World Vision

COVID-19 AFTERSHOCKS

SECONDARY IMPACTS THREATEN MORE CHILDREN'S LIVES THAN DISEASE ITSELF

WORLD VISION INTERNATIONAL

Summary

COVID-19 is not currently perceived as a major threat to children, particularly because of the relatively low number of girls and boys believed to have contracted the disease[i]. Severe infections are rare and, according to the University of Oxford, child deaths have, to date, been relatively few[ii]. But such positive statistics mask a much bigger threat to the world's youngest citizens. Based on evidence from the 2014-16 Ebola outbreak in West Africa, millions of girls and boys in the world's poorest and most fragile places are facing disastrous "secondary" impacts from the pandemic that will put their lives and their futures at risk.

Too many children, especially those living in fragile contexts, already face unacceptable threats to their wellbeing and futures. World Vision's experience in Ebola has shown us that beyond COVID-19 itself, children will inevitably face heightened food insecurity; increased risk of violence, neglect, abuse and exploitation; and the interruption or total breakdown of essential services including formal and informal education. While children may not suffer the worst symptoms of COVID-19, millions of young lives will be put at risk as weak health systems become overwhelmed by the pandemic and precious resources are diverted.

Key findings of this report

As the UN recently wrote in its Global Humanitarian Response Plan COVID-19, while all countries need to respond to this pandemic, those with existing humanitarian crises are particularly vulnerable, and less equipped and able to do so. Our analysis examines the 24 countries prioritised by the UN in their plan[1]. It does not include refugees or migrants covered by the latest UN regional response plans. After considering the secondary impacts of the 2014-2016 Ebola outbreak in three countries and considering the existing needs in each of the 24 countries we concluded the following:

Increased threats from COVID-19:

- As many as 30 million children's lives are at risk from secondary health impacts[2]:
  - Over 26 million children are at greater risk of being exposed to potentially fatal infectious diseases due to a 30% reduction in Diphtheria-tetanus-pertussis (DTP3) immunisation coverage.
  - More than 5 million additional children could suffer from malnutrition, including severe wasting, an increase of almost 40% from current numbers
  - 100,000 additional children, an increase of 50% from current levels, could die from malaria.

These are shocking figures that compound the already awful situation for many millions of men, women and children in these countries:

- 149.5 million people, including 76.5 million children, are already in need of humanitarian assistance
- 95.5 million people, including 41.5 million children, are already in need of health assistance
- 100 million people, including 42 million children, are already in need of basic water, sanitation and hygiene (WASH) services, including handwashing facilities, which are so critical in preventing the spread of disease.

The lives of millions of children in fragile contexts affected by conflict, instability and displacement, are already at unprecedented risk. According to the World Health Organisation (WHO), the global COVID-19 response may leave these children and their communities behind if adequate efforts are not made to mitigate these risks. As countries' health systems are overwhelmed by COVID-19, children and other vulnerable groups will have less or sometimes no access to other routine but critical primary and tertiary health care services.

Our findings highlight potentially devastating impacts which could reverberate through these communities and countries for years to come, compounding what are already extremely difficult situations, and threatening to undermine hard-fought gains in strengthening health services and other areas of development.

1 The 24 countries are: Afghanistan, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Colombia, DRC, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, Occupied Palestinian Territory, Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela and Yemen. These had pre-existing Humanitarian Response Plans.

2 The approximate total of the individual health impacts noted below. It does not account for possible double-counting of children when tallying the different impacts – e.g. the same child could both be affected by decreased immunisations and malnutrition. In addition to the secondary health impacts we have included here, there are many more potential risks that could result from COVID-19, including psychosocial trauma and mental health needs.

Background

World Vision was on the frontline of the Ebola epidemic in Guinea, Liberia and Sierra Leone between 2014 and 2016. While it was adults who bore the brunt of this disease, we guessed then what data now shows: that secondary impacts put many more children's lives and futures at risk. Secondary impacts can include increased food insecurity; a greater risk of violence, neglect, abuse and exploitation; and the interruption or total breakdown of essential services including formal and informal education and health services.

Based on research and evidence from the 2014-16 Ebola Outbreak in West Africa, this report has estimated some of the very real secondary health impacts of COVID-19 which could be felt by children in 24 of the world's poorest and most fragile countries. Their effects will reverberate through these communities and countries for years to come, compounding what are already extremely difficult situations and threatening to undermine progress made towards increasing health, wellbeing, and prosperity.

As a result of the 2014-16 Ebola epidemic, Guinea, Liberia, and Sierra Leone lost an estimated $2.2billion of their gross domestic product due to health costs, lives lost, lower agricultural production, and reduced investments[iii]. The world is only beginning to understand the impacts of pandemics like COVID-19 on the least-developed countries as a whole and over the long term.

High-risk countries

Well before COVID-19, these 24 countries were already experiencing humanitarian crises due to a range of issues such as conflict or extreme climate events. Such crises take a significant toll on the women, girls, men and boys living in these contexts; they have left health systems ill-prepared, and they have created inherent challenges in reaching those most in need.

Significant numbers of people in these countries reside in precarious and insecure conditions including large over-crowded refugee/internally displaced persons (IDP) camps or densely populated urban settings. Girls and boys in such hazardous settings are particularly vulnerable to a number of threats including malnutrition, disease, physical and sexual exploitation and abuse, gender-based violence and child marriage, child labour, absence from education, and significant mental and psycho-social health challenges and trauma.

Children and their families in these contexts often live in poor quality and cramped housing that do not allow for physical distancing. Also, they have limited prospects for livelihoods or must work despite very difficult circumstances.

Many people in these countries have limited or no access to basic services and supports, including basic healthcare.

Weak health system capacities

To date, the COVID-19 pandemic has largely affected developed countries with strong health systems—yet even in those countries, governments are struggling to contain it. Even the best-equipped countries are experiencing high mortality rates, medical supply shortages, and overburdening of health care providers and facilities.

Many health systems were underprepared and underdeveloped prior to the COVID-19 pandemic. A World Health Organisation analysis of 182 Member States found that 18% were not ready to respond to an infectious disease outbreak[iv]. The countries identified in the UN's Global Humanitarian Response Plan are prime examples.

Many of these countries also experience the double burden of high infectious disease rates alongside non-communicable diseases such as cancer, and injuries. For pandemic response, capacity is limited. Critical care capacity in Africa, for example, is the lowest in the world.

In 23 of the 24 countries identified as humanitarian priorities in the UN's Global Humanitarian Response Plan[v], an average of 1.28 hospital beds are available per 1,000 people. Contrasting that with the G20 country average of 5.1 and the G7 country average of 5.4, it is clear that increased needs for intensive care would quickly overwhelm these fragile health systems. Requirements for ventilators, electricity, and oxygen are not achievable in many of these contexts, and intensive care beds and the skilled staff required to operate them are nearly non-existent. Across 22 of the 24 countries[3], there are only 0.65 doctors per 1,000 people. Across 23 of the 24 countries[4], there are only 1.33 nurses per 1,000 people.

With the emergence of COVID-19, these already limited resources risk being diverted solely to pandemic response, leaving other health needs completely ignored and putting children at increased risk.

The Global Health Security Index, led by Johns Hopkins University, assessed the readiness of 195 countries to respond to infectious disease threats. Analysing capacity for prevention, detection, response, health services, norms, and risk, they compiled a readiness grade out of 100. Collectively, the 195 countries had an average score of 40.2 out of 100 – not particularly high already. For the UN's 24 priority countries, however, the average score is 29.4 – a significant capacity gap, and a concerning sign of the likelihood for these health systems to be completely overwhelmed. The table below, shows the comparative scores between these 24 countries and global averages.

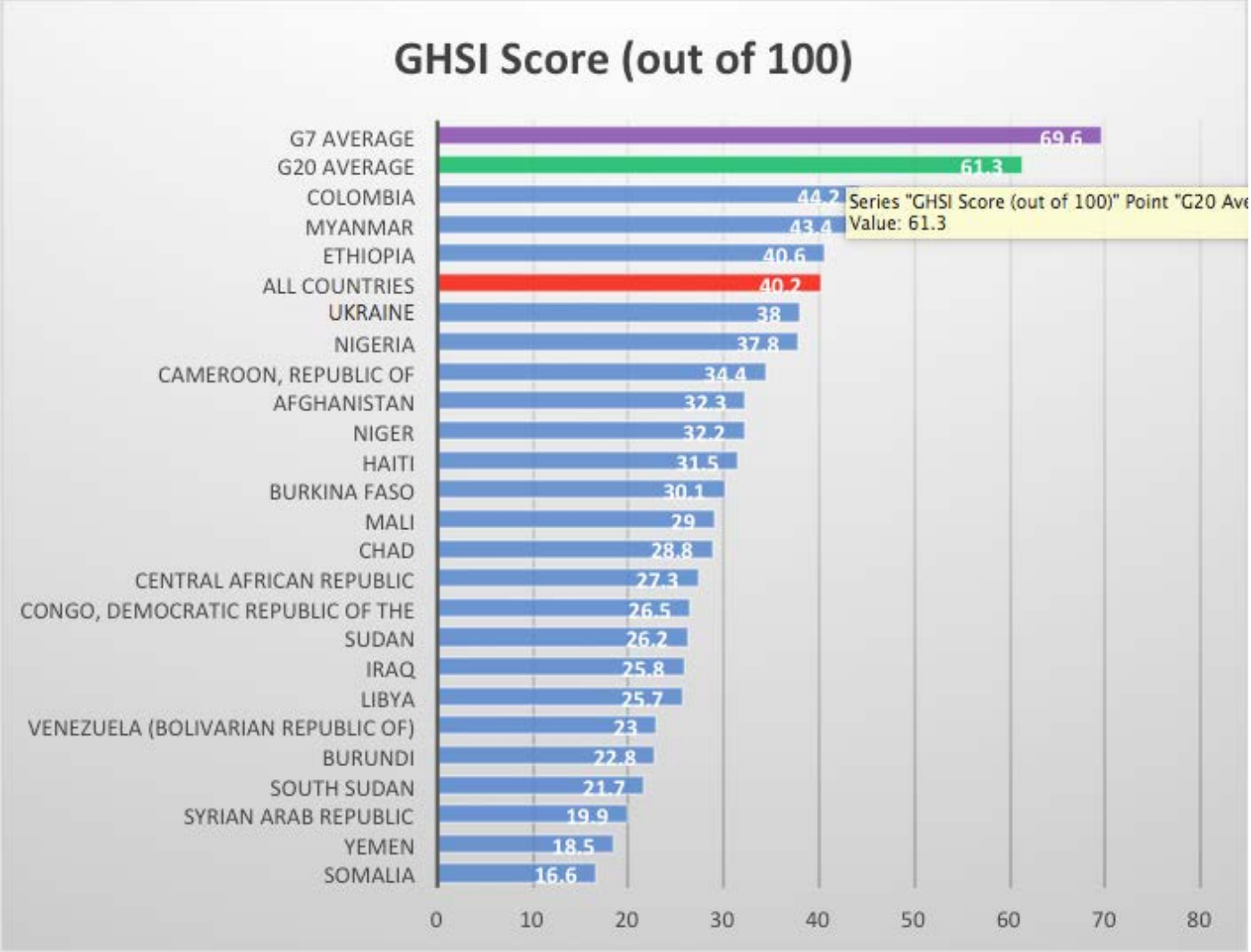

Table 1 Comparative GHSI score between the UN's 24 countries and global averages

3 No data for Palestine, South Sudan
4 No data for south sudan

Quantifying current health-related needs

Our review of the most recent Humanitarian Response Plans and/or Humanitarian Needs Overview for each of the 24 priority countries highlights already staggering levels of need that will make it challenging – if not impossible – to simultaneously respond to COVID-19 and other pressing health challenges.

Identified humanitarian needs (in millions) (grey boxes indicate data not available)

Country	Population[5] (2019)	Total people in need	Total children[6] in need	Health – total	Health - children	WASH[7] – total	WASH - children	Nutrition – total	Nutrition children
Afghanistan	37.2	9.40	5.30	3.70	2.00	4.90	2.70	3.30	2.70
Burkina Faso	20.3	2.20	1.30	1.60		1.90		0.95	
Burundi	11.6	1.70	1.00	0.55	0.32	0.49	0.28	0.34	0.19
Cameroon	25.3	3.90	2.00	2.60		1.90		0.53	
CAR	4.8	2.60	1.20	2.20	0.99	2.30	1.04	1.30	0.98
Chad	15.8	5.30	2.60	0.95		1.80	0.89	4.00	
Colombia	49.8	5.10	2.10	4.53		4.58		4.50	
DRC	86.7	15.60	9.10	5.60	3.30	8.00	4.68	4.70	3.49
Ethiopia	110.1	8.40	4.53	5.90	3.19	7.00	3.78	4.40	2.73
Haiti	11.2	4.60	2.10	2.20	1.06	0.77	0.30	0.07	
Iraq	40.4	4.10	1.89	2.80	1.43	1.85	0.70		
Libya	6.6	0.90	0.27	0.53		0.24			
Mali	19.7	4.30	2.40	1.50	0.84	0.14	0.08	0.98	0.72
Myanmar	54.3	0.99	0.36	0.62	0.23	0.87	0.32	0.18	0.06
Niger	23.2	2.90	1.60	1.20	0.73	1.70	0.94	2.00	1.30
Nigeria	201.0	7.10	4.12	5.30	3.92	3.60	2.09	2.80	1.74
oPt	5.2	2.20	1.10[8]	1.30	0.60	1.80	0.92		
Somalia	15.6	5.20	3.20	3.20		2.70		1.30	
South Sudan	13.3	7.50	4.00	3.60	1.94	5.50	2.97	2.00	1.46
Sudan	42.5	9.30	5.30	8.60	5.42	7.60	4.56	3.30	2.51
Syria	18.5	11.70	5.00	13.20	5.10	15.50	6.20	4.70	3.10[9]
Ukraine	43.8	3.40	0.50	1.30	0.26	2.80	0.39		
Venezuela	32.8	7.00	3.20[10]	2.80		4.30		1.90	
Yemen	29.6	24.10	12.30	19.70	10.20	17.80	9.20	7.40	4.90
TOTAL	919	149.49	76.46	95.48	41.53	100.04	42.03	50.65	25.87

While not all of these countries' populations (nor all the people identified in pre-COVID-19 response plans) represent the most affected and at-risk due to the pandemic, the existence of significant humanitarian crises and their relatively weak health systems makes them highly vulnerable to both the primary and secondary impacts of COVID-19. Essential services and programmes are likely to be suspended or interrupted as efforts and resources are redirected to COVID-19 responses.

The UN has identified children as a group of priority concern, highlighting their increased risk of experiencing violence; suffering mental health and psychosocial impacts; lack of access to health services; and malnutrition. Girls (and women) are often at further increased risk of not being able to access health services – including for gender-based violence – as a result of gender norms[vi].

Our analysis demonstrates that the combination of pre-existing weak health systems, populations with high need, and this current pandemic may lead to catastrophic mortality for children.

5 Source: United Nationas Population Division
6 <18 years unless otherwise noted
7 Water, sanitation and hygene
8 0-14 years
9 6-69 months for this sector
10 0-19 years

Estimating secondary health impacts of COVID-19

2014-16 Ebola outbreak in West Africa's secondary impacts on children

Although key differences exist, the 2014-16 Ebola outbreak in West Africa provides valuable insights into the secondary health impacts children can experience during an infectious disease outbreak where weak health systems are already stretched to their limit, people's routines are disrupted, and fear takes hold.

The World Health Organisation (WHO) described the outbreak as the "largest, most severe and most complex Ebola epidemic" in history. More than 28,000 people were infected, and over 11,000 people died before the international public health emergency ended in June 2016. Most of the cases occurred in three countries: Guinea, Sierra Leone, and Liberia. The virus spread rapidly within the region, revealing the failures of disjointed and under-resourced healthcare systems.

Though the full impact of COVID-19 on girls and boys is still being determined by the WHO and leading health authorities[vii], initial analysis indicates that children do not appear to be at higher risk of infection or mortality than adults. During the Ebola outbreak of 2014-16, children also represented a smaller proportion of the total cases, due in part to social and cultural practices as they were less often involved in the gatherings or religious practices that contributed to the virus' spread. However, the secondary impacts on girls and boys were profound.

Applying Ebola's secondary impacts to COVID-19

While there is much we do not yet understand about COVID-19, we do know that in a large scale outbreak situation local health systems will be overwhelmed. World Vision applied evidence of the secondary health impacts on children experienced during the 2014-16 Ebola outbreak in West Africa (described above) to estimate the potential consequences of COVID-19 in 24 of the world's poorest and most fragile countries.

These issues are always context-specific, dependent on a country's health system capacity, infrastructure, demographics, culture and other factors. Estimates present a potential scenario of the secondary health impacts that children could face as a result of COVID-19 outbreak in their contexts.

Increase in malaria deaths

Malaria is the fourth highest killer of children under 5 among all infectious diseases, surpassed only by pneumonia, diarrhoea, and sepsis[viii]. Although global mortality rates for children under five have fallen 34% in the past 10 years, the toll on children and their families is still significant.

During the Ebola outbreak of 2014-2016, the region saw a 50% reduction in access to healthcare services, which led to increased deaths from malaria by an average of 50.5% across Guinea, Sierra Leone, and Liberia.

Part of this was due to fear – outpatient visits dropped to as low as 10%, as people were afraid to visit health facilities in case they caught the virus themselves. Similar fears are being seen with COVID-19. Also, lockdowns are initiated globally and people are encouraged to stay home.

For 23 of the 24 UN countries with Humanitarian Response Plans[ix], a similar 50% increase in malaria deaths would lead to more than 100,000 additional children dying from malaria – an increase from 203,218 to 305,844.

Malnutrition

In Sierra Leone, the Ebola outbreak reduced opportunities to screen for malnutrition, contributing to a 2% increase in severe acute malnutrition by the end of the outbreak. Although community screening eventually returned to normal, only one quarter of children were able to access treatment for malnutrition, leading to prolonged health impacts[x]. According to UNICEF, malnutrition causes nearly half of all deaths in children under 5, either directly from acute forms or from increased vulnerability to infections and other illnesses[xi].

As a result of the current pandemic, children and their families are also experiencing reduced access to nutritious food. Children previously fed through schools or other support programmes may no longer have access to these services, not least because of government restrictions on movement and social gatherings. Markets are closed, limiting opportunities to buy or sell produce and other food items. Price hikes are becoming common, forcing families to make difficult decisions about when to eat, and who to prioritise[xii].

Across 22 of the 24 UN countries[xiii], more than 13.1 million children are estimated to be experiencing moderate or severe malnutrition. Children under five with severe acute malnutrition are 9 times more likely to die from preventable diseases than well-nourished children. If each of these countries saw the same 2% jump in overall prevalence that was seen during the Ebola epidemic, the

total number of children experiencing moderate or severe malnutrition would reach more than 18.1 million[11] – more than 5,000,000 additional children experiencing moderate to severe malnutrition.

Malnutrition is an underlying cause of 45% of all preventable child deaths under five, but the risks do not end there. For those children who don't die because of malnutrition, their health and growth will still be stunted as will their future educational and economic attainment.

Decreased immunisations

The Ebola outbreak also led to a 30% decrease in childhood immunisation rates in Sierra Leone, Guinea, and Liberia, as health resources were redirected, social gatherings were limited and physical distancing reduced the ability to provide vaccines to children[xiv]. In the long-term, this put children at heightened risk of otherwise preventable infectious diseases, and put communities at risk of further outbreaks and strains on the health system.

In the UN's 24 countries, coverage rates for three doses of the diphtheria-tetanus-pertussis (DTP3) vaccine meant that more than 88.6 million infants under one year of age[12] were protected from infectious disease. A 30% decrease in childhood immunisation screening rates could put 26.6 million children[13] at risk of being under- or unvaccinated, exposing them to potential fatal infectious diseases.

And that is just the tip of the iceberg – DTP3 vaccine coverage rates are commonly used as a proxy for childhood immunisation rates, which means that if DTP3 coverage suffers, childhood vaccine coverage for other dangerous infectious diseases, such as polio, could be similarly compromised.

Impacts of reduced access to Reproductive, Maternal, Newborn, and Child Health (RMNCH) services

Pneumonia is currently the most dangerous infectious disease for children, killing more than 800,000 children under five globally every year. Progress in reducing these deaths has also been slower than hoped, declining by about 54% since 2000, with much progress left to be made[xv]. Diarrhoeal infections are the second most dangerous infectious disease for children, causing 437,000 deaths in children under five each year.

Given this impact, it is critical that children experiencing acute respiratory infections or diarrhoea are treated quickly and comprehensively. Epidemics and pandemics, however, put this treatment at risk.

Researchers identified a 58% drop in hospital visits for under-five acute respiratory infections, and a 23% decrease in visits to community health facilities in Guinea[xvi]. For diarrhoeal infections, the drops were 60% and 25% for hospital visits and community facility visits respectively. These findings reinforce the earlier statement that parents may have been reluctant to bring children to health facilities out of fear of contracting Ebola, putting them at great risk of untreated killer diseases.

For the 24 UN countries, impacts could be significant. In 2018,[14] across the countries, 206,543 children have died from diarrhoeal infections, while 373,618 children died from acute respiratory infections. If treatment drops by 23-25% at a minimum, child deaths will increase significantly. If the drops are as high as 58-60%, these countries could face massive increases in child deaths due to acute respiratory infections. Either way, the impacts to families, communities and countries will be catastrophic.

11 13,106,283 to 18,107,325 children
12 88,676,229
13 26,602,689

14 The last year with complete data.

Recommendations

World Vision[xvii] calls on Governments, the UN, civil society organisations and donors to:

• Urgently scale up global COVID-19 prevention and response measures for children and their families to strengthen health systems, maintain essential health service delivery, equip frontline health workers, engage and communicate effectively with communities including children, and provide critical child protection interventions and mental health and psychosocial support (MHPSS). In particular:

- Governments should expand access to essential health services, especially for those most vulnerable and at risk, by rapidly mobilising community health workers, providing response training and ensuring appropriate supply chains (e.g., for personal protective equipment) for front-line workers, scaling digital platforms for surveillance and case monitoring, and providing free primary health care and COVID-19 diagnosis and treatment.
- Governments should 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 communities, local partners, faith leaders, and other stakeholders to help prepare and protect individuals, families, and the public's health, in line with the WHO's COVID-19 Preparedness and Response guidance.
- Governments should make child protection and mental health and psychosocial support core components of their COVID-19 response. They should develop an MHPSS strategy for reaching those directly and indirectly impacted, especially those most vulnerable. This support should address fear, stigma, negative coping strategies, and other needs identified through assessments and build on positive, community-proposed coping strategies, promoting close collaboration between communities, inclusive of faith actors, and health, education, and social welfare services.
- Donors should urgently commit emergency funding for health system strengthening, provide technical resources for support, and ensure equitable distribution of supply chains. They should also finance risk communication/community engagement and provide any necessary online MHPSS training.

• Adopt policies and fund COVID-19 response plans that holistically address the secondary impacts of the pandemic on children and families, particularly with respect to child protection, gender-based violence, education, water and sanitation, food security, and livelihoods.

• Protect ongoing investments in humanitarian and development assistance for the most vulnerable, adapt programmes to be COVID-19 sensitive in existing humanitarian response contexts, ensure and where possible maximise humanitarian access including creation of exceptions for humanitarian workers' and supply chain movements, and find alternatives to humanitarian programme suspensions where COVID-19 prevention policies are required.

Appendix 1: Priority countries for UN Global Humanitarian Response Plan for COVID-19

Due to the characteristics and impact of the COVID-19 pandemic described previously, all countries with an ongoing humanitarian response are prioritised in the Global Humanitarian Response Plan (HRP). This includes countries with an HRP or a Regional Refugee Plan (RRP), the Refugee and Migrant Response Plan for Venezuela (RMRP), and countries covered by the Regional Refugee and Resilience Plan (3RP) for the Syria crisis, and the Joint Response Plan for Rohingya Humanitarian Crisis (JRP). Iran is also included due to the particularly severe impact of the pandemic and call for international assistance.

Priority regions and countries

Humanitarian Response Plans

Afghanistan	Ethiopia	oPt
Burkina Faso	Haiti	Somalia
Burundi	Iraq	South Sudan
Cameroon	Libya	Sudan
CAR	Mali	Syria
Chad	Myanmar	Ukraine
Colombia	Niger	Venezuela
DRC	Nigeria	Yemen

Regional RRPs

Angola	Jordan	South Sudan
Burundi	Kenya	Syria
Cameroon	Niger	Uganda
Chad	Nigeria	Tanzania
DRC	Lebanon	Turkey
Egypt	Rep. of Congo	Zambia
Iraq	Rwanda	

Venezuela Regional RMRP

Argentina	Costa Rica	Panama
Aruba*	Curaçao*	Paraguay
Bolivia	Dominican Rep.	Peru
Brazil	Ecuador	Trinidad and Tobago
Chile	Guyana	
Colombia	Mexico	Uruguay

Others

Bangladesh	DPR Korea	Iran

i https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30152-1/fulltext
ii https://www.cebm.net/covid-19/global-covid-19-case-fatality-rates/
iii https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/cost-of-ebola.html
iv https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30553-5/fulltext
v Hospital bed numbers not available for the occupied Palestinian Territories
vi https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf p.16
vii https://www.cdc.gov/coronavirus/2019-ncov/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Fchildren-faq.html#anchor_1584387482747
viii https://data.unicef.org/topic/child-health/pneumonia/
ix Data on the occupied Palestinian Territories not available
x https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515560/
xi https://data.unicef.org/topic/child-health/pneumonia/
xii For a summary of probable impacts of COVID-19 on food systems see https://www.gainhealth.org/sites/default/files/news/documents/covid-19-crisis-and-food-systems-probable-impacts-and-potential-mitigation-and-adaptation-responses.pdf
xiii Data on the Central African Republic and Venezuela were not available
xiv UNDP. 2014. "Assessing the socio-economic impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone: The Road to Recovery." http://www.africa.undp.org/content/dam/rba/docs/Reports/EVD%20Synthesis%20Report%2023Dec2014.pdf
xv https://data.unicef.org/topic/child-health/pneumonia/
xvi Rapid Assessment of Ebola-Related Implications for Reproductive, Maternal, Newborn and Child Health Service Delivery and Utilization in Guinea. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4542265/
xvii This report has focused on the 24 countries with existing Humanitarian Response Plan (HRP) listed in the UN's Global HRP. In its own response plan https://www.wvi.org/publications/coronavirus-health-crisis/covid-19-emergency-response-plan World Vision has prioritised the 17 countries where it believes it can have the biggest impact: Afghanistan, Bangladesh, Brazil, Democratic Republic of Congo, Haiti, India, Indonesia, Iraq, Kenya, Lebanon, mainland China, Mongolia, Philippines, Senegal, South Africa, Syria, and Thailand.

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and communities to overcome poverty and injustice. Inspired by our Christian values, we are dedicated to working with the world's most vulnerable people. We serve all people regardless of religion, race, ethnicity or gender.

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