In the spring of 2020, in-person education was abruptly suspended at institutions of higher education across the United States in response to outbreaks of SARS-CoV-2 infection and the COVID-19 pandemic. During the ensuing 6 months, university administrators scrambled to identify strategies for the safe reopening of college campuses and the resumption of in-person instruction. Empirical evidence to inform these campus reopening decisions was virtually nonexistent. Federal guidance reflected this, offering conflicting advice that all too frequently seemed more politically motivated than scientifically justified. The response from the nation's colleges was equally mixed. Many schools elected to remain closed and conduct their business online. Others reopened their doors, adopting widely divergent precautionary measures ranging from a return to near normalcy to something closer to near lockdown.1

More than a full academic year later, we still have only the vaguest sense of what actually worked, what did not work, what was overkill, what was critical, and why. Anecdotal reports suggest that adhering assiduously to a combination of contact tracing, dedensification, masking, handwashing, social distancing, installation of upgraded ventilation systems, and high-cadence, asymptomatic testing may have been associated with a substantial decrease in the transmission of infection within and beyond campus walls.2 However, other studies suggest that the town-gown interaction may have been more complicated.3,4 Solid causal data, controlling for time, place, circumstance, increased levels of protection attributable to natural infection, the arrival of effective vaccines, and the emergence of more virulent viral variants, are only now beginning to emerge.

Hockstein and colleagues5 contribute to our understanding by describing and evaluating a COVID-19 mitigation strategy implemented at Delaware State University (DSU) during the 2020 to 2021 academic year. The centerpiece of the DSU strategy was a program of routine, asymptomatic testing for SARS-CoV-2 infection, implemented alongside a variety of nonpharmaceutical interventions that included dedensification, hybrid classroom teaching, the cancelation of all athletic competitions, and education and outreach about social distancing, masking, and handwashing. In a campus cohort of some 2300 people, polymerase chain reaction testing for SARS-CoV-2 was to be performed twice each week, regardless of symptoms, among all students and faculty and staff members. During the fall 2020 semester, 36 500 tests had weekly positivity rates ranging from 0.0% to 1.8%, with a mean of 0.5%; in spring 2021, 39 000 tests had weekly positivity rates of 0.2% to 4.0% (mean, 0.7%). These positivity numbers were far below the comparable values observed statewide over the same period. Throughout the period, quarantine and isolation residence hall occupancy numbers remained manageable, never exceeding 50 individuals.

These findings are particularly noteworthy because they emerge from a historically Black institution. Historically Black colleges and universities (HBCUs) struggle with comparatively limited budgets to serve a clientele at disproportionate risk.6 HBCU endowments are a mean one-eighth the size of the endowments at historically predominantly White colleges and universities. Most HBCU enrollees are from low-income families or are Pell Grant awardees, and more than 90% rely on financial aid of some type. Housing-insecurity and food-insecurity issues are far more prevalent among HBCU students than among most other college student populations. Many of the basic activities of daily living and amenities that students at other colleges may take for granted, such as reliable internet access, to cite just one example, can pose insurmountable logistical challenges for...
HBCU students. Therefore, keeping HBCU campuses open may advance not only educational goals but also critical health and social missions. It is all the more worthy of celebration and congratulations, then, that a residential HBCU was able to mount a response that so many other, better-endowed schools dismissed as too costly or infeasible.

The findings of Hockstein et al also offer us a fortuitous, natural case study of the association of tracking and enforcement with the success of a SARS-CoV-2 screening program. While the DSU screening program was mandatory in name, rates of compliance with the mandate were low: 51% in the fall 2020 semester and 54% in the spring 2021 semester. This may reflect, in large part, the absence of a tracking mechanism to monitor the comings and goings of the large number of students whose permanent residence was close enough to campus that they would leave campus and return home for extended periods. Low adherence to the testing protocol makes it difficult to draw inferences about the effectiveness of the screening intervention. Students at highest risk of infection may have been more likely to opt out of screening. However, one notable group was an exception to this: athletes. Although athletic competitions were canceled, athletes were required to attend practices in person, permitting the athletics department to oversee screening and ensure that virtually all student athletes met their testing obligations. The absence of any notable outbreaks among DSU athletes suggests a lesson for us all about the power of incentives to bring individual behaviors into closer alignment with communitarian objectives.

To use a hackneyed academic phrase, more research is needed. Despite the approval and widespread availability of highly effective vaccines, college administrators are still confronting the challenges posed by SARS-CoV-2. Modeling studies suggest that colleges that achieve campus vaccination rates greater than 90% may safely return to normalcy, with minimal need of other prevention interventions. However, only 25% of the approximately 4000 colleges and universities in the US have adopted student vaccination mandates. There is no possible public health justification for this. Administrators at the other 75% of colleges are sacrificing the safety of their students and staff, endangering the members of their surrounding community at greatest risk of infection, and caving to public opinion, pressure from elected officials, or their fears of declining enrollment. Whatever the motivation, it is a dereliction of their most sacred duty. However, it highlights the timely contribution of Hockstein and colleagues to prevention portfolio design, the safe return to normalcy in higher education, and averting outbreaks that extend beyond campus walls.

ARTICLE INFORMATION

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REFERENCES


