

Educational Leaders' Need for Health Literacy During the COVID-19 Pandemic

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ABSTRACT

School leaders will face great challenges balancing health considerations of students and school staff with powerful political forces demanding that schools reopen as early as possible. In order to navigate this new educational landscape, school leaders will need to work with medical and public health officials to acquire health literacy. This will enable them to understand medically accurate information while rejecting politically inspired misinformation they will receive in the coming year. Health literacy will be an important skill needed by educational leaders to make the best possible decisions during this unprecedented pandemic.

Keywords: child health, communicable diseases, crisis management, public health, risk management, school health services, scientific literacy

Public school educational leaders face incredible pressure to open, or keep open, schools in the spring of 2021, despite the rapidly rising number of COVID-19 cases in the USA. Much of the discussion about the topic of COVID-19 has become politicized. For example, President Trump threatened to eliminate funding to school systems that choose not to open as usual (Luhby, 2020) and

even convinced the Center for Disease Control (CDC) to change its school reopening guidelines because they were “too tough” (Phelps, 2020). School leaders need to acquire health literacy skills in order to navigate the maze of information and disinformation that will be coming in the next few months in order to provide a safe environment for their students.

MAIN ARGUMENT/LITERATURE

Sørensen et al. (2012) defined health literacy as “people's knowledge, motivation, and competence to access, understand, appraise and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention, and health promotion to maintain or improve quality of life” (Definitions of Health Literacy section, para. 3). School leaders possess an enormous responsibility to care for the health of their students. Health literacy will play a crucial role in the ability of school leaders to accomplish this objective, as will be discussed in the following examples.

School leaders must take care to understand the assumptions underlying medical advice. For example, the American Academy of Pediatrics (AAP) has offered advice for school openings that rests on the premise that “the coming school year should start with a goal of having students physically present in school” (American Academy of Pediatrics, 2020, para. 7). Valid reasons exist to support the premise, but school officials must be aware that the AAP advice will favor in-person school attendance even though “many questions remain” about the extent to which children transmit COVID-19—both to adults and students in school and to others in the home or the community (American Academy of Pediatrics, 2020, para. 7). The premise of maximizing the number of students in school also underlies the suggestion that distances between students can be reduced to three feet rather than six feet, thereby enabling schools to place more students in each classroom.

The use of qualifying words like “may” couch recommendations that lack a firm scientific basis. The most important issue with questionable scientific support is whether children transmit the virus in a manner similar to adults. Schools leaders must keep a close watch on this issue because the in-person return to schools will be doomed if children spread the virus to others. The scientific evidence suggests children are largely asymptomatic carriers of the disease, experience milder symptoms, and are less likely to spread the virus (Ludvigsson, 2020). Some less rigorous evidence suggests that children can spread the virus, as occurred at the Kanakuk Kamps in Missouri where the number of people testing positive rapidly increased from 2 to 82 and forced the camp to close (Golden, 2020). A similar case occurred in Georgia at a residential camp where 260 attendees, largely children and young adults, tested positive

(Kane, 2020). Obviously, the same type of occurrence can arise in schools if children prove capable of spreading the virus in a manner similar to adults.

Management of pandemics and outbreaks in schools is largely based upon studies involving children impacted by influenza. In the case of influenza epidemics, children are the main spreaders of the disease (Canadian Paediatric Society Infectious Diseases and Immunization Committee, 2005). Research from influenza-infected populations in the area of school closure and management practices during pandemic influenza outbreaks indicates decreased transmission rates if initiated early, with impacts primarily on attack rates (Jackson et al., 2014). However, school closures might not be as effective in the situation of COVID-19, as we lack evidence regarding transmission via child-child contact or through school. The findings of current systematic reviews on COVID-19 often must be interpreted with caution, as some cited reviews include un-reviewed studies. However, children do not live in a vacuum and family transmission remains an important factor to consider.

The term *school age children* generally encompasses those 5-18 years of age. However, it would be a serious error to treat all ages of children as identical for purposes of COVID-19 infection and transmission. The age of the child must be considered in the policy development of school re-opening. Current studies identify children 10 years and under as less likely to test positive or transmit COVID-19 to adults (Gudbjartsson et al., 2020; National Center for Immunisation Research and Surveillance, 2020). In contrast, children aged 11 and above appear to be more similar to adults in terms of the risks of infection and transmission. School districts may need to consider the possibility of offering different attendance options for younger students versus secondary school students.

The chronic shortage of school nurses may exacerbate the issues raised by the COVID-19 pandemic. Nationwide, just over a quarter (25.2%) of schools (public and private) do not have a school nurse on their payroll (Willgerodt et al., 2018). The implementation of strategies often will occur without the support or guidance of school nurses, who are often the lone person with health expertise at the school level. School leaders will be expected to navigate and interpret large amounts of scientific information mixed with politically inspired misinformation from state, local, and federal public health policy advisors. It will be imperative for school leaders to confer with trusted medical experts to navigate difficulties present when sifting through the conflicting information. Relationships must be built with local health officials, while school systems with strong health departments will need to take advantage of the expertise of their medical experts. In addition, someone with medical expertise should be present in each school to help navigate the inevitable COVID-19 issues that arise, such as children with symptoms whose parent refuses to pick up their children.

Comparisons about school openings in the U.S. to other developed nations that have successfully reopened schools neglect to mention that many of these nations have additional infrastructure in place, allowing support of schools reopening. Universal healthcare coverage and employment subsidy are two important resources we do not enjoy in the U.S., which would possibly have an impact on the ability to safely reopen and care for those who may possibly become infected.

The need to absorb and digest the vast amount of medical information cannot distract school leaders from considering the basic facts related to school operations, especially in the face of parent and political pressure to reopen schools fully. However, when schools open, students will need to be spread out more than normal. Such spreading out inevitably will lead to smaller class sizes. To cite two simple examples, if elementary classes need to decrease from 25 students to 20 students, that entails 25% more teachers and classrooms for every 100 students. A more drastic decline from 24 students per class to 12 would require twice as many classrooms and teachers. Similar examples could be illustrated to show the lack of feasibility with respect to plans offering choice between small “hybrid” classes and online course offerings. The only way school systems could afford to return children to school in substantial numbers reflecting pre-pandemic levels would be to ignore CDC social distancing guidelines, which absolutely cannot be an option unless the goal is to turn schools into COVID-19 Petri dishes.

Another issue schools must address in 2021 will be vaccinations for children. Although a COVID-19 vaccine for children will likely not be available until late 2021 (Boyle, 2020), it will be critical to schools’ reopening and to the resembling of school life pre-pandemic. Sallie Permar, MD, PhD, immunologist and professor at Duke University School of Medicine, noted, “It [pediatric vaccine] will be the basis of eliminating COVID-19 in our population” (para 4 as cited in Boyle, 2020). In the meantime, reopening schools will hinge on perhaps the most basic issue: the school budget. Schools face great pressure to open and stay open in the spring as well as strong desires to return to pre-pandemic operations (Hill & Jochim, 2020).

CONCLUSIONS/ IMPLICATIONS

School officials must acquire health literacy in order to manage schools in a safe and healthy manner during the COVID-19 pandemic. They will need to analyze the complicated medical literature while understanding how to reject misinformation spread for political reasons. School leaders will need to work with legitimate medical and public health experts in order to make the best

decisions for their students, the adults who work in schools, and for the community as a whole.

REFERENCES

- American Academy of Pediatrics. (2020, June 25). *COVID-19 planning considerations: Guidance for school re-entry*. American Academy of Pediatrics. <https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/>
- Boyle, P. (2020, October, 19). *We can't defeat COVID-19 without vaccinating children. There aren't even any kids' clinical trials yet*. Association of American Medical Colleges. <https://www.aamc.org/news-insights/we-can-t-defeat-covid-19-without-vaccinating-children-there-arent-even-any-kids-clinical-trials-yet>
- Canadian Paediatric Society Infectious Diseases and Immunization Committee. (2005). Influenza in children. *Paediatric Child Health*, 10(8), 485-487. 10.1093/pch/10.8.485
- Golden, A. (2020, July 9). *Kanakuk Kamps battle a COVID cluster*. NBC News. <https://www.nbcnews.com/news/us-news/kanakuk-kamps-battle-covid-cluster-n1233186>
- Gudbjartsson, D. F., Helgason, A., Jonsson, H., et al. (2020). Spread of SARS-CoV-2 in the Icelandic population. *New England Journal of Medicine*, 382, 2302-2315. 10.1056/NEJMoa2006100
- Hill, P. T. & Jochim, A. (2020, October 29). *Can public education return to normal after the COVID-19 pandemic*. Brookings. <https://www.brookings.edu/blog/brown-center-chalkboard/2020/10/29/can-public-education-return-to-normal-after-the-covid-19-pandemic/>
- Jackson, C. Mangtani, P., Hawker, J., Olowokure, B., & Vynnycky, E. (2014). The effects of school closures on influenza outbreaks and pandemics: Systematic review of simulation studies. *PLoS One*, 9(5), e97297. 10.1371/journal.pone.0097297.
- Kane, A. (2020, July 31). *A Georgia sleepaway camp's coronavirus outbreak is a warning for what could happen when schools reopen, CDC says*. CNN. <https://www.cnn.com/2020/07/31/health/georgia-camp-coronavirus-outbreak-cdc-trnd/index.html>
- Ludvigsson, J. F. (2020). Systematic review of COVID-19 in children shows milder cases and a better prognosis than adults. *Acta Paediatrica*, 109, 1088-1095.

- National Center for Immunisation Research and Surveillance (NCIRS). (2020). *COVID-19 in schools – the experience in NSW*. http://ncirs.org.au/sites/default/files/2020-04/NCIRS%20NSW%20Schools%20COVID_Summary_FINAL%20pub%20lic_26%20April%202020.pdf
- Phelps, J. (2020, July 9). *No revisions to school reopening guidelines despite Trump demand, just 'additional information': CDC director*. ABC News. <https://abcnews.go.com/Politics/revisions-school-reopening-guidelines-trump-demand-additional-information/story?id=71694982>
- Sørensen , K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., & Brand, H. (2012). Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*, 12(80). Retrieved from <http://www.biomedcentral.com.ezproxy.lib.vt.edu/1471-2458/12/80> [Google Scholar], p. 3)
- Willgerodt, M.A., Brock, D. M., & Maughan, E.M. (2018). Public school nursing practice in the United States. *The Journal of School Nursing*, 34(3), 232-244.

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