

Coronavirus Disease 2019 (COVID-19)

CDNA National Guidelines for Public Health Units

Version 8.0
June 2024

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Title: COVID-19 CDNA National Guidelines for Public Health Units

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Summary of revision history

Note this table is a summary of key revisions to this guidance. For full revision history, refer to the [Department of Health and Aged Care](#) website.

Version	Date	Revised by	Changes
Version 8.0	12 June 2024	CDNA	Full revision to reflect changes in evidence, epidemiology and public health response. Revised: Summary, the Disease, Routine Prevention Activities, Surveillance, Testing, Cases and Contacts sections. New: Special settings section. Removed: Appendix A - Current variants of concern and Appendix B - Additional guidance and resources. Moved: Appendix C: Glossary of terms into main body of guidelines.
Version 7.4	14 October 2022	CDNA	Revised: Reinfection definition, isolation and restriction guidance
Version 7.3	09 September 2022	CDNA	Revised: Isolation and restriction guidance
Version 7.2	22 July 2022	CDNA	Revised: Reinfection definition.
Version 7.1	08 July 2022	CDNA	Revised: Reinfection guidance.
Version 7.0	03 June 2022	CDNA	Full revision to present evidence-based recommendations for public health in the context of widespread community transmission across Australia. Appendices have been separated from guidelines main body. Appendix A. New: Current variants of concern, Appendix B. New: Additional guidance and resources, Appendix C. New: Glossary of terms, Appendix D. Moved: Full revision history.

Disclaimer

These guidelines for public health units (PHUs) outline Australia's national minimum standard for the routine public health management of coronavirus disease 2019 (COVID-19). They are intended to reflect the current evidence base, with pragmatic guidance provided where evidence is still evolving. In the event of a new SARS-CoV-2 variant of concern (VOC), these guidelines may change rapidly or be supplemented with additional public health information and procedures. Jurisdictions may implement policies that exceed the national minimum standard based on the local epidemiological context, available resources, and other factors. The Communicable Diseases Network Australia (CDNA) will review and update these recommendations as new information becomes available.

Readers should not rely solely on the information contained within these guidelines. Guideline information is not intended to be a substitute for advice from other relevant sources, including, but not limited to, advice from a public health specialist or other health professional. Clinical judgment and discretion may be required to interpret and apply these guidelines. Public health units should refer to and follow jurisdictional guidance regarding disease management, where appropriate.

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1. Summary

Public health priority

These guidelines outline the national minimum standard for the routine public health management of COVID-19 in Australia. In the event of a new SARS-CoV-2 [variant of concern \(VOC\)](#), updated guidance recommending additional public health actions may be required. Outside the context of a new VOC, the public health management of COVID-19 should be focused on [routine prevention activities](#) to prevent transmission in the community and high-risk populations.

Public health priority classification and response

Priority Classification	Public health response timeline
Urgent	Where there is a new VOC, whose characteristics require the need for urgent public health action, act immediately – respond within 24 hours.
High	For outbreaks in high-risk settings , act as soon as possible – respond within one working day.
Routine	Individual cases in most community settings do not require follow up.

Case management

Healthcare providers are responsible for the management of individual COVID-19 cases. Recommend seeking early medical care for cases at [increased risk of severe disease](#) or in [high-risk settings](#).

Public health action focuses on advice to cases regarding mitigations to minimise secondary transmission of SARS-CoV-2 and management of cases in [high-risk settings](#).

See [Case management](#) for further information.

Contact management

Contact management is not routinely undertaken for COVID-19. For certain outbreaks in [high-risk settings](#) or where there is a new VOC, consider the need for contact tracing and management.

Advise contacts to monitor for symptoms. Recommend seeking early medical care, if symptoms develop, for those at [increased risk of severe disease](#) or in [high-risk settings](#).

See [Contact management](#) for further guidance.

2. The disease

Infectious agent

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), an RNA virus, is the infectious agent which causes COVID-19 (the disease). SARS-CoV-2 is the ninth coronavirus documented to affect humans, with all previous human coronaviruses having strong evidence of zoonotic origins (1). The World Health Organization (WHO) considers the most likely origin of SARS-CoV-2 to be zoonotic (2).

Disease occurrence and public health significance

The first cases of 'pneumonia of unknown cause' detected in Wuhan, China, were notified to WHO on 31 December 2019 (3). The cause was identified as a novel coronavirus. WHO declared the outbreak a Public Health Emergency of International Concern (PHEIC) on 30 January 2020, and a pandemic on 12 March 2020 (4). On 5 May 2023, WHO announced COVID-19 represented an established and ongoing health issue which no longer constituted a PHEIC (5). As of 3 March 2024, WHO has reported over 774 million confirmed COVID-19 cases globally and over 7 million deaths (6).

As of 7 June 2024, over 11.8 million COVID-19 cases have been notified in Australia, since the first locally acquired case on 2 March 2020 (7, 8). The public health significance of COVID-19 is greater among specific groups, such as Aboriginal and Torres Strait Islander people and older people, particularly those aged over 70 years, who may be at increased risk of severe disease and have higher case notifications than other cohorts (9-11).

Intensive disease control efforts by governments, the community, and the private sector, controlled COVID-19 transmission in Australia for the first two years of the pandemic. However, transmission in the community became widespread once the highly infectious Omicron variant became the dominant circulating variant. At this time, vaccination coverage of a two-dose primary course of COVID-19 vaccine was above 80% for the Australian population recommended to be vaccinated (12). On 20 October 2023, Australia's Chief Medical Officer declared that COVID-19 was no longer a Communicable Disease Incident of National Significance, reflecting the reduction in public health risk due to the combination of high vaccination rate and immunity from infection (hybrid immunity), access to antiviral treatments and the reduced disease severity associated with the Omicron variant (13-15).

Regular increases in population-wide infections, termed waves, occur due to the incursion/emergence of new SARS-CoV-2 variants and other factors such as waning immunity and increased social mixing. Waves of COVID-19 in Australia do not currently

occur in a seasonal pattern, unlike other respiratory viruses which generally peak in winter (16).

Variants of concern and interest

Like other viruses, the genetic structure of competent SARS-CoV-2 evolves over time, often with minimal impact on its transmission and pathogenicity properties. However, some mutations can affect its properties in a way that poses an increased risk to public health. The WHO Technical Advisory Group on SARS-CoV-2 Virus Evolution monitors SARS-CoV-2 variants and determines whether they meet the definition of a variant of interest or VOC. In Australia, monitoring for VOCs is undertaken by the Communicable Diseases Genomics Network (CDGN). For more information, see the [CDGN](#) website.

The VOCs circulating in Australia vary in their potential for transmission, clinical presentation, and disease severity. SARS-CoV-2 genomic lineages are defined using the Phylogenetic Assignment of Named Global Outbreak nomenclature. Lineages reflect evolutionary relationships and are organised hierarchically following the phylogenetic tree structure.

The WHO designated key variants using letters of the Greek alphabet to aid public communication. In 2021, the VOCs which affected Australia included Alpha (B.1.1.7), Beta (B.1.351), Delta (B.1.617.2), Gamma (P.1) and Omicron (B.1.1.529 and BA sublineages). Since December 2021, the Omicron variant and recombinant strains have dominated due to a significant competitive advantage over other lineages.

Mode of transmission

SARS-CoV-2 is most commonly transmitted person-to-person, primarily through inhalation of respiratory droplets or smaller aerosolised particles. Most transmission occurs through close contact with an infected individual. Transmission may also occur over larger distances in poorly ventilated indoor settings (17-19).

Less commonly, transmission can occur indirectly via contact with contaminated surfaces or fomites (20-24).

There is limited evidence to suggest transmission may also be possible via other routes, such as faecal-oral (25, 26). Zoonotic transmission of SARS-CoV-2 has also been demonstrated (27).

Incubation period

The median incubation period of ancestral strains of SARS-CoV-2 is 5 to 7 days, with a range of 1 to 14 days (28-30). However, successively shorter incubation periods have been identified for each emerging VOC (31-35). Current estimates for the pooled mean incubation period for different sublineages of Omicron range from 3.5 days for BA.1, to 4.1 days for BA.2 (36).

Infectious period

The infectious period for SARS-CoV-2 varies based on individual factors and the specific VOC and subvariant. The start of the infectious period for COVID-19 is considered to be from 48 hours prior to symptom onset (or positive test if asymptomatic) (37). In general, individuals may be considered infectious until they are free of acute symptoms, which may be up to 10 days (37). Only a very small proportion of people may remain infectious for longer than this (38). People who are asymptomatic may still shed virus and infect others over this period (39-41). Individuals with severe disease, or who are significantly immunocompromised may be infectious for longer periods (42).

Testing, with either a [nucleic acid amplification test \(NAAT\)](#) or rapid antigen test (RAT) cannot reliably determine infectivity as these tests can detect non-viable viral shedding that does not necessarily correlate with infectivity (42-44).

Clinical presentation and outcome

COVID-19 presents with similar symptoms to other acute respiratory infections (ARI), such as influenza and respiratory syncytial virus (RSV). Symptoms may include:

- fever
- chills
- sore throat
- sneezing
- shortness of breath
- runny nose
- cough
- loss of smell and/or taste
- headache
- fatigue
- muscle or body aches
- nausea (with or without vomiting)
- diarrhoea.

COVID-19 cannot be distinguished from other respiratory viral illnesses without diagnostic testing.

SARS-CoV-2 may cause severe disease, including pneumonia, acute respiratory distress syndrome, and complications affecting other organ systems. The risk of severe disease varies depending on the COVID-19 infection and vaccination history, age, and health status of the infected individual, the specific SARS-CoV-2 variant, and other factors.

Some people with COVID-19 go on to develop post-acute sequelae of COVID-19, commonly referred to as long COVID (45). While severe disease in children is uncommon, paediatric multisystem inflammatory syndrome (also known as multisystem inflammatory syndrome) is a rare but serious complication (46, 47).

Immunity against SARS-CoV-2 wanes following both natural infection and vaccination (48). Reinfection following recent COVID-19 and/or prior to recovery from COVID-19 is therefore common (49-51). However, both previous infection and vaccination appear to be protective against severe disease in subsequent infections (52, 53). Hybrid immunity (immunity in persons who have had both prior vaccination and infection) has been shown to provide greater immunological protection than either alone (54, 55). The risk of reinfection is generally higher in people who are significantly immunocompromised (50, 56, 57).

In October 2023, the case fatality ratio (CFR) among COVID-19 cases in Australia was approximately 0.2% (58). The CFR is higher among older people or those with comorbidities, with approximately one third of deaths occurring in January 2022 among residents of aged care facilities (16).

For the latest information on COVID-19 incidence, severity, transmission, and vaccination in Australia, see:

- [Coronavirus \(COVID-19\) case numbers and statistics | Australian Government Department of Health and Aged Care](#)
- [Australian Respiratory Surveillance Reports](#)

Groups at increased risk of severe disease

Older age is strongly associated with increased risk of severe disease and death, with risk significantly greater for those older than 70 years of age compared with younger people (59-62). People who have existing chronic health conditions, are immunocompromised, are Aboriginal and/or Torres Strait Islander people, live in residential care facilities, are living with a disability, or are pregnant, may also be at increased risk of severe disease and death (63, 64). [Vaccination](#) significantly reduces the risk of severe disease and death in at-risk groups (65-69).

Persons at increased risk of severe disease should be encouraged to discuss with their general practitioner the development of a COVID-19 plan for implementation if they develop ARI or test positive for COVID-19.

For further information, see the Department of Health and Aged Care website: [Groups at higher risk from COVID-19](#).

3. Routine prevention activities

Evidence has demonstrated that public health measures are effective in reducing SARS-CoV-2 transmission, particularly during periods of increased community transmission (70). Public health prevention activities for COVID-19 are similar to that for other respiratory viral infections. These measures can be applied at the individual, organisational and community level.

Vaccination

Vaccination remains the most important measure to protect against severe outcomes from COVID-19. Vaccines for SARS-CoV-2 are very effective at minimising the risk of severe disease and death but have limited effectiveness in preventing infection or transmission of the virus to others.

The Australian Technical Advisory Group on Immunisation recommends a primary course of COVID-19 vaccination for all Australians aged 18 years and over. A primary course is recommended for children aged 6 months to less than 18 years at increased risk of severe disease or death from COVID-19.

Further COVID-19 vaccinations are recommended every 6-12 months for certain groups based on age and risk factors for severe disease.

For further details regarding COVID-19 vaccine recommendations, see [Clinical guidance for COVID-19 vaccine providers](#) and [The Australian Immunisation Handbook \(COVID-19\)](#).

Prevention

Simple prevention activities can help limit transmission of SARS-CoV-2 in the community (71, 72). The magnitude of COVID-19 waves may be reduced through accessible and effective communications targeted towards the community and appropriately tailored for specific groups (73, 74). Communications regarding prevention should emphasise the importance of:

- [vaccination](#) of eligible people
- staying at home when unwell with a COVID-19 compatible illness (see [Isolation and restriction](#))
- correct hand and respiratory hygiene
- maintaining physical distance (at least 1.5 metres) from others, where possible, especially when indoors
- avoiding visiting high-risk settings when a case or contact (see [High-risk settings](#))
- optimised ventilation.

Wearing appropriate and well-fitted face masks may lower the risk of infection or transmission under some circumstances and may be considered as an additional layer of protection, particularly when indoors or where it is not possible to maintain physical distancing (75, 76). Mask-wearing may be required in [high-risk settings](#) or under certain conditions but should not replace other forms of prevention (77). For more information on the use of face masks and particulate filter respirators (PFR) in the community, see the [Department of Health and Aged Care](#) website.

Improved indoor air quality through natural or mechanical ventilation can reduce SARS-CoV-2 transmission (78, 79). Implementing appropriate infection prevention and control activities is critical to prevention, including in healthcare and other high-risk settings. For more information, see the [Australian Commission on Safety and Quality in Health Care](#) website.

Research is being undertaken into potential therapeutic agents for pre- and post-exposure chemoprophylaxis to further reduce the risk of COVID-19 infection in defined populations (80). However, there are presently no pharmaceutical agents approved for use in Australia for this purpose.

Recommendations for people with acute respiratory symptoms

To prevent transmission of SARS-CoV-2 and other respiratory viruses, strongly recommend people with acute respiratory symptoms to:

- stay at home until acute symptoms have resolved, other than to seek medical care (including [testing](#)) or for other urgent reasons
- if they must leave home
 - avoid visiting family or friends in residential care facilities or hospitals, and other people [at increased risk of severe disease](#)
 - wear a mask when unable to appropriately physically distance from others
 - for necessary medical or other appointments, call ahead to notify of symptoms prior to arrival, if able
- proactively seek prompt medical advice to consider the need for [testing](#) for SARS-CoV-2 (and other respiratory pathogens) if at increased risk of severe disease. Early use of appropriate antiviral medications can prevent severe infection. For information, see the [Department of Health and Aged Care](#) website.

4. Surveillance

Surveillance objectives

The key surveillance objectives for COVID-19 are to monitor:

- SARS-CoV-2 activity in Australia
- the virological and genetic characteristics of SARS-CoV-2
- epidemiological and clinical characteristics of COVID-19 (including severity and mortality)
- outbreaks in high-risk settings and population groups to inform response
- public health intervention effectiveness and health care system impact and capacity associated with COVID-19.

Australian National Surveillance Plan for COVID-19, Influenza and RSV

The [Australian National Surveillance Plan for COVID-19, Influenza and RSV](#) provides a national framework for the collection, analysis and reporting of health-related data for these viral respiratory diseases in Australia. It outlines the surveillance indicators and data sources used to monitor disease activity, severe disease, health service impact, and effectiveness of interventions to inform public health decision-making and national policy responses.

Reporting of COVID-19 cases

Central state/territory communicable diseases units will provide data to the National Notifiable Diseases Surveillance System.

Australian Respiratory Surveillance Reports

The [Australian Respiratory Surveillance Reports](#) are published routinely to provide a national overview of the epidemiology of COVID-19, influenza, and RSV infection, drawing on information from several different surveillance systems. The reports detail the distribution of respiratory virus activity in the community, the severity of infections, populations that might be more severely affected, and the impact of respiratory illness activity on the healthcare system and community.

SARS-CoV-2 genomic surveillance

Genomic sequencing is a critical part of SARS-CoV-2 surveillance. Genomic sequencing may be used to:

- monitor transmission dynamics
- identify lineages with concerning features such as VOCs
- monitor new incursions
- inform public health responses.

Jurisdictions have different priorities and capacities which may change over time. Based on their established workflow and epidemiological context, targeted sequencing of clinical specimens is undertaken by states and territories. Where possible, non-targeted sampling (i.e., randomly or systematically selected clinical samples) in combination with targeted clinical sampling is recommended to maximise the population representativeness of SARS-CoV-2 genomic surveillance data. Wastewater based genomic sequencing is also used in some jurisdictions to provide information on the growth and proportions of emergent and circulating variants within the population.

5. Testing

Primary testing methods

Details on the different testing methodologies for SARS-CoV-2 can be found in the [Public Health Laboratory Network guidance on laboratory testing for SARS-CoV-2](#).

The gold standard for diagnosing acute symptomatic COVID-19 infection is with a NAAT (e.g., reverse transcription polymerase chain reaction). RATs may be used as an alternative and more accessible testing method, providing fast results following the correct collection of an appropriate respiratory sample. RATs have been approved by the Therapeutic Goods Administration for home or point-of-care use to detect the presence of viral protein from SARS-CoV-2. RAT sensitivity is inherently lower than that of NAATs, resulting in a higher rate of false negative tests. Performance of different RATs can vary from test to test and depend on the individual SARS-CoV-2 variant and prevalence of infection in the community. For the purposes of surveillance, a positive RAT result does not require a confirmatory NAAT.

Testing recommendations

Follow jurisdictional guidance on testing for SARS-CoV-2. Emphasise the importance of early testing for people who are at increased risk of severe disease who have symptoms compatible with COVID-19. Early testing enables steps to be taken to limit onward transmission and facilitate access to [oral antiviral treatments](#) for eligible people.

Additional testing recommendations or requirements may be implemented for people who work in or attend [high-risk settings](#).

Regardless of testing, people with COVID-19 compatible symptoms should be advised to follow the [recommendations for people with ARI symptoms](#).

6. Cases

Definitions

Case definition

For surveillance case definitions please see [CDNA surveillance case definitions | Australian Government Department of Health and Aged Care](#).

Case management

Follow up of individual COVID-19 cases is not routinely required outside the context of a new [VOC](#). Public health action focuses on advice to cases regarding mitigations to minimise secondary transmission of SARS-CoV-2 and management of cases in [high-risk settings](#).

Cases should have access to up-to-date jurisdictional advice on managing their illness, accessing medical care, and minimising the risk of onward transmission in the community. This includes advice on:

- the importance of [staying at home while unwell](#) and [additional mitigations](#), and
- the risk of transmission to their household/household-like and social/workplace [contacts](#), and
- the recommendation for cases to discuss with their employer when to return to their workplace and any additional requirements in line with their workplace health and safety policy.

Response times

Respond immediately, within 24 hours, where there is a new VOC whose characteristics require the need for urgent public health action.

Act as soon as possible, generally within one working day, for outbreaks in [high-risk settings](#).

All other COVID-19 cases may be considered routine.

Case investigation

Individual cases do not require routine follow up. However, follow-up may be indicated in some circumstances, particularly in [high-risk settings](#).

Clinical management

PHUs are not routinely involved in individual clinical management of COVID-19 cases. The medical management of individual cases is the responsibility of the case's healthcare provider.

Isolation and restriction

Isolation of COVID-19 cases in the community is recommended as an effective way to reduce the spread of infection. Information for cases should advise they have the potential to infect others for up to 10 days after the onset of symptoms, with a very small proportion of people infectious for longer than this (38). Cases should be strongly advised to stay at home until their acute symptoms have resolved (usually 5 to 7 days).

Please refer to [High-risk settings](#) for advice on COVID-19 case management in these contexts.

In addition to staying at home, COVID-19 cases are recommended to employ the following additional mitigations while symptoms are present:

- wear a mask when indoors for necessary trips outside the home
- work or study from home where feasible
- undertake appropriate hand and respiratory hygiene
- avoid crowded areas
- observe local work health and safety policies.

Persons who are highly immunocompromised can be infectious for prolonged periods. These cases should be guided by their treating physician on the length of time they should stay at home and employ additional mitigations when outside the home (81).

7. Contacts

Contact tracing for COVID-19 cases is not routinely undertaken in Australia. In the context of widespread community transmission, unless there is significant concern for a new [VOC](#), contact identification and management should be generally limited to [high-risk settings](#).

Identification of contacts

The risk of developing COVID-19 increases with the duration and level of contact with an infectious case. People who have had close or prolonged contact with a case, such as household and household-like contacts, have the highest risk of developing COVID-19 (82).

Cases should be encouraged to advise those with whom they have been in close or prolonged contact, while infectious, of their potential exposure.

Contact management

Asymptomatic contacts of a COVID-19 case should:

- monitor for symptoms and if symptoms develop, manage as per [recommendations for people with acute respiratory symptoms](#)
- practice correct hand and respiratory hygiene
- follow workplace advice.

See [Entry of COVID-19 cases and contacts to high-risk settings](#).

8. Special settings

High-risk settings

High-risk settings include, but are not limited to, healthcare, residential care, and other settings where both:

- a high proportion of people are at increased risk of severe disease; and
- there is an increased risk of SARS-CoV-2 transmission.

Jurisdictions may monitor outbreaks of COVID-19 among high-risk settings. The public health response to outbreaks is determined by jurisdictions (and may vary within jurisdictions) and based on prioritisation which considers local reporting requirements, available resources, and the capacity for self-management by facilities and their organisational leads.

For information on the control and public health management of outbreaks of ARI (including COVID-19) in specific high-risk settings, see the CDNA guidelines for [residential care facilities](#) and [disability residential services](#).

Routine prevention activities

The potential clinical impact of COVID-19 in [high-risk settings](#) is inherently high. These settings must implement routine prevention activities to minimise the risk and impact of an incursion or outbreak of COVID-19. This includes:

- encouraging [vaccination](#) of eligible people
- complying with infection prevention and control activities and regulations (including the use of personal protective equipment)
- controls to prevent contact between well and unwell attendees
- outbreak management plans.

Environmental controls, such as improving indoor air quality through optimised ventilation, and cleaning and disinfection practices, can also reduce the risk of SARS-CoV-2 transmission (78, 79). For more information, see the [Australian Commission on Safety and Quality in Health Care](#) website and [Coronavirus cleaning and disinfection for health and residential aged care homes](#) guidelines.

Entry of COVID-19 cases and contacts to high-risk settings

COVID-19 cases

In addition to the standard advice regarding the [management of COVID-19 cases](#), additional procedures and guidance may be implemented, at either the jurisdictional or facility level, to address staff return to work and attendance of visitors to [high-risk settings](#). Facilities should have policies in place to address testing, exclusion, and

return to work for staff with ARI and/or COVID-19. Guidance should be tailored to the specific setting type, considering the level of risk and potential clinical consequences of an incursion.

Clearly advise people with COVID-19 or [symptoms of ARI](#), through appropriately tailored public messaging, not to visit settings where there are people at high risk of severe disease (e.g. residential aged care homes (RACH), or hospitals) until both acute symptoms have resolved and at least 7 days from symptom onset (or 7 days after testing positive if asymptomatic). Please refer to jurisdictional advice for exact timeframes to enter high-risk settings.

In exceptional circumstances (such as visiting persons undergoing end of life care), with mitigations in place, it may be appropriate for persons with COVID-19 or symptoms of ARI to enter a RACH; this should occur on a case-by-case basis in discussion with the involved RACH.

Cases who work in [high-risk settings](#) should talk to their employer about their return to work and take additional precautions in accordance with local workplace policies and guidance.

COVID-19 contacts

Advise asymptomatic [household and household-like contacts](#) of COVID-19 cases to defer visits to [high-risk settings](#) until at least 7 days have passed since their last contact with a COVID-19 case, other than for necessary reasons such as seeking medical attention. If a visit to a [high-risk setting](#) cannot be avoided, advise contacts to wear a surgical face mask and observe physical distancing. Please refer to jurisdictional advice for exact timeframes to enter high-risk settings.

In selected circumstances (such as visiting persons undergoing end of life care), with mitigations in place, it may be appropriate for persons who are COVID-19 contacts to enter a RACH; this should occur on a case-by-case basis in discussion with the involved RACH.

Contacts who work in [high-risk settings](#) should talk to their employer about their return to work and take additional precautions in accordance with local workplace policies and guidance.

Facilities may implement additional mitigations for contacts entering specific [high-risk settings](#), particularly during periods where the risk of transmission is high. These may include testing, mask-wearing (i.e., surgical or PFR), and avoiding common areas.

Other special settings

Specific settings, such as correctional facilities, childcare centres, and cruise ships are prone to rapid transmission of SARS-CoV-2 and other respiratory viruses. [Routine prevention activities](#) should be employed, where appropriate, to minimise the risk of an incursion or outbreak of COVID-19 in these settings.

Advise people with [ARI symptoms](#) to avoid attending settings with a high potential for rapid transmission. People who develop symptoms while in these settings should be advised to consult with the setting management, wear a surgical mask, practice correct hand and respiratory hygiene, and maintain physical distance from others, where possible.

9. Appendix: Glossary of terms

Term	Definition
Acute respiratory symptoms	The symptoms experienced by a person while they have a respiratory infection (infection of the nose, throat, larynx, trachea, bronchi and/or lungs). These symptoms may include (but are not limited to): cough, shortness of breath, sore throat, runny or blocked nose.
Ancestral strain	The original SARS-CoV-2 virus that was first reported in Wuhan, China, in December 2019.
Asymptomatic	Having no symptoms.
Case fatality ratio	The proportion of individuals diagnosed with a disease who die from that disease.
Confirmed COVID-19 case	A person meeting the laboratory definitive criteria for being a confirmed COVID-19 case.
Exposure	Contact or potential contact with an infectious COVID-19 case.
Genomic Surveillance	Collecting SARS-CoV-2 genomic sequence data from representative populations to detect new variants and monitor trends in circulating variants.
High-risk of severe disease	People with risk factors, such as older age or other health conditions, which contribute to a greater risk of serious illness due to COVID-19.
High-risk setting	High-risk settings include healthcare, residential care, and other settings where both a high proportion of people are at high-risk of severe disease and there is an increased risk of SARS-CoV-2 transmission.
Household or household-like contact	A person who lived with, or spent a substantial amount of time indoors with, a COVID-19 case during their infectious period.
Incubation period	The time between exposure to a COVID-19 case during their infectious period and the first appearance of symptoms.
Infectious period	The time where a COVID-19 case is contagious and can pass on infection to other people.
Jurisdiction	An Australian state or territory.

Natural infection	Infection of SARS-CoV-2 antigens eliciting an immune response and antibodies, as opposed to vaccination.
Novel coronavirus	A new coronavirus strain that has not been previously identified in humans.
Nucleic acid amplification testing	Testing method which detects the presence of nucleic acids (the genetic material) of the SARS-CoV-2 virus. This includes polymerase chain reaction tests.
Outbreak	A greater number of cases than what is normally expected in a given population. In closed populations, such as a residential care facility, health authorities may define an outbreak as two or more cases in a given time period.
Particulate filter respirators	A type of respiratory protection which, when correctly fitted, protects the wearer from infectious agents disseminated through airborne droplet nuclei or small particles which can remain infective over time and distance.
Personal protective equipment	Equipment used to protect the wearer from SARS-CoV-2 infection. This may include surgical masks, particulate filter respirators, gloves, goggles, glasses, face shields, gowns, and aprons.
Rapid antigen testing	Testing method which detects the presence of specific proteins of the virus. They are most accurate when used to test symptomatic individuals and can be used unsupervised with self-collected specimens. These tests are not as accurate at detecting the virus as a nucleic acid amplification test.
Recombinant	A process in which the genomes of two SARS-CoV-2 variants (that have infected a person at the same time) combine during the viral replication process to form a new variant that is different from both parent lineages.
Reinfection	A subsequent confirmed SARS-CoV-2 infection in a person with a past known history of COVID-19 that is determined to be separate to the previous infection based on epidemiological and/or laboratory findings.
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2, the virus that causes COVID-19 disease.
Variant	A viral genome (genetic code) that may contain one or more mutations to the ancestral strain (original virus).
Variant of concern (VOC)	A SARS-CoV-2 variant with characteristics that make it more transmissible or cause more severe illness than the ancestral strain and may require additional public health action.
Viral shedding	When a person releases detectable viral RNA from their bodies.
Whole genome sequencing	A method of genomic surveillance that describes the nucleic acid (DNA/RNA) sequence of an organism at a given moment in time.

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