Testimony of David Zweig, Journalist, Westchester County, New York, United States House of Representatives Early Childhood, Elementary, and Secondary Education Subcommittee Hearing "Back to School: Highlighting Best Practices For Safely Reopening School" Wednesday, September 29, 2021

Good morning, and thank you Chairman Sablan, Ranking Member Owens and Members of the Subcommittee for inviting me to testify today. As an American citizen, I feel honored to be able to speak at a Congressional Hearing.

Since the spring of 2020, I have been researching and writing about the nexus of kids and schools and COVID. From the beginning of the pandemic I've looked not only at the circumstances in our country but, critically, contrasted them with the circumstances surrounding and the policies affecting children and schools in other countries.

In late April of 2020, schools began reopening in much of Europe. Roughly a month later, the education ministers from 22 EU countries that had reopened or planned to reopen schools convened for a conference, and they said that reopening schools had not led to an increase in cases. Yet, in America, schools stayed closed for the duration of the academic year.

That spring set the tone for much of America's approach to children and schooling for the rest of the pandemic. Today, we are seeing similar patterns play out in many of our schools with excessive mitigation measures, where, once again, the US differs greatly from most of our peer nations across the Atlantic.

Since, at least right now, there is general agreement that schools should be open, the relevant discussion is *how* they should remain open.

One issue is quarantine protocols that repeatedly send great numbers of healthy children home for days or for more than a week at a time. Instead, schools should consider employing Test to Stay. In this program, if a student is exposed at school, they get tested, and if negative they continue to attend school. A large study of more than 200 schools in England found that quarantining students offered no benefit over Test to Stay[1]. This program is also preferable to routine surveillance testing, considering the latter's onerous costs, logistics, and potential for high rates of false positives.[2] Some countries are not employing either practice, and are simply following the classic advice "if you're sick, stay home," recognizing that asymptomatic people are believed to account for a minority of transmissions.

The most charged topic, and one that I have researched extensively and written about, is mask mandates in much of America for schoolchildren, regardless of age, developmental appropriateness, or community rates. Recently, the CDC released two studies which concluded that school mask mandates correlated with lower case rates.[3][4] The studies, however, have major limitations, among them variously not accounting for vaccination rates among staff and eligible students nor changes in community case rates over time. Carl Bergstrom, a widely cited biologist during the pandemic, wrote that one of the studies

[1] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01908-5/fulltext
[2] https://www.washingtonpost.com/outlook/2021/04/19/schools-covid-testing-cost/
[3] https://www.cdc.gov/mmwr/volumes/70/wr/mm7039e1.htm
[4] https://www.cdc.gov/mmwr/volumes/70/wr/mm7039e3.htm?s_cid=mm7039e3_w

was “embarrassing,” noting that, despite the authors’ initial assumption, the study could not infer causality.[5] This doesn’t mean the findings are incorrect, only that the conclusions drawn from those findings should be far more understated.

Conversely, the CDC published a large comparative study earlier this year, of more than 90,000 students, that found no statistically significant benefit of student masking mandates.[6] It also found no statistically significant benefit of HEPA filters, distancing, hybrid models, or barriers. I know this can be hard to believe, considering many of these interventions have been pillars of our pandemic response in schools, but those are the results.

But debating the merits of conflicting studies on mask mandates distracts from and undermines confidence in the tools that we know work, such as fresh air, and vaccinating the adults around children. Moreover, the highly politicized domestic arguments around student masking often fail to acknowledge the markedly different approach to this issue beyond our borders.

The World Health Organization and UNICEF have repeatedly advised against masking children under age 6, and recommend masks on kids aged 6 to 11 only under certain circumstances. The European Centre for Disease Prevention and Control does not recommend masks for primary students.[7] Some European countries have limited mask requirements for older students as well. Yet the CDC recommends that all American children aged 2 and up wear masks in school.

To be clear: millions of children in Europe are not wearing masks in schools. Yet there is no evidence that kids in Europe are at greater risk of severe illness or bad outcomes, or that their surrounding communities are at greater risk than their counterparts in the U.S.

We should ask ourselves why so many nations in Europe and elsewhere have already settled this issue from a policy perspective: They don’t make kids wear masks. So why do we?

Masks are not a benign intervention. They interfere with language acquisition, reading comprehension, and socioemotional development. Quite simply, seeing faces is a fundamental part of how humans, and especially children, connect and communicate with each other. Children are now entering their third year of interrupted schooling. A child who was in kindergarten in 2020 is now in second grade, and has yet to experience a normal full year of school. None of us know what the impact will be nor what it is like as a child to wear a mask all day every day for years on end.

The claim that some kids “don’t mind” wearing masks may be true insofar as children have been repeatedly told that masks are needed for their safety and that wearing them is a virtuous act. There is a reason adults remove their masks when they need to communicate clearly, such as at press conferences or in interviews, and we don’t wear masks at home. Whether masks are a necessary intervention on children is a separate topic from whether they impose a burden. Let’s not pretend about the latter.

More broadly, to what end are we implementing these interventions in schools? COVID, as has been known since the very beginning, thankfully poses very limited risk of severe disease to almost all children. The CDC has estimated that up to fifty percent of pediatric COVID cases are asymptomatic.

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[5] https://twitter.com/CT_Bergstrom/status/1441582851678523393

[6] https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e1.htm?

[7] https://www.ecdc.europa.eu/en/covid-19/questions-answers/questions-answers-school-transmission

More children die of the flu in many seasons than have died of COVID over a much longer time frame. Two separate peer reviewed studies, published by the American Academy of Pediatrics, found that 40% or more of pediatric COVID hospitalizations are for incidental cases, where a child was in the hospital *with* COVID but not *from* COVID.[8][9] While concerns about pediatric long COVID are real, multiple studies with control arms have shown that the prevalence of symptoms of long COVID, many of which are vague and common, such as headache and fatigue, are similar in children with and without a history of COVID[10][11]. This isn't to say that COVID poses no risk to children, only that much of the public's perception of its risk to kids is considerably misaligned with its actual risk to them. Data from the UK shows that an unvaccinated child is at lower risk than a vaccinated adult.[12]

Risk averse does not mean doing everything conceivable to mitigate the spread of a virus to kids. Rather, we are trading the risk of one harm for the amplification of risks from other harms. Keeping kids home, alone in their bedrooms, glassy eyed in front of screens all day is not "playing it safe." Nor is preventing them from seeing their friends' smiles and their teachers' faces. For a few weeks this was no big deal. But now in academic year number 3 of the pandemic, we need to demand very specific metrics for when these interventions on children can end. Europeans, once again, are way ahead of us. And it is not because they have "beaten the virus"; among European countries, the case rates, vaccination rates, and mortality rates cover a wide range, above and below those rates here in the U.S. It is because all of these other nations recognize the harms these burdens impose on kids. And although the risk of COVID is of course not zero, relative to so many other dangers that children face, from drowning to suicide to car accidents to other respiratory viruses, COVID is below all of them. This is not my opinion. This is what the data clearly shows. We've never made kids throughout the country wear masks for the flu, nor do we send entire classes home if a child tests positive for influenza.

It is important to mention that questioning guidelines is not only okay, but an act that should be encouraged. Robust debate, including that within the scientific community and the media, is a cornerstone of a healthy democracy. The CDC's guidance for summer camps, released in late April, called for children to wear masks in nearly all circumstances and at all times, including outdoors. I published an article a little more than a week after the guidance was posted, featuring quotes from esteemed experts, including the editor in chief of *JAMA Pediatrics*, who called the recommendations "draconian" and "ridiculous."[13] Shortly after much of the media amplified my article the CDC changed its recommendation, even though none of the underlying data had changed. More recently, there has been vehement pushback against the CDC's decision to overrule the guidance of its advisory committee and open eligibility for vaccine boosters to anyone aged 18 or older deemed at increased risk. "It is worrisome to me that anybody less than 30 is going to be getting a third dose without any clear evidence that that's beneficial to them and with more than theoretical evidence that it could be harmful to them,"

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[8] https://hosppeds.aappublications.org/content/early/2021/05/18/hpeds.2021-005919

[9] https://hosppeds.aappublications.org/content/early/2021/05/18/hpeds.2021-006001

[10] Technical article: Updated estimates of the prevalence of post-acute symptoms among people with coronavirus (COVID-19) in the UK: 26 April 2020 to 1 August 2021 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/technicalarticleupdatedestimatesoftheprevalenceofpostacutesymptomsamongpeoplewithcoronaviruscovid19intheuk/26april2020to1august2021

[11] https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(21)00198-X/fulltext#%20

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1016465/Vaccine_surveillance_report_-_week_36.pdf

[13] https://nymag.com/intelligencer/2021/05/experts-cdcs-summer-camp-rules-are-cruel-irrational.html

said Paul Offit, a member of the FDA's advisory committee and a pediatric infectious disease specialist.[14] Science is a verb, science is a process, and science does not equal policy.

I urge the members of this committee to ask the CDC to provide specific, evidence-based reasons why its masking guidance differs so dramatically from that of the WHO, UNICEF, and the ECDC, and why our nation's schoolchildren have dramatically different burdens imposed upon them relative to their European peers.

[14] https://www.statnews.com/2021/09/24/biden-covid-19-boosters-pitting-white-house-against-scientific-advisers/