For Implementation from September 27th

Guidance for COVID-19 Contact Tracing for Children (>3 months to under 13 years of age)

V1.1 23.09.2021

Version	Date	Changes from previous version	Author
1.1	23/09/2021	Added in wording around those who have had previous confirmed COVID-19 infection	HPSC guidance team
1.0	23/09/2021	First draft, in line with contact tracing recommendations from the 27th September 2021 for children under 13yrs	HPSC guidance team

All HPSC guidance should be read and interpreted in conjunction with the 'Government's Framework of Restrictions'

This document summarises recommendations for contact tracing of COVID-19 in children aged > 3 months to under 13 years in all settings with the exception of household, Special Educational Needs (SENs), respite care and other vulnerable clinical situations.

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, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of these guidelines.

This guidance is under constant review based upon emerging evidence at national and international levels and national policy decisions.

These guidelines are aligned with the principles of Art 3 IHR.

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Preface

This guidance has been developed to reflect the current situation in relation to COVID-19. It outlines the measures that should be adopted for the management of close contacts in children who are > 3 months to under 13 years of age or attending primary educational settings.

Household contacts definition

** The definition of a household contact, will now include a child aged under 13 years, who was present over-night, in the house or in close contact in a residential setting, of a case whilst they were infectious i.e., any child who was attending a 'sleepover' when someone in the household was infectious with Covid-19, will also be designated a close-contact and required to restrict their movements and be tested.*

Key points

- It is essential that anyone who has symptoms of COVID-19 self-isolates at home immediately and contacts their GP to arrange a Covid-19 test.
- All children should attend for vaccination when eligible.
- Automatic contact tracing is no longer recommended for children aged > 3 months to under 13 years of age who are asymptomatic but were close contacts of cases outside of household settings* and vulnerable settings (e.g. Special Educational Needs (SENs), respite care).
- Children > 3 months to under 13 years of age, who are identified as a close contact in primary educational/childcare settings or other non-household settings and who are asymptomatic will no longer be required to restrict movements or be tested, unless indicated on public health grounds. This applies regardless of the number of confirmed cases identified in these non-household settings.
- Children > 3 months to under 13 years of age who are identified as **household contacts** (regardless of their symptomatic status), who are not fully vaccinated or who have not had laboratory confirmed COVID-19 infection in the previous 9 months, will still be required to restrict their movements. They will have testing arranged for them by the HSE Contact Management Programme (CMP). Please see here for further information on the impact of vaccination/prior infection on contact tracing.
- Children > 3 months to under 13 years of age who are not fully vaccinated, regardless of symptoms, and who are in **Special Educational Needs settings (school or class) (SEN) or respite care** will be referred for a Public Health Risk Assessment and may be required to have one COVID-19 test (if possible) and restrict movements for 5 days if advised.
- It is important to adhere to good respiratory etiquette, hand hygiene practice and also adhere to the general public health measures and physical distancing advice.
- Please ensure that appropriate measures are taken to improve ventilation in facilities where ventilation is identified as being inadequate following a risk assessment. Adequate ventilation of indoor spaces, either through natural ventilation (i.e. opening windows and external doors) or by mechanical means (e.g. central air-conditioning unit) is extremely important.

Background

Effective vaccines against COVID-19 are now available and a robust vaccination programme is underway in Ireland for children aged 12 years and older. Although precautions to prevent introduction and spread of the virus are still required, vaccines have been proven to reduce the spread of COVID-19 and reduce the risk of severe disease and or hospitalisation.

As well as vaccination, the primary way to prevent the spread of the SARS-CoV-2 virus is by implementing a series of non-pharmaceutical interventions (NPIs), such as physical distancing, wearing of a face covering and frequent hand hygiene. Increasingly the importance of improving ventilation in reducing transmission, especially in closed environments, has been understood and implemented either through natural ventilation (i.e. opening windows and external doors) or by mechanical means (e.g. central air-conditioning unit).

Social, sporting and educational facilities are communities providing not only for the educational needs of pupils, but also many of their holistic, health and pastoral needs. Within these settings social interaction and physical activity can be learned and occur in a place of safety, support and warmth.

Schools are a core part of local communities, therefore it is a community endeavour to keep schools open and pupils, staff and communities safe. It is crucial that all staff, pupils and their families follow national public health advice, within and outside the school setting, and consider carefully their activities and risk exposures, to ensure the opportunity for infection with Covid-19 and spread within our own communities is minimised. The lower the rates of community infection, the less likely we are to experience significant cases, concerns or outbreaks in the school setting.

It is important to note that in the months since the Covid-19 pandemic has occurred, we have learned that[1]:

- Children seem more likely than adults to have no symptoms or to have mild disease. Please see here for information on symptoms
- Investigation of cases identified in school settings suggests that child to child transmission in schools is uncommon and not the primary cause of Sars-CoV-2 infection in children, particularly in pre-school and primary educational settings
- Children are rarely identified as the route of transmission of infection into the household setting

- Children are not more likely than adults to spread infection to other people.

In addition, recent research[2] conducted by the National Centre for Immunisation Research and Surveillance (NCIRS) in Australia examined SARS-CoV-2 transmission in all schools and early childhood education and care (ECEC) services and associated households in New South Wales (NSW), Australia between 16 June 2021 and 31 July 2021, with contact tracing and test follow-up data until 19 August 2021, when delta was identified as the circulating variant.

Key findings of the study include:

- In 51 educational settings (19 schools and 32 ECEC services) there were 59 individuals (34 students and 25 staff members) with COVID-19 who attended the educational setting while infectious. For these 59 primary (first) cases, 2,347 close contacts from schools and ECEC services (1,830 students and 517 staff members) were identified. Testing for SARS-CoV-2 infection occurred for 96% of close contacts.

- Most children in this study had no or only mild symptoms from COVID-19, while 70 out of 2,864 cases (2%) across the state required hospitalisation. Many of these hospital admissions were for "social reasons" – particularly ill parents not being able to care for children. Of those admitted (70), 2 were born in hospital and 25 cases were admitted for social and vulnerable reasons.

- The overall transmission rate from primary cases to close contacts was **4.7%** (106 secondary cases, comprising 69 students and 37 staff members, in 2,253 tested close contacts). Virus transmission occurred in 19 of the 51 educational settings (38%; 3 primary schools and 16 ECEC services).

- The highest transmission rates occurred in ECEC services between staff members (16.9%) and from a staff member to children (8.1%). The study states that "the spread between children themselves was very low". ECEC services were fully open with high attendance rates during this period and many staff were not yet age-eligible for vaccination.

- **Transmission was low in primary schools (1.2%; 9 secondary cases in 728 close contacts)**. This may possibly be linked to the school holiday period and subsequent

limited onsite attendance in Term 3, when the majority of Greater Sydney was under stay-at-home orders and students engaged in remote learning.

- The results suggest that staff and children who caught COVID-19 at a school or ECEC service occasionally passed it on to their household members. For the 106 secondary cases where infection was acquired within the school or ECEC service, a total of 181 of their 256 household contacts (across 96 households) were subsequently infected with SARS-CoV-2 (attack rate 70.7%)

- The rate of transmission of the SARS-CoV-2 Delta variant in both schools and ECEC services, as well as in households was around five times higher than seen in educational settings and households in this study in 2020 with the original strain of the COVID-19 virus.

Recommendations

As of the 27th September 2021, a decision was taken by Government in line with recommendations from NPHET to cease routine contact tracing of asymptomatic close contacts in children >3 months to under 13 years, including those attending primary educational and childcare settings. It is now recommended that:

- Anyone who has symptoms of COVID-19 should self-isolate at home immediately and contact their GP to arrange a COVID-19 test.
- All children should attend for vaccination when eligible.
- Automatic contact tracing is no longer recommended for children aged > 3 months to under 13 years of age who are asymptomatic but were close contacts of cases outside of household settings and vulnerable settings (e.g. Special Educational Needs (SENs), respite/ residential care).
- Testing of **asymptomatic** non-household close contacts > 3 months to under 13 years is discontinued with a focus on clinically relevant disease. There will be transition to testing for public health action and surveillance as indicated on public health or clinical grounds.
- Children > 3 months to under 13 years of age, who are identified as a close contact in non-household settings and who are asymptomatic will no longer be routinely required to restrict movements, unless advised by Public Health Risk Assessment. This applies regardless of the number of confirmed cases identified in the non-household settings.

- Cases and outbreaks in Special Educational Needs settings, and respite care should have a Public Health Risk Assessment which may still require children to be identified as close contacts, be referred for testing and have their movements restricted. the advice for children who are close contacts in these settings is to have one COVID-19 test (if possible) and to restrict movements for 5 days if advised.
- Children > 3 months to under 13 years of age who are identified as **household contacts** (regardless of their symptomatic status), who are not fully vaccinated or who have not had laboratory confirmed COVID-19 infection in the previous 9 months, will still be required to restrict their movements. They will have testing arranged for them by the HSE Contact Management Programme (CMP). Please see here for further information on the impact of vaccination/prior infection on contact tracing.
- Public Health advice remains the same that any child > 3 months to under 13 years of age with symptoms consistent with COVID-19 should immediately self-isolate, should not attend childcare or school or socialise and follow current public health advice. Please see here for further information.
- It is important to adhere to good respiratory etiquette, hand hygiene practice and also adhere to the general public health measures and physical distancing advice.
- Please ensure that appropriate measures are taken to improve ventilation in facilities where ventilation is identified as being inadequate following a risk assessment. Adequate ventilation of indoor spaces, either through natural ventilation (i.e. opening windows and external doors) or by mechanical means (e.g. central air-conditioning unit) is extremely important.

References

1. Covid-19 in children and the role of school settings in Covid-19 transmission, ECDC 2020

2. COVID-19 in schools and early childhood education and care services – the experience in NSW: 16 June to 31 July 2021; September 2021 National Centre for Immunisation Research and Surveillance (NCIRS) Report