Physical distancing at school
Practice and evidence review

Background

School closures related to COVID-19 have affected nearly 1.6 billion (90%) children and adolescents worldwide. Even where remote learning has been provided, the physical closure of schools has demonstrated a range of negative social and health consequences for children and adolescents, affected learning outcomes, wellbeing, and exacerbated inequities. These adverse effects have occurred in part because, in addition to learning and socializing, schools often provide children and adolescents with other services, ranging from meal and physical exercise programs to the provision of health care and mental health services.

In this brief, we explored the national policies of selected high-income countries with regard to physical distancing in schools. For the majority of countries reviewed, physical distancing in the school setting, where recommended, is aimed at older students and adults. Many recommend keeping children in separate groups to allow for effective contact tracing and isolation in the event of a detected case. Increasing evidence from these and other countries demonstrates that transmission in schools is rare; reopening has not resulted in increased levels of community transmissions. However, strong physical distancing policies reduce allowable class sizes, the consequence of which is keeping children and adolescents out of school.

Objective

In this brief, we explore1 the current evidence to support physical distancing in schools, including guidelines by global and regional disease prevention agencies and a number of high-income countries with large urban populations. We focus on this measure because of the significant associated implementation and resource requirements vis-à-vis increased physical space and teaching staff.

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1 We reviewed the most recent guidelines by health protection agencies (WHO, CDC, ECDC) published in their website and searched for national school policies for elementary schools of most populous Western and Central European Countries and English-speaking countries. For scientific evidence, we searched the COVID-19 databases of the Lancet, JAMA, and Nature journals and national public health agencies, as well as PubMed/MEDLINE and Science Direct databases. We included only peer-reviewed systematic and rapid reviews or large cohort studies and excluded preprints.
Summary of evidence

The large multi-country and national cohort studies and systematic reviews show that compared to adults, children and adolescents are at lower risk of severe illness, hospitalization, and death from COVID-19, and that there are fewer reported COVID-19 cases in children and adolescents than in adults. (1)(2)(3)(4)

While most COVID-19 transmissions (46-66%) occur between household members,(5) the schools are not driving COVID-19 outbreaks,(6)(7)(8)(9): school re-opening has not resulted in increased levels of community transmission, child to child transmission in schools is uncommon, and children in school settings are not the primary transmitters of COVID-19 to adults.(7)(9)(10)(11) Surveillance testing of staff and children in schools in New York City, including in the most affected neighborhoods, confirm these findings.(12)(13)

Evidence on extended school closures from previous experience in both high and lower income settings shows an association with poorer academic performance and learning, dropout, food insecurity,(14) increased vulnerability to violence and child abuse,(15) and adolescent pregnancy.(16) Evidence from the ongoing COVID-19 epidemic suggests increased anxiety, depression and loneliness among children and adolescents. These impacts are likely to continue after social isolation as this age group is also disproportionately affected by social deprivation. (17)(18)

Published peer-reviewed evidence on the effectiveness of physical distancing in reducing the spread of COVID-19 is limited. We identified only one systematic review by Chu et al. according to which at least 1 meter distancing is likely associated with a reduction in infection. However, none of the studies included in this review were from a school setting and only a few were specific to COVID-19.(19)

Global and regional policy

While no specific studies had been conducted with regard to COVID-19, the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) both recommend physical distancing be practiced in schools.

The recommendations of these two agencies differ in terms of the distance that should be maintained between students and with teachers. The CDC recommends physical distancing at least 6 feet apart, physical barriers where this distance cannot be maintained, and mask use for all students and staff while acknowledging challenges in use for children in up to third grade, and people with breathing difficulties or special educational or healthcare needs.(20) WHO recommends 1 meter (3.3 ft) distancing and mask for adults and children over 12 years in areas defined as having community transmission1 of COVID-19. In areas with less transmissions (cluster transmission2 and sporadic/no cases3) distancing is not recommended between students although it is recommended for adults.(22) European Centre for Disease Prevention and Control (ECDC) follows the WHO guidance on 1 meter desk spacing in schools.(23)

Country policies - examples

A number of countries have developed their own national policies for physical distancing in schools. Many recommend keeping children in separate groups to allow for effective contact tracing and isolation in the event of a detected case.(24)(25)(26) For the majority of countries reviewed, physical distancing in the school setting, where recommended, is aimed at older students and adults. The recommended distance ranges from none to 2 meters.

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1 Defined as “countries/territories/areas experiencing cases, clustered in time, geographic location and/or by common exposures.”
2 Defined as “countries/territories/areas experiencing cases, clustered in time, geographic location and/or by common exposures.” (21)
3 Defined as “countries/territories/areas with no cases or one or more cases, imported or locally detected.” (21)
Norway for instance has no requirements for younger children but recommends 1 meter for older children and adults.\(^{(24)}\)

In New Zealand, a 1-meter distance is recommended only between adults during a risk of community transmission, and also between students during high risk of transmission.\(^{(27)}\)

France, \(^{(28)}\) Portugal, \(^{(26)}\) and Italy \(^{(29)}\) – countries that have reintroduced strict public restrictions – recommend a distance of 1 meter for all students and adults. In addition, they recommend masks ranging from age 6 years and above in France to 10 years in Portugal, and 6 or 12 years in Italy, depending on the local epidemiological situation.

In Spain, 1.5 meter desk spacing is advised with the exception of grades 1-2 (6-8 year olds). Masks are obligatory from age 6 onwards.\(^{(30)}\)

Australia has no requirements for students but recommends that adults keep a distance of 1.5 meters.\(^{(31)}\) The UK has no distancing requirement for students and encourages 2 meters for adults.\(^{(25)}\) Scotland requires 2 meters for adults and recommends 2 meters for older students.\(^{(32)}\)

Germany has a federal recommendation of 1.5 meters for all students and adults,\(^{(33)}\) however, states can make their own decisions. Berlin for example has no distancing requirements for students.\(^{(34)}\) In Switzerland, the decision making is also at state level. Geneva has no distancing requirement for students, although it does recommend distancing of 1.5 meters for adults, \(^{(35)}\) whereas Zurich recommends 1.5 meters for both older students and adults. \(^{(36)}\)

**Conclusion**

Given the negative consequences associated with school closures, countries where current physical distancing requirements are more stringent than those proposed by WHO should consider the effects of their policy on learning and student well-being. The risks and benefits of the measures need to be carefully considered, in particular as according to the increasing evidence, transmissions in schools are rare and re-opening has not resulted in increased levels of community transmissions.

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