Position statement: Return of South African children to school

30 May 2020

Summary

The South African Paediatric Association (SAPA) supports the government's position that children should return to school on 1 June 2020. There is uncertainty about the future trajectory of COVID-19 in South Africa, with more infections and a long duration being predicted. Children biologically contain SARS-CoV-2 better than adults, are less likely to get sick if infected, have milder disease, are unlikely to die from COVID-19, and are probably less infectious than adults. Although children are at higher risk of being infected once at school, this additional risk to themselves and others is outweighed by the benefits of them returning to school.

Background

There is controversy regarding the imminent reopening of schools in South Africa with conflicting views expressed by government, teacher trade unions, political parties, civil society organisations, school governing bodies, and parents, amongst others. This has led to much parental, caregiver, and child anxiety about whether children should return to school.

The Department of Basic Education (DBE) has proposed a staggered reintroduction of public schooling, with learners in Grades 7 and 12 starting school on 1 June 2020. There are concerns about schools' levels of preparedness and the possibility of them becoming nodes of SARS-CoV-2 spread.

This position paper represents the view of the South African Paediatric Association, a professional society representing paediatricians in the public and private sector in South Africa. The position is supported by the Paediatric Management Group.

Evidence to support recommendations

There is a paucity of data on SARS-CoV-2 in children, particularly in low resourced countries. None of the following statements is definitive, but reflect current best evidence.

1. **Acquiring SARS-CoV-2**
    a. Children are less likely to acquire SARS-CoV-2 than adults. Children account for 1-3% of reported cases across countries. Children and young people have lower susceptibility to SARS-CoV-2, with a 56% lower odds of being an infected contact.[1]
    b. Children have less severe disease, accounting for less than 1% of severe cases and deaths.
    c. Children are more likely to have an asymptomatic infection than adults.
2. **Transmission in children:**
    a. The ability of children to transmit SARS-CoV-2 is dependent on their susceptibility, symptoms, viral load, social contact patterns and behaviour.[1]
    b. At a population level, children may be less likely to transmit and have a minor role in transmission. A systematic review of household cluster studies suggests that children

were the index (transmitting) case in only 3 of 31 (10%) individual cluster studies.[2] A population-based contact-tracing study from Australia reported only two secondary cases in students and none in staff from 18 index cases (9 students, 9 staff).[3]

c. There are no published studies on the mechanisms of transmission of SARS-CoV-2 in children. Data on viral load in children, a potential marker of higher transmission is limited. A German study indicated that viral load may be lower in children than adults.[4]

3. **Teachers** are not at high risk of being infected by children. Teachers are at a higher risk of contracting the virus from other adults (e.g. colleagues), at home or in the community (outside school). Teachers with comorbidities are at increased risk for severe COVID-19.
4. **School opening**
    a. There are no data on the relative contribution of school closures to transmission control. COVID-19 modelling studies predict that school closures alone would prevent only 2-4% of deaths, much less than other social distancing interventions.[5]
    b. COVID-19 incidence in South Africa will inevitably increase over the next three months and possibly for longer. Postponement of re-entry to school to reduce transmission risk to negligible would entail a delay of many months before schools could reopen.
    c. School opening in many highly-resourced countries has not resulted in any major COVID-19 outbreaks. There have been sporadic cases reported, e.g. 70 infected children in France in the first week of reopening among 1.4 million children who returned to school.
5. **Reduction of Transmission**
    a. Measures taken to reduce transmission risk in school settings include attempts to reduce learner mixing (e.g., by increasing spacing between learners in classes, closing playgrounds, cancelling non-essential activities and meetings, keeping learners in fixed class groups or classrooms, staggering school start and break times across classes, shortening the school week or days), reduced class sizes, and extra handwashing or hand sanitiser use.
6. **Additional considerations**
    a. It is expected that there will an increased circulation of various pathogens and illnesses that ordinarily appear during the winter months in South Africa, including influenza, respiratory syncytial virus (RSV) and rotavirus.
    b. Most South African schools will be unable to easily keep children 1.5 metres apart in classrooms, and winter conditions will prohibit outdoor learning or keeping classroom windows open. Similarly, ensuring that physical distancing is maintained during school transport may be problematic.
    c. Recent South African **surveys of parents** have suggested that only one-quarter are supportive of sending their children back to school, while principals fear not having enough healthy staff.
7. **Risk-benefit analysis**
    a. The **benefits of returning to school,** particularly for poorer children, include the positive impact on their learning, access to the School Nutrition Programme (one meal per day), and mental health and well-being gains. Only about 20% of school children are currently benefiting from online schooling according to the DBE. School reopening will increase parents' and caregivers' ability to return to work.

Recommendations

Despite the relatively scant and weak quality of available evidence, particularly from resource-poor settings, it is necessary to make decisions about the return to school balancing the risks and benefits of any actions.

1. SAPA supports the position that children should be returning to school immediately. While it is certain that children face an increased risk of SARS-CoV-2 infection once back at school, the consequence for children will be milder compared to adults. Paediatric Kawasaki-like multi-system inflammatory syndrome is rare.
2. Most children, including those with asthma, allergic conditions and HIV can return to school. Children with severe immunosuppression, uncorrected significant congenital heart conditions, chronic organ failure, chronic severe respiratory disease and severe neurodevelopmental disability should stay at home. Advice from a paediatrician should be sought if there is uncertainty.
3. Schools should undertake measures that are known to reduce pathogen transmission. Schools should provide water, sanitation and waste management facilities and follow environmental cleaning and decontamination procedures. Wherever possible, disinfection measures to clean high traffic areas should be conducted at the start and end of each day and regularly during the course of the day. The focus should be on surfaces that are frequently touched (railings, lunch tables, sports equipment, door and window handles, toys, teaching and learning aids, etc.) Cleaning of the environment should be with soap and water and/or wiping with alcohol or chlorine-based solutions. Safety during school transport requires similar attention.
4. For individual children, measures such as physical distancing (learners at least 1 meter apart), masking, regular handwashing with soap (or sanitiser use, if water is unavailable) should be implemented. The use of decontamination tunnels or spraying of children has no benefit and may be harmful.
5. Where all the above measures are not available, SAPA's view is that educational activities should nevertheless commence as safely as is possible, while the government expediently attends to addressing any deficiencies.
6. An individual child older than 4 years should be required to wear a cloth face mask to prevent disease transmission. Use of plastic shield masks or other higher safety category masks is unnecessary, although not discouraged. There is no need for children to routinely put on aprons, gloves or other protective gear.
7. Sick learners, teachers and other staff should not go to school. Children who have a fever, cough, runny nose, sore throat, or diarrhoea and vomiting should stay at home. Symptom screening should be undertaken at school entry each day. It should, nevertheless, be recognised that most children (and many teachers) will be asymptomatic carriers. There is minimal benefit for routine thermal screening.
8. Teachers should take standard workplace precautions, including physical distancing in staff-rooms, to reduce the risk of SARS-CoV-2 transmission. Teachers with medical comorbidities or other risk factors for severe COVID-19 should preferably be allowed to participate in lower-risk activities at school, undertake virtual jobs or teach remotely.
8. Children should receive intensive age-appropriate education around the behaviour change required from them during the first few days back at school, and regularly thereafter.
9. Additional measures such as staggered school starting and ending times and different break schedules should be considered to reduce learner congregation. Extracurricular activities at

schools, including sports, should be curtailed until the pandemic is under better control to reduce transmission risk.

10. No nutritional supplements, medication, or other agents prevent COVID-19 disease acquisition or recovery in children.
11. Children who are well but who have an infected household contact should remain at home for 14 days from the onset of the contact's symptoms. There should be no requirement for children to have a negative SARS-CoV-2 test before being allowed to return to school.
12. Children who have a SARS-CoV-2 infected classroom contact, defined as close contact (less than 1.5 m) with an infected learner or teacher for 15 or more minutes while not wearing a mask should be advised to stay at home for 14 days.
13. If a child develops symptoms of COVID-19 disease, he/she should be tested. If negative, he/she can return to school immediately. If positive, or if no testing is done, the child will have to remain at home for 14 days from the onset of his/her symptoms (see National Institute of Communicable Diseases guidelines).[6]
14. Children with high-risk individuals at home (such as the elderly) should be advised to reduce contact time with them and do this more safely (e.g. wearing a mask during contact time), with more vigilant attention to home cleansing, and developing a home routine that minimises risk such as limiting the sharing of towels and kitchen utensils.
15. There is no consensus on what constitutes a school outbreak and when a school should be considered for full or partial closure because of an excessive number of COVID-19 cases. This situation can be managed by educational authorities in conjunction with public health experts on a case-by-case basis once schools reopen. Entire school closures should be avoided unless necessary. Individual class closure(s) is/are a more practical and sustainable solution.
16. Regular reassessment and evaluation of the situation will be crucial over the forthcoming months. A routine school monitoring system for COVID-19 infections in learners and staff should be instituted by the DBE.
17. We acknowledge that parental anxiety is not unfounded, with some children at higher risk for severe disease. Parental and caregiver autonomy must be respected. High-risk children and those children whose caregivers elect not to send them to school are as entitled to education and efforts should continue to facilitate this.

These recommendations may, and will, be amended based on emerging and accumulating evidence.

References

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3. (NCIRS) NCfIRaS. COVID-19 in schools - the experience in NSW. Sydney: NSW Government, 2020.
4. Held L. A discussion and reanalysis of the results reported in Jones et al. 2020. OSFPREPRINTS 2020
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6. National Institute of Communicable diseases. Clinical management of suspected or confirmed COVID-19 disease. Version 4 (18th May 2020). https://www.nicd.ac.za/diseases-a-z-index/covid-19/covid-19-guidelines/