COVID-19 and the Case for Universal Health Coverage

BUILD BACK BETTER TO DELIVER HEALTH FOR ALL

Save the Children

"COVID-19 poses a significant threat to children's rights to survival and development, and to the highest attainable standard of health."

Michelle Bachelet, UN High Commissioner for Human Rights[1]

The impact of the COVID-19 crisis on children's health and well-being is devastating. Across much of the world, the pandemic is ravaging health systems, economies and livelihoods, and disrupting the delivery of routine health and nutrition services. Decades of progress on child survival and other development gains for children risk unravelling.

Even before the pandemic struck, children faced huge health challenges. In 2019, 5.2 million children under five died, most from preventable causes;[2] more than 190 million children under five – just over a quarter of children in that age group globally – were stunted or wasted;[3] half of the world's population did not have access to basic health services.[4] Now, these figures will inevitably be exacerbated by the impact of the coronavirus crisis. Those worst affected will be the most vulnerable and marginalised children and their communities.

This crisis has come just as we enter the Decade of Action – a global effort to mobilise needed action to achieve the Sustainable Development Goals (SDGs) by 2030.[5] It arrived on the heels of the first-ever UN High-Level Meeting on Universal Health Coverage (UHC) and its resulting Political Declaration,[6] endorsed by all Member States, which was meant to accelerate action towards achieving SDG target 3.8 – "financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[7] While the current pandemic poses a threat to achieving these goals, political and public support for health and health systems around the world has never been higher.

We must urgently turn the rhetoric of these political commitments into action. The pandemic is a wake-up call for the investment needed to build strong and resilient health systems that can prepare for and respond to disease outbreaks while continuing to deliver – and expand access to – critical routine services. More evident than ever is the need for protection for the most vulnerable people in society through universal health coverage.

THE RISK OF COVID-19 ERODING SOMALIA'S FRAGILE HEALTH SYSTEM

Somalia has one of the world's highest rates of under-five mortality (117 per 1,000 live births)[8] and the sixth highest lifetime maternal death risk (829 deaths per 100,000 live births).[9] Moreover, the population is faced with a chronic nutrition crisis, with malnutrition rates increasing and remaining stubbornly high. Some of the most vulnerable women and children often struggle to access health services, forced to travel long distances to reach a public health centre, which then may not be well equipped. As a result, they may be discouraged from seeking healthcare, leading to low uptake of services, such as vaccination and delivery in facilities.

Despite signs that the outbreak is now stabilising, the initial rapid spread of COVID-19 in Somalia increased pressure on the already weak healthcare system. Most of the country's health resources were dedicated to the pandemic response. Frontline health workers, critical for providing essential services to women and children, were overstretched and themselves vulnerable to illness. Some of the most urgent maternal health complications in hospitals in southern Somalia were left unaddressed as doctors had fallen ill with COVID-19 and were unable to work. This has had a long-term impact on the already ailing health system, undermining the chance of a quick recovery.

The Federal Government's Ministry of Health and the Federal Member states in Somalia are working with partners to expand health services, including delivering specific maternal and child nutrition services. Mobile health clinics have been set up across the country to ensure services reach the most vulnerable populations.

OVERSTRETCHED AND DISRUPTED HEALTH SYSTEMS: THE SECONDARY IMPACTS OF COVID-19 ON CHILDREN'S SURVIVAL

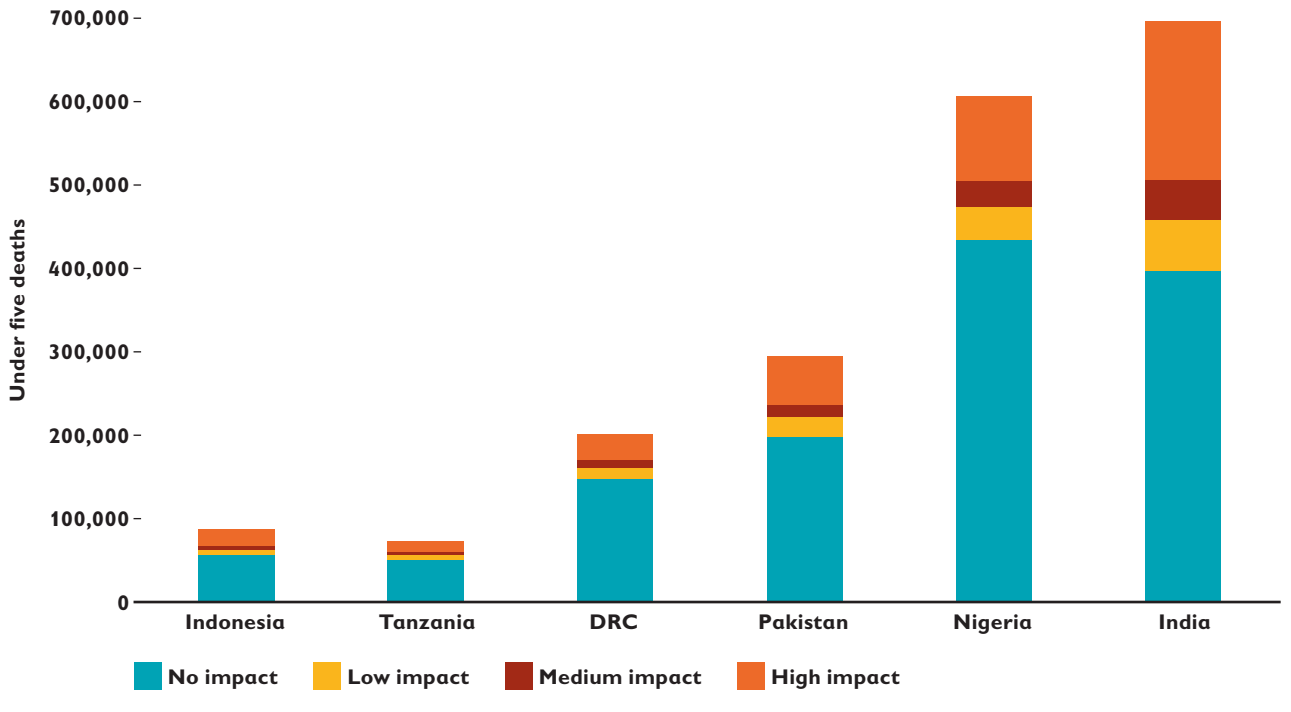
The secondary impacts of the pandemic on children's health and survival are projected to be devastating. This is due to weak and overstretched health systems and disruptions to essential health and nutrition services. The poorest countries and those facing conflict or unrest will be worst affected. Countries face the impossible dilemma of having to prioritise COVID-19 and its treatment over other deadly diseases, with health resources and health workers diverted to respond to the pandemic.[10] This is compounded by supply chains disruptions, shortages of medicines, vaccines and other commodities, and reduced demand for and take-up of services. As in previous pandemics, the most deprived and marginalised people will be worst affected.[11]

Projections show that over six months in low- and middle-income countries, up to 1.2 million more children could die due to increased strain on health systems, disruptions to routine healthcare and increased wasting.[12] A 10–45% increase in child mortality is projected. India, Nigeria, Pakistan, the Democratic Republic of Congo, Tanzania and Indonesia could among be the most severely impacted, with increases in child mortality ranging from 56% in Indonesia to 75% in India (Figure 1).

According to World Health Organization (WHO) data from 105 countries, around 90% of countries reported disruptions to essential services during COVID-19, with low- and middle-income countries worst affected.[14] Nearly 70% of countries have defined a set of essential health services to be maintained during the COVID-19 outbreak. This was more likely if countries already had an established national essential health services package pre-COVID. Meanwhile, only a little over half of surveyed countries have allocated additional public resources to maintain essential health services during the pandemic, and only around 40 low- and lower-middle income countries.[15]

Based on a new Save the Children survey of children and caregivers across the globe, 89% of respondents reported that their access to healthcare, medicine and medical supplies had been affected by the COVID-19 crisis. Respondents reported facing barriers due to closures (10%) and long queues (12%) at health centres, in addition

FIGURE 1. ADDITIONAL UNDER-FIVE DEATHS DUE TO STRAINS ON HEALTH SYSTEMS, SERVICE DISRUPTIONS AND WASTING



Source: Lancet, 2020[13]

to medicine shortages (15%).[16] Evidence from Save the Children programmes in 27 countries[27] also reveals disruptions to essential services. Reasons for this included:

- health systems being overburdened or ill equipped because facilities and health workers have been diverted to respond to COVID-19
- a lack of personal protective equipment or infection prevention and control skills among health workers
- health worker absences because of COVID-19 infection or fear of infection
- reluctance of people to access services due to stigma, fear and mistrust
- the impact of lockdown measures.

UNICEF data from 85 countries found various health system constraints among the main reasons for service disruptions – such as closure/postponement of services (43%), health worker gaps (24%), lack of key supplies (12%) and suspension of community engagement (8%) – in addition to reduced demand (52%) and lack of income to pay fees (7%).[18] A monthly survey conducted by the Global Financing Facility with local staff in 36 countries similarly revealed disruptions to the health workforce in 87% of countries and issues with the supply of medicines in 75% of countries.[19]

WHICH SERVICES ARE WORST AFFECTED?

While a range of health and nutrition services have been disrupted, routine immunisation is most significantly affected.[22] The latest global immunisation figures showed that global coverage before the pandemic had stalled at 85%, with nearly 20 million children missing out on routine vaccination.[23] Experts warn that, with at least 68 countries facing service disruptions due to COVID-19, the number of unvaccinated children globally could increase four-fold, putting around 80 million children at increased risk of vaccine-preventable diseases.[24] COVID-19 is also affecting the introduction of new vaccines into routine immunisation schedules, with two out of three planned introductions interrupted in Gavi-eligible countries.[25]

DISRUPTIONS TO ESSENTIAL SERVICES IN INDONESIA

There have been hundreds of thousands of confirmed COVID-19 cases and thousands of COVID-19 related deaths in Indonesia. Local social restriction regulations have meant that integrated health posts were closed for months and health and nutrition services have been disrupted. This increases the risk of malnutrition and outbreaks of disease among young children. A survey conducted by the Ministry of Health and UNICEF found that in nearly 84% of the reporting health facilities, immunisation services are significantly disrupted.[20]

COVID 19 has created challenges for health workers such as Fatima, a midwife in Rano village in Indonesia. For example, when providing health services in her village, she is now required to follow government regulations on physical distancing. Midwives and health workers, like Fatima, are carrying out door-to-door visits to households to inform people about COVID-19 and how to prevent it. Alongside this, Fatima is continuing to provide maternal care and basic immunisation for 0–9-month-old babies.

"Immunisation services for children must continue during this pandemic," says Fatima. She hopes that the pandemic will end soon so she can provide the best health services possible to people in her village.

Save the Children has been working with the Ministry of Health to support health workers like Fatima. We have:

- supported the MoH and health facilities to distribute personal protective equipment for frontline health workers
- supported the development of programme adaptation guidelines and their dissemination to health providers, community cadres, community leaders and religious groups at sub-national level
- provided support to the national COVID-19 task force (a government structure) to develop an online platform for volunteer management, mobilisation, capacity building and stakeholder response mapping.

Health system disruptions and the impact of COVID-19 on economies and food systems are having a devastating effect on children's nutrition. According to the latest global data, more than 190 million children under five were stunted or wasted in 2019.[26] The World Food Programme estimates that the pandemic could lead to 20% more children under five suffering from acute malnutrition in 2020 – an increase of 10 million children.[27] Meanwhile, a recent study projected that 6.7 million children under five will be affected by moderate to acute wasting this year because of COVID-19 (a 14.3% increase), with South Asia and sub-Saharan Africa worst hit.[28] Together with disruptions to nutrition and health services, this could result in 111,000–178,000 more children under five dying in 2020.

Services for women, adolescent girls and newborn babies will also be highly impacted. Studies estimate that reduced access to services in low- and middle-income countries could lead to a 10% decline in the use of short- and long-acting reversible contraceptive methods. As a result, the needs of an additional 49 million women for modern family planning are likely to be unmet, with an additional 15 million unintended pregnancies in 2021. Many of these will be high-risk pregnancies among adolescent girls, particularly due to COVID-19 lockdown measures and reduced access to sexual and reproductive health services essential to reduce harm to girls and babies. Moreover, 1.7 million women are unlikely to get the care they need when giving birth and a further 2.6 million newborn babies are at risk of experiencing complications.[29]

Global projections indicate that reduced coverage of the treatment for pneumonia, neonatal sepsis and diarrhoea could together lead to up to 78,000 additional deaths a month,[30] accounting for around 41% of additional child deaths.

PRIORITISING ESSENTIAL SERVICES DURING THE PANDEMIC

It is critical that essential health and nutrition services continue to be prioritised where it is safe to do so. WHO provides guidance to help countries to continue to safely deliver high-quality, essential services during the pandemic, in order to mitigate the impact of disruptions.[31] However, it is clear from the overwhelming evidence that services continue to be interrupted on a large scale, with grave impact on children and their communities.

The health gains and economic costs of different policy responses will, of course, vary based on context. Recent studies and commentaries highlight that context-specific and comprehensive approaches that take into account unintended impacts of any decisions may be more appropriate.[32] For example, in low-income countries some response measures, such as movement restrictions, may have lower returns for health than in other contexts and at the same time have more damaging consequences for the populations.[33] A recent study found that the benefits of maintaining routine immunisation delivery for children in countries in Africa outweighed the potential risks of COVID-19 from accessing vaccination services in clinics.[34] Past outbreaks provide similar insights that secondary health impacts could be greater than the direct impacts of viruses.[35]

The Center for Global Development has developed a net impact calculator to help decision-makers consider the trade-offs of potential containment strategies, including the indirect health impacts of different policy responses.[36] Governments may need to work strategically with partners to ensure the provision of essential services, especially at a time when the public health system is over-stretched. This must be alongside efforts to sustain demand for services and to ensure people are and feel safe attending health centres. This is vital to maternal and child survival and to avoid outbreaks of other diseases, especially in countries with already high levels of under-five mortality and malnutrition, where children will be at particularly high risk.

REMOVING USER FEES

Health is a basic human right. But in many resource-poor countries healthcare is not free at the point of use. This results in high out of pocket spending, making up 40% of total health expenditure on average in low-income countries.[37] In 2017, out-of-pocket payments made up 77% of Nigeria's national health expenditure and 74% in Bangladesh.[38] Many families face an impossible choice between healthcare and having enough to eat. Every year around 100 million people are pushed into extreme poverty paying for healthcare.[39] Save the Children and UNICEF calculated that prior to the pandemic nearly one-third of children in low- and middle-income countries (586 million children) were living in families who could not make ends meet.[40]

Projections for 2020 are even bleaker; this number could increase by between 90 and 117 million in 2020, and could remain at this level even in 2021.[41]

WHO recommends that countries remove user fees so that essential health services are free at the point of use.[42] Removing user fees will be even more critical as livelihoods are threatened as a result of the COVID-19 related economic downturn. This will ensure that people are not deterred from seeking care, which could make it harder to bring the outbreak under control. To ensure public health, governments in a number of low- and middle-income countries, including Vietnam and South Africa, have introduced free COVID-19 testing and treatment at public health facilities.[43] Yet many countries have retained user fees for non-COVID-19 illnesses and services, which continues to be a barrier to accessing preventive care and treatment.[44]

In countries that rely heavily on user fees and other informal payments to prop up their national health budget, governments will need to adjust their health financing policies to ensure care, free at point of use, without straining the health service further. Introducing innovative methods for achieving this during the pandemic can pave the way for ensuring that the removal of financial barriers is sustained in the long term, especially for the most vulnerable families. In the poorest countries and those facing conflict or unrest, donor support will also remain crucial.

PRIORITISING INVESTMENT IN RESILIENT HEALTH SYSTEMS

Strong and resilient health systems are widely recognised as critical in responding to COVID-19 – including the need to continue to deliver essential services. Public investment in health systems is the most equitable way to finance UHC and ensure financial protection for the most vulnerable people.[45] COVID-19 will increase pressure on national health systems around the world. And for countries with weak and fragile systems, if measures to prepare them are not adequately resourced, the impact will be particularly severe. The investment needed in public health systems is essential for both health security and UHC.[46]

The 73rd World Health Assembly in 2020 saw Member States unanimously adopt the COVID-19 response resolution, including commitments on increasing domestic financing and development assistance where needed towards achieving UHC.[47] WHO has emphasised that investments in primary health care and UHC establish a vital foundation for countries to respond and adapt to the pandemic,[48] while ensuring the capacity to continue to deliver high-quality and equitable access to essential services.

Much like in other sectors, in order to respond to the pandemic and ensure sustainable investment, governments and donors will need to act swiftly and decisively to adapt to the new financing and health context countries are facing. While there are concerns about shrinking fiscal space for health due to the economic impacts of the pandemic and fears of widespread recession, which could affect the availability and allocation of both donor and domestic resources, there is also immense opportunity to ensure that health becomes a permanent, long-term political priority across the world.

DOMESTIC INVESTMENT – NEW CHALLENGES AND OPPORTUNITIES

Governments have the primary responsibility to deliver health coverage for their citizens and must allocate resources to their health systems, in the short term but also in the long term, to ensure health security and health for all. While some have made progress in increasing resources for health in recent years, shrinking fiscal space means there are serious concerns about government capacity to meet their commitments. Increased spending on health historically stems primarily from economic growth and positive macroeconomic conditions.[49] Many governments were already spending far below the recommended proportion of gross domestic product (GDP) needed to ensure equitable access to healthcare. Based on International Monetary Fund data, at the moment, governments in low and middle-income countries are allocating an additional small amount to health to deal with the immediate impact of the pandemic (0.3% of GDP in Nigeria; 0.4% of GDP in Kenya).[50] A recent study found that over US$52 billion ($8.60 per capita) is needed every four weeks in additional healthcare costs to tackle the pandemic in 73 low- and middle-income countries.[51] The amount needed far outweighs that being spent, risking a rise in out-of-pocket payments to sustain the health system.[52]

While achieving current health financing targets – eg, allocating 5% of GDP and 15% of the government budget towards health – may seem challenging

in the current context, they must remain a goal as countries look to build back better from the pandemic.[53] A key lesson that emerged from the Ebola outbreak was the crucial importance of building comprehensive health systems capable of responding to both routine health needs and disease outbreaks.[54]

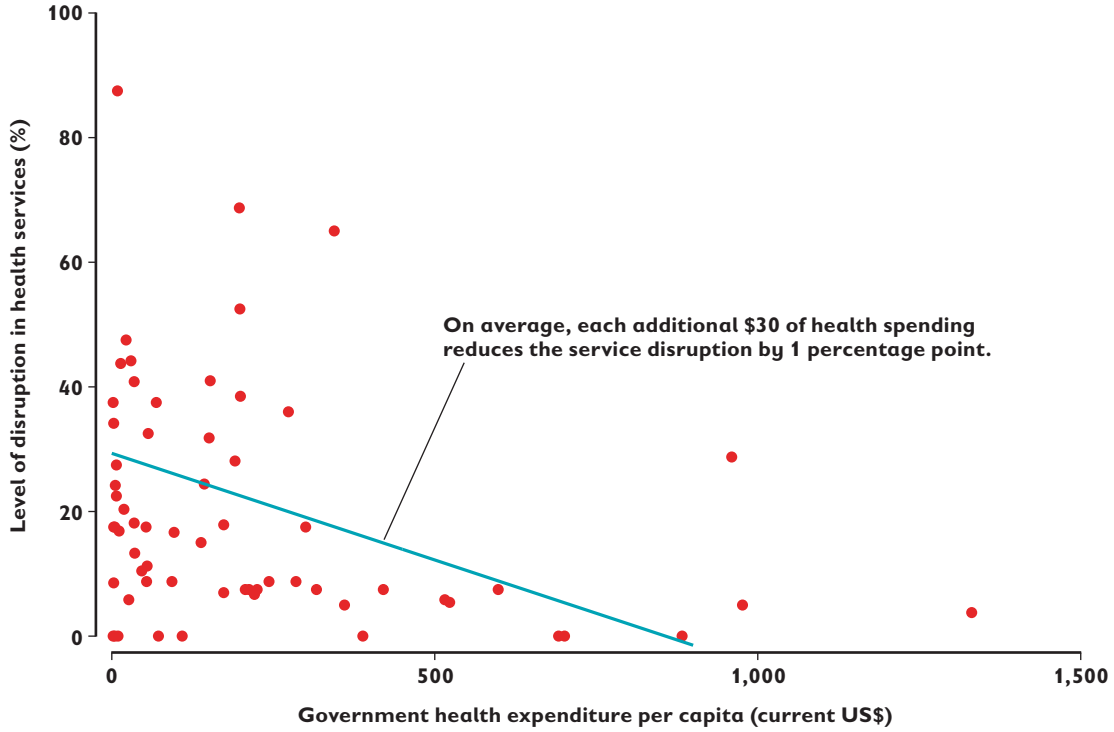
Based on our analysis of available data from June 2020, countries with lower levels of public investment in health faced bigger disruptions to essential services (Figure 2). In Rwanda, for example, a key contributing factor to the successful response to COVID-19 has been the system of UHC in the country,[55] which has delivered free COVID-19 testing and treatment.

With economies shrinking and pressure growing on health systems to respond to COVID-19 and its growing secondary impacts, prioritisation will be imperative. Both traditional and innovative financing approaches will need to be employed – such as increasing progressive and redistributive taxation and budget allocations to health; making efficiency gains; and prioritising investments from debt relief.[56]

Progressive and redistributive taxation remains the most equitable form of health financing and, despite economic pressures and expected drops in tax revenue in 2020, it will continue to play a central role in financing health and nutrition services during the pandemic and beyond.[57] It must continue to be a priority in long-term planning and building back from COVID-19 to drive more sustainable and equitable health financing. Innovative taxation approaches, such as taxing surplus profits and wealth, are another opportunity to generate revenue for health and to address inequalities, both in the immediate and long term.[58] Governments must also implement measures to reduce leakages through corruption, tax avoidance and tax evasion. Countries with more restricted fiscal space prior to the pandemic will struggle the most and will need to rely more on external support and alternative approaches to prop up needed financing.[59]

Budgeting will also be important in ensuring resources for health. Despite current fiscal constraints and pressure on government budgets, health systems must continue to be a priority.

FIGURE 2. COUNTRIES WITH THE LOWEST PUBLIC INVESTMENT IN HEALTH SEE THE LARGEST DROPS IN ESSENTIAL SERVICES



Data: UNICEF COVID−19 Socioeconomic Impacts (internal/June 2020), WHO Global Health Expenditure.
Levels of disruptions based on unweighted average across all health sectors with existing data.
Trend line based on OLS regression between both indicators, weighted by total population in each country.

INVESTMENT IN ETHIOPIA'S PRIMARY HEALTH CARE SYSTEM AMID COVID-19

Despite Ethiopia's impressive progress in reducing under-five and maternal mortality, rates for child and maternal deaths remain high: 51 per 1,000[62] and 401 per 100,000 live births, respectively.[63] There is also a striking disparity in coverage and uptake of high-impact interventions among different regions and districts. The pandemic has disrupted health systems in unprecedented ways. Essential health and nutrition services have seen an average disruption of 12–15%, based on the latest available data from July/July 2020.[64] This has improved since March when it was as high as 20–30%.[65] It is estimated that child mortality could increase by 15% due to the pandemic.[66]

Low public health financing remains a major challenge for the country's health system. It leaves households vulnerable to impoverishment from catastrophic health expenditure and limits access to essential health services for the poorest people. While government health expenditure per capita doubled from US$3 in 2007 to US$6 in 2017,[67] it remains far below the US$86[68] per capita recommended to deliver essential primary health care. Worryingly, 34% of total health expenditure comes from household out-of-pocket payments and domestic government health expenditure is only 1% of GDP.[69]

The economic impact of COVID-19 is also negatively affecting the health sector by limiting the government's ability to generate revenue. This has the potential to reduce government expenditure on health at the national and sub-national level. It will inevitably lead to an increased need for out-of-pocket payments to prop up the health system, leading to catastrophic health spending by those who are poorest and widening the inequity gap.

Low-income countries in particular must increase the share of their government budget allocated to health; it tends to be lower than in high-income countries.[60] Improving public financial management – eg, improving budget allocations, spending procedures and execution rates – will also be important and has the potential to free up resources for health systems. This could potentially increase health budgets by 0.5% of GDP in developing countries.[61]

While decisions on the cancellation or suspension of debt in the face the pandemic is beyond the power of governments of low-income countries, decisions around how they spend any debt relief is critical. Governments must convert suspended debt service payments into investments in children, ensuring that money freed up from debt savings are reallocated to priority areas, such as investment to strengthen health systems.

It is critical that governments allocate resources equitably. Unfortunately, decisions about how public money is spent tend to benefit wealthier groups and areas more, with resources often allocated to services out of reach of the most deprived and marginalised people.[70] Moreover, some groups of children, such as refugee and internally displaced children, are at risk of being overlooked altogether. There is evidence that when resources are reallocated to respond to pandemics, inequalities in health system financing tend to worsen.[71] Governments must ensure that equity is at the core of financing and budget decisions, including prioritising funding for those groups and areas that are furthest behind. This includes targeting spending at primary health care level, where the benefits for the most deprived and marginalised people will be greatest.[72]

THE ROLE OF DEVELOPMENT AID

Fiscal constraints in the current economic climate may pose an increasing challenge for some governments to raise needed domestic resources for their health systems. This will be particularly difficult for the poorest countries, those facing the burden of conflict or civic unrest, those with weaker health systems, and those with large informal economies.[73] Official development assistance (ODA) has been critical in supporting government responses to COVID-19, in addition to its long-standing role in supporting countries to strengthen health systems.[74]

The role of ODA will likely increase as other forms of development financing are affected by the pandemic.[75]

Despite recessions hitting donor countries as they themselves grapple with the impacts of the pandemic on their economies, development aid must continue to be a stable and transformative resource for low- and middle-income countries, supporting them to build back better from the pandemic.[76] The international community must continue to prioritise aid commitments, which will be important both during and after the pandemic. Financing and support from donors must be coordinated and aligned to national priorities to help build and sustain comprehensive and universal health and nutrition services. It must also help strengthen domestic resource mobilisation and health financing systems.

RECOMMENDATIONS

We must act now to accelerate efforts towards achieving Universal Health Coverage. Save the Children calls on governments, donors and multilateral organisations to protect the health and well-being of a generation of children and ensure their right to survive and thrive, in line with the UN Convention on the Rights of the Child.

National governments should:

- Improve equitable coverage of health and nutrition services, including removing financial and non-financial barriers to accessing services and prioritising efforts and resources to make services available free at the point of use, at least for vulnerable children and families and those with pre-existing health conditions.
- Increase domestic public investment in strong and resilient health and nutrition systems. This is critical in preparing for and responding to public health emergencies, as part of wider efforts to deliver good-quality essential services for all, as part of universal health coverage.
- Ensure that essential routine services – such as maternal, newborn and child health, sexual and reproductive health (including for adolescents), immunisation and nutrition (including counselling and support for infant and young child feeding), which are critical for child and maternal survival – are maintained and strengthened during the COVID-19 outbreak.
- Provide safe and legally mandated spaces for civil society organisations and communities, including children, as key stakeholders in achieving UHC and good nutrition for all, to engage in decision-making about and monitoring of health and nutrition service provision and in developing and disseminating inter alia child-friendly health information.
- Ensure suspended debt service payments are converted into investments in children, guaranteeing that money freed up from debt savings is reallocated to priority areas, such as investment to strengthen health systems.

Donors and multilateral organisations should:

- Prioritise flexible financing and technical support to strengthen the capacity of national health and nutrition systems and domestic resource mobilisation efforts to increase the fiscal space for health and nutrition.
- Prioritise support to the most vulnerable countries, including those with weak health systems and those in fragile or conflict-affected settings, to enable preparedness, response and continued delivery of essential health and nutrition services, free at the point of use.
- Use international and national platforms to call for the removal of user fees and provide guidance on how countries can make progress in this regard.
- Meet long-standing aid commitments and continue to prioritise wider investments and support for health systems and child survival to protect and prioritise the delivery of essential services, ensuring that support is aligned to support comprehensive and universal health and nutrition services.
- Protect civil society space. Support and finance the systematic strengthening and mobilisation of civil society organisations and communities, with children at the forefront, to hold their governments to account on child survival commitments and resources to ensure no one is left behind.
- Support initiatives to suspend debt service payments for low-income countries and work with national governments to ensure that money freed up from debt savings is converted into investments in children.

ENDNOTES

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[3] *The State of Food Security and Nutrition in the World 2020*, Food and Agriculture Organization, International Fund for Agricultural Development, UNICEF, World Food Programme and World Health Organization, http://www.fao.org/3/ca9692en/online/ca9692en.html

[4] World Health Organization, 'Health Financing' (webpage), https://www.who.int/health_financing/topics/financial-protection/key-policy-messages/en/

[5] United Nations Sustainable Development Goals, Decade of action (webpage), https://www.un.org/sustainabledevelopment/decade-of-action/

[6] 'Universal health coverage: moving together to build a healthier world', Political Declaration of the High-level Meeting on Universal Health Coverage, 2019, https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

[7] SDG target 3.8 falls under SDG goal 3 to ensure healthy lives and promote wellbeing for all at all ages. See: https://www.who.int/sdg/targets/en/

[8] See note 2

[9] WHO Global Health Observatory. Date accessed 10 September 2020.

[10] Gilbert M, Pullano G, Pinotti F, et al., 'Preparedness and vulnerability of African countries against importations of COVID-19: a modelling study', *Lancet*, 2020; 395: 871–877

[11] Y-Ling Chi et al (2020) Beyond COVID-19: A Whole of Health Look at Impacts During the Pandemic Response, Center for Global Development, https://www.cgdev.org/sites/default/files/PP177-Beyond-COVID-scoping-paper.pdf

[12] This is based on coverage reductions of 39.3–51.9% and wasting increase of 50% over 6 months across 118 low and middle income countries. These additional deaths would represent an increase of 9.8–44.7% in under-5 child deaths per month, and an 8.3–38.6% increase in maternal deaths per month, across the 118 countries. Source: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30229-1/fulltext#seccestitle70

[13] The no impact scenario is the projected trajectory based on historic rates of change. The low impact scenario is a small reduction in coverage and increase in malnutrition; the medium impact scenario is based on moderate reductions in coverage and increase in malnutrition; and the high impact scenario is based on large reductions in coverage and increase in malnutrition. Source: T Robertson et al, 'Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study', *Lancet*, 12 May 2020, https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30229-1/fulltext#seccestitle70

[14] World Health Organization, Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report, 27 August 2020, https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

[15] See note 14

[16] J Edwards (2020) *Protect a Generation: The impact of COVID-19 on children's lives*, Save the Children International, https://resourcecentre.savethechildren.net/node/18218/pdf/protect_a_generation_report_en_spread_090920.pdf. This quantitative data found in this report was gathered from a sample of Save the Children programme participants with email or phone contact details in 37 countries, across the regions of Asia, East and Southern Africa, West and Central Africa, Latin America and the Caribbean, Middle East and Eastern Europe, Pacific, and North America. The 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. In total, 17,565 parents and caregivers and 8,069 children aged 11–17 years old participated in the programme participant survey.

[17] Afghanistan, Bangladesh, Bolivia, Colombia, Dominican Republic, Egypt, El Salvador, Ethiopia, Guatemala, Haiti, Honduras, Ivory Coast, Kenya, Malawi, Laos, Myanmar, Nepal, Nicaragua, Pakistan, Peru, Philippines, Rwanda, Senegal, South Sudan, Sudan, Uganda, Venezuela.

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[21] Government structure at the time

[22] See note 14

[23] World Health Organization, 'Immunization coverage', 24 July 2020, (webpage), https://www.who.int/news-room/fact-sheets/detail/immunization-coverage

[24] World Health Organization, 'WHO and UNICEF warn of a decline in vaccinations during COVID-19', press reléase, 15 July 2020, https://www.who.int/news-room/detail/15-07-2020-who-and-unicef-warn-of-a-decline-in-vaccinations-during-covid-19

[25] Gavi Board paper, July 2020

[26] See note 3

[27] United Nations World Food Programme, 'Coronavirus threatens global surge in malnutrition, jeopardizing future of an extra 10 million children' press release, 20 May 2020, https://www.wfp.org/news/coronavirus-threatens-global-surge-malnutrition-jeopardizing-future-extra-10-million-children

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Cover photo: A girl waits in a health clinic in Mogadishu, Somalia.
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