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Vaccinate children and adolescents against SARS-CoV-2 to secure their access to education and protect their mental health

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Given the elevated transmissibility of circulating SARS-CoV-2 variants, vaccination coverages as high as 90% in adults may be necessary to fully relax control measures in the fall.¹ Such targets may be hard to achieve given vaccine hesitancy. There is therefore a risk that COVID-19 might cause substantial stress on healthcare next winter. The vaccination of children and adolescents could help mitigate this risk by ensuring they do not act as a reservoir from which SARS-CoV-2 could disseminate.¹ However, since COVID-19 is mild in children,² such intervention might be ethically problematic if the population benefits come without individual benefits for children. Here, we argue that vaccinating children and adolescents is important to secure their continued access to education and protect their mental health.

In case of an important COVID-19 epidemic rebound in the fall, we anticipate that control strategies will evolve to preferably target unvaccinated individuals, accounting for the limited contribution of vaccinated individuals to disease spread. Having a child attending secondary education currently increases the risk of SARS-CoV-2 infection by 18-30%.³ This contribution to disease spread should dramatically increase once children are the only unvaccinated group, leading to a larger proportion of infections and clusters occurring in schools. While such clusters might be tolerated if hospitalisation levels remain low, there is a point beyond which class closures might be reinstated. This would be highly detrimental to the education and well-being of children and adolescents who are increasingly suffering from disruption to schooling.⁴ School closure can impact school learning, lead to anxiety and depressive symptoms, exacerbate tensions or even intra-family violence and deepen social inequalities.

Early data from clinical trials suggest that the BNT162b2 Covid-19 mRNA vaccine is safe and highly immunogenic in adolescents aged 12-15 years,⁵ and the Food and Drug Administration on 10 May 2021, followed by the European Medicines Agency on 28 May 2021, have extended the use of this vaccine to include adolescents aged 12-15 years. Side effects in vaccinated adolescents should be carefully monitored at population level to make sure that rare but severe side effects would not go unnoticed. As data from ongoing trials in

children less than 12 years of age will become available in the fall, vaccination in younger age groups may be considered.

At a time when we all wish for a return to normal life, we cannot ignore that children share the same aspirations. The vaccination of children against COVID-19 would be the best way to insulate them from the risk of class closures, secure their continued access to education and protect their mental health.

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