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Adverse childhood experiences should be priority in global response to COVID-19

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Abbreviations: ACEs- Adverse Childhood Experiences

Contributors' Statement Page

Dr. Berhe W. Sahle conceptualized the study, drafted the initial manuscript, and reviewed and revised the manuscript. Dr Richard and Prof Renzaho have provided critical revision of the manuscript for important intellectual content.

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We read your editorial[1] and accompanying letter[2] with interest. Children are at low risk of novel coronavirus disease 2019 (COVID-19) infection and tend to experience a milder clinical course and a very low risk of death. [3] Despite the low risk of COVID-19 to children, their risk of exposure to adverse childhood experiences (ACEs), such as childhood maltreatment, household dysfunction, maladaptive parenting, violence and economic adversity, has substantially increased due to the social, financial and psychological consequences of the ongoing COVID-19 pandemic.

Mass unemployment has an adverse impact on the health, financial and social circumstances of workers, families, and communities. Globally, the number of people

reporting depression and anxiety symptoms spiked after the lockdown. Financial hardships and stress from confinement increase the risk of suicide, alcohol abuse, divorce and conflict, domestic violence, mental illness, negative parenting practices and loss of social support networks. The rates of domestic violence and alcohol misuse have increased substantially during the lockdown.[4] ACEs are linked with an increased risk of unhealthy lifestyle behaviours, obesity, suicidality, and chronic diseases, including mental disorders and cardiometabolic outcomes across the life course. [5] About 30% of all mental disorders are attributable to ACEs, including 30% of cases of anxiety, 40% of cases of depression, and 67% of lifetime suicide attempts. [6]

The COVID-19 pandemic has led to a further increase in the burden of ACEs. Even after the global pandemic wears on, it is likely that the health impact of ACEs will continue across the life-course. Unfortunately, at present, there is no systematic approach to the prevention of exposure to ACEs or identification of those exposed to ACEs who are at increased future risk of poor health outcomes. ACEs are diverse and their impact on health and well-being are multifaceted, involving a complex interplay of many biological and behavioural pathways. As a result, preventing and responding to ACEs requires integrated, system-wide, multisectorial approaches to effectively prevent and mitigate the negative impacts of ACEs. Addressing the underlying social determinants of health such as socioeconomic adversity, unemployment, and/or poor and unsafe housing and living conditions could have the largest population level impact on ACEs. Evidence-based parenting and home visiting programs reduce ACEs and global psychopathology. Comprehensive community-wide programs have been shown to reduce child maltreatment and build community-wide resilience. Vulnerability to the impacts of COVID-19 and availability of resources and readiness to respond to the COVID-19 pandemic varies across countries. Addressing access barriers to health and social services, especially among disadvantaged families will be essential to the early detection and responding to ACEs. As such, our response to COVID-19 should consider the socioeconomic, cultural and political context of the affected communities.

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