

EDITORIAL

Schools closed due to COVID-19 pandemic can be reopened early and safely

Opinions differ about whether school closures are a good way to control the spread of the COVID-19 pandemic, as the negative social consequences may outweigh the potential health benefits. The human toll of disrupted education and decreased literacy may persist for a long time and disproportionately harm the most marginalised students.¹ On the other hand, the shift to distance learning, particularly for high school students, has been shown to decrease the spread of COVID-19 to teaching staff or family members, who have close contacts with students.² We can expect future closures based on safety concerns due to the conflicting data regarding the role of virus transmission in schools.³ If periods of distance learning cannot be avoided, the adverse effects can be reduced by early reopening. An Israeli study by Shapiro et al in this issue of Acta suggests that reopening can be safe and efficient as long as hygiene and social distancing routines are in place.⁴

The authors examined the transmission of COVID-19 after schools reopened by examining data from 2.7 million individuals who belonged to one of the not-for-profit organisations providing universal health coverage. The total number of children under the age of 18 years was 762,707. The authors were able to identify all children with a positive polymerase chain reaction (PCR) tests and the test results for their household members. In addition to the PCR data, a comprehensive demographic and health profile was available for this paediatric population.

The total number of children who were PCR positive during the 4 months study period was 1032, and 41.9% of these were asymptomatic. A more severe course, which required hospital admission, was seen in 24 children (2.3%), and their median age was 13 years. Contact with a confirmed COVID-19 case was regarded as the most likely source of infection. In 76.9% of cases, this contact was with a family member, in 11.8% of cases, the exposure took place in their school, and in 8.4% of cases, the source was unknown. The number of COVID-19 cases in children did not increase significantly after school reopening, and these results were in agreement with a similar, but larger nationwide study from Israel.⁵ The number of positive samples before school opening compared to 27 days after school opening was 1.0 vs. 1.7% in children aged 10–19 years and 0.8 vs. 1.0% in children aged 0–9 years a non-significant increase. There was, however, an increase in confirmed cases in adults and predominantly in the 40–59 age group from 0.3 to 1.6% RR, rate ratio 4.72 5.

The authors attributed this increase in adult COVID-19 cases to either transmission from asymptomatic children and adolescents or

to the simultaneous easing of social distancing rules that occurred at the same time.

The positive outcome reported in the Shapiro et al study about the safety of rapid school opening is encouraging and well documented. However, it does come with a caveat. Back to school does not mean back to business as usual. All education facilities that opened in Israel had to comply with strict hygiene and social distancing regulations. These included learning in small groups of maximal 15 students, submissions of daily health statements and mandatory facemask use from fourth grade (10 years of age) and above. If schools were opened without similar precautions, the results could be quite different.

CONFLICT OF INTEREST

There are no competing interests.

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