

The Hight Cost of COVID-19 for Children

Strategies for mitigating its impact in Latin
America and the Caribbean

Diana Hincapié
Florecia López-Boo
Marta Rubio-Codina

Social Protection and Health
Division

DISCUSSION
PAPER N°
IDB-DP-00782

The Hight Cost of COVID-19 for Children

Strategies for mitigating its impact in Latin America and the Caribbean

Diana Hincapié
Florencia López-Boo
Marta Rubio-Codina

June 2020

<http://www.iadb.org>

Copyright © 2020 Inter-American Development Bank. This work is licensed under a Creative Commons IGO 3.0 Attribution-NonCommercial-NoDerivatives (CC-IGO BY-NC-ND 3.0 IGO) license (<http://creativecommons.org/licenses/by-nc-nd/3.0/igo/legalcode>) and may be reproduced with attribution to the IDB and for any non-commercial purpose. No derivative work is allowed.

Any dispute related to the use of the works of the IDB that cannot be settled amicably shall be submitted to arbitration pursuant to the UNCITRAL rules. The use of the IDB's name for any purpose other than for attribution, and the use of IDB's logo shall be subject to a separate written license agreement between the IDB and the user and is not authorized as part of this CC-IGO license.

Note that link provided above includes additional terms and conditions of the license.

The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the Inter-American Development Bank, its Board of Directors, or the countries they represent.



scl-sph@iadb.org

www.iadb.org/SocialProtection

The High Cost of COVID-19 for Children

Strategies for mitigating its impact
in Latin America and the Caribbean

Diana Hincapié
Florencia López-Boo
Marta Rubio-Codina

The High Cost of COVID-19 for Children

Strategies for mitigating its impact in
Latin America and the Caribbean

Authors:

Diana Hincapié
Florencia López-Boo
Marta Rubio-Codina

2020



The High Cost of COVID-19 for Children

Strategies for mitigating its impact in Latin America and the Caribbean

Diana Hincapié
Florencia López-Boo
Marta Rubio-Codina

Abstract

The pandemic may have a devastating impact on children's physical, mental, and socioemotional development, both in the short and the long run. These repercussions have received little attention because of the low rates of COVID-19 in this population. However, child mortality, morbidity, and poverty are projected to rise, resulting in major losses of human capital and deepening inequality. Lack of access to basic services (sanitation, health, education), disparities in parenting skills, limited internet connectivity, and unequal access to technology will further widen the socioeconomic gap in child development. Nonetheless, this crisis also offers a chance to transform early childhood services, making them more cost-effective, equitable, and resilient, as we see happening in various countries in Latin America and the Caribbean. This paper compiles and lays out strategies for innovative new ways to provide services and mitigate the crisis' impact on children.

JEL codes: J13, I1, I2, I3

Keywords: COVID-19, child development, early childhood, parenting programs, childcare centers, preschools, reopening early childhood services, children's health



How the COVID-19 crisis is making children vulnerable

The COVID-19 pandemic has drawn attention away from children because, from an epidemiological standpoint, they have been less impacted by the virus (Box 1)¹. However, this crisis may have devastating consequences for children in the short, medium and long run. A [recent article](#) projects a potential rise in worldwide infant mortality for the first time in over 60 years due to the indirect impacts on children's nutrition and access to basic health services. This possible 10% to 50% increase is driven by acute malnutrition (low weight-for-height) and reduced availability of oral rehydration solution for and antibiotics for pneumonia and neonatal sepsis. There is also alarming evidence that [immunization schedules are being interrupted](#) in several countries.

Box 1. The risk of infection in children and their role in transmitting the virus.

According to the U.S. Centers for Disease Control and Prevention, [people under age 18 make up 1.7% of all past and present COVID-19 cases in the U.S., while those under age 4 account for 0.46%](#). Globally, from Korea to Spain to Italy, under 2% of those who have contracted COVID-19 are children. In Iceland, where 6% of the population was tested, none of the 848 tests for children came back positive. Similarly, in the Italian city of Vo', where 70% of the population was tested, 2.6% of the residents were infected, but none of them was under age 10. Another study of 2000 children with COVID-19 in China found that 90% had no symptoms, 39% developed pneumonia without showing obvious symptoms, and 6% had serious infections. In short, there is evidence that children are significantly less affected than adults in terms of both total cases and severity of infections, with a limited number of deaths in children under 10, as shown by [a recent meta-analysis of 78 studies](#). Also noteworthy are studies from [England](#) and [France](#) that show a higher incidence of acute pediatric cases in male children, mirroring the pattern seen in adults. But whether children are major spreaders of the virus is yet to be confirmed. [Researchers in the Netherlands](#) monitored 54 families (239 people) and found no cases in which the child contracted the virus first. However, [a study by the Charité Institute of Virology in Berlin](#) noted statistical limitations in the Dutch study and argued that viral loads can be as high in children as in adults. As a result of its findings, the study cautions "against an unlimited re-opening of schools and kindergartens in the present situation." More serological studies at the population level and on children who attend childcare centers and preschools will be available soon. If these studies find children to be a frequent source of infection, whether for other children or for adults, this would suggest that they are major spreaders of the virus, as is the case with influenza. Under this scenario early childhood services would best remain completely or partially closed. If, on the other hand, it is discovered that children are rarely a vector of contagion, reopening would be a safer option.

Furthermore, early childhood services—whether childcare centers, preschools, or parenting programs—have experienced unprecedented disruption. Despite efforts to stay in contact with the children and their families and to continue remotely offering a certain degree of service, the situation is expected to seriously undermine children's development, [learning](#), and [physical and](#)

¹There is major debate about how the disease manifests itself in children. It could take different forms than in adults, such as multiple inflammatory syndrome or [Kawasaki disease](#).



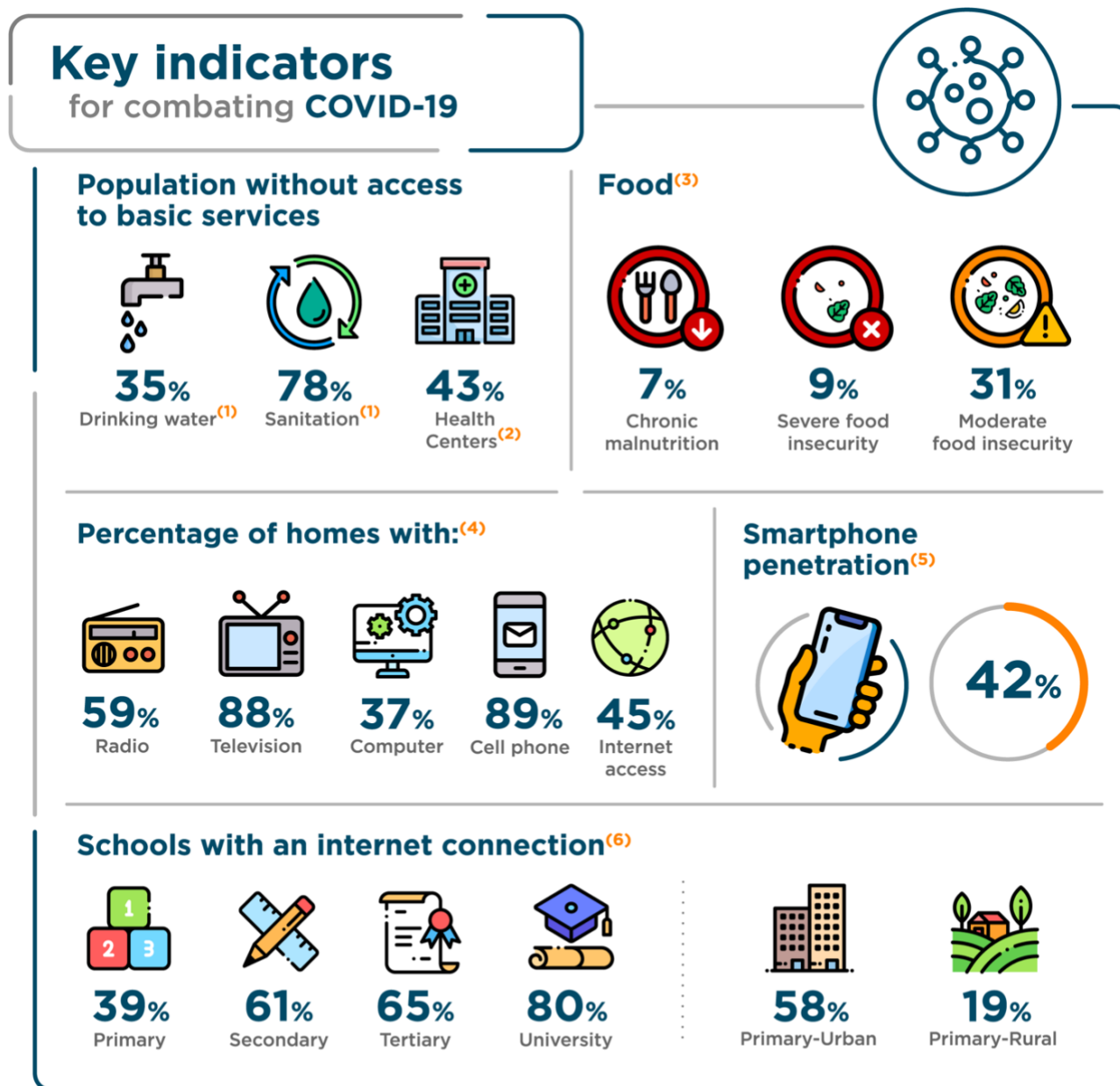
[mental health](#). As children's routines break down and they are confined to their homes, they have much fewer opportunities for physical activity and exposure to stimuli and opportunities for learning. Additionally, children may spend more time in front of screens, develop irregular sleep patterns, and eat less healthy diets. Perhaps more importantly, the drop in the quantity and quality of children's interactions with their caregivers in the home, or the lack of socialization and personal contact with their classmates, educators, and teachers could also affect children's socioemotional state and stress and anxiety levels.

Given the restrictions currently in place and despite the gradual reopening of some childcare services and the progressive return of economic activity, millions of mothers and fathers are forced to do the job of caring for their children and fostering their development alone. This makes parenting practices at home particularly crucial, at a time when caregivers may be significantly less able to respond in an affectionate and timely way to their children's needs, interests, and worries. The situation is also unquestionably affecting the emotional state and mental health of caregivers for several reasons, including changes in household dynamics; unequal division of chores and caregiving work; stress from having to juggle childcare and work; job and income loss; health-related anxiety; and the gaps left when families are cut off from or even lose aunts and uncles, grandparents, or other people who normally helped raise and care for children. These tensions within families also exacerbate cases of [domestic abuse and violence](#) for both children and their caregivers.

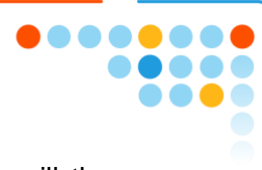
We know that in Latin America and the Caribbean, [there is a close correlation between parenting practices and socioeconomic status](#). Better educated and higher-earning parents generally raise their children in ways that are more sensitive, receptive, rich, and varied (they read and tell more stories and play more with their children, for example). This group is also better equipped to reorient behavior through positive disciplinary practices, and they resort to physical or psychological violence much less frequently.

The region also clearly lags behind on other key indicators for dealing with the COVID-19 crisis (Figure 1). For example, there are very sharp disparities in households' level of vulnerability. In terms of education, many children have little to no learning opportunities, despite the online portals, platforms, and educational strategies that have been, and continue to be, rolled out. This is the case because many schools and childcare centers have neither the equipment nor technology needed to effectively use them. In 2015, for example, only 39% of the region's primary schools had internet access, with a marked difference between rural primary schools (19%) and urban ones (58%). Access to educational materials and resources is also unequal, as over half of homes in 20 countries in the region have no access to internet, computers, or smart phones. Additionally, many households have limited ability to implement the health and hygiene measures necessary to contain the pandemic. According to WHO data from 2015, only 22% of the region's population had safe sanitation services, compared to 39% globally, while 65% had access to drinking water in the home, as opposed to 71% worldwide.

Figure 1. Key indicators for combating COVID-19



Notas: (1) Data from the WHO-UNICEF Joint Monitoring Programme for Water Supply and Sanitation. The data reported is from the safely managed services category, since these services are compatible with SDG 6.1 and 6.2. Safely managed drinking water is defined as an improved **drinking water** source located on premises, available when needed, and free of microbiological and priority chemical contamination. Safely managed sanitation is defined as a private improved facility where fecal wastes are safely disposed on site or transported and treated off-site; plus a handwashing facility with soap and water. (2) Data from ECLAC for 2015. It is estimated that in 2016 only 57.3% of employees that have been with an employer for 15 or more years were on a health insurance plan. (3) Data from the FAO for 2018. The FAO defines severe food insecurity as a reduction in food supplies to the point of causing hunger. (4) This is an average of 20 countries in the region reported by the International Telecommunications Union (ITU) from 2016 to 2019. (5) Based on Newzoo's 2018 global mobile market report. This calculation includes seven countries: Argentina, Mexico, Chile, Brazil, Colombia, Venezuela, and Peru. (6) Calculations based on the OECD and IDB digital economy toolkit from 2015.



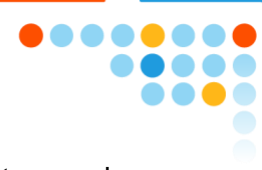
In Latin America and the Caribbean, the most unequal region on the planet, not only will the current crisis drive up poverty levels, it will also dramatically increase [inequalities in wealth and access to health and social services](#). [The existing gaps in children's development, which correlate to parents' socioeconomic status and level of education](#), will be compounded by setbacks in children's health; deeper poverty as households lose income; learning and development deficits due to closures of early childhood services; gaps in parenting skills; and the digital divide, all of which may result in a catastrophic loss of human capital. Additionally, countries may see their tax revenues plummet right when it becomes most pressing to prioritize healthcare and social and job protection schemes to mitigate the health and socioeconomic crisis. This poses the serious risk that funding will be stripped from early childhood services that, in many cases, serve to level the playing field. All of these factors make children in the region even more vulnerable than they already were, given that traditionally this age group [is the one with the least investments](#). Therefore, governments urgently need to create support mechanisms for those caring for children at home and prioritize actions that allow early childhood services to continue fostering children's development. This will require tapping into all available resources, technological or otherwise, and developing innovative new strategies to meet the needs of every family, regardless of its socioeconomic status.

The state of early childhood services in the region

UNESCO reports that [19.6 million preschool-aged children](#) (children under age 5 or 6, depending on how each country's system is structured) are temporarily out of school due to COVID-19. Everything suggests that around 90% of the region's early childhood centers will remain closed for as long as quarantine and social distancing measures last, although a few countries like Nicaragua have chosen to keep them open. In Mexico, centers for children were initially set to continue their activities, as they were [considered essential services](#), but many have closed or begun operating at low capacity as the health situation worsens and demand drops. Some centers in the country have remained open as emergency childcare centers serving essential personnel, in coordination with the health sector.

Likewise, the in-person component of parenting or family support programs—which are usually provided as home visits or in group sessions—have also been temporarily suspended in most countries. This is true of Argentina's Primeros Años program, Uruguay's Centros de Atención a la Infancia y la Familia (CAIF), or Peru's Cuna Más program, among others. On the other hand, [Brazil's Criança Feliz program continues to make its weekly home visits](#), as long as the safety and protection of the staff and families can be guaranteed and unless the local pandemic situation makes visits inadvisable.

Currently many countries in Latin America and the Caribbean, like Argentina or Peru, [have set no date for resuming educational services for children](#) or work with families. Colombia plans to avoid any in-person interaction in all of its early childhood services until at least the end of July, and preschools are expected to remain closed until the next school year in most countries where the school year ends in June. There is, however, some variation across the region. Uruguay, for example, has already reopened preschools and childcare facilities in rural areas (which were closed in March and April) and is planning to gradually reopen urban ones on a voluntary and



location-by-location basis. Mexico is also preparing to gradually reopen childcare centers and preschools in June and July.

Table 1 shows the status of early childhood services in a selection of countries in the region, as of the publication of this note.

Table 1. Status of childcare centers and parenting programs (selected countries)*

		Childcare centers	
		Closed	Open
Parenting programs	Remote services	Argentina ⁽¹⁾ Chile ⁽²⁾ , Colombia, Ecuador, Jamaica, Panama, Paraguay ⁽³⁾ , Peru.	Mexico ⁽⁴⁾ , Uruguay ⁽⁵⁾
	In-person services		Brazil, Costa Rica ⁽⁶⁾ , Nicaragua

Notes: *Preschools remain closed in most countries, except Nicaragua, where they stayed open during the quarantine. ¹. Food packages are handed out at childcare centers. ². Support by mobile app for childcare centers. ³. Food packages are handed out at childcare centers. ⁴. In practice, many centers are closed and those still open have low attendance. ⁵. Only rural centers are open. ⁶. Parents decide whether their children will attend.

Early childhood services' short-term response

Although childcare centers and preschools are shut and parenting programs have temporarily suspended home visits and group sessions, early childhood services have not been completely discontinued. On the contrary, in most cases programs have quickly redirected their actions to ensure regular contact with children and their families and remotely offer at least some degree of service.

In general, the services' immediate response has focused on:

1. **Regularly monitoring children's health and well-being** (as often as every week in many countries) by phone or digital messaging, or by mobilizing community workers (ideally outfitted with personal protective equipment) in places with limited connectivity. In addition to gathering information on children's health and nutrition and compiling it into dashboards, these points of contact are used to identify and redirect specialized and priority care for cases that trigger red flags, including those where children's rights are being violated. This communication is also used to share information about COVID-19 (symptoms and action protocols) and messages about good health and hygiene practices to prevent infections.
2. **Ensuring safe delivery of highly nutritious food packages to children and pregnant women**, whether directly to their homes or by arranging pickups at childcare centers, schools, or other community centers in a way that avoids crowds or other risky situations. The



packages often contain advice on how to eat a healthy and balanced diet despite possibly restricted access to food as a result of the current situation.

3. **Offering essential health security services**, promoting the continuity of basic services and facilitating strategies for giving mandatory immunizations, whether at health centers or in homes. Some programs have also distributed cleaning and protection kits to families.
4. **Facilitating access to basic social protection and income services**, coordinating with social transfer programs to deliver existing cash assistance or additional compensatory aid. Early childhood services' periodic contact with families is also used to identify new beneficiaries for cash transfer or food programs and thus update records, provide follow-up, and give guidance to existing beneficiaries.
5. **Promoting development and learning** by providing families with games and educational resources—mostly designed for preschool-aged children—digitally, by telephone, in instant messages, on social media, or through community channels like bulletin boards and loudspeakers in markets or in educational programs on analog media like TV and radio. Many services have set up online portals with libraries of games, storybooks, songs, and activities, among other resources, designed to help young children develop skills.
6. **Preventing rights violations** by setting up specialized hotlines, online chats, and other virtual channels where psychologist can offer emotional support to children and their caregivers and limit abuse and mistreatment.

To provide these responses, services have had to make a massive effort to restructure their activities, adapt their dynamics and the way they work, and conform to the different formats available for reaching children and families (Box 2). This required remotely training the technical teams, community organizers, caregivers, and teachers tasked with using the new methods to provide services. Platforms with educational resources (activities, materials, and guidelines) have also been created to support them in their “new role.”



Box 2. Early education and preschool from home

As most schools have closed, it has become necessary to make efforts [to continue children's education](#) on three main fronts: maintaining the connection between children and educators and between families and schools; delivering appropriate educational content; and supporting and monitoring learning processes. Countries' response capabilities have varied based on their pre-pandemic contexts and technological infrastructures, as have the means they have used to provide solutions—from online learning platforms and systems to portals with educational content, or radio, television, and print materials for children in the most remote or least connected areas. For example, the infrastructure developed by [Plan Ceibal](#) has allowed Uruguay to swiftly roll out content for preschool-aged children and keep in touch with families during the pandemic. Specifically, it has focused on 5 strategies: (i) making tablets available to families (loans and use varied from center to center); (ii) setting up early education platforms and applications for parents to download on personal devices, such as the Matific platform for learning math or the Dragon Box app for developing number sense; (iii) developing the "Ceibal at Home" strategy for keeping teachers, children, and most of all families in communication (for example, through emails to parents or mass social media campaigns) in order to familiarize them with the Plan's resources, with how to use the technology, and with socioemotional learning; (iv) creating a "teacher space" as part of the education management system to provide teachers with digital resources, with specific activities organized by age; and (v) offer access to digital books via the Biblioteca País, which holds over 7000 titles for children of all ages.

How to tackle medium-term challenges and the transition to a new normal

Early childhood services will not reopen right away. And in the medium-term, they will not return to the same dynamics, intensity, and ways of providing the service either. So in addition to pursuing the immediate strategies described in the previous section, services will need to continue reinventing themselves to provide an experience that gives priority to their fundamental goals of promoting children's development and learning in a way that is essentially virtual or that limits personal contact to a bare minimum. To this end, we offer the following recommendations, many of which are already being implemented by several countries:

1. **Design simple educational content (activities and games) and protocols for implementing and sharing them that are flexible and well-suited to each context.** Ideally, this content should use materials that can easily be made from items available in the home, be done as part of everyday routines (getting dressed, taking a bath, eating, cooking, or washing up), and be based on daily life. This will encourage and make it easier for families to do the activities. The content should also be versatile enough to be shared using different channels—for example, websites, phone calls or virtual meetings (tele-support), videos, text messages with or without visuals, or radio and TV programs. This content must also be accessible in areas that are rural or that have no internet, so it should be possible to disseminate it using more traditional means of communication, like delivering physical activity cards to homes or using information boards at strategic points like markets or community centers. The content should also be easy to understand and accessible for caregivers with



different levels of education (including those with low literacy) or from different cultures, so ideally it should be very clear, with strong visuals and limited text. This content could be rounded out with packages of toys and other play-based educational materials (books, puzzles, crayons, notepads) or instructions for building toys at home from recycled materials.

2. **Develop messages on good parenting practices that, along with the content, support, assist, and empower caregivers in their role**, with the aim of generating a positive psychosocial and socioemotional atmosphere in the home. That is, design and communicate messages that foster opportunities to look at picture books and tell stories; play games involving sorting objects by size, shape, or color; learn new concepts; and sing and dance, among others. In sum, the messages should encourage quality time between children, their caregivers, and other family members; promote affectionate, receptive, and sensitive interactions; and prevent physically or psychologically violent disciplinary methods or other forms of child abuse. The intense time pressures and high levels of stress and anxiety families are currently experiencing could lead to this type of abuse. These messages should also include strategies for providing emotional support to caregivers, designed to boost their self-esteem, encourage them to go easy on themselves, and help them stay calm and positive despite the demands of the situation. Box 3 contains a specific proposal for play-based educational content and messages.

Box 3. A proposal for promoting play and interactions in the home

Reach Up and Learn is a home visiting program/curriculum based on a model that has been successfully implemented and evaluated in vulnerable households, first in Jamaica¹ and then in other low- or middle-income countries. Its aim is to improve parenting practices and children's development through play and interaction. In response to the pandemic, *Reach Up and Learn* has put together a manual with a selection of games and language activities from its curriculum for children under age three. The activities are organized by three-month age groups, and priority was given to those requiring little to no materials and those that can be integrated into everyday household routines such as bathing, eating and household chores. The manual has a first section designed to help programs adapt the activities to their needs and context and to the best means of communication (radio, social media, messaging, phone calls, etc.). Then, its second section holds the activities themselves, which are organized into activity cards, written in very simple language, and illustrated with images so they can be used directly by families. The manual also includes advice on how to strengthen the bond between children and their caregivers and support children's socioemotional development (for example, by displaying affection; responding to their interests, needs, and worries; and praising them on their attempts and achievements). It also addresses emotional care for caregivers themselves, which is essential if families are to successfully perform their vital work of promoting young children's development. The manual is available in [English](#), [Spanish](#) and [Portuguese](#).

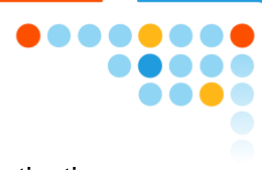
It is important to incorporate [the lessons of behavioral science](#) into the content and design of these messages to increase their effectiveness and make good practices more lasting. For



examples, they should be crafted bearing in mind that despite good intentions, behavioral biases—like inconsistency, mental fatigue, or limited attention—can restrict parents' ability to optimally foster their children's development. In practice, this means messages need to be simple, attractive, timely, and in aligned with prevailing social norms.

3. **Activate special support strategies for children and their caregivers in the areas of health, nutrition and socioemotional assistance** when professionals identify red flags or signs of risks or rights violations—for example, malnutrition, skipped immunizations, neglect, abuse, or a depressed caregiver—during "tele-support" or follow-up calls. This special support should be provided by experts (nutritionists, psychologists, social workers) and can be given over the phone or by other virtual means. The support should be as personalized and personable as possible. In more serious cases involving factors like severe psychological disorders, child abuse, or domestic violence, specific action protocols should be set in motion with the appropriate local authority.
4. **Launch national communication campaigns using mass media** like radio, television, or nationwide texting in order to: (i) raise awareness among families and communities of the importance of investing in children; (ii) inform them about different strategies and resources available to them (food supplies, educational kits, tele-support, etc.); (iii) share programs with specialized content to promote play, learning, and good parenting. For example, the Cuna Más program in Peru plans to broadcast its own and third-party productions and content using the Cuna Digital and Cuna Radial strategies. Costa Rica, Honduras, Panama, and other countries in the region broadcast Sesame Street content on television to promote good hygiene and development among preschool children.
5. **Design educational content and online platforms to provide training and qualifications for community workers and educators** who are directly in charge of implementing the above strategies. This training should cover not only the new content and materials, but also how to provide services remotely and develop digital and socioemotional skills like empathy or active listening. The aim of these training processes should be to equip educators with everything they need to properly support families and children under such challenging circumstances. Currently many countries are relying on virtual platforms (like the Avispa Platform in Colombia) to upload existing resources and content, and on virtual forums and videoconferencing for training processes. However, many educators have limited internet access, and as it will not be possible to hold in-person trainings in upcoming months, it is important to also design mixed-mode solutions (like virtual classrooms in combination with content that can be accessed by phone or other off-line devices) or solutions that use more traditional communication channels. It is crucial that training processes be designed to meet educator's needs and provide solutions to the challenges they face in the contexts where they work. They should also incorporate access to mentors and ongoing online support, as these resources are highly relevant to the quality of the service.

One of the main challenges for implementing these strategies is ensuring that the services are offered to all users, including those living in more remote or inaccessible areas, or those belonging to indigenous groups, which generally have less access to internet and other media, as well as



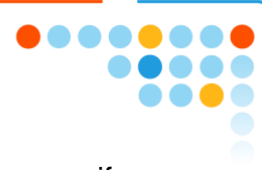
greater needs. Another challenge is to make this contact meaningful, accessible, and motivating enough to promote and sustain behaviors and practices within the homes that lead to development and learning. In other words, the difficulty lies in maintaining and generating interactions in this virtual environment where visitors/caregivers/educators cannot demonstrate the activities or interact in person with children and their families.

At the same time, early childhood services are establishing protocols and guidelines for gradually returning to working in person with children at childcare centers and preschools and for resuming the meetings offered by programs working with families. These protocols should be defined in coordination with the health, social protection, and employment services. For economic activity to start back up again, inevitably a minimum number of childcare and preschool services will need to reopen to care for the children of those returning to the workplace. These centers need to [meet certain health and hygiene criteria](#) for a safe and healthy reopening.

Adapting these criteria² to the context of early childhood and preschool education involves:

- (i) **Properly equipping and readying facilities to reopen** after prolonged closures. This recommendation entails inspecting water systems to make sure they are in good condition to prevent health risks to children, verifying that ventilation systems are working properly, and, if possible, spacing chairs, tables, and cribs two meters apart, as well as designating an area in the facility for any child who displays COVID-19 symptoms during the school day. Ideally, the relevant health authority would certify the facility's health-readiness.
- (ii) **Keeping facilities clean and disinfected.** It is recommended to pay special attention to frequently touched surfaces, like door handles, sinks, or toys; close off common use areas like libraries, gyms, play areas, and cafeterias, or use them in shifts and disinfect them after each use, although it is preferable to serve children in the classroom; make sure children are not sharing dishes or silverware; use bedding, pillows, and towels that can be washed and identified separately; avoid using objects that are hard to wash or disinfect, like cushions and soft toys; and, where possible, make sure there are enough supplies, like art implements and puzzles, for each group of children. If this is not possible, one option is to set up shifts and clean and disinfect materials between each use.
- (iii) **Making sure all children and staff show up and stay healthy.** One option is to measure people's temperature as they enter the facility, observing safety and confidentiality protocols. Surveys can also be given to find out whether children or anyone in their homes has shown symptoms. It is also important to take steps to prevent infections, like having adults wear masks at the facility; keeping children's belongings in separate containers and labeling them, or asking caregivers to take them home and wash them daily; ventilating the space more by opening doors and windows and/or using fans; and taking additional precautions when handling food, changing diapers, or helping children in the bathroom. To keep children and staff healthy, there also needs to be flexible sick leave (or leave for caring for sick people) for both staff and parents of sick children. To the extent possible, it

² Based on the opinions of early childhood experts and on their interpretation of the [CDC criteria](#), the [John Hopkins Bloomberg School of Public Health guidelines](#) (May 15, 2020), and the [ReopenDC Committee on Education and Childcare criteria](#) (May 20, 2020).



is also important to make arrangements to have enough staff to cover absences if someone needs to miss work.

- (iv) **Restricting the access** of nonessential visitors, volunteers, and family members to the facility, and limit how often people enter and exit. This also means canceling any extracurricular activities, meetings, or events in the facility, as well as any outings.
- (v) **Maintaining social distancing** by (i) reducing the number of children per caregiver per classroom³, whether by organizing shifts during the day or on different days (giving priority to children according to their educational needs or their parents' work-related needs) or by adapting alternative spaces (common rooms, cafeterias, or roofed play areas) as classrooms; (ii) spacing chairs and cribs well apart in classrooms; and (iii) staggering drop-off and pickup times to avoid crowds at the door and to be able to give surveys for identifying symptoms or take temperatures. It is also important for groups not to mix—that is, groups/classrooms should always have the same children and the same caregiver every single day. If several groups share a classroom, the spaces for each group can be marked off with colored strips or marks on the floor, for example.
- (vi) **Guaranteeing access to water and soap for frequent handwashing**, or access to sanitizer and disinfectant gels. Staff and older children should use products containing at least 60% alcohol. Also, ensure access to paper towels.
- (vii) **Properly preparing the center's staff**. Teach and emphasize the importance of covering one's nose and mouth when coughing or sneezing, of washing hands properly and often, of not touching one's face, and of correctly using masks, gloves, and smocks, including how to best take them off and wash them. It is also recommended to put up signs in visible places in facilities, especially entrances, to inform parents about these and other strategies to stop the spread of COVID-19. Additionally, the center's staff should be prepared psychologically to provide the service while applying social distancing, to overcome fears of infection, and to equip children to understand the changes in routine and other differences or one-time situations that arise at the center.
- (viii) **Providing tools to help children understand these changes in routine**. Programs can develop play-based and educational materials or use [existing](#) ones to explain the importance of physical distance, of the use of masks by adults, of being in contact with fewer children, or of doing fewer activities, or of doing activities differently than usual, among other topics.
- (ix) **Providing tools to help children understand the loss of a family member**. Evidence shows that even two-year-old children are aware of changes in their surroundings and react to distress in their environment. Also, children's understanding of disease, loss, and death evolves over the course of childhood, and it is important that children and caregivers experiencing this type of situation be given special support.
- (x) **Staying in ongoing contact with parents** through consistent, clear, and transparent communication. Parents need to be familiar with the steps taken and changes made by the center and understand the reasons for them. At the same time, it is important to

³ Many programs set this limit at 10 people per classroom (including children and adults) for preschool and 5 to 8 for daycares for children under age three (3 to 6 children per classroom/group).



understand their fears and worries and respect their decision to not bring their child to the center. Cooperation with parents is crucial.

Other key recommendations to consider include protocols for transporting children to and from schools—since using public transportation is generally unadvisable—and for informing authorities and families when children display symptoms and or taking them home in that situation.

There are many unanswered questions about how to begin reopening day cares and preschools, partly due to limited knowledge about children's potential to transmit the virus (see Box 1). There is also much uncertainty regarding the degree to which centers can put into practice all or most of the health and hygiene measures recommended for safe reopening. There should be room to depart from these measures as required based on centers' contexts and capabilities, especially if it is found that young children are rarely a vector of transmission. In any case, it seems reasonable to move towards a gradual reopening process with a mix of in-person and virtual services, starting in low-risk areas where the disease's spread is under control such as in the countryside, to take the example of Uruguay. That said, rural areas are often where it is most difficult to follow reopening protocols, given their weaker physical, technological, and staffing infrastructure.

There are also many uncertainties related to 'reopening' parenting programs, whether this means returning to full, in-person service or hybrid schemes that combine in-person and virtual aspects. As more evidence comes in about the infection rate in children and their role in transmitting the virus, as compared to adults, epidemiological models can be designed to help determine the relative risks of home visits—done by educators who go from house to house—or group meetings attended by various caregiver-child pairs. Applying social distancing in a group environment with children who are crawling or walking could be very difficult, but it might be a more viable option with pregnant women and children under 6 months. In any case, it seems wise to plan to limit the frequency of interactions and space them out as much as possible, by meeting every two weeks instead of every week, for example. Another prudent measure would be to hold meetings in open spaces (home visits in entryways or patio areas, if possible, or group sessions in a park, plaza, or sports field). It is also recommended to properly inform and prepare staff, teaching them the hygiene measures to take before contact with a new family (hand washing, correct use of masks and other personal protective equipment); giving them the right tools to help children and their families understand changes in routines or disease and loss; and providing them with psychological support to cope with the anxiety caused by their job's risks and by working under such unusual circumstances.



An opportunity to strengthen the implementation of early childhood services at scale

This note opened with a brief overview of COVID-19's potential short-term effects on children and how they could lead to a loss of human capital, wider development gaps for children, and more pronounced inequalities. Studies tracking people conceived (or in utero) during pandemics, natural disasters, and famines (for example, the 1918/19 influenza pandemic or the 2010 Chile earthquake) show that children can suffer lifelong negative consequences as a result of these shocks.

According to forecasts by the [Inter-American Development Bank \(IDB\)](#) and [ECLAC](#), the global economic crisis could last until 2021 in the best of cases. This will affect children since the economy will not immediately bounce back after quarantine measures are lifted. In practice this means many children will fall into or spend their early years in poverty or extreme poverty, causing negative repercussions throughout their lifetimes.

But despite all its grim consequences, this crisis also offers an opportunity to transform how early childhood services are provided in the region. For example, the shift in curricula towards more simple and versatile content that uses readily available household items, that can be easily integrated into household routines, and that places more importance on the role of the caregiver in the home (including aspects that promote their sense of self-sufficiency and emotional self-care) can open the way for these actions to reach and be accepted in more diverse geographical areas and communities.

Changes in how childcare centers and preschools are organized and equipped in order to maintain physical distance, and especially smaller group sizes and student-teacher ratios, can help improve the engagement and attention children receive and, as a result, enhance the nature of interactions. In the same vein, stricter protocols for processes, routines, and group management and organization as facilities reopen could also increase efficiency and improve transitions between play and learning—another element identified as key to improving the quality of interactions between teachers/caregivers and children.

Similarly, designing mass media implementation protocols could provide an opportunity for these services to reach more vulnerable groups, such as rural and dispersed rural populations, indigenous groups, and other groups with limited internet access. In addition, some countries in the region are making a push to improve connectivity and access to internet and platforms. This technology can be leveraged to provide more efficient early childhood services by, for example, reducing the frequency of contact with parents or having professionals monitor and handle specific issues (violence, mental health) over the phone. Technology can also be used to effectively provide virtual training to caregivers and educators, not only on how to use technology to move their work with children or classes online, but also on how to provide good emotional support specifically for this moment in time. These trainings can be enhanced by online professional guides to support caregivers and educators in this process.

To conclude, the novel coronavirus may impact the development of children in the region—by driving up poverty rates, limiting access to basic services, and undermining caregivers' mental



health—and, even worse, it could also slow or even reverse the major progress the region has made in recent decades. The government, the private sector, and civil society urgently need to act to mitigate the impact this will have on populations. Our aim is for this crisis, despite its negative effects, to become an opportunity to design and provide services that help build societies that are more equitable and more resilient to future crises. Thus, the current context could be taken as a chance to create a roadmap for the effective implementation of services at scale in a post COVID-19 world, as described in the preceding paragraphs.

The IDB's early childhood team is working with countries to develop strategies to support programs and is adapting materials and tools that proved effective prior to the pandemic to the current situation. It is crucial that these contents and strategies reach those who need them the most and, to achieve this, countries will have to work together and constantly compare notes on challenges and innovative solutions. To facilitate this work, we have set up a [COVID-19 web portal](#) with information on the status of services in the countries, links to materials and resources that are already developed and in use, and reopening/operation protocols and guidelines. Together we must give priority to protecting and supporting children and their caregivers during the COVID-19 response and recovery to mitigate this crisis' negative impacts on children in the region.

