

Schooling in the time of COVID-19
Towards a consensus on schooling in the European Region during the
COVID-19 pandemic

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Contents

1.0	Purpose.....	3
2.0	Background.....	4
3.0	General principles.....	5
3.1	Epidemiological conditions	5
3.2	Risk mitigation measures	5
3.3	Roles and responsibilities.....	6
3.4	Addressing the needs of those with specific vulnerabilities.....	6
3.5	Online and blended learning.....	6
3.6	Targeted risk assessments for certain activities	6
4.0	Intersectoral governance.....	7
4.1	Public health and health services support	7
5.0	Operational considerations and risk reduction/mitigation.....	8
5.1	Transmission scenarios and consequent measures.....	8
5.2	Additional considerations: transport, extracurricular activities, and (state) examinations	13
6.0	Communicating effectively and building stakeholder engagement.....	13
7.0	Research and evaluation	14
8.0.	Next steps	15
	Sources.....	16
	Acknowledgements.....	18

1.0 Purpose

This working paper serves as a reference point for national education and health authorities as they seek to plan and implement effective schooling during the ongoing COVID-19 pandemic. Originally prepared to inform the high-level meeting on “Schooling in the time of COVID-19” held on 31 August 2020,^a it seeks to provide a general framework and upstream considerations for decision-makers.

Without detailing specific recommendations,^b this working paper sets out a series of guiding principles and operational considerations to help decision-makers identify suitable and feasible measures to prevent introduction and further spread of severe acute respiratory syndrome coronavirus (SARS-CoV-2, the virus that causes COVID-19) in school settings, as far as possible. These considerations are aligned with emerging scientific knowledge and more formal guidance issued by WHO headquarters.^c

Physical attendance at school and participation in school activities are important for the social and psychosocial development of children and adolescents and, accordingly, the starting point of this document is having students physically present in school. This objective should be pursued with full attention to the complementary objectives of:

1. implementing the most feasible pedagogical practices in this exceptional situation, given the need to ensure that children’s education is as unaffected and uninterrupted as possible;
2. ensuring the safety of children and educators, along with other school staff;
3. keeping COVID-19 transmission under control.

In the context of COVID-19, reopening of schools (as well as their closure) should be guided by the best interest of the child, including their health and well-being, and overall public health considerations based on an assessment of the overall associated benefits and risks, and informed by cross-sectoral and context-specific evidence. This includes education, public health and socioeconomic factors.

The working paper is not a final statement of WHO Europe’s position. The Regional Office will continue to monitor the evidence that emerges from research and practical experience and will update the document accordingly in the coming weeks and months.

^a Following a proposal of the Italian Ministry of Health, the WHO Regional Office for Europe organized a virtual briefing on the topic of schooling during the COVID-19 pandemic, which was jointly hosted by the Honourable Dr Roberto Speranza, Minister of Health of Italy, and Dr Hans Kluge, Regional Director, WHO Regional Office for Europe.

^b Along with individual Member States, WHO has provided specific guidance concerning schools in the context of COVID-19. This relates to public health measures and infection prevention and control, face masks for children and essential resource planning, among others. This document draws on these, as appropriate, and they are listed in the sources at the end.

^c The information in this document is based on current evidence until 26 August 2020, and also reflects practice-based experience from the Region collected during an expert group discussion on “Schooling in the time of COVID-19” held on 14 August 2020 and the high-level meeting held on 31 August 2020.

2.0 Background

Schooling amid the pandemic presents a serious policy challenge for both the education and health authorities as countries seek to reconcile the objectives of schooling children and adolescents in a safe, friendly and educationally effective environment while keeping wider societal COVID-19 transmission under control. Supporting effective schooling during the current phase of the pandemic is crucial in contributing to their health and well-being. Reopening of schools or enabling children to return to schools and schooling is a critical element of societies learning to live in the “new normal”.

Since early 2020, around 180 countries have closed their schools, leaving about 1.5 billion students missing out on learning and putting unprecedented pressure on education systems worldwide.^d Children and adolescents have been negatively impacted by school closures, both in terms of their education as well as their mental and physical health. These have disproportionately affected those who are already vulnerable and deprived (e.g. persons with disabilities, children with underlying health conditions, those with socioeconomic deprivation and poverty, children in remote areas).

In addition to the immediate-term effects, the potential long-term effects too cannot be overlooked: younger children carry their learning ability with them as they grow older, so a poor start means greater learning difficulties later. For older students, a good education is often a stepping stone to employment, and poor education can result in fewer opportunities and lower earnings later; a low-skilled workforce has a consequent impact on the economy. It is also the case that school closures, especially at the kindergarten, pre-school and primary school levels, have meant a greater caring burden at home for parents (disproportionately women), who may themselves be struggling with different work modalities.

Systematic reviews and evidence from transmission clusters suggest that, overall, children have significantly milder illness than adults and are more likely to have asymptomatic infection, which means that the infection can go undetected or undiagnosed. At present, limited data are available on susceptibility to infection in children compared to adults, and the ability of children to spread infection compared to adults. Evidence has been gathered mostly in the early stages of the epidemic or in (quasi) lockdown scenarios. Age patterns of infection therefore need to be interpreted with caution to understand what role children may play in driving community transmission. Recent clusters in secondary schools, and serological and antigen studies suggest that the epidemiology of COVID-19 varies by age group within the paediatric population. Adolescents may have infection that is more transmissible than young children, and have transmission patterns similar to those of young adults.

There is limited evidence to date that schools are driving transmission of COVID-19 within the community, as in most cases, countries had already closed schools as part of the implementation of wider public health and social measures (PHSM) during the early stages of the pandemic. However, there are indications that community transmission is imported into or reflected in the school setting. In addition, there are examples

^d More specific data, including on countries in the European Region, are available on the UNESCO website: <https://en.unesco.org/covid19/educationresponse>.

of transmission in schools, which have led to further community spread. Given that all countries have implemented additional non-pharmaceutical interventions in addition to school closure, it is currently difficult to assess the true impact of school closure/opening on the transmission of COVID-19 from the school setting to the wider community.

Education and health authorities share a common policy interest in the well-being of children and adolescents. This unites them in a common objective to find sustainable approaches to keep schools open in the interest of ensuring educational continuity within a safe and conducive learning environment, while keeping COVID-19 transmission in schools and the wider community under control. Targeted, time-limited, and local closures should be contemplated where safety considerations for children as well as educators and other school staff require such actions to be implemented. The safety and well-being of educators is a prerequisite for the delivery of safe and effective education. This difficult policy challenge presents an opportunity for the education and health authorities to work closely together to build successful cooperation strategies that will be beneficial for the well-being of children and adolescents over the longer term.

3.0 General principles

As noted at the outset, the intent of this document is to ensure that children's right to education is served while ensuring their safety and that of others. In addition, the document intends to help keep broader community COVID-19 transmission low.

3.1 Epidemiological conditions

The epidemiological conditions that have guided decisions on the reopening of economies and society during the transition process apply to reopening of schools. Identifying, containing, mitigating and suppressing viral transmission remain key objectives to keep COVID-19 under control. It is only in a situation where COVID-19 is under control that schooling can be conducted safely and sustainably.

3.2 Risk mitigation measures

As a guiding principle, taking into account the transmission status within a particular community, the risk mitigation measures introduced should start with those that are least disruptive to children's education and socialization, and gradually move to the adoption of local, time-bound, targeted, disaggregated measures that entail a greater degree of educational disruption as levels of transmission in the wider local population increase.

A wide array of measures can be considered for risk mitigation in school settings. Protective measures related to hand hygiene and respiratory etiquette, physical distancing, wearing masks and respecting the "stay home if sick" instruction are cornerstones of schooling within the COVID-19 reality.

Modulation of PHSM will be expected throughout the coming months. At the outset, it needs to be understood by all stakeholders that school closure is the least optimal measure. But closures that are

localized and limited in time and scope may need to be introduced from time to time to rapidly bring viral transmission under control and protect school populations and the wider community. This should not be viewed as a school or policy failure since schools are part of the communities in which they are located and the epidemiological situation in schools will mirror and reflect that in the community.

3.3 Roles and responsibilities

Policies and protocols clearly setting out the respective roles and responsibilities of the education authorities, schools, educators, children, parents, health authorities, public health services, primary care doctors and paediatricians need to be established in advance and communicated clearly to all concerned (see section 4 below). Inter alia, these will include measures for prevention and protection, algorithms for response to cases and clusters, and agreed thresholds that trigger partial or full school closure. Decision-making should not be delayed until a crisis occurs and parents and educators need to know in advance what to do and where to call for help for a variety of scenarios. (Section 5 sets out a matrix of control and prevention measures for schools, by level of disease transmission.)

3.4 Addressing the needs of those with specific vulnerabilities

Specific policies will need to be in place for at-risk children with special educational needs or health conditions (especially children with chronic respiratory difficulties who may end up stigmatized), as well as educators (all the school workforce) with specific health conditions that render them vulnerable to more severe infection.

3.5 Online and blended learning

Online learning cannot substitute for the physical schooling experience. But in the current situation, there is a need to prepare and plan for online learning to be available to complement school-based learning in the coming scholastic year. This will be necessary during temporary closures, and can be an alternative for children and educators with health conditions. Online learning may be needed during episodic quarantine and may complement school-based learning in circumstances where children have to limit school presence to respect physical distancing needs in smaller classrooms.

Blended schooling (understood as a combination of in-person and online schooling), although challenging from an educational perspective, will become an important element of any schooling policy during the COVID-19 pandemic. Indeed, in countries across the Region, this has already been the case. This will keep the children, staff and families as safe as possible, while giving them the exposure to school-based education and not totally deprive them of the socialization inputs that they need as part of their holistic development. This approach recognizes that teachers may require support (training and equipment) to build their skills to deliver education through these approaches, and with due attention to their mental health (support services should be set up).

3.6 Targeted risk assessments for certain activities

Classes such as physical education, singing, music and drama are key school-based activities for children's development. It is known that these activities may present additional risks and specific risk assessments

may need to be carried out to modify the nature of the activities undertaken, e.g. organizing outdoor activities, minimizing student contact. Such risk assessment must keep the well-being of the child as the central tenet of considerations rather than a blanket cancellation of these activities.

Finally, equity needs to remain a core principle when implementing these policies to ensure that underserved populations are not further disadvantaged.

4.0 Intersectoral governance

Public health and education authorities at national, regional and local levels need to set up the appropriate joint decision-making structures to handle schooling in the time of COVID-19. Consultation with other sectors, such as transport, sports, culture and employment, will also be necessary. The level of autonomy to be given to localities and individual schools in determining the appropriate course of action within the overall framework will vary between countries but should be determined in advance to avoid having to handle a crisis. One size does not necessarily fit all contexts and factors such as the physical school architecture and class size need to be considered when determining the degree to which harmonization is sought. Nonetheless, pursuing common approaches, e.g. regarding the measures that parents should take in specific circumstances, can go a long way in reducing uncertainty and confusion.

4.1 Public health and health services support

In terms of specific “needs”, the role of intersectoral coordination becomes especially apparent with respect to the following:

- There should be clear organizational division of roles among sectors and services so that parents, schools and public health authorities know exactly who has what role, both primary and secondary.
- An emergency response team composed of education and health authority representatives should be set up to coordinate contingency plans for disease outbreaks between national, local and school authorities.
- The health sector should provide continuous support to schools to ensure that COVID-19-related operations and all other health issues are addressed adequately, promptly and without unnecessary overmedicalization of the situation.
- A plan should be available for routine testing programmes of staff in schools that are open in communities where there is no current community transmission.
- Clear and seamless protocols and pathways should be put in place for isolation, testing, contact tracing and re-entry involving school health services where these are available. Where school health services are not available, each school may need to put in place a temporary clinical reference point for consistent oversight and management of children and educators displaying symptoms of possible COVID-19 – this could be a general practitioner (GP), paediatrician or representative of the local public health service.
- Protocols should include balancing confidentiality of data while ensuring sufficient information to enable timely, effective and comprehensive contact tracing.

- Open and transparent risk communication is necessary, especially when a case occurs. Public health services will need to provide on-site support to school authorities and teaching staff for communication during such an event.
- Psychosocial support and assistance would help school authorities to manage the “anger” of those affected (if they contract the infection from someone who is infected first) and avoid stigmatization of children returning after recovering from the illness.
- Surveillance of the epidemic needs to be ongoing, with each school reporting sickness absences on a real-time basis to identify potential clusters as soon as possible. This will require enhanced cooperation between the health and school authorities and development of a real-time dashboard with quantitative and qualitative indicators feeding into the national integrated surveillance systems.

Not just at school level, but national and local frameworks and operational policies should also have an inbuilt mechanism for regular review and updating, based on new knowledge and guidance. Feedback should be received from schools/school and health authorities on what works and what does not work.

Decision-making may include school boards where these have responsibility, based on the initiative of the local public health service and the school/education authorities, in line with previously established criteria. Decisions need to be clearly presented, involving parents in the design of and providing support for continuation of remote schooling. A clear set of criteria for decision-making and agreed thresholds for action will be needed, including technical assistance at the national and subnational levels to set local quantitative criteria.

5.0 Operational considerations and risk reduction/mitigation

National authorities need to consider policy options for the implementation of a range of school-based measures. These will need to be adapted according to the level of local transmission and assessment of the local situation. Stressing that this is a working framework to help Member States with their thinking, and in no way a definitive approach, a range of epidemiological indicators are provided in the matrix in Table 1 to enable authorities to assess the level of local transmission. Authorities then need to determine which school health-related control and prevention measures need to be implemented according to the level of COVID-19 transmission. The proposed public health measures need to be adapted according to the local epidemiology and local educational context. A basket of indicators is provided. Most countries will not have all these (at least at a local level); however, policy-makers can select appropriate measures to inform local action.

5.1 Transmission scenarios and consequent measures

Prior to reopening a given school, its emergency preparedness and response plans must be reviewed and updated. In line with national guidance, the plan should be developed in collaboration with local public health authorities, the school nurse and/or doctor (where available), students, parents, caregivers, guardians and wider community members, as appropriate. Such plans are in place to protect staff, students and their families from the spread of COVID-19 and will need to contain an updated emergency

response plan for when/if a student, teacher, staff member or family member tests positive for COVID-19.

Mitigation measures in schools can be organized into three categories: personal prevention and control measures, administrative prevention and control measures, and environmental and engineering prevention and control measures. Personal prevention and control measures comprise individuals' behaviours to protect themselves and those around them. Administrative prevention and control measures are processes and policies that keep students, teachers, staff and parents as safe as possible. Environmental and engineering prevention and control measures would include physical structures put in place to ensure physical distancing and healthy environments within the school premises.

Besides the transmission level, the mitigation measures required will need to be adapted according to the sociodemographic characteristics of the population at risk, such as their age (preschool, primary and secondary school), socioeconomic status (e.g. access to digital tools at home) and ethnicity (e.g. language-appropriate guidance). For example, early evidence suggests that preschool-age children are at least as likely to shed virus as older children, so implementing measures to reduce transmission remain important. Physical distancing for such a group is impractical, and measures such as the use of class bubbles and protection for vulnerable staff become more important.

Table 1. Schooling in the time of COVID-19: operational considerations for each transmission scenario for COVID-19^e

This “matrix” represents a working draft framework presented to Member States as part of a consultation on 31 August 2020 reflecting thinking at the time and will be updated based on emerging evidence. The indicators have been adapted based on WHO Considerations for school-related public health measures in the context of COVID-19 published on 14 Sept https://apps.who.int/iris/bitstream/handle/10665/334294/WHO-2019-nCoV-Adjusting_PH_measures-Schools-2020.2-eng.pdf		
Level of transmission	Indicators	School measures*
No cases	No cases detected locally - No laboratory-confirmed cases locally % positive in comprehensive surveillance (at testing rate >1/1000/week) = 0%	- Health education - Promote regular handwashing - Provide all necessary supplies (hand sanitizer or soap and water, tissues, closed-lid bins, sitting and distance markers) - Promote respiratory hygiene - Monitor absenteeism among staff and children - Sick children and staff stay at home - Ensure regular cleaning - Open windows to improve indoor air ventilation once an hour - Establish mechanisms for psychosocial support - Maintain clear and consistent communication with parents and the wider community, and ensure community engagement in all processes; establish an information-sharing mechanism - Ensure up-to-date information about the COVID19 pandemic
Sporadic cases	One or more cases, imported or locally detected. One or more of the following: - One or more cases detected locally - All cases linked to a cluster % positive in comprehensive surveillance (at testing rate >1/1000) <5%	As above PLUS: - Minimize crowding by staggering arrivals and departures, numbering entries based on age group/class, designating seats/places and marking the floor to ensure physical distancing between children of at least 1 m - Do not discontinue physical education and after-school activities but, whenever possible, choose outdoor venues over indoor spaces – if indoors, ensure that the area is well-ventilated

^e Measures are drawn from WHO guidance. Please see “Sources” below.

Clusters	Experiencing cases, clustered in time, geographical location and/or by common exposures. At least two of following: • % confirmed cases linked to clusters >80% • % positive in comprehensive surveillance (at testing rate >1/1000) <5% for at least 2 weeks • % positive in sentinel surveillance <5% for at least two weeks • Reproductive number significantly <1 • Continuous decline in the number of hospitalization and ICU admissions of confirmed and probable cases at least for the last 2 weeks • Decline in the number of deaths among confirmed and probable cases at least for the last 3 weeks	As above PLUS: • Promote physical distancing in classes (>1 m between children, class bubbles/capsules) • Coordinate closely with local health authorities • Detect and investigate suspected cases and clusters • If a case is confirmed, trace contacts and quarantine • If there is evidence of wider school transmission, consider temporary closure of the school with virtual schooling
Community transmission	Experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to: large numbers of cases not linkable to transmission chains; large numbers of cases from sentinel laboratory surveillance; and/or multiple unrelated clusters in several areas of the country/territory/area. At least two of the following: • % confirmed cases linked to clusters <80% • % positive in comprehensive surveillance (at testing rate >1/1000) >5% for at least 2 weeks	As above PLUS: • Consider use of masks by all staff and children (as per WHO guidance) • Continue implementing multiple social distancing strategies according to age group: for classrooms, movement through the school building, gatherings and after-school activities • Consider the community context and ways to accommodate needs of staff, children and families at high risk • If there is evidence of wider school transmission, consider short-term, local school closure as part of a package of PHSM to reduce community transmission, particularly in areas with increasing trends of COVID-19 cases, hospitalizations for COVID-19 and COVID-19 deaths

	• % positive in sentinel surveillance >5% for at least 2 weeks • Reproductive number significantly >1 • Continuous increase in hospitalization and ICU admissions of confirmed and probable cases at least for the last 2 weeks • Continuous increase in the number of deaths among confirmed and probable cases at least for the last 3 weeks	
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* NOTE: These measures will be adapted according to the sociodemographic characteristics of the population, in particular, age group (preschool, primary, secondary), socioeconomic status and ethnicity.

As the matrix indicates, a series of measures need to be considered and applied as appropriate. These cover key areas of prevention, control and response, and are in line with WHO guidance on infection prevention and control (IPC) measures, covering the provision of essential personal and institutional cleaning and disinfection products, water, sanitation and hygiene (WASH) facilities, implementation of physical distancing measures, and use of face masks.

5.2 Additional considerations: transport, extracurricular activities, and (state) examinations

Additional issues that schools and authorities need to think through relate to school transport, whether provided by the school, public transport serving the school or parents or others who bring students to the school premises. Policies regulating transportation will need to be locality-specific. Use of active commuting and private transport could complement the use of public transport systems. Use of face masks where physical distancing is not possible should be considered for children over 6 years. Where school-organized transportation systems are in place, staggered starting and finishing times should be considered. This would increase the number of journeys made as there would be fewer students per trip, which would thereby provide the possibility of physical distancing on school transport. Additionally, providing information and guidance to transport operators would be helpful in ensuring that measures are implemented.

Different communities make use of after-school/extracurricular activities to different extents. Children who rely on after-school activities for sports, dance, music, performing arts, etc. have been impacted by the closure of these activities. It is not reasonable to expect children and adolescents to refrain from participating in these activities, even if this entails mixing with children outside their school “bubble”. However, exceptionally, in localities where community transmission is ongoing and where such activities are identified as hotspots for transmission, temporary closure or suspension needs to be considered. All the risk mitigation IPC measures that have been put in place earlier on should be maintained and rigorously enforced as schools reopen.

Students who face examinations at a critical period in their scholastic cycle – final exams or advancement exams, for example – must be supported. Systems and back-up alternative plans for such (state) examinations upon which educational progression is dependent need to be made in advance for Spring 2021. This could include special physical classroom arrangements, provisions for more than one date to be made available for students who are unwell or in quarantine, or other modalities relevant to the individual school or institutional setting in which such exams are set.

6.0 Communicating effectively and building stakeholder engagement

The reopening of schools is an issue that involves all of society. Getting parents and students involved in sharing the same principles of solidarity and common action for common protection is key to success. Building trust and ownership of the strategy and measures by all stakeholders early on will help to minimize anxiety and anger if or when cases or clusters occur, and schools are temporarily closed.

Educators, parents, children and adolescents as well as local health services in the community are the key stakeholders who need to be regularly informed and consulted. Their engagement and support for the measures taken is a critical component for successful implementation.

Flexible approaches that are empathic to concerns raised by parents and children themselves should be considered during this exceptional period. Presence at schools needs to be encouraged through confidence-building measures. The following additional measures may need to be considered as part of the overall policy approach:

- preparation of teaching materials and communication/education for teaching staff on COVID-19 and how to protect themselves and the children;
- communications outreach on COVID-19 and the framework of risk reduction measures to specifically target and involve older children and adolescents;
- social compact with teachers (teacher trade unions and professional associations) on occupational health;
- mechanisms for continuous feedback to enhance the policy framework, and response in different scenarios.

The Schools for Health in Europe (SHE) Network, which is based around the “health-promoting schools” approach, is supporting countries in ensuring the well-being of schoolchildren in the WHO European Region by sharing examples of good practice and teaching materials developed for the COVID-19 context.^f The SHE advocates a health promotion approach as the uniting factor, along with a focus on the physical, environmental, social and mental well-being components, and is therefore particularly relevant during the COVID-19 crisis.

7.0 Research and evaluation

Interventions need to be frequently reviewed as new evidence becomes available. Cohort studies, sampling in asymptomatic children, and large population surveys (with adequate sampling of children in different age groups) in different contexts and transmission scenarios are required. WHO has developed special study protocols to support such vital investigations, known as the Unity studies.^g

Evaluation should include the impact of school closure on transmission as well as adverse effects on social, physical and mental health and well-being, and negative long-term behavioural, health and educational outcomes.

- Sharing of best practices by countries will help inform plans of other countries.

^f Schools for Health in Europe Network Foundation (SHE) (<https://www.facebook.com/SchoolsHealthEurope/>, accessed 12 September 2020).

^g Coronavirus disease (COVID-19) technical guidance: the Unity Studies – early investigation protocols. In: World Health Organization [website] (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/early-investigations>, accessed 12 September 2020).

- Consensus on a set of data should be shared with international institutions. Ideally, a monitoring working group should be set up at the regional level to review and guide countries through this process.
- Statistics on transport utilization and mobility data relative to school-age children and adolescents should be gathered and made available for public health analysis to identify how commuting patterns influence the transmission of SARS-CoV-2.

8.0. Next steps

This document provides a series of policy considerations that can enable policy-makers to shift from a purely “precautionary” position of imposing swift, uniform and clear actions in times of imminent threats, to more proportionate and specific actions with fewer unintended consequences. As science continues to provide more clarity, interventions can be further refined with the aim of reducing disruption to education while keeping COVID-19 transmission under control.

During the high-level meeting, Member State representatives were invited to reflect on the issues, proposals and measures contained in the document and to provide feedback on the following four guiding questions:

- Is the document and matrix understandable and feasible to implement; what is missing?
 - Are the incidence thresholds as defined useful delineators, and are the corresponding indicators and measures practicable in your context?
- What are the interventions and actions being envisaged in your country?
- What are the main outstanding issues that need further research and deliberation?
- How can the Regional Office for Europe provide further support to Member States in the coming weeks and months?

On the basis of the exchange of experiences and deliberations during the meeting, and in view of participants’ request for WHO Europe to establish a regular set of meetings to help gather and disseminate the best evidence as it becomes available, the Regional Office is proposing three new directions as the way forward:

1. building a coalition across Member States to inform our actions and move forward jointly to implement the best possible measures on the provision of schooling for all;
2. agreeing a unified set of data to learn more about the impact of COVID-19 on children, their families and communities to better inform future policy;
3. preserving equity as a core guiding principle to ensure that underserved populations are not further disadvantaged.

As the situation changes rapidly and further evidence accrues, Member States requested WHO Europe to create a “living platform” that can provide a basis for updating documentation, based on emerging evidence and experience. In order to facilitate the timely collection, analysis, dissemination and exchange

of practices, a Member States network will be established. A WHO Europe Secretariat will support this initiative linking up with focal points from Member States, other agencies, including the European Centre for Disease Control and Prevention (ECDC), WHO headquarters and United Nations (UN) partners. This will build on existing data collection mechanisms and expand them to cover school-relevant issues not collected so far, including from the COVID-19 Incident Management Support Team of WHO Europe and the Health Systems Response Monitor.

A Regional Technical Advisory Group will be established to review emerging evidence as Member States reopen schools and implement measures for schooling. Members will include epidemiologists, paediatricians, ethicists, virologists, youth representatives and representatives from major regional stakeholders. The Group will review the control measures taken by national and local governments, and will assess them in terms of their effectiveness and potential adverse effects on child health and well-being, and their impact on children's rights. From this, the Group will propose a unified set of data to learn more about the impact of COVID-19 on children, their families and communities with the ultimate aim of better informing future policy.

WHO Europe will also facilitate a youth-led initiative to engage in dialogue and document children's and adolescents' perspectives of the effects of the applied measures, and to ensure that children and adolescents are heard as equal stakeholders in the process.

It is anticipated that this work will allow for an update to this document, and for the Secretariat to convene a high-level Member State meeting for end-November or early December to help countries make decisions for the next school half-year, the first half of 2021.

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