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Guidelines for the Education Sector up to Secondary Schools



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Preamble

These guidelines are applicable for childcare centres, kindergartens, primary and secondary educational settings for the scholastic year 2021/22, thereby referred to as 'School/s' in this document. Each School should adapt these guidelines according to the specific setup of the School itself and in line with other guidelines as issued from time to time by the Public Health authorities. Certain measures are applicable to specific educational settings only and this will be specific in the heading.

These guidelines are meant to mitigate, as much as possible, against the transmission of COVID-19. Although the risk of infection is reduced, it can never be completely eliminated. Policy makers, the educational sector, parents/guardians and students need to understand that a risk of transmission will still exist even if these guidelines are rigorously followed and implemented however the risk is reduced.

General Information on COVID-19

The virus which causes COVID-19 disease is mainly spread through droplets from a sick person and can also be spread through contact (by touch). Viral particles may also remain suspended in the air (aerosols). COVID-19 disease often presents with coughing or sneezing which release droplets of infected fluid. Most of these droplets can fall on nearby surfaces and objects - such as desks, tables, machinery, equipment, floors, walls, clothes, or telephones. People can catch COVID-19 by touching contaminated surfaces or objects – and then touching their eyes, nose, or mouth.

Symptomatology

Children generally present with milder illness than adults. The symptoms include fever, cough, nasal congestion, sore throat, sneezing and/or gastrointestinal symptoms. Headaches, muscle aches and breathlessness are other symptoms which were reported amongst paediatric cases. Others may also complain of the more COVID-19 specific symptoms of a loss of smell and/ or taste. Emerging studies consistently reporting a proportion of children remaining asymptomatic whilst infected (13-40%)¹. COVID-19 symptoms and clinical manifestations in adolescents are similar to that of adults.

There is a very low risk of children or young adults becoming severely ill and requiring hospitalisation from an infection with COVID-19 virus with an even lower risk of death. Those with comorbidities are more likely to exhibit severe manifestations of the infection.

Epidemiology

In Malta, currently children comprise the largest unvaccinated group of persons. Local epidemiology has shown that 0–11-year-olds comprise around 5.5% of the notified cases² [EDCD rate for Jan-May 2021 of 1-11 year olds 8.5%] whilst children and adolescents aged between 13-18 years of age comprise 19.4% of the notified cases in this time period. ECDC pooled data covering the period until June 2021 has shown an increased proportion of

¹ ECDC. (2021, July). *COVID-19-in-children-and-the-role-of-school-settings-in-transmission-second-update*
<https://www.ecdc.europa.eu/en/publications-data/children-and-school-settings-covid-19-transmission>

² This covers a period between 1st June 2021-12th August 2021 Source: COVID-19 Public Health Response Team, 2021



children 5- 11 years being notified as compared to the previous observation period with the highest rate of increase resulting in 16–18-year-olds. It is expected that as older children and adolescents are offered vaccination the confirmed cases in children will increase. Overall children still comprise the minority of reported cases. There is thought to be bias in the likelihood to test younger children which may contribute to the decrease in notification in this group. Children do not exhibit the strong age-sex association in notified cases which is noted in adults.

Although children in the pre-school and primary ages may be equally susceptible to infection as compared to older children and adults, studies report they are less likely to transmit the infection to others. In light of the more transmissible variants, the susceptibility and infectiousness of cases in children, adolescents and staff is higher than with previous variants although vaccination does attenuate this. With all factors being equal, secondary transmission within the school setting is more likely if the index case is an adult as compared to a child. Research which compared the risk of infection based upon occupational category, found that teachers were not at an additional risk as compared to other occupations. The studies carried out relate to periods prior to dominance of the delta variant in Europe³.

Closure of Schools as a last resort

Evidence has shown that in the run up of the third scholastic year affected by the COVID-19 pandemic, whilst non-pharmaceutical interventions such as rigorous physical distancing and even closure of schools have been effective and justified at the outset of the pandemic, now the overwhelming priority is to enable the physical presence of children in school whilst protecting the health of children and the school community. Experience and monitoring of viral spread in schools has shown that this mirrors the epidemiology in the community and that with adequate mitigation measures at a community level together with timely public health intervention through early identification of cases and quarantine of close contacts, outbreaks in schools can be contained.

³ ECDC. (2021, July). *COVID-19-in-children-and-the-role-of-school-settings-in-transmission-second-update*. <https://www.ecdc.europa.eu/en/publications-data/children-and-school-settings-covid-19-transmission>



The educational losses, social disruption and distress need to be considered along alongside the physical distancing measures in the delicate risk-benefit balance between protecting from infection an overwhelmingly unvaccinated population such as schoolchildren under the age of 12 years and the consequences of that as opposed to the educational achievement and the social interaction which make schools such an important part of a child's life. Additional efforts are required to consider those who were already disadvantaged and socially vulnerable such as those with additional learning needs who unfortunately have been most impacted by the school closures and disruptions. The temporary closure of schools should be considered a measure of last resort in an aim to curb uncontrolled viral spread because otherwise the losses incurred through schools' closure are too great. This policy position is in line with that of WHO, OECD and UNICEF.



Principles of mitigation of transmission in school settings

Vaccination

>90% of those eligible are fully vaccinated
Effective at decreasing serious illness, hospitalisation and death

Physical distancing

Staggered timings in/out
Staggered breaks
Distances between persons

Ventilation

Outdoor activity is preferred to indoors
Adequate ventilation in classrooms

Cohorting

Keep group of students/educators constant where possible throughout the day inc. breaks

Masks

Effective means of source control

Enhanced Hygiene

Hand hygiene/Respiratory hygiene
Do not attend school if unwell
Cleaning/Disinfection of premises

Public Health Action

Timely testing of symptomatic persons
Schools Contact Tracing Team
+COVID 19 Liaison Officers in School

Measures to be adopted in Schools

Vaccination

All those students and staff who have been offered a COVID-19 vaccine and have not yet taken this vaccine are encouraged to accept this offer. Persons who are fully vaccinated are shown to be much less likely to develop severe illness, hospitalisation or die from COVID-19 infection. Although infection in vaccinated persons particularly with the more transmissible delta variant is still possible (though to a lesser degree than those unvaccinated), vaccination together with all the other mitigation measures is critically important to prevent spread of viral illness. It is important for all parents to be encouraged to take a full course of an effective COVID-19 vaccine since this offers protection to them directly, their immediate family and the school community at large.



Individual Hygiene Recommendations

- ✓ Parents/Students should assess for any signs of illness in the morning before attending School. Persons who are unwell (students/staff) should not attend School.
- ✓ Temperature screening of students/staff may be carried out at school entrance. A screening temperature $>37.2^{\circ}$ C or anybody who appears unwell should not be admitted into school
- ✓ Hand hygiene is paramount to decrease spread of the virus. This can be achieved by frequent washing with soap and water using correct techniques or using sanitisers placed at critical points in the facility. Washing of hands and use of sanitisers at the School should be rigorously encouraged, taught and monitored and performed at regular intervals and using visual cues such as posters. The use of sanitisers by younger children should be supervised. Personal sanitisers should be provided by the parents each student with this being kept in class for the younger children. Guidance on appropriate hand hygiene can be found [here](#)⁴. In babies and toddlers hand hygiene using soap and water is preferred. Resources on hand washing can be accessed from <https://www.who.int/pmnch/covid-19/toolkits/child/wash/en/>
- ✓ Avoid touching one's face (including one's mask) particularly the eyes, nose and mouth.
- ✓ Sneezing/ coughing should be into a tissue or the crook of one's elbow ensuring appropriate disposal of the soiled tissues and cleaning of hands afterwards.
- ✓ Unnecessary contact between staff and students and amongst the students themselves should be avoided eg. Hugging, shaking hands etc.
- ✓ Avoid touching frequently touches surfaces with one's open hand, lift buttons, railings etc. Ensuring rigorous hand hygiene afterwards
- ✓ Procedures and personal protective equipment recommended for changing diapers in younger children and assisting students with disabilities (Annex B).
- ✓ A medical certificate to enable the child to return to school after sickness is required from the doctor (even if the child is absent for a single day). This certificate will

⁴ <https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Advice%20on%20handwashing%20and%20the%20use%20of%20gloves.pdf>



provide the date when the child can resume in-person learning. Please be aware that the child is expected to be free of symptoms for 48 hours before return to school and the date given on the certificate for return to school will take this into consideration.

Personal belongings

- ✓ Students should not bring non-essential items to school besides from communication devices or educational material.
- ✓ All food items are to be carried and presented in containers which can be cleaned and wiped down before handling by staff, otherwise these should be handled by the student ensuring proper hand hygiene before and after eating meals.
- ✓ Water fountains/ dispensers where 'no contact' is required for filling of one's flask/cup are permitted ensuring adequate hand hygiene before and after.
- ✓ All food items are to be carried and presented in containers which can be cleaned and wiped down before handling by staff, otherwise these should be handled by the student ensuring proper hand hygiene before and after eating meals.
- ✓ **Childcare:** Pushchairs or any kind of infant carriers would not be permitted in the childcare or kindergarten with the exception of children with special needs whose equipment would be permitted to enter the centre
- ✓ Personal toys are not allowed with the exception of toys or educational material designed to stimulate children with disabilities or special needs.
- ✓ **Childcare/Kindergarten:** Only toys that could be easily cleaned should be used. Certain smaller toys, soft toys and possibly ball pits should be avoided unless one can be certain that they are adequately cleaned between one group of children and another. Playdough/sand should not be shared between children. It would be ideal if children had their own craft accessories which would not be shared between them.



Enhanced hygiene practices in the premises

- ✓ Premises and resources are to be cleaned daily using approved products. For further details regarding the methods and agents recommended kindly refer to **Annex A**.
- ✓ Premises are to be cleaned thoroughly between one cluster of students and another. Common functional rooms and common resources used by different groups of students need to be cleaned appropriately at regular intervals and at the beginning and the end of each day.
- ✓ Unauthorised personnel are not allowed in the School. No parents or guardians are allowed in the School except in cases of emergency.
- ✓ **Childcare:** If common functional rooms are used by different groups of children throughout the day besides cleaning the premises any shared toys, furniture should be cleaned and disinfected.
- ✓ **Childcare:** Common functional rooms like dining rooms, nappy changing areas and common areas should be used alternately by different groups and not simultaneously.
- ✓ Toilets must be cleaned regularly, at least three times a day with a log of the cleaning time kept. Hand blowers should not be used. Paper towels are recommended for appropriate hand hygiene
- ✓ Students in the same classroom and/or bubble should be encouraged to wipe down their desks and equipment before and after use.
- ✓ Special considerations using the correct agents or use of protective covers in computer labs. Similarly, libraries should consider quarantining books for a couple of days before making them accessible to other children. Exemplary hand hygiene needs to be ensured.
- ✓ Floor cleaning should be carried out more regularly and frequently throughout the day, and as necessary and as required in the case of spillages.
- ✓ Frequently touches spots such as door handles, light switches, handrails, tables should be cleaned with particular attention several times during the day.



Physical Distancing

A number of measures working synergistically help to achieve physical distancing between individuals

- ✓ Staggered/start and end times will allow for less crowding at the entrances of the School limiting the direct contact with parents as much as possible
- ✓ Where possible, a physical distance of 2 metres should be maintained in common areas e.g. such as in reception areas and at toilet sink stations. If this is not possible, Perspex screens should be installed at a 2-metre height from the ground
- ✓ Ideally the common areas should be organized for there to be a one-way flow of staff and students.
- ✓ Staggering breaks ensures that less bubbles would encounter one another in the playground
- ✓ In the years where students are taught by subject teachers, where possible the students should remain in the classroom whilst the teachers move from class to class. Where this is not operationally feasible, timetables should be set in a way that minimises the mixing of bubbles and classrooms.
- ✓ Unauthorized personnel should not enter the School. Only students, authorised personnel, management and persons required for unavoidable works are allowed. No parents or guardians are to be allowed in the School at any time except in cases of emergency.
- ✓ Communication from the parents/guardians with School's staff and management for day-to-day necessities can only be done through online services.
- ✓ Any written reports regarding children's development should be made electronically.
- ✓ Collaborators and contractors who provide agreed services to the School are to abide by these same guidelines when providing a service to the school.

In the Classroom/Laboratories/Workshops

The physical distancing measures are of particular importance since this is the setting within which the students would be spending the largest amount of time whilst at school.



- ✓ Where possible and appropriate, students and desks should all face in the same direction and none should be facing each other.
 - ✓ It is very important that there is no unnecessary contact between students, or between students and staff members.
 - ✓ Staff members should avoid walking around the class unnecessarily.
 - ✓ Daily attendance of students should be taken for each classroom/group and capacity monitoring should be done through regular daily checks.
 - ✓ Teaching and non-teaching staff must keep **2 metres** between themselves (between staff) and between staff and students.
 - ✓ For Learning Support Educators to be able to provide the service required of them, they may need to work at close distance to the students they are supporting. However, the distance may vary as it depends on the needs of the individual student. The LSE should wear both a mask and a visor
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- ❖ Year 9 (Form 3) upwards where the whole age group would have been given the opportunity to be vaccinated and considering the positive uptake of the vaccine, maximum efforts should be made to maintain at a minimum a distance of **1 metre** in all directions between students whilst sitting in their chairs (except if desk is placed near a wall).
 - ❖ However, for children in Year 8 (Form 2) downwards where the majority of children are aged less than 12 years and for whom the COVID-19 vaccine is not yet licensed, maximum efforts should be made to maintain an adequate physical distance of **1.5 metres** between students in all directions whilst sitting in their chair (except if desk is placed near a wall).
 - ❖ In the childcare and the kinder settings, it is understood that children may be unable to maintain an adequate physical distance from others although this should be encouraged. The limitation of the size of the cohort is what determines the size of the bubble and the number of potential interactions the child may have.



Staff rooms

It is recommended that, if possible, staff attend the staff room at staggered times. They are to remove their mask only to eat/ drink. It is important that the cumulative time a staff member spends in the staff room in the presence of other persons is reduced to the barest minimum (ideally less than two hour per day), whilst always maintaining an adequate physical distance from others at all times. If a system of 'hot desking' is in operation, each person should be responsible to clean the surfaces and shared electronics with suitable agents before and after use. Meetings should be held virtually wherever possible.

Classroom 'bubbles'/Cohorting

- ✓ Where possible/feasible students and staff should remain within the same classroom/cluster/group whose composition remains constant
- ✓ Limit the mixing of children such as staggering playground times and keeping groups separate for special activities such as art, music and exercise
- ✓ School staff particularly those who directly engage with younger children/students such as Child carers, Kindergarten educators should avoid as much as possible to work in other childcare centres or institutions.
- ✓ Other teaching/ non-teaching staff performing essential functions in the School are permitted provided that mitigation measures are adhered to rigorously, a physical distance of 2 metres is maintained, masks are worn and the individual is only present for the duration of the required intervention which should at maximum be the duration of a lesson

❖ Childcare Centres:

- ✓ In order to allow for better distancing, the COVID-19 Maximum Child Capacity per Childcare centre is based on 6 square metres per child instead of the 5 square metres per child set in the National Standards for Childcare facilities (2006).



- ✓ The number of children allowed to attend shall be subject to the available space and the number of available carers in accordance with the carer to child ratio as established in the National Standards
- ✓ There should be a designated care system where the carer takes care of the same children over a period of time. Children and carers must remain within the same cluster/group which composition remains constant. This applies to both children and staff.
- ✓ The designated clusters/groups shall only stay in room/s intended for the care of the children.
- ✓ There should be no more than 6 supervised children per cluster/group⁵
- ✓ If possible, at nap time ensure that the children's naptime mats are spaced out as much as possible ideally 2 metres apart. Consider placing children head to toe in order to further reduce the potential for viral spread.

❖ Kindergarten

The size of the cohort in the kindergarten years should be based upon a calculation of a 1.5 metre distance between one child and another and a 2-metre distance from a kindergarten educator in relation to the particular room size. In any case maximum efforts should be made in order that the total number of children as established in the calculation of distances should be capped at 15 children in Kinder 1 and 19 children in Kinder 2.

Ventilation

Outdoor lessons and activities are encouraged since this allows for additional ventilation and also better distancing between students. Any viral particles are easily diluted in the air as opposed to when one is within an enclosed space where cross-ventilation using open apertures and ventilation systems becomes more important for circulation of the air.

⁵ National Standards for child daycare facilities.

<https://tfal.org.mt/en/professionals/PublishingImages/Pages/Tools/Standards%20Child%20Day%20Care%20Facilities.pdf>

In indoor settings, regular and adequate ventilation is essential to reduce the level of possible pathogens in the air. Doors and/ or windows should be kept open throughout the day to allow for cross ventilation. To improve ventilation, efforts should be made to keep windows open during lessons and also, at regular intervals such as mid-way through lessons, in-between lessons and during breaks prop windows even further open to force greater circulation of the air. If the ambient temperature is uncomfortable for the children during the winter months, they should be encouraged to wear more layers of clothing. If air-conditioning is to be used, this should be used in accordance with the guidelines issued by Public Health authorities⁶. Filters should always be cleaned well and maintained properly.

Masks

Masks must be worn in indoor public spaces in accordance with article 26 and 27 (c) of Public Health Act and the Mandatory Use of Medial or Cloth Masks Regulations and the Standards on Masks/Visors⁷. Evidence to date shows that wearing a mask is an effective means of preventing spread to others in conjunction with maintaining an adequate physical distance from others. In educational settings the use of masks for the Schools included in this Guidelines are outlined in the table below:

Childcare	✓ Students do not wear masks
Kindergarten	✓ Students wear masks in common areas & school transport, but mask <u>can</u> be removed when in the presence of children of the same bubble in class. ✓ Mask can be removed to eat and during physical exertion
Primary & Secondary School	✓ Students are required to wear face mask at all times including in class, in common areas and on school transport ✓ Mask can be removed to eat and during physical exertion
Staff	✓ Staff members are required to wear a face mask at all times

⁶ https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Guidance_Air-conditioning-and-ventilation-systems_23Jun20.pdf

⁷ (<https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Standards%20-%20Use%20of%20Face%20Masks%20and%20Visors%20.pdf>).



	<p>in common areas and on transport</p> <ul style="list-style-type: none">✓ Mask can be removed to eat and during physical exertion✓ Staff e.g. LSEs and child-carers who may have closer contact with students are advised to wear a mask + visor
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The Standards for Masks allow for specific medical and behavioural conditions for which there are certified exceptions to mask use. As yet, there is no evidence that face shields are effective as source control or protection from respiratory droplets as masks thus, we recommend that masks should be used in preference to visors (or in conjunction with them), while the use of visors alone is discouraged. However, in certain situations where a mask is not practical or cannot be tolerated (e.g. children with special needs, certain health issues) visors can be used as an alternative to masks.

Exceptions to the wearing of mask or visors is during physical activity and in specific medical and/or behavioral conditions in line with the Public Health guidance on the use of masks and visors⁸.

Considerations for Specific Activities in Schools

With an aim to allow Schools to operate as ‘normally’ as possible in view of the psychological impacts and disruption which students have faced during the Pandemic, certain activities which have previously not been permitted in view of a possible increased risk of contagion should be resumed with caution provided adequate mitigation of the activity.

⁸ https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Standards_Use_of_Face_Masks_And_Visors.pdf

Gatherings

Small, essential, occasional gatherings comprising students and members of the school community may take place ensuring that the bubble concept is maintained. They should take place preferably outdoors or else in large well-ventilated indoor areas. In view of structural differences in School layouts, management should consider the following factors - outdoors is preferred to indoors and the size of the space available needs to be considered relative to the students one would like to accommodate.

The students in the gathering should be seated according to their class bubble, still maintaining an adequate interpersonal distance and at least 2.5 metres from other bubbles. These gatherings should not last longer than 30 minutes. Orderly entrance/exit from the gathering is expected in order to avoid mixing between students. Examples of such gatherings could include mass or assemblies for example.

Sports Activities

It is important that children continue to partake in sports activities both during formal physical education lessons and also any other activities which may be organised during the School day. All sports/games activities carried out during school are to be guided by the guidelines regulating sports activities⁹. The use of gymnasiums is also permissible and relevant guidelines should be followed¹⁰. It is recommended that students engage in games and/or activities within the **same group in their cluster/class**. Masks should be worn before and after sports activity with adequate hand hygiene before handling one's mask.

When students are going to be using shared resources, these should be sanitised between each successive group of students. Equipment which cannot be cleaned/disinfected should not be used.

⁹ https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Obligatory_Conditions_And_Guidelines_For_The_Return_To_Sport_In_Malta.pdf

¹⁰ https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Obligatory_Conditions_And_Guidelines_For_Gymnasiums_And_Fitness_Centres.pdf



Music Lessons/Drama

Singing, music lessons involving wind instrument lessons and drama may present additional risks in view of the potential of aerosol generation. Additional measures should be adopted during these lessons such as preferably holding these lessons outdoors, increasing the physical distances between students.

Special Occasions

Although sharing food should not be permitted, occasions like birthdays or end of school celebrations could still be organized within the class bubble ensuring that food brought in is individually portioned e.g. cupcakes. Other mitigation measures remain applicable throughout.

Tuck Shops

These are permitted to operate as long as the students go to the tuck shop in an orderly fashion in their class bubble maintaining the mitigation measures as indicated and that the food is provided is individually packaged.

Outings

Educational outings and school fieldwork can and should take place in accordance with general guidance on cohorting, social distancing, masking and use of sanitization. Care should be taken to respect these principles even when planning transport to and from the venue. In deciding on the outing, one should assess the risks of the proposed outing, avoiding situations where there may be crowding and interaction with other persons including both other bubbles, or persons from the public.

School Transport

The following recommendations should be considered for school transport:

1. Increase the frequency of transport services
2. Keep journeys as short as possible
3. Retaining the same cohort/cluster of students on every journey. This is essential to allow for proper contact tracing



4. Keeping accurate records of all students on each trip including their seating positions
5. Keep vehicles well ventilated, keeping windows open and no air recirculation
6. Maintain safe physical distancing between students to decrease the number of occupants in the vehicle
7. All students and staff are to wear masks and/or visors at all times.
8. Availability of sanitizers in the vehicle
9. Proper cleaning of the vehicle between journeys
10. Parents of students to take temperature of their children in the morning before attending School. If there are signs of illness, the students should not go to school.

Public Health Action

The following measures comprise a set of Public Health policy decisions which are aimed at prioritising the early identification and management of COVID-19 cases in Schools with an aim to rapidly mitigate and outbreaks of infection which may result and minimise the disruption of teaching and learning.

A) Testing

Any person (student/staff) who has symptoms of COVID-19 should book a COVID-19 test <https://www.covidtest.gov.mt> or by calling 111. Medical Doctors have been provided with guidance on when to recommend a COVID-19 test for children with symptoms. The most reliable test currently available is the Reverse Transcription Polymerase Chain Reaction test (RT-PCR test) for SARS-CoV-2 the virus which causes COVID-19.

Besides the RT-PCR test, Rapid Antigen Tests (RATs) are now also available on the market and also provided within the public service by certified RAT providers¹¹. The available RAT tests are also applied by obtaining a nasopharyngeal swab test. Standards on the use of RATs¹² have been published and should be followed. Contact tracing within the schools will begin in those circumstances where a RAT test

¹¹ <https://legislation.mt/eli/ln/2021/49/eng/pdf>

¹² <https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Pages/rapid-antigen-testing.aspx>.



is considered confirmatory and/or in those instances where public health deems action is necessary.

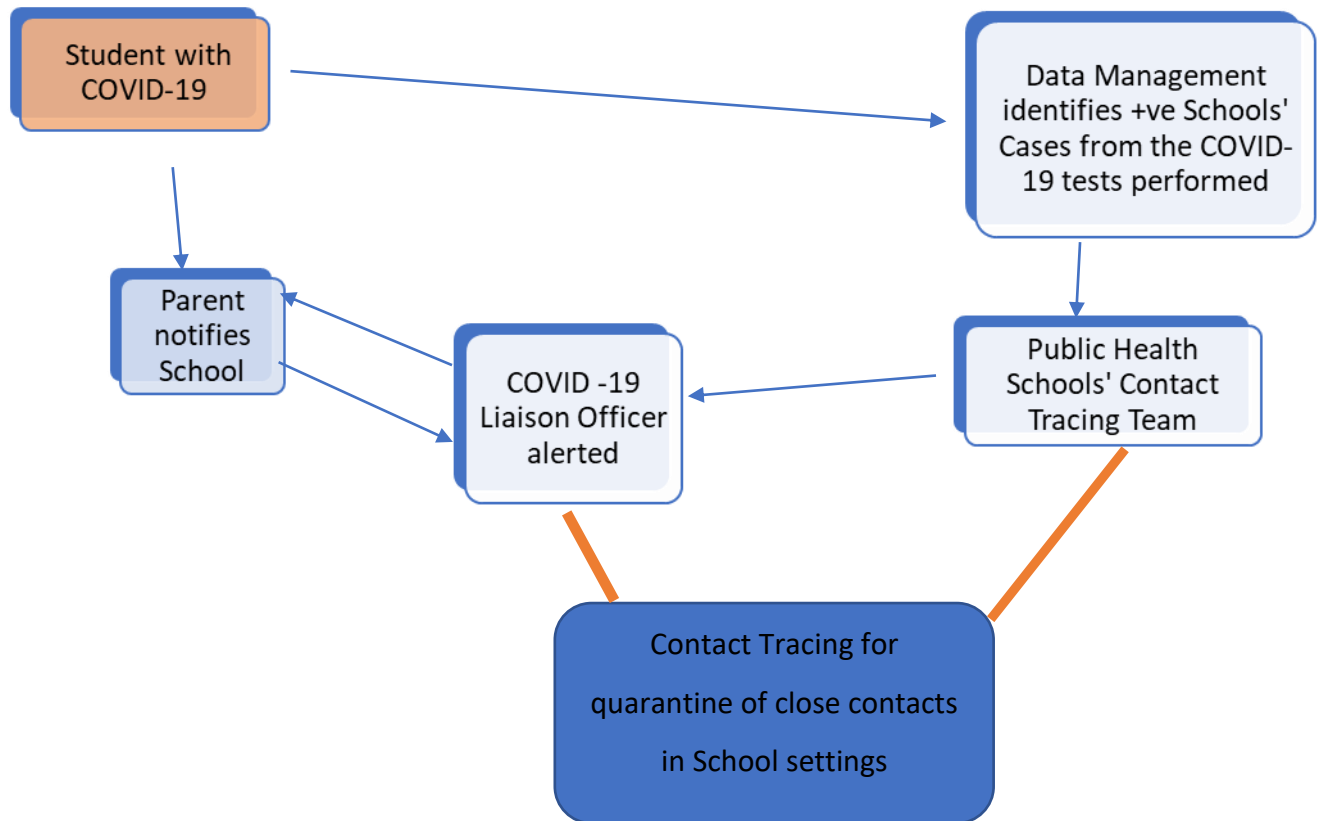
In instance where one is an asymptomatic close contact of a confirmed case, one may wish to be tested for COVID-19. The timing of such a test should be at least 2 days after the last exposure to the positive case. If exposure has taken place 8 or more days previously then an RT-PCR test is indicated. If at any point a person who may have been exposed to COVID-19 exhibits symptoms, then a COVID-19 test should be booked without delay.

B) Schools' Contact Tracing Team/ COVID-19 Liaison Officers in Schools

A joint team between Health and Education ministries has been established during the Pandemic with set policies and procedures to rapidly identify and take public health action within schools in the event of a positive case of COVID-19.

Concerted action of School Management to keep accurate records of all students as regards attendance, seating plans and contact details are imperative to the speed at which contact tracing can take place.

Each school needs to have COVID-19 Liaison Officer/s whose details need to be communicated to public health authorities. The roles and responsibilities of the COVID-19 Liaison Officer can be found in Annex C. The process by which a positive case is notified and contact tracing takes place is outlined in the figure below.



Contact Tracing protocols for persons (students/educators) who are identified as being in close contact of a positive case of COVID-19 are based upon an individualised risk assessment carried out by the Schools' Contact Tracing Team in accordance with specified protocols which are based on the ECDC criteria of exposure to COVID-19¹³. Public Health action may be taken in specific settings based upon the risk assessment carried out.

¹³ ECDC. (2021, July). *COVID-19 in children and the role of school settings in transmission-second update*. <https://www.ecdc.europa.eu/en/publications-data/children-and-school-settings-covid-19-transmission>



High-risk contacts or primary contacts who are quarantined and are also fully vaccinated would be able to be released from quarantine 'early' in accordance with the [Public Health Standards for Quarantine of Primary Contacts](#)¹⁴.

If a child is noticed to be sick whilst at school

- ✓ Plan to have an isolation room (such as office) within the school or area that can be used to isolate a sick child until the child is collected by the parent/guardian.
- ✓ Disinfect the rooms where the adult and/or child were sick.
- ✓ If a sick child has been isolated clean and disinfect surfaces in your isolation room or area after the sick child has gone home.
- ✓ If COVID-19 is confirmed in a child or staff member, the Centre will be contacted by Public Health and direction will be provided. Guidance on cleaning an area where one or more positive COVID-19 cases were identified can be found on [Cleaning of Non-Hospital Premises Settings after confirmed COVID-19 cases](#)¹⁵.

Shielding of Students

The need to shield children should be based on a discussion and in-depth assessment between the caring **hospital consultant paediatrician**, the child's parents and school management. As much as is possible, children who are deemed to require shielding should still be able to attend school physically and the benefit of attending school should be weighed with the need to keep children and young people with certain underlying conditions safe. Alternative arrangements and measures may be implemented by the school to allow the child to physically attend school. Moreover, this measure should not be used to

¹⁴ <https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/Standards%20for%20quarantine%20of%20vaccinated%20primary%20contacts.pdf>

¹⁵ <https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Cleaning%20and%20disinfection%20of%20non-hospital%20settings%20after%20confirmed%20COVID-19%20positive%20case.pdf>



increase truancy or absenteeism, particularly for the children who are most vulnerable (either for medical and/or social reasons).

Annex D contains an updated list of clinical conditions which are to be used to guide hospital consultant paediatricians for the assessment of children who may require shielding. The certificate does not divulge the illness or medical condition that the child is suffering from. Also, this protocol does not delve into the type or suitability of shielding as this needs to be determined between the caring physician, the parents and school. Hospital consultant paediatricians are to contact parents of children who may require shielding to determine whether a certificate should be issued. Parents who are in doubt or who have not been contacted by their hospital paediatrician, may consult their family doctor who in turn will advise the parents accordingly, in line with the list of conditions in Annex D.

Children living with household members who require shielding or are sick do not require shielding themselves and can/should attend school.

Shielding of Staff

The Legal Notice LN 111 of 2020 Protection of the Vulnerable was repealed on the 5th June 2020 and clinically vulnerable people are no longer required to stay at home. The principal measure to combat COVID-19 infection is ensuring that at the first available opportunity one takes the full course of an EMA approved COVID-19 vaccine which would have been made available to all students and staff in this setting. The vaccination roll out in Malta was such that medically vulnerable persons were prioritized for vaccination. Moreover, it has been announced that immunocompromised persons would be offered an additional dose of a COVID-19 vaccine starting in September 2021. In light of the above measures, there is no specific group of persons who warrant blanket shielding.

Possible additional measures for shielding of students in schools

- Minimise contact with other children and staff



- Maintain interpersonal distances of greater than 2m
- Choosing a seating plan which would decrease exposure of the child to other children and staff
- Student may be advised to wear an N95 type mask
- Use of physical barriers such as Perspex
- More frequent hand washing and sanitizing
- Enhanced cleaning
- Use of private transport

For information regarding the shielding of employees please refer to Guidance for Offices and Workspaces¹⁶

¹⁶ https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Guidance_For_Offices_And_Workspaces.pdf



Annex A: Cleaning

- ✓ In general, the infectivity of coronaviruses on inanimate surfaces (such as wood, metal, fabrics and plastic) decreases depending on the material and environmental conditions such as temperature, humidity and UV radiation. The cleaning of surfaces remains an important measure to ensure hygienic conditions.
- ✓ Premises and resources are to be cleaned daily using approved products. A combination of cleaning with soap and water and disinfection will be most effective in removing the COVID-19 virus. Both cleaning and disinfection is most effective, using a combination of household detergents and disinfectants. A detergent is designed to break up oil and grease with the use of water. Anything labelled as a detergent will work. Cleaning should start with the cleanest surface first, progressively moving towards the dirtiest surface. Change water regularly. When surfaces are cleaned, they should be left as dry as possible to reduce the risk of slips and falls, as well as spreading of viruses and bacteria through droplets. Disinfecting means using chemicals to kill germs on surfaces. It is important to clean before disinfecting because dirt and grime can reduce the ability of disinfectants to kill germs. Disinfectants containing $\geq 70\%$ alcohol, ammonium compounds, chlorine bleach or oxygen bleach are suitable for use on hard surfaces (surfaces where liquids pool, and do not soak in). The packaging or manufacturer's instructions will outline the correct way to use disinfectant. Disinfectants require time to be effective at killing viruses. If no time is specified, the disinfectant should be left for ten minutes before removing.
- ✓ Premises need to be cleaned thoroughly between one group/cluster of students and another.
- ✓ It is recommended that where possible soft flooring should be wiped down by detergents and washed properly at the end of each day.
- ✓ Attention to use approved products which are suitable for children <3years of age according to one's educational setting.
- ✓ Toilets must be cleaned regularly, at least three times a day. Toilet seats, fittings, wash basins and floors must be cleaned. In case of contamination with faeces, blood or vomit, disinfectant wipes should be used after removal of the contamination with a disposable cloth soaked in disinfectant.



- ✓ Protective gloves and mouth and nose protection must be worn by members of staff.
- ✓ A log detailing the time when the toilet facility has been cleaned and by whom should be filled in for each toilet facility. The use of disposable towelling in toilets is encouraged.
- ✓ The following areas should be cleaned particularly thoroughly and, if possible, several times a day in heavily frequented areas:
 - Door handles and any other handles on drawers, windows, etc.
 - Stairs and handrails,
 - Light switches,
 - Tables, phones,
 - and all other grip areas.

Childcare:

- ✓ Linen must be changed daily. The use of disposable towelling is encouraged.
- ✓ Use bedding (sheets, pillows, blankets, sleeping bags) that can be washed. Keep each child's bedding separate, and consider storing in individually labelled bins, cubbies, or bags. Cots and mats should be labelled for each child. Bedding that touches a child's skin should be cleaned at least weekly and certainly before use by another child.
- ✓ Common resources used by children require to be sanitised between one use and another and at the beginning and at the end of the day.
- ✓ Personal sanitising products for children are to be supplied by parents/guardians and are to be kept at the centre.
- ✓ Toys and other items need to be cleaned and sanitized regularly and certainly before another cluster/group uses these toys and items.
- ✓ Due to its heavy use as a play and exercise area for children, floor cleaning should be carried out more regularly and frequently throughout the day, and as necessary and as required in the case of spillages. Soft flooring should be wiped down by detergents in between use of different groups and washed properly at the end of each day.



- ✓ All areas to be cleaned will be checked by assigned personnel and will be documented and signed by means of a check list.

Guidance related to the cleaning measures to be undertaken after having one of more confirmed COVID-19 cases within the premises can be found on the public health website ¹⁷.

¹⁷ <https://deputyprimeminister.gov.mt/en/health-promotion/covid-19/Documents/mitigation-conditions-and-guidances/Cleaning%20and%20disinfection%20of%20non-hospital%20settings%20after%20confirmed%20COVID-19%20positive%20case.pdf>



Annex B: Procedure for Changing nappies in younger children and students with disability

When changing the nappy of a student, the staff member must start by washing/ sanitising his/her hands together with those of the student. Disposable gloves must also be worn during this time. Follow safe diaper changing procedures and these should be illustrated using a procedures poster in all diaper changing areas.

Steps should include:

- Preparation (includes putting on gloves, mask **and** visor)
- Cleaning of the student
- Removal and discarding of trash (soiled diaper and wipes)
- Replacing of a clean diaper
- Washing of student's hands
- Cleaning up and disinfection of the changing station
- Washing of hands

After changing nappies, the playworker/carer must wash his/her hands again (even if gloves were used) and the nappy changing area should be disinfected with a fragrance-free bleach as a sanitizing or disinfecting solution. If other products are used for sanitizing or disinfecting, they should also be fragrance-free. If the surface is dirty, it should be cleaned with detergent or soap and water prior to disinfection. Despite nappy changing being an activity where there is inherent contact, wearing appropriate PPEs would decrease one's risk of being identified as a high-risk contact.

Feeding, or Holding a Student with Disabilities

- Staff should wash their hands, neck, and anywhere touched by a student's secretions.



- Staff should change the student's clothes if these are soiled. They should replace their own overshirt or clothing, if there are secretions on it, and wash their hands again.
- Parents are to send a change or two of clothes every day.
- Contaminated clothes should be placed in a plastic bag.



Annex C: COVID-19 Liaison Officer in Schools

One or more COVID-19 Contact Person should be designated in each School. The Ministry for Education, the Independent Schools Association and the Church Schools will collect a list of these persons and their contact details for their respective schools for onward transmission to the Public Health authorities.

The role of this COVID-19 Contact Person would be to:

- ✓ Familiarise oneself with this guidance document and ensure this is implemented within the School;
- ✓ Organise the training of staff in COVID related mitigation measures
- ✓ Act as a contact point for staff, students and parents who may have queries with respect to the COVID mitigation measures implemented within the School;
- ✓ Ensure that when children are unwell, they are appropriately isolated as per mitigation plan and arrangements are made for collection by parent/guardian;
- ✓ In conjunction with the Education and Public Health authorities, collaborate on the development of an 'Early Warning System' which aims to look at trends in sick leave amongst staff and absenteeism amongst students to be able to predict or detect potential clusters of cases
- ✓ Serve as the designated person for liaison with Public Health authorities ensuring that one has access to the attendance records of the students, staff and contact details as required in the event of a positive case within the school.



Annex D: Paediatric conditions that may necessitate shielding September 2021¹⁸

The following are paediatric conditions for which children may be asked to shield. Advice to shield depends mainly on community transmission of SARS-CoV-2 and public health advice on when extremely vulnerable or less vulnerable people should shield. Degree of vulnerability is not the same for all conditions listed below, is also dependent on the severity of the condition and will be determined by the caring consultant.

Advice for shielding is also affected by:

- a) The Covid-19 vaccination status of the child
- b) the complexity of the underlying condition,
- c) guidance given by the caring hospital consultant,
- d) age of the child, and the mental capacity of the child with respect to the ability to perform hand hygiene, respect social distancing and put on and take off a face mask safely and
- e) the capacities of schools to provide help with shielding of vulnerable children: schools need to be well prepared for this and work to provide inclusive education to all children irrespective of any underlying condition the child might have. There should be no form of discrimination against children who suffer from a condition that makes them vulnerable.

Conditions that may put children more at risk* to COVID-19 are as follows:

****Not all children with these conditions have the same risk to COVID-19 and the need for shielding may vary depending on the epidemiology of SARS-CoV-2.***

¹⁸ Based on Covid-19 –shielding guidance for children and young people. RCPCH: 22nd September 2020



Immunodeficiency disorders

- Severe combined immunodeficiency, combined immunodeficiency which is severe or who have concurrent co-morbidity, HLH on active treatment, primary immunodeficiency disorders who need a transplant (up till 6 months post-transplant and as certified by their hospital consultant, children post bone marrow transplant with significant graft versus host disease on immunosuppressants, children being prepared for or after a solid organ or stem cell transplant as determined by their hospital consultant and children with Autoimmune polyendocrinopathy-candidiasis-ectodermal dystrophy (APECED). Concurrent co-morbidity means significant lung disease, renal impairment or chronic liver disease.
- HIV infection AND with a CD4 count less than 200 or had an opportunistic infection within the last 6 months or have detectable viral load or are not on any antiretroviral treatment.

Oncology

- Are on induction chemotherapy for Acute Lymphoblastic Leukaemia (ALL) or Non-Hodgkin's lymphoma or are on chemotherapy for Acute Myeloid Leukaemia (AML) or for relapsed and/or refractory leukaemia or lymphoma.
- Are post autograft transplant in the last 6 months or post allogeneic transplant within the last 12 months or until immune reconstituted.
- Are on CAR-T therapy or within 6 months from administration or until immune system has recovered.
- Are on chemotherapy for any cancer diagnosis or within 6 months of its completion or are on long term maintenance steroids.
- Have completed treatment for cancer but have ongoing significant respiratory, cardiac, renal or neurological conditions.

The majority of children in the following categories DO NOT need shielding but some may be asked to do so only if determined by their hospital consultant on a case-by-case basis.

Cardiology

- Fontan, single ventricle physiology, especially with evidence of failure, and or end organ damage.
- Persistent cyanosis (oxygen saturations <85% persistently)
- Pulmonary Arterial Hypertension (PAH) especially those on pulmonary vasodilator therapy.
- Severe and or symptomatic heart failure, particularly those on heart failure therapy.

Haematology

- Sickle cell disease with additional co-morbidities or with a history of at least one chest crises needing intensive care treatment or at least two chest crises necessitating treatment in the previous 12 months.
- Thalassaemia or other inherited or congenital anaemia with severe iron overload and additional co-morbidity.
- Asplenia or functional asplenism only if have other co-morbidities.

Neonatal

- Ex-premature infants with continuing oxygen and/or intermittent non-invasive ventilation requirements.
- Any infant who is eligible for palivizumab.

Neurology

- Patients with significant difficulty with swallowing (e.g. myotonic dystrophy patients).
- Patients at significant risk of decompensation during infection (e.g. mitochondrial disease).
- Patients with symptomatic heart failure, particularly those on heart failure therapy (e.g. Duchenne muscular dystrophy).
- Patients with myasthenic syndromes.



Gastroenterology, Hepatology & Nutrition

- Paediatric inflammatory bowel disease (IBD) patients with ANY of the following:
 - Whilst on intravenous or oral steroids $\geq 20\text{mg}$ prednisolone (or $>0.5\text{mg/kg}$) or equivalent per day.
 - Have started biologic therapy plus immunomodulatory or systemic steroids within previous six weeks.
 - Have moderate to severely active disease not controlled by moderate risk treatments who may require an increase in treatment.
- Intestinal failure patients requiring Home Parenteral Nutrition (HPN) with any of the following:
 - Primary immunodeficiency or immunodeficiency induced by drugs as part of their therapy.
 - Other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
- Liver disease with any of the following:
 - Decompensated liver disease.
 - Receiving post-transplant immunosuppression or on liver/small intestine/multi-viscera; transplant waiting list.
 - Other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
 - Active or frequently relapsing autoimmune liver disease where an increase in treatment is likely needed.

Renal

- Renal transplant especially if in the last 3 months.
- On a high level of immunosuppressive medication for active disease undergoing induction treatment: those who are currently receiving or completed treatment within 6 weeks of high dose steroids of 20 mg/day or above (or $30\text{ mg/m}^2\text{ /day}$) AND cyclophosphamide or rituximab or other immunosuppressants.



Respiratory

- Have significant impairment in ability to cough and to clear airway secretions: including children with severe neurological diseases such as severe cerebral palsy, neuromuscular disabilities, severe motor impairment and severe metabolic disease.
- Require a cough assist device to help with clearance of airway secretions.
- Life-dependent on long term ventilation, both invasive (via tracheostomy) and non-invasive (CPAP and BiPAP).
- Severe lung disease requiring continuous or overnight supplementary home oxygen and/or intermittent non-invasive ventilation.
- Children with:
 - Cystic fibrosis and Primary ciliary dyskinesia.
 - Severe bronchiectasis.
 - Severe restrictive lung disease such as interstitial lung disease or obliterative bronchiolitis.
 - Severe asthma: children treated with biological agents or maintenance oral steroids.
 - Children with repaired congenital thoracic abnormalities such as congenital diaphragmatic hernia / trachea-oesophageal fistula only if significant airway or lung problem.

Down syndrome

Children with Down syndrome do not require shielding except if they have a co-morbid condition that falls in any of the criteria described above and as determined by their hospital consultant