



POSITION STATEMENT: Public school closure

The paediatric community, as represented by the Paediatrician Management Group (PMG) and the South African Paediatric Association (SAPA), is disappointed with the recent cabinet decision to close all public schools again. Following on the original SAPA position statement, supported by PMG, we believe this recent decision is not based on best available scientific evidence and it is not in the best interest of children in South Africa.

We have taken note of all the conflicting views expressed by government, teacher trade unions, political parties, civil society, school governing bodies and parents. We remain sympathetic to all parents/caregivers, children and educators who are fearful and anxious. However, we are of the opinion that is in our children's best interests to return to school.

This position paper represents the views of PMG and SAPA. These two paediatric bodies represent all paediatricians in South Africa.

Evidence to support this statement:

1) Children's risk to acquire SARS-Cov2 infection is lower than adults

- a) Children (0-18 years) account for only 1-5% of reported cases across countries. In South Africa children account for 5% of cases.
- b) South African case distribution by age data confirms that 5-9 years old have an incidence of 15 per 100 000 population; 10-14 year have an incidence of 22 per 100 000 population and 15-19 year old have an incidence of 38 per 100 000. In comparison the incidence in the 20 to 60 year old groups varies between 94 to 228 per 100 000 population.
- c) A recent media statement released by the Western Cape Education Department (WCED) confirmed that only 0.1% of all learners who had returned to school tested positive for SARS-CoV-2 and no deaths of learners were reported to the WCED. Although this percentage is affected by the current Western Cape testing strategy, it is nonetheless reassuring that the reopening of schools have not resulted in any significant outbreaks at a population level.

- d) Children and young people have a lower susceptibility to SARS-CoV-2, with 56% lower odds of being an infected contact.¹

2) Children's risk to transmit SARS-CoV2 in a household is lower than adults

- a) Family cluster/Household studies showed that children are rarely the index case and that children seldom cause outbreaks.²⁻⁵
- b) Zhu *et al* confirmed that children were only responsible for household transmission in 9.7% of households.⁴
- c) In the Italian cohort of Garazzino 67% (113/168) of children had at least one parent who tested positive for SARS-CoV-2 infection and in 78% of cases the symptoms in relatives preceded the symptoms in the child, confirming that children are rarely the index case in a household.⁶ We have observed the same pattern in South Africa to date.

3) Children's risk to contribute to school outbreaks is very low

- a) Evidence points towards very limited spread of COVID-19 between children. There are no reported large outbreaks in schools in any country. This supports the argument that asymptomatic children attending schools are unlikely to spread the disease.
- b) *Danis et al* reported not a single secondary case following a symptomatic 9 year old boy's contact with 172 children in 3 different schools.⁷
- c) The Australian National Centre for Immunization Research in New South Wales described nine high-school students and nine staff with confirmed COVID-19 in 15 schools. Of the 735 students and 128 staff contacts only two children may have contracted SARS-CoV-2 from these initial school cases, but no staff contracted SARS-CoV-2.⁸
- d) In Ireland 6 school cases were identified (3 older than 18 years, 3 between 10-15 years). A total of 1155 (949 children and 101 adults) contacts were screened and not a single secondary case was identified.⁹
- e) In the Western Cape (WC) more than half of the schools have not reported a single positive case despite very high community transmission in the WC at the time of the reopening of schools. In the schools who have reported a case, 72% reported only 1 or 2 cases. As of the 16th of July, there were only 333 (0.8%) active Covid-19 cases amongst WCED staff, indicating that teachers are not at greater risk than other essential workers. There have been no reported outbreaks in WC schools and weekly new staff cases have been decreasing since the reopening of schools despite ongoing high community transmission rates.
- f) There is no reported South African data that proves that reopening of schools played a significant role in community transmission rates.

4) Children's risk for serious disease or death with COVID is extremely low

- a) Children have a much milder disease than adults and deaths are extremely rare. Studies from China, Italy, UK and USA all report very low numbers of critically ill children and deaths in children <19 years.^{6,10}
- b) By the 9th June 2020 only 2.6% of all COVID-related admissions in South Africa were for children 0-18 years and only 0.4% of all COVID reported deaths were in children 0-18 years.
- c) SARS-CoV-2 has caused less childhood deaths compared to Influenza from the onset of the SARS CoV-2 pandemic. Research from 7 high income countries on 42,846 confirmed paediatric Covid-19 children showed 44 Covid-19 and 107 Influenza paediatric deaths during the 2020 pandemic.¹¹ During the South African Influenza season of 2017 an estimated 580 children died of Influenza.
- d) Furthermore, injury related deaths continued to dominate as the number one cause of paediatric mortality during 2020. Paediatric mortality from unintentional injuries, pneumonia and Covid-19 infections was 0.77, 0.22 and 0.03 respectively, per 100 000 childhood population.¹¹
- e) Using StatsSA data from 2016, Prof Servaas van der Berg and Dr Nic Spaull from Stellenbosch University, estimated the regular mortality risk for ages 0-19 years in SA is a 1 in 1000 chance, while the projected COVID-19 mortality risk in the same age group is 1 in a 76 000 chance (0.001%).¹²

5) High risk learners and educators are protected

- a) Even though there is scant data on the role of co-morbidities in children, the Department of Basic Education (DBE) has already made provision to allow high risk learners to stay at home.
- b) In addition, all school staff members with co-morbidities have also been allowed to stay at home without any loss of income. Therefore, those who have been and would be attending school are per definition, not high risk.
- c) Within the paediatric population, children of school going age are considered to have the lowest risk for hospitalization and critical disease.¹⁰

6) Limited benefit of school closure to contain a pandemic

- a) There is no clear evidence that school closure results in a significant reduction in community transmission or overall deaths. A COVID-19 modelling study done in the UK which was based on the previous H1N1 epidemic and the SARS outbreak, predicted that school closures alone would possibly prevent only 2-4% of deaths. This is much less than other social distancing interventions.¹³

7) Major harms of school closure

- a) Access to basic education is a basic human right enshrined in our constitution. By the end of August the majority of learners would have missed half of their school year. Only about 20% of school children have access to online schooling according to the DBE and it is estimated that only 10% of households have internet access. This lack of access to education is disproportionately affecting vulnerable and disadvantaged children.
- b) The knowledge and skill gap between those with access and those without will only continue to increase and this loss of education will have long term and far reaching economic effects.

- c) The DBE has not implemented any meaningful strategies since March, to mitigate any of these effects and a significant percentage of learners have not received any educational material since March 2020.
- d) In 2018, 77% of children in public schools, approximately 9-million children, received a school meal every school day (Statistics South Africa, 2019a). It is still unclear how schools plan to continue with the feeding scheme without any staff members present or how caregivers/children will collect the meals.
- e) The emotional and psychological effects on children during and after lockdown is immense. Recent international reviews show that lockdowns, school closures and natural disasters raise levels of substance abuse, depression, domestic violence and child abuse.¹⁴ A recent study in Hubei reported that 25% of 8 - 12 year old children developed depression.¹⁵ In South Africa, many learners are already under immense emotional and psychological stress due to poverty, malnutrition, crowded living conditions, child abuse, gender-based violence and other violent crime. The OPTIMUS study in 2016 reported that 42% of 15 to 17-year-old children reported some form of maltreatment.¹⁶
- f) School closures increase childcare obligations, especially of healthcare or essential workers. *Bayham et al* estimated that if mortality rates for COVID-19 increased from 2.00% to 2.35%, as a result of healthcare worker shortages, school closures would result in more deaths than the lives gained due to slower COVID-19 spread.¹⁷
- g) By reopening the economy while keeping schools closed, many parents/caregivers are forced to leave their children at home unattended. Less than one-third of children live in households where both parents are present, and almost 42% live in households where the mother is the only parent present (Statistics South Africa, 2019). It is estimated that more than 2 million children aged 0-15 years will be left at home unattended, increasing their risks for accidental injury, abuse, fear, anxiety and isolation.

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8) Uncertainty about the peak of the pandemic

- a) To date, it has been clear that transmission rates vary greatly between provinces, with the Western Cape leading initially, followed by the Eastern Cape and now Gauteng. Current international data suggests that countries may experience multiple peaks over the next 12 months. It is therefore unclear when the teacher unions and the cabinet would consider it “safe” again to reopen schools if the so called “peak” varies geographically and is difficult to predict. This current government strategy will lead to ongoing future interruptions.
- b) It seems illogical to close all schools in all provinces and districts if community transmission rates vary so significantly. Allowing school communities to monitor and manage their risks based on local transmission would enable more schools to continue with their school activities and limit interruptions over the next 12 months.

Summary

In our view as paediatricians the benefits of attending school still outweighs the risks. Public schools should be allowed to reopen. School communities should be allowed to reopen their schools immediately if they are able to do so safely. Those school communities who are at risk, either due to

high local transmission rates, or poor infrastructure should be identified and supported immediately to mitigate their risks so that they can reopen as soon as possible. Where schools are unable to reopen, the DBE must still ensure that all learners continue to have safe access to feeding schemes and adequate academic material via radio, television, cell phone applications and all other means necessary. Educators must be held accountable for providing ongoing academic support and material at all times.

We urge government to place the health, well-being and needs of children as their first and foremost priority and to not allow fear or politics to harm the children of South Africa. We ask that they adhere to the Children’s Act of 2005: “In all matters concerning the care, protection and well-being of a child the standard that the child’s best interest is of paramount importance, must be applied.”

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