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# Children during the COVID-19 pandemic: children and young people's vulnerability and wellbeing in Indonesia

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## ABSTRACT

This Viewpoint discusses the impact of the COVID-19 pandemic, and the Indonesian government's response, on children and young people. By adopting a geographical and socio-spatial analysis the paper discusses the extent to which the response to the crisis has aggravated the detrimental impacts of the emergency on children. We argue that the government's decision to transition to the 'new normal' was premature, endangering marginalized children who have less power, weaker voices, and a lack of access to the necessary resources to protect themselves. The paper focuses on children's vulnerability and inequality during the crisis, and demands careful consideration for the governance of emergency response and recovery policies in the future.

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COVID-19; children; child protection; child vulnerability; child wellbeing; Indonesia

## Introduction

This Viewpoint outlines the impact of COVID-19 on children and young people in Indonesia during the first ten months of the pandemic. Although it is well documented that globally children are less at risk than adults from COVID-19 infection, we argue that children and young people in Indonesia are at an increased risk from the pandemic because of the precarious circumstances and socio-spatial contexts in which they live. Children make up a third of Indonesia's population with many of them experiencing escalating levels of poverty and increased marginalization, as well as a lack of access to formal social protection programmes or well-resourced health systems. From a geographical perspective the risks Indonesian children are facing during the pandemic are closely connected to where they live and how the infectious disease affects their caregivers, families, peers, and communities. Children also bear the socio-economic consequences related to school closures and other social restrictions. By adopting a socio-spatial analysis this paper discusses the extent to which the pandemic and the Indonesian government's response to the crisis has impacted children, in different geographical locations.

While acknowledging that the situation is continually changing, the paper first provides a situational analysis of the pandemic in Indonesia, until early 2021. This overview is followed by a summary of the socio-spatial dimensions of COVID-19, and how children's existing vulnerabilities have been accentuated by the pandemic and the government's response. The Viewpoint concludes by making policy recommendations aimed at alleviating the vulnerabilities experienced by Indonesian children and young people during and after the pandemic.

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This evidence-informed Viewpoint reflects the ongoing situation in Indonesia related to COVID-19 in 2020/21, synthesizing findings on children's vulnerability during the global outbreak. The article draws on available data sources, including the World Health Organisation (WHO), Our World in Data (University of Oxford), the Indonesian Public Health Experts Association (IAKMI), data published by the Government of Indonesia, and recent journal articles, media reports and anecdotal accounts, to provide an assessment of the pandemic's impact across the nation. The Viewpoint is also informed by relevant policy papers to which the two lead authors have contributed (Bappenas, PUSKAPA, UNICEF, KOMPAK. 2020). By building on these available resources, the paper provides an assessment of the pandemic's impact on children and young people's well-being during the crisis. In particular, the paper employs geographical and socio-spatial perspectives to unpack the implications of the COVID-19 pandemic on children and young people in marginalized communities, in different geographical areas.

## The COVID-19 pandemic in Indonesia

The Republic of Indonesia in Southeast Asia is the world's fourth most populous country, with over 267 million living in the world's largest archipelago (BPS 2019). More than 56 percent of the population live on the main island of Java. In 2019 approximately 31.56 percent (84 million) of the Indonesian population were children defined as 0–17 years of age (BPS 2019). Indonesia is a rapidly urbanizing nation with almost 56 percent of the population living in urban areas (BPS 2019). The capital city Jakarta has a population of 10.8 million, while the nation has one of the largest rural populations in the world (Roberts, Sander, and Tiwari 2019).

Indonesia announced the first two cases of COVID-19 on 2 March 2020. Although initially reluctant to report the growing number of infections as it wished to protect the economy, by May 2020, the Indonesian government had banned all domestic flights and internal migration. The government also imposed large-scale 'social restriction' measures, including the closure of businesses and shops in cities. The two measures were imposed for a couple of months. Individuals were encouraged to 'stay at home', while the government rolled out social protection programmes (cash transfers and staple food) to cushion the impact for the poor and unemployed.

Indonesia currently ranks 19th in the world for COVID-19 cases and is one of the worst affected countries within the Southeast Asian region (WHO 2021; Tempo 2020). Since announcing the first positive cases in March 2020, the nation has officially recorded over one million positive cases, with a growing daily infection rate of over 12,000 a day (WHO 2021; Ratcliffe and Cahya 2021). By early February 2021, 29,998 people had officially died from the virus (Ratcliffe and Cahya 2021; WHO 2021). COVID-19 cases have been confirmed in all of Indonesia's 34 provinces, exposing local governments to a variety of geographical and infrastructural challenges. The country has also recorded a worsening national positivity rate of between 27 and 28 percent which is far higher than the 5 percent WHO guidelines as a safe level to lift restrictions (The Jakarta Post 2020b; Ratcliffe and Cahya 2021). In addition to a high positivity rate, Indonesia's testing capacity remains extremely low at 0.05, making it hard to predict the actual number of positives (Lindsey and Mann 2020; Emont 2020).

It is suspected by many health experts that the official COVID-19 death rate in Indonesia is understated, and much higher than reported. Evidence to support this assumption has been a spike in the number of burials in Jakarta, with a 61 percent increase during the first 10 months of 2020, indicating that the death tally was much higher than official data shows (Allard, Kapoor, and Widiyanto 2020; Lamb 2020). Although Indonesia recorded its first case of COVID-19 in March 2020, a recent study has shown that deaths began to surge in January 2020, suggesting the virus was circulating from December 2019 (Lamb 2020). Further to this, hundreds of those who have died were not tested. The situation is compounded by the fact that Indonesia has no adequate system to report a death. A survey in 2016 revealed that only 2 percent of households who experienced a death in the past year had reported it to civil authorities (Kusumaningrum et al. 2016). Without

reliable statistics, therefore, it is difficult to provide an accurate projection on mortality rates associated with COVID-19. Even with the underreporting, however, Indonesia's COVID-19 case fatality rate (CFR) is above the global average, currently standing at 4.2 percent of those who tested positive for the virus (Roser et al. 2020). Indonesia also has among the world's highest COVID-19 death rates in children below the age of 17, with a CFR of 0.9 percent; 45 times higher than the United States at 0.02 percent (The Jakarta Post 2020c).

In addition to low testing and high positivity rates, Indonesia has an extremely ill-equipped health system, with only 1.4 hospital beds and 0.03 ventilators for every 1,000 individuals, and only 2.6 beds for every 1,000 people in most provinces (Bappenas, PUSKAPA, et al. 2020), at least at the beginning of the pandemic. Doctors and nurses are even more scarce, with 0.4 doctors for every 1,000 Indonesians (World Bank 2020), much lower than the Organization for Economic Cooperation and Development (OECD) average of 3.4 (OECD 2020). To date at least 647 health professionals have died from COVID-19 since the start of the pandemic, which is a higher rate than in the USA (Fachriansyah and Gunawan 2020; Ratcliffe and Cahya 2021). The growing number of cases and lack of adequate health facilities and resources has led senior health experts to warn of 'a collapsing healthcare system' (Sakriyah and Atika 2020). At the time of writing patients are being turned away from emergency rooms, with hospitals in some regions reportedly 'on the brink of collapse' (Ratcliffe and Cahya 2021).

### Socio-spatial analysis of the pandemic

From a geographical perspective the pandemic hit the urban areas hardest in Indonesia with the cities of Jakarta and Surabaya on the island of Java experiencing some of the highest infection rates. Within these cities unequal risks and exposures are inscribed in the way urban spaces are organized by the state. An estimated 22 percent of urban residents in Indonesia live in informal slums, accounting for around 29 million people (Roberts, Sander, and Tiwari 2019). In Jakarta, 35 percent of households live in overcrowded areas, with a lack of access to clean water and sanitation, adequate housing or open public spaces (Roberts, Sander, and Tiwari 2019). 28 percent of Jakarta residents live in houses with less than 7.2 m<sup>2</sup> per capita. At the start of the 'social restrictions' imposed by the government, families living in overcrowded *kampung* (informal urban neighbourhoods) were not able to practice social distancing within their communities. There was also limited adherence to the self-protection measures of mask, hygiene, and physical distancing modelled from global guidelines. This was particularly the case for those for whom food, shelter and a safe place to rest were more of a priority than ensuring social distancing, as it is the social density, social networks, and interaction that supports these communities.

Poor and marginalized communities that mostly depend on the informal economy rely on public spaces and facilities much more than other populations (Achmadi and Purdey 2020). Unlike middle class children who have limited dependency on their neighbourhoods, thereby making it easier for them to quarantine, children from poor communities and urban *kampung* rely on public and communal spaces such as streets, market, mosques, and schools for playing, interacting, and socializing, and also to earn money. However, the restrictions and physical distancing measures removed children from these spaces, confining them to their home (or neighbourhood) without alternative access for open and safe public spaces.

The pandemic hit the Indonesian economy hard, with a 5.3 percent reduction in GDP in 2020; the worst economic slump since the Asian Crisis of 1998 (Sparrow, Dartanto, and Hartwig 2020). Approximately 70 million Indonesians above 15 years old (55 percent) work in the precarious informal sector, including domestic work, motorcycle taxi, delivery services, street vendors and market workers (Octavia 2020). During the strictest 'social restriction' phase, many *kampung* imposed a filter system, allowing residents to exit the *kampung* to maintain their livelihood in the city, often in the informal economy. Without a workforce that usually flocks to offices and business centre areas, however, many street vendors and others in the informal economy found themselves

confronted with dire economic risks (Pudjianto 2020). A number of studies predict that the poverty rate in Indonesia will have risen from 9.2 percent by the end of 2020 (Lindsey and Mann 2020). Under the worst-case scenario the poverty rate will have increased to 16.6 percent with an additional 19.7 million people becoming poor, and a further 20 percent in danger of falling under the poverty line (Lindsey and Mann 2020; Suryahadi, Al Izzati, and Suryadarma 2020). An increase in extreme poverty can lead to other severe risks, including hunger, violence, exploitation, homelessness and mental illness among children (Bhabha 2020).

The extent to which COVID-19 has increased the number of children living in poverty is yet to be assessed. However, based on the literature on previous economic crises, two potential corollaries can be anticipated in the Indonesian context. First, as family's finances worsen, children in poor families are more likely to work to supplement their household's economy (Priyambada, Suryahadi, and Sumarto 2005; Manning 2000; Suryahadi, Priyambada, and Sumarto 2005). Families may also decide to give up schooling as a way to ease the family's economic burden (Manning 2000). Although the government has recently increased the amount of conditional cash transfers for families with school-aged children in order to keep them in schools, it is yet to be seen if such an increase is sufficient to offset the loss of income. Secondly, given that even before the pandemic a significant number of children were engaged in the waged economy, especially in the informal sector, it is anticipated that the economic contraction will impact on children. While a few forms of social assistance are provided to families regardless of their children's schooling status, substantial economic packages are only given to families with school-aged children who were in school before the pandemic, excluding children who do not live with their families or go to school.

Mobility and informal social arrangements have always been an essential feature of poor people's livelihoods in Indonesia, in the relative absence of government support, and the reliance on traditional practices such as providing mutual support have notably increased during the pandemic (Neilson 2020). For many migrants, rural areas, the agricultural sector, and subsistence farming are part of the informal safety net to which they return to when times get tough. This was also observed during the 1998 Asian financial crisis (Neilson 2020). For example, many hospitality workers from the tourism sector in Bali have taken up farming since the start of the pandemic (Laula and Paddock 2020). Community solidarity and civic participation is sustaining the community through the crisis, rather than government effective responses (Bennett 2020).

In July 2020, two months after announcing the 'social restrictions', the Indonesian government decided to lift them, a move termed by authorities as the 'new normal.' With few regulations or guidance, offices, businesses, and industries were told to transition to their pre-pandemic activities, albeit with some new ways of doing things, following minimal safety and public health protocols. After the return to the 'new normal', the state attempted to recategorize and reorganize spaces throughout the country, through epidemic risk mapping and the creation of different coloured 'zones'. These geographical zones went from green (COVID-19 free) through to yellow (low risk), orange (medium risk), and red (areas with high rates of transmission), depending on the reported level of infection in the geographical area. According to this zoning system, thirteen of the 57 high risk areas in the country were capital cities of provinces (Adjie 2020). The classification and zoning, however, was based on inaccurate data and low testing coverage, with little transparency regarding the process (The Jakarta Post 2020a). Furthermore, by basing the zoning solely on the level of infection, the government assumes all areas to have similar existing infrastructures, socio-economic characteristics, and healthcare capacity, once again disregarding pre-existing socio-spatial inequalities.

Despite the lack of confidence in the new zoning system, it has provided bureaucrats and employers with the opportunity to open schools and workplaces in low risk 'green zones.' In early August 2020, schools in yellow zones could reopen if the local government and the parents gave permission. This was despite daily increases of infections, and that pupils and workers may be travelling from orange and red zones, thus bringing infection with them. These policy actions were not without negative consequences, especially on children's protection and wellbeing. In

many places where schools reopened there was a surge in the number of infections among students and teachers (Widianto 2020). The zoning system, we believe, has created new geographies of risk, often borne by the most vulnerable among the citizens, including children. As parents are being forced to make daily assessments and arrangements for child-care, it is families who shoulder much of the excess of economic activities by trying to minimize and mitigate the risks of infection for all family members. As the polemical debate about schooling during the COVID-19 pandemic intensifies in countries around the world, it is fertile ground to interrogate the position of school in the current social and economic system, and to re-imagine its role in the post-pandemic world.

### Children's vulnerabilities during the COVID- 19 pandemic

When discussing the impact of COVID- 19 and Indonesian government policy on children in Indonesia, it is important to consider the impact of disasters on children's vulnerabilities more broadly. According to the Indonesian Centre for Child Protection and Wellbeing (PUSKAPA), child vulnerability can be defined as:

A condition that is disproportionately experienced by children due to a lack of access as a result of poverty, remoteness, mobility limitations, lack of responsiveness of public services, and exclusion based on age, disabilities, and social identities such as gender, religion, ethnicity, and sexuality. These vulnerabilities are often associated with a sudden shock or a gradual shift in social norms or structures (PUSKAPA 2019)

Children are often among those most at risk during a national emergency. Disaster events, including pandemics, also impact the mental health of children and young people, who are more likely to experience post-traumatic stress disorder, behavioural problems and depression (Peek 2008; Jia et al. 2010). Psychological trauma and emotional distress can be caused through family separation and death, separation from social networks, and abrupt changes to daily life, including enforced isolation and the inability to attend school or access an education (Chaimontree 2010).

Following Bhabha (2020), Adger (2006) and Smit and Wandel (2006), children's vulnerabilities during the current pandemic can be seen as the result of a number of interrelated factors associated with a sudden shock, including pre-existing structural inequality and inadequate access to essential support and facilities, underpinned by socio-spatial organization. Children's vulnerabilities are also caused by a gradual shift in social norms which are shaped by structures and regulations imposed by adults, including governments. In other words, children living in different geographical and socio-economic spaces experience a range of risks and vulnerabilities. These diverse geographies within Indonesia provide the stage on which the COVID-19 pandemic is set.

In the context of the pandemic, several causes of child vulnerability in Indonesia have been identified. First, children's physical health has been compromised by COVID-19, due to pre-existing health conditions, reduced access to health services, and limited options to practice physical distancing and hygiene. Children living in informal settlements such as urban *kampung* are often disconnected from government provision of clean piped water and sanitation systems (Roberts, Sander, and Tiwari 2019; Nastiti et al. 2014). As many *kampung* are built on wasteland including by the riverbank, floods and inundation are frequent, often leading to regular outbreaks of diarrhea and other water-borne diseases (Agustina et al. 2013; van Voorst and Hellman 2015). According to various reports, an unprecedented number of children (compared to other countries), including hundreds of newborns and those under 5 years of age, have died from COVID-19 in Indonesia, revealing weaknesses in the country's fragile health system. Paediatricians and health officials believe that the relatively high number of child deaths is due to underlying factors and comorbidities that have impacted their immunity, including diarrhea, dengue fever, tuberculosis, malnutrition, stunting and anaemia (Aljazeera 2020).

COVID-19 has also disrupted the supply chains for immunizations in Indonesia, leading to an anticipated spike in diphtheria, cholera, measles and polio in the future (UNICEF and Ministry of Health 2020). Even before the disruptions caused by the pandemic, the 2018 Indonesian Basic

Health Survey showed that the proportion of fully immunized children (12–23 months old) was a mere 58 percent. Logistics and the under-resourced health systems have been identified as some of the challenges in achieving universal immunization. Poverty may also be a factor (Efendi et al. 2020). Meanwhile, the government appears to be hinging its hopes on a Chinese made COVID-19 vaccine, CoronaVac. A promise of a total of 180 million vaccinations by March 2022 has dismissed the challenges related to the effectiveness and distribution of the vaccine (Barker 2021). Some health experts are doubtful about the vaccine's efficacy and are sceptical that two-thirds of Indonesia's population can be vaccinated within a year. There is also an increasing reluctance towards vaccination in Indonesia (Pronyk et al. 2019), including potentially toward COVID-19 vaccines (Harapan et al. 2020). Such complexities are intensified by socio spatial injustices in Indonesia. For example, marginalized populations including students living in communal boarding houses, transient and circular migrants, street connected children and homeless individuals or families, may be excluded from accessing a vaccination, even though they are at an increased risk of being exposed to the virus.

A second cause of vulnerability is that children are only as safe as the families and communities in which they live, as they are exposed to the same health risks and economic pressures. As previously mentioned, there is concern that economic pressure from COVID-19 will result in an increase in school drop-outs and a 'surge' in child marriage, both common tactics used by impoverished families to reduce economic burden (Susanti 2020). Further, any changes in a child's caregiving environment due to the pandemic – both as a result of a caregiver falling ill or having reduced mobility at home – may increase their vulnerability. From a mental health perspective the overwhelming amount of technical information about COVID-19 has induced anxiety in some children, accompanied with a failure by adults to address the emotional and psychological responses they may be experiencing (Dalton, Rapa, and Stein 2020). For many children there are limited social options or safe spaces to retreat to, especially for those living in an abusive environment, which could increase children's exposure to domestic violence or abuse (Jumo, Flanagan, and Pugg 2020). Significant limitations on movement and a lack of access to safe green and public spaces for a long period of time can also lead to physical and mental health issues, especially in cities (World Bank 2020). The pandemic with the imposed physical restrictions will exacerbate these risks.

Meanwhile, the services that usually support children are temporarily closed in Indonesia or cannot be easily accessed, with a decline in the responsiveness of drop-in centres and other support services for vulnerable children and young people. Some safe houses are no longer operating, and due to a lack of child-care arrangements NGO workers have been forced to stay at home to look after their own children. Consequently, many children's basic needs are not being met and there has been a limited or declining quality of services overall. This includes inadequate access to healthcare and nutritional services (as some *Puskesmas*/health centres have closed), education, child focussed NGOS, civil registration services, social assistance, and mental health services.

Marginalized children are also experiencing barriers to online technology through public-access computing. This is due to uneven digital landscapes that prevent children from low socio-economic backgrounds, and those living in rural and remote areas, from accessing the internet and related virtual spaces (Beltsazar 2020). Some of these online services come at a cost, including the ownership of devices, and credit cards or some sort of virtual payment, which vulnerable families often do not have access to. At the same time, access to the internet does not necessarily mean children are able to explore the virtual world productively and safely for their education, entertainment, access to information, social interaction, or self-expression.

There is limited information about how children living outside of family environments, in institutions or in precarious circumstances, are being affected by the pandemic. This includes street connected children, and children living in crowded conditions that carry greater risks of transmission such as detention and correctional facilities, religious boarding schools (*pesantren*), orphanages, and drop-in shelters. There have been reports that homeless children are occupying more marginal

urban spaces so that they are not arrested by police during the strict restrictions, which puts them at greater risk of sexual violence (Washington 2020). As elsewhere in the world, children in refugee communities, who are fleeing their countries of origin and awaiting resettlement by the UNHCR, are also at an increased risk (Bhabha 2020). As anecdotal evidence, the impact of the pandemic on an informal community-based school for refugee children in Java has been described as 'devastating' for the children and refugee community (email correspondence with co-author). Social distancing for refugee communities is impossible because they live closely together. The serious mental health concerns for refugee children and young people languishing in Java has been severely compounded by COVID-19, with little or no mental health support available to them.

In addition to accounts of children in refugee communities, there are reports that students of *pesantren* (Islamic boarding schools), are also at increased risk (Makruf 2020). Most children in *pesantren* come from low income families, who are among the hardest hit by the pandemic. Further, the live- in education in *pesantren* increases the risk of local transmission among boarders. It is difficult to transfer this type of education to online or virtual mode. In addition, most *pesantren* lack adequate infrastructure and facilities, including clean water and sanitation, as well as the financial capacity to mitigate the risks of local infection among their students and teachers (Makruf 2020). Another potentially vulnerable group are children of transnational and urban migrant workers. Information is scarce about the impact of the pandemic on these left behind children, although there are reports of migrant workers stuck in Malaysia and Saudi Arabia, unable to return home (Walden and Wijaya 2020).

Finally, there is an existing overarching system of discrimination in Indonesia, caused by incomplete and inaccurate data being used as the basis for the pandemic response, which excludes the most vulnerable. One example of this discrimination is when informal housing has been categorized as illegal by the government and not administratively recognized. As a result people living in informal housing have not been included in the disbursement of support packages (Rahardjo 2006). This social exclusion has created challenges, especially for migrants, to register themselves with local authorities and access social protection programmes. Spatial invisibility leads to administrative invisibility, which then leads to denial of rights and basic services, as without formal identification people are often denied the public provision of services. Further, an analysis of the 2019 Susenas reveals that due to Indonesia's suboptimal civil registration system over seven million children in Indonesia were unregistered at birth, with only 55 percent of under-one's births registered during the same period (BPS 2019). Consequently, millions of children exist without having been officially recorded on official databases, resulting in no access to formal government support programmes during the pandemic.

## Conclusion

The COVID-19 pandemic has produced and will continue to amplify vulnerabilities among children who are poor, invisible, and stigmatized, as well as those who have limited access to services and who are suffering from discrimination as a result of their identity and social status. Community strength, civic participation, and solidarity are among the positive responses in Indonesia's ongoing battle against COVID-19. However, the scrambled health, protection, and population data systems urgently require reform.

There are some clear recommendations that have emerged from this Viewpoint, which can mitigate the impact of the pandemic on the most vulnerable, including children. First, the government must drastically increase its testing capacity and coverage, followed by a set of proper tracking, tracing, and safe isolation regulations, and the streamlining of case data management. The government needs to increase its capacity to care for the infected, including increasing the number of hospital beds, ventilators, and frontline workers, and equipping the latter with adequate skills and physical protection. There is also an urgent need to provide infrastructure that facilitates compliance with public health measures, and to ensure the protection of everyone, especially the most vulnerable.



Furthermore, it is essential that age, gender, and disability response mechanisms are put in place, to support children, women, elderly, and people with disabilities in need of special assistance during the pandemic.

Second, the government should strengthen its demands for individual compliance to social distancing regulations, by launching empathetic and strategic inducements to follow health protocols. Weaponizing truant officers with legal sanctions against violations should be the last resort. Instead, the government should design human-centred approaches to reward and promote compliance, while guaranteeing adequate basic needs to the most vulnerable families and communities is essential. Citizens can mobilize awareness to observe hygiene practices and wear masks in public, but the government needs to support communities with clean running water, adequate sanitation, safe public transportation, and sufficient supplies of food and medicine. The government also needs to expand and strengthen access to the internet and digital technologies for the poor and vulnerable, especially school children, while improving the quality of virtual services. Additional efforts around COVID-19 should include addressing the current gap in basic immunization programmes, maternal and child health services, family support, and counselling so that the services reach at-risk communities, including children and young people.

Third, the government must increase the scope and quality of the Government social protection and safety nets, especially basic services, health insurance schemes, and cash transfers, to ensure that they reach the most vulnerable. It is also imperative to develop a clear strategy to equitably and ethically distribute COVID-19 vaccines at no cost to the vaccine recipients.

Finally, there has been a dearth of documentation related to children's own perspectives during the pandemic, reflecting the general lack of attention to children's experiences during policy making and government planning. As discussed in this Viewpoint, the pre-existing inequalities embedded in Indonesian socio-spatial organization have had a direct impact on children's vulnerabilities which have been exacerbated by the pandemic. Furthermore, a lack of tailor-made responses for children during the pandemic has been partly due to the continued marginalization of children's views and experiences in policy formation and strategic planning (Freeman 2020). As in all disaster response planning, rights-based research with children is essential in the future, to ensure policy making and COVID-19 responses are appropriate for all children and their affected communities, and that their rights are not being violated in the name of protection. In the long-term, this means confronting and addressing the existing structural and socio-spatial inequalities underpinning social life, reorganizing spaces in a more equitable way, and ensuring that children and their well-being are put at the centre of government planning, as well as disaster mitigation and recovery discourse.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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