



Child and adolescent health needs attention now, and in the aftermath of the COVID-19 pandemic

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There is mounting concern that large-scale COVID-19 containment and physical distancing policies are likely to impact adversely on the lives of millions of children, adolescents and their families (McKee and McCartney 2020). There is also a justified fear that in particular children and adolescents in vulnerable life situations, such as children receiving statutory care, with special needs or at risk of abuse and violence, will be victims of this unprecedented and unexpected global crisis (Jansen et al. 2017, 29). These groups were already less likely to seek and receive care prior to COVID-19 and are at risk of educational underachievement (Jansen et al. 2017).

The extent to which children and adolescents are affected will depend on the variation in nature and strictness of the policy response globally and also across

Europe. A comparison of the seven countries in which the EUPHA Child and Adolescent Public Health section (CAPH) directorate lives and works (Denmark, Finland, The Netherlands, Portugal, Spain, Switzerland, and the UK) yielded both identical policy responses, such as physical distancing and closing of schools, and differences, such as restrictions on gathering ranging from no gathering allowed (Spain) to more liberal policies allowing for up to 10 people to meet throughout the peak pandemic (Denmark and Finland). All day care facilities and schools were closed with the exception of Finland and opening of school policies varied considerably. None of the countries restricted access to acute care; however, all, except for Denmark, restricted elective and planned care to some extent. Preventive care was partly restricted in the Netherlands, Portugal, Switzerland and the UK, but in most

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countries, it was explicitly advised to continue with vaccination programs for children age 0–24 months.

In addition to policy, the communication of containment policies messages is of relevance. In five of the countries, prevention policies and public health messaging was provided in foreign languages for minority groups including sign language, but in the UK and Portugal health communications and policies information were not translated nor was sign language provided (UK). Variation herein reflects the variation in health outcomes. Further, differences in pre-Corona economy are certain to cause variation in managing the health and economic crises. Already now child poverty rates differ considerably across Europe, alone across the seven countries child poverty rate ranges from 3.7 (Denmark) to 19.6 (Spain) (OECD 2020).

Innovative interventions and adaptations of existing interventions were implemented to mitigate adverse consequences of the pandemic. National interventions focused on acceptance of public health measures, implementation of the COVID-19 policies, and on influencing mechanisms as well as direct mitigation of the negative economic consequences of the COVID-19 measures and policies taken. Some initiatives aimed directly at children and adolescents, such as the provision of child and adolescent friendly information about COVID-19 or help parents to cope and speak with children about COVID (Switzerland). Many countries delivered education via television to improve access to schooling (the Netherlands, Portugal, Switzerland) or provided school meals as take away food (Finland). Similarly, there were interventions aimed to improve access to care, via providing online consultations (the Netherlands, Spain and Denmark) and helplines for children and adolescents with mental health problems (Denmark, Portugal).

There is an urgent need to formulate immediate policy for both acute and long-term care with a focus on children and adolescents to ensure that the collateral damage of COVID-19 is as limited and short-term as possible. We differentiate child and adolescent public health into eight core public health priorities, all most probably affected by the pandemic (Children's Commissioner 2018): (1) injuries, (2) mental health (3) maltreatment, (4) risky behaviors, (5) nutrition in early life and prevention of childhood and adolescent obesity, (6) vaccination uptake, (7) access to health care, and (8) inequity in child development and learning. For some health priorities, first evidence is already available. A study from New Zealand reported a reduction of 48% in injury-related admissions in children aged 0–14 years (Christey et al. 2020), while the USA observed an increase in daily number of calls to poison centers for exposures to cleaners and disinfectants, also in children (Chang 2020). In North-Italy a 77–88% decrease in emergency department visits compared to 2018 and

2019 was observed (Lazzerini et al. 2020), probably related to a reduction of accidents, “stay at home” policy and fear of contracting COVID-19. Symptoms in children with preexisting mental illnesses are shown to worsen (Jiao et al. 2020, 12, 13), while others develop them (Lee 2020, 11). Regarding child and adolescent nutrition, a longitudinal study among children and adolescents in Italy showed that eating changed in an unfavorable direction 3 weeks into their confinement during the national lockdown (Pietrobelli et al. 2020, 22).

The EUPHA Child and Adolescent Public Health section (CAPH) directorate launched a call to all members of the EUPHA section to report on their ongoing studies to provide an overview on the research and their contribution to tackle the COVID-19 impact on child and adolescent health. Non-members, worldwide, are invited to participate (surveylink: <https://ww3.unipark.de/uc/CAPH>). Solid data and research in child and adolescent health is ever so important, as is identifying the most vulnerable and providing targeted support. The CAPH directorate encourages public health researchers to investigate both beneficial and adverse effects of the COVID-19 pandemic and make use of the variety in COVID-19 policies and interventions for further understanding of measures and health consequences in the context of children and adolescents.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval The authors followed the ethical standards in their research for this editorial. No data in humans were collected for this manuscript.

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