Summary of data sources, assumptions and prior distributions

Model inputs	Data sources, assumptions, rationale (references)
Vaccine effectiveness against symptomatic infection	Data from the Increase Community Access to Testing (ICATT) platform was used.(1) Here data were collected from 49 states in the USA, of children and adolescents presenting to drive-through sites for testing between 26/12/2021-21/02/2022 (predominantly Omicron transmission period). A test negative case control analysis was conducted to calculate vaccine effectiveness against symptomatic infection. Immunocompromised cases were excluded from the analysis. A child was considered vaccinated if tests were taken at least 2 weeks after the second vaccine dose. We used data for vaccine effectiveness at 2 months post second dose. Vaccine effectiveness (reported on page 2215) is 16.6% in the 12-15 year-old age group in the period 30-90 days post second dose. We assumed the same vaccine effectiveness for our age cohort of 12-17. Vaccine effectiveness was reported as 28.9% in the 5-11 year-old age group the period 30-90 days post second dose.(1) Please see supplementary table 1 for final assumptions.
Risk of symptomatic infection under current transmission status	Cases of COVID-19 from NSW between 1/1/2022 and 30/7/22 were used to estimate risk of symptomatic infection under current transmission status for our age cohorts of 5-11 and 12-17 year-olds.(2) Found at: https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20220730.pdf. Census data from Australian Bureau of Statistics was used to estimate the probability of each specific age and gender cohort being infected. This reports Australian demographic data from the 31/12/2021.(3) Please see supplementary tables 2-2.5 for calculations and assumptions.
Community transmission levels	We selected community transmission scenarios of 1%, 2%, 5% and 10% of the population being infected with SARS-CoV-2 over a 2-month period for the purposes of the model.
Risk of developing (background) myocarditis	A population based retrospective observational study of linked administrative databases from Ontario, Canada was used to populate the risk of developing background myocarditis.(4) The study identifies hospitalisations and emergency department visits for myocarditis between 2015 and 2020. The study would miss mildly symptomatic and asymptomatic myocarditis, however would capture all cases of clinical concern. As the incidence rates of myocarditis are significantly higher in the 16-17 cohort compared for 12-15 cohort, we have stratified this outcome to 5-11, 12-15 and 16-17. Furthermore the paper reports the incidence of myocarditis over a 12 month period, we have converted this to a 3 month period. Supplemental Table S6 of the paper provides the data stratified to sex and age. We assumed the same myocarditis rates in the 16-19 age cohort presented in the paper for our 16-17 age cohort.(4) Please see supplementary table 3 for final assumptions.

Risk of developing mRNA COVID-19 vaccine-associated myocarditis	Rates of myocarditis following vaccination with Comirnaty (Pfizer) were estimated using publicly-available post-marketing surveillance data published by the Therapeutic Goods Administration (TGA).(5) The TGA provides rates of myocarditis following second doses and all doses. Data following risk after second dose was used in this model. See supplementary table 4.
Risk of developing SARS-CoV-2 infection-induced myocarditis	Data sourced from a retrospective cohort of 40 health care systems using electronic health records between January 1 2021 and January 31 2022. The study population included persons with documented SARS-CoV-2 testing, viral illness diagnostic codes or COVID-19 vaccination during the study period. The authors then compared incidence of cardiac complications, in particular myocarditis and pericarditis post infection and vaccination. The study period included the Ancestral, Delta and Omicron period. The model will be updated once data is available for the Risk of developing SARS-CoV-2 infection-induced myocarditis in the Omicron only period. The incidence rate of myocarditis was calculated in the first 21 days post SARS-CoV-2. Cases were excluded if they had received a vaccination in the 30 days prior to or post SARS-CoV-2 infection.(6) See supplementary table 5 for final assumptions.
Vaccine effectiveness against hospitalisation from COVID-19	The data were sourced from a case control, test-negative design of vaccine effectiveness against laboratory confirmed COVID-19 leading to hospitalisation in 31 hospitals across 23 states in the USA. The study period was from 1/7/2021- 17/2/2022, with the Omicron period defined from 19/12/2021- 17/2/2022. Adolescents were defined as 12-18 years of age, and we assumed the same vaccine effectiveness for 12–17-year-olds. We used vaccine effectiveness data for 2-22 2 doses of Pfizer vaccination (43%). For 5–11-year-olds, the vaccine effectiveness reported was 68% during the Omicron period. The median time since vaccination was 34 days, the paper does not stratify vaccine effectiveness data for time from vaccination.(7) See supplementary table 6 for final assumptions.
Risk of hospitalisation from COVID-19	5-11 age group: We used data from a Singaporean study conducted between 21/1/22 and 8/4/22 of all reported cases of COVID-19 to the Ministry of Health. The study collected data on all hospital admissions in the unvaccinated population with 146 hospitalised cases amongst a 16909 unvaccinated children. Therefore 0.86% of the unvaccinated population between 5-11 year-olds were admitted to hospital. (7) We assume all hospitalisations were due to SARS-CoV-2 infection.(8) 12-17 age group: We used data from four linked New York databases for COVID-19 cases and vaccinations between 30/11/2021-30/1/2022. From the 3/1/2022 over 90% of sequenced cases were Omicron. Therefore, from the tables provided in the study we calculated the total number of cases of COVID-19 in the unvaccinated population and the total number of hospitalised cases in the unvaccinated population from the 3/1/2022-30/1/2022. (9)

	See supplementary tables 7 and 7.1 for final assumptions.
Vaccine effectiveness against a severe outcome from COVID-19	The data were sourced from a case control, test-negative design of vaccine effectiveness against Critical COVID-19 in 31 hospitals across 23 states in the USA.(7) In the paper, critical COVID-19 was defined as cases requiring life support (i.e, non-invasive ventilation, invasive ventilation, vasoactive infusions, extracorporeal membrane oxygenation or death). In our model, we defined severe outcome as Intensive Care Unit admission or death. The study period was from 1/7/2021- 17/2/2022, with the Omicron period from 19/12/2021- 17/2/2022. Adolescents were defined as 12-18 years of age, and we assumed the same vaccine effectiveness for 12-17 year-olds. Vaccine effectiveness against critical Covid-19 is reported as 79%. The study had insufficient data to report vaccine effectiveness against Critical Covid-19 in the 5-11 age group, we assume the same vaccine effectiveness in the 5-11 age group as 12-18.(7) See supplementary table 8 for final assumptions.
Risk of suffering a severe outcome from COVID-19	"Severe Outcome" is defined as Intensive Care Unit Admission or death associated with SARS-CoV-2 infection. The data were sourced by approaching the Paediatric Active Enhanced Surveillance (PAEDS) network investigators.(10) This is a sentinel site, hospital-based, active surveillance system for multiple childhood diseases including COVID-19. Pre-print data was made available by the PAEDS network for identified cases with a severe outcome due to COVID-19 in Australia between the 1/12/2021 and 31/08/2022, defined as the Omicron period. "Severe Outcome" where COVID-19 was not the primary cause for admission, but an associated diagnosis were excluded from the data. Vaccination status for cases was not provided. The "Risk of Severe Outcome from COVID-19" in the unvaccinated population, may be an underestimation, as the data were collected when vaccinations were available for the paediatric population. Please see supplementary table 9.
Vaccine effectiveness against SARS-CoV-2 infection-induced MSI	The evaluation of COVID-19 vaccine and MSI was conducted across 29 hospitals in 22 US states between the 1st July 2021 and 7th April 2022. A test negative case control design was used to estimate vaccine effectiveness. Fully vaccinated was defined as 2 doses of Pfizer Vaccine at least 28 days prior to hospital admission.(11) The Omicron period was defined as January 1st onwards, the study reports the Omicron variant exceeded 50% of all SARS-CoV-2 infections from the 18th December onwards, and with a likely lag of 2-4 weeks from infection to development of MSI, January 1st was deemed the Omicron period. For the 12-18 age group, figure 4 of the paper shows and aOR of 0.08 of developing MSI in vaccinated population vs unvaccinated for the Omicron variant and therefore a Vaccine Effectiveness of 92%.

	The paper does not stratify the 5-11 age group by variant and reports an overall aOR of 0.22, of developing MSI in vaccinated vs unvaccinated 5-11 years olds and therefore vaccine efficacy of 78% (1-aOR*100). We have assumed this vaccine effectiveness to represent the Omicron variant See supplementary table 10 for final assumptions.
Risk of developing SARS-CoV-2 infection-induced MIS-C	"Severe Outcome" is defined as Intensive Care Unit Admission or death associated with SARS-CoV-2 infection. The data were sourced by approaching the Paediatric Active Enhanced Surveillance (PAEDS) network investigators(10). This is a sentinel site, hospital-based, active surveillance system for multiple childhood diseases including COVID-19. Pre-print data was made available by the PAEDS network for identified cases with a MIS-C due to COVID-19 in Australia between the 1/12/2021 and 31/08/2022, defined as the Omicron period. Vaccination status for cases was not provided. The "SARS-CoV-2 infection induced MIS-C" in the unvaccinated population, may be an underestimation, as the data were collected when vaccinations were available for the paediatric population. See supplementary table 11.
Risk of suffering a severe outcome from SARS-CoV-2 infection-induced MIS-C	Data was sourced from a study of 29 hospitals in 22 US states between 1st July 2021 and 7th April 2022, therefore spanning both Omicron and Delta variants. This study was test negative case control, primarily designed to estimate vaccine effectiveness vs MSI-C. In supplementary table 4 however the paper does describe the percentage of cases admitted to intensive care during the Omicron predominant period. It reports 58.5% of MSI-C cases were admitted to Intensive care in the Omicron predominant period across both age cohorts.(11) Please see supplementary table 12 for final assumptions

Supplementary Tables

Supplementary Table 1: Pfizer vaccine effectiveness against symptomatic infection with SARS-CoV-2 omicron variant, 8 weeks post-administration of two dose regimen.

Age group (years)	2 doses
5-11	16.6%
12-17	28.9%

Sources:(1)

Supplementary Table 2: Notifications of COVID-19 by Age between 1/1/2022 and 30/7/2022 (Omicron Period) in New South Wales

Age	Cases of COVID-19
5-9	179,039
10-19	396,821

Source: (2)

Supplementary Table 2.1: Notifications of COVID-19 by Age between 1/1/2022 and 30/7/2022 (Omicron Period), extrapolated to age groups used in our model

Age	Cases of COVID-19
5-11	258,403.2
12-17	238,092.6

Supplementary Table 2.2: Percentage Contribution of Age Cohort compared to Total Cases of Covid-19 between 1/1/2022 and 30/7/2022 in NSW.

Age	Cases of Covid-19	Percent of Total Cases
5-11	258,403.2	9.46%
12-17	238,092.6	8.71%
All Age Groups	2,732,472	

Supplementary Table 2.3: Number of Expected Cases with 1%, 2%, 5% and 10% Community Transmissions by Age Cohort

Age	Community Transmission (%)			
	1%	2%	5%	10%
5-11	24,366.8	48,733.7	121,834	243,668
12-17	22,451.6	44,903.2	112,258	224,516
Total Number of Cases in Australia	257,666.05	515,3321.1	12,888,330.25	2,576,660.5

Total Population of Australia: 25766605, as of Australian Bureau of statistics data on 31/12/22. To Calculate contribution of 5-11 year old in each community transmission scenario, (total number of cases in Australia in transmission scenario/100)*9.46. To calculate contribution of 12-17 year olds (Total Number of Cases in Australia/ 100)*8.71.

Sources: (2,3)

Supplementary Table 2.4: Number of Expected Cases with 1%, 2%, 5% and 10% Community Transmissions by Age and Gender

	Community Transmission (%)			
	1%	2%	5%	10%
Age and Gender				
5-11 Male	11574.25	23148.51	57871.27	115742.5
5-11 Female	12768.23	25536.46	63841.14	127682.3
12-17 Male	10664.51	21329.02	53322.56	106645.1
12-17 Female	11764.64	23529.28	58823.2	117646.4

NSW data report 47.4% of Covid-19 cases were in Male and 52.5% in females amongst all age groups between 1/1/2022 and 30/7/22. We presumed the same gender distribution in our age cohorts of 5-11 and 12-17.

Source: (2,3)

Supplementary Table 2.5: Risk of Symptomatic Infection under Current Transmission, by Age and Gender.

	Community Transmission (%)			
	1%	2%	5%	10%
Age and Gender				
5-11 Male	0.00992	0.01984	0.0496	0.0992
5-11 Female	0.011577	0.02213999	0.057885	0.11576907
12-17 Male	0.01107	0.02214	0.05535	0.1107
12-17 Female	0.012994	0.025989	0.064971954	0.129944

Australian Bureau of Statistics reports 1,166758 males aged 5-11; 1102905 females aged 5-11; 963371 males aged 5-11; 905363 females aged 12-17 (3). Risk of symptomatic infection: Number of Cases in specific age and gender/ total population of specific age and gender cohort

Sources: (2,3)

Supplementary Table 3: Background incidence of myocarditis over 3 months

Age group (years)	Incidence rate of myocarditis per 100,000 population in 1 year		Incidence rate of myocarditis per 100,000 population in 3 months		Risk of myocarditis in a 3 month period	
	Male	Female	Male	Female	Males	Female
5-11	0.46	0.26	0.115	0.065	0.00000115	0.00000065
12-15	1.31	0.27	0.3275	0.0675	0.000003275	0.000000675
16-17	7.99	1.54	1.9975	0.385	0.000019975	0.00000385

Source: (4)

Supplementary Table 4: Rates of likely myocarditis cases following second dose of Comirnaty (Pfizer) reported by TGA, Australia, 25 January 2021 to 18 September 2022

Age (years)	Rate of myocarditis following second dose per 100,000 doses		Risk of myocarditis following second dose	
	Male	Female	Male	Female
5-11	0.2	0	0.000002	0
12-17	13.6	2.8	0.000136	0.000028

Source: (5)

Supplementary Table 5: Myocarditis from SARS-CoV-2 infection (up to 21 days post-infection)

Age group (years)	Incidence rate per 100,0000 of myocarditis in the 21 days post SARS-CoV-2 infection		Risk of developing myocarditis in the 21 days post SARS-CoV-2 infection	
	Male	Female	Male	Female
5-11	17.6	5.4	0.000176	0.000054
12-17	59.0	24.7	0.00059	0.000247

Source: (6)

Supplementary Table 6: Vaccine effectiveness against Hospitalisation from COVID-19 in 31 hospitals across 21 states in the USA

Age group (years)	Vaccine Effectiveness (two doses of Pfizer)
5-11	68%
12-17	43%

Source: (7)

Supplementary Table 7: Hospitalisations from COVID-19 in Singapore during the Omicron wave from 21/1/2022-8/4/2022 in 5-11 age group

Age group (years)	Number of Cases Hospitalised	Total Number of Cases	Percentage of Cases Hospitalised (%)
5-11	146	16909	0.86

Source: (8)

Supplementary Table 7.1: Hospitalisations from COVID-19 in New York during the Omicron wave from 3/1/2022-30/1/2022 in 12-17 age group

Age group (years)	Number of Cases Hospitalised	Total Number of Cases	Percentage of Cases Hospitalised (%)
12-17	287	39143	0.73

Sources: (9)

Supplementary Table 8: Vaccine effectiveness against Severe Outcome from COVID-19 in 31 hospitals across 21 states in the USA

Age group (years)	Vaccine Effectiveness (two doses of Pfizer)
5-11	79%
12-17	79%

Source: (7)

Supplementary Table 9: Severe outcomes from COVID-19 including ICU admission and death from COVID-19 in Australia during the omicron wave from 1/12/21-31/8/22

Age group (years)	Incidence of Severe Outcome Per 100 SARS-CoV-2 Infections	Risk of Severe Outcome from SARS-CoV-2
5-11	0.008	0.00008
12-17	0.008	0.00008

Source: (10)

Supplementary Table 10: Vaccine effectiveness against Multisystem Inflammatory Syndrome (MSI) from COVID-19 in 29 hospitals across 22 states in the USA

Age group (years)	Vaccine Effectiveness (two doses of Pfizer)
5-11	78%
12-17	92%

Source: (11)

Supplementary Table 11: Risk of Developing MSI from SARS-CoV-2 Infection in Australia during the omicron wave from 1/12/21-31/8/22

Age group (years)	Incidence of MSI Per 100 SARS-CoV-2 Infections	Risk of MSI from SARS-CoV-2
5-11	0.009	0.00009
12-17	0.005	0.00005

Source: (10)

Supplementary Table 12: Risk of Developing a severe outcome from MSI, including ICU admission.

Age group (years)	Risk of Developing severe outcome from MSI (%)
5-11	58.5
12-17	58.5

Source: (11)

Supplementary Table 13: Summary of nodes and relationships between nodes in a Bayesian network for assessing risks versus benefits of the Pfizer COVID-19

Node name (number)	Description	Potential values	Node type	Parent nodes	Child nodes
Vaccine (n1)	Vaccine dose number and current distribution	None, Two Pfizer Two Moderna	Input	N/A – Default priors: distribution of Vaccination coverage in Australia	Vaccine induced myocarditis (n10), Vaccine Effectiveness from hospitalization (n5), Vaccine Effectiveness from severe outcome (n6), Vaccine Effectiveness from MSI (n7), Vaccine Effectiveness from symptomatic infection.
Age (n2)	Age group (years)	5-11, 12-15, 12-17	Input	N/A – Default priors: population distribution of Australia by age	Vaccine induced Myocarditis (n10), Background myocarditis over three months (n11), Vaccine Effectiveness from hospitalization (n5), Vaccine Effectiveness from severe outcome (n6), Vaccine Effectiveness from MSI (n7), Vaccine Effectiveness from symptomatic infection, Risk of symptomatic infection under current transmission and vaccination statis (n9), Hospitalization From Covid (n13), Severe Outcome from Covid-ICU_death, Myocarditis from Covid over 3 months (n12), Multisystem inflammatory Syndrome from Covid (n15).
Sex (n3)	Sex	Male, female	Input	N/A – Defaults to uniform distribution	Vaccine induced Myocarditis (n10), Background myocarditis over three months (n11), Vaccine Effectiveness from hospitalization (n5), Vaccine Effectiveness from severe outcome (n6), Vaccine Effectiveness from MSI (n7), Vaccine Effectiveness from symptomatic infection, Risk of

					symptomatic infection under current transmission and vaccination statis (n9), Hospitalization From Covid (n13), Severe Outcome from Covid-ICU_death, Myocarditis from Covid over 3 months (n12), Multisystem inflammatory Syndrome from Covid (n15).
Community transmission at x% over 2 months (n4)	Probability of infection over 2 months based on different levels of community transmission	None, ATAGI definitions of low, med, high, 1%, 2%, 5%, 10%	Input	N/A – Defaults set to uniform distribution	Risk of symptomatic infection under current transmission status (n17)
Vaccine effectiveness from hospitalization (n5)	Effectiveness of the vaccine at preventing hospitalization.	Effective Not Effective	Intermediate	Vaccine (n1) Age (n2),	Hospitalization from Covid (n13)
Vaccine effectiveness from severe outcomes (n6)	Effectiveness of the vaccine at preventing severe outcome, defined as intensive care admission or death.	Effective Not effective	Intermediate	Vaccine (n1), Age(n2)	Severe Outcome from Covid-ICU_Death (n14)
Vaccine effectiveness from MSI (n7)	Effectiveness of the vaccine at preventing Multisystem Inflammatory Syndrome from COVID-19.	Effective Not effective	Intermediate	Vaccine (n1), Age(n2)	Multisystem Inflammatory Syndrome from COVID-19 Infection (n15)
Vaccine effectiveness against symptomatic infection (n8)	Effectiveness of the vaccine at preventing symptomatic SARS-CoV-2 infection	Effective, ineffective	Intermediate	Vaccine (n1), Age(n2)	Risk of symptomatic infection under current transmission and vaccination status (n9)
Risk of symptomatic infection under current transmission and vaccination status (n9)	Probability of symptomatic COVID-19	Yes, no	Intermediate	Vaccine effectiveness against symptomatic	Hospitalization from Covid(n13), Severe Outcome from Covid-ICU_death (n14), Myocarditis from Covid over 3 months(n12),

				infection(n8), Risk of symptomatic infection under current transmission status(n17), Age(n2)	Multisystem Inflammatory Syndrome from Covid (n15)
Vaccine induced myocarditis (n10)	Probability of developing myocarditis after second dose of Pfizer COVID-19 vaccine	Yes, no	Outcome	Vaccine (n1), Age(n2), Sex (n3)	Nil
Background myocarditis over 3 months (n11)	Probability of developing myocarditis over 3 months (background rate in those who have not had vaccine or infection)	Yes, no	Outcome	Age group (n2), Sex (n3)	Nil
Hospitalisation from COVID-19 (n13)	Probability of Hospitalization from COVID-19 by age and variant	Yes, no	Outcome	Risk of symptomatic infection under current transmission and vaccination status(n9), Vaccine effectiveness from hospitalization(n5), age(n2)	nil
Severe Outcome from COVID-19 (n11)	Probability of Severe Outcome from COVID-19, including ICU and Death. Stratified to age, variant and vaccination status	Yes, no	Outcome	Risk of symptomatic infection under current transmission and vaccination status(n9), Vaccine	nil

				effectiveness from severe outcome(n6), age(n2)	
Myocarditis from COVID-19 (n12)	Probability of developing my(ocarditis related to SARS-CoV-2 infection	Yes, no	Outcome	Age(n2), Sex (n3), Risk of symptomatic infection under current transmission and vaccination status (n9)	nil
MSI from COVID-19 (n15)	Probability of developing MSI by age and Vaccination Status	Yes, No	Outcome	Age(n2), Risk of symptomatic infection under current transmission and vaccination status(n9), Vaccine effectiveness from MSI(n7)	Severe Outcome from Multisystem Inflammatory Syndrome from Covid ICU_death(n16)
Severe Outcome from MSI (n16)	Probability of developing a severe outcome including ICU and Death from MSI	Yes, No	Outcome	Multisystem Inflammatory Syndrome from Covid (m15)	nil

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