

The impact of COVID-19 on children: insights from the Western Cape experience

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Children's relative neglect in the initial phases of the COVID-19 pandemic, resulting in many negative direct health and collateral effects, points to the need for a purposive, co-ordinated, child-centred approach to addressing children's needs in times of crisis.

In the initial phases of the COVID-19 epidemic in South Africa, children experienced relative neglect, as they were deemed to be at low risk for contracting and spreading COVID-19 infection. Overwhelmed by adult infections, the health system responded slowly to children's complex needs brought about by the epidemic.

This in-depth case study outlines the impacts of the COVID-19 epidemic on child health in the Western Cape, and the subsequent remediating responses. The case study draws on multiple data sources including routine data, case examples of health system and organisational responses, and experiential evidence from practitioners across the health system. It draws substantially on a series of advocacy briefs that examine the multi-dimensional impacts of COVID-19 on children in the Western Cape.

Approximately 12 000 children (persons under 18) contracted COVID-19 in the province (March 2020 to March 2021). Thousands more were affected by the illness and death of relatives, and by the collateral effects of the epidemic

including increased hunger, violence, injury and mental health problems, coupled with the disruption of healthcare services, schooling, early childhood development programmes, and social support networks.

Essential child health services were de-escalated and child-health resources were re-allocated for adult COVID-19 care, with both immediate and long-term consequences for child health. A proactive response from child health services, aided by the Western Cape's relative socio-economic advantage, a strong civil society response, and a stable, well-functioning health system, helped to mitigate harm, but not before significant damage was done.

The Western Cape experience signals that, even in a well-resourced setting, children's needs may be overlooked in times of crisis and there is a critical need for 'voices' speaking for and alongside children in all decision-making spaces, and for pro-active, well-planned, child-focused responses.

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Introduction

From the outset, children (persons under the age of 18) were considered by global public health experts to be least susceptible to acquiring and transmitting SARS-CoV-2 (COVID-19), and likely to experience only mild illness. Whilst generally true, this narrative resulted in the needs of children being overlooked in the COVID-19 response, resulting in significant collateral damage.

This chapter examines the extent to which children's rights and health needs were identified and responded to through a case study of the Western Cape (WC) Province, one of the early epicentres of the epidemic in South Africa. The WC is a relatively well-resourced province with a well-functioning healthcare system, strong and stable senior leadership,¹ and effective child health services. Yet even here, a concerted response to children's needs was initially absent, and slowly gained traction as the epidemic progressed.

Through this enquiry we identify lessons and opportunities to meet children's needs more effectively in successive COVID-19 waves and similar disasters. Whilst recognising the social and structural determinants of child health and the need for an integrated, intersectoral response, this chapter focuses primarily on child health and the health system.

Methodology

The case study draws on secondary quantitative and qualitative sources, including routine health and education

data; COVID-19-specific epidemiological data; qualitative case studies from practitioners and non-governmental organisations (NGOs); and experiential insights from practitioners and academics (including the authors), who engaged in: contact tracing teams, child health service delivery, guideline development, data management, research and advocacy. It draws on a series of advocacy briefs that examine the multi-dimensional impacts of COVID-19 on children in the WC.²

The situation of children in the Western Cape

Children's prior living conditions, care arrangements and access to services had a profound impact on their vulnerability to shocks such as COVID-19. The nearly two million children in the WC³ fare better than children in other provinces (Table 1), with nine out of 10 having access to health care and basic services and living in households where someone is employed. However, their relative advantage masks significant and growing inequities. For example, while provincial under-five mortality rates dropped by 38% between 2009 and 2016, the urban-rural gap is widening, with rural districts lagging behind.² Similarly, child mortality differs widely across the Metropolitan municipal district. Across the province, 23% of children live below the poverty line, 10% in food-insecure households, and 17% in informal housing, where overcrowding and poor water and sanitation increase their families' vulnerability to COVID-19 infection.⁴

Table 1: Social determinants of child health, WC vs South Africa, 2018

| | Western Cape | South Africa |
|-----------------------------------|--------------|--------------|
| Poverty | 23% | 59% |
| Unemployment | 8% | 30% |
| Hunger | 10% | 11% |
| Informal housing | 17% | 9% |
| Overcrowding | 20% | 18% |
| Inadequate water | 9% | 30% |
| Inadequate sanitation | 11% | 21% |
| Far from clinic | 6% | 20% |
| Children living with both parents | 54% | 34% |

Source: Statistics South Africa, 2019.⁵

In addition, children's care arrangements often change as families seek better access to employment, education, childcare and protection. While half of WC children live with both biological parents, a third live only with their biological mother, nearly one in 10 children live with neither parent,

and others live with family in other provinces. Secure care arrangements are imperative in an epidemic, where fears of infection undermine family and community support networks, and serious illness or death of primary caregivers may render children in need of care and protection.

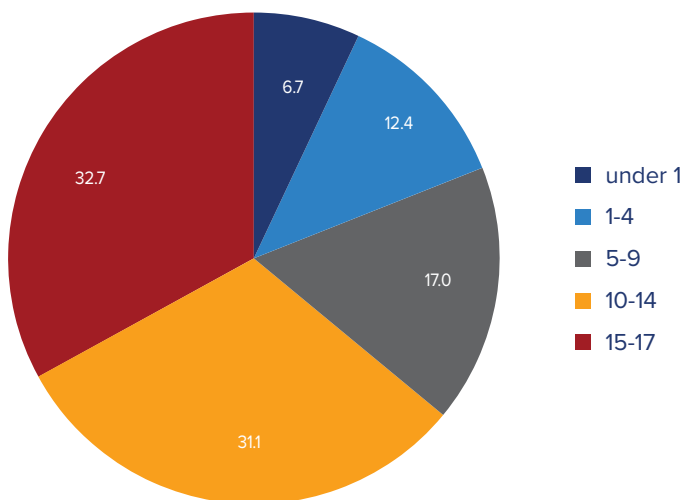
The epidemiology of COVID-19 in WC children

Many uncertainties hampered initial efforts to identify, diagnose and manage children exposed to, or infected by, COVID-19. The initial 'Guidelines for Case-finding, Diagnosis, Management and Public Health Response in South Africa' released in February 2020⁶ failed to distinguish between adults and children, and children with common respiratory illnesses overlapped with the case definition for COVID-19. Testing capacity was limited, and information and guidelines changed rapidly,

yet case-finding among children eventually improved. Both the national and provincial responses were largely adult-centric, with limited and fragmented guidance for addressing child health concerns. National paediatric guidelines were slow to emerge, and Gauteng, KwaZulu-Natal and the WC consequently developed their own provincial guidelines.

Despite children accounting for only 4% of COVID-19 infections in the WC, at least 12 300 contracted the virus from March 2020 to March 2021, and most were older adolescents (Figure 1).

Figure 1: Laboratory-confirmed COVID-19 (%), under 18 years^a



Although a small percentage of the total, the absolute number of child infections is significant and poses many psychosocial sequelae for children and families. In addition, almost 268 000 adult infections in the same period (with close to 52 000 hospitalised and 12 000 deaths as at 21 July 2021) have profound implications for children's care, protection and mental health.

Testing of and positive tests among children were evenly split between the public and private sector – with positive proportions highest in 15–17-year-olds (17%).

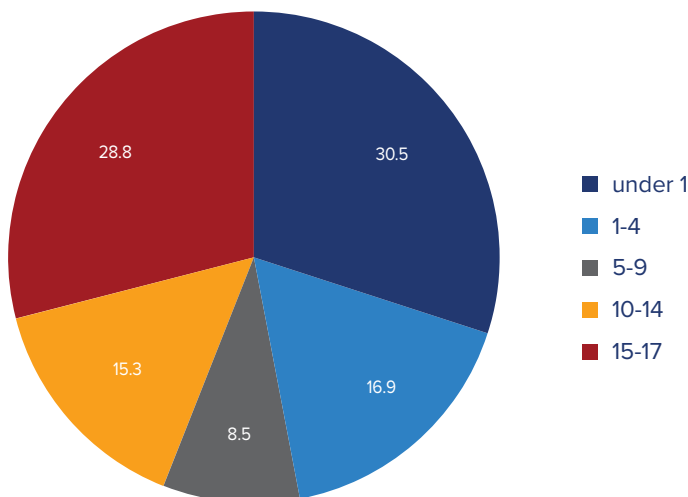
The Metro district, where most children live, accounted for 57% of cases, followed by the Garden Route (16%) and Cape

Winelands (14%). Metro cases were unevenly distributed across sub-districts, possibly due to a combination of test-seeking behaviour and restriction of testing to higher-risk persons, particularly in the public sector during waves one and two of the COVID-19 epidemic.

Fifty-nine child deaths were recorded in the first year of the epidemic; in 22% of these cases, the COVID-19 diagnosis was deemed incidental, and an estimated 50% had underlying comorbidities. Most deaths (57%) were recorded in the Metro district. Figure 2 shows that children under 4 (who constituted only 19% of laboratory-confirmed cases) accounted for 48% of child deaths, followed by older adolescents in the 15–17-year age group (28,8%).

a Western Cape Provincial Health Data Centre, 2021.

Figure 2: COVID-19 deaths, under-18 (March 2020–March 2021)^a



Epidemiological monitoring suggests little evidence of transmission at school,^b in keeping with the National Institute for Communicable Diseases' (NICD) position that 'schools are not the main drivers of infection in children'.⁷

Health system response

Given the relative de-prioritisation of children's needs, it is important to reflect on how to improve our response to children's COVID-specific and other healthcare needs in future.

The initial child health service impact

In the Metro district, provincial and local health authorities de-escalated health services before the national lockdown⁸ to limit transmission and ring-fence capacity to manage increasing COVID-19 patient numbers.

At Primary Health Care (PHC) facilities, emergency, obstetric and services for acute serious childhood conditions continued and appointments were introduced for other essential health services. Children with long-term health conditions (LTHCs) such as HIV and TB were given a one- to two-month supply of medication and ongoing pre-packaged

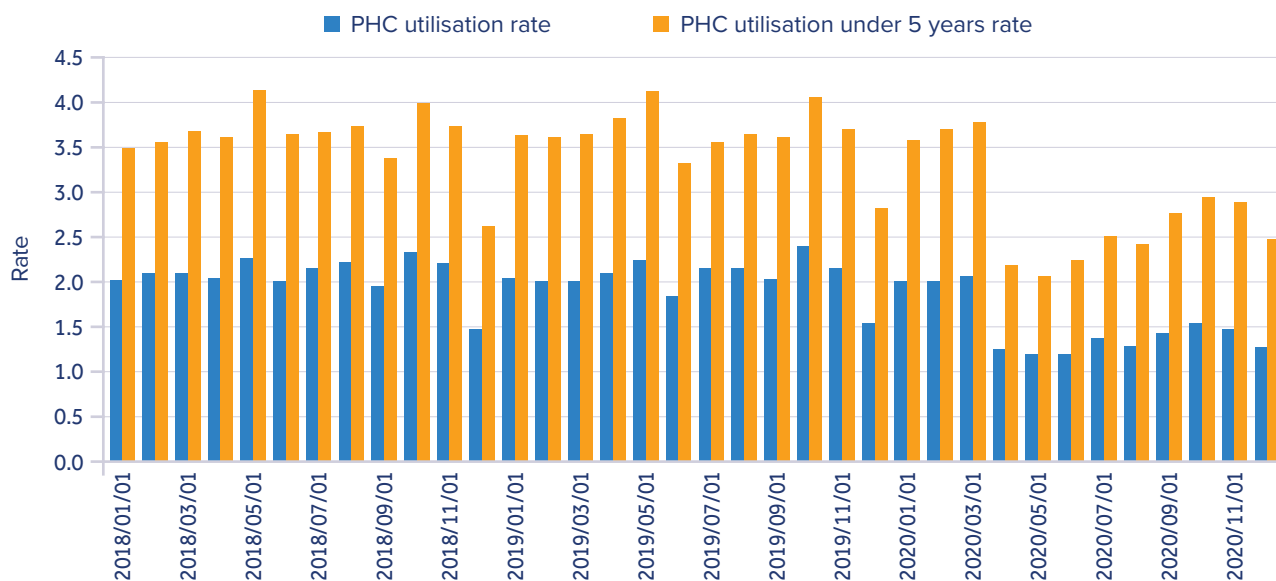
supplies were delivered to their homes by community health workers (CHWs).⁹ In addition, CHWs screened and tested symptomatic patients for COVID-19, but later focused on high-risk patients because of long turnaround times for COVID-19 test results.¹⁰

In hospitals, paediatric services were scaled back to accommodate increases in adult COVID-19 admissions. For example, adolescent patients with LTHCs at Groote Schuur Hospital were moved to Red Cross War Memorial Children's Hospital (RCWMCH)¹¹, and the Adolescent Unit and general paediatric wards were closed to increase adult bed availability. Yet, more than a year later, the beds have not re-opened for adolescents and children. Similar re-allocations of paediatric beds occurred at district hospitals. Outpatient services were also de-escalated, with follow-up arranged only for patients in need. Elective procedures and surgery for children were postponed at tertiary hospitals.

PHC services for children suffered significant setbacks: while there was little change in the coverage of antenatal visits <20 weeks, the coverage of postnatal visits at six days declined; the proportion of children under 1 year who were fully immunised dropped by 13% during April and May 2020;¹² and the overall PHC headcount for child health services declined by 23% from 2019 to 2020 and has yet to return to pre-COVID-19 levels (Figure 3).

^b Personal communication: Professor Mary-Ann Davies. May 2021.

Figure 3: PHC utilisation rate – 2018 to 2020^c



From 2019 to 2020, there were decreases in TB testing (50%) across all age groups, and in the number of TB cases diagnosed (40%).^c HIV testing (across all ages, including pregnant women) and the initiation of antiretroviral therapy (ART) also declined in April and May by 50% and 40% respectively.^c The number of HIV-positive children started on treatment and the number of children under 15 remaining on ART also declined. Positive birth HIV PCRs remained stable, but the 10-week PCR positivity rate went up by 36% from a monthly average of 2.3 in 2019 to 3.6 in 2020. This could be due to a decrease in postnatal visits and an increase in postnatal HIV transmission rates. These data suggest that the epidemic could have long-term consequences, including increased TB and HIV in both mothers and children.

The response

Advocacy for child health

Children were inadvertently overlooked in several key decision-making and practice spaces, and concerted advocacy efforts were required at various levels of the health system to ensure that their needs were actively considered and addressed. Advocacy efforts were spearheaded by individuals, through the formation of new teams and the repurposing of existing child health fora. Initial efforts were piecemeal, 'in-the-moment', and reactive.

Governance structures such as the district-level silver command and provincial-level gold command structures, and the provincial outbreak response (contact tracing) team had to be lobbied consistently to consider children's complex health needs and endorse and to implement child-focused structures and guidelines to address children's health care, protection, nutrition support, and social assistance. Similar efforts were required in: health facilities where paediatric beds were under threat; quarantine and isolation facilities where children were not specifically

considered; and intersectoral spaces, such as residential care facilities, which were inadequately prepared for COVID-19.

In response, several child-specific guidelines were developed to: guide clinical management at different levels of care¹³ sensitise contact-tracing teams to the presence of children in households, and provide appropriate advice on how to ensure children's care, health, and safety;¹⁴ and guide early childhood development (ECD) programmes, residential care facilities and schools in managing children. In all instances, the benefits of family-centred care¹⁵ were highlighted, as even in an infectious epidemic, avoiding separation of young children from caregivers, wherever possible, was essential.

A provincial response plan

An important milestone in child health advocacy efforts was the provincial Maternal and Child Health (MCH) Services Response Plan, developed and disseminated through the Deputy Director-General to provincial health management and all health facilities.¹⁶ Recognising children's compromised access to essential health services, the Response Plan provided an integrated framework for maternal and child health services, including guidance on de-escalation of services; algorithms to guide clinical care and service delivery; personal protection equipment (PPE) guidelines for mothers and children; and service delivery plans.

In addition, the Provincial Paediatric Clinician's COVID-19 Working Group (consisting of paediatricians, epidemiologists, public health specialists and laboratory staff), was established and met weekly to coordinate efforts, share knowledge and experiences, and develop provincial paediatric guidelines.

^c District Health Information System, 2021.

Strategies to protect child health services

Different strategies were employed to protect essential child health services and reverse some of the early damage to child health.

A Metro district forum, established to address seasonal surges in diarrhoea, was repurposed to address the impact of COVID-19 on children – from testing, contact tracing and clinical management, to health promotion and food security – while continuing to monitor essential child health services, and diarrhoea and pneumonia cases.

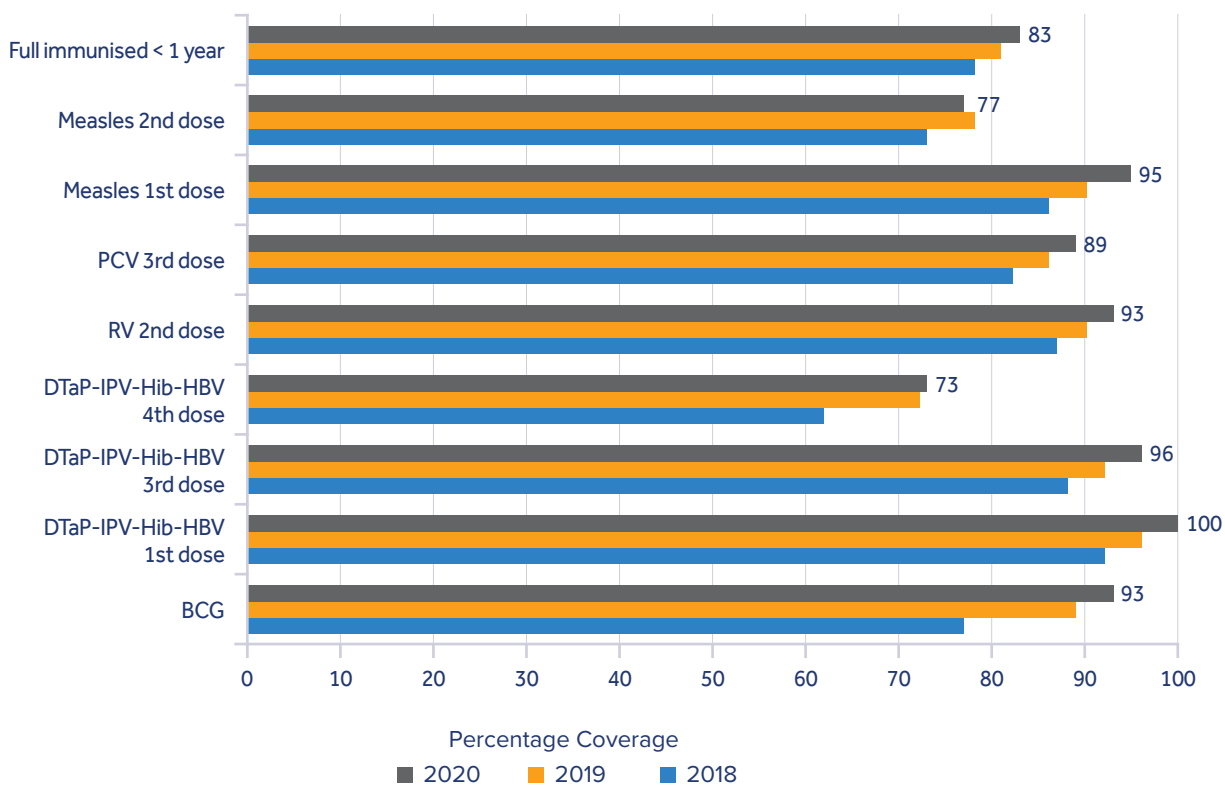
Collaborative strategies across health authorities and child health services were initiated to address the initial decline in routine MCH services (Figure 3). Radio messaging, posters, telephonic appointments and SMS reminders were used to encourage caregivers and children to visit clinics. In other sub-districts, outreach tools were developed to

help CHWs screen for COVID-19 symptoms and other common childhood conditions; CHWs also distributed health promotion materials and encouraged caregivers to attend PHC facilities. Telephonic consultations were used to provide test results and adherence counselling, and sites adjacent to health facilities, such as libraries, town halls and gazebos, were used for preventative, promotive and follow-up services. In rural settings, new and existing virtual platforms were employed for patient care and information, consultations, ward rounds and training, coupled with more efficient use of electronic prescriptions and referral systems.

Impact of the health system strategies

These child-centred responses had many positive impacts, including an increase in immunisation coverage following the catch-up drive to restore essential child health services (Figure 4).

Figure 4: Immunisation coverage in the Western Cape, 2018–2020^c



Despite decreased access, the total number of cases and out-of-hospital deaths from conditions like pneumonia and diarrhoea decreased compared to previous years, possibly due to physical distancing and hygiene measures. However, in-hospital mortality rates for pneumonia in children younger than five increased from 2.0 to 2.8 deaths per 1 000 pneumonia admissions, and from 1.8 to 3.0 for diarrhoea. This may be due to delays in care-seeking caused by travel restrictions, clinic closures and fear of infection.

Encouragingly, improved data management and sharing with health service providers are now regular features of Metro forum meetings, and a provincial dashboard with key child health indicators is being developed to facilitate informed decision-making and more rapid responses to child health needs.

Further collateral consequences

The epidemic also had a profound impact on children’s food security and nutrition; protection from violence and injury; access to schools and early childhood development (ECD) programmes; and psychosocial well-being.

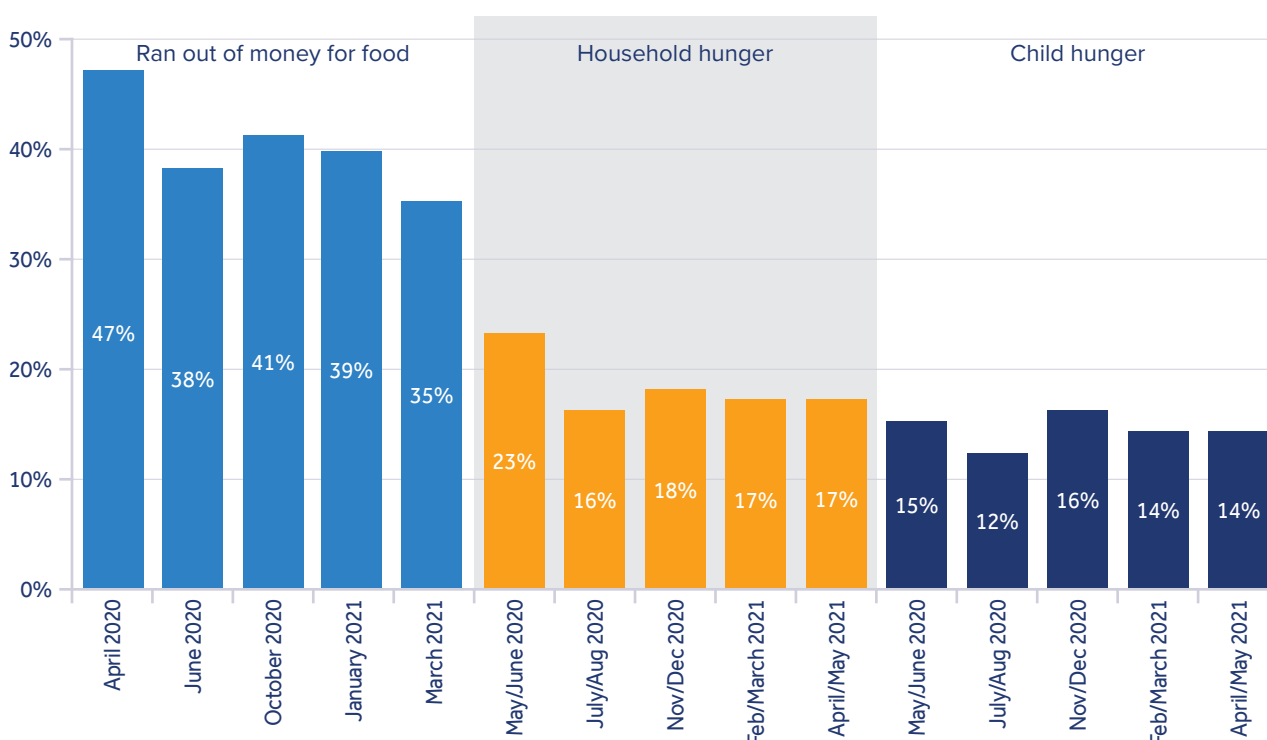
Child nutrition

Hard lockdown precipitated a dramatic increase in unemployment and food insecurity, posing a direct threat to children’s nutrition and health. Prior to the epidemic, child hunger affected 2.1 million children (11%) nationally, of which 197 000 (10%) lived in the WC.⁴ By April 2020,

47% of households had no money for food, with 15% of households reporting child hunger (Figure 5).¹⁷ Families tried to shield children from hunger by eating less, or by purchasing cheaper foods that were high in energy and low in nutrients, which could have exacerbated existing levels of childhood stunting (27%),¹⁸ overweight and obesity (13%) and micronutrient deficiencies (>40% for vitamin A and zinc).^{19,20}

By mid-2020, government’s relief package offered some respite, but household and child hunger increased sharply following the phasing out of the caregiver and top-up grants.²¹ By April 2021, one in seven households reported child hunger.²²

Figure 5: Lack of money for food, household, and child hunger – 2020 to 2021



Source: NIDS-CRAM Wave 5 Report, 2021.

At the same time, the disruption of routine health services compromised children’s access to the Nutrition Therapeutic Programme (Table 2). Exclusive breastfeeding at 14 weeks remained unchanged at 38%. The decrease in incidence of severe acute malnutrition (SAM) observed in 2020 may be

artificial, as cases remained unidentified due to decreased access and avoidance of health services, and the full extent of child deaths due to SAM is not known. Potential increases in SAM due to a decrease in the real value of the Child Support Grant is a concern and must be mitigated.

Table 2: Nutrition Indicators for children <5 years in the Western Cape, 2020^c

| Indicator | 2018 | 2019 | 2020 |
|--------------------------------------|------|------|------|
| Exclusive breastfeeding at 14 weeks | 38% | 39% | 38% |
| Coverage Vitamin A 12–59 months | 49% | 51% | 44% |
| Incidence severe acute malnutrition* | 1.8 | 1.7 | 1.1 |
| Coverage of food supplementation** | 9 | 9 | 7 |

* and ** are reported per 1000 under-five population

At the same time, the epidemic triggered innovative responses to address food insecurity through schools and

ECD programmes, such as the efforts of the Western Cape Food Forum (Box 1).

Box 1: The WC Food Forum

The Western Cape Food Forum harnessed the efforts of government, the private sector and civil society organisations (such as the Community Action Networks (CANS), community kitchens and faith-based organisations) to provide a co-ordinated response to rising hunger and food insecurity.

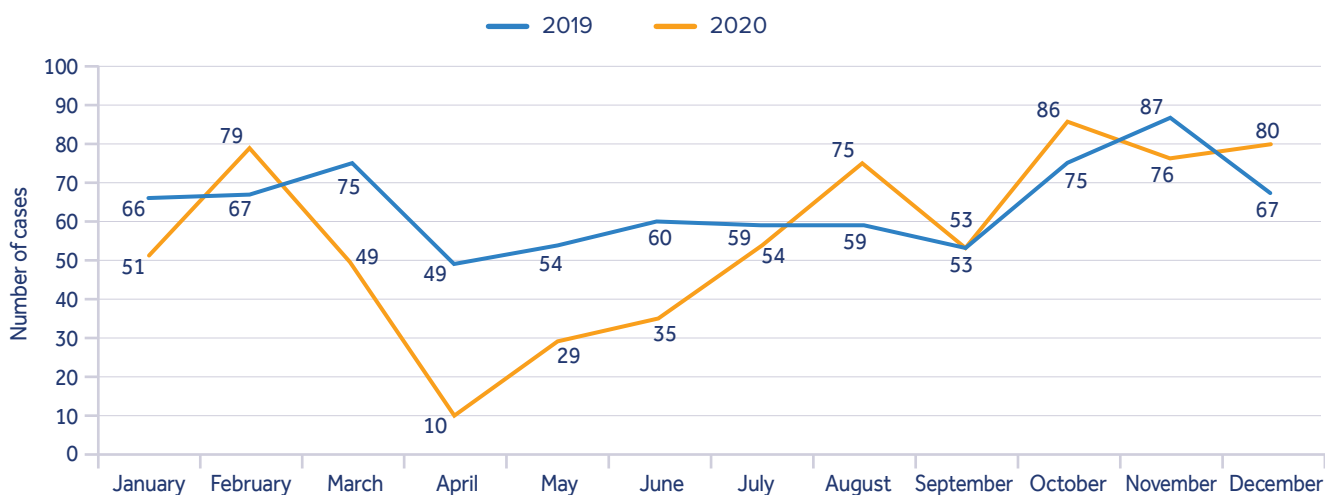
The Forum adopted an agile approach to the unfolding crisis, emphasising collaboration, speedy communication, collective problem-solving, and accountability. These proved critical in building a shared agenda, identifying blockages, and standardising practices. Key innovations included mapping the food relief effort to target food distribution more effectively, and introducing a digital voucher system to enable community kitchens to buy food from local suppliers.²³

Violence and injury

The economic pressures and social isolation of COVID-19 lockdown increased stress, conflict and the risk of violence in the home, both between intimate partners and by caregivers against children. In addition, many families were confined to small, one-room dwellings, increasing young children’s risk of burns, poisoning and other injuries.

The Red Cross Children’s Hospital Trauma Unit^d recorded a 15% decrease in the numbers of children treated for unintentional injuries from 2019 to 2020, driven primarily by a 56% decrease in road traffic injuries during hard lockdown when there were fewer cars on the roads and children were not attending school (Figure 6). Yet injuries in the home increased over the same period – with a 5% increase in serious falls, 10% in burns, and 13% in dog bites.^d

Figure 6: Motor vehicle injuries presenting at Red Cross Hospital, by month, 2019 and 2020^d

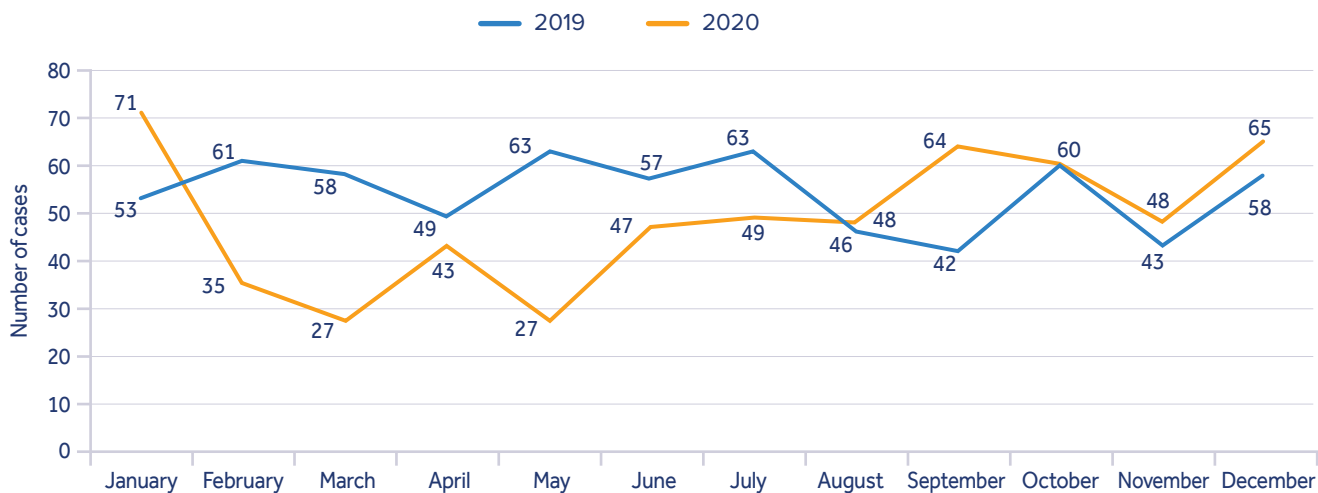


^d ChildSafe Trauma Database, 2019-2020.

Intentional injuries (child abuse) showed a 10% decrease from 2019 to 2020, with a more than 50% decline during Levels 5 and 4 lockdown restrictions (Figure 7). However, this may simply reflect a lack of reporting rather than ‘real’

decline, as lockdown limited children’s support from family, friends and trusted adults such as teachers, as well as their access to health care, child protection and police services.

Figure 7: Non-accidental injuries presenting at Red Cross Hospital, by month, 2019 and 2020^d



Care and education

Schools and ECD programmes are important sites for provision of care, support and protection for children in times of crisis, and the impact of the closure of schools and ECD programmes during COVID-19 is likely to be felt for years to come.

Impact on ECD programmes

ECD programmes such as ECD centres, partial care facilities, playgroups and childminders make a critical contribution to providing food, care and early learning opportunities for young children, whilst enabling caregivers to work.

In 2017, 39% of children younger than three years, and 66% of 3–5-year-olds attended an early learning programme in the WC.^e Yet many of these programmes were fragile prior to COVID-19 and relied on a mix of government subsidies^f, user fees and donor income. In addition, most programmes serving poor communities did not qualify for the subsidy as they do not meet the registration requirements set by the Department of Social Development. The epidemic and lockdown Regulations intensified these vulnerabilities. In most provinces, ECD programmes were closed for four months without subsidies, and despite a court-ordered re-opening, many programmes could not afford to re-open.

Whilst the WC continued to subsidise registered ECD facilities which stayed open for food distribution, the epidemic effects were nonetheless devastating. Children, especially those in unregistered programmes, could not access daily meals, safe care and learning opportunities. Programmes lost income and personnel, with many facing

permanent closure. This left children and families isolated – without childcare and with limited access to support systems outside the home.

Encouragingly, community-based organisations, NGOs and business partnerships stepped up to support ECD facilities. The Drakenstein ECD Support Programme developed by Inceba Trust, which supported 70 ECD centres serving vulnerable children in the rural Drakenstein District, is one such example. The Trust helped to distribute food parcels and vouchers, supported ECD facilities to re-open safely, fast-track registration and access to the subsidy, provide support and training in nutritious meal preparation, equip practitioners and parents with health and nutrition information; and monitor progress.

Impact on schools

Children’s education was profoundly disrupted by the COVID-19 epidemic. Schools across the country closed for the first three months of lockdown. Schools partially returned in phases, coupled with online learning, and were scheduled to re-open fully (meaning all grades attending on all days of the week) only in the second half of 2021.²⁴

The WC has approximately 1.1 million school children, attending 1 514 public sector ordinary and special-needs schools.²⁵ During 2020, approximately 447 (almost a third) schools experienced COVID-19 infections; 1 200 learners contracted COVID-19 (less than 1%), and 3 900 required quarantine (mainly from community-acquired infections rather than school outbreaks). One hundred

e Statistics South Africa. General Household Survey 2017.

f The R15 per child per day subsidy is earmarked for nutrition, salary and administrative support.

COVID-19-related deaths occurred (99 educators and one learner), directly affecting 96 schools and causing widespread fears about safety and lost teaching time.

Schools had to institute safety measures and improve infrastructure to comply with COVID-19 regulations. Some schools were able to introduce innovations (e.g. new handwashing facilities; vegetable gardens to supplement school meals; mask-making and safe transport), whilst others fell short of the necessary requirements.⁹

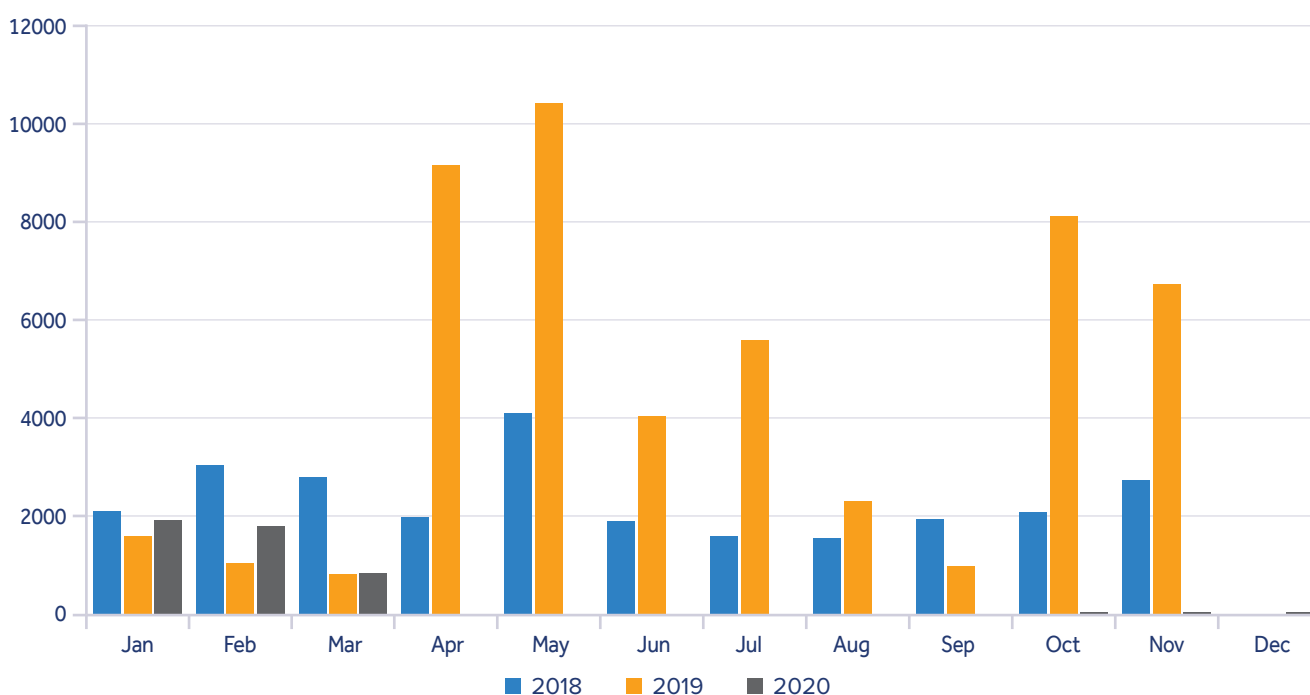
The National School Nutrition Programme (NSNP) distributed more than 1 million meals to a reported 65 000 (15%) of 490 000 eligible learners during the first two months of lockdown.²⁶ Yet by November 2020, only 50% of eligible

learners received a daily school meal. Access remained significantly reduced with partial school re-openings.⁹

School health services were also de-escalated, reversing considerable coverage gains made in 2019 for Grade R/1 screening for health conditions as specified in the Integrated School Health programme (Figure 8), and these have yet to be fully re-instated. This limited the availability of support for learners with comorbidities and mental health problems, and also created backlogs in vaccinations, screening, and adolescent sexual and reproductive services.

Encouragingly, the WCED Directorate for Inclusive and Specialised Education Support developed a psychosocial support system with a focus on Grade 12 learners.

Figure 8: Grade R and Grade 1 learners screened for health conditions^a



Working across boundaries

Responding to the COVID-19 pandemic in a manner that addresses children’s complex needs required a multifaceted response, as actions in many other sectors, illustrated earlier in the chapter, have a profound impact on child well-being. As part of the COVID-19 response, collaborating across sectoral boundaries was essential to allow resources, innovations, intellectual and social capital to synergistically work together. For example, fortnightly meetings were held between the Departments of Health and Education to exchange information, provide advice and solve school challenges. Similar engagements were

sought with the Department of Social Development to put in place systems to identify and respond to children in need of care and protection when caregivers became seriously ill or died. Importantly, guidelines were developed by health colleagues on how to manage COVID-19 in children’s residential care facilities.²⁷

The examples of good practice presented in this chapter demonstrate the essential role of community-based partners such as the Western Cape Food Forum, as well as those who work in the private and business sectors.

A crucial part of the response in periods of disaster involves seeking out children’s perspectives and inputs, to ensure that responses are tailored to meet children’s questions,

^g Western Cape Government: Education. 2021 *School Readiness Monitoring*. Draft powerpoint presentation. Cape Town: WCED; 2021.

concerns and expressed needs for information and support. In Box 2, the perspectives and experiences of the COVID-19 pandemic as expressed by children themselves illustrate

the added depth of understanding that can be gained about children's situation when they are given a voice – and which can guide appropriate service responses in turn.

Box 2: Children's voices

Two WC initiatives captured children's experiences during COVID-19: interviews conducted by RX Radio's young reporters^h; and the Western Cape Children's Commissioner's engagement with child government monitors.²⁸

Monitors described how they were "stripped from seeing friends, teachers, and extended family", raising concerns about their lack of support systems, and asking:

When are we going back to school? How do I look after my family? Who can I go to talk to? Who can help me?

They described their feelings of loneliness, anxiety and uncertainty:

We are all so focused on this pandemic's physical effects, but we forget the astronomical impact this is having on our mental health.

A reporter in Grade 12 described how many students were "literally panicking about their future", while others expressed fears about the re-opening of schools and their frustration at being excluded from critical decisions about their health, safety and education:

I personally believe that decision-makers barely acknowledge the opinion of children.

Conclusions

The COVID-19 epidemic has placed unprecedented stress on families, communities, health systems and societies, and has intensified vulnerability and inequality with children being massively affected, both directly and collaterally.

This chapter illustrates how powerful narratives can be, and how the messages that children were not at high risk from COVID-19 led to children's needs being overlooked, exposing over a third of the population to unnecessary harm.

Encouragingly, the child health community in the WC was able, over time, to advocate for and institute a more child-centred response to the epidemic.

Key levers that aided the safeguarding of children in the WC were:

- a relatively well-resourced and functional health system that allowed for innovation and adjunct services;
- long-standing relationships that enabled necessary collaborations across many different partners;
- stable and concerted leadership distributed throughout the health system;¹
- unprecedented civil society responses; and
- multi-media communication technologies that supported various aspects of the epidemic response.

While some of the immediate impacts on child health have been addressed, the emerging concerns of long COVID-19 in children, as highlighted in high-income countries, must be

considered in further service plans and responses, especially in the education sector where it may hamper learning.

Recommendations

General

- A whole-of-society approach to protect and support children and families in times of crisis should be invoked, using child-centred intersectoral teams to coordinate government and civil-society efforts to support children and families, and service provision.
- Interventions should be extended beyond COVID-19 to holistically address child and family needs for income support, good nutrition, routine health services, childcare, protection and psychosocial support.
- Surveillance and referral systems should be strengthened to identify and respond to children at risk who require care and protection.
- Interventions in health, school and ECD programmes should be coupled with greater investment in the social protection system, including an increase in the value of the Child Support Grant, to protect the most vulnerable children and families against income- and food insecurity.
- Child protection services should be classified as essential under the Disaster Management Act,²⁹ and the safeguarding of women and children systematised by improving access to helplines; activating local response teams; and establishing appropriate and accessible referral pathways.

^h A radio station run for and by children at Red Cross War Memorial Children's Hospital.

Specific to health

- Every opportunity should be used to assess children's food security and safety, levels of domestic violence experienced and their need for psychosocial support.
- At-risk children whose adult caregivers are ill and being treated and hospitalised should be identified.
- Separating children and caregivers should be avoided wherever possible.
- Routine maternal and child health services should be protected.
- Guidelines for the care and management of children in all settings should be developed.
- Strategies to address backlogs and restore child health services should be implemented.

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