

UPDATE TESTING AND QUARANTINE IN CHILDREN UNDER 12

RAG meeting 17/09/2021

DISCLAIMER: *This advice was presented at the meeting of the Risk Management Group on 20/09/2021. Final decisions were taken by the Interministerial Conference of Public Health, in attendance of the Ministers of Education, on Wednesday 22/09/2021. Important differences exist between the final decisions and the recommendations in this advice. Please see [website](#) for applicable procedures.*

CONTEXT AND QUESTION:

On 29/06/2021 the RAG gave comprehensive advice on COVID-19 prevention and management in children (available [here](#)). After passing several political validation steps, a modified version of the advice was agreed upon on the 28th of August and implemented at the start of the new school year, 1/9/2021. Not all measure that were considered in the previous advice, such as the use of a stepwise approach with alarm levels and systematic screening, have been implemented. During previous discussions, it was agreed upon that the advice would be revised if the epidemiological situation remained favorable, especially regarding hospital admissions and intensive care use. This revision was planned early October, to allow for evaluation of the effect of previous relaxations and avoid rapidly changing guidelines. However, as virus circulation is currently high in Belgium, especially in the younger age groups, this has not unexpectedly resulted in several thousands of children being quarantined. In view of the high vaccination coverage in certain regions of the country and relaxation of most non-pharmaceutical interventions, it is felt by some that the quarantine measures in children are disproportionate and no longer warranted. **An urgent revision of the current guidelines is therefore requested, with the explicit aim to avoid as much as possible quarantine of children under 12y.**

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1. Recommendations

- **All efforts should continue to increase vaccine coverage in the adult population**, especially in regions who are lagging behind.
- Careful monitoring of the epidemiological situation and impact of the different measures should continue. The focus should be on hospitalizations and an maintaining enough capacity in the intensive care units to continue non-COVID care. High viral transmission can be tolerated as long as it does not threaten the capacity of the healthcare system. The **RAG reiterates and strongly asks that measures to control viral transmission should consider society at large** (e.g. remote working, ventilation, masks, covid-safe ticket) and not only focus on children or the educational system.
- For the education system, the RAG stresses again the importance of preventive measures in general, and adequate ventilation in particular.
- As was stated in the RAG advice of 16/08/2021, testing of symptomatic individuals remains a priority, with the exception of children <6y of age. As stated in the RAG advice of 06/09/2021 **child-friendly alternatives to nasopharyngeal testing**, such as anterior nasal swabs, or-nasopharyngeal swabs or saliva testing can be used. The case definition should be applied with some common sense, as explained e.g. in the communication by VVVJ.
- **Since children <12y have not had the opportunity to be vaccinated, the RAG proposes to apply the same quarantine rules after high-risk contact as for vaccinated adults.** This means that, in case of a high-risk contact, children require quarantine and need to be tested by PCR as soon as possible. When a first negative test result is obtained, the quarantine ends. After a positive test, the child is placed in isolation for 10 days and his/her high risk contacts outside the class group are traced. After a first negative test, a second PCR-test should be done 7 days after the last exposure. Children who already tested positive within the past 180 days only require testing in case of possible symptoms..
- **The same definition of high-risk contacts is used as in adults.** If it is impossible to do a detailed risk analysis, the entire class will be considered as a high-risk contact. As children are in fact unvaccinated and there is a residual risk of infection after the first negative test, **contact tracing starts as soon as the 1st case is detected**. This approach will avoid late interventions, with increased risk of high viral transmission. The ‘tightening’ of the measures (since the previous approach only considered high-risk contacts as soon as 2 cases were detected in a class) is compensated by the release of quarantine as soon as a 1st negative test result is obtained. Early intervention might also limit further spread.
 - The representatives of CLB, PSE/ONE and Kaleido disagree with this recommendation, as they feel it will result in too many quarantines, will not be accepted and will again overburden school health services.
- To avoid repeated cycles of testing and quarantine, **no additional contact tracing within the class needs to be done for cases that are detected by the second testing round at day 7**, except for isolation of the positive cases. If more than 4 cases or >25% of the class group is tested positive (D0 or D7), the entire class group needs to go into quarantine for 7-10 days. The case counting stops as soon as there are 7 consecutive days without cases.
- To avoid particularly long quarantine periods for household members that cannot be isolated from index cases (e.g. infected parents or siblings), **an additional test of the contact should be offered at the end of the isolation period of the index case. If this test is negative, quarantine ends.** An additional test remains recommended 7 days after the last exposure.

2. Elements of discussion

- A **balanced risk/harms approach** needs to be taken, where both the interests of the children and the impact for society are being taken into account.
- It is considered **too early to allow unlimited spread** of the virus throughout the population as long-term prediction models still indicate the potential for a significant rise in hospitalizations and burdening of the health care system. Some consider shielding of at-risk individuals an appropriate alternative to contact tracing in children. However, the “motivation-barometer” survey showed that especially unvaccinated persons are not motivated to comply with measures. Additionally, at-risk individuals occur in all age groups, so the potential of this approach is unclear. Whilst vaccines offer excellent protection against severe disease, breakthrough infections do occur. Transmission in vaccinated individuals appears reduced but possible.
- High-levels of viral circulation will also have an impact on (partially unvaccinated) school staff. Classes in Brussels have already been closed due to a lack of school staff.
- The **level of viral circulation is not only determined by measures for children** but also by measures in the society at large. To which extent measures in children can be relaxed, will therefore also depend on which other measures are still taken.
- Other preventive measures in schools, such as ventilation, remain important.
- Reducing quarantine measures in children might present the advantage of inducing more **natural immunity** in this age group for which vaccines are not yet available. At the moment, little is known about the longevity of natural immunity in children.
- As COVID-19 is **generally considered a mild infection in children**, especially of primary school age, the direct benefit of quarantine to children is very limited. For children with underlying diseases however, controlling viral circulation in schools presents the advantage of offering them a safe environment whilst awaiting approved vaccines for this age group.
- Testing of symptomatic children serves to identify and isolate the most infectious children whilst allowing other children with relatively mild respiratory symptoms and a negative SARS-CoV-2 test to continue in-person learning.
- Testing of symptomatic children is essential in order to trace contacts. Contact tracing is a targeted measure where only measures are taken for those children with an identified exposure to the virus, allowing more freedom for all other children.
- As **symptoms of COVID-19 are very unspecific** and a higher level of circulation of other respiratory viruses is expected during the winter season, this might lead to regular testing and overwhelming of the first-line healthcare providers. Use of rapid antigen tests might however limit the amount of learning time that is lost due to testing.
- **Regular testing of high-risk contacts** might be equivalent to quarantine in terms of infection prevention. However, as past experiences have shown, this approach is challenging in terms of logistics.
- Careful consideration should also be given to the **operational aspects** of a chosen approach, as school health services are already overburdened.
- The current **definition of a cluster** is the occurrence of 2 cases (without apparent source of infection outside the class room) within 14 days. The 14-days window is chosen based on the incubation period / serial interval of SARS-CoV-2. As in times of high community transmission it is often difficult to judge whether infections are linked within the classroom or have an outside source, it can be considered to shorten this interval to 7 days in order to avoid false identification of clusters.
- On the other hand, it is felt that the **approach of only taking measures as soon as a 2nd case is detected, is not very efficient** and leads to unnecessary closures of an entire class because measures are taken too late.
- **Repetitive screening** of school staff and children could help to keep infectious individuals out of the class room. On the other hand, it requires considerable logistics and might lead to overdetection of asymptomatic cases with unclear infectiousness. If screening of children is implemented, it should also be implemented in other areas of society, like workplaces.

- As vaccination coverage and the epidemiological situation show large regional differences, a regional approach can be considered, taking local vaccination coverage (e.g. at the level of the “eerstelijnszone”) into account. However, this will undoubtedly pose problems in areas where vaccination coverage is different than in neighbouring areas and does not take into account mobility between those different areas.
- Secondary attack rates have been shown to be clearly higher in **household contacts**, which are therefore always high-risk contacts. In case of infected siblings/parents that are unable to isolate from the index case, the total duration of quarantine is up to 17 days which is very challenging.
- Measures need to remain intelligible to the general public and need to be consistent. Although the situation is complex, the aim should be to have as few different rules as possible. Rapidly changing guidelines harm the confidence in and adherence to all COVID measures.

3. Current guidelines in Belgium

Briefly, measures can be summarized as follows:

Children <6y (crèche, kindergarten):

- testing of symptomatic individuals ONLY after identified risk exposure
- 1 case
 - index = adult: all children considered as HRC
 - index = child: no additional measures
- 2 cases within 14d with probable contamination within the class → all children HRC

Children 5-11y (primary school):

- testing every case complying with case definition
- 1 case
 - index = adult: all children considered as HRC or individual risk-assessment if possible
 - index = child: no additional measures
- 2 cases within 14d with probable contamination within the class → all children HRC

Adults and adolescents:

- HRC according to standard definition: direct contact or >15' at <1,5m
- Unvaccinated HRC are tested 2x and have minimum 7d quarantine. Vaccinated HRC are released from quarantine after a first negative test.

4. Epidemiological situation

4.1. OVERALL SITUATION IN BELGIUM

For an evaluation of the epidemiological situation, we refer to the [RAG epidemiology](#). For the first time since July, the number of new hospital admissions has stabilized. Importantly, the overall alert level in Belgium is currently at 2 (out of 5), but with large regional differences and alert level 4 in both Brussels and Liège.

4.2. SITUATION IN CHILDREN AND SCHOOLS

An extensive description of the situation in schools throughout **the past school year** is provided in a thematic report ([NL](#) / [FR](#)). Key figures are copied below:

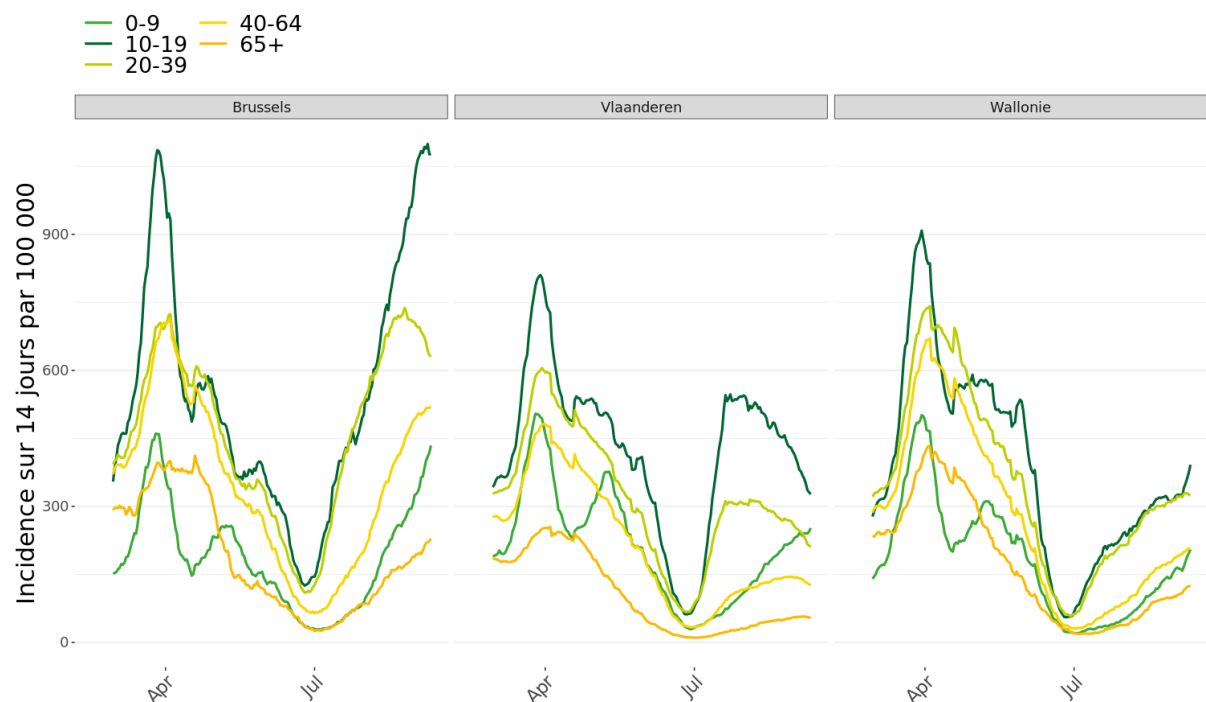
Tableau 1. Les principaux indicateurs épidémiologiques COVID-19, par groupe d'âge et pour l'ensemble de la population belge, 01/09/2020-30/06/2021.

	0-2 ans	3-5 ans	6-11 ans	12-17 ans	Population totale	% du total qui a <18 ans
Cas confirmés	4 784	8 097	67 873	77 939	1 003 109	15,8
Hospitalisations*	743	57	88	151	55 883	1,9
Décès	<5**				15 081	<0,03
Tests	149 748	183 888	929 871	892 058	13 128 185	16,4
Taux de positivité	3,4 %	4,6 %	7,7 %	9,3 %	8,5 %	/
Population par groupe d'âge ³	357 357	378 648	937 984	765 076	11 492 641	21,2

* basé sur la surveillance clinique des hôpitaux, corrigé pour une sous-déclaration probable de 35%.

** moins de 5 décès dans le groupe de population des 0 à 17 ans pendant toute la période.

However, the situation in terms of vaccination coverage and preventive measures, both in the general society and in schools is different in many ways from the past school year. Since beginning of summer, the 14-day cumulative incidence in children is rising:



4.3. DATA FROM CONTACT TRACING

It is important to note that school started only on 1 September 2021 so the **effect of the new contact tracing measures is difficult to assess**, especially as secondary cases will require some time to appear. Due to changes in data collection systems, we currently only have data available from the Flemish-speaking education.

In the first 2 weeks since school start, for all school levels:

- 2,812 children (0,13% of all school population) were index cases and 5,322 high-risk contacts (0,44%). Hence less on average less than 2 HRC per index case have been identified.
- For 86% of index cases, NO students are placed in quarantine. For 93% of index cases <5 HRC are placed in quarantine.
- In primary school, 6.9% of children put in quarantine received a positive test later on, i.e. 1-2 additional cases per class put in quarantine.

From 1 September, in general contact tracing data from the call centre we can observe:

- For all age groups, 20.4% of high-risk contacts test positive on the first test. On the second test, 11.5% test positive.

- Secondary attack rates are twice as high in household contacts than in other close contacts.
- For **non-household** high-risk contacts, the test-positivity rates are:

	1 st test	2 nd test
0-5y	15.4%	16.7%
6-11y	12.1%	5.3%
12-17y	9.4%	2.6%

5. Recommendations in other countries

See annex 1 for more details

	Definition HRC	Test	Quarantine
NL	>15' <1.5m	D5	10 days, unless negative test
FR	Entire class	D0+D7	7d + 7d mask
DK	Entire class	D0+D4+D6	none
UK	<1m any duration	D0	Waived for all -18y
DE	Different according to Bundesland. Mostly daily testing without Q		

6. Literature update

For overall literature updates, we refer to previous RAG advices and the Sciansano fact sheet.

6.1. REPEATED TESTING VS. QUARANTINE

With regards to comparing repeated testing with quarantine: 1 recent study was identified.

A cluster-randomized trial from the UK recently compared daily testing of HRCs with Q for HRCs of 10 days, in secondary schools (pupils aged 10-17y) from Mid-April until end of June 2021. (1)

- Daily testing was done with rapid antigen tests on anterior nose swabs : pupils self-swab at school, school staff read out the Ag tests. No testing on weekends.
- Testing ended after 5 negative tests. After a negative test result, school attendance was allowed but pupils were asked to self-isolate after school and in weekends (no data on compliance...)
- Positive Ag test results were considered as a confirmed COVID-19 infection, no need for confirmation
- Outcomes assessed: **numbers of school days missed and number of symptomatic infections confirmed by PCR**
- Note: at the time of intervention, all schools in UK (so the control group) had twice-weekly testing with Ag test for asymptomatic students available

Importantly: **neither of their outcomes shows a significant difference between intervention and control group. Point estimates favor the intervention group** in terms of number of school days missed, but differences are small. This is most likely due to only ~half of pupils in the intervention group really participating. Sometimes classes in the intervention group were closed anyway because of concerns of community transmission rates/delta variant or there was not enough staff available to do testing or students refused to be tested.

The point estimates of infection also tended towards a slight reduction in infection in the intervention group, which might be explained by more voluntarily uptake of the screening program without the risk of causing all your contacts to quarantine in case of a positive result. But again, no significant change. Reassuringly though, no evidence that transmission would increase under a scenario of repetitive testing.

Important caveats from the study :

- The overall test-positivity of school-based close contacts was only 2%, so it is not very surprising that allowing further school attendance did not drastically increase viral transmission. The low test-positivity might be due to a difference in definition of high-risk contacts.
- Even with basic infrastructure for rapid antigen testing already in place in all schools, there seemed to have been important logistical barriers with only about half of eligible participants really participating.

Modelling estimates from France, using field estimates for adherence to screening in the Spring wave of 2021, indicated that **weekly screening would reduce the number of cases by 24% in the primary and 53% in the secondary school compared to symptom-based testing alone**, if R=1.3 and 50% adhered to screening. (2) This adherence was met in primary schools (53% (95% confidence interval 21-85%)), but insufficient participation was recorded in secondary schools (10% (1-38%) in middle schools, 6% (2-12%) in high schools). **Regular screening would also reduce by 90% the number of student-days lost compared to reactive class closure.**

6.2. INCUBATION PERIOD OF DELTA VARIANT

With the emergence of the more transmissible Delta variant, it has been hypothesized that the incubation period might have shortened. Different analyses (mostly pre-prints) by the same group of authors and of the same outbreak in China reported epidemiological parameters. The outbreak occurred in May-June 2021 when delta variant was dominant. One analysis estimated the **mean incubation period** at 5.8 days (95% CI 5.2-6.4) with 95% of the infected persons developing symptoms within 11.5 days (3). This is in line with previous estimates for the Wuhan strain. However, in another analysis *Zhang et al.* observed a mean incubation period of 4.4 days (95%CI: 3.5-5.0) which seems slightly shorter (4). Regarding **the serial interval**, while *Kang et al.* demonstrated a time-varying serial interval which has been reduced to 4.0 days (95% CI 3.1-5.0) in mid-June 2021, *Zhang et al.* observed a mean serial interval of 2.3 days (95%CI: 1.4-3.3) for the same outbreak (3,4). Only one other study to date, using data from 32 household transmission pairs in Singapore, observed no difference in the serial interval period of Delta vs. wild-type virus (5). Finally, *Zhang et al.* observed a **generation time** of 2.9 days (95%CI: 2.4-3.3) (4)

To conclude, while the incubation period does not seem shorter, the high transmissibility of the Delta variant might be explained by its higher viral load, leading to a more important infectiousness soon after exposure (6). In summary, it currently remains unclear whether the incubation time for the delta variant really is shorter.

6.3. SYMPTOMS IN CHILDREN

Molteni et al reported data from UK school children aged 5-17 years with a positive SARS-CoV-2 test between March 2020 until February 2021. (7) Symptoms are reported for subgroups 5-11 years ('younger children') and 12-17 years ('older children'). The most prevalent symptoms are summarized in the figure on the right.

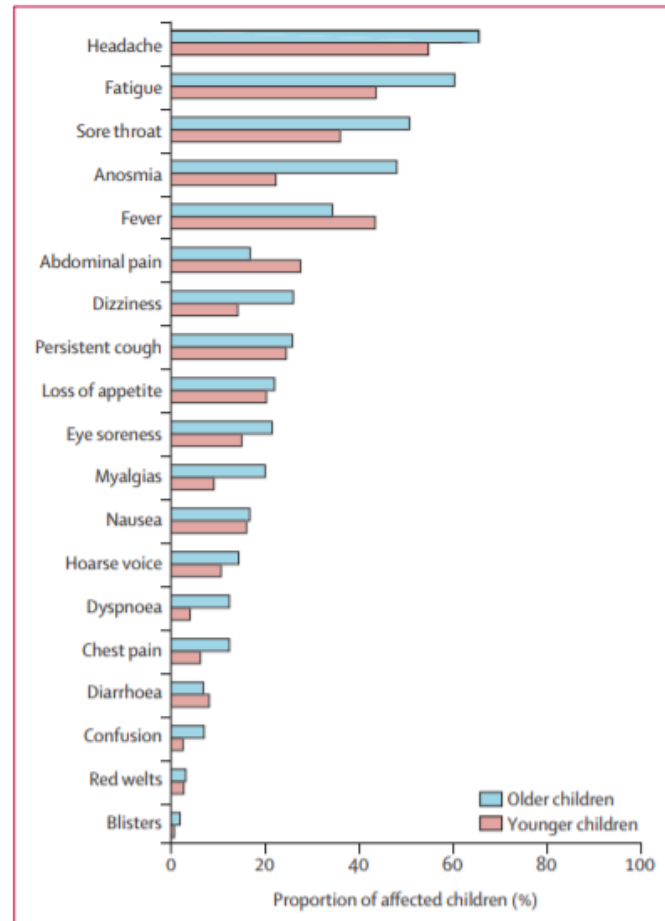


Figure 2: Prevalence of symptoms reported over the course of illness in younger (age 5–11 years, n=588) and older (age 12–17 years, n=1146) children testing positive for SARS-CoV-2

Data refers to children with symptom onset between Sept 1, 2020, and Jan 24, 2021.

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7. Molteni E, Sudre CH, Canas LS, Bhopal SS, Hughes RC, Antonelli M, et al. Illness duration and symptom profile in symptomatic UK school-aged children tested for SARS-CoV-2. *Lancet Child Adolesc Health* [Internet]. 2021 Aug 3 [cited 2021 Aug 23];0(0). Available from: [https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642\(21\)00198-X/abstract](https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(21)00198-X/abstract)

Annex 1 – international recommendations

The Netherlands (sources: [Kinderen, school en COVID-19 | RIVM](#); [Generiek kader Kinderopvang en scholen \(0-12 jaar\) | RIVM](#); [Coronavirus en basisonderwijs en speciaal \(basis\)onderwijs | Coronavirus COVID-19 | Rijksoverheid.nl](#); [Corona en kinderopvang | Coronavirus COVID-19 | Rijksoverheid.nl](#))

Testing of children until 12y

Kinderen mogen wel naar school of de opvang als zij verkoudheidsklachten hebben. Maar bij zware klachten, zoals veel hoesten, koorts of benauwdheid blijven zij thuis. Kinderen kunnen getest worden. Laat uw kind in ieder geval testen en houd het thuis als:

- Uw kind zware klachten heeft, zoals veel hoesten, koorts of benauwdheid.
- Uw kind ernstig ziek is, overleg met uw huisarts of het kind getest moet worden.
- Uw kind nauw contact heeft gehad met iemand met corona.
- Uw kind klachten heeft en contact heeft gehad met iemand met corona.
- De GGD adviseert om te testen vanwege een uitbraakonderzoek.

Heeft uw kind zware klachten en laat u het kind niet testen? Houd uw kind thuis. Uw kind mag weer naar school of de kinderopvang als het 24 uur volledig klachtenvrij is. Blijven de klachten aanhouden? Dan mag uw kind na 7 dagen thuisblijven ook weer naar school of de opvang.

In an advice of 2 September 2021, the RIVM recommends that if a pupil is infected, the Municipal Health Service (GGD) checks which classmates are close contacts and therefore need to be quarantined or tested. The procedures for day care and primary school are further explained in the protocols developed by RIVM and the Dutch Ministry of education:

- Close contacts (children or school employees who had contact with the infectious person for more than 15 minutes on one day at a distance of less than 1.5 metre, from two days before the first day of illness) go into quarantine for ten days, unless they are considered immune (fully vaccinated or recovering from previous infection). They can be tested on day 5, and if negative leave quarantine.
- Other contacts both immune and non-immune, do not have to go into quarantine, but it is still recommended that they are tested on day 5.
- In the event of several infections at a school, the GGD can advise additional measures to be taken. Schools and GGD will always have to act according to their own judgement and the approach will therefore be tailor-made.

Denmark (source: [Transitional guidance for managing infection in the field of day care, education and training - Danish Health and Medicines Authority \(sst.dk\)](#))

The Danish health authorities published guidelines for the management of COVID-19 infections in children in primary schools, day care centers and child leisure facilities on 6 September 2021.

- Children who are close contacts (all children or pupils in the room or equivalent group division/class/team) and who have neither been fully vaccinated nor previously infected within the last 12 months are exempted from quarantine. They have to test as soon as possible (with PCR or RAT) and only stay in quarantine until the test result. They are tested again with PCR on the 4th and 6th day, according to the general guidelines for testing close contacts. They can during that period go to day care/ school if the first test was negative and if they have no symptoms of COVID-19. If they do not want to be tested, they have to stay in quarantine for 7 days.
- Children who are close contacts and who have been fully vaccinated or previously infected in the past 12 months are recommended to be only tested on the 4th and 6th day after the last contact.

France (source: [Que se passe-t-il si un élève est cas confirmé de covid-19 ? | Ministère de l'Education Nationale de la Jeunesse et des Sports](#))

In France, if a pupil in kindergarten or primary school is confirmed to have COVID-19, the whole class is closed for 7 days, and high-risk contacts in other classes go in quarantine for 7 days (unless they had

a COVID-19 infection in the past 2 months). All high-risk contacts and pupils of the class are tested as soon as possible and on day 7 with a PCR (possibly on saliva) or a RAT on a nasopharyngeal swab. If the 2nd test on day 7 is negative they can return to school. Parents of pupils of an elementary school have to provide a certificate of honor and the pupils have to wear a mask for another 7 days. If not, they stay in quarantine for 14 days.

United Kingdom (sources: [Schools COVID-19 operational guidance - GOV.UK \(www.gov.uk\)](#); [Contingency framework: education and childcare settings \(publishing.service.gov.uk\)](#))

The government of the UK updated its guidelines on school measures on 27 August 2021. Close contacts are no longer identified by the schools, but by NHS Test and Trace, just as for contact tracing in out-of-school settings. Contacts from a school setting will only be traced where the positive case and/or their parent specifically identifies the individual as being a close contact. Following the current UK contact tracing guidelines, contacts do no longer need to go in quarantine if they are fully vaccinated or below the age of 18 years and 6 months. They are only encouraged to take a PCR test and to wear a mask when travelling on public or dedicated transport.

If the number of positive cases substantially increases, schools should have contingency or outbreak management plans. Any measures in schools should only ever be considered as a last resort, kept to the minimum number of schools or groups possible, and for the shortest amount of time possible. A separate contingency framework was developed for this purpose. Suggested thresholds for the contingency plan are: 5 children, pupils, students or staff, who are likely to have mixed closely, test positive for COVID-19 within a 10-day period; or 10% of children, pupils, students or staff who are likely to have mixed closely test positive for COVID-19 within a 10-day period. Suggested actions to take include increased testing and temporarily reinstating face coverings.

Germany: measures differ by Bundesland; See [Corona und Schule: Diese Regeln gelten im neuen Schuljahr in den Ländern - Das Deutsche Schulportal \(deutsches-schulportal.de\)](#)

Baden-Württemberg

Instead of quarantine, all students in a class should test themselves daily for at least five days with a corona rapid test if a classmate is infected. What is new after the decision of the federal states is that this now applies to all types of schools.

Bavaria

In the event of a corona case, the entire class should no longer go into quarantine. Symptom-free children, who are considered close contacts, should be able to end them with a negative corona test after five days at the earliest.

Berlin

Only children and adolescents with a positive PCR test in a 14-day quarantine. Contact persons outside the closest family would no longer be determined.

Hesse

If there is a corona case, all students and teachers of the class or course association (with the exception of the vaccinated and convalescents) must be tested on each day of class in the following two weeks. Medical masks must then also be worn at the seat. In the case of further confirmed corona infections, the two-week period begins again.

North Rhine-Westphalia

Quarantine regulations have been relaxed. In the future, in the event of a corona case at schools in NRW, only the infected pupils will have to be quarantined.

Rhineland-Palatinate

If a corona infection occurs in schools, only the infected students and teachers within the class or study group have to go into quarantine. Everyone else in the class must instead test for Corona daily for five consecutive school days. The obligation to test does not apply to vaccinated and recovered persons.

Saarland

The quarantine rules for schools and day-care centres are being relaxed with immediate effect. Against the background of hygiene and infection protection measures at schools, the health authorities are prepared to order quarantine only for close contacts – in the direct vicinity of the infected. Close contacts could test themselves after five days by PCR test – this also applies retroactively. Vaccinated and convalescent are usually exempt from quarantine, but "depending on the respective virus variant".

Saxon

There are also new quarantine regulations: Each new corona case will be reported to the health department as before. This should then decide on the basis of the new guidelines and the respective situation on the ground. In the age groups up to 12 years, as a rule, only the affected students should be quarantined, all others may continue to attend school, but should be tested three times a week over a period of 14 days – as well as the teacher.

Schleswig-Holstein

In the event of a corona case, quarantine no longer applies to the entire learning group, but only to immediate seat neighbours and to children who are in close contact with each other beyond school.

Thuringia

Simpler quarantine rules for corona cases in schools. In principle, quarantine should no longer be ordered for the entire class association in a case. Children who are sent to quarantine as close contacts and have no symptoms should therefore be able to end them with a negative test after five days at the earliest. The local health authorities should also be able to decide differently in individual cases. Quarantine orders should generally be issued "with a sense of proportion" and depending on protection concepts with ventilation, corona tests and the wearing of medical masks. For other children in the class who are not classified as close contacts, intensified tests should be carried out "for a certain period of time".