Author’s response to reviews

Title: Temporary exclusion of ill children from child care centers in Switzerland: practice, problems and potential solutions

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Version: 1 Date: 26 Jul 2017

Author’s response to reviews:

Dear Editor,

We thank you and the reviewers for evaluating our manuscript and for the most valuable and constructive comments. Please find enclosed a revised version of our manuscript. The revisions were made along the lines suggested by the reviewers. We have addressed the comments in a point to point reply and have included a file with all changes highlighted in yellow.

Reply to the comments from Reviewer 1:

Comment 1: AAP guideline was updated in 2015. Suggest authors to be specific for the AAP standard referred in this study

Thank you for pointing this out. We checked the updated 2015 version, which has not changed compared to the 2011 version in the issues relevant to this manuscript. This has been specified in the manuscript (Methods section, line 25-26, page 5).

Comment 2: All of the numbers in Table 1 & 2 should be double-checked to make sure accuracy.

We double-checked the numbers which were all correct. We added the following explanation in the footnote of table 2: “The sum of the percentages of the subcategories may not be equal to the total percentage of the category, due to (i) once-only mentions not described in the table but counted for the category’s total percentage and (ii) directors who stated several ambiguities (subcategories) within one category.”
Comment 3: The finding that there was no significant difference in handling ambiguous situations between directors with access to pediatrician and those without is interesting. The ultimate outcome of excluding sick child is to protect other children and staff. It would be very helpful if authors have information comparing number of outbreak/cluster situation in centers with and without access to a pediatrician consult.

We agree that comparing outbreak situations between different CCCs would be of great interest and might even show the effect of access to a paediatrician. However, we hope you agree that adequately addressing this topic would have gone beyond the scope of our questionnaire-based study.

Reply to the comments from Reviewer 2:

--In abstract, the final sentence, "For various reasons, collaboration with a paediatrician may be of additional benefit" is vague and could briefly indicate what reasons, or simply state that many child care centers would benefit from collaboration with a pediatrician.

We totally agree. As commenting these reasons would take too much space for the abstract, we decided to simplify the sentence as suggested (Abstract, line 20-21 page 2).

--p. 3, first sentence indicates, "In resource-rich settings, 30 to more than 80%..." It's unclear why "resource-rich" is specified or what it means. Does it mean that in non-resource-rich settings, different %s of children are in formal care? The 30-80% range is also very broad.

We agree that the term resource-rich can be misleading, and we did not compare resource-rich settings to non-resource-rich settings. We replaced this term by accurately naming the geographic regions for which these numbers are reported. The range is very broad indeed, we now discriminated between the overall mean and a range up to 80% referring to particular countries, e.g. in Northern Europe. (Background section, line 2-4, page 3)

--p. 3, line 10 - is there evidence that can be cited that temporary exclusions of ill children reduce disease transmission?

To our knowledge, no studies specifically address the effect of exclusion of ill children on transmission rates in CCC. However, there is evidence about similar situations in school settings
which we now mentioned in the manuscript (Background section, line 6-9, page 3). We added the corresponding references, too (reference 13 and 14).

--p. 4, line 44 - Since reporting from center administrators may be considered human subjects, depending on methods, it would be helpful to clarify whether the IRB indicated the research did not qualify as human subjects research, or whether the decision to not seek IRB approval was the authors’ decision.

Deciding not to seek ethics review was the author’s decision (Methods section, line 26-28, page 4). However, this decision was in accordance with the institutional review board’s standards. We did send a questionnaire to CCC directors and asked them for voluntary collaboration, i.e. answering the general questions and did never address data of an individual child.

-- p. 5, line 29 - a two-sided t-test may be the same as a 2-tailed test, I believe. The t-test appears to be an independent samples t-test.

This issue was clarified (Methods section, line 2, page 6) by stating that the independent two-tailed t-test was used.

--p. 11, line 52 - what are conditions that are contagious but do not provide medical indication for temporary exclusion (i.e., referred to as contagious vs contagious and dangerous) (this is likely my own lack of knowledge)

Many conditions are contagious (common cold type) but do not need i.e. justify interventions such as exclusion in every day practice. This means exclusion is not justified if transmission is not effectively prevented by exclusion or if transmission is not as harmful that it outweighs the exclusion as an intervention. If disease transmission may be linked to risk for severe disease or risk for outbreaks, exclusion is to be considered. We explained and exemplified this in Discussion section, line 9-14, page 12.

Reply to the comments from Reviewer 3:

1. It would help to better explain in the introduction the rationale to use the AAP guidelines as a tool. Is AAP the only organization to develop such guidelines? It is clear that no standards
have been adopted in Zurich, but are there no similar recommendations across Europe? Or is perhaps the AAP recommendation the gold standard?

Thank you for this question. The AAP guideline has indeed the character of a standard reference (understandable for CCC staff, endorsed and updated by AAP, reevaluated scientifically) and is easily accessible and available in Switzerland. (This statement has been added in the Background section, line 19-23, page 3)

2. The study mailed questionnaires to 488 CCC in Zurich, but is that the complete list of all CCCs? I suspect that it is, but a description of the proportion of all CCCs that are represented by this initial list would be helpful.

Yes, these 488 represent all the CCC in Zurich (based on the official operating license they need and entries from an online directory), we now clarified this in the manuscript (Methods section, line 20, page 4)

3. The authors mention some potential selection bias. But is there no way to compare the sites that participated to those that did not, especially in things such as public vs. private operation, geography, etc. Anything that could give us a sense of whether the sites that participated were similar to the sites that did not participate, would be helpful.

There was indeed a difference in response rates between the urban centre and the rest of the Canton. However, the reasons for this difference remain unclear. We now mentioned this in the manuscript (Result section, line 7-8, page 6; Limitations and strengths, line 21-24, page 12).

4. In the methods, the only measures that are described are the "ambiguities", but it would be helpful to talk about what other things were measured and how, including whether the sites had standard operating procedures, the rating scale that was asked of the CCC directors, etc.

Thank you for this important remark. We now added an extra paragraph to the methods section (line 2-9, page 5)

The constructive comments allowed us to improve our manuscript. We thank you for considering the revised manuscript which has been seen and is approved by all authors for publication in BMC Health Services Research and look forward to your feedback.

On behalf of all authors, kind regards

Christoph Berger