

# **SHARED RESPONSIBILITY: Recommendation on Limited Face-to-Face**

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Department of Education**

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This report is respectfully submitted to the President, to recommend the conduct of pilot implementation or dry-run of face-to-face classes in low-risk areas, on a limited scale and under strict health and safety measures. This report is divided into four parts: (A) Principles and general framework; (B) a brief update on the implementation of the school year; (C) key considerations on the resumption of face-to-face classes; and (D) Recommendations for consideration of the President.

## **A. Principles and General Framework**

At the outset, we lay down the framework and principles that will govern any conduct of face-to-face classes at this time when COVID-19 is yet to be fully contained:

- 1) Given the direct interest that the President has taken on resumption of face-to-face classes on account of its public health implications, the conduct of face-to-face classes in basic education is a matter for the President to decide. Inputs from the Secretary of Education are recommendatory;
- 2) Should the President approve conduct of face-to-face classes, the Department of Education will implement the decision with the participation of the other key players in the educational system, namely:
  - The host local government unit;
  - The parents who are responsible for health and safety standards in the home; and
  - The transport providers;
- 3) The express support of the host local government unit must be secured; the written consent of parents is required; transport providers must observe health standards in their vehicles; and external organizations are invited to support, give feedback and help generate resources to ensure the success of the program; and
- 4) Face-to-face classes shall first be piloted in select areas before DepEd makes a final recommendation to the President.

Thus, the general framework of the policy decision will be that of shared responsibility. The tendency at present is to blame one department for events and situations beyond its control – be it floods, wet modules, family issues of learners and teachers, and transport systems. If face to face classes will be resumed, the host community – LGUs, parents, organizations, transport providers, will assume and share the corresponding responsibilities. We resume face to face classes as one.

## B. Update on the School Year

As the President is aware, we were able to successfully open SY 2020-2021 for basic education (Kindergarten to Grade 12) last October 5. This decision ultimately had the support of the parents, with 25.05 million learners as of November 11, 2020 enrolled in combined public and private schools, and inclusive of non-formal education (Alternative Learning System or ALS). This represents 90.2% of our enrollment last year, which is higher than the adjusted enrollment target that we submitted to NEDA. The reduction in enrollment was experienced mainly in private schools, where enrollment reached only 51.7% of last year’s enrollment. In contrast, our enrollment in public schools for formal education even increased by 2.4% than last year’s enrollment. (See Table 1)

**Table 1. Enrollment, Kindergarten to Grade 12 (as of November 11, 2020)**

	<b>Total Enrollment</b>	<b>Last SY Enrollment</b>	<b>% of Last SY's Enrollment</b>
Public, Private, SUCs/LUCs	25,050,526	27,770,263	90.21%
Public Only	22,765,030	22,572,923	100.85%
Public, Formal	22,356,296	21,833,051	102.40%
<i>Alternative Learning System (ALS)</i>	408,734	739,872	55.24%
Private Only	2,226,292	4,304,676	51.72%

We were able to proceed with this school year with great effort, transforming education delivery from one based in classrooms, to one that is through distance learning, in a span of a few months. This involved developing new learning resources, including printed and digital modules, online learning where available, and supplemented by television and radio-based instruction. We mobilized resources from DepEd’s own appropriations, in cooperation with DBM which spared us from further contributing to the budget needs for *Bayanihan 2*. The local government units also gave considerable contributions to support learning continuity.

## C. Key Considerations on Resumption of Face-to-Face Classes

The President’s decision not to allow face-to-face classes as we opened the school year reflected his concern for the health and safety of the children, given that

there are many things that are not yet known about COVID-19 transmission among children in school setting.

The President's decision was also prescient of the sentiments of the parents, as shown by the results of a survey conducted by Pulse Asia in mid-September before the opening of classes. While 60% of the respondents agreed to DepEd's decision to open the schoolyear through distance learning, and only 25% disagreed (15% were undecided), the greater proportion of the respondents (73%) agreed with the President to wait for a vaccine before allowing students to physically attend school. Only 23% were agreeable to physical attendance in schools in low-risk areas, provided health and safety precautions are observed.

However, there have already been developments since the opening of classes. For one, we have started to open up economic activities as COVID-19 situation has improved in many areas and have already been placed under Modified General Community Quarantine (MGCQ).

It is within this context that we again report to the President and share various considerations to determine whether the no face-to-face classes policy can already be reconsidered at this time in certain areas under stringent conditions.

We submit that there are four considerations that need to be examined: (1) The necessity for face-to-face classes in the learning process; (2) COVID-19 risk factors in school setting; (3) The health and safety prevention and management standards for COVID-19 in school setting; and (4) The sharing of responsibility especially in case infections or exposure occur.

### **(1) Necessity for face-to-face classes in the learning process**

The pandemic has compelled education systems around the world to adopt distance learning modalities for basic education at a scale not done before. While there are major challenges that confront the department, students, teachers and school leaders, this has at the same time presented new opportunities that will serve us well for adapting to the future of education post-COVID-19.

Among the positive developments that are happening include: the use of low to high technologies for remote or distance learning, along with the development of the required learning resources; the greater reliance of learners on self-learning, which will serve them well in this time when knowledge and information are digitally accessible; the reconnection of schools with parents as instructional partners in the learning process; and the expansion of the learning spaces to include not just the physical classrooms, but also the home, community spaces, and the virtual space. All these are changing the landscape of education globally, and our hands-on experience with our learning community allows us to gain experience and knowledge on these new modalities.

Still, face-to-face classes remain a necessity for education. The social aspect of learning where students are able to interact with their teachers and classmates cannot be fully replaced by distance learning modalities. The skills of students for self-learning is uneven. Household resources to assist children in the learning process are also uneven, affected by household income, education of household members, access to internet, number of children in the household needing to be assisted, and work situation of household members. Without more consistent instructional guidance by teachers, the learners finding it difficult to learn by themselves and without household capacity for instructional support will be left behind. The time devoted for the learning process, without direct monitoring by teachers, also differ vastly across students and households. Allowing teachers to see their students face-to-face, even on an intermittent schedule, will enable greater opportunities to check on the learning progress of the students and to provide needed instructional supervision and interventions.

Thus, DepEd would want to reintroduce face-to-face classes where such can be made consistent with the public health standards of government in light of COVID-19, and upon approval of the President. The challenge is to identify when, where and how this can be done, and the next three considerations are relevant in responding to these questions.

## **(2) COVID-19 risk factors in school setting**

Two factors are relevant to the risk factors in school setting.

The first is the overall COVID community risk categorization. Based on the latest IATF Omnibus Guidelines on the implementation of community quarantine (as of November 19, 2020), for places under ECQ, MECQ, and GCQ, face-to-face classes remain suspended. Additionally, children below 15 years old are required to remain in their residences at all times.

However, for MGCQ areas (transition phase between GCQ and New Normal), certain quarantine measures are already being relaxed. The basis for the quarantine classification of an area are the COVID-19 cases and transmission levels, and the utilization level of critical health care facilities.

While the Omnibus Guidelines still provides, under Section 5 (3), that children below 15 years old are required to remain in their residences at all times, there is relaxation for tourism purposes subject to certain conditions. There is also some level of opening for education purposes under Section 5 (6). For K to 12, a level of discretion is recognized for the Basic Education Learning Continuity Plan of DepEd. There is a clause that for the purpose of the said Section 5 (6), the prohibition under Section 5 (3) does not apply.

However, it is not enough to know the quarantine classification of an area in evaluating the resumption of face-to-face classes. The second factor that needs to be

considered is the more specific risk factors among school-age children, and the possible role that children coming to school may play in COVID-19 transmission. On this aspect we are guided by the information and data from the DOH and the IATF. We also look at studies and relevant literature, as well as engage expert advice, by reputable institutions.

In a roundtable discussion held last October 15, 2020 with UNICEF Philippines, WHO Philippines, and the ADB on the resumption of face-to-face classes, UNICEF's presentation included a slide summarizing some of the global evidence on COVID-19 infection among children. These include: children and adolescents comprise a small proportion of total reported cases; most cases in children result from household exposure; and children as index case for transmission is low. (See box 1)

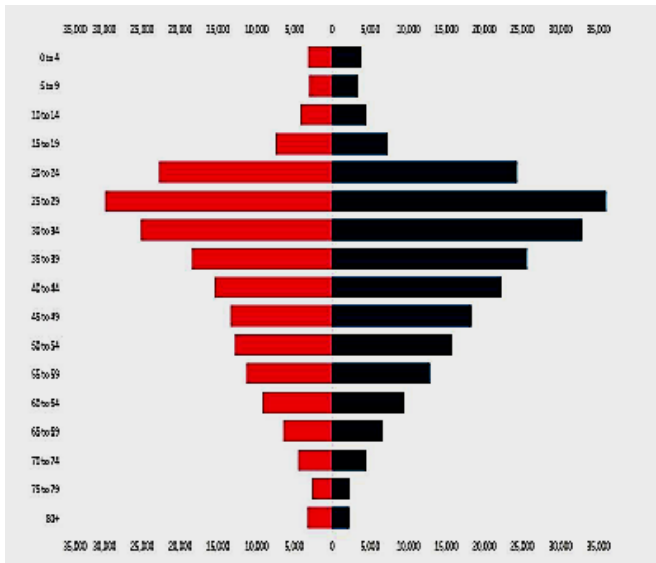
**Box 1. Summary of Global Evidence of COVID in Children (Excerpt from UNICEF Philippines PPT presentation, 15 October 2020 roundtable discussion with DepEd)**

**Global evidences**

- Children and adolescents comprise a very small proportion (1-5%) of total reported cases
  - Increasing trend within the 0-19 years continuum
- Most cases in children result from household exposure (91%) – *US CDC*
- Child as index case for transmission is low (8%) – *Switzerland*
- Secondary infections in schools is far lower:
  - **Australia:** Evaluation of 15 schools, only 2 secondary infections were identified among 735 student contacts
  - **France:** 0 secondary cases among 112 school contacts
- Children have lower risk for developing severe symptoms or critical illness
  - **China:** from 728 children with COVID, 5% were severe, with < 1% critical
  - **Germany:** Transmission by children is low, presumably due to milder case presentations
- Severity with co-morbidities – limited data still
  - However, in a recent US Study of 48 children with COVID, 83 % has pre-existing medical conditions

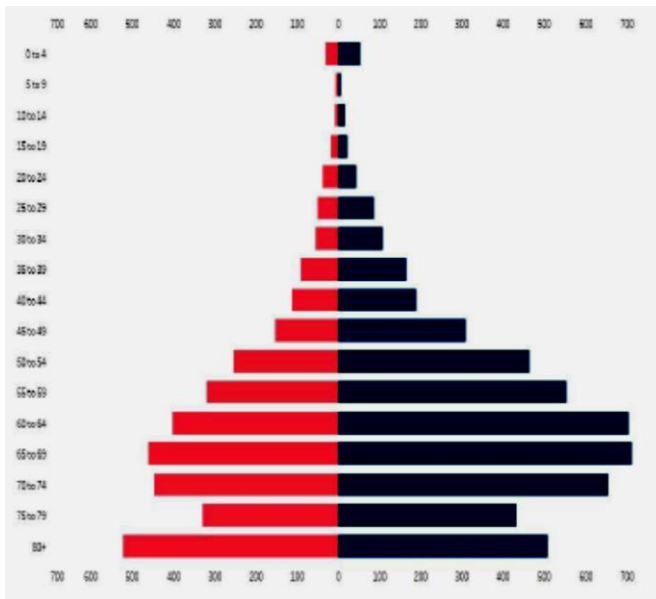
The lower incidence among children relative to older age groups is reflected in the profile of Philippine data on COVID cases and deaths. This is shown by the relatively smaller proportion of cases and deaths in the 5-19 years old age groups, as shown in Figures 1 and 2.

**Figure 1. Age and Sex (F/M) Distribution, COVID-19 Case Counts, as of November 29, 2020**



Source: DOH, Beat COVID-19 Today, Issue 216, November 29, 2020

**Figure 2. Age and Sex (F/M) Distribution, COVID-19 Deaths, as of November 29, 2020**



Source: DOH, Beat COVID-19 Today, Issue 216, November 29, 2020

Despite the relatively lower incidence for school-age children, WHO Philippines notes that there is a higher incidence of asymptomatic positive cases among children. One of the PPT slides of WHO Philippines at the roundtable discussion with DepEd shared that in known seroprevalence studies<sup>1</sup>, 40-75% of seropositive children reported no previous symptoms. It also noted that symptom-

<sup>1</sup> Seroprevalence studies or surveys on COVID-19 uses antibody tests to estimate the percentage of people in a population who have antibodies against SARS-CoV-2.

based screening failed in 45% of children with infection. This poses challenges for symptom-based screening, testing and tracing among children. WHO Philippines also notes that there is still inadequate evidence for transmission in school settings.

The challenge of higher prevalence of asymptomatic cases among children is corroborated by a recent study cited in an August 20, 2020 article (*Children's role in spread of virus bigger than thought*) in The Harvard Gazette ([Looking at children as the silent spreaders of SARS-CoV-2 - Harvard Gazette](#)). Among the findings of the cited study titled *Pediatric Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2): Clinical Presentation, Infectivity, and Immune Responses* by Lael M. Yonker, et. al. published in the Journal of Pediatrics (see <https://www.jpeds.com/action/showPdf?pii=S0022-3476%2820%2931023-4>) was that “children can carry high levels of virus in their upper airways, particularly early in an acute SARS-CoV-2 infection, yet they display relatively mild or no symptoms.” They also found “no age correlation with viral load, indicating that infants through young adults can carry equally high levels of virus”.

The above discussion points to two things.

First, the reintroduction of face-to-face classes can only be done in areas already categorized as low risk. Under the present IATF classifications, these are in areas at least already under MGCQ. Within these areas, further community risk assessment may be done. For example, certain areas may have very limited outside contact that they may practically be considered as bubbles.

Second, while the global and Philippine proportion of school-aged children in total recorded COVID-19 cases and deaths are relatively low, there are emerging children-specific medical findings that pose challenges in COVID-19 prevention and management in school setting. This will be taken up in the next consideration.

### **(3) The health and safety prevention and management standards for COVID-19 in school setting**

Given the specific challenges and risks associated with children, all the more that carefully planned health standards and stringent enforcement are needed to ensure safe return to school in areas and for students permitted to conduct face to face classes.

The character of COVID-19 that it is transmitted mainly from respiratory contact or exposure with/to an infected person. This can happen in any place or at any time. Thus, in the context of resumption of face-to-face classes, the observance of health standards should cover health standards in the home, during travel, and while in school.

#### **1. Health standards in the home.**

As shared by WHO Philippines in its presentation, most children are infected at home. When face-to-face classes resume, there is possibility of these children infected in home setting, especially if asymptomatic, to be coming to school and exposing the teacher and classmates in school setting. Consequently, if transmission in school setting happens, it can be carried by other children to the home and potentially infect family members.

Thus, it is very important that households of school-going students observe proper health standards at home, especially for members going out for work or for necessities, and for the students that will participate in face-to-face classes.

Because of the relatively higher incidence of asymptomatic infection among children, it is very important that parents do not send children to school when there is a known infection or exposure in the household, or anyone exhibiting flu-like symptoms. This fact should be fully disclosed to the teacher, for monitoring and proper precautions in school premises.

## **2. Health standards in going to school and coming back home.**

The travel of students to and from school can be an occasion for close contact. Thus, physical distancing, wearing of mask and face shield, and proper respiratory etiquette must be practiced at all points of travel including at drop-off and pick-up, and in school entrances.

Based on the data generated from DepEd's Learner Enrollment and Survey Form (LESF), consolidated as of August 27, 2020, of 15,491,572 responses, 8,006,531 or 51.7 person walk to and from the schools. Another 2,190,220 or 14.1% ride family-owned vehicle. These students, comprising a combined 65.8% of the responses, pose less risks of exposure during travel. The higher risks of exposure are for those using public transportation (4,640,500 or 30.0%) and those using school service (654,321 or 4.2%). Such travel must observe social distancing, wearing of masks and face shield, and respiratory etiquette inside the vehicles and in pick-up and drop-off points. (See Figure 3)



**Figure 3. Learner Enrollment and Survey Form, Responses on How Children Go to School, Processed Data as of August 27, 2020.**



### **3. Health standards while in school premises.**

DepEd is able to secure greater supervision of the enforcement of health standards within school premises. We will implement the standard prevention protocols prescribed by the DOH and IATF, and add measures particularly adapted to school settings. We quote excerpts from the concluding portion of the earlier-cited Yonker, et. al. study, as its findings may require some adjustments in the school-based health standards:

“Limiting the spread of SARS-CoV-2 infections in children is of particular concern as schools plan for reopening. Our findings suggest that it would be ineffective to rely on symptoms or temperature monitoring to identify SARS-CoV-2 infection. Instead, infection control measures should minimize the possibility of viral spread, with focus on strategies including social distancing precautions, mask use, and/ or remote learning. Moreover, schools could screen all students for SARS-CoV-2 infection and establish routine screening protocols. Without infection control measures such as these, there is significant risk that the pandemic will persist, and children could carry the virus into the home, exposing adults who are at greater risk of developing severe disease. This risk is particularly high in lower income communities, where household size may be larger with multigenerational cohabitation and greater housing density. These recommendations contradict previous reports from the initial phase of the pandemic, which found children to be less likely to be the index case for viral transmission within a household.”

We divide the health standards into two categories: preventive measures, and management in case of infection or exposure.

#### **c.1. Preventive measures**

- **Intermittent/Staggered Classes**

The President’s commitment to ensure full protection to our children remains DepEd’s overriding policy direction. Thus, in the absence of a

vaccine, we will not implement full scale face-to-face classes. Instead, it will be blended with distance learning.

Face-to-face classes will be intermittent, staggered or in shifts, with reduced class size. This will afford social distancing, limit contact intensity, and keep monitoring to manageable levels.

In a blending of face-to-face and distance learning modalities, face-to-face classes will serve the following purposes:

- To allow face-to-face activities in aid of distance learning, including: directly checking the learning progress and soliciting feedback from the learners; conduct formative and summative assessments face-to-face; conduct interactive and collaborative activities among the learners; allow access to school-based resources such as libraries, laboratories and workshops, and internet connectivity; conduct teacher-student consultations; among others.
- Allow learners to access mental health and psychosocial support services in school.
- Allow learners to access learner support services such as school health and nutrition activities, youth formation activities, and permitted school sports activities, among others, provided they do not constitute mass gathering.

The school shall restrict conduct of large gatherings and activities such as field trips, sports festivals, and flag ceremony.

- **Prioritization of students for face-to-face classes**

Because face-to-face classes will not be at full scale, there will be prioritization on who will participate in face-to-face classes. Among those that may be prioritized include: Learners with learning disabilities; Children who require childcare, such as those whose parents must work outside the home, or who have no responsible adults at home; Learners heavily dependent on face-to-face learning interventions, such as Key Stage 1 learners; Learners who struggle to meet the required learning competencies; Senior high school learners enrolled in Technical-Vocational-Livelihood (TVL) track requiring workshop equipment in school; and, Learners documented to be affected by mental health concerns that may be alleviated by face-to-face interactions.

Priority shall also be given to learners with demonstrated readiness to observe health protocols.

Learners with existing health or medical conditions that make them vulnerable to COVID-19 (i.e., immunocompromised) shall remain under predominantly distance learning modalities.

- **Individual health protocols**

Learners, teachers, and school personnel shall be required to strictly observe individual health protocols including:

- Respiratory etiquette (When sneezing/coughing, use tissue or inner portion of elbow to cover nose and mouth, and be sure that proper distance is maintained. Do not cover the mouth with the hand.)
- Physical distancing (at least 1 meter apart) at all times
- Frequently clean hands by using alcohol-based hand rub or by proper handwashing with soap and water.
- Proper use of face masks at all times. Both nose and mouth must be covered. Those with no symptoms may use cloth/washable face masks. The school shall keep surgical masks available at the school clinic and at school entrances in case an individual manifests any COVID-19 or flu-like symptom
- Proper disposal of tissue and non-reusable masks after use
- Teachers shall allot a specific period for regular and thorough handwashing with soap and water, subject to the strict observance of physical distancing.

- **School health and safety standards**

***Proper orientation.*** All learners, teachers and personnel, on the first day of their reporting to school, shall be provided with orientation on all health standards to be strictly observed at home, during travel to and from the school, and within school premises.

Information, education, and communication (IEC) materials containing key messages on health and safety shall be displayed in strategic areas of the school.

***WASH in Schools.*** All schools conducting face-to-face classes shall strengthen the implementation of the Comprehensive Water, Sanitation and Hygiene (WASH) in Schools (WinS) Program. The school shall ensure that learners, teachers, and personnel have access to hand soaps/hand-sanitizers/alcohol-based solutions/other disinfectants in restrooms, classrooms, entrances, etc.

***Regular disinfection.*** The school shall regularly clean/disinfect frequently touched surfaces and objects (tables, doorknobs, desks,

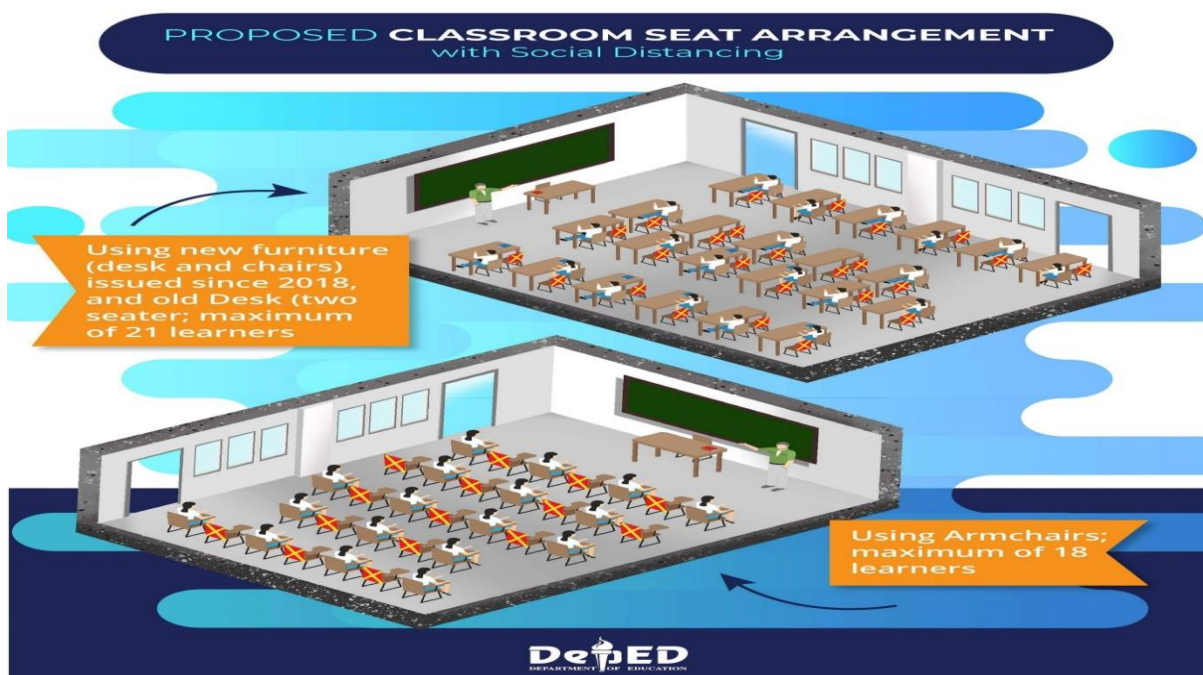
and school items) using bleach solution.

**Screening and health check.** Even as symptoms or temperature monitoring to identify COVID-19 infection may not be as effective for children, it will still be routinely performed at school entrances. All learners, teachers, personnel, and visitors shall be checked for temperature using a thermal scanner prior to entering the school. Those who will have a reading of 37.5° Celsius and above shall be given a surgical face mask and brought to a private screening area for further examination and appropriate management, intervention, or referral. The teachers shall also conduct health checks inside the classroom.

**School clinic and health services.** The school, with the support of concerned DepEd offices, shall ensure the establishment /refurbishment of a school clinic to provide basic health services to learners, teachers and personnel, and to visitors when needed. The school clinic shall ensure the availability of Emergency Health Kits that include PPEs and other needed supplies and materials.

**Preventive alert system.** The school shall ensure the operationalization of the Preventive Alert System in Schools (PASS) for COVID-19 per DepEd Memorandum No. 15, s. 2020.

**Physical arrangement in schools.** All classrooms must have proper ventilation. Open windows are preferred over air- conditioning systems. Classrooms shall follow the following physical layout for physical distancing, as provided in Enclosure No. 4 of DepEd Order No. 014, s. 2020:



The school shall ensure that a Materials Recovery Facility (MRF) is set up for proper waste segregation.

*Physical and mental resilience.* The school shall provide psychosocial and mental health discussions covering topics such as validating and normalizing feelings, calming down and controlling emotions, identifying and addressing needs, sources of strength, and other relevant topics. The school shall maintain/set-up a guidance office staffed by a registered guidance counselor or a designated guidance associate trained on MHPSS

## **c.2. Management in case of infection or exposure**

*Overall responsibility of the School Head in the management of cases.* The School Head, with the support of the School DRRM Team, shall ensure the monitoring of all COVID-19 cases (close contacts, suspect, probable, confirmed) among learners and personnel under his/her jurisdiction, as well as the coordination with DepEd school health personnel and local health authorities, and the provision of necessary support as the school may be able to provide.

The School Health and Nutrition Units/Sections (composed of medical doctors, dentists, nurses, and nutritionist-dietitians) shall provide technical assistance to the schools in the management of COVID-19 cases, including the operation of the school clinics.

*Coordination/referral system with local health authorities.* The health personnel or the designated clinic teacher(s) shall ensure that the school has an established and open communication line/referral system with local health authorities identified by the local government unit to respond to and manage COVID-19 cases in the locality where the school is situated (e.g., barangay health station, rural health unit, etc.) This includes the availability of the necessary contact information (e.g., emergency numbers) of the said health authorities.

The health personnel or the designated clinic teacher(s) shall also ensure an established and open communication line with the School Health and Nutrition Unit/Section of the SDO for proper coordination and necessary reporting.

*Management of cases arising from face-to-face engagement.* Personnel or learners who show any COVID-19 symptom(s) shall be immediately provided with a surgical mask and assisted to the clinic or to a private screening. The same shall be done to personnel or learners who, while in school, are informed of their exposure to/status as a close contact of a confirmed case. The

family/parent(s)/guardian(s) of the concerned learner shall be immediately notified.

The situation shall be referred/fully disclosed to the health authority (e.g., barangay health station, rural health unit) for further evaluation or referral to a hospital if needed. The same process shall be observed for teachers or other personnel who will exhibit symptoms of the virus.

*Contract tracing, disinfection of school facilities, and modification/suspension of face-to-face activities.* The School DRRM Team shall ensure that contact tracing, as required by the local health authorities, are initiated and completed.

*Monitoring of the cases during quarantine, isolation, or treatment.* Concerned learners and personnel shall strictly observe the advice of health authorities, including the possibility of home quarantine or isolation in a quarantine facility or confinement.

The condition of the learner or the personnel shall be closely followed up by the attending/assigned school health personnel or the designated clinic teacher, and necessary information shall be reported to the SDO School Health and Nutrition Unit/Section, as required by existing reporting mechanisms (e.g., submission of data for the DepEd COVID-19 Situational Report).

Trained PFA providers of the school shall be mobilized to provide necessary mental health and psychosocial support to concerned personnel or learners.

#### **(4) The sharing of responsibility in case infections or exposure occur**

While health standards and precautions will guard against the spread of COVID-19 in school setting, it does not provide full guarantee against infection and exposure by learners as well as teachers. As discussed previously, the recent research findings that there is relatively higher incidence of asymptomatic positive cases, but possibly still with high viral loads, provides risk factors peculiar to children in school setting.

In the unfortunate event that a learner participating in face-to-face classes gets infected by COVID-19, or becomes exposed to a known COVID-19 positive individual, the management protocols discussed above are set in motion. However, while DepEd undertakes various management actions such as first aid, coordination and referrals, the question of assignment of responsibility is left hanging. For example, who pays for the costs during quarantine, or treatment?

We submit that there should be shared responsibility among DepEd, the parents, and the LGUs on the resumption of face-to-face classes and its implications. Without acceptance that the responsibility is shared, DepEd will likely be solely blamed for any incidence of infection/exposure.

Shared responsibility is best achieved through local consultation among DepEd, the relevant LGU units, and the parents directly or through the PTA. In these consultations the respective roles, responsibilities and commitments of all sides shall be discussed and agreed upon. The agreement on shared responsibility may be evidenced by documentation in various possible forms, such as minutes of meetings, resolutions, and the like.

A parent's permit for the student to participate in face-to-face classes shall be required. This permit shall include various undertakings to observe health standards not just in school, but also at home and during travel, as well as the responsibility to immediately disclose any onset of symptoms or known exposure by any member of the household. In such instances, the student shall not be sent to school until the household incident resolves.

The requirement of a permit means that face-to-face classes in areas or schools where this may be allowed will not be compulsory, but rather voluntary on the part of the learner/parents.

### **Contextualization by field units**

The discussion above provides an overall framework and spells out minimum standards on local risk classification and health and safety protocols. However, field units are expected to adopt various localized contextualization in terms of prioritization of learners, grouping of learners, class scheduling, learning delivery strategies, partnerships, resource mobilization, consultation and coordination mechanisms, among others.

Regional Directors shall provide regular reports and updates on the conduct of face-to-face classes within their respective jurisdictions to the Secretary through the Undersecretary for Field Operations.

### **Pilot implementation or dry-run in month of January, 2021**

If approved by the President, DepEd shall conduct pilot implementation in select areas categorized as low risk, and with commitment for shared responsibility among DepEd, LGUs and parents, in the month of January, 2021 and following the activities and timeline provided in Table 2.

DepEd shall coordinate with the COVID-19 National Task Force for the monitoring of the conduct of the pilot implementation.

The outcome of the pilot implementation shall be evaluated to identify areas for improvement, and to make final recommendation on more expanded implementation.

**Table 2. Activities and Timeline for the Pilot Implementation/Dry-Run**

<b>Period</b>	<b>Activities</b>
<b>December 14-18, 2020</b>	Submission by Regional Directors to the Secretary, through the Undersecretary for Field Operations, of nominated schools for pilot implementation or dry-run
<b>December 28, 2020</b>	Selection by the Secretary of pilot schools from among the nominated schools
<b>January 4-8, 2021</b>	Orientation, mobilization and readiness confirmation of selected pilot schools
<b>January 11-23, 2021</b>	Implementation of pilot activities, including joint monitoring by DepEd and the COVID-19 National Task Force
<b>January 25-29, 2021</b>	Submission of Regional reports on the pilot implementation; Evaluation for final recommendation to the President

#### **D. Recommendations**

As stated above, while DepEd was able to open SY 2020-2021 under distance learning modalities, face-to-face classes remain a necessity for education. Thus, DepEd seeks permission from the President to allow the pilot implementation of face to face classes in select schools for the period January 4-15, 2021.

Such pilot implementation will be done under the following conditions:

1. The selected schools shall be within an area classified as low risk (at least under MGCQ)
2. There is evidence of shared responsibility among DepEd, LGU and parents.
3. Participation by students shall be voluntary, with express permission by the parents.
4. Documented readiness of the selected schools for pilot implementation, with submitted documentation on the following:
  - Risk classification of the area
  - Documentation of acknowledgement of shared responsibility among DepEd, LGU and representatives of parents
  - Covered students and classroom management plan
  - Checklist of compliance with readiness requirements for:
    - Health standards in the home
    - Health standards during travel to and from school
    - Health standards in school premises



DepEd shall report to the President on its evaluation of the outcome of the pilot implementation, on which basis it will make a recommendation on whether face-to-face classes will be implemented on a larger scale.

- End -