

Schools and COVID-19 in Aotearoa New Zealand: Keeping schools open as safely as possible

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24 January 2022

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Key points

- The surge of the Omicron variant overseas is causing significant disruption to healthcare and schooling. Comprehensive planning for children in the event of an Omicron outbreak is required.
- Child-centred policy decisions should aim to protect children from both the direct and indirect harms of COVID-19 and the pandemic.
- COVID-19 is a less severe illness among children than in older age-groups.
- Aotearoa New Zealand has a highly vaccinated adult population with all school-aged children now eligible for the vaccine, providing direct protection to COVID-19.
- Policy decisions that protect children from the indirect harms of the pandemic should also be prioritised.
- Schools are not a major driver of transmission when other higher risk contexts remain open.
- School closures cause significant indirect harm to children, including widening educational inequities, poorer mental health, behavioural difficulties, social isolation, family stress, family violence, and food insecurity.
- Māori and Pacific children and children from low socioeconomic backgrounds are disproportionately negatively impacted by school closures.
- Indirect harms from school closures may have life-long impacts through toxic stress on the developing brain and educational inequities.
- Test-to-stay and surveillance strategies using rapid antigen testing may be constrained by supply and come with operational challenges but still warrant consideration as sound public health policies.
- Despite efforts, a massive COVID-19 outbreak, such as with the Omicron variant, may lead to unavoidable school closures, due to significant school-based outbreaks, critical numbers of staff falling ill, or local lockdowns.

Recommendations

- Closing schools in order to reduce overall community transmission should not occur if other higher-risk contexts in society remain open. Closing schools should be a last resort, and enacted only as part of a localised lockdown.
- An equitable, rapid vaccine rollout for 5- to 11-year old children is necessary to uphold Te Tiriti o Waitangi.
- Urgently optimising COVID-19 mitigations such as ventilation and mask-wearing in schools as part of a multi-layered approach in light of the Omicron variant, and ahead of winter 2022.
- Work to improve ventilation within schools should be adequately resourced so changes are timely and equitable.
- Mandatory mask-wearing for staff and students in Year 4 and upwards should continue when schools return.
- To avoid inconsistencies in school closures between schools, guidance produced by the Ministry of Education could advise on thresholds for safe staffing.
- In the event of unavoidable school closures, we advocate for preserving access to school for regular outdoor learning sessions and activities (e.g. twice weekly physical education sessions, small group learning sessions, games). Opportunities for interacting with friends and teachers will maintain relationships and connection to school and come with so many benefits for children at very low risk.

- Public communication directed to parents, including the discussion of indirect harms to children from lack of access to schooling, would support parents to make informed decisions on school attendance/return.

Introduction

The COVID-19 Omicron (B.1.1.529) variant situation is rapidly evolving with daily case numbers surging overseas; a function of the new variant's increased transmissibility and potential to evade immunity from previous infection and vaccination (1). The explosion of COVID-19 cases is causing serious disruption to essential services and schooling in many jurisdictions (2). It is imminent that Omicron will breach MIQ and spread rapidly throughout Aotearoa New Zealand. When this happens, it is likely that there will be calls to close schools. **What would this mean for children and young people? What sorts of policy decisions are optimal for them?**

Much of the public health commentary thus far has focused on protection from COVID-19 infection, that is, on reducing the direct harms of COVID-19. But in children, this commentary needs to be balanced by inclusion of protection from significant indirect harms.

Direct harms refer to COVID-19 illness among children and their whānau. Indirect harms include, but are not limited to, bouts of isolation and quarantine, school closures, family stress, and household financial strain. Children can experience or be exposed to family violence, abuse and neglect, food insecurity, and overcrowding.

From a child-centred perspective, the stated goal of policy decisions should be to protect children from both the direct and indirect harms of COVID-19 and the pandemic.

Direct harms of COVID-19 infection in children

In terms of direct harms from COVID-19 infection, children experience less severe illness from COVID-19 compared to older age groups. The majority of children who are infected with COVID-19 experience a mild or asymptomatic illness (3). In rare cases, serious illness requiring hospitalisation and complications such as multi-inflammatory syndrome in children (MIS-C) and persisting symptoms (long COVID) can occur and these constitute good reasons for all children to be vaccinated to protect against COVID-19 (3). Children with certain pre-existing conditions are at increased risk of severe illness. Though infrequent, severe illness and hospitalisation from COVID-19 are expected to be inequitably distributed with worse outcomes for tamariki Māori and Pacific children, as is seen for other illnesses in Aotearoa New Zealand (4–6).

Emerging observational data and paediatric clinical experience suggests that infection with the Omicron variant is less severe and conveys a lower risk of hospitalisation compared to the Delta variant, including among the paediatric population (7–9). A significant proportion of paediatric hospital admissions are due to incidental COVID-19 infection rather than COVID-19 illness per se, or due to social admissions when parents or caregivers are too ill to look after their children.(10)

However, massive community transmission is likely to put pressure on healthcare systems due to large numbers of cases, even if the proportion of children needing hospital care is very low. Caution in applying lessons from overseas data directly to the New Zealand population is needed, because the success of the elimination strategy and MIQ controls so far has meant New Zealand children are relatively immunologically naive against COVID-19 compared to their overseas peers, potentially biasing estimates of severity.

Emerging evidence suggests that a small proportion of children can also experience persistent symptoms, such as cough, headache, fatigue, and concentration difficulties, following COVID-19 infection - commonly referred to as long COVID (11). Emerging evidence suggests long COVID symptoms are consistently less common among children than adults, but it is uncertain what

proportion of children experience long COVID symptoms following an infection (11,12). The majority of studies find that persisting symptoms in children resolve by 8 to 12 weeks (11). Further research is required as the small evidence base on long-COVID symptoms in children is limited by a large number of studies containing significant methodological flaws (11).

Vaccination protects children and their families from COVID-19

At the time of writing, 93% of eligible persons in Aotearoa New Zealand have received two vaccination doses to protect against COVID-19 and over 700,000 booster doses have been administered (13). Inequities persist with 83% of eligible Māori having received two doses (13). Overall vaccine coverage of the 12- to 19-year age group is high and still climbing, having reached 90% for two vaccine doses and 95% for single doses but with slower uptake for Māori (13).

The 5- to 11-year paediatric vaccine rollout which commenced on January 17th is a turning point in the pandemic for school-aged children. Vaccination with the Pfizer mRNA vaccine offers protection for children from COVID-19, mitigating direct health impacts of the virus. The Pfizer vaccine has an excellent side effect profile, serious adverse events are rarely reported, and the risk of myocarditis following vaccination is extremely low (14).

Vaccine efficacy against symptomatic infection in 5- to 11-year-olds was estimated to be 91% in the Pfizer clinical trial after two doses. In adolescents, two doses are 91% effective against MIS-C, 94% effective against hospitalisation, and 98% effective against ICU admission (15). A single dose of the Pfizer vaccine can also provide excellent protection against hospitalisation in the short term, estimated at 85% among 16- to 17-year-olds (15), and also against MIS-C (16).

There is no available data yet as to the extent that two Pfizer doses protects children from severe illness or hospitalisation after Omicron infection, however among adults, two Pfizer doses still offers a high degree of protection against hospitalisation (15). It is also not known whether vaccination protects against long COVID in children, but the incidence of persisting symptoms following infection with the Omicron variant is also unknown.

The Pfizer vaccine has a very safe side effect profile for children. Between 3rd November to 19th December 2021, over 8.7 million paediatric doses of the Pfizer vaccine were administered to 5- to 11-year old children in the United States (14). Serious adverse events were very rare with a lower rate of myocarditis observed compared to older age groups (14). Wide experience now with adolescents and adults adds weight to this excellent long term safety information.

It is essential that the paediatric vaccine rollout is rapid and equitable to uphold Te Tiriti o Waitangi, learning from the inequitable vaccine rollout in adults, and using school sites where possible to increase equity of access for tamariki and their whānau (6).

Booster doses for adults aged 18-years and older also indirectly protect children. Children suffer immensely when parents, caregivers, and whānau members fall ill, are hospitalised, or die from COVID-19 (17). An equitable and rapid rollout of booster doses is an urgent priority, alongside continuing to close equity gaps in first and second doses for Māori.

[A call to protect children from indirect pandemic harms](#)

Aotearoa New Zealand has a highly vaccinated adult population with primary and intermediate school-aged children now also eligible for the vaccine, providing them with direct protection to COVID-19. This is on the background of children having a lower risk of severe disease than older age groups. In light of this, **we call for policy decisions that also protect children from the indirect harms of the pandemic.** Policy decisions should uphold the holistic needs of children who are largely voiceless in society.

Definitions: Open Schools and Closed Schools

A key pillar in preventing indirect harms to children in the pandemic is to keep schools open for in-person learning as much as possible. In this piece, we use the term “school closure” to refer to school sites being closed for in-person learning. Online or remote learning may be occurring, or there may be a hybrid model where some in-person learning occurs for a small number of students.

Schools are essential services

Schools are essential services for children. Alongside formal education, schools are where children make friends, play, exercise and move, and access books, stimulating resources, resource teachers and in some cases health services. Schools are a key component of the social safety net for children and their whānau, providing school meals, identifying children at risk of abuse and neglect, and providing wraparound social and psychological support.

Over 2020, school closures were part of COVID-19 mitigations in all Organisation for Economic Co-operation and Development (OECD) countries, in an effort to reduce community transmission of SARS-CoV-2 (18). Within Aotearoa New Zealand’s elimination strategy, stringent lockdowns, including school closures, were used to effectively stamp out community transmission, resulting in schools reopening fully and for long periods when COVID-19 community cases were zero or low. Aotearoa New Zealand topped the OECD for the number of days that schools were fully open over the first eighteen months of the pandemic (18).

In a post-elimination context, school closures are a last resort for controlling community transmission

In a post-elimination context, prolonged school closures are not an optimal, evidence-based, or sustainable strategy for children. A recent systematic review of observational studies including data from 150 countries was inconclusive as to the impact of school closures and school reopenings on SARS-CoV-2 community transmission (19). Another recent systematic review and meta-analysis concluded that secondary attack rates were markedly lower in schools than in households, with the incidence of school infections rising and falling as a reflection of overall community infections (20). While these studies were completed before the rise of the Omicron variant, it seems reasonable to expect that similar patterns will hold, even though the Omicron variant is much more transmissible.

We contend that schools are not the major drivers of community transmission in society when compared to other workplaces and other sites of community interaction (churches, sports fixtures, gyms, restaurants and bars), perhaps due to multi-layered mitigations to prevent COVID-19 transmission in schools (21).

In light of this evidence, closing schools in order to reduce overall community transmission should not occur if other higher-risk contexts in society remain open. Closing schools should be a last resort, and enacted only as part of a localised lockdown.

Educational harms from prolonged school closures

There is strong evidence that prolonged school closures cause educational harm due to lost learning. Concerningly, school closures and remote learning exacerbate existing educational inequities (18). Reports based on standardised educational assessments in England found that, at the primary school level, for instance, learning losses represented up to 2.2 months in reading and 4.5 months in maths for disadvantaged students by the first half of the autumn 2020 school term (18). Catch-up learning happens after schools reopen, but students from disadvantaged backgrounds can continue to lag behind their advantaged peers (18).

In Aotearoa New Zealand, Māori and Pacific children experience significant educational disadvantages. Educational inequities have persisted for generations of Māori and Pacific students. Because of this Māori and Pacific students are most negatively impacted from school closures, and have the most to gain from schools remaining open for in-person learning (22,23). Māori and Pacific communities are fully aware that the education system produces differential outcomes for their children. To achieve high attendance for Maori and Pacific in this context

specific messaging will be required. This should be culturally specific and delivered by Māori and Pacific people who understand the barriers their communities face (24).

Emotional and social harms from prolonged school closures

Prolonged school closures and lockdowns can be a significant strain on children's emotional and mental health. While many children demonstrate resilience in the face of widespread restrictions, a substantial proportion of children experience poorer mental health, increasing behavioural concerns, lack of access to friends, play opportunities, and stimulating resources (25). Social isolation, economic insecurity, financial stress and parents having divided attention at home, contribute to increased family stress, family violence, worsened parental mental health, and food insecurity (26). Children from disadvantaged families are disproportionately negatively impacted (25).

These findings are echoed in New Zealand surveys completed at the time of the first nationwide lockdown. One-in-ten participants in a New Zealand survey completed in April 2020 during lockdown reported having directly experienced some form of family harm during lockdown, including sexual assault, physical assault, harassment and threatening behaviour (27). These are likely to be underestimates of true incidence due to lower response rates from vulnerable communities.

A survey of the Growing Up in New Zealand child cohort completed in May 2020 during Alert Levels 2 and 3 by 10- and 11-year-old children found that children who reported household financial worries and children with two or more wellbeing and developmental difficulties when they were 8 years old, were more likely to have higher depression and anxiety scores during the lockdown (28). Children who were learning from home at the time of the survey were more likely to report poorer health compared to children of essential workers who had returned to school (28).

Children with neurodevelopmental and behavioural difficulties are at increased risk of abuse and neglect, particularly within challenging family contexts due to increased family stress and reduced access to disability and educational supports, social workers, therapists, and respite.

The impact of toxic stress upon the developing brain

Children living in stressful family environments rely upon access to safe, nurturing adults in the wider whānau and community, and safe and stimulating contexts outside of the home such as school, early education, and play opportunities, to maintain resilience. Exposure to prolonged, highly stressful experiences in childhood - that is, toxic stress - can lead to permanent changes in the architecture of the developing brain and stress-hormone systems with life-long impacts on health, development, cognition, and learning (29,30). These impacts are harder to quantify than case counts and hospitalisations but are very real. Calls for school closures driven by concerns regarding possible long-term effects of COVID-19 infection need to be weighed against the known life-long harms to children resulting from school closures.

Social support for children and families

Some of these harms can be mitigated by social support for children and their families in the event of isolation due to illness, school closures, or local lockdowns. Community health providers and other community-based organisations provide support to families in the form of food parcels, essential items, and home-based healthcare. Priority funding should allow these organisations to rapidly upscale their activities in the event of an Omicron surge, particularly for Māori, Pacific and low socioeconomic communities. Supplying households with adequate income also enables compliance with restrictions to increase and may reduce toxic family stress (31).

Mitigations to prevent COVID-19 transmission in schools

While the incidence of COVID-19 within schools generally reflects the level of COVID-19 in the surrounding community, COVID-19 mitigations in schools are effective in reducing COVID-19 transmission (32,33). When prevention strategies are consistently and correctly used, the risk of SARS-CoV-2 transmission in the school environment is decreased (32,34).

It is vital to consider the needs of students attending special schools. Mitigations are a crucial component of protecting special school students. Special schools need a more intensive response to protect their higher risk students and would benefit from dedicated plans and a higher level of Ministry and public health support. The recommendations that we make below are most applicable to mainstream schools.

Continuing a multi-layered approach to mitigations

Improving ventilation, using well-fitted masks, physical distancing where possible, good hygiene, and the avoidance of high-risk activities such as singing indoors, are all known to reduce COVID-19 transmission within schools, particularly when these preventative measures are layered up (21,32–34).

These measures need to be urgently optimised to account for the higher transmissibility of the Omicron variant and in anticipation of winter. It is also vital that we consider the health and wellbeing of children with pre-existing conditions who are at higher risk within schools.

Although mitigations may not prevent all instances of transmission, these may prevent a proportion of class outbreaks and wider school closures. Each day of in-person school time counts.

Vaccination of teachers and students is a key layer of protection. Mandates for school staff to have received two vaccine doses are in place, and we recommend careful consideration as to whether mandates are extended to include booster doses as well, which will protect both staff and students alike.

Enabling best practice

Schools, particularly in the Auckland region, are already experienced in implementing a suite of evidence-based mitigations to prevent transmission. However, optimisation of these mitigations could be enhanced by the Ministry of Education review of school mitigation plans with the Ministry providing support and tailored recommendations to enable best practice, acknowledging the uniqueness of each school's built environment.

Ventilation strategy

Ventilation is a crucial layer of the multi-layered approach in light of SARS-CoV-2 airborne transmission (35,36). Ventilation works in the background to protect every person in a space without the need for alteration in behaviour, making it an ideal mitigation strategy. New Zealand is currently well positioned to maximise natural ventilation and outdoor learning during the summer months. Plans are currently underway to support schools to identify areas of need within the school environment through the use of CO₂ monitors and other tools, and to implement strategies and solutions to optimise ventilation. **Adequate resourcing for Ministry of Education property and ventilation teams and schools in this endeavour is essential**, to ensure that schools are well-supported to progress this work in a timely fashion.

Where adequate natural ventilation is not possible and/or for high risk spaces such as staff rooms and nurse offices, in some overseas jurisdictions (for instance Germany, USA, Australia) portable HEPA air cleaners for air filtration are installed in schools as an additional layer of protection (37,38). The provision of any portable HEPA air cleaners needs to uphold health equity, ensuring that schools in higher risk communities are adequately resourced.

Making these investments will benefit children's health over the long term through preventing health harms from other common respiratory viruses such as influenza and RSV.

Masks

Wearing a face mask to protect others from potentially infectious aerosols and droplets, called source control, has been shown to be a highly effective infection control strategy to limit the spread of COVID-19. **An urgent review of optimal masking strategies in schools needs to be**

undertaken. The efficacy of masks is a function of the quality and fit of the mask, and user mask behaviour. Inconsistent mask use may have contributed to school-based outbreaks (39,40).

We recommend that masks continue to be mandatory for staff and for students in Year 4 and upwards, and recommended for students in lower year levels when schools return. This cut-point reflects the desire to balance the prevention of COVID-19 transmission against the developmental needs of young children, especially the large numbers of children with speech, language, and hearing difficulties. Lowering the age for mandatory masking can be considered in light of changing circumstances, with consideration for children with developmental and sensory difficulties. Where schools are able to create a strong mask-wearing culture, overseas experience shows that it is possible for even young students to comply.

Teachers specifically need to be provided as much individual protection as pragmatically possible, especially as they are a critical workforce to maintain the safe and effective running of the school. Decisions regarding optimal masks for the teacher workforce are best made by infection control expert groups. However, in principle we see that in an Omicron outbreak, teachers may be exposed more frequently to COVID-19 compared to other professionals in the workplace due to the fact that teachers interact with large numbers of students, and vaccines will not be mandated in order for students to access school. In light of this, we would advocate for strong mask protections for teachers.

Test, trace and isolate

Aotearoa New Zealand has so far employed a successful test, trace and isolate strategy, including as a COVID-19 prevention strategy within schools. However, overseas experience has shown that the exponential growth of Omicron outbreaks rapidly outpaces testing capacity and overwhelms contact tracing systems.

It is very likely that in the event of an Omicron outbreak in Aotearoa NZ that our testing and contact tracing systems would come under similar pressure. Rapid antigen testing could be used, as overseas, but may also suffer from similar supply constraints. Access to COVID-19 testing resources may need to be prioritised for healthcare settings treating higher risk individuals. This may necessitate a shift to using symptom-based diagnostic criteria in schools.

We recommend that symptom-based diagnostic criteria for COVID-19 infection are established in advance for children, with consideration of individual stand-down periods that balance the need to limit COVID-19 transmission with the need to prevent undue excess loss of learning time in the context of diagnostic uncertainty.

Cohorting

Cohorting has been a pragmatic solution to limit the number of exposed individuals being stood down following an incursion within a school setting and preventing whole school closures. We recommend continuing with cohorting. However, in the event of a massive COVID-19 outbreak, cohorting may not be practicable, as cohorts may need to be altered due to teacher illness or isolation, and in this situation a flexible approach will be needed.

Surveillance testing and rapid antigen testing strategies

Many overseas jurisdictions are using PCR or rapid antigen testing (RAT) in novel ways to maximise in-person schooling while at the same time reducing transmission of COVID-19 in schools by removing sources of infection as early as possible (41). Two main strategies are being implemented overseas with some success at present.

The first strategy is described as Surveillance Testing in which teachers and students are regularly tested at home or school regardless of symptoms to identify potential infections as early as possible, usually with the use of RAT. School students and staff in Denmark, for instance, are required to test weekly, and in high-spread areas, surveillance testing is twice-weekly (41).

The second strategy, Test-to-Stay, aims to maximise the number of in-person school days for non-infectious children who have been identified as close contacts of a case. In Test-to-Stay, children and teachers identified as close contacts have a daily RAT, either at school or at home, through the incubation period following exposure. If the test is negative and they have no symptoms, they can still attend school. The Test-to-Stay strategy has been adopted in numerous jurisdictions overseas (41).

Modelling from the Doherty Institute in Melbourne found that Test-to-Stay is “as effective for outbreak prevention as 14-day contact quarantine and dramatically reduces days of missed face to face learning.” (42)

The use of surveillance testing and RAT for schools comes with significant operational challenges. If an at-home testing model is used, it is likely to be more successful in areas with good digital literacy and access to internet (e.g. if families need to complete and upload results prior to attending school). If this was to be implemented it would need to be done in a pro-equity way e.g. resources for low decile schools to undertake RAT tests on arrival at school, which has its own operational and human resource challenges. There is a global shortage of RATs for COVID-19. In the context of limited supply, from a nationwide public health perspective, RAT resources may need to be prioritised for other contexts as described for testing above. Further challenges include ensuring that home testing is performed with high fidelity, and that test results are reported accurately and acted upon appropriately.

Our discussions with leading COVID-19 paediatricians in Australia where these strategies are used have identified the need for technological infrastructure to be in place before any such strategies are rolled out. Despite supply constraints, the public health principles and modelling behind these strategies are sound. **We strongly recommend that consideration is given as to whether such strategies are workable for New Zealand and to plan to build supporting infrastructure for a time when any supply and resource constraints have eased.**

Closing schools and online learning

We have called for the closure of schools to be an intervention of last resort. But this does not mean that we believe that schools should remain open for onsite learning at all costs. Within the COVID-19 Protection Framework, it is possible that in the event of a massive COVID-19 outbreak schools may need to close due to significant school-based outbreaks, critical numbers of staff falling ill, or due to local lockdowns.

Because of the disruptive nature of the pandemic, schools and students need to be ready to revert to online learning. Equitable access to learning is paramount. Students from disadvantaged homes may not have access to the devices needed to participate in online learning, and these same students are also at higher risk of infection or isolation, due to inequitable community spread. A student's access to school can change in an instant, and schools need to be prepared to support students quickly.

In the event of a massive Omicron outbreak, school staffing may be impacted to the point where even maintaining online learning is not possible. DHBs and the Ministry of Health are currently already working through plans to maintain healthcare services in the face of an Omicron outbreak. This planning should extend to the continued running of other essential services including schools. **To maintain learning of any form, thresholds for safe staffing need to be considered. It may be useful for the Ministry of Education, in consultation with schools and teacher unions, to produce guidance which maintains consistency between schools on these thresholds.**

A call for outdoor student sessions in the event of school closures

Whole school closures are a blunt tool to reduce community transmission. Because the risk of transmission is very low when meeting outdoors, we urge that a more nuanced approach is taken in light of Delta and Omicron's airborne transmission.

In the event of unavoidable school closures, we strongly advocate for the preservation of regular in-person outdoor sessions at school sites, even if indoor learning is not feasible. These could include, for instance, physical education classes, small group learning sessions, and games for primary schoolers.

Regular outdoor sessions for students would have so many benefits at very low risk. Interactions such as these would reduce social isolation, maintain friendships and relationships with teachers, maintain a sense of belonging to the school community and familiarity with the school environment, and improve mental health and wellbeing for students. It would also provide opportunities for teachers to sight children, and for families to feel connected, retaining the vital role that schools play in our social fabric.

Specific communication plans for children

The New Zealand government has been praised internationally for its strong communication throughout the pandemic. Press briefings have focused on the direct harms of COVID-19 infection and the need for stay-at-home measures. **The government COVID-19 communication strategy needs to become more nuanced regarding children.** Parents need to be well-informed that COVID-19 poses a lower level of risk to children compared to older age groups. Parents also need to hear of the benefits of vaccinating children, the value of in-person education, and the rationale behind mitigations in schools. Clear, culturally appropriate communication would go a long way to support parents. Without specific communication plans for children, we expect high rates of absenteeism particularly among already disadvantaged or ethnic minority communities.

Conclusion

Aotearoa New Zealand has so far done well to keep schools open during the pandemic, in large part due to the elimination strategy. However, in a post-elimination context, prolonged school closures as a way of curbing community transmission are not an optimal, evidence-based, or sustainable strategy for children. As children and whānau become increasingly vaccinated, we need to protect them from the indirect harms of the pandemic which will be inequitably felt.

Should schools need to close, we advocate for the preservation of regular outdoor sessions at school for students. These opportunities for interacting with friends and teachers will maintain relationships and connection to school and come with so many benefits for children at very low risk.

The rise of the Omicron variant means that mitigation measures to prevent COVID-19 transmission in schools is more crucial now than before. These mitigations should be embedded and maintained to allow them to be ingrained in school culture rather than trying to establish processes in a crisis.

Omicron has the potential to be very disruptive. Keeping schools open as much as possible, and as safely as possible, is the most equitable and holistic plan for children. Plans to realise this goal are urgent and necessary.

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