World Vision

Policy Brief

COVID-19 & Risks to Children's Health and Nutrition

May 2020

Children do not represent a high risk group for direct COVID-19 fatality, and in fact recorded child deaths resulting from COVID-19 are near zero.[1] However, experience with previous epidemics has shown that the indirect health and nutrition impacts resulting from overwhelmed health and food systems can be more devastating for children than the specific disease itself.

Recent evaluations of health systems in low-income, fragile and humanitarian contexts have found most have low capacity to implement an epidemic response. [2] [3] Epidemic responses place an extraordinary burden on health systems struggling to provide quality services in even non-epidemic periods. To illustrate this point, in 23 of the 24 countries prioritised by the UN's Global Humanitarian Assistance Plan for COVID-19, there is an average of 1.28 hospital beds per 1,000 people vs. 5.1 in G20 countries, and only .65 doctors and 1.3 nurses per 1,000 people. [4]

Evaluation of the indirect health impacts of the 2014-2016 Ebola epidemic on children in West Africa demonstrates that in the global COVID-19 pandemic, tens of millions of children's lives are at risk.

As with COVID-19, Ebola did not significantly affect children directly, however they were catastrophically affected by subsequent lack of access – a 50% reduction - to routine primary and tertiary health services. In Guinea, childhood immunisations decreased by 30%; and in Sierra Leone, health facility-based deliveries decreased by 30%.

This pandemic especially jeopardises the health of millions of girls and boys already facing unacceptable threats to their well-being and futures in the poorest and most fragile contexts. In these countries, where health systems are least able to adequately prevent, contain, and respond to COVID-19 while maintaining routine primary health care (PHC) services, children will continue to suffer from and succumb to other treatable illnesses/conditions such as malaria, pneumonia, diarrhoea, and sepsis, as well as from other preventable causes.

Children and their families—especially those reliant on food assistance—are also experiencing reduced access to nutritious food, and food systems are disrupted. Globally, nearly half of all deaths in children under five are caused by acute malnutrition or the vulnerability it creates to other infections and illnesses. [7]

During the 2014-2016 Ebola epidemic, the proportion of children diagnosed with severe acute malnutrition in Sierra Leone (using a weight-for-age ratio at health facilities) increased from 1.5% pre-outbreak to 3.5% post-outbreak.[8] It is feared that COVID-19 related movement restrictions and diversion of resources are reducing opportunities and capacity to screen for and treat malnutrition, with devastating results for the most vulnerable children.

Further complicating low health system capacity is frequent population mistrust of health services. Research on institutional mistrust and misinformation in communities during the 2018-2019 Ebola outbreak in North Kivu, Democratic Republic of Congo demonstrated that only 32% of the population trusted health authorities to represent their best interest.[9]

In epidemic situations, mistrust, fear of contamination, fear of stigmatisation and, in some conflict situations, fear of violence targeted at health facilities, act as significant barriers to health and nutrition seeking behaviours, thereby limiting children's routine access to newborn, infant and child healthcare.

The COVID-19 pandemic has created and is exacerbating numerous vulnerabilities for children around the world. As a result of the crisis, the UN projects an estimated 42 to 66 million children may fall into extreme poverty; 78 million children are missing out on measles campaigns in at least 23 countries; 368 million children are missing out on the school meals they greatly depend on to avoid malnutrition; and millions are at risk of various forms of violence due to quarantine/lockdown situations.[10]

It is imperative that COVID-19 response efforts at all levels, especially in low-income, fragile and humanitarian contexts, prioritise children's continued access to routine primary health care (PHC), inclusive of essential nutrition services and specialised measures to address psychosocial distress, and mainstream child protection into health responses.

World Vision has extensive experience protecting children's health and nutrition in emergencies, including epidemics, from longstanding HIV and Malaria campaigns to Avian Influenzas, Zika and Ebola. At the core of these responses are technical and logistical support to ministries of health (MoHs), risk communication, community mobilisation, and essential health, nutrition and water, sanitation and hygiene commodity supply chain support. Globally, World Vision's health programmes support over 220,000 community health workers (CHW) on the front lines of health services, have distributed over 24 million insecticide treated bed nets for children, diagnosed over 150,000 people with Tuberculosis, and have treated 1.5 million children under five years for wasting.

During the 2014-2016 Ebola crisis, World Vision reached 1.6 million people in Sierra Leone. This was accomplished by establishing 12 district Ebola recovery command and control centres, maintaining a fleet of over 1,000 ambulances, overseeing over 36,000 safe and dignified burials, training over 1,000 health professionals in infection prevention and control and 36,000 teachers in psychological first aid, and distributing 5.4 million personal protective equipment (PPE) items and 7,000 hygiene kits.

More than 276,000 Sierra Leoneans received food and cash vouchers, and faith leaders reached more than 371,000 with critical risk communication messages.

Based on this and other experiences responding to epidemics, World Vision's COVID-19 health response is prioritising child survival and development through emphasis on health system strengthening, community mobilisation and advocating for food security. The three objectives of the response are: to ensure appropriate risk communication with the most vulnerable populations; to protect and enable frontline community and other health workers to maintain emergency response measures and routine PHC; and to reinforce essential health and nutrition commodity supply chains. World Vision is working to achieve these objectives and scale critical interventions in close partnership with local MoHs.

World Vision is mobilising up to 220,000 CHWs to maintain and expand both COVID-19 response and essential PHC services, equipping them and other frontline health workers with PPE, health commodities, digital support platforms and cutting edge protocols to keep them safe.

World Vision is reaching out to a network of 400,000 faith leaders to build their capacity to serve as effective risk communication and community engagement agents. CHWs, faith leaders and other frontline workers are receiving capacity building in psychological first aid to help better serve families and caregivers in distress.

In addition to scaling up infant feeding in emergency guidance, World Vision is investing in preventing increasing malnutrition through food distribution, cash and voucher transfers, credit to small scale farmers and support for savings groups. World Vision is rapidly scaling water, sanitation and hygiene infrastructure, such as for hand washing and health facility support.

For example, in the Asia Pacific region as of 9 May 2020, World Vision has reached over 7 million people with promotion of preventive behaviours, established over 6,500 public hand washing stations, worked with over 2,700 faith leaders, trained over 3,200 CHWs, provided PPE to over 26,000 medical personnel, distributed over 38,000 disinfection kits to health facilities and nearly $5 million in cash and voucher assistance, and reached 533,000 people with food security assistance.

In the Philippines, World Vision is distributing food and sanitation kits to vulnerable children and communities impacted by COVID-19. Photo Credit: World Vision

[1] University of Oxford's Centre for Evidence-Based Medicine, "Global COVID-19 Case Fatality Rates," updated 30 April 2020. https://www.cebm.net/covid-19/global-covid-19-case-fatality-rates/

[2] Kandel, N., Chungong, S., Omaar, A. &, Xing, J., "Health security capacities in the context of COVID-19 outbreak: an analysis of International Health Regulations annual report data from 182 countries," The Lancet, Vol. 395, Issue 10229, p1047-1053, 28 March 2020 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30553-5/fulltext

[3] Johns Hopkins Centre for Health Security, NTI & The Economist, "2019 Global Health Security Index." https://www.ghsindex.org/

[4] WHO, "Global Health Observatory Data Repository - Global Health Workforce Statistics." https://apps.who.int/gho/data/node.main.HWFGRP?lang=en

[5] Parpia, A., Ndeffo-Mbah, M., Wenzel, N. & Galvani A, "Effects of Response to 2014–2015 Ebola Outbreak on Deaths from Malaria, HIV/AIDS, and Tuberculosis, West Africa," Emerging Infectious Diseases, Vol. 22, No.3, March 2016. p1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4766886/

[6] UNDP, "Assessing the socio-economic impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone: the Road to Recovery," December 2014. p39,42 https://www.undp.org/content/dam/rba/docs/Reports/EVD%20Synthesis%20Report%2023Dec2014.pdf

[7] UN Inter-agency Group for Child Mortality Estimation, "Levels and Trends in Child Mortality Report – 2019," September 2019, p16. https://data.unicef.org/resources/levels-and-trends-in-child-mortality/

[8] Kamara, M., Najjemba, R., van Griensven, J., Yorpoi, D., Jimissa, A., Chan, A. & Mishra, S., "Increase in acute malnutrition in children following the 2014–2015 Ebola outbreak in rural Sierra Leone," Public Health Action, Vol 7, Supplement 1, 21 June 2017, p S27-S33(7). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515560/

[9] Vinck, P., Pham, P., Bindu, K., Bedford, J. & Nilles, E., "Institutional trust and misinformation in the response to the 2018–19 Ebola outbreak in North Kivu, DR Congo: a population-based survey," The Lancet, Vol. 19, Issue 5, May 2019, p225-236 https://www.thelancet.com/action/showPdf?pii=S1473-3099%2819%2930063-5

[10] UN, "Policy Brief: The Impact of COVID-19 on Children," 15 April 2020, p2 & 9. https://www.un.org/sites/un2.un.org/files/policy_brief_on_covid_impact_on_children_16_april_2020.pdf

World Vision's Recommendations

The COVID-19 pandemic is putting millions of children at heightened risk, and jeopardising their immediate and long-term health and well-being. As countries around the world battle to prevent, contain and respond to COVID-19, it is critical that their efforts reach those most vulnerable and ensure PHC is continued and accessible to all. All stakeholders must take proactive measures to mitigate the impacts of COVID-19 on children's health and nutrition, and response efforts should consider vulnerable children's needs and rights. Based on extensive experience working with children, families and communities in emergencies, including epidemics, World Vision recommends the following:

Governments should:

- Classify frontline health and humanitarian workers as 'essential' and allow for exceptions to travel and movement restrictions to ensure continued provision of critical assistance to affected children.
- Establish PHC business continuity plans to ensure uninterrupted essential health services, especially for girls and boys of all ages, informed by analysis of risks and barriers to children's to access healthcare.
- Ensure frontline health workers, including CHWs, are protected, and equipped with the training and supplies necessary to not only respond to COVID-19, but also maintain essential PHC services.
- Rapidly scale digital platforms to support and supervise frontline health workers and expand surveillance, contact tracing, case monitoring, and telehealth interventions. Rapidly scale digital platforms to support and supervise frontline health workers and expand surveillance, contact tracing, case monitoring, and telehealth interventions.
- Protect essential health and nutrition commodity supply chains from COVID-19 related disruptions and ensure that PHC and COVID-19 services and essential commodities are free of charge for those most vulnerable, including children. Prioritise the expansion of mental health and psychosocial support (MHPSS) as a core component of COVID-19 responses, strengthening safe and efficient referral mechanisms between health, MHPSS, child protection, and gender-based violence (GBV) response service providers.
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- Work with relevant in-country stakeholders at all levels to develop, implement, and monitor an action plan for communicating effectively with the public, and engaging with children, communities, local partners, faith leaders, and other stakeholders, in line with the World Health Organisation's (WHO) COVID-19 Preparedness and Response guidance.[11] Ensure communication plans are child-friendly and, where possible, promote safe child participation.
- Ensure that critical food assistance and nutrition programmes (e.g., community management of acute malnutrition) are adapted safely and functioning throughout the COVID-19 response. Regularly assess the food security and nutritional status of highly vulnerable populations, including refugees, internally displaced people, and those living in urban slums and informal settlements, and strengthen referral mechanisms between health, nutrition, food security and child protection actors.
- Intensify efforts to prevent malnutrition including: measures to protect, promote and support breastfeeding and adequate complementary feeding practices, including responsive and active feeding during illness; prepositioning of essential nutrition commodities, and shifting from health facility service delivery to community-based treatment options.

[11] WHO, "Risk Communication & Community Engagement Action Plan Guidance: COVID-19 Preparedness and Response," 16 March 2020 https://www.who.int/publications-detail/risk-communication-and-community-engagement-(rcce)-action-plan-guidance.

UN agencies should:

- Urgently assess technical guidance gaps in critical health service delivery and prioritise their development and dissemination to implementers. This should include guidance to assess children's health and protection status, identify requirements for child recipients of specific health care services, determine the needs of specific groups of children, and promote child-friendly health service delivery.
- Assess national health service delivery gaps and coordinate effective response through clusters. This should include the engagement of health, nutrition, food security, child protection, and GBV coordination mechanisms to strengthen child-friendly health services and ensure mainstreaming of child protection and GBV risk mitigation for girls and boys of all ages.
- Identify innovations required for effective response and advocate for and dedicate funding to their development (e.g., digital platforms, vaccine/treatment, testing, household-led MUAC).
- UN Country Teams should ensure health, nutrition and humanitarian workers have access to quality PPE and essential supplies.

Donors should:

- Urgently commit emergency funding for health system strengthening and, when necessary, humanitarian health programming for direct service delivery via mobile health teams or other modalities to ensure provision of a package of basic health services that extends to the community level for children and their families. Provide technical resources to support emergency response planning and implementation.
- Provide technical resources to support emergency response planning and implementation.
- Ensure equitable distribution of essential health commodities, especially for emergency response items like PPE and hygiene materials.
- Provide funding for risk communication and community engagement efforts, as well as rapid online MHPSS training, when necessary and possible.
- Support emergency nutrition, food assistance and cash voucher programmes to ensure the food security of vulnerable populations throughout the epidemic.

Food distribution in Gwembe district, in the Southern province of Zambia, one of the most affected by drought. World Vision has introduced interventions at all distribution points to prevent and respond to the coronavirus. Photo Credit: World Vision

NGOs should:

- Facilitate and support health and humanitarian worker preparedness and safety to respond to COVID-19, as well as continue provision of PHC at community level.
- Support essential health and nutrition commodity procurement, distribution and logistics needs where national gaps are assessed.
- Align and support surveillance and vulnerability monitoring data with the MoH. This support should include monitoring commodity access within the most vulnerable populations to inform timely advocacy with key stakeholders when necessary.
- Assess the availability of MHPSS services and provide qualified personnel to boost knowledge and skills to deliver MHPSS to children, people with disabilities, and other vulnerable adults.
- Support nutrition screening and monitoring, and food security assessments including market price monitoring and analysis, taking steps to ensure continuity of emergency nutrition and food assistance programming for the most vulnerable populations by safely adapting operational standards.
- Advocate for access to communities as an exception to movement restrictions. Safely engage with children and their families to assess COVID-19 knowledge, beliefs and preventative practices. In collaboration with MoHs and UN agencies, support development of COVID-19 community-based communication plans, sensitise community leaders/champions, including faith leaders, and rollout messaging.

Private actors sector should:

- Continue to rapidly increase critical quality-assured health commodity supply chains and establish preferential pricing for or donate these essential commodities (e.g., PPE, hygiene materials). Where possible, also waive user fees for public goods like health system software.
- Accelerate research and development of COVID-19 treatment and vaccination with assured strategies for rapidly scaled production and prioritisation of distribution to the most vulnerable.

Faith leaders should:

- Use their role as trusted community members to promote and share vital, accurate and science-based information about COVID-19.
- Provide spiritual counselling and support to strengthen children's and families' emotional well-being and resilience.

World Vision is undertaking the largest humanitarian response in its 70-year history to limit the spread of COVID-19 and reduce its impact on vulnerable children and their families, aiming to reach 72 million people, half of them children, over the next 18 months and raising US $350 million to do so. Response efforts will cover 70 countries where World Vision has a field presence, prioritising scale up of preventative measures to limit the spread of the disease; strengthening health systems and workers; supporting children impacted by COVID-19 through education, child protection, food security, and livelihoods; and advocating to ensure vulnerable children are protected. For more information, read World Vision's COVID-19 Global Response Plan.

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World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families, and their communities to reach their full potential by tackling the root causes of poverty and injustice. World Vision serves all people, regardless of religion, race, ethnicity, or gender.

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