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Editorial

COVID-19, Health Inequities, and Behavioral Health Issues Facing Children

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The SARS-CoV-2 outbreak, resulting in school closures and social isolation orders, caught school children and parents by surprise, mildly leading to behavioral health issues (1). Ironically, even the public health, healthcare, and scientific communities around the globe were caught flat-footed. Despite claims of preparedness by public health agencies worldwide, mortality and morbidity statistics reveal a different story of a poorly prepared workforce and inadequate infrastructure in dealing with COVID-19. In addition to the more than 661.5 million confirmed cases of COVID-19 and the more than 6.7 million deaths directly attributed to it (2), excess deaths from COVID-19 as a contributing factor are estimated at 17.7 million (3). However, these statistics hardly reflect the true extent of the COVID-19 disaster, which has also exacerbated social determinants of health, resulting in health disparities (4).

At the beginning of the pandemic, many argued that SARS-CoV-2 was an equal opportunity offender, meaning that it treated people of all backgrounds equally, including rich and poor, urban and rural, employed and unemployed, young and old, literate and illiterate, and homeowners, renters, and homeless. The argument appears convincing at first glance. Statistics; however, show that vulnerability to infection, hospitalization, and mortality varies by population subgroups, with some ethnic groups and the socially vulnerable experiencing greater vulnerability. For instance, in the United States, the risk of COVID-19 mortality is 2.3 times higher for Hispanic or Latino persons, 2.4 times higher for American Indian or Alaskan Native persons, and 1.9 times higher for Black or African Americans, compared to persons who are non-Hispanic White (5). Almost all of the risk factors for infection are a result of long-standing inequalities and inequities. A utopian world would have infection rates and poor, but in reality, systemic inequities, structural biases, and "isms" are very prevalent. These inequities and biases lead to inequitable distribution of socioeconomic factors that determine people's health, which are called "social determinants of health." The era of COVID-19 has brought unequal risks to people's ability to avoid infection and, if infected, to avoid infecting loved ones, friends, coworkers, and others.

Although children were less susceptible to infection (6), they remained at the lowest level among the socially vulnerable, considering the indirect negative effects of COVID-19. Several socio-economic disadvantages of parents as a result of COVID-19 were proximate determinants of poor behavioral and physical health of school-age children. These vulnerabilities led to poor COVID-19 outcomes for parents without child support, overcrowded homes, a lack of social support when parents or children are infected, and blue-collar employment as essential workers. During school closures, children had to stay home and were overwhelmed by parents' stress in dealing with the devastation of job loss, food insecurity, and school closures. Children who observe suffering parents and siblings tend to stress, anxiety, fatigue, and behavioral health issues. Socio-economically disadvantaged parents lack the knowledge and social support to protect their children against secondary infection. The other extreme was overprotective parental anxiety and the resulting "helicopter-parent effect," which strictly enforced social isolation from peers and relatives. Such isolation and obsessive control over children's movement during COVID-19 became a significant source of stress and anxiety among them (7).

Children in poor socio-economic families were

more severely affected. For instance, financially disadvantaged parents may have lived in crowded homes and worked in an industry where telework is not allowed and their jobs require close contact (8), so they were not able to exercise social distancing. Further, infection tends to spread rapidly through shared air conditioning among people with poor housing conditions, exposing children to the avoidable risk of infection. Also, children of some parents with a lack of health education and knowledge of COVID-19 often did not believe in isolation and allowed them to engage in social activities conducive to the spread of CoV-02 infection. The stress of hiding a positive COVID-19 result due to the social stigma associated with the disease exacerbated behavioral health issues for some ethnic minorities, as they were reluctant to test and report their contacts when they tested positive for CoV-2.

As a result of the pandemic, many unanticipated effects of COVID-19 on students occurred, and the resulting deaths left many children orphaned and socially vulnerable. A study by Hills and colleagues estimated that 10.5 million children lost parents or caregivers and 7.5 million children experienced COVID-19-associated orphanhood from the start of the pandemic to May 2022 (9). Although Covid-19 deaths have declined in developed countries, the death toll is four times higher in low-income countries compared to high-income countries and about a third of the world's population remains unvaccinated, causing the continuation of orphanhood due to COVID-19 (10). The pandemic also led to many school closures around the world, which, as part of a broader social lockdown, caused adverse mental health symptoms and health behaviors among children and adolescents. On average, children reported symptoms of anxiety and trauma above the population threshold, decreased life satisfaction, and low well-being scores. There have also been reports of a decrease in physical activity, an increase in screen time, an increase in the number of meals eaten per day, and a rise in childhood obesity rates among young children during school closures (1).

Conflict of Interest

The authors of this manuscript declare no relationships with any company whose products or services may be related to the subject matter of the article. Gulzar H. Shah is a member of the editorial board.

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