THE HIDDEN IMPACT OF COVID-19 ON CHILDREN'S HEALTH AND NUTRITION

A GLOBAL RESEARCH SERIES

Save the Children believes every child deserves a future. Around the world, we work every day to give children a healthy start in life, the opportunity to learn and protection from harm. When crisis strikes, and children are most vulnerable, we are always among the first to respond and the last to leave. We ensure children's unique needs are met and their voices are heard. We deliver lasting results for millions of children, including those hardest to reach.

We do whatever it takes for children – every day and in times of crisis – transforming their lives and the future we share.

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PHOTO: MARK WAHWAI/SAVE THE CHILDREN

The Hidden Impact of COVID-19 on Children's Health & Nutrition

About the research

The research sampled three distinct population groups:
1. Save the Children program participants.
2. specific population groups of interest to Save the Children.
3. the general public.

A representative sample of Save the Children program participants with telephone numbers or email addresses was obtained in 37 of the 46 countries. The results presented in this report focus on data from our representative sample of 17,565 parents/caregivers and 8,069 children in our program participants group.

Response overview

31,683 public responses including

13,477 child responses aged 11-17

The study was implemented in 46 countries and resulted in the largest and most caomprehensive survey of children and families during the COVID-19 crisis to date.

KEY FINDINGS

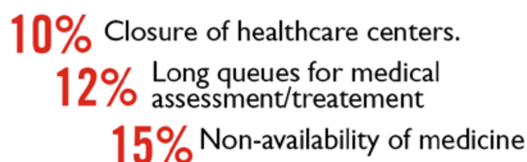
Access to healthcare and medical supplies

89% of parents/caregivers reported their access to general healthcare, rehabilitation service, medical supplies, or items/support to stay healthy are affected.

Greater challenges to access to healthcare were reported among households:

Parents/caregivers faced barriers to accessing healthcare and medications due to:

- 10% Closure of healthcare centers.
- 12% Long queues for medical assessment/treatement
- 15% Non-availability of medicine



Infant and young child feeding

94% of parents/caregivers who breast fed their child before COVID-19 were able to continue breastfeeding.

1 in 2 parents/caregivers reported some concerns about continuing breatfeeding.

24% concern about being separated

28% fear getting the baby infected

Only 55% of parents/caregivers that use infant formula or breast-milk substitutes could access it since the start of the COVID-19 outbreak.

Physical Health

15% of caregiver reported having children in the household fallen sick since the outbreak of COVID-19

Higher proportions have fallen sick among houlseholds

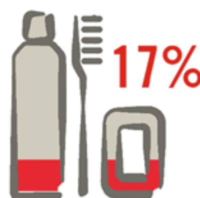
- with child/children having chronic condition 27%
- with parent/caregiver with disability 22%

65% of parents/caregivers reported difficulties obtaining basic health services including:

- 29% COVID tests
- 20% couselling
- 22% in-person healthcare service

Health and hygiene needs

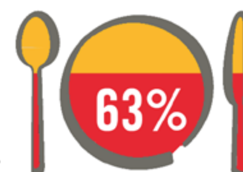
The health and hygiene needs to stay healthy



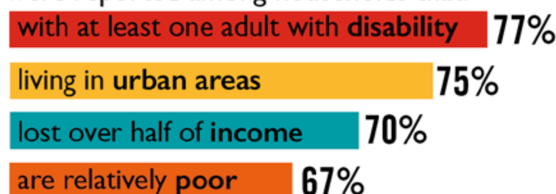
Only 17% reported not needing any of these health and hygiene items. The need reported higher among those living in urban area, those from poor households and those belongs to minority groups.

Nutrition needs

63% of parents/caregivers reported barriers to accessing meat, dairy products, grains, fruits and vegetables.



Greater challenges to access nutritious food were reported among households that:



Executive summary

ABOUT THE STUDY

COVID-19 has spread rapidly within and between countries across the globe. Governments worldwide have implemented measures to contain the spread of COVID-19, including school closures, home isolation/quarantine and community lockdown, all of which have had secondary impacts on children and their households. Save the Children launched a global research study to generate rigorous evidence on how the COVID-19 pandemic and measures implemented to mitigate it are impacting children's health, nutrition, learning, wellbeing, protection, family finances and poverty and to identify children's and their families' needs during these times. The research also captures children's views and messages for leaders and other children.

The research was implemented in 46 countries and results in the largest and most comprehensive survey of children and families during the COVID-19 crisis to date, with **31,683 parents and caregivers and 13,477 children aged between 11 and 17 participating in the research**. The research sampled three distinct population groups: 1. Save the Children programme participants; 2. specific population groups of interest to Save the Children; 3. the general public.

A representative sample of Save the Children programme participants with telephone numbers or email addresses was obtained in 37 of the 46 countries. The results presented in this report focus on implications for children's health and nutrition, drawing on data from our **representative sample of 17,565 parents/caregivers and 8,069 children in our programme participants group**. The research presents differences in impacts on and needs of children by region, age, gender, disability, minority group, indicators of poverty and more.

KEY FINDINGS

HEALTH

Access to healthcare and medical supplies

- The COVID-19 pandemic has caused significant disruption to access to healthcare and medical supplies.
- The vast majority (89%) of parents and caregivers reported that their households' access to healthcare, medicine, medical supplies or items needed to stay healthy have been affected as a result of the COVID-19 pandemic. This increased to nearly all for households where at least one child has a disability (96%) and households where at least one parent/caregiver has a disability (94%).
- The primary reason parents and caregivers say that they are not going out to get food, healthcare or medical supplies is due to worry about getting infected by COVID-19 (73%). Government restrictions, such as national or community lockdown or quarantine measures were reported by 43% of parents/caregivers as stopping them from going out to get food, healthcare or medical supplies. Disruptions to transportation were reported by 23% of parents and caregivers.
- Other barriers that parents and caregivers said stopped them from accessing healthcare, medication or menstrual products included the closure of healthcare centres (10%), long queues and not being able to get assessed or treated (12%) and that healthcare centres and pharmacies have run out of needed medicines (15%). In addition, households are having trouble paying for healthcare and medical supplies.
- About two-thirds (65%) of households reported not being able to access health services and support needed in order to stay healthy. This included medication (32%), COVID-19 tests (29%), in-person healthcare (22%), counselling (20%) and remote healthcare (19%) among others.

Health and hygiene needs

- Parents and caregivers said that the health and hygiene items most needed to keep them and their family safe during the pandemic were sanitiser/soap (reported by 56% of parents/caregivers), masks (52%), food delivery (47%) and water delivery (20%). Fewer than one in five (17%) reported not needing any of these health and hygiene items.
- Parents and caregivers also reported that they needed mental health services, respite care, domestic violence services, physiotherapy and help with assistive devices.
- Children also expressed concerns about the health system and called for health-related support. They urged governments and policy makers to take immediate steps in expanding access to health centres, medicines and equipment for testing.
- The biggest concerns for children included testing positive for COVID-19 and that a family member or friend would test positive.

NUTRITION

Access to food and nutrition

- Nearly two-thirds of parents and caregivers (63%) reported barriers to accessing meat, dairy products, grains, fruit and vegetables.
- Half of parents and caregivers (52%) reported that food items were too expensive, 14% said food shops or markets were closed, and 15% said food shops or markets had run out of these items
- Barriers to accessing meat, dairy products, grains, fruit and vegetables were reported at higher rates for:
  - parents with disability (77%) compared to those without disability (62%)
  - urban households (75%) compared to rural households (57%)
  - households that reported losing more than half of their income during the COVID-19 pandemic (70%) compared to those who haven't (54%)
  - households classified as relatively poor (67%) compared to non-poor households (60%).

Infant and young child feeding

- The majority (94%) of parents of breastfed infants reported that they were able to continue breastfeeding during the COVID-19 pandemic. This was true irrespective of the parent's disability status.
- However, nearly half (49%) of them had concerns about continuing breastfeeding during the COVID-19 outbreak. Parents' primary concerns about continuing breastfeeding included fear that their baby would get infected from breastfeeding (28%) and fear of being separated from their baby (24%) if they became infected. This demonstrates a high prevalence of misconceptions and misinformation regarding COVID-19 and breastfeeding.
- About half (47%) of the parents/caregivers with infants wanted to feed their infant with infant formula or breast-milk substitute. More than half of these parents/caregivers (55%) were able to access infant formula or breast-milk substitutes since the start of the COVID-19 outbreak.

PHOTO: SAVE THE CHILDREN

KEY IMPLICATIONS AND RECOMMENDATIONS

Government leaders, donors, policymakers, programme implementers and UN agencies must urgently increase efforts to improve access to preventative and curative services and care to protect children from the impacts of the COVID-19 pandemic. They can and should do this in the following ways:

Promote increased and equitable access to universal health and nutrition services and care.

- Support the safe continuation of and minimal disruption to essential childhood health and nutrition services, particularly for community case management of childhood illnesses and malnutrition.
- Ensure routine maternal and newborn services such as skilled birth attendance at delivery and preventative services such as immunisation, which are critical for maternal and child survival, are maintained and strengthened during the COVID-19 outbreak.
- Ensure provision of adequate personal protective equipment (PPE) for health staff, including community health workers (CHWs). Adequate infection prevention and control (IPC) measures must also be in place at healthcare centres and community-based service delivery points to ensure the safety of healthcare workers and clients while receiving services.
- Advocate for public and private health services to be made free at the point of use, especially for vulnerable children and families, and for the removal of other financial and non-financial barriers (eg, lack of transportation) to accessing services as part of efforts to achieve universal health coverage.
- Support direct provision of services in humanitarian settings for preventative care and treatment of childhood disease and malnutrition, particularly when access to health services is significantly reduced due to community lockdown, restrictions on movement or disruptions to transportation. Ensure availability of essential medicines and medical supplies in all contexts.
- Support health system strengthening by leveraging attention on global health systems and global health security during the pandemic, and the importance of outbreak management and prevention of disease transmission.

Elevate levels of COVID-19 testing.

- Increase capacity for improved testing, tracking and tracing in all locations. Advocate and support the policy environment to accomplish this.

Ensure risk communication and community engagement to tackle harmful beliefs and messaging that reduce health-seeking behaviour.

- Support families and communities to access accurate information on COVID-19 risks, transmission mechanisms and preventive measures, and increase their confidence in the use of healthcare services. This should include locally and culturally appropriate risk communication and community engagement (RCCE) efforts designed to detect and rapidly respond to public perceptions and to counter any misinformation, misconceptions or rumours regarding COVID-19.

- Increase use of communication channels such as social media, TV and radio as effective platforms to disseminate key information on COVID-19 to communities. Ensure all COVID-19 RCCE messaging is accessible to all, including children and people with disabilities.

Protect, promote and support breastfeeding and protect existing positive practices.

- Protect and promote early initiation and exclusive breastfeeding for the first six months and continued breastfeeding after six months in accordance with WHO guidelines on breastfeeding and COVID-19, whether or not mothers or their infants have suspected or confirmed COVID-19.
- Ensure the implementation of strict measures in compliance with the International Code of Marketing of Breast-milk Substitutes and country-specific legal norms to prevent inappropriate use of such products.
- Governments must provide regularly updated guidance on appropriate and timely support for infant and young child feeding in line with WHO guidance and protect breastfeeding by upholding the standards and recommendations of the Code and subsequent related World Health Assembly resolutions. Governments should ensure guidance reaches and is accessible for all, including people with disabilities.

Protect food security and livelihoods and access to nutritious foods.

- Ensure that safe and nutritious food is affordable and accessible for all by financing and scaling up social protection schemes alongside measures to address livelihoods and food system challenges.
- Guarantee access to basic food and markets by considering long-term, costed nutrition plans which better integrate nutrition within the health system and other relevant sectors and provide children with access to food even when markets are closed.
- Cash transfers should be coupled with nutrition messaging to achieve the greatest impact on nutrition outcomes.

Provide food and non-food items to cover basic needs in deprived communities.

- Supplementary food distributions and water supply support should be an important component of COVID-19 responses, complementing social protection mechanisms where necessary, with a particular focus on marginalised communities and populations.
- Support vulnerable communities – especially children – to access important basic items for infection prevention such as masks, soap, sanitiser and sanitary products.

Promote mental health services.

- Support the provision of mental health and psychosocial support (MHPSS) to tackle mental ill-health resulting from isolation and lockdown measures.
- Domestic violence services should be scaled up and considered as an adaptation to programmes targeting women and girls to address and mitigate various forms of domestic violence that may occur as a result of lockdown measures. Develop robust systems to identify and provide psychosocial support for children experiencing violence at home.

Improve analysis, design and implementation of programmes and advocacy work to include marginalised and deprived communities, households and individuals.

- Responses to COVID-19 should be based on analysis which is sensitive to gender, disability, poverty, location and exclusion to ensure the inclusion of people with disabilities, chronic health conditions and those from ethnic minority backgrounds.
- Ensure programme design and budgeting is inclusive and removes financial and non-financial barriers for people with disabilities, those from minority groups or who are excluded because of gender to better access health and nutrition programmes and information.
- Enhance partnerships and collaboration with rights-holder associations such as representative organisations of people with disabilities, women and minority groups at different levels when planning and implementing programmes.

PHOTO: SAVE THE CHILDREN

Introduction and aims

STUDY BACKGROUND

On 30 January 2020, the World Health Organization (WHO) Director General declared the outbreak of coronavirus disease (COVID-19) a Public Health Emergency of International Concern (PHEIC) (WHO, 2020a), then on 11 March 2020 declared the COVID-19 outbreak a global pandemic (WHO, 2020b). The PHEIC remains in place at the time of writing (late August, 2020). The number of cases and deaths from the coronavirus outbreak continues to rise exponentially. As this report is being written, nearly 22 million people from more than 200 countries have been infected and nearly 800,000 have died (WHO, 2020d).

The global coronavirus COVID-19 outbreak is already having a serious impact on global and national economies, health systems, education systems and more – and ultimately on the fulfilment of children's rights. A number of governments have implemented measures to contain the spread of COVID-19, ranging from social distancing and behavioural changes to home isolation/quarantine, school closures, business closures and community lockdown. Around 1.5 billion children and youth were affected by school closures in the first half of April 2020 (UNESCO, 2020).

In addition to the immediate impacts on children's health rights and those of their caregivers, the social and economic disruptions caused by the outbreak of COVID-19 present a range of other risks to children's right to education and to their wellbeing and protection. These may derive directly from the outbreak, from measures taken to respond to it and from wider economic and other disruption. The WHO's Coordinated Global Research Roadmap (2020c) summarises the available literature on this topic:

> *These measures all have secondary impacts. Quarantine, for instance, has impacts on the mental [5–7] and physical health [8] of populations… A rapid systematic review of publications reporting previous events of quarantine for infectious disease outbreaks, identified how knowledge of the disease, clear information regarding quarantine procedures, social norms, perceived benefits of quarantine, perceived risk of disease, and ensuring sufficient supplies of food, medicines and other essentials were important factors to promote adherence to the uncomfortable realities of quarantine measures [10]. Others have highlighted the critical role of trust, interpersonal and international cooperation that emerge in response to a collective effort in tackling a major public health crisis [11].*
>
> (WHO and R&D Blueprint, 2020: 60)

RESEARCH PURPOSE

This research report presents selected findings from a large-scale cross-thematic research study on the impact of the COVID-19 pandemic on children and their families. The purpose of the study is to understand:

1. The impact of school closures, home isolation/quarantine and community lockdown on children's health, nutrition, learning, wellbeing and protection.
2. The economic impact of the COVID-19 pandemic on households with children.
3. The health, psychosocial, learning and protection needs of children during times of school closures, home isolation/quarantine and community lockdown.
4. Children's right to be heard when talking about COVID-19.
5. Children's messages for leaders and other children around the world.

This knowledge will be used by Save the Children and shared with governments, donors, partners and other stakeholders to inform the development of a variety of information products, services, programmes and policies across multiple sectors.

RESEARCH QUESTIONS

This research report presents findings addressing the following health- and nutrition-related research questions:

- What is the impact of the COVID-19 pandemic on access to healthcare and medical supplies?
- What are the barriers to accessing food, healthcare and medical supplies?
- What are the health and hygiene needs of children and their households during COVID-19?
- What is the impact of COVID-19 on children's and household members' access to food and nutrition?
- What are the nutrition needs of children and their households during COVID-19?
- What is the impact of COVID-19 on breastfeeding and infant and young child nutrition?

PHOTO: SAVE THE CHILDREN

Research design and methods

This section provides a summary of the study research design and methods. The full Study Methods Report describes the methods and sample in detail, as well as the limitations of the design and methods. The full Study Methods Report is available here: https://resourcecentre.savethechildren.net/library/hidden-impact-covid-19-children-global-research-series.

This study was approved by the Save the Children US Ethics Review Committee (SCUS-ERC-FY2020-33). Approval was also obtained from local Independent Review Boards in the countries where the research was undertaken, if such bodies existed.

STUDY POPULATIONS AND SCOPE

This research study was carried out among current programme participants of Save the Children-led or partner-led programmes in the 37 countries listed in Table 1. The study was implemented only in those countries where local Save the Children or partner staff could

TABLE 1: COUNTRIES WHERE THE RESEARCH WAS IMPLEMENTED

Region	Countries where the research was implemented among Save the Children programme participants
Asia	Afghanistan, Bangladesh, Cambodia, India, Indonesia, Laos, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka
Eastern and Southern Africa (ESA)	Ethiopia, Kenya, Malawi, Mozambique, Somalia, South Sudan, Uganda
West and Central Africa (WCA)	Burkina Faso, Niger, Senegal, Sierra Leone
Middle East and Europe (MEE)	Egypt, Lebanon, Syrian Arab Republic Albania, Kosovo
Latin America and the Caribbean (LAC)	Bolivia, Brazil, Colombia, Dominican Republic, El Salvador, Paraguay, Peru
North America	United States of America
Pacific	Papua New Guinea, Solomon Islands

quickly mobilise resources to carry out the study. These countries were not randomly selected and are therefore neither representative of all countries across the world, nor representative of all countries in which Save the Children operates.

The survey questionnaire and Participant Information Sheet were translated using a back-translation process into 28 languages to facilitate uptake in all countries where the research was implemented.

SAMPLING, RECRUITMENT AND DATA COLLECTION MECHANISMS

The research was designed to obtain a representative sample of current Save the Children beneficiaries. Remote data collection methods had to be used due to the presence of COVID-19 and the risk of contracting or transmitting COVID-19 during in-person data collection activities. The study population was therefore necessarily reduced to only those programme participants with remote contact details (phone number or email) listed at the individual or household level. For this reason, the research can only be considered as representative of Save the Children programme participants with remote contact details in those countries where the study was implemented.

A random sample of current programme participants across all programmes (derived from a programme database of programme participants with contact details) was obtained in the majority of countries. A stratified random sample of current programme participants across all programmes (derived from a programme database of programme participants with contact details) was obtained in a few countries.

There were only two eligibility criteria for participation in the study:

1. Adult respondents (aged 18 and above) had to be parents and/or caregivers of children aged 0–17 living in the same household (Part 1 of the survey);
2. Child respondents had to be aged 11–17 (Part 2 of the survey).

Data was collected through a single online SurveyMonkey (Enterprise version) survey, completed either directly by the respondents themselves or indirectly via an interviewer. The majority of beneficiaries, in the majority of countries, were reached by phone and invited to participate in the study. In these cases, an interviewer would talk through the survey and enter the participants' responses directly into the online survey on their behalf. Programme participants were also invited to participate in the study after being sent the survey link by email, text messaging, WhatsApp or other instant messaging platform. They could then complete the online survey in their own time using a device of their choice.

Permission for in-person interviews was granted in Papua New Guinea due to the absence of COVID-19 cases at the time of the study. The Papua New Guinea sample therefore included all beneficiaries, regardless of whether or not they had remote contact details. In the United States of America, a census of all current programme participants was obtained and the population invited to participate in the study through a printed flyer with a QR code linking to the online survey.

The minimum requirements for participation in the study were a confidence level of 90% and margin of error of 5%. For the majority of countries, this meant a minimum sample size of 273 adult respondents. A detailed description of the sampling approach and final response numbers per participating country can be found in the full Study Methods Report, available at: https://resourcecentre.savethechildren.net/library/hidden-impact-covid-19-children-global-research-series.

LIMITATIONS OF THE RESEARCH DESIGN

The sample is skewed:

- Towards programme participants with stable internet and/or phone access and who were willing to absorb the cost of receiving phone calls or using their data plan.
- Towards those who can speak or read and write in the languages that the survey has been translated into, and against those who cannot. To overcome this, efforts were made to translate the online survey into a range of languages and to engage interviewers who could speak local languages/dialects, verbally translate the survey questions (following a written and tested translation) and then enter the participant responses into the more mainstream language in the online survey on the participant's behalf.
- Towards those with time and interest and against those with limited time and less interest (self-selection bias).

This unfortunately biases the study sample against the most marginalised and deprived. Similarly, the sample is also skewed against those with certain disabilities. To foster inclusivity, survey respondents could engage the assistance of another when participating in the survey.

THE SURVEY QUESTIONNAIRE

Data was collected through a single survey divided into two parts. The first part was for the adult parent or caregiver and gathered household level information, as well as information specifically about the parent/caregiver and children in their care. This part of the survey questionnaire also prompted the parent/caregiver to think about one particular child ('the indexed child') and answer some specific questions about them related to COVID-19. Prompts in the survey were designed to prioritise the capture of data on school-age children, while still facilitating the collection of data on an even spread of children of different ages.

If the adult parent/caregiver had a child aged 11–17, they were then asked whether they consented to their child answering some additional survey questions – the second part of the survey. If the adult parent/caregiver consented, they passed the survey to their child, who then went through an assent process before being asked to answer the children's questions.

Only one adult and one child (aged 11–17) per household could complete the survey. If the adult had more than one child aged 11–17, then they could choose which child would complete the children's section of the survey.

There are various limitations with the questionnaire structure that are discussed in the full Study Methods Report (available at: https://resourcecentre.savethechildren.net/library/hidden-impact-covid-19-children-global-research-series). A notable limitation is that the survey questionnaire did not ask whether the child respondent was the same individual as the indexed child. This is a limitation of the survey that prevents comparison between adult reports on a child and the child's self-reports.

The Washington Group Short Set of Questions on Disability (WG-SS) was used to disaggregate data for disability.[*] The WG-SS was asked of the adult respondent and about the indexed child by proxy of the adult respondent. Child respondents did not respond to WG-SS, preventing data disaggregation for the child respondent by disability.

[*] Person with disability is defined as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

Being a self-report survey, there will likely be response bias, particularly for survey questions around parenting, family relationships, violence and income losses. Bias in self-reporting of income can involve a combination of expectation bias, privacy concerns and the general challenge of accuracy of reporting income for people (mainly rural and informal sector) with multiple income sources without triangulation.

DATA COLLECTED

The survey was designed to capture information across multiple sectors or themes, including household economies, health and nutrition, child education and learning, child protection and child rights. The survey questionnaire is presented in the full Study Methods Report (available at: https://resourcecentre.savethechildren.net/library/hidden-impact-covid-19-children-global-research-series). An overview of the data collected in the survey is shown in Table 2 on page 13.

DATA ANALYSIS

Probability weighting was used to weight the beneficiary sample against the total beneficiary population. Regression analysis was performed using the F-Statistic test in STATA. A p-value of <0.05 was used to denote statistical significance.

The quotes featured in this report were selected following qualitative analysis of five open-ended survey questions answered by the child respondents. The qualitative analysis employed a conceptual content approach to identify key themes that children described. A framework method supported this approach, whereby a pre-emptive thematic framework, protocol and coding template were developed to support consistency in coding by numerous analysts coding for different countries and languages. The framework allowed flexibility to code inductively and therefore new emerging themes could be added during the coding process. All of the children's open-ended responses were examined and coded, irrespective of any perceptions on saturation point. Quotes and case studies reported as a result of the qualitative data analysis are consistent with these key themes, or are noted as particularly salient and important to the child respondent.

PHOTO: MALAMA MWILA/SAVE THE CHILDREN

TABLE 2: OVERVIEW OF DATA COLLECTED IN THE SURVEY

Level of variable	Household level	Individual level		
Respondent	**Parent**	**Parent**	**Parent**	**Child**
Subject of variable	**Household**	**Parent**	**Indexed child**	**Child participant**
Item	• Schools closed (weeks) • Home quarantine (weeks) • Stores closed (weeks) • Geography, migration and displacement • Country/settlement type • Migration and displacement due to COVID-19 • Parent/child separation due to COVID-19 • Number/gender of adults • Number/gender of children • Number of habitable rooms • Household wealth • Income lost (amount) • Income lost (sources) • Ability to pay for basic needs • Coping strategies in home • Government support and social protection floors • Household physical health and nutrition • How many household illnesses since COVID-19 • Barriers to medical care • Barriers to medications • Barriers to food and nutrition • Barriers to other health/ sanitation items • Medical care, medication and other health/ sanitation items needed	• Gender • Age • Minority status • Disability status • Relationship to children in household • Parent's/caregiver's wellbeing and perceptions of family relationships • Parent's/caregiver's feelings and worries • Changes in relationships with children and in the household • Violence in the home	• Gender • Age • Disability status • Chronic health condition • Children's learning and education: • Attendance at school prior to COVID-19 • Access to and use of learning materials • Barriers to learning • Teacher remote support for home-based learning • Parent/caregiver support for children's home-based learning • Perceptions of children's learning • Likelihood of children returning to school after COVID-19 • Children's wellbeing and family relationships • How children feel and sleep since COVID-19 • Changes in children's behaviour and sleep since COVID-19 • Children's contact with friends and doing activities for fun • Children's safe use of the internet • Child rights • Whether parent/ caregiver talks to their children about COVID-19 • Breastfeeding and infant nutrition practices, concerns and needs	• Gender • Age • Children's learning and education: • Whether children feel they are learning at home • What helps or stops children from learning at home • Children's wellbeing: • What children do to have fun • What children miss and miss out on by not attending school • Children's contact with friends • How children describe their home situation • What children have enjoyed most about being at home • Children's rights: • Children's right to information about COVID-19 • Children's right to be heard when talking about COVID-19 • Children's messages for leaders • Children's messages for other children around the world

Study sample numbers and characteristics

Data were collected from **17,565 adult respondents** and **8,068 child respondents**, from across the seven regions in which Save the Children operates: Asia, Eastern and Southern Africa (ESA), West and Central Africa (WCA), Latin America and the Caribbean (LAC), the Middle East and Europe (MEE), the Pacific and North America. The detailed characteristics of the programme participant respondents are presented in Table 4 below. More detailed breakdowns of the sample numbers and characteristics by region are presented in a separate Sample Characteristics report, available at: https://resourcecentre.savethechildren.net/library/hidden-impact-covid-19-children-global-research-series.

TABLE 4: SAVE THE CHILDREN PROGRAMME PARTICIPANTS, WORLDWIDE SAMPLE

Variable	Adult respondent (parent/caregiver)		Child respondent (11–17 years of age)		Indexed child	
	Number of adult respondents	Percentage of adult respondents	Number of child respondents	Percentage of child respondents	Number of indexed children	Percentage of indexed children
Total	**17,565**	**100**	**8,069**	**100**	**16,110**	**100**
Region						
Asia	6,915	39.4	3,686	45.7	6,559	40.7
ESA	3,274	18.6	1,588	19.7	3,084	19.1
WCA	1,372	7.8	646	8.0	1,282	8.0
LAC	3,047	17.3	1,129	14.0	2,716	16.9
MEE	2,166	12.3	794	9.8	1,772	11.0
Pacific	251	1.4	140	1.7	235	1.5
North America	518	2.9	81	1.0	444	2.8
Europe and others	22	0.1	5	0.1	18	0.1
Gender						
Female	10,554	60.1	4,336	53.7	8,075	50.1
Male	6,055	34.5	3,619	44.9	7,945	49.3
Prefer not to say/other	62	0.4	11	0.1	90	0.6
Non-response	894	5.1	103	1.3	–	0.0

continued on next page

Variable	Adult respondent (parent/caregiver)		Child respondent (11–17 years of age)		Indexed child	
	Number of adult respondents	Percentage of adult respondents	Number of child respondents	Percentage of child respondents	Number of indexed children	Percentage of indexed children
Age						
0–1	N/A	N/A	N/A	N/A	809	5.0
2–4	N/A	N/A	N/A	N/A	1,591	9.9
5–10	N/A	N/A	N/A	N/A	4,932	30.6
11–14	N/A	N/A	4,531	56.2	4,770	29.6
15–17	N/A	N/A	3,398	42.1	4,008	24.9
18–24	1,154	6.6	N/A	N/A	N/A	N/A
25–29	2,197	12.5	N/A	N/A	N/A	N/A
30–39	6,363	36.2	N/A	N/A	N/A	N/A
40–49	4,514	25.7	N/A	N/A	N/A	N/A
50–59	1,804	10.3	N/A	N/A	N/A	N/A
60+	744	4.2	N/A	N/A	N/A	N/A
Non-response	789	4.5	140	1.7	–	0.0
Disability status						
Has disability	997	5.7	N/A	N/A	623	3.9
Does not have disability	15,337	87	–	–	12,582	78
Non-response	1,231	7.0	8,069	100.0	2,905	18.0
Has a chronic health condition						
Has health condition	N/A	N/A	N/A	N/A	1,087	6.7
Does not have health condition	N/A	N/A	N/A	N/A	14,921	92.6
Non-response	N/A	N/A	N/A	N/A	–	0.0
Family member belongs to a minority group						
Yes	4,588	26.1	2,168	26.9	4,318	26.8
No	10,400	59.2	5,041	62.5	10,098	62.7
Prefer not to say	540	3.1	202	2.5	498	3.1
Non-response	2,037	11.6	658	8.2	1,196	7.4
Relatively poor						
Poor (below median wealth index)	6,278	35.7	3,506	43.5	6,278	39.0
Not poor (on or above the median wealth index)	5,762	32.8	3,425	42.4	5,762	35.8
Non-response	5,525	31.5	1,138	14.1	4,070	25.3
Settlement type						
City	5,099	29.0	2,268	28.1	4,863	30.2
Large or small town	2,912	16.6	1,218	15.1	7,618	47.3
Village	8,593	48.9	4,364	54.1	2,755	17.1
Don't know	172	1.0	79	1.0	155	1.0
Non-response	789	4.5	140	1.7	719	4.5

PHOTO: SAVE THE CHILDREN

Results

CHILDREN ARE WORRIED ABOUT THEIR OWN AND THEIR FAMILY'S HEALTH

We asked children "What worries you the most about the COVID-19 outbreak?" Nearly nine and a half thousand children (9,467) from our programme participants and general public samples told us their two biggest worries were: 1. testing positive for COVID-19; 2. a family member or friend testing positive for COVID-19. Children also expressed worries related to the spread of the virus and concerns about the health system. Here are some of their worries, in their own words:

> *"I am very fearful of testing positive for corona."*
> Girl, age unknown, Somalia

> *"What worries me the most is the infection of COVID-19 on my family members."*
> Girl, 15 years old, Cambodia

> *"Afraid of mother and grandparents will get infected and exposed to the virus because of their age."*
> Girl, 17 years old, Indonesia

> *"Food and health deficiency and fear of disease outbreaks among my family."*
> Girl, 16 years old, Lebanon

> *"The weak medical infrastructure in our country and thereof lacking the ability to support the citizens infected."*
> Boy, 13 years old, Bangladesh

> *"That we get infected and that the health system is very bad."*
> Girl, 15 years old, Nicaragua

> *"I'm worried about how fragile our healthcare system is."*
> Girl, 16 years old, Somalia

> *"I worry that if government cannot control this situation it will affect a lot of people and spread over all districts."*
> Boy, 13 years old, Afghanistan

> *"That it stays and eventually kills us since we don't have a proper healthcare system and worse of all we live in an IDP where the pandemic can spread faster than in any other place."*
> Girl, 17 years old, Somalia

> *"That my dad wants me to go out but I don't want to, as I'd rather be careful and stay in a bit longer so we can get out of this situation more quickly, than desperately go out too soon and make everything take longer (and I am scared because I have diabetes)."*
> Girl, 13 years old, Argentina

THE IMPACT OF THE COVID-19 PANDEMIC ON ACCESS TO HEALTHCARE AND MEDICAL SUPPLIES

The COVID-19 pandemic has had significant impact on access to healthcare, medicines and medical supplies at both individual and household levels. The **vast majority (89%) of parents and caregivers surveyed reported that their households' access to healthcare, medicine or medical supplies have been affected** as a result of the COVID-19 pandemic.

Access to healthcare and medical supplies is especially important when someone in the home falls ill. 15% of households reported that since the outbreak of COVID-19 an adult or child had fallen ill due to any cause, and this figure increases with the number of people residing in the household. In households with one child, 5% reported that a child had fallen ill due to any cause, while 27% of households with 6 or more children reported a child falling ill.

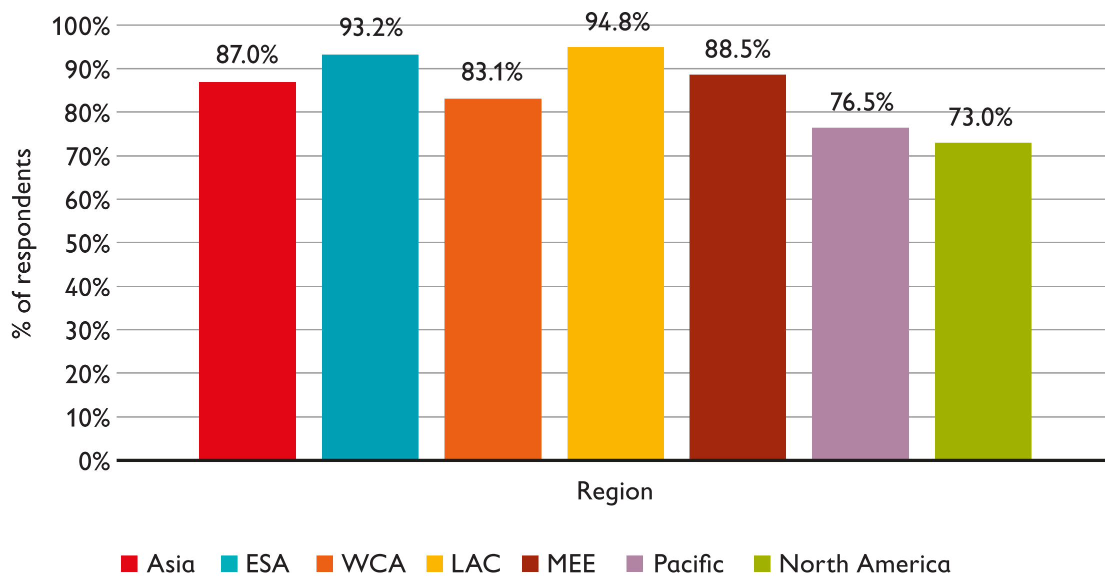
The majority of households where at least one parent/caregiver (94%) or one child (96%) has a disability reported that their access to healthcare, medicine or medical supplies have been affected as a result of the COVID-19 pandemic, compared to those where the parent/caregiver (89%) or indexed child (90%) have no reported disability. Parents and caregivers with a disability represent around **5%** of all programme participant respondents, while **3%** of indexed children were reported to have a disability. Having an adult family member who had fallen sick since the outbreak of pandemic was reported by more parents/caregivers with a disability (31%) than without a disability (14%). Among households with at least one child with a disability, 22% confirmed that children in the household had fallen sick due to some illness since the outbreak of COVID-19, compared to 16% of households having no children with a disability.

Access to healthcare was significantly impacted in households with a child with a chronic illness (95%). Such households were nearly twice as likely (27%) to report children falling sick due to any illness than households without a child with a chronic health condition (14%). Just under half **(45%) of these households indicated that they have not been able to provide regular health and rehabilitation services to their child with a chronic health condition since the outbreak of COVID-19**. This figure increased to 55% in households where the child with a chronic health condition also had a disability. 59% of parents/caregivers with a disability reported that they are unable to provide **their child with their usual regular health and rehabilitation, compared to 44% of those without a disability**.

The majority (93%) of households with members identifying as belonging to a minority group reported significantly greater difficulty accessing healthcare, medicine, medical supplies or other items needed to stay healthy than non-minority households (89%). The majority (94%) of households that received government benefits before COVID-19 reported their access to healthcare has been negatively impacted by COVID-19, compared to 88% among those who did not receive government benefits. Similarly, 93% of those who had lost more than half of their income since COVID-19 reported reduced healthcare access, compared to 86% among those who had not lost more than half their income.

Access to healthcare was a greater challenge for urban respondents (93%) than for rural respondents (88%). For urban households with a child with a chronic health condition, 97% reported difficulty accessing healthcare, compared to 94% in rural households with a child with a chronic health condition. However, rural households with a child with a chronic health condition reported a child falling sick due to any illness at a higher rate (16%) than urban households with a child with a chronic health condition (12%).

FIGURE 1. PROPORTION OF RESPONDENTS WHOSE ACCESS TO HEALTHCARE OR MEDICAL SUPPLIES HAS BEEN AFFECTED BY COVID-19, BY REGION



Respondents in all regions of the world indicated access to healthcare had been disrupted since the pandemic began. Reported disruptions are highest in East and Southern Africa (93%) and Latin America and the Caribbean (95%).

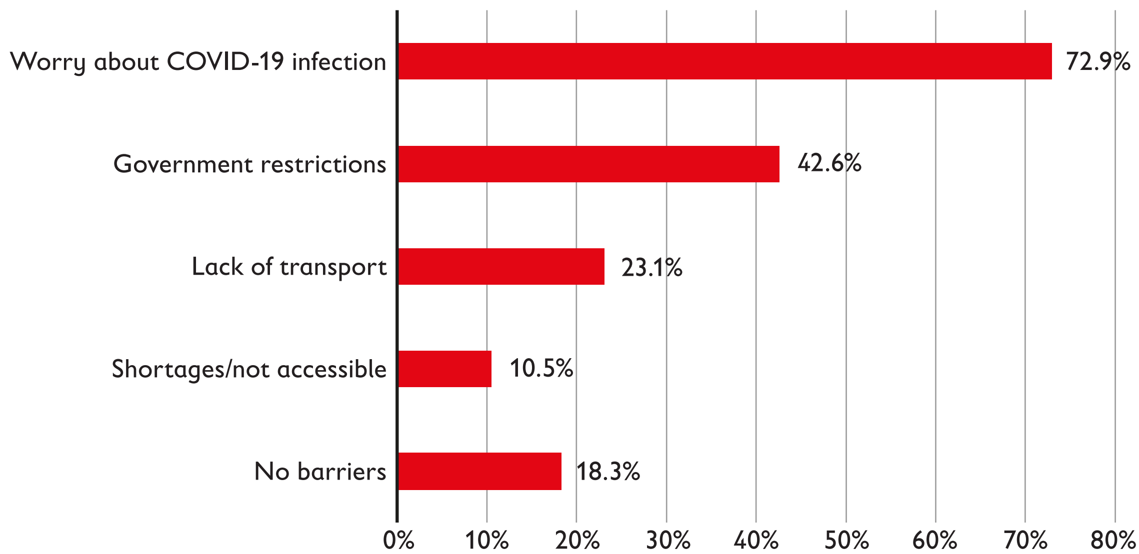
BARRIERS TO ACCESSING FOOD, HEALTHCARE AND MEDICAL SUPPLIES

Nearly three-quarters (73%) of parents/caregivers cited concerns about getting infected with COVID-19 as a reason for not leaving the home to get needed food, healthcare or medical supplies. Other reasons included government restrictions (43%) and lack of transport (23%). One in 10 (11%) reported shortages of food, healthcare and medical supplies as a barrier.

Parents and caregivers were also asked what barriers, other than reasons for not going out, stopped them from accessing healthcare, medication or menstrual products (if applicable). **A third of respondents (34%) reported at least one additional barrier to accessing healthcare, medication or menstrual products.** Specifically, 15% of parents and caregivers indicated that healthcare centres and pharmacies had run out of the medicines they needed, 12% reported long queues resulting in not being assessed or treated and 10% mentioned healthcare centres being closed as key barriers.

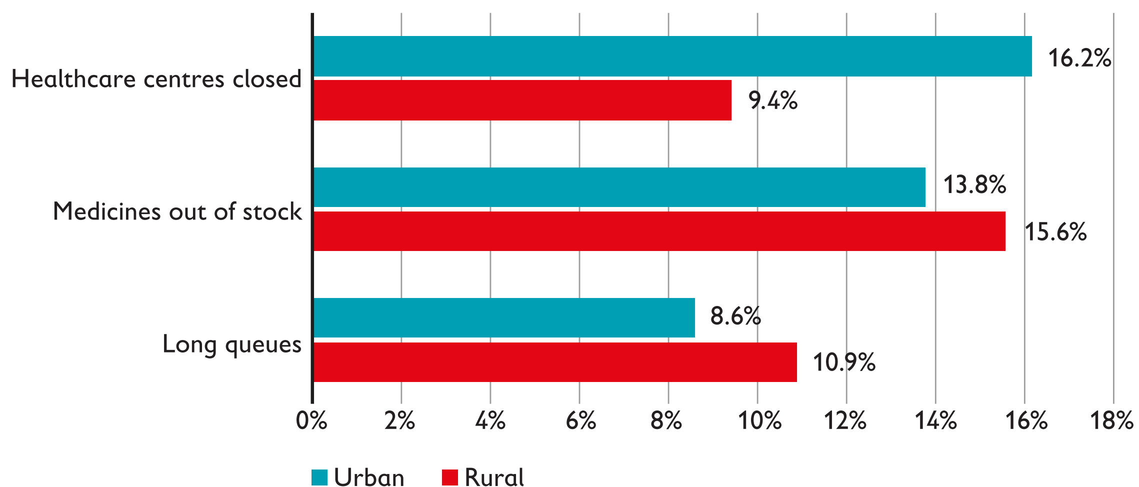
> "You have forgotten my village, we don't have healthcare facility and there are many children who don't go to school, so we want a school to be built and healthcare facility."
>
> Girl, 16 years old, Somalia, message for leaders

FIGURE 2. REASONS STOPPING PARENTS/CAREGIVERS GOING OUT TO GET FOOD, HEALTHCARE OR MEDICAL SUPPLIES



Access issues were more pronounced for households where the respondent had a chronic health condition or a disability, or at least one child had a disability. **In households where either the parent/caregiver or a child had a disability, more than half (53%) faced at least one barrier to accessing healthcare or medication, compared to 33% of households where neither the parent/caregiver or a child had a disability.** Of those households with at least one parent/caregiver or child with disability, 25% reported that healthcare centres or pharmacies had run out of medicines they needed (versus 14% for no-disability households), 24% reported healthcare centre closures (versus 9%), and 17% reported long queues as the main barriers to access (versus 11%).

FIGURE 3. BARRIERS FOR HOUSEHOLDS TO ACCESSING HEALTHCARE AND MEDICINES



Among households where the parent/caregiver identified as belonging to a minority group, 37% reported facing at least one barrier to accessing healthcare or medicines, compared to 32% of households who were not from a minority group. Specifically, 18% of households from a minority group mentioned as key barriers non-availability of medicines at healthcare centres or pharmacies (versus 13% for non-minority groups), 15% indicated long queues at healthcare centres (versus 10%) and 12% reported healthcare centres being closed (versus 9%).

Overall, a higher proportion of households in urban areas (37%) reported experiencing barriers to accessing healthcare or medicines compared to those in rural areas (33%). A higher proportion of households in rural areas than urban areas reported as barriers the closure of healthcare centres (11% and 9% respectively) and lack of availability of medicine (16% and 14% respectively). Households in urban areas reported long queues as a barrier to access at a higher rate than those in rural areas (16% and 9% respectively).

Households classified as relatively poor (below median wealth index) were more likely to report limited availability of medical and pharmaceutical supplies as a barrier than those classified as not-poor (those who were on or above median wealth index) (16% compared to 12%). They were also more likely to report long queues as a barrier to accessing healthcare or medicine (13% compared to 9%).

HOUSEHOLDS ARE HAVING TROUBLE PAYING FOR HEALTHCARE AND MEDICAL SUPPLIES

Of those who reported losing household income due to COVID-19, 42% had trouble paying for either healthcare or medical supplies, or both. Specifically, 35% had trouble paying for healthcare and 23% had trouble paying for medical supplies.

Poor households, those who reported losing more than half their income and those who had received government benefits all reported increased difficulty in paying for healthcare and medical supplies compared to more advantaged respondents. Relatively poor households were disproportionately affected by income loss, with 45% reporting trouble paying for healthcare and medical supplies, compared to 37% who were not poor. Similarly, 47% of those who had lost more than half of their income since the pandemic reported difficulty paying for healthcare and medical supplies, compared to 34% of those who had lost less than half of their income. Among those who received government benefits before COVID-19, 47% reported they had trouble paying for healthcare or medical supplies, compared to 41% among those who were not recipients of government benefits before COVID-19.

Parents and caregivers with a disability were more likely to report difficulties paying for healthcare and medical supplies (55%), compared to those who did not have a disability (43%). Similarly, nearly **half (49%) of households with at least one child with a disability also reported difficulties paying for healthcare and medical supplies**, compared to those without a child with a disability (43%). There was no statistical difference in difficulty in paying for healthcare or medical supplies by gender or by location of households in rural or urban areas.

> **"I would tell our leaders to protect people from coronavirus and help us with health services by bringing medicines for everyone"**
>
> Girl, 17 years old, South Sudan, message for leaders

CHILDREN AND THEIR HOUSEHOLDS REPORT CRITICAL HEALTH AND HYGIENE NEEDS THAT THEY CANNOT MEET

Children were asked, "What can adults in your home do differently during the outbreak of COVID-19?". Our programme participants and children from the general public provided over 10,000 responses to this question, with very clear requests. The top theme was that children wanted their parents and caregivers to spend more time with them. However, the next key themes focused on health, including water, sanitation and hygiene, where children wanted their parents to take COVID-19 more seriously and to follow health/social distancing guidelines. For example:

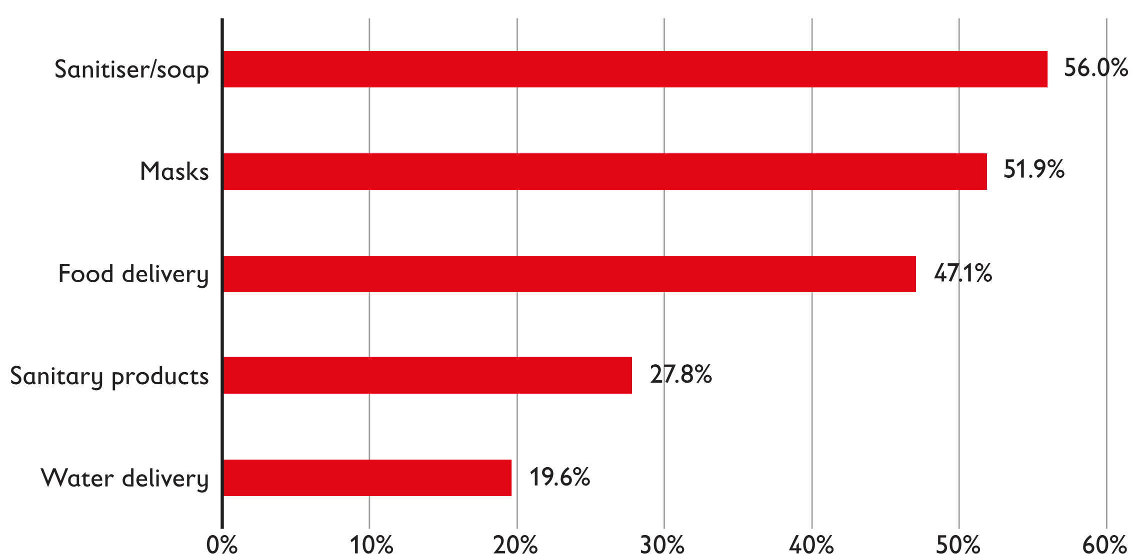
> *"Provide us with adequate soap for handwashing."*
> Girl, 15 years old, Malawi

> *"Make efforts to have more food at home."*
> Boy, 14 years old, Mozambique

> *"I want medication, food, money and I want to play."*
> Girl, 11 years old, Palestine

Masks, sanitiser/soap, water, food and sanitary products were among the items that programme participants indicated they needed to stay healthy during the COVID-19 pandemic, yet only 17% of households indicated that they do not need any of these health and hygiene items. More than half of parents/caregivers reported that they did not have the masks (52%) or sanitiser/soap (56%) they needed, while 47% and 20%, respectively, reported they needed food and water deliveries to stay healthy.

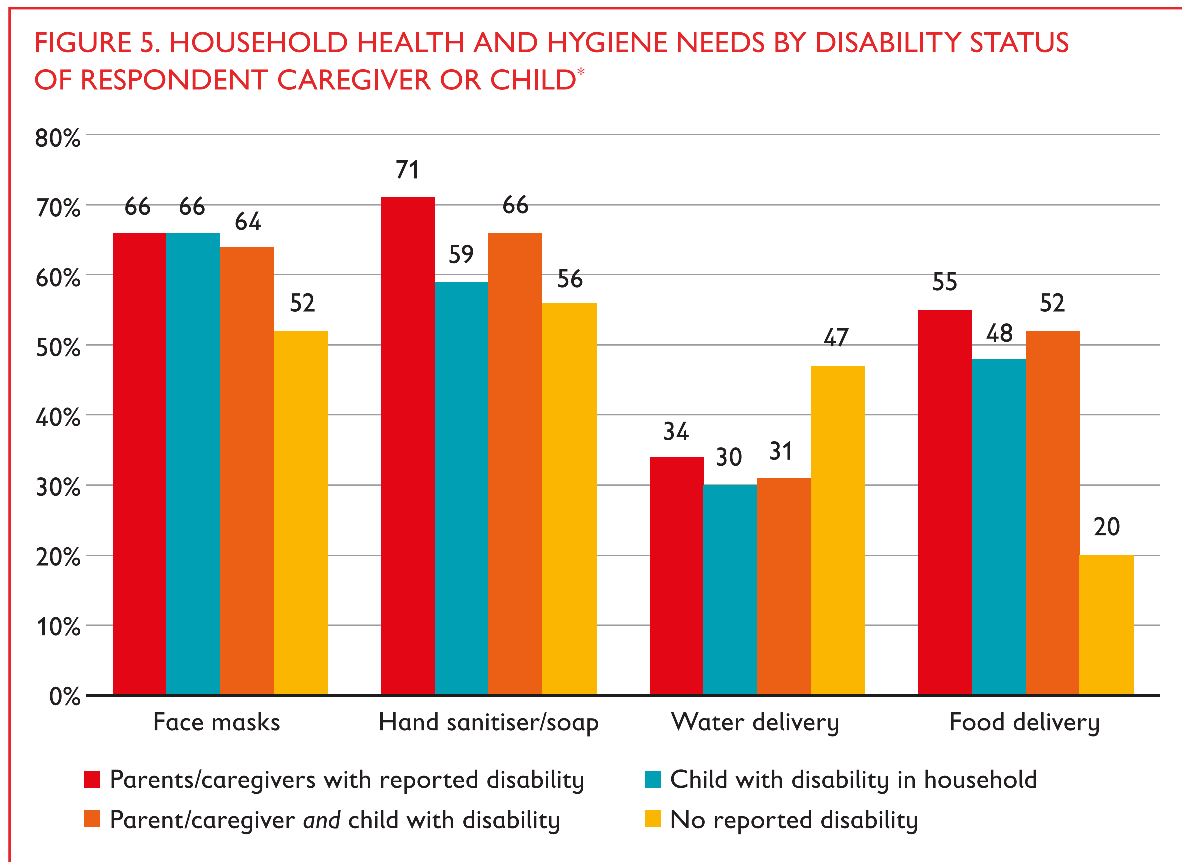
FIGURE 4. HEALTH AND HYGIENE NEEDS (ALL RESPONDENTS)



> **"We need food, water, clothes and health centres."**
> Boy, 16 years old, Niger, message for leaders

Reported access to health and hygiene supplies was significantly more limited for parents and caregivers with a disability; two out of three (66%) reported they could not access face masks, nearly three out of four (71%) reported limited access to hand sanitiser or soap, one in three (34%) reported needing but not having water delivery and over half (55%) reported needing but not having food delivery. A similar pattern was observed among households with at least one child with a disability, with 66% (masks), 59% (sanitiser/soap), 30% (water delivery) and 48% (food delivery) indicating they did not have the items required to stay healthy. In households where either the caregiver or at least one child was reported to have a disability, 64% (masks), 66% (sanitiser/soap), 31% (water delivery) and 52% (food delivery) reported they did not have the items that they required.

FIGURE 5. HOUSEHOLD HEALTH AND HYGIENE NEEDS BY DISABILITY STATUS OF RESPONDENT CAREGIVER OR CHILD*

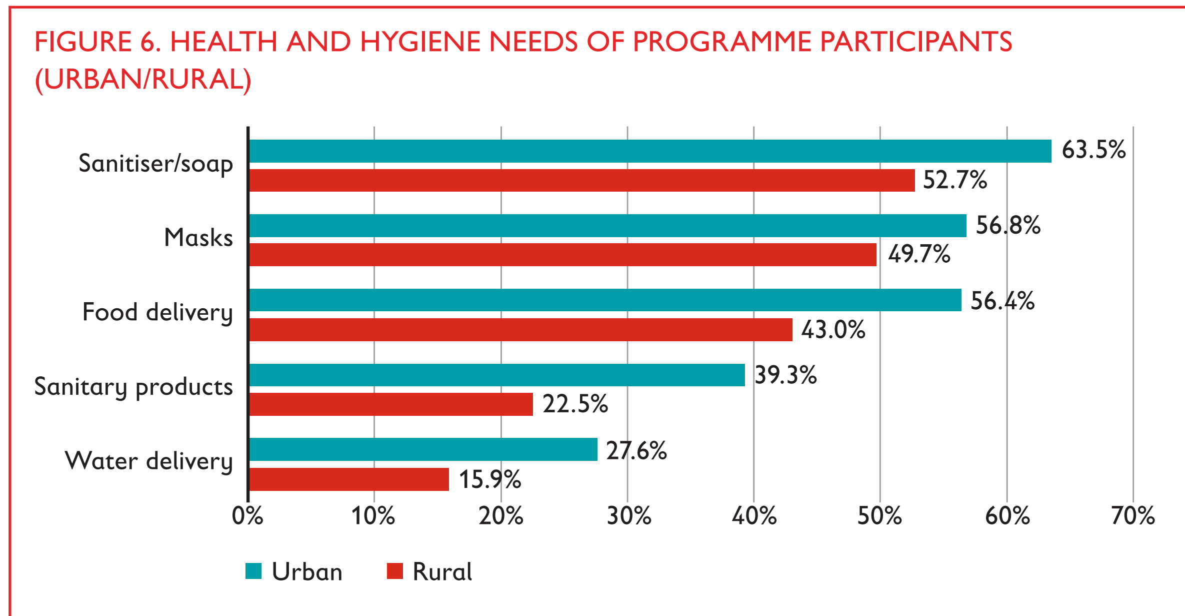


> **"So many people are hungry and do not have enough to eat. I would demand leaders to provide food to these people otherwise they might die of hunger."**
>
> Girl, 15 years old, India, message for leaders

* As the WG-SS was only posed to the adult respondent and about the indexed child by proxy of the adult respondent, households without disability here means those households where neither of these reported disabilities. Disability status of other household members is however unknown, making a full conclusion on disability in the household hard to arrive at.

A higher proportion of relatively poor households (52%) indicated they needed food delivery to stay healthy compared to non-poor households (43%). Households with members who identify as belonging to a minority group reported a significantly higher need for masks (58%), sanitiser/soap (63%) and water delivery (23%) compared to non-minority households (50%, 53% and 18%, respectively). However, a significantly lower proportion of minority households indicated they needed food delivery to maintain their health compared to non-minority households (41% versus 50%). Significantly higher proportions of households in urban areas reported these health and hygiene needs compared to those in rural settings (see Figure 6).

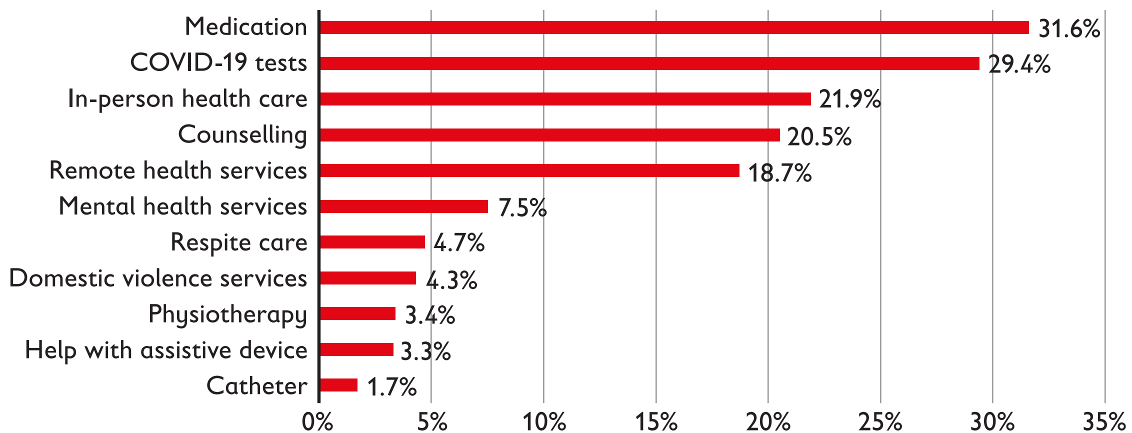
FIGURE 6. HEALTH AND HYGIENE NEEDS OF PROGRAMME PARTICIPANTS (URBAN/RURAL)



Needed supports and services including COVID-19 tests, remote and in-person healthcare, physiotherapy, counselling, mental health services, medication and domestic violence services were reported as inaccessible by nearly two out of three parents and caregivers (65%). Among these, 29% indicated they needed testing for COVID-19, 19% access to remote healthcare services, 22% access to in-person healthcare services, 32% medicines and 3% physiotherapy. Counselling services were a need for 21% of respondents, while mental health and domestic violence services were needed by 8% and 4% of respondents, respectively.

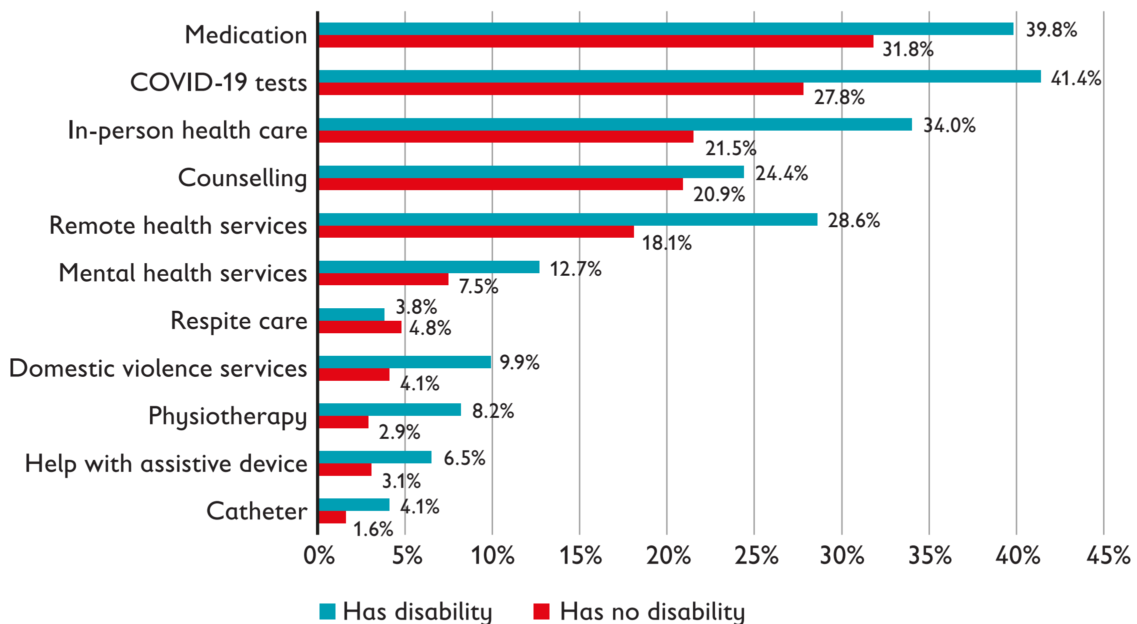
> "I am asking the leaders of my country to bring more tests and medicines for this disease."
>
> Boy, 11 years old, Mozambique, message for leaders.

FIGURE 7. HEALTH SERVICES NEEDS OF PROGRAMME PARTICIPANTS



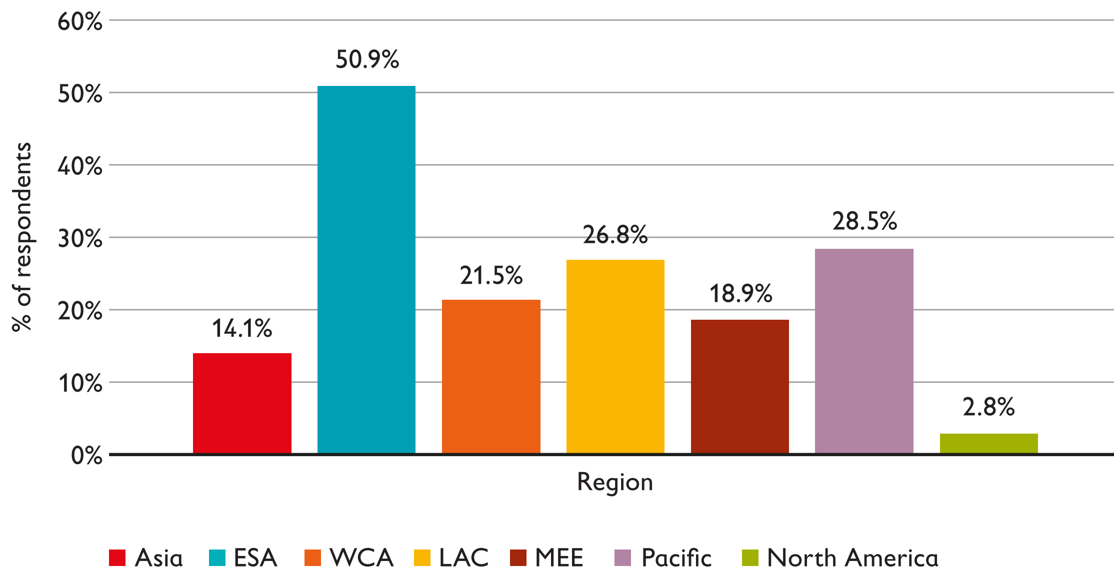
Reported health service needs, except for respite care, were significantly higher for households in which at least one parent/caregiver or one child has a disability (see Figure 8).

FIGURE 8. HOUSEHOLD HEALTH SERVICES NEEDS BY DISABILITY STATUS OF RESPONDENT PARENT/CAREGIVER OR CHILD



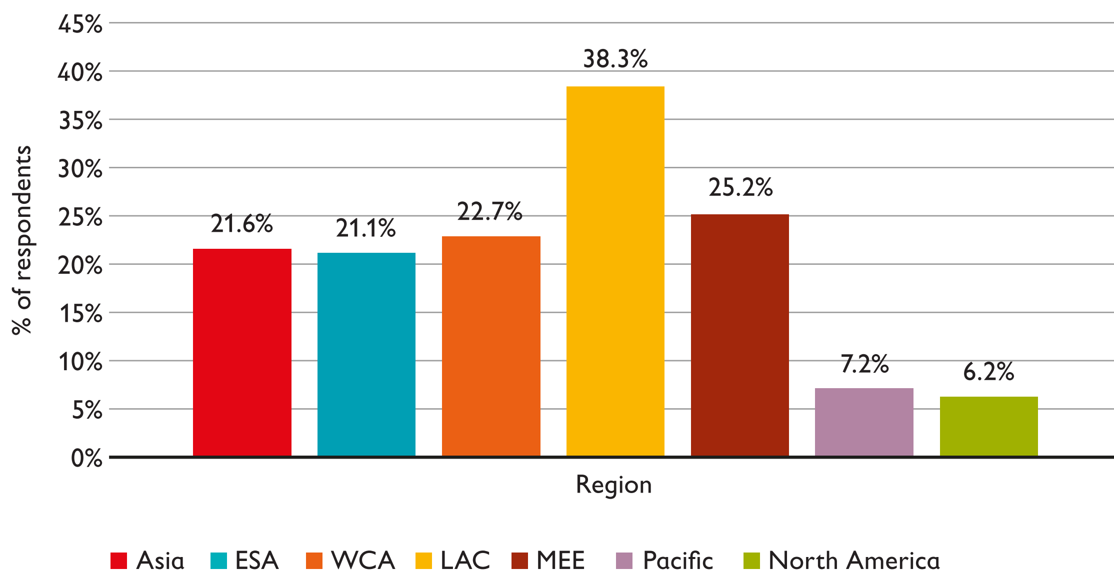
COVID-19 tests are not available consistently around the world. **Just over half of respondents in Eastern and Southern Africa (51%) reported that they needed but were not able to access COVID-19 tests.** About a fifth of respondents in the West and Central Africa (22%) and Middle East and Europe (19%) regions indicated they lacked access to need COVID-19 testing, while fewer than one in five respondents in Asia (14%) reported poor access. Only 3% of respondents in North America reported not being able to access COVID-19 testing.

FIGURE 9. PROPORTION NOT ABLE TO ACCESS NEEDED COVID-19 TESTS, BY REGION



Access to in-person healthcare was most limited in Latin America and the Caribbean (38%), followed by the Middle East and Europe (25%), West and Central Africa (23%), Asia (22%) and Eastern and Southern Africa (21%). In both North America and the Pacific there were fewer than 10% reporting limited access to in-person healthcare.

FIGURE 10. REPORTING LIMITED ACCESS TO IN-PERSON HEALTHCARE, BY REGION



Children were asked "If you were asked to write a letter for leaders in your country, what would you say?". Nearly eleven thousand (10,718) children responded from our programme participants and general public samples. While education and financial assistance were children's first priorities for world leaders, a large number called for health-related support. They urged governments and policy makers to take immediate steps in expanding coverage and access to health centres, medicines and equipment for testing.

> *"Increase health centres to test and cure COVID-19."*
> Girl, 12 years old, Afghanistan

> *"Create more and more booths to collect samples in every Upazila and provide information as soon as possible."*
> Boy, 17 years old, Bangladesh

> *"I am asking the leaders of my country to bring more tests and medicines for this disease."*
> Boy, 11 years old, Mozambique

> *"To provide COVID-19 tests to the communities."*
> Girl, 13 years old, South Sudan

> *"Hopefully the government support still continues. Enhance the fight against COVID-19. Hopefully they increase the equipment to be able to test more (people)."*
> Boy, 17 years old, Philippines

> *"Build isolation centres, provide soaps for washing hands, provide hand washing facilities."*
> Boy, 12 years old, South Sudan

> *"Help to disseminate the preventive measures since some people did not know how to [protect] themselves from the COVID."*
> Girl, 15 years old, Cambodia

> *"That they open free health services everywhere so that people have access to doctors without having to go to hospitals."*
> Girl, 16 years old, Nicaragua

> **"The government should provide strong measures to detect the disease, isolate and treat cases. The government should put in place some groups to carry out regular epidemic intelligence gathering."**
>
> Girl, 15 years old, Nigeria, message for leaders

NUTRITION

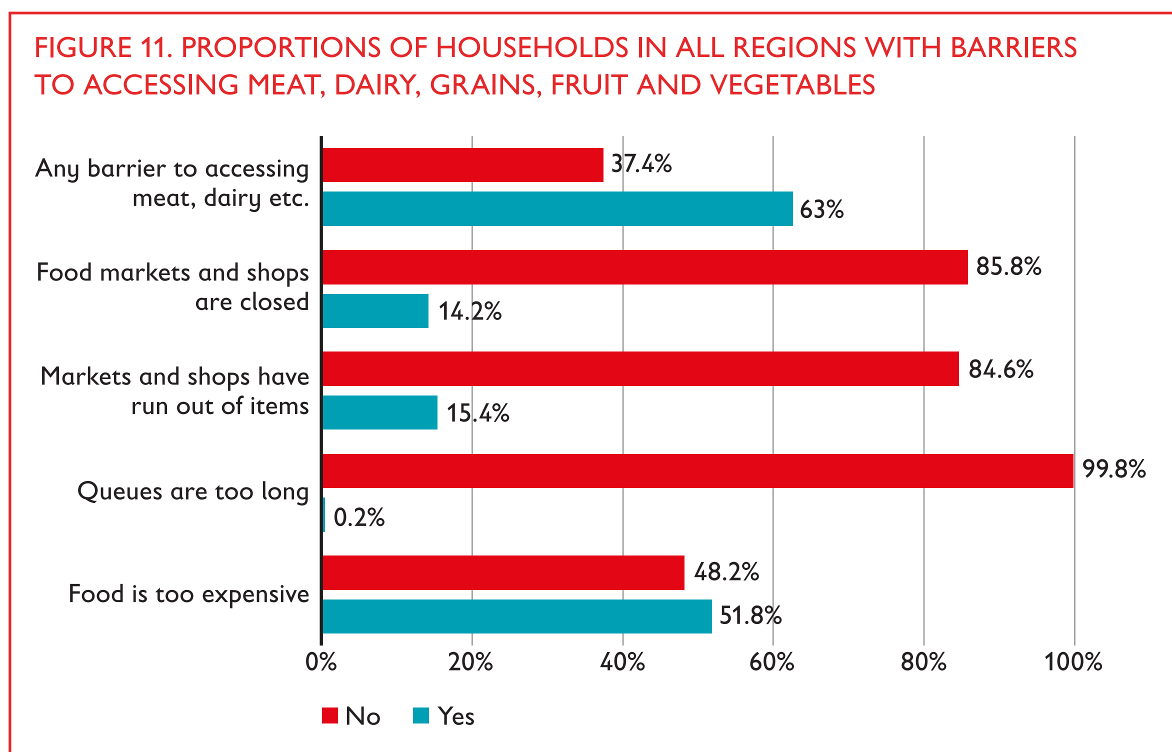
THE IMPACT OF COVID-19 ON CHILDREN'S AND HOUSEHOLD MEMBERS' ACCESS TO FOOD AND NUTRITION

Nearly two-thirds of parents and caregivers (63%) reported barriers to accessing meat, dairy products, grains, fruit and vegetables since the outbreak of COVID-19. Households that reported losing more than half their income were more likely to have barriers to accessing these food items (70%) than households that had not lost more than half of their income (54%). Relatively poor households (67%) were more likely to experience barriers to accessing these food items, compared to non-poor households (60%).

A higher proportion of urban (75%) than rural households (57%) reported barriers to accessing meat, dairy products, grains, fruit and vegetables. Significantly higher proportions of households from the Latin America and the Caribbean (67%), Eastern and Southern Africa (64%) and Asia (63%) regions reported barriers to accessing these food items, compared to other regions.

In addition to lockdown measures related to COVID-19, a number of barriers to accessing diversified diets were reported by participants across all the regions. Just over half (52%) of parents and caregivers reported that meat, dairy products, grains, fruit and vegetables were too expensive. The proportion of parents and caregivers with disability reporting that these food items were too expensive (61%) was much higher than those without disability (52%). More than one in ten (14%) reported that food markets or shops were closed during the pandemic and 15% stated that they didn't find these foods available in markets or shops where they were open. Few households responded that queues were a barrier to accessing food.

FIGURE 11. PROPORTIONS OF HOUSEHOLDS IN ALL REGIONS WITH BARRIERS TO ACCESSING MEAT, DAIRY, GRAINS, FRUIT AND VEGETABLES



HOUSEHOLDS ARE HAVING TROUBLE PAYING FOR FOOD AND CRITICAL NUTRITION

More than 85% of parents and caregivers in households that had lost income due to COVID-19 said that they had trouble paying for foods or critical nutrition supplements. Among poor households that reported income loss, 90% also reported difficulty paying for food or nutrition supplements compared to non-poor households (80%). More urban households also reported being affected by this income loss compared to their rural counterparts. While 89% of respondents in urban areas reported difficulty paying for food or critical nutrition supplements due to income loss since the outbreak, the proportion was 83% for rural participants.

Looking at food and critical nutrition supplements separately, the vast majority **(81%)** of parents and caregivers in households that had lost income due to COVID-19 said that they had trouble paying for food, and one-third (33%) said they had trouble paying for nutrition supplements. The majority **(87%) of respondents from households that lost more than half their income are struggling to pay for food** compared to 68% of those that have not incurred such losses.

A strong majority of **households** that can be classified as relatively **poor struggle to pay for food** (85%), compared to 75% of respondents from non-poor households. Similarly, 37% of poorer households reported struggling to pay for nutrition supplements compared to 27% of respondents from non-poor households. Living in an **urban setting** significantly affects the ability of respondents to pay for food: **85% of urban dwellers reported having trouble paying for food, compared to 78% of rural dwellers**.

The highest proportion of respondents who are having trouble paying for both food and healthcare is found in West and Central Africa (92% and 61% respectively), followed by Asia (83% and 40% respectively) and Eastern and Southern Africa for food specifically (79%).

BREASTFEEDING AND INFANT AND YOUNG CHILD NUTRITION DURING THE COVID-19 PANDEMIC

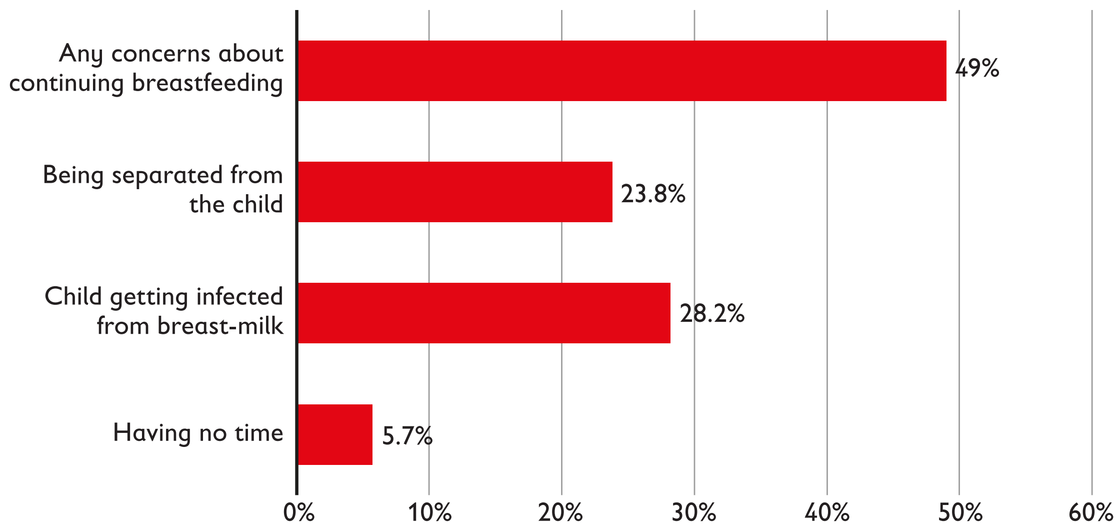
More than three-quarters (77%) of respondents reported that their child was being breastfed (either exclusively or non-exclusively) before the COVID-19 outbreak. A lower proportion of parents with disability (59%) and of a child with a chronic health condition (41%) were breastfeeding before the outbreak. The vast majority of parents (94%) reported that they have continued breastfeeding their child since the COVID-19 outbreak.

Nearly half (49%) of those parents who were breastfeeding their child before COVID-19 had concerns about continuing breastfeeding during the COVID-19 outbreak. The most common concerns were fear of their baby getting infected from breastfeeding (28%) and fear of separation from the child due to COVID-19 infection (24%). Most of the parents (about 95%) had no concern about having time to breastfeed their child during the COVID-19 pandemic.

Concern about being separated from their child was significantly higher among parents/caregivers with disability (60%) compared to those without disability (22%). This concern was also higher among parents/caregivers in rural areas (29%) compared to urban areas (8%).

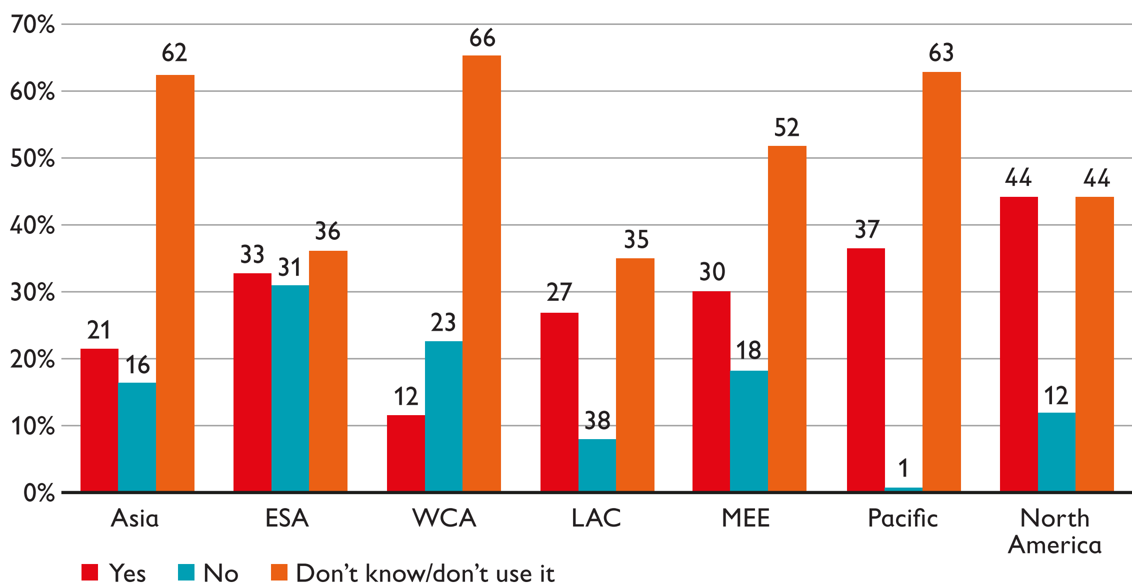
> **"Help families to survive."**
>
> Boy, 15 years old, Senegal, message for leaders

FIGURE 12. PROPORTION OF PARENTS WITH CONCERNS ABOUT CONTINUING BREASTFEEDING DURING COVID-19



One-quarter (25%) of parents/caregivers had access to infant formula or breast-milk substitutes for their infants and toddlers when they wanted, from government/private hospitals, local shops or non-governmental organisations/charities. This includes babies breastfeeding exclusively, non-exclusively and babies not breastfeeding. More than one in five respondents (21%) did not have access when wanted to infant formula or breast-milk substitutes.

FIGURE 13. PROPORTION OF RESPONDENTS ABLE TO ACCESS TO INFANT FORMULA, BY REGION



Over half (54%) responded that they don't use infant formula or breast-milk substitutes and thus did not know if it was accessible. When we exclude this group of respondents from the analysis, we find more than half (55%) of parents/caregivers that wanted to use infant formula did have access to formula or breast-milk substitutes since the COVID-19 outbreak.

Access to infant formula or breast-milk substitutes was significantly higher in North America (44%) and the Pacific (36%) than Asia (21%) and West and Central Africa (only 11%).

> "The thing which I would like to tell them about are the issues related to food security and health services. They should try to extend such facilities even in this quarantine and after quarantine because many people are dying in this situation due to starvation and lack of health services."
>
> Boy, 17 years old, Nepal, message for leaders

PHOTO: GIANFRANCO FERRARO/SAVE THE CHILDREN

PHOTO: MARK WAHWAI/SAVE THE CHILDREN

Conclusion

COVID-19 has impacted children across the world in multiple, interrelated ways. While COVID-19 itself primarily affects the health of older, adult populations, the pandemic more broadly – as this report has shown – has had significant consequences for children. These include household and community access to health services and supplies, access to adequate nutrition, breastfeeding behaviours and perceptions and access to wider support services including counselling and rehabilitation. The outcomes for children, and the results of this survey, often differ based on disability within the household and poverty levels.

In terms of **access**, the pandemic has caused disruptions to healthcare delivery and access worldwide. The vast majority of those surveyed in this study indicated their access to healthcare, medicine and medical supplies have been affected due to COVID-19. In households where the parent/caregiver respondent or at least one child has a disability or chronic health condition, the challenges in accessing healthcare are even greater. In addition, this survey has shown that income loss, belonging to a minority group and living in an urban area negatively affect access to healthcare. Notably, the impact of the pandemic on access to healthcare observed among minority groups warrants continued analysis in terms of deprivation and minority/ethnic discrimination. This is especially relevant as around a quarter (26%) of programme participants stated that they are from ethnic minority households.

Among programme participants, concerns relating to contracting COVID-19 were the predominant reason for not accessing health services when they were available. A number of other specific barriers were cited as reasons stopping parents/caregivers from accessing healthcare or medical supplies. These include government restrictions such as national or community lockdown, restrictions on movement and quarantine measures, lack of transportation and shortages in basic supplies.

At the household level, additional barriers to accessing healthcare included the closure of facilities, long queues resulting in not being assessed or treated and lack of availability of medicines at healthcare centres or pharmacies. These barriers disproportionately affected households where the parent/caregiver or at least one child was living with a disability, was from a minority group or was classified as relatively poor. Job or income loss also reduced access to healthcare and medical supplies.

A marginally higher proportion of respondents living in rural rather than urban areas reported the closure of healthcare centres and lack of availability of medicines as obstacles to accessing healthcare.

In terms of **continuation of regular health and rehabilitation services**, almost half (45%) of those parents and caregivers who had a child with a chronic health condition had not been able to access services to support their children's physical health since the COVID-19 outbreak. The inability to access regular healthcare or rehabilitation services for children was reported to be higher in urban than rural settings. However, there was no such difference observed between genders or wealth groups.

Respondents said that the **items most needed** during the pandemic to keep them and their families safe included masks, sanitiser/soap, water, food and sanitary products. However, fewer than one in five (17%) reported not needing any of these health and hygiene items. More than half reported they needed masks and sanitiser/soap, as well as food and water deliveries, to maintain their health.

Essential health needs identified by respondents included access to medicines/medication, COVID-19 tests, in-person healthcare, counselling and remote healthcare. Other important needs mentioned included access to mental health services, respite care, domestic violence services, physiotherapy and help with assistive devices. **About two-thirds (65%) of programme participants reported not being able to access the support/services they needed.**

More than three-quarters (77%) of respondents reported that their child was being breastfed (exclusively or not) before the COVID-19 outbreak. The vast majority of parents (94%) reported that they have continued breastfeeding their child since the COVID-19 outbreak. **Nearly half (49%) of those parents who were breastfeeding their child before COVID-19 had concerns about continuing breastfeeding during the COVID-19 outbreak. The most common concern was fear of their baby getting infected from breastfeeding** (28%) and fear of separation from their child due to COVID-19 infection (24%). Most parents (about 95%) were not concerned about having time to breastfeed their child during the COVID-19 pandemic. This – a situation which would normally be reversed – may be a positive outcome of movement restrictions and 'stay at home' directives. However, almost half (47%) of the respondents wanted to use infant formula or breast-milk substitute, and 55% of these reported being able to do so **since the COVID-19 outbreak**. This higher interest in using infant formula or breast-milk substitute among parents could be due to increased concerns or fears around breastfeeding during COVID-19 outbreak. Reported availability of infant formula or breast-milk substitute when wanted was significantly higher in the North America (44%) and Pacific (36%) regions. This could possibly happen in the absence of or inadequate monitoring of marketing and inappropriate use of infant formula in the context of a disease outbreak, such as the COVID-19 pandemic.

Around two-thirds of parents/caregivers reported barriers to accessing meat, dairy products, grains, fruit and vegetables to enable a diversified diet, particularly in the Latin America and the Caribbean, Eastern and Southern Africa and Asia regions. This was due to food items being too expensive for the respondents to purchase, food markets being closed, or these foods not being available in markets or shops when they were open. This lack of access to foods caused by disrupted market systems has important implications for vulnerable groups such as pregnant and lactating mothers, children under two who need a diversified diet for their optimum growth and health and children in general.

More than 85% of parents and caregivers in households that had lost income due to COVID-19, and particularly those who had lost more than half of their income, had trouble paying for foods or critical nutrition supplements. Poor and urban households were more impacted by income loss due to COVID-19.

Recommendations

The findings from this study have important implications for programming, policy and advocacy in the communities where we work. Government leaders, donors, policymakers, programme implementers and UN agencies must with urgency take action to protect children and their families from the impacts of the COVID-19 pandemic. They can and should do this in the following ways.

Promote increased and equitable access to universal health and nutrition services and care.

Governments should ensure the safe continuation of essential child health and nutrition services, particularly community case management of childhood illnesses and treatment of malnutrition during the COVID-19 pandemic and beyond. Routine maternal and new-born services such as antenatal care and skilled birth attendance at delivery and preventative services such as immunisation, which are critical for maternal and child survival, must be maintained and strengthened. Governments must ensure availability of essential medicines and medical supplies, including adequate personal protective equipment (PPE) for all front-line health workers, including community health workers. Adequate infection prevention and control (IPC) measures must also be in place at health facilities and community-based service delivery points to ensure the safety of healthcare workers and clients while receiving services and to increase client confidence to seek needed healthcare.

Programme implementers should work with relevant stakeholders to ensure children and their parents/caregivers have access to services. This can include working with private transport unions to make affordable transportation available. In humanitarian settings where access to health services is significantly reduced due to community lockdown, restrictions on movement or disruptions to transportation, direct provision of essential services, including mobile and community-based maternal, child and reproductive health services should be supported. Equitable access to healthcare should be increased by capacity-strengthening of both public and private systems at national and sub-national levels.

Over the longer term, governments should work to restructure their health systems to be more resilient and flexible to support response to future epidemics and pandemics. This could include a review of policies and regulations on roles and responsibilities of various health staff including community health workers, task-shifting, community engagement in emergency preparedness, strengthening of logistic supply systems, etc.

Efforts to achieve universal health coverage (UHC) must be intensified by advocating for both public and private health services to be made free at the point of use, especially for vulnerable children and families, and the removal of other financial and non-financial barriers to accessing services (eg, lack of transportation). Governments should provide safe and legally mandated spaces for civil society organisations (CSOs) and communities, including children, to engage in decision-making for health and nutrition service provision, as key stakeholders in achieving UHC and good nutrition for all.

Elevate levels of COVID-19 testing.

Governments should elevate levels of COVID-19 testing and make it accessible to all those who need it. Public health officials and policy makers should advocate for and support the implementation of improved levels of testing, tracking and tracing in each national setting, while assessing and building on the policy environment in each locality.

Ensure risk communication and community engagement to tackle harmful beliefs and messaging that reduce health seeking behaviour.

Families and communities should be supported to access accurate information on COVID-19 risks, transmission mechanisms and preventive measures in order to increase their confidence in the use of healthcare services. This should include locally- and culturally-appropriate risk communication and community engagement (RCCE) efforts designed to detect and rapidly respond to public perceptions and to counter any misinformation, misconceptions or rumours regarding COVID-19. Communication channels such as social media, TV and radio should be used as effective platforms to disseminate key information on COVID-19 to communities. Governments and programme implementers must ensure that all COVID-19 RCCE messaging is accessible to all, including children and people with disabilities.

Protect, promote and support breastfeeding and protect existing positive practices.

The WHO recommends that mothers with suspected or confirmed COVID-19 should be encouraged to initiate or continue to breastfeed. Mothers should be counselled that the benefits of breastfeeding substantially outweigh the potential risks for transmission. Governments should protect and promote early initiation and exclusive breastfeeding for the first six months and continued breastfeeding after six months in accordance with WHO guidelines on breastfeeding and COVID-19. Governments must provide regularly updated guidance on appropriate and timely support for infant and young child feeding in line with WHO guidance and protect breastfeeding by upholding the standards and recommendations of the International Code of Marketing of Breast-milk Substitutes and subsequent related World Health Assembly resolutions. They must ensure the implementation of strict measures in compliance with the Code and country-specific legal norms to prevent inappropriate use of breast-milk substitutes. Governments should ensure guidance reaches and is accessible for all, including people with disabilities.

Provide food and non-food items to cover basic needs in deprived communities.

Supplementary food distributions and water supply support should be an important component of COVID-19 responses where they are needed to complement social protection or humanitarian assistance mechanisms, with a particular focus on marginalised communities and populations. Vulnerable communities – especially children – should be supported to access important basic items for infection prevention such as masks, soap, sanitiser and sanitary products.

Protect food security and livelihoods and access to nutritious foods, considering the number of people hungry is predicted to double by the end of 2020 to 265 million, according to a World Food Program projection (WFP, 2020).

Governments must ensure that safe and nutritious food is affordable and accessible for all by financing and scaling up social protection schemes, alongside measures to address livelihoods and food system challenges. Access to basic food and markets should be guaranteed by considering long-term, costed nutrition plans which better integrate nutrition within the health system and other relevant sectors, thereby providing children with access to food even when markets are closed. Cash transfers should be coupled with nutrition messaging to achieve the greatest impact on nutrition outcomes.

Promote mental health services.

Programme implementers should consider incorporating mental health and counselling services as adaptations to existing programmes, because mitigation measures to curb the spread of the virus such as community lockdown, movement restrictions, social distancing and isolation may have psychosocial and mental health effects on individuals. Provision of mental health and psychosocial support (MHPSS) services to tackle mental ill-health resulting from isolation and lockdown measures should be supported and promoted. Domestic violence services should also be scaled up and considered as an adaptation to programmes targeting women and girls in order to address and mitigate various forms of domestic violence that may occur as a result of lockdown measures. Robust systems to identify and provide psychosocial support for children experiencing violence at home should also be developed.

Improve analysis, design and implementation of programmes and advocacy work to include marginalised and deprived communities, households and individuals.

Responses to COVID-19 should be based on analysis which is sensitive to gender, disability, poverty, location and exclusion to ensure the inclusion of people with disabilities or chronic health conditions and those from ethnic minority backgrounds. Governments and programme implementers should ensure programme design and budgeting is inclusive and removes financial and non-financial barriers for people with disabilities, from minority groups, or excluded because of gender to better access health and nutrition programmes and information.

Partnerships and collaboration with rights-holder associations such as representative organisations of people with disabilities, women and minority groups at different levels should also be promoted and enhanced when planning and implementing programmes.

PHOTO: SAVE THE CHILDREN

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“WE HAVE TO BE MORE PATIENT THAN WE’VE EVER BEEN, MORE CONNECTED THAN WE’D EVER IMAGINE AND MORE RESPECTFUL TO ALL PEOPLE.”

- A 17 YEAR OLD GIRL FROM PANAMA.

A heartfelt thank you to all the parents, caregivers and children who took part in our global research in these COVID-19 times.

Your candid responses and honesty in expressing your concerns, fears, hope for the future were beneficial & will prove invaluable to develop Save the Children COVID response and advocacy work further.

A heartfelt thanks for all of us at Save the Children

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