and needs of traditional owners and Aboriginal Victorians; and the interests and needs of vulnerable communities.

IPMAC is dissolved when the Premier's pandemic declaration is revoked or not renewed.

1.1   Establishment and Membership

IPMAC was established on 11 February 2022. As required by section 165CE(4) of the PHW Act, as a group the Committee, have skills, knowledge and experience in all the following areas:

- public health
- infectious diseases
- primary care
- emergency care
- critical care
- law
- human rights
- the interests and needs of traditional owners and Aboriginal Victorians
- the interests and needs of vulnerable communities.

2. Purpose of the Review

The purpose of the Review of COVID-19 Communications in Victoria (the review) is to assess the Victorian Government's communication approach relating to pandemic orders and health related communications against best practice to identify any learnings that can inform pandemic communications going forward.

2.1 Scope of Review

The new Part 8A of the PHW Act, effective from 15 December 2021, introduced the requirement that IPMAC be established to provide advice to the Minister for Health on the exercise of powers under this part of the PHW Act while there is a pandemic declaration in place. The review explores how pandemic orders made by the Minister for Health, through the exercise of powers under the PHW Act from 15 December 2021 to 12 July 2022, have been communicated to the Victorian community.

For the purpose of this review "communication" is defined as: COVID-19 communications and engagement delivered by or on behalf of the Victorian Government, including media, strategic communications, advertising, digital and social, and community and stakeholder engagement.

While the analysis is related to pandemic order changes from 15 December 2021 onwards, it is recognised that many communication structures and strategies regarding COVID-19 restriction changes were developed and in place prior to this date and any communications need to be considered in this context.

2.2 Limitations

Between15 December 2021 and 12 July 2022, the Minister for Health made 78 pandemic orders. Communicating what this means for the Victorian community has required a multi-faceted whole of government approach. Therefore, it has not been possible to individually consider how each pandemic order has been communicated. Given we are still experiencing a pandemic, limited research is available on the evaluation of COVID-19 communications in other jurisdictions or globally.

IPMAC has received limited information on the investment made by government in pandemic order communications and evaluations for communications activities.

IPMAC's assessment does not consider pandemic communications which the Department of Justice and Community Safety (DJCS), is responsible for as this information was not provided to the Committee. The review has also not been informed by Behaviours and Attitudes Survey (BAS) data as the Department of Premier and Cabinet (DPC) did not make this information available to IPMAC.

2.3   Committee's Approach to the Review

The key inputs to the review include:

- research into best practice approaches to communications, at the broad level and more specifically as it relates to COVID-19 communications
- research into how other jurisdictions have approached COVID-19 communications, specifically relating to pandemic orders (or equivalent) focussed on New South Wales (NSW), Queensland, Western Australia, New Zealand, England and Singapore
- documentation and analysis of Victoria's multi-faceted whole of government approach in communicating pandemic orders including community engagement mechanisms collected from the Department of Health (DH), Department of Jobs, Precincts and Regions (DJPR), Department of Education (DET), Department of Transport (DoT), Department of Families, Fairness and Housing (DFFH), DPC, and Department of Environment, Land, Water and Planning (DELWP).
- analysis of information requested and received from WorkSafe, Transport Accident Commission (TAC), VicHealth
- a Communications Roundtable convened by the Committee on 16 June 2022 with participation from communications experts across government and academia
- a range of case studies prepared by the Committee to explore how communications approaches have been tailored for different audiences focussing on:
  – Shift from control to empowerment: Multicultural and multifaith pandemic order communications through the COVID-19 pandemic
  – Communication of the Victorian COVID-19 vaccination program for priority people, places and workplaces, through an engagement and partnerships approach
  – Communicating rapidly changing restrictions and public health orders effectively to Syrian and Iraqi refugee and asylum seeker communities
  – Community engagement and culturally safe communications to support Victorian Aboriginal communities through the COVID-19 pandemic.

2.4   Principles against which COVID-19 communications were reviewed

The Committee considered a range of best practice approaches to communications including those relating to an emergency situation and health promotion to identify the following principles against which the pandemic orders would be assessed:

- simple, clear, consistent and current – timely and relevant
- accessible, sensitive and inclusive – culturally appropriate and accessible for priority groups
- targeted – diverse communication tools/channels using integrated approaches tailored to audience (simple versus comprehensive) involving and engaging those affected
- sensitive, evidence based and credible, is open and transparent, creates and maintains trust and is relatable
- enabling – guides health promoting opportunities and provides links to information and services
- proactive in public communication even in uncertainty and provides certainty around roles and responsibilities
- consistent with best practice – other jurisdictions

These principles were validated at a Communications Roundtable convened by the Committee on 16 June 2022 with participation from communications experts across government and academia. A copy of the attendance list is at **Appendix A**.

2.5   Background

The rapid emergence and spread of COVID-19 has had an unprecedented impact on Australia and across the world. On 5 January 2020, the World Health Organization (WHO) notified member states that an outbreak of pneumonia of unknown cause had been identified in China. On 30 January 2020, the WHO declared the coronavirus outbreak a Public Health Emergency and on 11 March 2020 declared COVID-19 a global pandemic.[6] The first Australian case of COVID-19 was recorded in Victoria on 25 January 2020. In response to the threat posed by COVID-19, a State of Emergency was declared in Victoria on 16 March 2020 by the Minister for Health on the advice of the Chief Health Officer (CHO) under the PHW Act.[7] This activated the powers of the CHO to issue directions and set requirements to eliminate or reduce risks to public health. The first direction from the CHO under these new powers included banning non-essential mass gatherings of over 500 people such as cultural events, sporting events or conferences.

In March 2020, Australia closed international borders except for citizens and residents for permitted travel and had significant caps in place. A hotel quarantine program was established in Victoria to manage quarantine of returning travellers.

On 30 March 2020, Stage 3 restrictions were put in place with four reasons to leave home and school closures followed on 7 April 2020. Stage 3 restrictions were eased on 1 June 2020 and then tightened on 21 June 2020 with caps on visitors to home and the extension of the State of Emergency. 28 June 2020 marked the start of the second wave in Victoria with the second lockdown commencing on 1 July 2020 and the State of Emergency extended on 19 July 2020. On 2 August 2020, Victoria declared a State of Disaster and Stage 4 restrictions were introduced in metropolitan Melbourne with a new peak of daily cases at 725 on 5 August 2020.

Victoria's Roadmap for reopening was released on 5 September 2020 with metropolitan Melbourne and regional Victoria moving through the steps at different times. With varied restrictions in place, a border between metropolitan and regional Victoria was in place, often referred to as the 'ring of steel', restricting movement between areas of differing levels of restrictions. Restrictions were aligned on 8 November 2020 with travel allowed anywhere across the state.

While the border to other states from Victoria was closed at various times, the first time Victoria closed its border to another state was with South Australia on 19 November 2020. A permit system was then set up on 21 November for travellers entering Victoria from South Australia with the scheme ending on 12 December 2020. On 1 January 2021, Victoria closed its border with NSW. A permit system was again put in place for travellers entering Victoria on 11 January 2021. A traffic-light system was introduced at the same time to classify outbreak risks in other states and determine permit requirements. Lockdown number three commenced on 12 February 2021 and Australia's COVID-19 vaccine rollout began on 22 February 2021 with a phased roll out implemented across the country. Victoria experienced a further three lockdowns commencing 27 May 2021 (lockdown four), 15 July 2021 (lockdown 5) and 5 August 2021 (lockdown 6). By 4

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6   World Health Organization, Listings of WHO's response to COVID-19, media release webpage, 2020 <https://www.who.int/news-room/detail/29-06-2020-covidtimeline>

7   Premier of Victoria, State of Emergency Declared in Victoria Over COVID-19, media release, 2020, Victorian Government, *Victoria Government Gazette*, no. s 129, 16 March 2020.

October 2021, Melbourne marked 245 days of lockdown since the start of the pandemic and became the city with longest cumulative time in lockdown due to the COVID-19 pandemic across the world.

At the 6 August 2021 meeting of National Cabinet, all states and territories agreed to the National Plan to Transition Australia's COVID-19 Response. The national plan outlined a clear path of vaccination targets to achieve the phased "opening back up in a careful and safe way."[8] Phase A stipulated the need for measures to accelerate vaccination targets while strong suppression to minimise community transmission was still required. This phase was associated with closed international borders, inbound passenger caps, early and stringent lockdowns, and effective Test, Trace, Isolate and Quarantine strategies. Vaccination targets were set for Phase B at 70% and Phase C at 80% to enable the gradual easing of restrictions, once these where achieved.[9]

The Victorian Government announced the second plan *Victoria's Roadmap: Delivering the National Plan* (the Roadmap), the state's strategy for implementing the transition phases of the National Plan on 19 September 2021. The Roadmap linked opportunities for increased social and economic participation for the Victorian community to vaccination coverage.[10]

The legislative framework for introducing pandemic orders was introduced on 15 December 2021 and set out in Part 8A of the PHW Act. This framework replaced the State of Emergency framework, which was designed to respond to serious, short-term events with an expiration date of 15 December 2021.

By the end of 2021 Australia had achieved relative global success in minimising the loss of life and burden of disease from COVID-19 infection on a global scale. This had come at significant sacrifice and cost, in particular to Victorians, requiring severe and significant lockdowns to keep the virus under control. With the rest of the world progressively opening up, and with the emergence of increasingly transmissible new variants, high vaccination coverage was considered essential to avoid significant loss of life when the state and country eventually moved to the next phase of the pandemic, ending the lockdowns and learning to live with COVID-19 sustainably, as outlined in the National Plan and Victorian Roadmap.

With high vaccination coverage attained, December-January 2021 signalled a major transition in the public health response in the peak of the Delta wave and emergence of Omicron. This saw the easing of major control measures around testing, contact tracing, isolation, quarantine and furlough requirements, scaling up of the booster vaccination program and vaccination of children aged 5-11 years. During January - July 2022 Victoria experienced successive waves of COVID-19 infection associated with the increasing dominance of the Omicron variants of concern, and multiple sub-lineages. While precautionary measures were maintained by the Victorian Government to protect vulnerable Victorians and protect the health system, in a general sense, restrictive measures continued to ease with many restrictions removed in April and further in June 2022.

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8   Department of the Prime Minister and Cabinet, *National Plan to transition Australia's National COVID-19 Response* webpage, 2021, Commonwealth of Australia <https://www.australia.gov.au/national-plan> accessed 7 July 2022.

9   Department of the Prime Minister and Cabinet, *National Plan to transition Australia's National COVID-19 Response* webpage, 2021, Commonwealth of Australia <https://www.australia.gov.au/national-plan> accessed 7 July 2022

10   Department of Premier and Cabinet, *Victoria's Roadmap: Delivering the National Plan* webpage, 2021, Victorian Government <https://www.premier.vic.gov.au/victorias-roadmap-delivering-national-plan> accessed 4 July 2022.

Between 15 December 2021 and 12 July 2022, 78 pandemic orders were made. During this period, changes to pandemic orders gradually became less frequent, changing four times in December 2021, three times in January 2022, four times in February 2022, once in March 2022, twice in April 2022, once in June 2022 and once in July 2022. This easing of restrictions coincided with a surge in cases with the emergence of the Omicron variant.

In April 2022, many of the public health measures were revoked through order changes, signalling a major transition of the Victorian Government's pandemic response, to one of 'empowering industry, workplaces and individuals to make decisions based on public health guidance'.

This transition was described by the new Minister for Health in July 2022 in the Statement of Reasons articulating a new objective of the public health response to be one of 'maintaining enjoyment of life and the continued operation of business, cultural, sporting and other activities.'

As at 12 July 2022, 94.6% of eligible Victorians over the age of 12 had received two doses of a COVID-19 vaccination. 68.6% of eligible Victorians over the age of 16 had received three doses (booster) of a COVID-19 vaccination.[11] The total number of deaths related to COVID-19 reported in Victoria since the pandemic begun was 4,091. IPMAC acknowledges the devastating impact on the individuals, families, and communities of those who have lost their life due to COVID-19, and for those who have suffered serious illness, and continue to do so.

The severity of COVID-19 disease has changed over the course of the pandemic. This is in part due to the evolution of the virus itself, but also in the public health response with advancements in vaccination, treatment and clinical management, and more recently the availability of new therapeutics and anti-viral medications.[12] In Victoria during the early waves caused by Wild Type variants, 12% of cases were hospitalised and the case fatality rate was 4%. During Delta this had reduced to 6% hospitalisation and a case-fatality rate of 0.5%. With Omicron Victorian experienced 1% hospitalisation and a 0.1% case fatality rate. Cohorts that remain the most vulnerable include those that most directly suffer the highest rates of severe disease, people with severe comorbidities, in residential aged care and specialist disability accommodation and in communities with low vaccination uptake.

IPMAC acknowledges that the public health measures adopted by the Victorian and Australian Governments prevented significant loss of life and illness that may have occurred if such efforts to minimise transmission and manage the risks of COVID-19 had not occurred.

Over the course of the pandemic there have been rapid and ongoing changes to COVIDSafe settings and public health advice and recommendations that have had to be communicated to the Victorian community.

Figure 1 below provides an overview of key changes to COVIDSafe settings and public health advice and recommendations from 15 December 2021 to 12 July 2022.

A copy of all the Pandemic Orders that have come into effect since 15 December 2021 is available on the Pandemic Order Register on the DH website at <https://www.health.vic.gov.au/covid-19/pandemic-order-register>.

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11   Department of Health, *Coronavirus update for Victoria* webpage - *12 July 2022*, 2022, Victorian Government
     <https://www.health.vic.gov.au/media-releases/coronavirus-update-for-victoria-12-july-2022>

12   Department of Health, 2022.

Figure 1: Summary of key changes from 15 December 2021 to 12 July 2022

December 2021	Key Changes
	15 December 2021 First ministerial pandemic orders issued under the new *Public Health and Wellbeing Act*. • Elective surgery rules updated, with rural and regional health services able to resume up to 75% of normal elective surgery activity. • Patron vaccination requirements removed for people under 18. • Patron vaccination requirements removed in real estate, places of worship, weddings, funerals and retail, except hair and beauty services. • Patron vaccination requirements remain at hospitality settings. • Face coverings no longer required at weddings, funerals, or ceremonial settings. • Deadline by which healthcare workers need to have their second COVID-19 vaccine to be eligible to continue working.
	20 December 2021 • Testing requirements ease for fully vaccinated international travellers and flight crew (with two doses), 72-hour isolation period no longer required. • 14-day mandatory hotel quarantine still required for not fully vaccinated international arrivals aged 18 and over.
	23 December 2021 • Face coverings required indoors for people aged 8 and over and when moving around major events with more than 30,000 people (except when seated outdoors). • Victorians encouraged to work from home and stick to seated service in hospitality venues.
	24 December 2021 • ATAGI reduces the third-dose interval to four months due to the prevalence of Omicron.
	30 December 2021 • New definition of 'close contact' as four or more hours in a household setting with a confirmed case. • Isolation requirements for positive cases reduced to 7 days, down from 10 days.

December 2021	Key Changes
	31 December 2021 • Testing changes to focus on highest-risk Victorians. PCR tests available for anyone who has symptoms and anyone who has tested positive on a RAT.

January 2022	Key Changes
	5 January 2022 • Distribution of free RAT kits begins under a pilot program.
	6 January 2022 • Changes to reduce PCR testing queues and ease pressure on pathology labs. Anyone who returns a positive RAT result is considered a 'probable case' with the same obligations as someone who returns a positive PCR test. • Non-urgent elective surgery temporarily reduced. • A density quotient of one person per two square metres introduced indoors at hospitality venues, entertainment venues and gaming venues. • Strong recommendation to undertake a RAT prior to visiting aged care facilities or hospitals.
	7 January 2022 • Victoria introduces mandatory reporting of positive RAT results – the first state or territory to do so.
	10 January 2022 • COVID-19 vaccine rollout begins for children aged 5 to 11.
	12 January 2022 • Booster deadline of 25 February 2022 introduced for healthcare, aged care, disability, emergency services, correctional facilities, quarantine accommodation and food distribution workers required to have a third COVID-19 vaccine to work onsite. Note: deadline was later extended to 12 March 2022. • Indoor dancefloors close (except at weddings). • Further visitor restrictions applied to hospitals and aged care settings. • Close contact isolation exemption for food and drink distribution workers. • Pandemic declaration extended for three months.

January 2022	Key Changes
	18 January 2022 • System-wide Code Brown announced to support the public hospital system, with medical staff redeployed. • Close contact isolation exemption for key workforces, e.g. emergency services, education, critical utilities, custodial facilities, transport and freight.
	19 January 2022 • ATAGI reduces the third-dose interval to three months.
	20 January 2022 • IVF procedures recommence.
	25 January 2022 • Get the Right Help for Your Recovery campaign launched to help Victorians manage their recovery from COVID-19 at home. • Booster deadline of 25 February 2022 introduced for education facility workers. Note: deadline was later extended for these workers to 25 March 2022. • Face coverings required for students in Grade 3 and above when indoors.
	31 January 2022 • School students and staff begin twice-weekly rapid antigen testing.

February 2022	Key Changes
	3 February 2022 • ATAGI approves a third dose for 16 and 17 olds.
	7 February 2022 • Day surgery resumes at up to 50% of normal levels at private hospitals and day procedure centres.
	10 February 2022 • ATAGI redefines 'fully vaccinated' as 'up to date' based on age and health status. All individuals aged 16 years and over are recommended to receive a booster dose to maintain an 'up-to-date' status.

February 2022	Key Changes
	14 February 2022 • Code Brown lifted – elective surgery resumes at various levels across the state.
	17 February 2022 • School surveillance testing program extended until the end of Term 1.
	18 February 2022 • Removal of density quotients at hospitality and entertainment venues. Dancefloors reopen. • Removal of check-in requirements at retail venues, schools (including childcare and early childhood) and for employees at many workplaces. Check-in and vaccination check requirements remain in all 'vaccinated economy' settings such as hospitality and entertainment venues. • 14-day hotel quarantine period for international visitors and aircrew who are not fully vaccinated or medically exempt reduced to 7 days.
	21 February 2022 • Novavax COVID-19 vaccine available to people aged 18 and over. • International borders open to travellers vaccinated with two or more doses. • Category 2 elective surgery resumes in metropolitan Melbourne. • Private hospitals in metropolitan Melbourne can undertake up to 75% of any elective surgery activity, increasing from 50% . • The cap for private hospitals in regional Victoria increases from 75% to up to 100%.
	25 February 2022 • Removal of face covering requirements for most indoor settings (still required in certain settings including education, public transport and healthcare settings). • Removal of recommendation for Victorians to work or study from home. • Third doses available through the in-home vaccination program to Victorians aged 70 and over.
	28 February 2022 • All restrictions on elective surgery removed.

April 2022	Key Changes
	5 April 2022 • Department of Health modelling estimates voluntary surveillance testing prevented 113,500 COVID-19 infections in Term 1. • Free RAT kits provided to schools and early childhood settings for Term 2.
	9 April 2022 • People with a disability able to access up to 20 free RAT kits per visit to a testing centre.
	12 April 2022 • Victoria's pandemic declaration extended for three months. • Border entry requirements for fully vaccinated or exempt non-cruise maritime crew align with requirements for air crew. • Vaccination requirements would not apply to any venue when it is operating as a polling place for the federal election.

	22 April 2022
	
	• Many rules shift from mandatory to recommended, with face coverings strongly recommended when physical distancing is not possible.
	• Most restrictions removed including:
	
	  – Patron vaccination requirements removed.
	
	  – Check-in requirements removed. Operators no longer required to keep attendance records or maintain a check-in marshal.
	
	  – Face coverings no longer required in education, hospitality and retail settings, or at events of any size.
	
	  – Close contacts no longer need to quarantine, provided they wear a face covering indoors, avoid sensitive settings and return at least five negative RATs over seven consecutive days.
	
	  – All visitor restrictions in hospitals removed except for face covering requirements.
	
	  – Events with more than 30,000 people no longer require public health pre-approval.
	
	  – Unvaccinated travellers no longer required to complete 7 days' quarantine.
	
	  – Pre-departure tests for unvaccinated air crew lifted.
	
	• Individuals required to notify their workplace contacts, in addition to their social contacts. Workplaces no longer required to individually identify and notify each potentially exposed worker.

April 2022	Key Changes

	• People who have had COVID-19 are exempt from testing or quarantine for 12 weeks, up from 8 weeks.
	
	• Critical and common-sense settings retained, including:
	
	   – Isolation requirements for positive cases.
	
	   – Workforce vaccination mandates.
	
	   – COVIDSafe Plan requirements for workplaces.
	
	   – Use of face coverings in certain settings.
	
	   – Visitor restrictions in care facilities.

June 2022	Key Changes
	24 June 2022 • Worker vaccine mandates lifted. Workers who interact with a vulnerable person still require three COVID-19 vaccine doses, this includes custodial, disability, emergency services, healthcare, residential aged care and specialist school workers. • Face coverings still required in certain settings including hospitals, care facilities, public transport, taxis, ride shares, and planes. • In line with the AHPPC statement, face coverings no longer required at airports. • Positive cases still required to isolate for seven days but may leave home to drive a household member directly to or from education settings or work without leaving their vehicle. They can also leave home to get medical care, a COVID-19 test, or in an emergency, including the risk of harm. • Visitor caps to care facilities, including residential aged care and disability are removed, with residents able to see any number of people as long as they test negative on a RAT that day.
	30 June 2022 • Victoria's mass PCR testing and COVID-19 vaccination programs scaled back by June 30, with the number of state vaccination centres decreasing from 39 to 12 and total state-run and private testing sites easing from 265 to approximately 180.

July 2022	Key Changes
	7 July 2022 • Free RATs program for schools and early childhood centres extended.
	12 July 2022 • Pandemic declaration extended for three months. • Significant new investment to boost public health messaging and engagement efforts with the community to encourage third and fourth COVID-19 vaccination doses, flu vaccination, the benefits of wearing a face covering and maximising ventilation indoors. The Stay Well in Winter campaign ran across TV, radio, outdoor and digital channels. • In line with AHPPC advice, the period when someone is considered a recently confirmed case was revised to four weeks, down from 12 weeks. • Positive cases still required to isolate for seven days but an additional reason to leave home added – to provide transport for a household member to obtain food, if essential. The infected person must remain in the car and wear a face covering at all times. • Face coverings strongly recommended in indoor and crowded settings. • Minister for Health requested that employers consider working from home arrangements. • All Victorians encouraged to make sure they are up to date with vaccinations, wear a good quality face covering, maintain good ventilation indoors and get a test if feeling unwell with COVID-19 symptoms.

3.   Government obligations under the *Public Health and Wellbeing Act 2008*

The purpose of the *Public Health and Wellbeing Act 2008* (PHW Act) is to promote and protect public health and wellbeing in Victoria. Part 2 of the PHW Act recognises that the State has a significant role in promoting and protecting the public health and wellbeing of Victorians.

3.1   Principles relevant to communication and information

Part 2 of the PHW Act contains a number of principles that guide its administration. The principles relating to communications are described below.

Under section 5 the principle of *evidence based decision-making* states that decisions as to the most effective use of resources to promote and protect public health and the most effective and efficient public health and wellbeing interventions should be based on evidence available in the circumstances that is relevant and reliable.

Under section 8 (2)(a) the principle of *accountability* states that members of the public should be given access to reliable information in appropriate forms to facilitate a good understanding of public health issues.

Under section 10 the principle of *collaboration* states that public health and wellbeing can be enhanced through collaboration between all levels of Government, industry, business, communities, and individuals.

3.1.1   The Secretary's functions relating to communication and information

Part 3 of the PHW Act states that the function of the Secretary of the Department of Health is to promote awareness and understanding of public health and wellbeing issues within the community; to support, equip and empower communities to address local public health issues and needs; and to establish and maintain a comprehensive information system.

3.2   Obligations relating to Pandemic Orders

The communication obligations under the PHW Act in relation to pandemic orders are contained in Part 8A and include:

- before a pandemic order, variation, extension, or revocation of an order comes into force, a copy of the order must be published on the pandemic order register (on the Department of Health's website)
- within seven days of a pandemic order being made, or a variation, extension, or revocation of an order, coming into force, the following must be published (on the Department of Health's website):
  – a copy of the written record of the advice given by the CHO
  – the Minister's statement of reasons for making, varying, revoking or extending the order – including, where relevant to decision making, what consultation occurred
  – the Statement of Charter considerations (the Minister's opinion on whether the order limits any Charter rights, and if it does, an explanation)
- this same material along with a copy of the pandemic order, variation or extension, must be tabled in Parliament within four sitting days of the orders being made
- following making of order, publication in full in the next general edition of Government Gazette; or in a special edition within 10 working days.

4. COVID-19 Pandemic Communications Approach

4.1 Overall COVID-19 Communications Approach

The overall communications approach for the COVID-19 pandemic spanned several key topics:

- vaccination
- provision of public health advice – mandated and recommended
- information updates on the pandemic itself, including case numbers and information about variants in the community
- changes to CHO directions and, from the 15 December 2021, pandemic orders, the subject of the committee's review.

4.2 Communicating pandemic declaration and Ministerial pandemic orders

The key objective of the approach to communicating Ministerial pandemic orders is to ensure Victorians are aware of the obligations imposed on them by the orders.

A whole of government approach was adopted that encompasses the DH providing a single, reliable, up to date source of public health information to inform consistent messaging across all sectors of the Victorian community. This is a translation of the pandemic orders into plain English and is distributed to relevant areas of government to ensure that messaging on pandemic order requirements and obligations is accurate and consistent. The strategy adopted has been to provide Victorians with clear, timely and up-to-date information using a wide range of channels and delivery mechanisms to maximise message distribution and reach.

Four pillars have been adopted, each with a role in communicating pandemic orders:

- media
- strategic communications and pandemic orders
- advertising
- digital and social.

4.3 Advertising campaigns

The DPC established a central campaigns team to deliver above the line, mass audience communications campaigns in March 2020. DPC played the lead advisory role in setting campaign strategy and delivering governance for COVID-19 campaigns to assist in disseminating accurate, up to date and timely information across all audiences. Departments reported fortnightly into a central DPC team for review and alignment of messaging.

As the analysis for this review is related to pandemic order changes from 15 December 2021 onwards, the campaigns run by DPC from December 2021 are listed below:

- Digital Vaccination Certificate campaign (through December 2021), reminding Victorians to digitally prepare to check in and show proof of vaccination status where required.

- COVID-19 Safe Behaviours Campaign (December 2021 - May 2022), encouraging the ongoing adherence of behaviours designed to slow the spread of COVID-19.

The DH was responsible for overall delivery of a range of health-specific campaigns including:

- A COVID-19 vaccination campaign for children aged 5 to 11 years to encourage vaccination uptake and support the blitz to vaccinate children in this age group over January and February 2022.
- Campaigns encouraging third dose vaccination and reinforcing the most compelling reason why Victorians should get their third dose vaccination, as soon as they are eligible, to keep themselves and loved ones safe from serious illness.
- Campaigns designed to reduce pressure on the health system including understanding when to call triple zero and how to identify symptoms that can be safely managed at home.
- Stay well in winter campaign encouraging third and fourth COVID-19 vaccination doses, flu vaccination, the benefits of wearing a face covering and maximizing ventilation indoors.

4.4   Community engagement

Community engagement has been a key delivery mechanism of the COVID-19 communications approach. The overall engagement focus for the COVID-19 pandemic has included:

- maximising vaccination uptake
- ensuring relief needs, including food and personal items for people required to isolate, are met, with targeted support for vulnerable cohorts
- monitoring and coordinating testing efforts
- supporting the community to understand and comply with CHO directions, and, from the 15 December 2021, pandemic orders.

A whole of government approach to community engagement was adopted that involved working relationships and partnerships with multiple government departments and agencies, Local Public Health Units (LPHUs), local governments, Aboriginal Controlled Community Health Organisations (ACCHOs), community leaders, and industry.

A broad range of engagement activities were undertaken including culturally and linguistically diverse (CALD) engagement, vaccination pop-up centres, industry forums, engagement with Aboriginal communities, communications and media, and local government engagement initiatives. Engagement channels included weekly meetings with community, informal individual and small group discussions, industry and community forums, social media, advertisements/promotion, phone/hotline, mail/letter box drop, council connectors, email, videos, information sessions, vaccination bus, vaccination neighbourhood pop-up, newspaper, and radio.

The COVID-19 Response 'Area of Operations' teams[13] were stood up in response to the 2021 COVID-19 Delta outbreak to deliver a coordinated community and place-based response, aimed at reducing the spread and impact of a pandemic virus. It contributed intelligence, planning, coordination and provided assurance at the regional level to provide a localised response. The nine Area of Operations aligned with the nine LPHUs with three metro and six regional teams.

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13   The 'Area of Operations' concluded on 31 March 2022 and the engagement functions and activities have transitioned into the COVID-19 Response.

Figure 2 provides a high-level overview of the communication roles and responsibilities across government and the mechanisms and tools utilised to deliver key messages relating to Pandemic Orders.

Figure 2: Whole of Government High Level Pandemic Orders Communications Framework
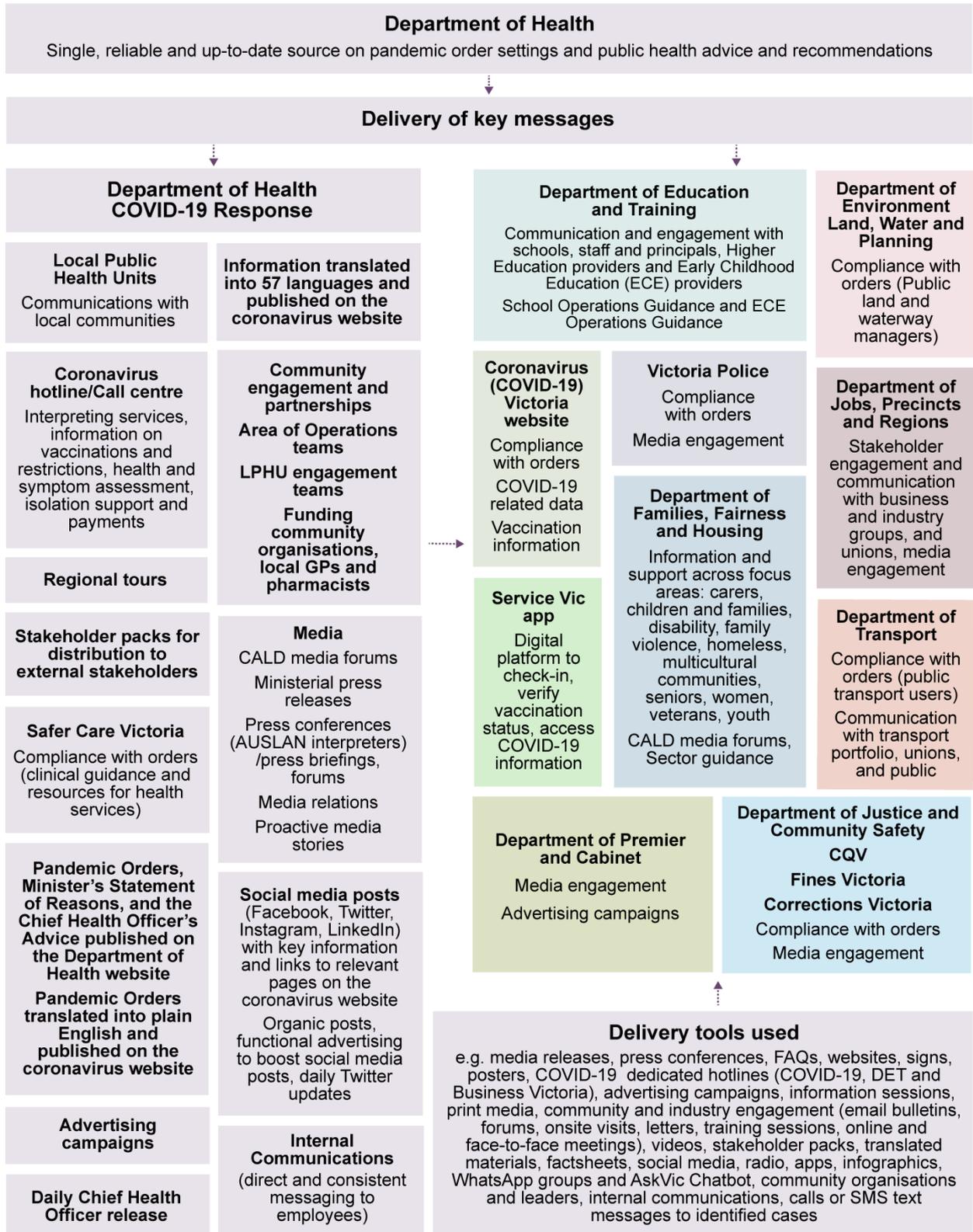
5.   Pandemic Communications in other jurisdictions

The Committee's review has been informed by an analysis of the COVID-19 communication strategies and outcomes across different jurisdictions in Australia and other English-speaking countries. The focus is on those with a comparable approach to Victoria - NSW, Queensland, Western Australia, New Zealand, England, Singapore and Canada.

The information was obtained through an examination of what was publicly available online for each jurisdiction between April and May of 2022.

The conclusions and comparisons between jurisdictions need to be considered in the context that with eased COVID-19 restrictions, current communications messaging is less complex and lower volume than that during the earlier stages of the pandemic.

The review considered whether:

- there was a legislated obligation from Government to publish pandemic orders or equivalent and where the information was published;
- there was published public health advice underpinning the restrictions;
- other public health advice was provided alongside the orders;
- there were dedicated feedback avenues (i.e. phone line) to help the public understand restrictions;
- inclusion was demonstrated through accessible materials and Frequently Asked Questions (FAQs);
- third party endorsers or sources were used to develop communication information and distribution practices;
- there was a role for community engagement practices to provide information to community groups;
- communication regarding inconsistencies in public health messaging (e.g. restriction exemptions for essential workers) was effective; and
- the government was perceived to be available and approachable to the general public.

The information collected has informed the Committee's assessment of best practice communications in section 7.1.7 Consistent with best practice - other jurisdictions.

5.1   Use of Behavioural Insights

IPMAC has explored the use of behavioural insights (BI) to inform pandemic communications in other jurisdictions given they provide insight into how and why people make decisions. The behavioural insights approach draws on evidence that drives behaviour and applies the evidence to practical issues.[14] BI recognises that decisions can be affected by multiple factors outside our conscious awareness such as social norms and how information is presented.

BI draw on different disciplines including "psychology, behavioural economics, user-centred design and systems thinking" to develop public policies, programs and services and enhance

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14   Hallsworth, M. and Kirkman, E., *Behavioral Insights*, 2020, United Kingdom, MIT Press, p. 1.

implementation.[15] Over 200 institutions around the world apply BI to improve policies and services.[16] The first unit – the BI Team also known as The Nudge Unit – was established in 2010 in the Office of the Prime Minister in the United Kingdom (UK) and is now a global social purpose company with offices around the world, independent of the UK government, The Behavioural Insights Team's About Us webpage is at <https://www.bi.team/about-us/our-offices/>. The team generates and applies BI to inform policy, improve public services and deliver results for society. The team has run more than 1000 projects to date and has partnered with government and non-government organisations (NGOs) at the federal level, and in Victoria, NSW, Western Australia, Tasmania and South Australia. The team creates blogs, podcasts, reports and tools that are publicly available on their website and look at the team's work across different policy areas. Throughout the pandemic, the COVID-19 team within the company published materials on the behavioural aspect of COVID-19 and encouraged policy makers, elected officials and other organisations globally to use the insights to inform decisions related to COVID-19.

In England, the Local Government Association provided councils with resources on how to apply BI to improve COVID-19 vaccination uptake. The resources drew on work by local authorities, academic research and key findings from related fields. They provided detailed explanations of behavioural science theories and frameworks to help councils understand the behaviour of residents, inform campaigns and address barriers to vaccine uptake. Councils have also been supported to apply behavioural insights techniques in service areas other than public health including housing, employment and skills, community safety, climate, environment and waste.

Australia followed the UK's lead shortly after the establishment of the Nudge Unit in the UK. The NSW BI Unit was established in 2012 and in July 2019 joined the Department of Customer Service. The unit publishes results from their work in occasional reports or through blogs which are publicly available on the NSW government website. BI reports have been published every two years since 2014. Practical guides are also available on the website to help apply behavioural insights to common challenges faced by government. The website offers the option to sign up to the unit's newsletter to receive updates on latest results on using behavioural insights, tips, upcoming events and workshops for NSW public servants. During the pandemic, the unit published blogs about the work they were undertaking to help people make informed choices and comply with protective behaviours and tips for individuals and organisations and included:

- 'How behavioural insights can help improve responses to COVID-19'
- 'How to encourage young people to wear face masks'
- 'How to consult customers during COVID-19'
- 'Teach-back and behavioural communication improved self-isolation while awaiting COVID clinic test results'.

The Australian Government has a central unit for applying BI to public policy called the Behavioural Economics Team of the Australian Government (BETA). BETA was created in 2015 to improve policy outcomes using behavioural economics and has developed over time. BETA now works across government to provide insights on how people really behave bringing together evidence from behavioural economics, psychology and other social sciences to design and test behavioural interventions.[17] BETA discloses trials ahead of time and aims to make findings public including

15   Victorian Government, *Behavioural Insights* webpage, 2021 <https://www.vic.gov.au/behavioural-insights>

16   Organisation for Economic Co-operation and Development, Behavioural insights webpage [information hub] <https://www.oecd.org/gov/regulatory-policy/behavioural-insights.htm>

17   Department of the Prime Minister and Cabinet, *About* webpage, 2021, Commonwealth of Australia <https://behaviouraleconomics.pmc.gov.au/about>

publishing information on their website about various projects they have worked on along with up to date research in fields such as behavioural psychology and applied BI, online training and events. While there are no COVID-19 related projects published on their website at the time of this report, in November 2021 BETA hosted an online series which explored the role of BI in the COVID-19 pandemic. *The series included three sessions exploring the topics of COVID-19 Behaviour, COVID-19 Misinformation and Building Back Better.18*

The Victorian BI Unit ("the Unit") was established in 2016 and is part of DPC's Strategic Communications, Engagement and Protocol Branch. The Unit works with government partners on projects that have a clear behavioural issue to help define a problem statement, assess whose behaviour is contributing to a policy issue and design and test behaviourally informed interventions. The Unit also provides BI advice which includes messaging in surveys, letters or websites and behavioural science evidence that might enhance policy implementation. In addition, the Unit runs workshops, training and leadership events to embed the use of BI more broadly across the Victorian Public Service.

The Unit has in the past published case studies of how BI have been used in Victoria to deliver solutions across different policy areas and key learnings, This included one on the BI work they undertook on boosting Human Papillomavirus vaccination rates in 2019.

IPMAC understands the Unit undertakes regular Behaviours and Attitudes Surveys (BAS) which are used to inform COVID-19 policy work across government. The findings from this survey are not released publicly. Based on the review, it appears that regular survey results are not released publicly by other jurisdictions. However, in comparison to England and NSW, Victoria's Unit has not published any information on how BI have informed Victoria's COVID-19 Response or any resources for policy makers and organisations on how to apply BI to inform decisions related to COVID-19.

As part of DPC, the Business Insights Unit collect and analyse media to create research, reports, tools and products that offer insights into digital activity to uncover emerging issues and give government a rich understanding of the sentiment, expectations and needs of Victorians.

It is understood this assists with the tailoring of communications and content, improving community engagement, and responding and reducing misinformation across The DPC 2020-21 Annual Report notes that business insights emerged as an essential service to government in both the response to COVID-19 and contributing to Victoria's recovery initiatives.[19]

Understanding the common narrative in media and social media can assist in the determination of levels of fatigue relating to specific restrictions. It can also be used in the development of messaging to answer frequent questions or to combat false or unproductive narrative and in the identification of trusted voices.

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18 Department of the Prime Minister and Cabinet, *Events* webpage, 2021, Commonwealth of Australia <https://behaviouraleconomics.pmc.gov.au/events>

19 Department of Premier and Cabinet, *Department of Premier and Cabinet Annual Report 2020–21*, 2021, Victorian Government.

6.   Review of best practice communications

IPMAC has undertaken research examining literature and best practice approaches relevant to this review with a focus on general communications, crisis and emergency risk communications, health promotion, BI and behaviour change.

6.1   General Communication

General communication literature identifies predominant themes that form the basis of good communication. Cutlip and Center's seminal 7C's of communication, to be clear, concise, concrete, correct, complete and courteous, published in 1952 is still included in university syllabuses.[20]

Targeted communication emerged as a key principle in original research as well as evidence-based guidelines. Communications need to consider the social and demographic context of the target audience and adapt the communication strategy accordingly.[21] If a message was consistent with an individual or communities' values, then this would be interpreted as more convincing.[22] Targeted communication may mean using electronic communications, including social media to convey facts and resources.[23] Communication occurs across mediums including formal televised news, radio, social media and direct messaging. Media interaction varies between different groups and demographics, therefore good practice avoids over-reliance on a single medium for communications.[24] The ability to provide targeted communications is evidenced to be of benefit to 'health equity and wellbeing'.[25] In many cultures there is value in establishing and maintaining a relationship, therefore effective cross-cultural communication involves conveying empathy, genuine-ness and establishing a human connection with recipients.[26]

20   Cutlip, S.M., and Center, A.H., *Effective Public Relations: Pathways to Public Favor*, 1952, Prentice-Hall.

21   Lanham, A., Lubari, E., Gallegos, D., and Radcliffe, B. *Health promotion in emerging collectivist communities: A study of dietary acculturation in the South Sudanese community in Logan City*, Australia, 2022, Health Promotion Journal of Australia webpage, vol. 33, iss. 1, pp. 224–231 <https://doi.org/10.1002/hpja.491>

22   World Health Organization, *Advocating intersectoral action for health equity and well-being: the importance of adapting communication to concept and audience* webpage, 2017, World Health Organization, Regional Office for Europe <https://apps.who.int/iris/handle/10665/329507>

23   World Health Organization, *Advocating intersectoral action for health equity and well-being: the importance of adapting communication to concept and audience* webpage, 2017, World Health Organization, Regional Office for Europe <https://apps.who.int/iris/handle/10665/329507>

24   Finset, A., Bosworth, H., Butow, P., Gulbrandsen, P., Hulsman, R.L., Pieterse, A.H., Street, R., Tschoetschel, R., van Weert, J., *Effective health communication–a key factor in fighting the COVID-19 pandemic* webpage, 2020, Patient Education and Counseling, vol. 103, iss. 5, pp. 873–876 <https://doi.org/10.1016/j.pec.2020.03.027>

25   World Health Organization, *Advocating intersectoral action for health equity and well-being: the importance of adapting communication to concept and audience* webpage, 2017, World Health Organization, Regional Office for Europe <https://apps.who.int/iris/handle/10665/329507>

26   Queensland Health, *Communicating effectively with Aboriginal and Torres Strait Islander people* webpage, 2015, Queensland Government <https://insight.qld.edu.au/shop/communicating-effectively-with-aboriginal-and-torres-strait-islander-people-qld-health-2015>

6.2 Crisis and Emergency Risk Communication

Risk communication is communication intended to provide audience members with the information they need to make informed, independent judgements about risks to health, safety, and the environment. Effective risk communication allows people most at risk to understand and adopt protective behaviours.[27] The communication task is to validate and harness concerns and recruit the audience's involvement in responding to the problem by guiding actions. Peter Sandman's risk communication model is used to tailor messaging based on the degree of hazard and community outrage.[28]

Crisis communication, in contrast, is more typically associated with public relations after a crisis or disaster. For this reason, crisis communication has traditionally formed part of emergency management models and disaster response. Established models for crisis communication in health focus on the public's emotional response.

Over the last two decades Belinda Reynolds, now a Professor at Tulane School of Public Health and Tropical Medicine and Mathew Seegar, a Dean at Wayne State University, both widely published and experienced, have led work to merge these traditions into more comprehensive approach for the Centers for Disease Control and Prevention (CDC), called 'crisis and emergency risk communication' (CERC).[29] This merged approach is, in part, a larger acknowledgment of the developmental features of risks and crisis, and recognition that effective communication must be an integrated and ongoing process.[30]

Key findings from the work of Reynolds and Seegar include:

• Timely communication during an emergency often necessitates communicating uncertainty.
• The ability to be informative improves trust and communications should be supported by the ability to provide numbers, context and changes to procedure. Speculation should be avoided.
• Effective on-going communication can provide transparency in decision making and avoid alienating the audience.
• Avoid over-reassuring or minimising risk.
• It is necessary to adjust risk communication language in response to the community and to proactively address counter-responses including myths.

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27 World Health Organization, *Communicating risk in public health emergencies: a WHO guideline for emergency risk communication (ERC) policy and practice* webpage, 2017, World Health Organization, Geneva <https://apps.who.int/iris/handle/10665/259807>

28 Sandman, P.M., *Responding to Community Outrage: Strategies for Effective Risk Communication*, 1993, American Industrial Hygiene Association.

29 Reynolds, B., and Lutfy, C., *Crisis and Emergency Risk Communication Manual*, 2018, United States Department of Health and Human Services, Centers for Disease Control and Prevention webpage <https://emergency.cdc.gov/cerc/manual/index.asp>

30 Seeger, M.W., *Best practices in crisis communication: An expert panel process*, 2006, Journal of applied communication research, vol. 34, iss. 3, pp. 232–244.

The six principles of CERC are:

1. Be First: Crises are time-sensitive. Communication information quickly is crucial. For members of the public, the first source of information often becomes the preferred source.

2. Be Right: Accuracy establishes credibility. Information can include what is known, what is not known, and what is being done to fill in the gaps.

3. Be Credible: Honesty and truthfulness should not be compromised during crises.

4. Express Empathy: Crises create harm, and the suffering should be acknowledged in words. Addressing what people are feeling and the challenges they face, builds trust and rapport.

5. Promote Action: Giving people meaningful things to do calms anxiety helps order, and promotes some sense of control.

6. Show Respect: Respectful communication is particularly important when people feel vulnerable. Respectful communication promotes cooperation and rapport. [31]

When deployed effectively, an integrated model such as CERC is an invaluable tool for engendering trust, protecting organisational value and helping the public make informed decisions.[32]

The 2014 Hazelwood Mine Fire Inquiry Report considered crisis communication methods used during the Hazelwood mine fire and outlined the following important aspects of crisis communication:

• Timeliness of communications: a communications strategy should be in place before the crisis occurs.
• Demographic context: consider social and demographic features of the target audience and develop communications accordingly. Communications should be tailored to resonate with the target audiences' values.
• Communication mediums: choose appropriate communication mediums based on the characteristics of the target audience. For example, if digital usage is low, use other communication mediums in addition to electronic communications. Use communication mediums to their full protentional to listen and engage with the target audience rather than just for one-way communication.
• Tone and style: acknowledge the crisis and express empathy and concern.
• Information vs communication: communicate with the target audience rather than only transmit information.

Within the WHO framework this is termed Risk Communication and Community Engagement (RCCE). An RCCE "infodemic" team within the WHO COVID-19 Incident Management support team complete a weekly analysis of approximately 20 million insights from social and news media to triangulate with other data and recommend actions to be taken.[33] This sustained capacity for communication to improve health behaviours, and dispel myths, is outlined in the WHO guideline for emergency risk communication policy.

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31 Centers for Disease Control, *CERC: Introduction*, 2018, United States Department of Health and Human Services, Centers for Disease Control and Prevention webpage <https://emergency.cdc.gov/cerc/manual/index.asp>

32 Reynolds, B., *Principles to enable leaders to navigate the harsh realities of crisis and risk communication*, 2010, Journal of Business Continuity & Emergency Planning, vol. 4, iss. 3, pp. 262–273.

33 World Health Organization, *Weekly Epidemiological Record*, 2022, vol. 97, no.27 pp. 313-324.

6.3　Health Promotion Communication

Health promotion is the "process of enabling people to increase control over, and to improve their health."[34] Health Promotion communication aims to provide links to information that enables the audience to access opportunities or to positively guide health behaviours. Health campaigns should consider competing rationalities guiding health behaviour including religious or cultural beliefs and financial pressures that may guide choices.[35] Communications must be sensitive to inequalities and differences within the community. Possible ways to align with the audience include providing analogies and stories or using a conversational and familiar tone. It can also be useful utilise a memorable story or fact, that can be easily repeated.[36]

Constructing a Health Promotion campaign should be informed with data about the health behaviours associated with a message as well as data on modes of communication.[37]

Health promotion literature considers the many ways an audience takes in a message. For some providing a visual aid, such as a message or road map can enhance retention whereas others may rely on written or verbal messaging. Health promotion is typically proactive in public communication aiming to address health behaviours, typically where there is a public health concern that the hazard and community outrage regarding a health threat is lower than desired.

6.4　Behaviour change

It is difficult to accurately attribute behaviour change to a single source as behaviour is influenced by multiple factors. To help achieve large-scale sustained behaviour change, it is important to have a clear understanding of what underpins the relevant behaviour being targeted.[38]

The review considered various models and theories used to predict and understand behaviour and develop campaigns including the Theory of Planned Behaviour, the Health Belief Model, the Transtheoretical Model, and the COM-B Model. Brief descriptions of these models are included in the table below.

34　World Health Organization, *Ottawa Charter for Health Promotion*, 1986, World Health Organization, Regional Office for Europe.

35　Berube, D.M., editor, *Pandemic Communication and Resilience*, 2021, Springer International Publishing.

36　World Health Organization, *Advocating intersectoral action for health equity and well-being: the importance of adapting communication to concept and audience* webpage, 2017, World Health Organization, Regional Office for Europe <https://apps.who.int/iris/handle/10665/329507>

37　Rootman, I., Goodstadt, M., Hyndman, B., et al., *Evaluation in health promotion: principles and perspectives*, 2001, WHO Regional Publications, European Series, No. 92.

38　Michie, S., and West, R. *Sustained behavior change is key to preventing and tackling future pandemics* webpage, 2021, Nature Medicine, vol. 27, pp. 749–752 <https://doi.org/10.1038/s41591-021-01345-2>

Model or Theory	Brief description
Theory of Planned Behaviour	The theory suggests that the most important predictor of behaviour is intention which, in turn, is predicted by attitude towards a behaviour, subjective norms and perceived behavioural control.[39] Generally, if one of the predictors is unfavourable, an individual is less likely to form an intention to perform the behaviour in question.
Health Belief Model	The model was developed to understand why people were failing to adopt certain health behaviours.[40] The model suggests that 'an individual's belief in the personal threat of an illness or disease together with their belief in the effectiveness of the recommended health behaviour will predict the likelihood of that individual adopting that behaviour'.[41] There are six constructs of the model including perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cue to action and self- efficacy.[42]
Transtheoretical Model (also known as the Stages of Change Model)	The model focuses more on changes in behaviour and suggests that individuals move through six stages of change when they want to change their behaviour: pre-contemplation, contemplation, preparation, action, maintenance, and termination.[43] Identifying at what stage of change an individual is at helps ensure the most appropriate and effective strategies are applied.
COM-B Model	Clear communication is not always enough to create behaviour change as individuals may face other barriers to adopting a behaviour. According to the COM-B Model, for any behaviour to occur, an individual must have the capability, the motivation, and the opportunity to adopt the behaviour.[44]

Victoria has a strong history of effective campaigns. The TAC is a Victorian Government-owned organisation that supports those who have been injured on Victoria's roads and promotes road safety.[45] Working closely with Victoria Police, DJCS and VicRoads, the TAC develops campaigns to promote safe behaviours and improve road safety.

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39 Ajzen, I. "The theory of Planned Behaviour" in Lange, P.A.M., Kruglanski, A.W. and Higgins E.T. (eds.) *Handbook of theories of social psychology*, London, United Kingdom: SAGE, vol. 1, pp. 438–459.

40 Rosenstock, I. M. *Historical Origins of the Health Belief Model*, 1974, Health Education Monographs, vol. 2, iss. 4, pp. 328–335.

41 Durand, H., Bacon, S.L., Byrne, M., et al. *Identifying and addressing psychosocial determinants of adherence to physical distancing guidance during the COVID-19 pandemic - project protocol* webpage, 2020, HRB Open Research, vol. 3:58 <https://doi.org/10.12688/hrbopenres.13090.2>

42 Becker, M.H. *The Health Belief Model and Personal Health Behavior*, 1974, Health Education Monographs, vol. 2, pp. 324–508.

43 Prochaska, J. O., and Velicer, W. F. *The Transtheoretical Model of Health Behavior Change*, 1997, American Journal of Health Promotion, vol. 12, iss. 1, pp. 38–48.

44 Michie, S., and West, R. *Sustained behavior change is key to preventing and tackling future pandemics* webpage, 2021, Nature Medicine, vol. 27, pp. 749–752 <https://doi.org/10.1038/s41591-021-01345-2>

45 Transport Accident Commission website <https://www.tac.vic.gov.au/>

IPMAC has undertaken consultation with TAC to gain a clearer understanding of how the organisation draws on models and theories to understand the behaviours being influenced and develop campaigns accordingly. Mass media campaigns alone often fail to achieve substantial behaviour change. They are more effective when supported by a mix of interventions such as education programs, regulatory change, enforcement, research and infrastructure improvements. Change in attitudes or behaviour is a lengthy and complex process and requires sustained campaigns.

TAC recognises that human behaviour is complex and influenced by various factors. Behavioural models have been used to consider factors that may influence the targeted behaviour, help determine where to focus efforts and guide the development of formative and evaluative research. The models used by TAC consider perceived consequences of unsafe behaviour or desired behaviour, perceptions of the likelihood of being affected, peer group expectations or influences, social norms, ability to engage in the behaviour, self-efficacy and response efficacy. Informative research including focus group discussions and analysis of survey data is undertaken to unpack these factors. Focus group discussions and questionnaires provide useful individual-level evidence alongside other data collected. Reconvened focus groups are particularly useful in understanding change in behaviour and attitude over time. The research undertaken also involves pre-testing messages with the target audience to determine its efficacy.

To illustrate this, a campaign encouraging motorcyclists to wear protective clothing on every trip was informed by behavioural models and research. TAC undertook research including focus group discussions, reviewing crash data and trends, formative market research, identifying the specific behaviour and defining the target audience. Behavioural models were used to consider multiple factors that are likely determinants of a person's intention to wear protective clothing and ultimately adopting the behaviour. This included consequences (injury, pain, impact on employment and family and friends), the ability to engage in the behaviour (is there storage at destination, is there barriers to access protective gear), likelihood of being affected (beliefs that short trips or trips on local roads are safe) and human vulnerability (low awareness of the impact of injury).

The research and likely factors affecting intention and ultimately actual behaviour informed the development of an advertising campaign launched in February 2022. The advertisement featured a motorcyclist not wearing protective clothing, except a helmet, and crashing on a local road. Graphic scenes were used to show the real consequences of not wearing protective clothing and importantly a clear action plan was provided – 'protect your entire body on every ride'.

Road safety campaigns are particularly renowned for their use of fear appeals. Whilst fear appeals can be effective when done well, it is not a one size fits all approach. It is vital to have a deep understanding of the target audience and barriers that may prevent the audience from adopting the behaviour.

TAC has also applied the Deterrence Theory to improve road safety and encourage compliant behaviour which suggests that people avoid offending if they fear the perceived consequences.[46] The theory includes three elements: certainty, swiftness and severity of punishment. Accordingly, education programs and campaigns by TAC have aimed to enhance the perceived risk of being detected, raise awareness of new or expanded forms of enforcement and raise awareness of new or changed penalties.

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46   Davey, J. D., and Freeman, J. E., *Improving road safety through deterrence-based initiatives: A review of research*, 2011, Sultan Qaboos University Medical Journal, vol. 11, iss. 1, pp. 29–37.

IPMAC also considered how WorkSafe, Victoria's workplace health and safety regulator and workplace injury insurer, has used models and theories to help guide campaign development. Previous WorkSafe campaigns showed that the Deterrence Theory had been used to help guide the development of some campaigns which focused on raising awareness of new and expanded forms of enforcement such as targeted proactive workplace visits and raising awareness of penalties for breach of workplace health and safety obligations.

The review also considered the campaign development process of VicHealth when planning and developing the 'This Girl Can' campaign. The campaign development process was comprehensive and included the use of a mix of models and theories. The use of the 'FLOWPROOF Model informed planning, implementation and evaluation, the Theory of Planned Behaviour guided the pre-formative research, formative research (focus group testing and stakeholder consultation) and a Program Logic was used to guide campaign development and evaluation'.

6.5   Summary

All guidelines for health emergencies support drawing upon strategies identified in risk communication, as well as the engagement principles of health promotion including the value of clarity and targeted messaging.

Numerous guidelines support an integrated approach, with communications embedded within the health emergency response, and adequately resourced.

Communication should be considered a loop and collaborative process with analysis of the community response to communication providing course correction of public health messages.[47] It is important to achieve good communications in order to promote uptake and acceptance of public health measures.[48] Communication leading to behaviour change can save lives, promote trust in government and organisations and increase the value of related public health control measures. Future strategy should build upon evidence and lessons learnt thus far from the COVID-19 response.[49]

To achieve meaningful behaviour change, a comprehensive process must be undertaken drawing on established models and theories, extensive research on factors likely to influence behaviour including focus group discussions and questionnaires to collect individual-level evidence, and pre-testing of messages with the target audience to determine efficacy.

47   Anwar, A., Malik, M., Raees, V., Anwar, A., *Role of mass media and public health communications in the COVID-19 pandemic* webpage, 2020, Cureus, 12(9) <http://dx.doi.org/10.7759/cureus.10453>

48   Ryan, R.E., Parkhill, A., Schonfeld, L., Walsh, L., Lowe, D., Merner, B., Nelson, N., Hill, S.J., *What are relevant, feasible and effective approaches to promote acceptance, uptake and adherence to physical distancing measures for COVID-19 prevention and control?,* 2021, World Health Organization, Regional Office for Europe.

49   Karidakis, M., Woodward-Kron, R., Amorati, R., Hu, B., Pym, A., Hajek, J., *Enhancing COVID-19 public health communication for culturally and linguistically diverse communities: An Australian interview study with community representatives*, 2022, Qualitative Health Communication, vol. 1, iss. 1, pp. 61-83.

7.   Analysis and Key Findings

To gain a deeper understanding of Victoria's multi-faceted whole of government approach in communicating pandemic orders the Committee requested information from relevant government departments on the role their Department played in the communication of Pandemic Orders from 15 December 2021. The information requested included, but was not limited to, information on COVID-19 communications and activities, key delivery mechanisms, investment and any challenges and learnings.

Information received from each department was assessed against the principles in **Figure 3** informed by the best practice communications research and key findings drawn to inform the Committee's recommendations.

Figure 3: Principles against which COVID-19 communications were reviewed
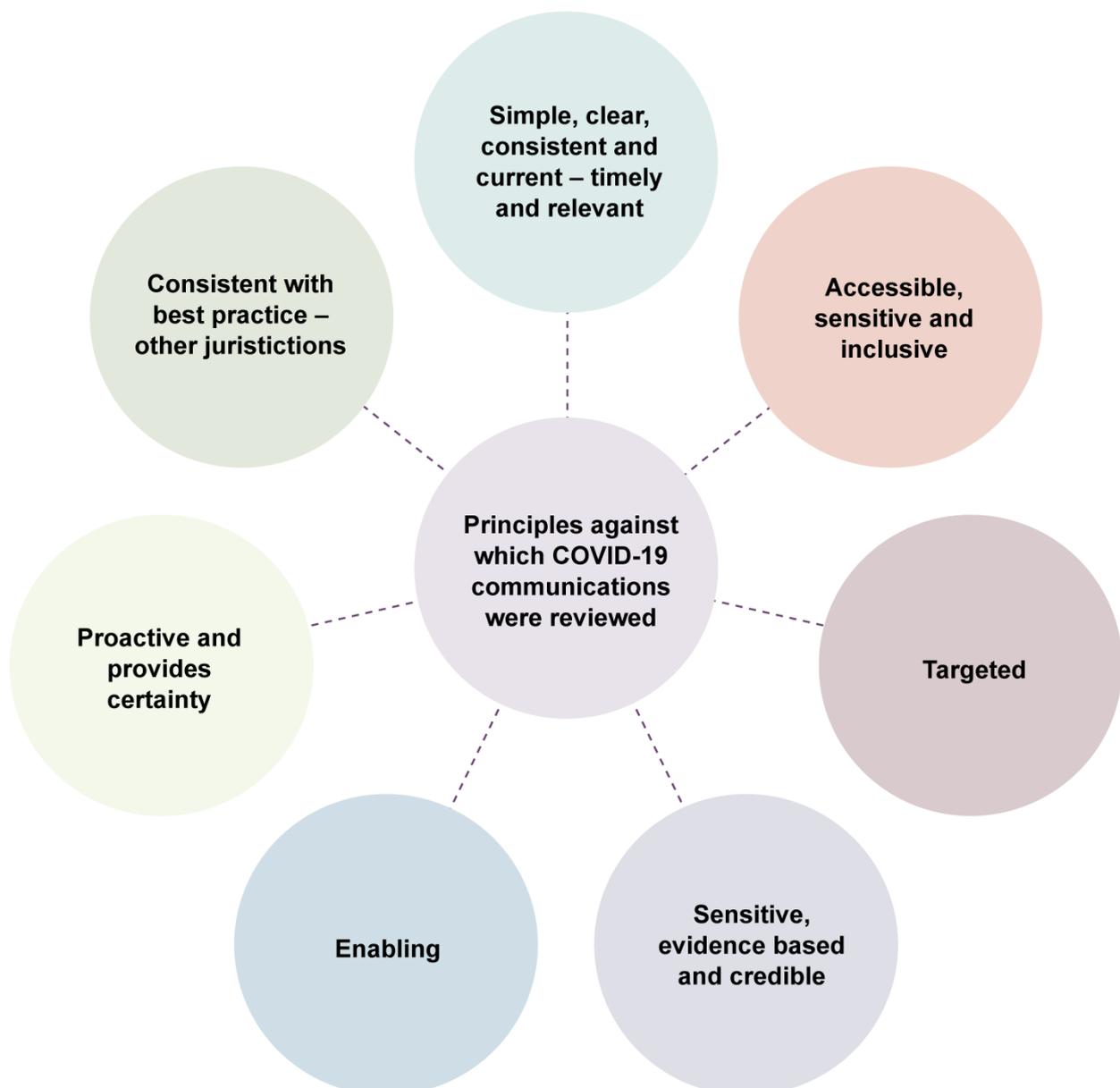
A range of case studies exploring how communications approaches have been tailored for different audiences have also been prepared and focus on:

• Shift from control to empowerment: Multicultural and multifaith pandemic order communications through the COVID-19 pandemic.
• Communication of the Victorian COVID-19 vaccination program for priority people, places and workplaces, through an engagement and partnerships approach.
• Communicating rapidly changing restrictions and public health orders effectively to Syrian and Iraqi refugee and asylum seeker communities.
• Community engagement and culturally safe communications to support Victorian Aboriginal communities through the COVID-19 pandemic.

IPMAC thanks the Victorian Multicultural Commission (VMC), Foundation House, and DH including the Aboriginal Health Division (AHD) for their assistance in providing information for the development of these case studies.

7.1   Analysis of Information provided by Victorian Government Departments

7.1.1   Simple, clear, consistent and current – timely and relevant

Due to the unprecedented and dynamic nature of the COVID-19 pandemic, Victorians needed clear and consistent information on COVID-19 and pandemic orders to understand risks and current requirements to comply with. The DH prepared a single, reliable, up to date source for distribution to relevant areas of government to ensure that information in relation to pandemic orders, public health advice and recommendations was accurate and consistent across all sectors of the Victorian community. Victorian Government Departments used this source to develop specific and relevant key messages for distribution through their networks and other delivery mechanism to their target audiences.

Due to public health considerations, fast-paced amendments to pandemic orders have been required. Consequently, communication and guidance for business and industry and translated materials had to be quickly amended to accurately reflect requirements and obligations under pandemic orders. It was frequently necessary for departments to seek further clarification from DH on how certain requirements were intended to apply. At times this was difficult to obtain in a timely manner. While necessary to ensure accuracy and facilitate compliance with pandemic orders, the lag time between pandemic orders being amended and guidance and translated materials being published and disseminated presented a challenge to all involved. To mitigate this, plain English information was provided to enable trusted sources to pass information to communities in a timely manner while translations and other resources were being prepared.

Departments used a variety of tools to provide clear and timely information on pandemic orders and maximise reach across Victoria. This included the use of media (COVID-19 press conferences with Auslan interpreters, Ministerial press releases, interviews, and media briefings), social media posts (Facebook, Twitter, Instagram, LinkedIn), websites to provide information and links to resources (departments' websites and coronavirus website which included FAQs, factsheets, templates, posters and signs), visual and audio messages, radio advertisements, community and industry engagement (meetings, webinars, information sessions, forums, face-to-face engagement, onsite visits, stakeholder packs with assets), COVID-19 dedicated hotlines (Coronavirus hotline, Aboriginal COVID-19 Infoline, Business Victoria COVID-19 hotline, DET COVID-19 hotline), phone calls and/ or SMS text messages to identified cases and close contacts, and advertising campaigns.

Information was regularly updated across different channels to reflect changes to pandemic orders and ensure Victorians received accurate and current information.
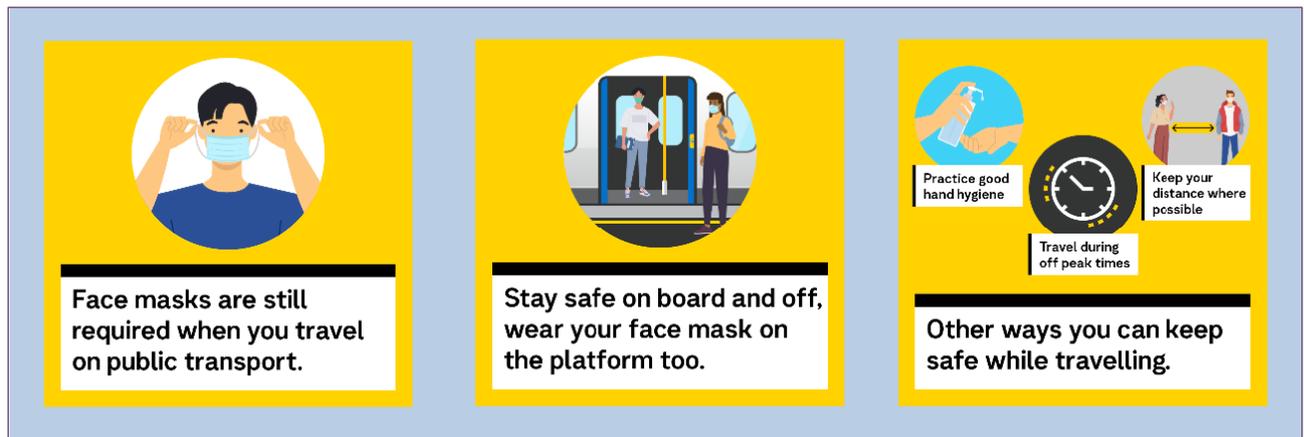
Source: Public Transport Victoria online Twitter account at <@ptv_official> (2022, July 27).

Press conferences were used throughout the pandemic to announce changes and explain requirements under pandemic orders in a timely, clear and easily understandable manner. This provided an opportunity for the government to reinforce public health messages to the Victorian community through action. As an example, the Premier, Minister for Health and public health officials wore a face covering in line with relevant pandemic orders during appearances and held press conferences outdoors where possible in line with public health recommendations.

Press conferences for significant changes to pandemic orders gained significant media coverage, including all metro TVs and major print outlets, as well as extensive radio and online coverage. Changes to face covering requirements were widely publicised, being the p1 lead story in the Herald Sun on 13 April 2022 foreshadowing face covering changes in schools. High levels of mask wearing compliance was observed in schools through COVIDSafe Assurance visits in Term 4 2021 and Term 1 2022, with compliance rates at 80% for students and 95% for staff. High levels of compliance indicated that the majority of Victorians were aware of and understood requirements under pandemic orders.

Documents that summarised significant changes to pandemic orders and public health advice in a simple and easy to understand format were often distributed to the media during press conferences. They were also published online along with media releases, shared on social media or published on the coronavirus website.

Source: [Department of Health online Twitter account at](#) <@VicGovDH> (2022, April 23).

To reflect the gradual shift toward empowering individuals, communities, and industry to play a greater role in the ongoing pandemic response in Victoria, daily COVID-19 press conferences ceased on 30 October 2021 and were only held as required after this date. Daily COVID-19 updates continued via other channels to ensure Victorians received current information including daily written CHO updates published online by the DH and sent directly to subscribers via electronic direct messages (eDM), daily data updates on COVID-19 with graphs showing case numbers, location and age group published on the coronavirus website and updates shared via the DH's Twitter page. Media releases continued to be issued in relation to changes and the most up-to-date requirements under pandemic orders ensuring ongoing clarity and visibility on current requirements.

Source: Department of Health online Twitter account at <@VicGovDH> (2022, July 12).

Source: Coronavirus website, 2022.

Established as a central source of COVID-19 information, the coronavirus website played a vital role in helping the public and businesses stay informed about how to comply with pandemic orders, attracting more than 174 million sessions in 2021-22.[50] For example, the website's clear Checklist for COVID cases attracted more than 3 million views and the Checklist for COVID contacts attracted nearly 3 million views in 2021-22.[51] The checklists clearly outlined isolation or quarantine requirements under pandemic orders and other relevant information such as permitted reasons to leave home, period of isolation or quarantine, notification requirements as well as contact details and links to services to support Victorians in isolation or quarantine.

A review of user experience undertaken in the first six months of 2022 by DH found that given the highly challenging environment at the time, the site was found to have provided helpful, useful, critical, trustworthy and reliable information.[52] The website included separate sections for helpful topics and featured FAQs, sector guidance, factsheets, posters, signs, templates (COVIDSafe Plans) and relevant exemption documents. The authorised worker permit was the most downloaded document with 340,020 downloads in 2021-22.[53]

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50   Department of Health, 2022.

51   Department of Health, 2022.

52   Department of Health, Internal review of user experience, 2022, Victorian Government.

53   Department of Health, 2022.

Collaboration across departments was key to ensure consistent information was published. Content on the coronavirus website was shared by three government departments – DJPR for business and work content, DET for education content with DH managing the remaining content. Departments also provided tailored information on their websites including links to relevant pages on the coronavirus website for further information. Content on websites was regularly updated in line with changes to pandemic orders to ensure Victorians received accurate and current information.

A study into the complexity and readability of COVID-19 materials on two government websites (DHHS and DET) during 2020 highlighted that 'an education level equivalent to senior secondary school would be required to readily understand the contents'.[54] This study was also referenced in the report by the PDAOC 'Review of the Pandemic (Visitors to Hospitals and Care Facilities) Orders' which found that 'due to the legalistic and complex language, pandemic orders have been difficult to interpret and understand'.[55] It should be noted that this study was done prior to the coronavirus website being established and the website has undergone numerous iterations since this time. An internal DH assessment of key pages of the coronavirus website gives them a readability of between grade 6 and grade 8 level with the Australian and Victorian style manuals both requiring grade 8 readability.

Using familiar language that Victorians recognised and understood was critical to ensure information on pandemic orders was understandable and to limit barriers to compliance. It was often necessary to use unfamiliar terms and medical jargon to accurately explain the COVID-19 virus, COVID-19 outbreaks and measures under pandemic orders and to provide legally accurate information. Key terms such as isolation, quarantine, contact tracing and lockdown became part of everyday life overnight and had to be clearly explained and understood to avoid confusion and inconsistent application. Providing a definition of unfamiliar terms on the coronavirus website and in pandemic orders helped Victorians understand measures and correctly comply with pandemic orders.

54 Serry, T, Stebbins, T, Martchenko, A, Araujo, N, McCarthy, B. *Improving access to COVID-19 information by ensuring the readability of government websites*, 2022, Health Promotion: Journal of Australia webpage <https://doi.org/10.1002/hpja.610>

55 Pandemic Declaration Accountability and Oversight Committee, *Review of the Pandemic (Visitors to Hospitals and Care Facilities) Orders*, 2022.

Source: Department of Health online Twitter account at <@VicGovDH> (2022, May 21).

To help keep COVID-19 messages relevant and combat message fatigue, messages and social media posts were often tied back to key dates or events in Victoria. Various campaigns were also developed to help Victorians celebrate days of significance and CALD cultural events safely.

Key findings:

Significant effort was made across government to ensure the timely provision of consistent and relevant information to maximise reach utilising a diversity of methods and platforms.

Due to the dynamic nature of the pandemic and the need to ensure accuracy, there were at times delays in government departments receiving a single, reliable up-to-date source from DH to develop tailored messaging on pandemic order changes for distribution through their networks to their target audiences.

Producing plain English messages while communication, guidance and translated materials were being amended to accurately reflect rapid changes to pandemic orders was vital in informing Victorians of changes and supporting compliance with current pandemic orders rather than those that had been revoked.

7.1.2   Accessible, sensitive and inclusive – culturally appropriate and accessible for priority groups

The ability to access information was vital to help Victorians understand what behaviours can be undertaken to protect their health, the community and comply with pandemic orders.

Pandemic orders were accessible to all Victorians before they came into effect with the PHW Act requiring them to be published on the Pandemic Orders Register on the DH website. The website had separate tabs for each pandemic order and relevant documents. Victorians with access to the internet could view and download current and revoked pandemic orders and relevant documents.

The requirement to publish all current and revoked pandemic orders and related documents created issues with ease of navigation of information on the Pandemic Orders Register as time progressed due to the large volume of information available. Availability of information related to pandemic orders on multiple Victorian Government websites also created issues with navigability of websites for relevant information.

The coronavirus website was a central source of accessible information on pandemic orders and public health advice. Plain English explanations of the changes to the orders were updated to this website as quickly as possible after any change. Information for people with a disability or special requirements and Auslan videos were also made available. In the 24 hours following pandemic order changes, there was a sharp increase in traffic to the coronavirus website, with at least 1 million unique views recorded to the site.

The Service Victoria website and application provided user-friendly processes. This helped Victorians to adhere to requirements under pandemic orders such as applying for border permits, exemptions to enter Victoria or using the QR Code check-in system to provide proof of a vaccination certificate. Alternatively, Victorians unable to access the digital platforms could rely on printed documents to adhere to requirements.

Departments identified the communication channels that their audiences were already using and utilised a range of mechanisms to disseminate information to ensure that Victorians could access information from a range of sources.

Communication and engagement were undertaken to reach Victorians who may not have internet access or are not computer literate. This included mass media which had a broad reach (tv, radio, advertising, press conferences with Auslan interpreters, interviews), posters and signs, audio messages on public transport, community engagement (face-to-face engagement and stakeholder packs), and COVID-19 dedicated hotlines (Coronavirus hotline, Aboriginal COVID-19 Infoline). Direct text messages and/or phone calls from DH to identified cases reinforced public health messages and ensured that Victorians who may not have had access to information about isolation requirements were aware of the relevant requirements and available support services.

The Case Studies included in this review highlight the limited reach of traditional public health messaging during the pandemic and the need for specific and targeted communications initiatives to reach different cohorts in the community. Information in relation to pandemic orders and public health advice was translated into 57 languages. Rapidly changing public health conditions and pandemic orders sometimes meant considerable delay in the provision of some translated resources. Consequently by the time they reached the community they were out-of-date. Translations were not available in all languages and dialects and written information is not effective in reaching communities who prefer oral communication or who have low literacy or access to technology.

The CALD Communities Taskforce (the Taskforce) was established by the government in August 2020 to address the distinct and significant challenges faced by Victoria's CALD communities during the COVID-19 pandemic. A significant investment was made to support this work with $68.6 million allocated over three years for delivery of a range of activities. The Taskforce played a key coordination and facilitation role. The Local Partnership Model (LPM) was implemented in Local Government Areas (LGAs) where there were disproportionate cases of COVID-19 in CALD communities to put in place initiatives designed to meet the CALD community's needs. Implemented across a number of phases, the Priority Response to Multicultural Communities (PRMC) Grant Program supported CALD communities with their immediate needs and to follow directions and pandemic orders, The Funding Decision Framework required the Taskforce to fund organisations with existing connection into community, which was a fast and efficient approach. As demonstrated in case study 1, funding enabled and empowered these organisations to share information through platforms communities were already using and implement tailored communications to meet local needs. This facilitated culturally appropriate and timely messaging.

A Communications and Translations Working group was formed out of the Taskforce with representatives across the VPS to share latest in-language resources and discuss common challenges and initiatives. This was used later as a platform to educate with external experts on how to better communicate with multicultural audiences.

Case Study 1

Shift from control to empowerment: Multicultural and multifaith pandemic order communications through the COVID-19 pandemic

Victoria's multicultural and multifaith communities are an important part of the state's celebrated diversity, with almost half of Victorian's born overseas or with a parent who was born overseas, and 1.5 million Victorians who speak a language other than English at home.

CALD communities often faced specific challenges in complying with pandemic orders including (but not limited to): larger household sizes with difficulties in physical distancing/ isolation, insecure employment and/or housing, working in public facing or essential roles, inability to access income supports (based on visa status), low levels of health literacy and English literacy, distrust of support services and government authority, lack of available culturally appropriate healthcare/services and information and religious and cultural values.

The COVID-19 pandemic highlighted the limited reach of traditional public health messaging within multicultural communities and the need for specific and targeted messaging to reach different cohorts within the community.

These factors led to CALD communities being over-represented in COVID-19 case numbers relative to the population.

Communication challenges

The rapid speed at which restrictions and public health orders changed created significant challenges. The centralised control and distribution of information meant it took more time to reach the intended audience. While information was translated into 57 different languages, it was not available in all languages or dialects. In some cases, due to restrictions changing again before the translations for the previous changes were finalised, it was up to nine days before the translations were complete. People were therefore unknowingly following old orders creating barriers to compliance.

> "When the Victorian government makes an announcement, that information is not translated, at least for several days, and then by the time it's translated, it's old news or there's already some other changes."

> "I don't know, look press conferences in general, you have a small minority of the community who are actively engaged. It has jargon in it that most of our community won't understand."[56]

> **Community member**

56 Hajek, J., Karidakis, M., Amorati, R., Hao, Y., Sengupta, M., Pym, A. & Woodward-Kron, R., *Understanding the experiences and communication needs of culturally and linguistically diverse communities during the COVID-19 pandemic* webpage, 2022, Research Unit for Multilingualism and Cross-Cultural Communication, School of Languages and Linguistics, The University of Melbourne
<https://findanexpert.unimelb.edu.au/scholarlywork/1641179-understanding-the-experiences-and-communication-needs-of-culturally-and-linguistically-diverse-communities-during-the-covid-19-pandemic>

Due to translation difficulties and distrust of support services and government authority the community wide messaging had limited impact on the behaviour of these communities and their compliance with restrictions and public orders. Translated materials were often too lengthy and complex making key information difficult to distil. Written information was not effective to reach communities who prefer oral communication or who have low literacy or limited access to technology. Different age groups within communities have different levels of literacy in both English and their first language. There is diversity in health literacy and access to technology for digital information channels. In the absence of baseline data, there were barriers to the equitable distribution of funds and resources across the breadth of communities. Fake news was widespread. Other challenges were encountered in reaching people as a result of the public health restrictions themselves.

> "There are many churches, mosques and gurdwaras [Sikh temple], et cetera. But because of lockdown, they can't gather. There is no congregation, so they don't go there. They don't meet people."[57]
>
> **Community member**

How were the challenges addressed?

Information was shared through platforms that multicultural and multifaith communities were already using with audio and visual messages coming from trusted community leaders, rather than authorities, being a particularly effective tool. Community leaders were empowered through the provision of the information they needed to connect and inform their communities which reduced mistrust and barriers and this was critical to facilitate compliance. This collaboration was a key strategy to promote public health messages used alongside: translation and interpreter services; translated posters, in-language animations, fact sheets and web content; plain English updates; social media; WhatsApp messaging; SMS, community radio and newspapers; websites and stakeholder information packs.

> "Education involves ensuring that people are aware of the risks of COVID-19 and how they can protect themselves; health promotion involves tailoring messages to community values, using trusted messengers, using channels different audiences can access, and establishing or linking with peak bodies to support ongoing work."[58]

In mid 2020, eleven roundtable forums were held with culturally, linguistically and faith diverse community leaders around Victoria to create a dialogue on COVID-19 where government officials could share information and advice on how to stay safe and reduce transmission risk, and community leaders could share insights on how to best engage their communities with public health messaging. Working with the VMC was a key factor in the success of accessing community leaders due to their pre-existing relationships and connections.

57 Hajek, J., Karidakis, M., Amorati, R., Hao, Y., Sengupta, M., Pym, A. & Woodward-Kron, R., *Understanding the experiences and communication needs of culturally and linguistically diverse communities during the COVID-19 pandemic* webpage, 2022, Research Unit for Multilingualism and Cross-Cultural Communication, School of Languages and Linguistics, The University of Melbourne <https://findanexpert.unimelb.edu.au/scholarlywork/1641179-understanding-the-experiences-and-communication-needs-of-culturally-and-linguistically-diverse-communities-during-the-covid-19-pandemic>

58 Department of Health, *Chief Health Officer Advice to Minister for Health (10 December 2021)*, 2021, Victorian Government.

Meet them where they are

Faith leaders participated in videos explaining why it was important to celebrate culturally significant days when restrictions were in place, and how vaccines aligned with their faith values of protecting the community, received a high level of engagement, effectively cutting through other messaging around these topics. (Example for Eid – mix of community leaders, more than 6,000 views organically, see the Victorian Multicultural Commission's Facebook watch post at
<https://www.facebook.com/multiculturevic/videos/231573434596242>

WhatsApp Community Leaders Group

In recognition of high usage of other social media platforms by multicultural communities, the CALD Communities Taskforce established a WhatsApp Community Leaders group in October 2020 to further build relationships with the community leaders already active on WhatsApp. The group had a focus on user-generated conversations as opposed to one-way communication from the Department. Community leaders were invited to join based on their strong connections to community in order to share insights and experiences and pose questions to their fellow community leaders in Victoria. The CALD Communities Taskforce communications team played the role of administrator and moderator, facilitating peer-led conversations while sharing timely and important Victorian Government updates in Plain English and in-language resources for fast and effective dissemination. This group remains active today with over 210 members.

Local Partnership Program – Moreland case study

The Moreland Local Partnership consists of 14 partners including ethno-specific organisations, neighbourhood houses and primary health providers. This partnership delivered tailored community led messaging to promote the vaccine and multiple vaccination hubs in the City of Moreland; developing flyers translated in multiple languages including Arabic, Turkish & Urdu, letterbox drops and Facebook posts and in-language messaging on SBS radio. The partnership also supported ethno-specific organisations such as the Alevi Federation to send short, translated SMS messages with vaccine information and the location of pop-up sites, as well as engagement with local GPs from CALD backgrounds to address misinformation. Vaccination sites were attended by bicultural workers from partner organisations including Arabic, Urdu, Greek and Turkish speaking workers. Overall feedback obtained at the sites was that the local partnership program encouraged participants to attend and get vaccinated.

Zainab*, a single mother, was concerned about getting her 14-year-old daughter vaccinated. She reached out to Farah*, a bicultural worker in the Moreland Local Partnership program. Farah sent Zainab information and spoke to her in her language. Farah drew on information obtained from training on vaccine confidence facilitated by the Local Partnership program. From this Zainab and her daughter attended a vaccine hub to meet Farah and were supported to get vaccinated.

*Names changed

Grant programs to elevate community voice

The Multicultural Communications Outreach Program supported multicultural and faith communities to create their own COVIDsafe content and encourage vaccination.

CALD Youth Campaign

To reach and engage with young people from diverse communities the Victorian Government funded a CALD Youth Content Campaign to support emerging CALD influencers in music and sport to create original COVID safe videos to share on their channels. The campaign built digital engagement through new networks between third party content creators (influencers), government agencies and hard to reach communities. Short Instagram and Facebook videos provided advice on how to lower the risk of COVID-19 and offered a platform for engagement for young people experiencing social isolation

Funding was provided to more than 130 organisations, some of which were first time grant recipients, for localised responses to localised needs based on data and feedback on community need. Having an existing community connection facilitated a fit for purpose and fast response. This was important in overcoming some of the ingrained distrust of support services and government authority identified within CALD communities due to past experiences with services in their country of origin, adverse experiences with local services, language barriers and a lack of culturally appropriate information.

Funding of organisations already working with specific communities enabled the use of local leaders that ensured a trusted voice and face delivered key information.

Example 1: Vos Kita was funded as an individual for a series of co-designed videos featuring the perspectives and stories of diverse Victorians with a disability. The 'These Are Our Voices' video series advocates for COVIDSafe behaviours and vaccination while also engaging in an open and honest dialogue about the experiences of multicultural people with a disability with vaccination, rapid antigen tests (RATs), disability discrimination and their insights for improvement. The videos feature eight disability champions: Janet Curtain, Dominic Hong Duc Golding, Elizabeth Jeroboam, Rose Brown, Barry Berih, Serap Filiz, Vincent Buhagiar, and Anna Dang. They use comedy, short-documentary style and even a cooking show format to tackle topics in engaging ways. The videos have been promoted through community organisations like AMES Australia; Youth Disability Advocacy Services (YDAS), NEDA, Vision Australia, and Power in Culture and Ethnicity (PCE). One of the video subjects Dominic Golding attended the UN Convention on the Rights of Persons with Disabilities (CRPD) in New York and shared the videos there.

Source: "These are Our Voices Documentary COVID-19 Chapter," VOS Kita, 2022.

Example 2: Africause held a community BBQ with an African and refugee mother's groups from the Collingwood public housing estates to provide information about COVID-19 vaccinations for children. They reported that the informal event and BBQ was a very successful way of reaching mothers who were hesitant about vaccinations for their children. They also created and shared COVID-19 content and messages were also created and shared through their social media accounts.
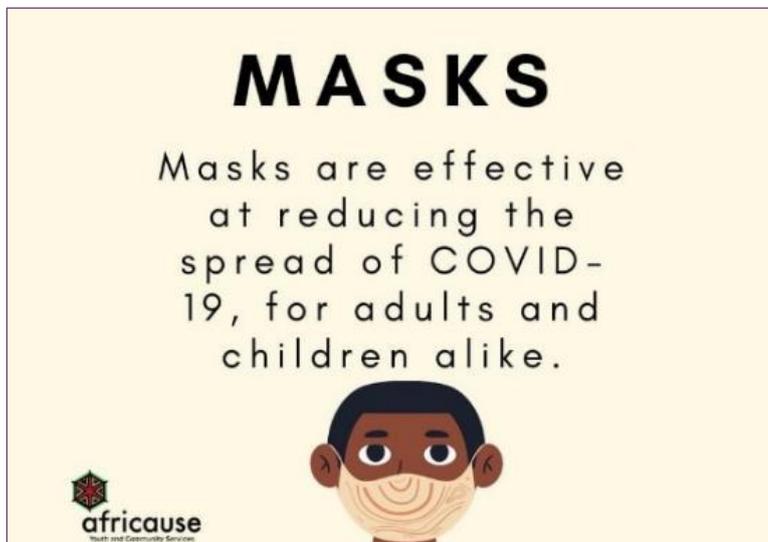
Source: Africause. (2021, September 4). [Online]. Facebook.

Example 3: Gulmi Samaj Victoria were funded through the first round of the Multicultural Communications Outreach Program to produce a range of COVIDSafe content for Victoria's Nepali community. This included education sessions, posters and a documentary video. They also worked with musicians to create a folk song that promoted vaccination, mask wearing and other COVIDSafe behaviours. In April, the song was performed live and recorded at a Nepalese New Year and COVID-19 awareness event.

Source: Gulmi Samaj Victoria Australia. (2022, April 15). [Online]. Facebook.

Example 4: Cross Cultural Community Connections created content for the Serbian community about vaccination and COVIDSafe behaviour, including content with cultural references like women dressed in traditional Serbian clothing. Their digital content and distribution of printed materials was able to reach more than 10,000 viewers in the Serbian communities across Victoria. Cross Cultural Community Connections also established connections with Macedonian, Bosnian and Croatian community members who requested copies of their content.

Source: "United against COVID-19 / Zajedno protiv COVID-a - SERBIAN," Cross Cultural Community Connections, 2022.

Bridging the translations gap with Plain English, audio and visual content

Using plain English information removed some of the complexity in messaging and reduced the delays in waiting for translated materials. Developing targeted strategies to meet the needs of different cohorts within communities meant that older and younger persons could access public health information in the way they preferred. The use of graphics, video and audio messaging enabled persons with different levels of literacy to have access to key public health information.

Proactive engagement with ethnic media channels was a critical tool. To increase the in-language content available in an accessible format on the day COVID-19 related announcements were made and in recognition of the key channel of community radio for many in CALD communities to receive local news, the National Ethnic and Multicultural Broadcasters' Council (NEMBC) were funded in August 2020 to deliver a Multilingual News Service (MNS) in the form of a regular audio news bulletin. The Service began in seven languages, but due to the positive reception of community and stakeholders, this was increased to 19 languages in November 2020. These audio bulletins were distributed to 12 Victorian community radio stations and proactively shared with multicultural stakeholders and community groups online. This Service is still active, and in 2021, expanded to include dedicated explainer bulletins in 20+ languages to address major announcements (new public orders) as well as explain new and complex information such as pregnancy and vaccination, how to get proof of vaccination and RATs.

Summary and key learnings

Programs should be co-designed and led by community wherever possible. Approaches led by community are representative of and engage the diversity within them. Trusted voices such as faith and community leaders, local elders and influencers are as important as medical professionals when sharing information with their communities.

Methods of communication must be varied to meet the diverse needs of community members including written and non-written formats. Diversity is important between communities but also within them in terms of varying levels of literacy, different access to technology and different beliefs and behaviours across age groups.

These innovative culturally appropriate approaches to COVID-19 pandemic orders communications were made possible through collaboration when the DH joined together with agencies across government including the VMC, DPC and the DFFH to collaborate and coordinate communications into, and engagement with, multicultural and multifaith communities.

Established in August 2020, the CALD Communities Taskforce was fundamental to building the capability of the service sector and organisations to engage with CALD communities. Maintaining this capability is critical to sustaining localised fit for purpose responses to localised needs.

There is greater need to support the interpreter/translation sector as there are many different ethnic and cultural groups, particularly smaller and emerging, whose languages are not captured and interpreters may not be easily available. Utilising and supporting existing trusted channels is effective and efficient and should be adopted as a standard communications approach. Engagement and the maintenance of ongoing relationships with the community should be embedded in departments and agencies whose role it is to ensure critical and coordination of communication and engagement. Building diversity within the departmental and agency communications and engagement teams with personnel who have lived experience, language and cultural skills/expertise will enhance reach to the leaders and communities. Demographic data can better guide evidence-based strategies, communication and engagement.

Case study 2 highlights the collaborative and pro-active approach DH undertook to provide culturally safe and equitable access to information and services to support Victorian Aboriginal communities during the pandemic.

DH AHD collaborated with First Nations owned agency Little Rocket, Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and Aboriginal community-controlled organisations and leaders to develop culturally sensitive communications such as the 'Community Unity Immunity' campaign. Regular cross-government meetings were held to manage outbreaks and concerns for Aboriginal community members. Additionally, DH held regular weekly meeting with VACCHO to evaluate and improve the effectiveness of communications and held regular internal meetings with AHD to evaluate communications to support Aboriginal community members to test and stay home. The engagement provided an understanding of culturally specific motivations for behaviour change and adherence with pandemic orders. Strength based language that promotes self-determination and protecting community resonated with Aboriginal community stakeholders over authoritative language such as 'you must isolate', hence culturally appropriate messages were produced to reflect this.

Information specific to Aboriginal communities was shared with the support of Aboriginal health services and organisations across Victoria.

Case study 2

Community engagement and culturally safe communications to support Victorian Aboriginal communities through the COVID-19 pandemic.

Victoria's Aboriginal community

Aboriginal Victorians are a diverse group of people, representing over 250 language, social or nation groups from across Australia.[59] There are currently 47,788 Aboriginal and Torres Strait Islander people making up the Victorian Aboriginal Community[60].The Aboriginal and Torres Strait Islander population of Victoria is split across Victoria, with 48.8% in metropolitan Melbourne, and 50.7% in the rest of Victoria (excluding Melbourne). This makes up 0.5% and 1.6% of the population respectively[61].

Aboriginal Victorians are a young population, with 95% aged between 0-64 years.[62] There was a 12% increase in the Aboriginal Victorian population from 2011-2016 indicating the Aboriginal population is growing at a much faster rate than the non-Aboriginal population[63], with continued growth between 2.5-2.8% expected by 2026.[64]

Life expectancy is an important indicator of overall health and access to health services. Life expectancy for Aboriginal people has generally been improving over the years however, despite gains, the latest estimate of the life expectancy gap between Aboriginal and non-Aboriginal Victorians remains approximately 7 years.[65]. There continues to be a higher burden of preventable disease for Aboriginal Australians. Embedding approaches to prevention and earlier intervention is vital to address this and increase protective factors supporting equitable health and wellbeing outcomes.

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59   Department of Health and Human Services, *Cultural Determinants of Health Literature Review KKBD*, 2019, Victorian Government.

60   Australian Bureau of Statistics (2019) *2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census* webpage, *2016*
<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20-%20Victoria~10002>

61   Australian Bureau of Statistics (2019) *2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census* webpage, *2016*
<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20-%20Victoria~10002>

62   Australian Bureau of Statistics (2019) *2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census* webpage, *2016*
<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20-%20Victoria~10002>

63   Department of Health and Human Services, *Korin Korin Balit-Djak, Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*, 2017, Victorian Government.

64   Australian Bureau of Statistics (2014) *3238.0 - Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026* webpage
<https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3238.02001%20to%202026?OpenDocument>

65   Victorian Government, *Victorian Government Aboriginal Affairs Report 2019* webpage, 2019
<https://www.firstpeoplesrelations.vic.gov.au/aboriginal-affairs-report>

Community engagement and culturally safe communications to support Victorian Aboriginal communities through the COVID-19 pandemic

The Victorian Department of Health (the department) has undertaken a collaborative and pro-active approach to provide culturally safe and equitable access to holistic health and wellbeing information and services to support Victorian Aboriginal communities through the COVID-19 pandemic. The approach recognises and embeds values of collaboration, self-determination, cultural safety, and Aboriginal ways of working.

The department identified that the broader COVID-19 'one-size fits all' approach did not suit Victorian Aboriginal communities, as it created barriers for people to access information and support services.

In response to this, the department partnered with the VACCHO peak body and broader Aboriginal community-controlled sector to develop culturally appropriate COVID-19 communications and engagement strategies that were informed by and reflected the needs of Victorian Aboriginal communities.

To ensure that Aboriginal community members felt safe, communications conveyed messaging that engagement was to support health and safety needs of Aboriginal communities, rather than a punitive approach to enforcing vaccinations and restrictions upon community members.

The engagement approach was underpinned by strong, collaborative relationships between the departments' AHD, VACCHO and ACCHOs and utilised existing relationships between Aboriginal organisations, Elders/community leaders, and community members.

The department also facilitated partnerships between ACCHOs, mainstream health services and LPHUs to coordinate resources including access to vaccines and support delivery of communications and services collaboratively. This included the provision of additional vaccination workforce, recruitment of Aboriginal nurses, emergency measures accreditation for Aboriginal Health Care Workers, and funding for agency nurses/vaccinators to support the ACCHO services and VACCHO vaccination bus program.

Engagement with Aboriginal communities was undertaken directly by ACCHOs and Aboriginal staff, who were known and trusted by Aboriginal community members, accompanied by Registered Nurses from the AHD and mainstream health sector. The approach recognised and responded to holistic health, social and emotional wellbeing needs and provided a 'one-stop shop' for information and support to community, in a safe and accessible environment that was tailored to and met the needs of individuals and families.

Communications were culturally safe and used visual design and language that was easily understood and related to by Aboriginal people. Communications included education and awareness on COVID-19 disease, outbreak management, restrictions, and vaccination campaigns.

Vaccination Campaigns for Victorian Aboriginal Communities

Two key examples of effective, tailored vaccination campaigns are 'Stronger Together' for 5-11-year-old's and 'Community, Unity, Immunity'. The campaigns re-enforced key messaging of protecting community and worked in conjunction with other community engagement strategies; such as the VACCHO vaccination bus program, to facilitate access for households and community unable to travel to health centres or vaccination hubs.

Both vaccination campaigns have been well utilised by ACCHOs and the broader Aboriginal community-controlled sector with positive feedback, engagement, and uptake by Victorian Aboriginal community members, which is reflected in vaccination rates.

Key Community Engagement Strategies

- Victorian Aboriginal Health Service (VAHS) and other ACCHOs providing access to services out of usual business hours and on weekends, with no appointment required
- Outreach to homes and communities to mitigate barriers to testing and vaccination, including to provide emergency relief (food and medical supplies)
- VACCHO vaccination bus - pop-up clinics and door-to-door visits, where community members could get information, ask questions, and be vaccinated when they were ready. This was a 'no wrong door' approach and non-Aboriginal community members living in the same street or area also attended to access vaccinations and information. This strategy was particularly noted to be beneficial in regional areas and for members of CALD communities
- Transport for community members to and from appointments at ACCHOs during lockdowns, to address underlying medical issues not associated with COVID-19.

Culturally Safe and Appropriate Communications

- Language and 'tag-lines' utilised in all communications and campaigns reflected values of self-determination and rights of choice e.g., regarding vaccination – 'When you're ready, we're ready' (to vaccinate), and 'Stronger Together' (i.e., everyone should get vaccinated)
- ACCHO social media platforms and local community networks were used and included high profile Aboriginal sports persons, actors, and singers to promote testing and vaccinations
- Development of tailored communications/campaign collateral – e.g., postcards, t-shirts, colouring books, pamphlets and posters, with recognisable images and 'tag – lines' that could be cross-utilised in ongoing communications and campaigns
- DH website and social media pages were used to share up to date information
- Establishment of the Victorian COVID-19 Aboriginal Infoline
- Aboriginal community forums and events were delivered to provide information and promote/increase uptake of vaccinations
- Media events were utilised to communicate key vaccination milestones e.g. 'Community, Unity, Immunity' launch at VAHS with Tony Armstrong and the Minister for Health.

Case Studies:

'Stronger Together' Vaccination for 5–11's and youth campaign

The department collaborated with artist Emma Bamblett, Little Rocket and VACCHO to create a suite of tailored communications and collateral for ACCHOs and Aboriginal community, which raised awareness about vaccinations, and how and where to access them. Communications were developed in consultation with the Victorian Aboriginal Child Care Agency (VACCA).

Emma was engaged to provide artwork for colouring books and pathway finders/footprints for the 'Australiana' theme in state-run clinics. Emma attended the launch of the first site at Peninsula Health in Frankston and spoke alongside Commander Jeroen Weimar, to the significance of her artwork and the importance of providing a child-friendly environment for vaccinations.

Source: Department of Health: COVID-19 Vaccination Campaign for 5-11 year olds Stakeholder Kit, 2022.

Emma was then invited to further develop her artwork and images for the Aboriginal and Torres Strait Islander 5 -11year old and youth campaigns.

Project partners identified key messaging, design concept and campaign awareness strategies. Ongoing collaboration ensured all communications, information and collateral developed contained culturally safe and appropriate language, (including plain English and was age appropriate etc) and identified which ACCHOs were providing 5-11 year old vaccination services.

The physical collateral packs, including fact sheets, posters, colouring books, stickers, and postcards were distributed to ACCHO clinics to support awareness and create a culturally safe youth friendly environment.

The electronic communications and collateral (such as social media tiles, posters, and fact sheets) were additionally distributed to Aboriginal organisations, Koorie Education Support Officers (school-based service), VACCA and other relevant organisations to be utilised for website, social media platforms, and other communications modalities as best suited to the local community.

In addition to digital assets and printed resources, the department also assisted in online forums and training in support of 5-11year old vaccination information.

Specialist paediatricians and Aboriginal medical practitioners supported multiple online forums updating essential information for parents, families, and communities to assist them in making informed decisions about COVID-19 vaccinations for their children and young people. These forums gave community members the opportunity to hear from experts in their field and ask any questions, while being supported in a culturally safe online space.

The department were also able to offer several online training programs for service providers and community members around building confidence in COVID-19 vaccinations. These online training sessions aimed to boost the knowledge and capacity of trusted service providers across Victoria to support key information being provided to local Aboriginal communities, while learning how to respond to and dispel misinformation.

'Community, Unity, Immunity'

The campaign was developed by the department in partnership with VACCHO, ACCHOs, Little Rocket Media and Aboriginal community members to assist in a call to action to come forward to get vaccinated.

The campaign provides imagery that is easy to recognise, resonates with Aboriginal community and identifies a space with culturally safe, accessible information and access to COVID-19 vaccinations.

'Community, Unity Immunity' Campaign collateral examples:

Source: Department of Health, Community, Unity, Immunity: Master Style Guide.

Initial discussions identified key messaging, language, and design concepts, as well as identifying and further developing communications and engagement strategies to support awareness for vaccination information and access.

This included consultations with Aboriginal health, homelessness/rough-sleeper and outreach organisations, to support people who may have limited access to social media and other barriers to receive information.

The physical campaign and communication collateral (i.e., posters, pamphlets, postcards, t-shirts) were available to all ACCHOs, Aboriginal organisations and mainstream partner organisations. The electronic communication collateral (posters, pamphlets, fact sheets, FAQs, social media tiles etc) could be shared to organisations and community members to utilise on their communication networks.

The key messages/themes and imagery could be utilised and incorporated into ongoing collateral and communications, including for various community forums held in regional areas, and community events/social media activity.

A television and radio advertisement featuring renowned actor Uncle Jack Charles was also developed and shared via advertising channels targeting Aboriginal and Torres Strait Islander audiences, including NITV, community radio and screens at health services. To launch the campaign, a media event was held at the VAHS with Uncle Jack Charles and Jill Gallagher, Chief Executive Officer (CEO) of VACCHO.
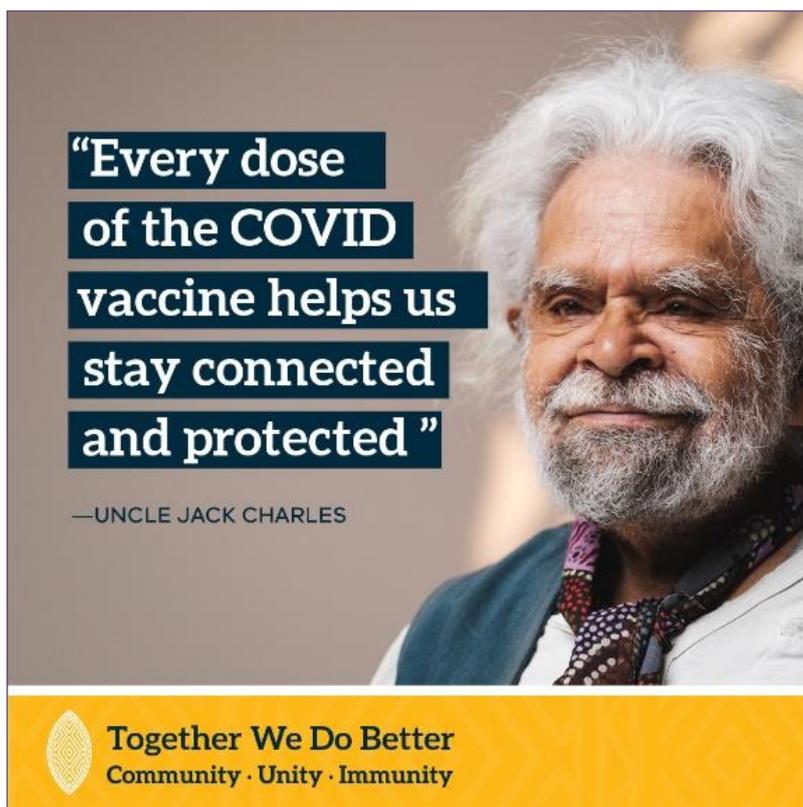
Uncle Jack TVC YouTube video link at *<https://youtu.be/PlumNDQHcdo>*

The cross-utilisation of key campaign messaging raised awareness of community engagement and vaccination activity which was undertaken by VACCHO and ACCHOs; such as the VACCHO vaccination bus, VAHS 'When you're ready, We're ready' campaign and the departments Aboriginal COVID-19 Infoline.

Summary and Key Learnings

The departments Aboriginal community engagement and communications strategies were successful in delivering culturally safe and appropriate information and services to the Aboriginal Community Controlled sector and Victorian Aboriginal communities. Collaborative partnerships between the department and Aboriginal organisations were a pivotal factor to success, which were underpinned by Aboriginal self-determination and community led approaches. It is important to recognise that communities know what they need and for engagement strategies and services to be informed by and tailored to local communities.

Key partners including VACCHO and ACCHOs remain highly engaged and keen to continue to collaborate into the future. The accessible and timely delivery of updated communications and engagement resources was particularly important to support the work undertaken by ACCHOs/ACCOs during regional and other area COVID-19 outbreaks (of note Greater Shepparton area Outbreak July/August/September 2021, and Mildura area September/October 2021).

The Community engagement and vaccination awareness activity undertaken by the ACCHO sector was a key driver supporting approximately a 40% increase in uptake of Dose 1 (43 – 84%) and Dose 2 (26 – 67+%) Vaccinations for the Victorian Aboriginal 16+ population in the two month period of September/October 2021.

Of note, Victoria achieved higher vaccination rates for Aboriginal and Torres Strait Islander people than all other states, with 86% fully vaccinated (2 Doses) by January 2022.

*Table below, from the 25 June 2022 Aboriginal and Torres Strait Islander Situation Report

Figure 1: Victorian Aboriginal and Torres Strait Islander (16+) Vaccination rates (25/6/22, Dept of Health Victoria)
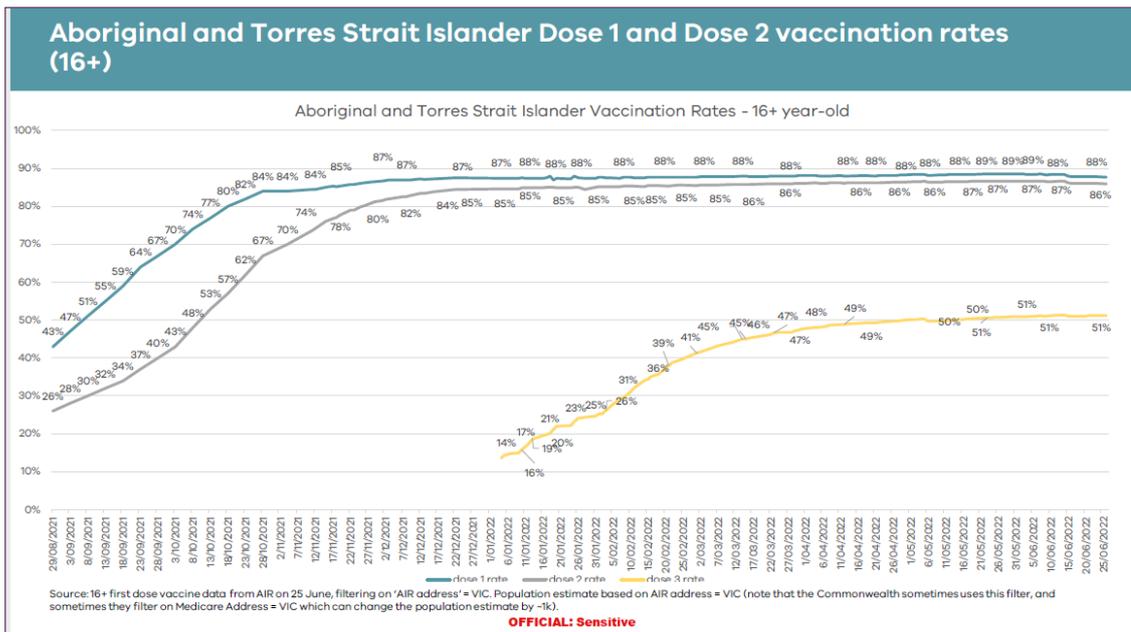
Though the Victorian Aboriginal (16+) population vaccination rates are below the Victorian Total (16+) population vaccination rates, they have remained higher than the National Aboriginal (16+) population vaccination rates. Please see below graphs for November 2021 onwards monthly information.

Figure 2: Dose 1 Vaccination Rates, Percentage of 16+ Population vaccinated (27/6/22, Department of Health Victoria).
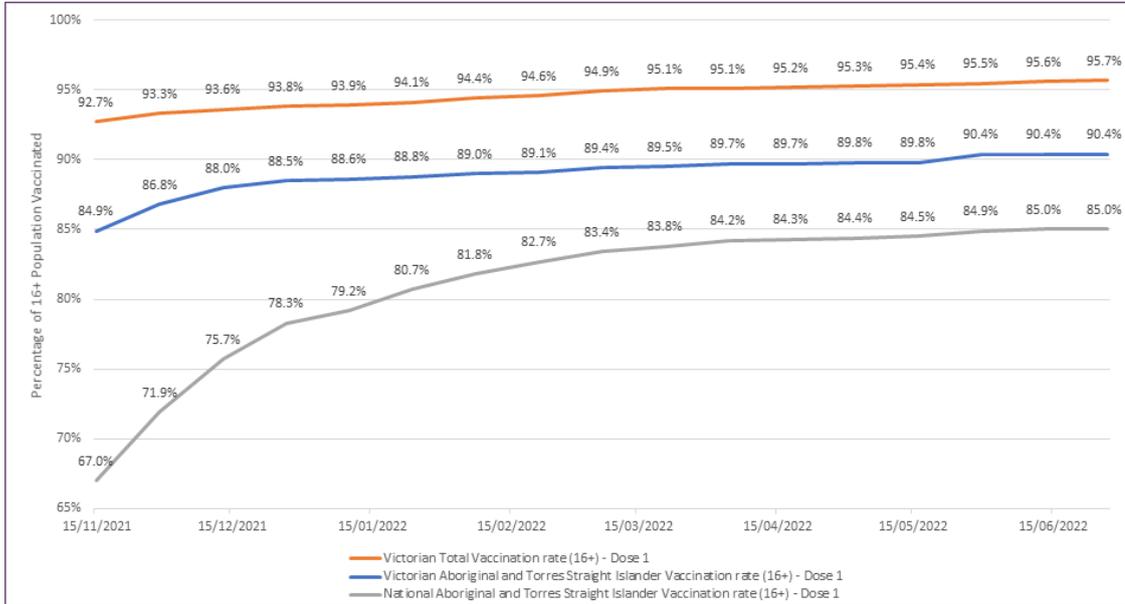
Figure 3: Dose 2 Vaccination Rates, Percentage of 16+ Population vaccinated (27/6/22, Department of Health Victoria)
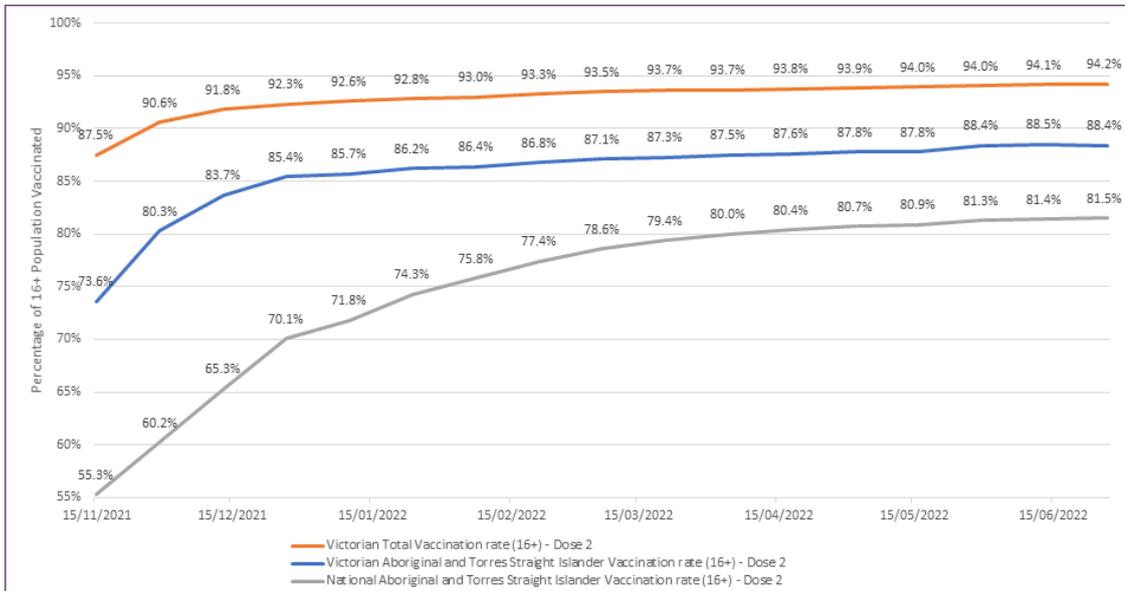
Key findings:

A significant investment beyond traditional public health communications was required of government to ensure accessibility for all Victorians.

To reach Victoria's diverse population it was critical to enable and empower communities to implement tailored communications to meet local needs, which facilitated a culturally appropriate approach and timely and accessible messaging. This was achieved through collaboration across government, with multi-cultural and Aboriginal communities to co-design and deliver messages through fit for purpose communications that met the diverse needs across and within these communities.

7.1.3   Targeted – diverse communication tools/channels using integrated approaches tailored to audience (simple versus comprehensive) involving and engaging those affected

A community as diverse as Victoria's required both a large-scale and a tailored COVID-19 communications to effectively reach everyone in the community. A whole of government approach to community and industry engagement was adopted that involved working relationships and partnerships with multiple government departments and agencies, LPHUs, local governments, ACCHOs, community leaders and industry.

Interactive meetings with engagement specialists from local government, state government, LPHUs and community organisations were convened by DH. Updated information was presented to the group and shared to support the COVID-19 response across Victoria. Up to 550 working group members were invited to this meeting, with an average of approximately 105 attendees per meeting over the past 6 months to June 2022.

A broad range of engagement activities were undertaken by government with different sectors developing tailored messages for their audiences. These were distributed through their networks using existing and new additional mechanisms. Various community and industry engagement mechanisms also provided effective feedback to refine guidance and messages.

The coronavirus website provided business support pages and sector guidance documents with tailored information to assist different sectors in Victoria. Delays in the provision of tailored advice to industry and businesses, due to rapidly changing public health conditions, were mitigated by engagement and partnerships with stakeholders to allow for clear and timely communication of pandemic order changes.

DJPR used a variety of channels to communicate requirements under pandemic orders and cater for the various ways in which businesses and industry consume information.

The Business and Events Engagement team conducted 22,567 on-ground direct business engagements from 15 December 2021 to June 2022. The team had a state-wide reach and spoke directly to small and large businesses to educate, address questions and concerns regarding COVIDSafe Settings and encourage compliance with pandemic orders. They undertook on-ground direct engagement campaigns and strategic engagement with CALD business groups within a wide range of communities such as Aboriginal, Syrian, Iraqi, Vietnamese, Bengali, Chinese, Croatian, French, Greek, Indian, Nepalese, Persian, Somali, Spanish, Sri Lankan and Turkish. In addition, the DJPR CALD Business Engagement team delivered videos on YouTube as a channel for

in-language communication of the pandemic order settings. In partnership with the City of Casey, sixteen videos were produced in Mandarin, Vietnamese, Dari, Arabic, Punjabi and Spanish.

DJPR used a variety of channels to communicate requirements under pandemic orders and cater for the various ways in which businesses and industry consume information.

The coronavirus website had various web pages dedicated to workplace requirements and provided links for businesses to download signs, posters, templates and COVIDSafe Plans in different formats, enabling them to comply with workplace requirements e.g, signage requirements. Between from 15 December 2021 to 6 June 2022 there was a significant number of downloads and visits to business support pages on the Coronavirus website. There were 334,556 views on the 'How we work current restrictions' page, 160,728 views on the 'COVIDSafe Plan' page, and 140,624 views on the 'Signs, posters, templates' page. The 'Signs, posters, templates' page had a total of 135,174 downloads (126,863 English, 8,311 In-language). The 'COVIDSafe Plan' page also had a high number of downloads with a total of 82,174 (78,078 English, 4,096 In-language).

Industry Information sessions/roundtables were held online along with consultations with Key Stakeholders led by the Industry Coordination and Recovery Group (ICRG) of DJPR (where appropriate). Industry engagement and information sessions were also a source of stakeholder feedback providing opportunities for 'Questions and Answers' which reinforced communications but also gauged their effectiveness informing responsive communication initiatives.

To complement all-sector roundtables conducted by DJPR, a number of smaller ad-hoc tailored engagements were undertaken for stakeholder groups and individual organisations where there were barriers to accessing information. These included tailored forums with Traditional Owners, the VMC, Local Government CEOs, Agriculture Victoria, Creative Victoria and regional business forums.

The Deputy State Controller (DSC) team held online workshops to provide information and assist businesses to implement COVIDSafe business practices as per the updated pandemic orders. These sessions were assessed for their effectiveness through in-session polls. They targeted all industry sectors, the top 15 being: Office workplace, Hospitality (cafes, restaurants, pubs, clubs, etc.), Allied health, Retail, shopping centres and supermarkets, Government (state or local), Community services, Building and construction, Hospitality (accommodation), Community group, Hair, beauty, personal services, Sport & fitness, Education, Manufacturing, Property and Real Estate and Tourism.

To further support compliance with workplace requirements under pandemic orders, various channels were used to distribute COVIDSafe Plans including: the coronavirus website where a pdf, word accessible and in-language versions of COVIDSafe Plans were available to businesses and a FAQs section to clarify matters in relation to compliance and enforcement; and provision of hard copy COVIDSafe Plans to CALD businesses during on-ground engagements. Industry info sessions referred to the COVIDSafe Plan requirement and directed stakeholders to the coronavirus website COVIDSafe Plans resources.

The 'Being COVIDSafe is Good for Business' campaign ran from 7 March to 1 April 2022 targeting three business segments: non-CALD metro, non-CALD regional and state-wide CALD (nine priority languages: Arabic, Greek, Hindi, Italian, Punjabi, Simplified Chinese, Traditional Chinese, Turkish and Vietnamese). The campaign focused on six key messages, including vaccination requirements. It drove considerable traffic to the coronavirus website and contributed significantly to increased traffic to in-language Business and Work pages on the website.

Different vaccination deadlines and requirements (two or three doses) for different worker groups were found to be challenging to communicate with specific stakeholders. Reminders were sent to DJPR stakeholders via SMS to support business and industry to understand industry specific mandates. This was used as an opportunity to direct business' and industry to information regarding vaccination requirements for their industry and to reinforce and link to broader COVIDSafe messaging.

DFFH shared posters in 36 languages with stakeholders, COVID-19 grant recipients and ambassadors, Local Councils, WhatsApp Community Leaders Group, VMC, DH and a VPS Working Group. They also communicated recommendations for disability support workers and volunteers to wear N95 respirators indoors.

DET communicated face covering requirements for staff and students at schools, Early Childhood Education (ECE) centres and Higher Education Studies settings. DET received feedback indicating CALD communities were not applying elements of the COVIDSafe initiative to the same level as other communities during early Term 1 and in response, used collated data to drive its CALD-focused back-to-school social media and radio campaign.

To communicate face covering requirements and encourage compliance, DoT used audio messages on public transport for passengers and visually impaired passengers and written signage that face coverings must be worn, displayed posters featuring passengers or staff wearing a face covering and made face coverings available at train stations. Regular forums and multi-method communication channels were established to bring together key stakeholder groups for specific COVID-19 briefings. These channels included an open round table discussion to provide feedback, and identify emerging risks, issues or opportunities for collaboration. Some of the information collected was then fed back into the government or DH for further advice or to inform future considerations for pandemic orders. In addition to DH official communication and advice, DoT provided a synopsis of specific changes that related to the transport portfolio areas, namely Commercial Passenger Vehicles and Ports and Freight. DoT undertook engagement with key stakeholders, portfolio areas (roads, public transport, buses, ports, freight and fisheries) and industry, especially where additional policy, procedure or controls were required to facilitate mandated adherence efficiently to avoid service delivery impacts. DoT used different mechanisms to communicate border restrictions and to engage with heavily impacted portfolio areas that required assistance with interrogating orders and obtaining DH advice to clarify policy and procedural development.

DH undertook stakeholder engagement with health services and health service CEOs so they could lead communication with their own staff and communities about changes to settings. This included regular briefings with health service CEOs, Board Chairs, Operations teams, aged care services, and daily communication via the CEO bulletin. DH held regular online meetings for sector stakeholders hosted by the Rapid Response Engagement Director with guest speakers including the DH COVID-19 Response Commander, DH Deputy CHO, medical experts and state government stakeholders.

Case study 3 highlights that a wide range of tools and channels were used to reach and engage with Victoria's multicultural and multi-faith communities, recognise their experiences understand barriers to compliance and the impact of COVID-19 on their communities.

Source: 2022 Multicultural Sector Briefing, Immigration Museum, Melbourne. Photograph by Christopher Hopkins.

Source: 2022 Multicultural Sector Briefing, Immigration Museum, Melbourne. Photograph by Christopher Hopkins.

Mass media campaigns for the broader Victorian population were complemented by targeted campaigns to reach specific communities. For example, the DH developed the FabJab campaign and worked closely with the Victorian Commissioner for LGBTIQ+ Communities to address vaccine hesitancy amongst the LGBTIQ+ community. DPC ran paid cultural observances campaigns in-language on social media and on multicultural social media, print and radio to recognise days of significance and cultural events during the pandemic and the importance of staying COVIDSafe. From December 2021 to June 2022, this included campaigns for Christmas, Lunar New Year, Pesach, Italian Liberation Day, Vaisakhi, Puthandu, Sinhalese New Year, Eid al-Fitr, Yom Ha'atzmaut, Orthodox Easter, Philippines Independence Day and Italian Republic Day.

As highlighted in Case study 1, a WhatsApp Community Leaders group and the MNS allowed timely and important updates to be shared with Victoria's multicultural community in plain English and in different languages.

DH was required to fill gaps in multicultural communications creatively. This demonstrated in the shift from heavy reliance on polymerase chain reaction (PCR) tests to RATs. RATs only came with English instructions, hence, pure translation of "check instructions on box" was not effective when encouraging CALD communities to use RATs. To fill this identified gap, RAT demonstrations were held at some vaccination centres in priority areas. Run in partnership with various stakeholders from grassroots of CALD community organisations through to peak multicultural and multifaith agencies and the VMC.

Case study 3

Communicating rapidly changing restrictions and public health orders effectively to Syrian and Iraqi refugee and asylum seeker communities

Communities from Syria and Iraq are not homogenous and are made up of many ethnic, religious and social groups. Some have been here for very long periods of time, others are comparatively new and dealing with settlement under the tremendous pressures of the pandemic. The experiences individuals, families and communities have lived through prior to arrival in Australia continue to be relevant in their current situation. In particular, the impacts of COVID-19 and how this situation may have triggered memories of their experiences of persecution, threats to survival and loss of trust in governments to protect. This combined with loss of control over decision-making has been further impacted by restrictions that limited the capacity to support each other daily. The very real challenges for families who had to isolate because of testing positive triggered memories of experiences of having to hide from persecutors, or other threats, the loss of agency over one's daily life, the loss of the opportunity to come together in places of worship given that faith and religion for many has been very much a part of their refugee experience, and the importance of their faith in their survival.

Rapidly changing restrictions/public health orders and contradictions such as churches/mosques not being allowed to gather in person for services but people generally able to gather for food, coffee etc. once restrictions eased were particularly challenging to communicate. It was difficult to keep up with the changes and to ensure that the messages were being shared across all the communities.

Other recurring challenges included: misinformation distributed through social media channels, particularly from overseas; mass communication strategies to disseminate information, even when translated, not necessarily reaching community members and self-proclaimed trusted sources. Translated information was not effective if it required a high level of literacy to be able to understand the information once translated and it often required nuance to be applied to how the messages were shared across the various platforms to ensure reach and access.

Communication tools and strategies

Communicating the rapidly changing public health controls required a trauma informed community engagement approach that required a thorough understanding of the communities and recognized these experiences and the impact of COVID-19.

The communications work through a trauma informed response to COVID-19 was operationalised to reach out to those who were ready for vaccination, those who were hesitant and those who were mistrusting and rejecting the vaccine as their responses. Feelings of fear and rejection were quite normal responses to abnormal pre-arrival experiences and times of uncertainty.

People were neither encouraged to make their mind up nor pushed to shift them from the state of mistrust to the state of hesitancy or to confidence. There was a focus on co-facilitating onsite, hybrid, online and livestreamed information sessions in partnership with health providers to address vaccine misinformation, communicate about vaccine development and engage with those hesitant to get vaccinated. This was done through telling them personal stories, seeking their challenges, barriers, feedback, inputs and helping them to navigate the system to access credible resources. This allowed them to make their decision to move gradually and at their own pace, from a stage of rejection to the state of hesitation and then to confidence.
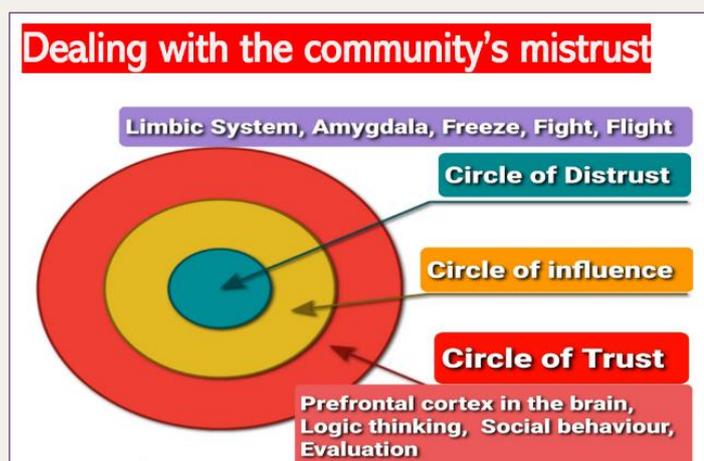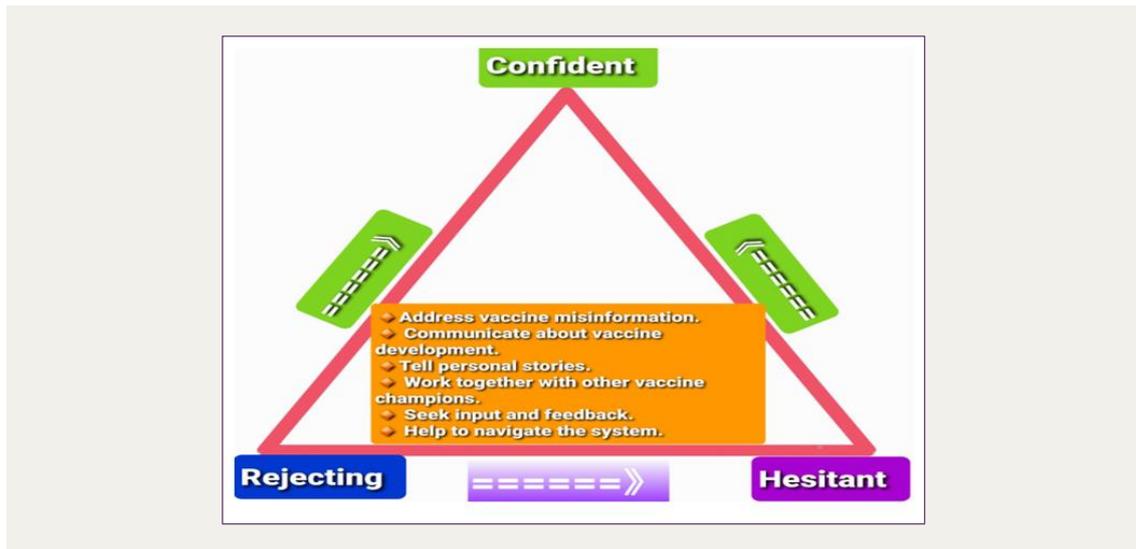
A wide range of tools and channels were used to reach and engage with the Syrian and Iraqi refugee and asylum seeker communities. Trusted relationships and channels with community champions and the COVID-19 Engagement and Partnerships Vaccination Ambassadors Program played a key role.

There was comprehensive use of social media including regular updates, constant postings on social media, videos and responding to posts related to information was a key tool to engage with community members. The Syrian and Iraqi communities (unlike some other communities) became very well versed in using social media to keep in touch. Community influencers played an important role in sharing information and messages. The translation of information into manageable 'chunks' supported more effective messaging on social media platforms.

> Foundation House posted on Facebook and promoted an Arabic song (Booster hope of life) sung by Adeeb Al-Iraqi which was developed through the Migrant Resource Centre (MRC) and the Federation of Ethnic Communities Councils in Australia (FECCA) to encourage vaccination booster uptake. 3,028 people were reached through this social media engagement. Australia Social Services Inc Facebook page post <https://www.facebook.com/102163585136917/posts/369729921713614/>

Misinformation was challenged with evidence, data and credible information from trusted sources but also presented in an accessible way to community including through using social media platforms the communities were accessing.

The Arabic speaking communities were one of the communities who were hugely impacted by conspiracy theories on social media. A Foundation House Community Liaison Worker undertook three surveys to assess the level of community hesitancy of the COVID-19 vaccine.

The first survey was undertaken in March 2021 and rates of hesitancy and community mistrust were as follows:

- Strongly convinced: 46.67%
- Strongly mistrust: 26.67%
- Convinced but still hesitant: 26.67%

The second survey was conducted in June 2021 and it showed how the communities mistrust was impacted and changed over time after emerging rare cases of blood clots and a few cases of fatalities as some side effects of the vaccine. Results were:

- Strongly convinced: 33.3%
- Strongly mistrust: 8.3%
- Not convinced but hesitant: 15%
- Convinced but still hesitant: 48.3%

These results informed the approach to target the conspiracy theories on social media by gathering credible information from the Local Public Health Unit and Department of Health, translated and then posted the information on social media and then addressed community concerns on social media.

Trying to ensure that community members had accessible information, including how to navigate the system, was important in strengthening the capacity of the community to understand and distribute relevant information.

Messages were communicated through community briefings, forums, information sessions, informal individual and small group discussions. Translated information on the DH website enabled up to 64% of Arabic speaking community members to reach credible information from a reputable source without being unduly influenced by the conspiracy theories which have left a deep impact on a small proportion of community members and vicariously affected other populations to approach the COVID-19 vaccination program.

The Community Team at Foundation House focused on the literal/informative social messaging that contained flyers, symbolic pictures and translated health information to engage and raise awareness of the CALD community members about COVID-19 Vaccine. This was informed by information from credible sources including the DH and the LPHUs and on some occasions was reviewed and approved by the Department for the credibility of the contents to be filmed and disseminated for the target communities.

Summary and key learnings

The development of communication and engagement strategies for refugee and asylum seeker communities needs to recognise the particular characteristics of their history and tailor information accordingly. This requires a good understanding of the community that can only be achieved through trusted relationships developed over time. Planning now for the ability to utilise these relationships and channels quickly if required in future, along with the identification of resourcing required now and in times of emergency should be prioritised.

These initiatives were only made possible through funding from the DH under the Community Engagement Grants program (the Ambassador Program) that aimed to provide financial support and resources to a range of organisations across Victoria to support priority groups and maximise the uptake level of the COVID-19 Vaccine. Foundation House was also critical, leading program delivery under their Community Capacity Building Program.

In future, the focus should be on partnering rather than just engaging with community and religious based organisations to deliver information sessions and services such as pop-up vaccination clinics as they would be more trusted and accessible to community members.

Frequent use of social media to update information, engaging in conversations on Facebook/WhatsApp groups etc. is resource intensive and needs to be realistically funded. Having community members already engaged through these channels ensures they are trusted sources of information for any critical messaging.

Key findings:

A broad range of communication and engagement activities were undertaken by government. They were informed by consistent messaging tailored for different sectors and priority cohorts and their audiences and distributed through their networks using existing channels and a diversity of new mechanisms.

Coordinated and planned stakeholder engagement where regular feedback was encouraged and collected enabled ongoing and future messaging to be tailored to the audience and address any gaps identified.

7.1.4   Sensitive, evidence based and credible, is open and transparent, creates and maintains trust and is relatable

Distrust and fear are common reactions to officials during an emergency such as a pandemic. Creating and maintaining trust and providing evidence based and credible information to ensure the public was aware of COVID-19 risks and encourage the adoption of protective behaviours was critical throughout the pandemic.

Press conferences provided a platform for the Victorian Government to be open and transparent about the current risks posed and measures required to address the risks and an opportunity for journalists to request further explanations or question changes to pandemic orders. The officials showed empathy to those impacted, acknowledging the challenges and what people were feeling.

The Premier, Minister for Health, the CHO and the COVID-19 Response Commander became familiar faces during the pandemic as they consistently appeared at COVID-19 press conferences to provide updates to Victorians. At one stage of the pandemic, the Premier addressed the media and the public for 120 consecutive days. The CHO also often appeared at press conferences to explain evidence based and credible advice in a clear and easy to understand format with data to support decisions being communicated.

Press conferences also featured everyday people, workers and experts to address messaging fatigue and convey relatable messages. Intensive Care Unit (ICU) nurses provided a first-hand account into the devasting impacts of COVID-19, highlighting the ongoing seriousness of COVID-19. They urged the community to get vaccinated, at the same time acknowledging that restrictions were difficult for the everyone. Victoria's Chief Psychiatrist appeared to talk about the impact of COVID-19 on Victorians' mental health and sense of well-being, and focused on children, teenagers and their families who might be at risk of being overlooked. Importantly, Victoria's Chief Psychiatrist highlighted the services available for help. Government officials were also joined by community leaders including a Western Bulldogs Australian Football League Women's Competition Coach and community general practitioners to share their experiences and reinforce COVID-19 messages to Victoria's multicultural and multi faith community, particularly in the north and the west which had a higher proportion of infections at the time.

Information on where outbreaks were occurring was highlighted in press conferences to alert the public to the risk of the spread of the virus and to encourage people who had attended outbreak settings to be alert for symptoms and get tested. This information was also available on the website and updated regularly for people to access.

Extensive COVID-19 related data was published daily and weekly on the coronavirus website, including files that allowed stakeholders, media and the public to download data. The data and information enabled Victorians to stay informed about the ongoing seriousness of COVID-19 and make informed decisions to keep themselves and the community safe.

DH published key information daily via the DH Twitter account with the CHO often re-tweeting this information with additional information and explanations included to add credibility to the data being shared. The regular sharing of data at the same time of day through the one channel assisted in creating trust in DH as the key source of COVID-19 related data for Victoria.

Misinformation was an ongoing challenge with trusted sources well utilised to combat this as credible sources delivering the evidence and data. This was particularly important in communities who were accessing information from overseas, in language. Self-proclaimed trusted sources were however, potential sources of misinformation as highlighted in Case Study 3.

Feedback from stakeholders and community leaders highlighted that DH communication and messaging was important in validating community based or local communication. A small organisation might be delivering the message to their community, but it was validated because they were able to say it came from the DH.

CALD media forums were held jointly with the VMC and public health leaders speaking at VMC community leader forums. The VMC and DH held regular virtual community leader forums for all community groups.

On the ground engagement partnered with virtual engagement with businesses was beneficial in establishing and maintaining trust, particularly in establishing a relationship with small to medium businesses who were initially more difficult to reach. DJPR obtained feedback from stakeholders through different mechanisms including Industry Engagement information sessions used to revise online guidance, the Business Victoria Hotline Call Centre and an email address for queries and

media queries/commentary. Feedback mechanisms provided a dynamic, constant, real time feedback loop and allowed communication to be further developed to address gaps or inconsistencies identified. Messages of appreciation left on online platforms such as MS Teams and ZOOM for the assistance provided by DJPR including clarification/information provided during the sessions, as well as emails/calls is a demonstration of the trust created.

Behaviour change theory was an important component of the campaign's strategy but as part of an emergency response this had to be done quickly. The notable difference being the length and complexity of messaging required to support the COVID-19 response. In this context, DPC gave consideration to the expertise required and assembled an experienced team of staff to deliver campaigns strategy from agencies such as WorkSafe, DoT, multicultural organisations and Health, with expertise and backgrounds in public health, emergency and crisis communications and behaviour change campaign delivery. Various key insights informed campaign development including data from the BAS, the Australian Bureau of Statistics (ABS), health-based data insights, Victoria Police on compliance with directions/orders, the DoT on mobility and patronage and COVID-19 case related data from the Department of Health such as epidemiology reports. Advertising campaigns were also informed by engagement with the community through forums led by DH and DFFH, data collected from Victoria Police on compliance with directions and pandemic orders, data from DoT on mobility and patronage and COVID-19 case related data from DH.

Location specific communications were informed by DH case data, VicPol data and DoT mobility data to determine placement of early advertising of public health guidance advertising in high traffic areas and areas of outbreaks. Engagement with CALD leaders informed the messaging and distribution efforts of campaign materials by trusted people in CALD communities, along with translated materials in paid campaigns.

Collaboration with media partners and creative services agencies informed the identification of communication channels and ensured the campaigns reached the intended audiences including specific age cohorts. Evaluation of media performance confirmed interest in and engagement with the materials.

In line with other Commonwealth/State public health arrangements during the pandemic, Victoria participated in forums to ensure campaign messaging was aligned across jurisdictions to minimise confusion of messaging and manage government saturation of the paid advertising space.

Case study 4 highlights that targeted engagement activities and partnerships with organisations, trusted sources and local government were fundamental in providing reach into the most vulnerable and high-risk communities, building confidence and ensuring evidence-based information was disseminated and well understood.

Case Study 4

Communication of the Victorian COVID-19 vaccination program for priority people, places and workplaces, through an engagement and partnerships approach

When the national rollout of COVID-19 vaccines began in February 2021 the Victorian Government was faced with the challenging task of vaccinating 85% of the total population in approximately 10 months.

Achieving this unprecedented goal was complicated by a number of factors. The initial phase of the delivery was undertaken in the context of minimal circulating COVID-19 in the community with a negligible number of new cases reported per week. This changed in August and September 2021 following new outbreaks in Victoria. During this period vaccine distribution through the Victorian government delivery channels was prioritised to communities with high numbers of new cases.

The Commonwealth was responsible for procurement and allocation of vaccine to the tatestates, with limited supply until August 2021. The proportion of overall vaccine doses provided through Victorian government delivery channels varied across the year and across areas, with 50-60% of overall doses administered by the state in June 2021 and declining to 20-30% in November and December 2021. The Victorian Government used a tight prioritisation system when supply was limited to maximise the benefit of the program, a source of tension with stakeholders in the period where consumer demand was greater than vaccine supply.

There was community hesitancy about the safety of a vaccine produced in a short timeframe. Vaccination recommendations from Australian Technical Advisory Group on Immunisation (ATAGI) were amended during the program in response to reports of adverse events associated with Vaxzevria and the recommended interval between doses was reduced in the context of outbreaks.

The DH made a significant investment of $9.3 million establishing an Engagement and Partnerships Program (the Program) to:

- Provide clear, credible, consistent and easy to access information and messaging about vaccinations and COVID-19 safe behaviours is in a timely manner
- Establish and facilitate partnerships to achieve a coordinated, place-based response to address hesitancy in the Victorian population and respond to outbreaks
- Ensure Victorians could access trusted and credible information about vaccination and the vaccine program, increasing confidence to get vaccinated.

The program centred on connecting community with opportunities for vaccination through:

- A call centre that enabled the provision of information, bookings for vaccination and outbound reminders
- An internet enabled platform for consumers to book vaccination at the main state provided vaccination locations
- Pop-up vaccination locations to target a particular high priority cohort.

The focus was on priority people, priority places and priority industries, settings selected to maximise reach, provide multiple opportunities to be exposed to the program messages and address socioeconomic disadvantage.

Priority people include:	Priority places include:	Priority workplaces include:
• CALD communities, particularly newly arrived migrants • Aboriginal Victorians • People with existing health issues • Younger and older Victorians • People with disability • Residents of aged care facilities • Older populations • Unpaid carers of any above.	• LGAs that have historically had the highest and most complex COVID-19 cases in Victoria • Border towns (for as long as there are positive cases in other parts of Australia) • High density housing.	• Tertiary and primary health care • LGA immunisers • Corrections facilities • Ports of entry (airports, ports) • Quarantine facilities • Workplaces that have historically experienced outbreaks including aged care, schools, meat processing, supermarket distribution, hospitality, health services and hospitals.

The chronology of delivery and engagement was influenced by vaccination eligibility, vaccine availability and outbreak response. Initial cohorts were prioritised to minimise the risk and impact of disease and to maximise the benefit of the limited initial supplies of vaccine. Communication and engagement requirements changed and evolved over the life of the program.

By mid-October, within eight months of the program commencing, the initial target of an 80% double-dosed population was achieved. A vaccine uptake rate of more than 93% of the eligible population were vaccinated by the end of 2021, exceeding the rates achieved by most high-income countries. The uptake varied by age group with more than 95% of people aged 40 or older fully vaccinated, compared with 85% in the 12-15 year and 18-29 year groups. Compared to other states Victoria achieved a remarkably equitable roll out, with little variation across LGAs when grouped by Socio-economic Indexes for Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD) quintile. Rural Victoria achieved the 80% double-dose target before metropolitan Melbourne. 86% of the Aboriginal and Torres Strait Islander population was fully vaccinated by 6 January 2022, a higher rate for this population than all other states.

Ambassadors and Champions

The Ambassador and Champions programs were established across Victoria, resulting in more than 1000 events with a direct reach of more than 57,000 person contacts.

The Ambassadors initiative recruited 224 health organisations, local government and ethnospecific organisations that had direct roles in support and connection with priority populations and communities of interest to provide evidence-based information through engagement activities to support individuals and communities to get vaccinated. The program had reach across the entire state in both specific geographic areas and through statewide peak bodies and service providers such as the Victorian Council of Social Services and the Asylum Seeker Resource Centre. The Ambassadors provided information to communities and performed case management functions through a funding

stream provided to refugee support agencies to provide supports to encourage vaccine uptake.

The Champions initiative recruited 49 Clinical Champions and 18 Community Champions to provide information through trusted health professionals and community members that had a CALD background. Most (70%) of the Clinical Champions were medical practitioners with 25 general practitioners and 10 from other specialist medical practitioners. These practitioners had a variety of cultural backgrounds with Vietnamese, Muslim, Indian and Chinese being the most common identified backgrounds. Eight of the 49 Clinical Champions, and 14 of the 18 Community Champions, participated as volunteers and did not seek reimbursement. Champions communicated information on the availability and benefits of vaccination through their networks and participated in events organised by the DH.

Communication and Engagement tools and approaches

Commercial mass media and social media channels were a focus to promote awareness of the program and its messages through the delivery of social marketing strategies, along with printed and video resources, website content, fact sheets, posters, FAQs and publications for specific settings and initiatives. Resources were made available to people and organisations directly or through the Ambassadors and Champions. Weekly Sentiment and Insights Reports and online resources including social scripts for people with autism, Auslan videos and translated materials were also accessible resources. There were more than 32 million vaccine-related page views on the Coronavirus Victoria website with volume varying over time with the changes in eligibility and program structure.

Advertising campaigns formed a significant part of the communications approach and included general and targeted audiences. Larger campaigns used TV, print, outdoor, radio and social media, while campaigns directed at particular audiences focused on target channels such as social media.

DH or combined DH/DPC vaccination campaigns aimed at the general population included:

- "Voices for Vaccine", August and October 2021
- "Your vaccination is your ticket", October 2021 to January 2022
- "Every third dose protects the one you love", January to September 2022
- "New Year, New Dose", 24 December – 11 January 2022
- 5-11-year-old vaccination, January to 31 July 2022
- Third Dose booster vaccination, 24 December 2021 to 31 July 2022
- Managing COVID at Home, January to 31 October 2022
- Other targeted vaccination advertising campaigns included:
- LGBTIQ+: "Fabjab (step up to step out)", October 2021
- Aboriginal and Torres Strait Islander: Uncle Jack vaccination campaign, November to December 2021

People focused engagement included 250 CALD community events from January to December 2021, strategic engagement with Aboriginal and Torres Strait Islander people, CALD, LGBTIQA+, refugee and asylum seeker, and youth communities, facilitation of nearly 8,000 appointments by Disability Liaison Officers and a High Risk Accommodation Response program.

Key outcomes of the place-based engagement included a sharepoint information hub for Ambassador use and establishment of a communities of practice for women's health, local government and youth sectors; along with LPHUs and local government working groups.

Short-term 'pop-up' clinics were a key engagement mechanism partnering with communities and groups to address identified gaps in coverage or accessibility. This made vaccinations more accessible to people at strategic locations across the state than the established high volume fixed sites.

Working with key industry peak bodies and organisations underpinned the industry engagement which involved working groups, information forums and training sessions for sectors including agriculture, construction, disability, distribution centres, emergency services, health care, mental health, meat and seafood processing and transport.

50 Murdoch Children's Research Institute vaccine hesitancy training sessions were held and attended by more than 800 people, including CALD and faith leaders, trade unions and peak bodies.

Program materials were informed by research including COVID-19 vaccine key cohort preparedness and communication strategies by Murdoch Children's Research Institute, University of Melbourne, Monash University, University of Sydney, University of NSW and training resources and programs developed with partners including the Murdoch Children's Research Institute, University of Melbourne and Common Cause.

Key Learnings

Evidence based program design informed by proven strategies for the engagement of populations and the delivery of health programs to communities provided the foundation for the extensive and targeted engagement achieved across the diverse Victorian community. This ensured that messages were received an understood and that vaccine accessibility was maximised across localities and socioeconomic groups. The evidence-based approach to the identification of communities in need enabled the targeting of interventions to increase uptake.

Initial research informing messaging and effective methods of increasing vaccine confidence provided a strong evidence base for the work of the Ambassadors and Champions. Early strategic planning underpinned initiatives such as ensuring workforce training and guidance on how to build confidence in the vaccine program. Credible and trusted sources played a key role in building trust and through the provision of training to individuals and organisations.

The establishment of the Ambassadors and Champions initiatives were fundamental in providing reach into the most vulnerable and high-risk communities. Localised social media (from Ambassadors) and word of mouth was critical to increasing confidence with the key target populations, achieved through the investment made in the resource intensive community development approach that built confidence with communities. Continued investment is required by Government to achieve the benefits that can be gained through partnerships and engagement on public health interventions.

Key findings:

The attendance of the Premier, Minister for Health, the CHO and the COVID-19 Response Commander at regular COVID-19 press conferences provided timely and informative contextual credible information including the uncertainties.

The government made a wide range of COVID-19 related data available publicly that was utilised as a part of the evidence base to inform public health controls.

The development of advertising campaigns was informed by the BAS but no detail was provided to the committee for analysis.

7.1.5   Enabling – guides health promoting opportunities and provides links to information and services

Most communication produced by departments included links to the coronavirus website as a central source of information on COVID-19 and support services available. Messages on the availability of financial support, emergency relief packages and emergency accommodation to support Victorians to comply with pandemic orders were conveyed across different channels. The public was regularly directed to the coronavirus website or the Coronavirus Hotline for further information. Multiple departments also offered COVID-19 hotline services including the Coronavirus hotline, Aboriginal COVID-19 Infoline, Business Victoria COVID-19 hotline and the DET COVID-19 hotline providing information and links to relevant services.

The coronavirus website included information on where to access a COVID-19 test and vaccination sites and encourage Victorians to engage in COVIDSafe behaviours.

On the ground engagement was undertaken by departments including the DH, DET and DJPR to support businesses and schools, provide guidance and observe compliance.

Source: Department of Health Twitter account at <@VicGovDH> (2022, April 9). [Online].

Increasing access to COVID-19 tests, relevant support services and face coverings enabled Victorians to adopt COVIDSafe behaviours and adhere to pandemic orders. During outbreaks, rapid response testing teams in regional Victoria expanded testing capacity and helped the public to get tested and comply with relevant requirements in a timely manner.

COVID Isolation and Recovery Facilities enabled Victorians experiencing homelessness to follow isolation requirements. The facilities provided accommodation for homeless Victorians who had COVID-19, were awaiting test results or were recovering. Emergency accommodation was also available for members of the Victorian community who needed support to quarantine or self-isolate safely and for frontline workers. This program enabled Victorians to comply with isolation requirements in a safe environment.

Direct text messages and/or phone calls from the DH to identified cases ensured they were aware of isolation requirements and were provided with further information about support services available.

Advertising campaigns included links to relevant websites and contact numbers of relevant services to enable viewers to take the action being recommended. For example, advertisements encouraging Victorian Aboriginal communities to get vaccinated provided links and advice that local Aboriginal Health Controlled Organisations can provide further information and allow people to book a vaccine appointment.

Face coverings were distributed to Victorians through state-run testing sites, community organisations, community health services and a number of disability service providers. To encourage passengers to adhere with face covering requirements and stay safe while travelling, face coverings were also available from Public Transport Victoria hubs and staffed train stations and handed out by authorised officers and some V/Line conductors.

Source: Department of Health Twitter account at <@VicGovDH> (2022, August 9). [Online].

Key findings:

Information to enable Victorians to access opportunities or positively guide health behaviours was promoted and made accessible at the point in time it was most likely to be accepted and utilised. For example, information to enable identified cases to access assistance if required was delivered to individuals after notification of positive test result.

7.1.6 Proactive in public communication even in uncertainty and provides certainty around roles and responsibilities

Victorians were informed of changes to pandemic orders ahead of changes coming into effect through a range of channels such as media (press conferences with Auslan interpreters, Ministerial press releases, interviews, and media briefings), social media posts, government websites (coronavirus website), community and industry engagement. SMS text messages were also sent to identified cases and close contacts to inform them of changes to isolation or quarantine requirements. For example, when deadlines and any extensions were set for relevant workers to receive a COVID-19 vaccine, dates were communicated to Victorians and relevant sectors in advance to provide clarity and certainty around workplace requirements and support compliance.

Source: Department of Health Twitter account at <@VicGovDH> (2022, April 20). [Online].

COVID-19 press conferences played a vital role in helping Victorians make sense of what was occurring across Victoria during uncertain times. Complex trends, data and modelling were explained to the public in an easy-to-understand format by trusted and credible sources. The decision to cancel daily COVID-19 press conferences whilst the pandemic is ongoing has resulted in a gap in communication and engagement with Victorians.

Most departments established a COVID-19 Division to communicate and coordinate COVID-19 information, provide tailored advice to stakeholders, and provide certainty around roles and responsibilities. The DH's COVID-19 Response Communications enabled seven-day a week communication functions. The DoT established a COVID-19 Response and Resilience Division to coordinate information, advice and support across the Transport Portfolio and provide information and clarity around roles and responsibilities. DJPR communicated and engaged directly with businesses and industry, delivering the following between 15 December 2021 and 6 June 2022:

- On-ground Business Engagement – 22,621 face-to-face visits with Victorian businesses, including 855 visits to CALD businesses
- Industry forums – engaged with more than 1,200 industry representatives, including peak bodies, industry associations and unions, through 12 business roundtables
- Information sessions – held 25 sessions of over 900 participants each to support businesses and industries with their COVIDSafe Plan
- Information sessions – held 6 sessions with 690 attendees to support CALD businesses
- eDM – more than 30,000 eDMs and 307 CALD specific.

Similar to other departments, DJPR obtained feedback from stakeholders and developed specific messages to address any identified gaps. For example, key stakeholders stated they required clarity on face covering requirements for workers in retail and hospitality at an Industry Information Session held earlier this year. A sector specific eDM was drafted and sent within a few days to provide clarification. Similarly, feedback from the Creative Industries sector requested clarity on face covering requirements for relevant workers, this was addressed by adding information to the online sector guidance.

Significant changes to pandemic orders and public health recommendations were often complemented by targeted communication and campaigns to address uncertainty in the community and misinformation DH created 125 social posts across Facebook, Twitter and Instagram regarding RATs once pandemic orders were amended to allow Victorians to self-report their positive COVID-19 results. These totalled 6,004,767 impressions and 182,064 engagements. Communications and media were also used to instil confidence that RATs had been procured, to inform Victorians where they could access them, and to encourage the public to use them after relying on PCRs since the beginning of the pandemic.

Source: Department of Health Twitter account at <@VicGovDH> (2022, January 23). [Online].

Key findings:

COVID-19 press conferences played a vital role in helping Victorians make sense of what was occurring across Victoria during uncertain times.

There has been an absence of regular communication and engagement with Victorians from the government and trusted experts.

Misinformation starts to take hold in the absence of more authoritative advice. Without clear messaging and expert advice from the government, the media turn to people in the community who have an opinion, contributing to distribution of misinformation and growing uncertainty in the community.

7.1.7   Consistent with best practice - other jurisdictions

The analysis of the Victorian Government's communications against consistency of best practice in comparison to other jurisdictions is limited as it has been undertaken using publicly available communications material at the time of the review.

In Victoria in 2021, 30.2% of people used a non-English language at home.[66] Some people who speak a language other than English at home may have low English proficiency and are therefore in particular need of targeted communication and engagement, including translated materials.[67] While information in Victoria was translated into 57 different languages, it was not available in all languages or dialects. In comparison, NSW Health had COVID-19 resources were available in more than 60 languages.

Consistent with other jurisdictions, the Victorian government undertook targeted engagement and communication to ensure critical COVID-19 information reached specific communities including establishing the CALD community taskforce, community engagement, CALD forums, WhatsApp group chat with community leaders, translated materials and posters.

The Victorian government went one step further and developed Australia's first multilingual chatbot, the AskVic WhatsApp chatbot, to provide relevant and reliable information in 8 languages via a channel that is already used by CALD communities. AskVic can answer questions and direct Victorians to more information on a range of topics including COVID-19, vaccination, financial assistance, housing and more. Creating an easy to use tool whereby Victorians can text a specific number saying "Hello" in their language and the chatbot responds in the preferred language supports multicultural communities to access reliable and translated information. "While the AskVic ChatBot is just getting launched, the test and feedback from participants has been overwhelmingly positive as a large majority found ChatBot useful or extremely useful (70%+)".[68]

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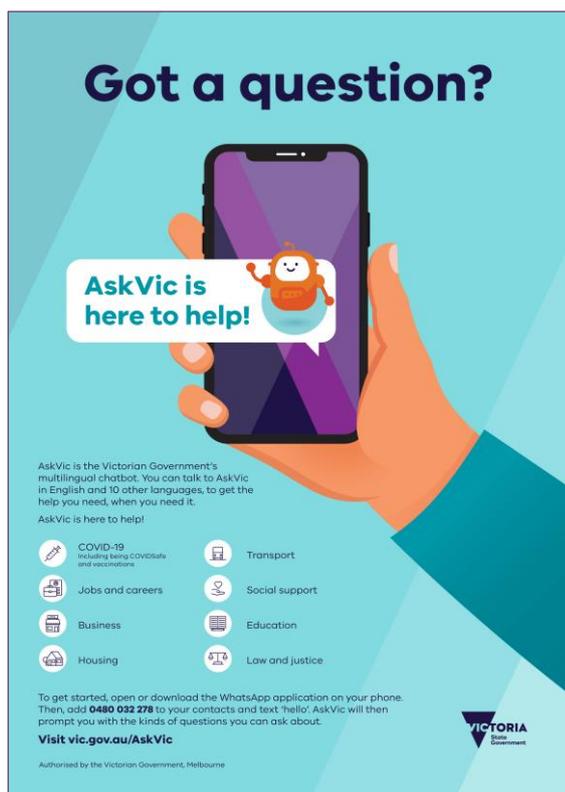
66 Australian Bureau of Statistics (2021), 'Language use at home', *2021 Victoria, Census All persons QuickStats* webpage <https://www.abs.gov.au/census/find-census-data/quickstats/2021/2>

67 Department of Families, Fairness and Housing, *Mapping the languages spoken in Victoria* webpage, 2022, Victorian Government <https://www.dffh.vic.gov.au/mapping-languages-spoken-victoria>

68 Think HQ, *AskVic, Victorian Government Multicultural WhatsApp ChatBot*, 2022, Think HQ webpage <https://think-hq.com.au/work/askvic-victorian-government-multicultural-whatsapp-chatbot>

Source: Department of Families, Fairness and Housing, Ask Vic Stakeholder Pack, 2022.

Whilst social media was used by the Victorian government to provide daily COVID-19 updates and information about changes to restrictions, NSW had greater engagement with the public via social media. NSW heavily used social media to support the dissemination of credible, timely and accurate COVID-19 messages and expand reach to different age groups.

NSW Health used puns, humour and rhymes in their COVID-19 messages on social media platforms. It was found that when humour was used to communicate COVID safe behaviours, such posts generated a greater engagement rate (3.5%) compared to an engagement rate of 1.92% for posts which were 'more factual or demonstrative'.

To address message fatigue, NSW Health developed creative ways to communicate COVID safe behaviours so that messages were not instantly recognised as health messages and disregarded. NSW found that their 'gamified' content which used an old school video game to communicate COVID safe behaviours generated 'on average 39% higher reach than posts that appear as more formal instructions'.[69]

Source: NSW Government. (2021, May 6). [Online]. Facebook.

To maintain ongoing engagement with the public, the public had the opportunity to ask health questions via the NSW Health Facebook page and a medical advisor would answer them during live

69   Quirk, G., *Getting COVID Safe behaviour messaging to cut through on social media* webpage, 2021, NSW Government <https://www.nsw.gov.au/onecx-program/blog/getting-covid-safe-behaviour-messaging-to-cut-through-on-social-media>

Q&A held regularly on Facebook live. The medical advisor would also provide a brief COVID-19 update about case numbers, trends, variants at the beginning of the session. The live sessions were recorded and posted on the NSW Health Facebook page.

Whilst the Victorian DH had created a TikTok account, no content had been shared. In comparison, NSW Health frequently used TikTok to disseminate simple and credible information about COVID-19 and explain changes to measures. TikTok trends were used to help the message resonate with audiences who might be fatigued with regular messaging. In 2021, the NSW Chief Health Officer worked with TikTok to inform and educate the public through an engaging LIVE Q&A on COVID-19. The NSW Chief Health Officer answered questions relating to COVID-19 measures across NSW and vaccinations from Australian TikTok creators from different backgrounds.[70]

Other jurisdictions developed COVID-19 resources specifically for children. The Queensland Department of Education developed a short animation and booklet explaining COVID-19 to children. Children's Health Queensland developed 'Birdie and the Virus', a storybook explaining COVID-19 to children in an age-appropriate way.[71] The storybook was also made available in 18 languages, as an animated video and a sing-along to help children understand the importance of COVIDSafe behaviours. The storybook was specifically designed to help kids cope with feelings and fears about COVID-19 and support their mental health and emotional wellbeing. Similarly, SA Health developed resources specifically for children including storybooks explaining COVID-19 and vaccines to children, colouring in sheets, stickers and achievement certificates for getting vaccinated. In comparison, Victorian government resources for children and families focused on how parents can talk to their kids about COVID-19 and vaccines. High Rise High Five, a children's colouring book, was developed with and for children living in public housing and explained how to stay healthy and safe during COVID-19. Resources were also developed to support secondary school students' mental health and wellbeing including mindfulness videos and activities to help students stay positive and engaged in their education.

Key findings:

While video messaging was used effectively for various groups, including multi-cultural communities, this communication tool could have been used more widely for groups such as young people who widely use the video-sharing app TikTok and businesses.

Social media was used effectively in Victoria to spread messages about COVIDSafe behaviours, explain key changes to pandemic orders and provide daily COVID-19 updates. Social media could have been used more and in different ways to ensure greater engagement with Victorians and facilitate two-way communication. For example, regular live Q&A sessions with a medical expert whereby viewers feel like they are part of a conversation and can engage with the medical expert.

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70   Thomas, B., *Ask Dr Chant: LIVE TikTok Q&A about Covid-safety in NSW* webpage, 2021,
     <https://newsroom.tiktok.com/en-au/ask-dr-chant-tiktok-livestream>

71   Department of Education, *Explaining Coronavirus to Kids Booklet* webpage, 2020, Queensland Government
     <https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/asides/covid-19-explained>

8.   Conclusion

There was a significant mobilisation of resources across government to ensure that Victorian's were aware of their obligations under public health directions and orders to support compliance.

Early in the pandemic it was recognised that traditional public messaging would not suffice. Collaboration across government facilitated a broad range of communication and engagement activities with an emphasis on timely, consistent and relevant messaging tailored for the diversity of audiences across the state.

Lessons were learnt during periods of significant public health control changes with approaches adapted and innovations introduced to address gaps in the receipt of information among particular population cohorts.

Enabling and empowering communities to implement tailored communications to meet local needs was a critical tool. The co-design of programs led by the community was able to ensure appropriate and timely messaging.

The use of trusted voices in message delivery gave credibility to the message being delivered and was important to counteract misinformation. COVID-19 press conferences were an important vehicle for providing timely and informative contextual credible information.

Communications were informed by behaviour change theory and intelligence but this was done quickly given the dynamic nature of this public health emergency. The Committee was not however, able to assess how behavioural and business insights was used to tailor and target messaging as this information was not made available. A wide range of COVID-19 related data was however available publicly that was utilised as a part of the evidence base to inform public health controls.

The end of the daily press conferences in October 2021 signalled a shift in the government's communications approach with a progressive reduction in messaging as the focus shifted to individual responsibility. During this period there has been insufficient alternative clear and easy to access information to enable individuals and industry to take on a greater role in protecting themselves and their workforces.

With the dismantling of the dedicated DH COVID-19 response on 1 July 2022 and the significant reduction in a dedicated workforce from 1500 to 260 at that time, there is now significantly reduced resourcing to provide the Victorian community with the information they need on managing risks related to COVID-19 to be able to make informed decisions about safe behaviours.

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Appendices

Appendix A

Independent Pandemic Management Advisory Committee (IPMAC) –
Communications Roundtable

Attendance List

Time & date

10am-12pm, Thursday 16 June 2022

Location
Penny Armytage AM

Location
Virtual via Microsoft Teams

Attendees:

IPMAC Members
Penny Armytage AM

Dr Peter Harcourt OAM

Pip Carew

University of Sydney
Professor Julie Leask

Associate Professor Claire Hooker

VicHealth
Alex Dandanis - Manager External Communications

Department of Premier and Cabinet
Fin Bird - Chief Communications Officer and Chief of Protocol

Victoria Police
Charles Morton -Executive Director, Media, Communications and Engagement

Transport Accident Commission
Joanne Whyte - Head of Marketing and Communications

Department of Justice and Community Safety
David Stockman - Executive Director, Strategic Communications

Department of Jobs, Precincts and Regions
Julia Scott - Chief Communications Officer

Joseph Lawrence

Department of Families, Fairness and Housing
Rebecca Skelton – Chief Communications Officer

Mandy Griffiths - Director, Priority Cohorts

Department of Health
Vanessa Williams - A/Executive Director COVID-19 Response Communication

Jayne Dullard

Melanie Chisholm -Executive Director, Engagement and Partnerships, COVID-19
Vaccination Program

Mohamed Mohideen- Head of Priority Communities Engagement, Vaccination Engagement team

Dr Naveen Tenneti-Executive Director, COVID-19 Strategy and Policy

Clare Malone – Director – IPMAC Secretariat

IPMAC Secretariat:
Karen Reimann, Ainsley Hemming, Maryan Qabo