Global Climate Change and Children’s Health

Samantha Ahdoot, MD, FAAP, Susan E. Pacheco, MD, FAAP, THE COUNCIL ON ENVIRONMENTAL HEALTH

Abstract

Rising global temperature is causing major physical, chemical, and ecological changes across the planet. There is wide consensus among scientific organizations and climatologists that these broad effects, known as climate change, are the result of contemporary human activity. Climate change poses threats to human health, safety, and security. Children are uniquely vulnerable to these threats. The effects of climate change on child health include physical and psychological sequelae of weather disasters, increased heat stress, decreased air quality, altered disease patterns of some climate-sensitive infections, and food, water, and nutrient insecurity in vulnerable regions. Prompt implementation of mitigation and adaptation strategies will protect children against worsening of the problem and its associated health effects. This technical report reviews the nature of climate change and its associated child health effects and supports the recommendations in the accompanying policy statement on climate change and children’s health.

Global climate change is a leading public health threat to all current and future children. Rising global temperature, known as “global warming,” is causing major physical, chemical, and ecological changes in the planet. The term “climate change” is used in this report to include these broader effects. There is now broad consensus among the world’s leading scientific organizations and approximately 97% of climate scientists that these changes are the result of human-generated greenhouse gas emissions. Rising greenhouse gas concentrations and climate change are part of a larger constellation of change resulting from contemporary human activity. Exponential increases in human population, habitat transformation, energy production and consumption, and climate change are putting unprecedented pressure on the earth, resulting in physical, chemical, and ecological changes that are fundamentally altering the planet. These accelerating changes threaten the biological systems on which the life, health, and prosperity of all children depend.

There is wide recognition of climate change among scientific bodies, international agencies, and world religions, and it is important for pediatricians to be aware of the effects of climate change on the health and security of individuals, families, and communities. Children are a uniquely
vulnerable group that suffers disproportionately from these effects. Children also have a fundamental right to justice in a matter as essential as the condition of the planet on which they will live and raise their own children. Although uncertainties remain regarding risks and policy response, given the overwhelming scientific consensus on the cause and potentially irreversible harm associated with climate change, failure to take prompt, substantive action would be an act of injustice to all children.

Pediatric health care professionals should increase their understanding of the health consequences of climate change so they are able to recognize and anticipate climate-associated effects and serve as advocates for children in the development of mitigation and adaptation strategies to address this global challenge. The purpose of this technical report is to educate pediatricians on the current knowledge of climate change and its effects on children's health. Specific recommendations for pediatricians and governments are included in the accompanying policy statement from the American Academy of Pediatrics on global climate change and children's health.

CAUSES OF CLIMATE CHANGE

Climate is typically defined as "average weather" over a period of time, classically 30 years. Our climate system is a highly complex system of interactive components that evolves under the influence of variations in the earth’s orbit, internal dynamics, and external drivers such as volcanic eruptions and human-induced changes in land use and the concentration of atmospheric gases.

The climate has changed naturally throughout Earth’s history. The last ice age ended only about 14,000 years ago. At that time, the global surface temperature was 5°C lower than it is today. The temperature gradually warmed over about 5,000 years and then remained stable until about 100 years ago. At that time, human activities caused a rapid increase in CO₂ and other greenhouse gas concentrations in the atmosphere, and global temperature began to rapidly increase. Atmospheric CO₂ has increased from approximately 280 ppm before the industrial revolution to 400 ppm in April 2013, a level last reached approximately 3 million years ago. This increase is primarily a result of fossil fuel emissions, although deforestation also affects the earth’s atmosphere by reducing carbon storage in vegetation and changing land surface reflectivity.

Approximately half of the total CO₂ increase has occurred in the last 40 years. The heat-trapping nature of CO₂ and other gases has been recognized since the 1800s and can be demonstrated by simple experiments. Leading scientific organizations agree that increasing greenhouse gases are the major driver of current climate change rather than natural factors that caused changes in Earth’s past (see Figures 1 and 2).

NATURE OF THE GLOBAL PROBLEM

Rising temperatures are causing observed changes across a range of climatic indicators (see Figure 3). These include worsening heat waves, shrinking ice sheets, rising sea level, increased humidity, worsening of some storms, and more frequent and severe wild fires.

Warming of the planet is unequivocal. Each of the last 3 decades has been successively warmer than any preceding decade since 1850. The global average temperature (combined land and ocean surface) increased 0.85°C (0.65–1.06°C) between 1850 and 2012 (see Figure 4). Much of this increased heat
has been absorbed by the ocean.\textsuperscript{19} In the United States, average temperature has increased by approximately 0.83°C since record keeping began in 1895, most of which has occurred since approximately 1970.\textsuperscript{23} Limiting temperature rise to 2°C above preindustrial times has been envisioned by the Intergovernmental Panel on Climate Change as a goal to prevent the most damaging consequences on humans, food systems, and ecosystems.\textsuperscript{17}

Associated with this global warming is a worldwide shrinkage of glaciers, decreasing mass of the Greenland and Antarctic ice sheets, and diminished spring snow cover in the Northern Hemisphere. According to the Third National Climate Assessment, the frost-free season has increased in every region of the United States, with increases ranging from 6 to 19 days (see Figure 5).

Global sea level has risen by approximately 8 inches since reliable record keeping began in 1880. The rate of rise of the global sea level has also accelerated, and it is projected to rise another 1 to 4 feet by 2100.\textsuperscript{23} Relative sea level rise in different regions varies because of local changes in land movement or coastal circulation patterns.\textsuperscript{22} Glacier mass loss and ocean thermal expansion attributable to warming explain approximately 75% of the observed global mean sea level rise.\textsuperscript{19}

Warmer air has greater capacity for water vapor than cooler air. Increased water vapor in the atmosphere has contributed to an increase in heavy precipitation events in most regions, including the United States, where increases have been greatest in the Midwest and Northeast (see Figure 6). In some areas, prolonged record high temperatures have been associated with droughts, particularly in the southwestern United States.\textsuperscript{23} Heat waves have become more frequent and prolonged in many regions, and the number of extreme cold waves in the United States is the lowest since record keeping began.\textsuperscript{23} Other forms of severe weather, such as hurricanes in the North Atlantic, have increased in intensity since 1970, although causality remains uncertain.\textsuperscript{19} There has also been an increase in wildfire frequency, duration, and severity in North American forests.\textsuperscript{24}

Climate change is already occurring, and past and present emissions make some continued changes inevitable. However, projected levels of global warming, sea ice shrinkage, and sea level rise by the mid-21st century vary greatly for different greenhouse gas emission scenarios. Higher future emission levels will result in more warming and thus more severe effects on the natural world and human society and health (see Figure 7).\textsuperscript{23}

**EFFECTS OF CLIMATE CHANGE ON CHILDREN’S HEALTH**

Observed changes in temperature, precipitation patterns, sea level, and extreme weather events are bringing instability to the major determinants of human health. Children are uniquely vulnerable to these changes. Their immature physiology and metabolism; incomplete development; higher exposure to air, food, and water per unit body weight; unique behavior patterns; and dependence on caregivers place children at much higher risk of climate-related health burdens than adults.\textsuperscript{25} It is estimated that 88% of the existing global burden of disease attributable to climate change occurs in children younger than 5 years old in both industrialized and developing countries.\textsuperscript{26} Children in the world’s poorest countries, where the disease burden is already disproportionately high, are most affected by climate change.\textsuperscript{27} Climate change is currently affecting child health through increased heat stress, decreased air quality, altered disease patterns of some climate-sensitive infections, physical and mental health effects of extreme weather events, and food insecurity in vulnerable regions (see Figure 8). At present, the global health burden attributable to climate change is poorly quantified compared with other health stressors.\textsuperscript{24} Over
the 21st century, however, the negative health effects are expected to increase.

**Heat-Related Illness**

Extreme heat is the leading cause of environmental deaths in the United States, killing more people than hurricanes, lightning, tornadoes, and floods. The body’s heat regulation system is able to cope effectively with thermal stress within certain limits. However, extreme temperatures exceed the body’s coping capacity, resulting in heat exhaustion and heat stroke, and potentially death. Excess morbidity and mortality attributable to extreme heat have been well documented. As temperatures increase and heat waves become more frequent, longer, and more severe, illness and death from heat exposure are expected to increase.

The health effects of extreme heat have been shown to outweigh the benefits of milder winters. Research on the relationship between temperature and morbidity and mortality in children is limited. However, studies have shown a unique vulnerability of children younger than 1 year old to heat-related mortality. One study from the Massachusetts Institute of Technology found that by the end of the 21st century, under a business-as-usual scenario, infant mortality rate may increase by 5.5% in girls and 7.8% in boys because of heat-related deaths. This vulnerability is consistent with the immaturity of infants’ thermoregulatory systems.

Several studies have shown increased pediatric hospitalizations and emergency department (ED) visits during extreme heat events. The health effects of extreme heat have been shown to outweigh the benefits of milder winters.

US student athletes are a high-risk group for exertional heat injury. Of the estimated 5946 people treated for exertional heat injury each year in EDs in the United States from 2001 to 2009, more than one-third were teenage male athletes, most commonly football players. The Centers for Disease Control and Prevention report heat illness as a leading cause of death and disability in high school athletes, with a national estimate of 9237 illnesses annually, with football players at highest risk. This risk appears to be increasing. ED visits for heat illness increased 133.5% between 1997 and 2006, according to 1 study. The number of deaths from heat stroke in American high school and college football players has doubled in the past decade. Another subpopulation of children in the United States at risk for extreme heat are child farm laborers, of which there are more than approximately 120,000. Children may also be indirectly affected by heat illness in family members. The 1995 Chicago heat wave resulted in more than 650 deaths, and the record-breaking 2003 European heat wave resulted in an estimated 30,000 premature deaths. There is a >90% chance that by the end of the 21st century, average summer temperatures will exceed the most extreme temperatures recorded in many regions across the world. Increasing heat exposure is likely to reduce work capacity and economic and social development in heat-exposed jobs in vulnerable countries. Global lost labor capacity in peak months is projected to double by 2050 because of heat stress. Thus, excess heat may influence children indirectly.

**FIGURE 3**

Examples of the many aspects of the climate system in which changes have been formally attributed to human emissions of heat-trapping gases and particles by studies published in peer-reviewed science literature. For example, observed changes in surface air temperature at both the global and continental levels, particularly over the past 50 years, cannot be explained without including the effects of human activities. Although many natural factors have affected climate in the past and continue to do so today, human activities are the dominant contributor to recently observed climate changes. Figure and legend source: NCA.
FIGURE 4
Three different global surface temperature records show increasing trends over the last century. The lines show annual differences in temperature relative to the 1901 to 1960 average. Differences between data sets, reflecting choices in data selection, analysis, and averaging techniques, do not affect the conclusion that global surface temperatures are increasing. GISS, Goddard Institute for Space Studies; HadCrut, Hadley Centre and the Climatic Research Unit at the University of East Anglia; MLOST, Merged Land–Ocean Surface Temperature; NCDC, National Climatic Data Center. Figure and legend source: NCA.23

through effects on family health and financial security.

**Air Quality**

Asthma is the most common pediatric chronic disease, affecting 6.8 million, or 9.3% of American children in 2012.59 Climate change has been projected to increase childhood asthma via an associated rise in air pollutants, including ground-level ozone. Ozone is a potent lung irritant that increases asthma morbidity and mortality. It is formed in the lower atmosphere in the presence of heat and light from precursor molecules (oxides of nitrogen and volatile organic compounds) that are emitted during fossil fuel combustion. Higher surface temperatures promote the formation of ground-level ozone, even in the absence of increased precursor molecules.61

Because of their higher minute ventilation and time spent outdoors during the summer, children are the group most vulnerable to ozone.62 Exposure has been associated with asthma exacerbations, increased ED visits and pediatric ICU admissions for asthma, and increased risk of developing asthma.63,64 Ozone concentrations in the United States have been projected to increase by 5% to 10% between now and the 2050s because of climate change alone.67 Climate change–associated ozone elevations have already been associated with a significant health burden and related cost, and this burden is expected to increase with additional temperature rise.68 Climate change–associated increase in ground-level ozone may increase child asthma ED visits, with 1 study projecting an increase of 5% to 10% in New York City by 2020.58

Wildfires produce smoke that contains hundreds of chemicals, many of which are harmful to human health. These include particulate matter, carbon monoxide, and ozone precursors. Wildfire smoke travels for thousands of miles and can affect far-away regions. For example, forest fires in Canada in July 2002 resulted in a 30-fold increase in airborne fine particles in Baltimore, nearly 1000 miles downwind. Exposure to wildfire smoke has been estimated to cause 260 000 to 600 000 global deaths annually.70 Exposed children, both asthmatic and nonasthmatic, have been shown to suffer substantial eye symptoms and upper and lower respiratory symptoms.71 The 2003 wildfire in southern California resulted in a 25% higher rate of asthma admissions in 5- to 19-year-olds during the fire and a 56% higher rate after the fires.72 These data are consistent with other studies showing increasing numbers of respiratory ED visits and hospital admissions with exposure to wildfire smoke.73 Wildfire smoke also elevates harmful ground-level ozone concentrations.74

In 2012, 9% of American children suffered from hay fever.59 The ragweed pollen season in North America has lengthened by 13 to 27 days since 1995 because of delayed first frost and lengthening of the frost-free period, with greater increases in higher latitudes.75 In addition, ragweed allergen production increases in response to increased levels of CO2 and increased temperature.76 Pollen counts from ragweed grown in today’s approximate CO2 level are twice the level as for plants grown at CO2 levels of the previous century.77 Elevated pollen counts place a greater number of children at risk for allergy-associated asthma attacks.78

**Infectious Diseases**

Climate influences the behavior, development, and mortality of a wide range of living organisms, some of which have the potential to influence child health. Determining the effects of climate change on infectious diseases is complex because of the confounding contributions of economic development and land use, changing ecosystems, international travel, and commerce.92 Although many uncertainties remain, there is evidence of a climatic contribution to range shifts of some climate-sensitive infections, emergence of novel diseases, and projected increases in diarrheal illness in vulnerable regions. Diarrheal illness is a leading cause of child mortality across the world, with approximately 1.6 million deaths...
annually in children younger than 5 years old. It is also a major cause of morbidity in the United States. There are an estimated 2 to 19 million cases of gastrointestinal illness attributable to drinking water in the United States yearly, and more than 19,000 cases of foodborne illness were reported in 2013, the highest incidence occurring in children younger than 5 years old. In general, cases of bacterial gastroenteritis, including Salmonella, Campylobacter, Escherichia coli, Cryptosporidium, and Shigella, increase when temperatures are higher, although patterns vary by organism and location. There is reason to be concerned that these infections may increase because of rising global temperatures. An increased incidence of community gastroenteritis with higher temperature has been documented. By contrast, higher temperature and humidity during cooler months have been associated with lower rates of diarrheal illness and hospitalization attributable to confirmed or suspected viral pathogens.

Heavy precipitation and drought events have also been associated with increased gastrointestinal illness resulting from disruption and contamination of water systems. In North America, most documented waterborne disease outbreaks occur after extreme precipitation events. Heavy downpours are increasing in the United States, and additional increases in frequency and intensity are projected, thus raising the concern of increased associated gastrointestinal illness.

The risk of Vibrio infection is strongly influenced by climate. Cholera remains a major global public health threat, with an estimated 3 to 5 million cases and 100,000 to 120,000 deaths attributable to cholera yearly. Although any age group can suffer, young children in areas with endemic disease are most affected. High temperature plays an important role in the transmission dynamics of cholera.

Because of these effects, climate change has been projected to increase the burden of diarrheal illness, particularly in low-income regions already experiencing a large burden of disease. Climate change is projected to cause an additional 48,000 deaths attributable to diarrheal
disease in children younger than 15 years old in 2030, primarily in Asia and sub-Saharan Africa. In these regions, climate change has been projected to increase the burden of diarrheal diseases by approximately 2% to 5% in 2020.

Climate influences a number of vectorborne diseases that affect children across the world. These include malaria, dengue fever, West Nile virus, Chikungunya, Lyme disease, Rocky Mountain spotted fever, plague, hantavirus pulmonary syndrome, and Chagas disease.

Malaria is a significant cause of child mortality globally, with an estimated 482,000 deaths in children younger than 5 years old in 2012. The effect of climate change on human malarial disease is uncertain because of multiple confounding variables. Current research indicates that climate change effects will probably be limited to increased malaria suitability over the African highlands, where the population at risk is large.

Dengue fever is similarly a major global health concern. It is the most rapidly spreading mosquitoborne viral disease in the world. The World Health Organization estimates there are 50 to 100 million infections yearly, including 22,000 deaths, mostly among children. Climate, including temperature and humidity, has a strong direct and indirect influence on the dengue virus and vector, although many other variables also influence disease occurrence. Although dengue is primarily a disease of tropical and subtropical regions, outbreaks have occurred in the United States, including Texas, Florida, and Hawaii. How climate change will influence disease patterns remains incompletely understood.

In the United States, West Nile virus has been a growing threat since it first appeared in 1999. Although predominantly affecting adults, it is an important cause of central nervous infections in children and is probably underdiagnosed in the pediatric population. Temperature influences both vector abundance and rates of virus replication and thus disease transmission. A review of disease cases in the central and western United States between 2002 and 2004 revealed that disease always entered new areas during years with above-normal temperatures. Precipitation has also been shown to affect mosquito populations and prevalence of West Nile infections, although results have been conflicting. Additional research on West Nile ecology in the setting of climate change is needed.

According to the Centers for Disease Control and Prevention, Lyme disease affects approximately 300,000 Americans each year, with boys 5 to 9 years of age at greatest risk. Increased Lyme disease transmission risk in the northeastern United States in recent decades is probably related to multiple factors, including disease reporting, reforestation, and increased deer populations. Rising global temperatures may have co-driven the emergence of Lyme disease in northeastern North America and expanded its range to higher latitudes and altitudes in Europe. Higher temperature also increases tick development rates and may drive an increase in the risk of tickborne infections where they are already endemic. Temperature has similarly strong influence on the development of the Chikungunya virus and its vector mosquito. Shifting distribution of the vector and disease transmission from southern to northern Europe because of climate change has been projected.

As ecosystems change because of the climate, newly emerging infections may occur or increase. Coccidioidomycosis, or valley fever, is caused by the Coccidioides fungus, which resides in soil from the southwestern United States to South America. In regions of the United States where coccidioidomycosis is endemic, incidence of reported cases has increased substantially, from 2265 cases in 1998 to 22,401 in 2011. Of the cases in 2011, 2166 were in children younger than 19 years old. Although the reasons for
this increase are uncertain, environmental changes, including drought, rainfall, and temperature, as well as soil disruption by human activity, may be contributing factors. Similar concern for climatic influence on disease incidence exists for amebic meningoencephalitis caused by *Naegleria fowleri*, an amoeba commonly found in warm freshwater lakes and rivers. Minnesota reported its first case in August 2010, the third warmest for August in that region since 1891. This fatal case occurred 550 miles north of the previous northernmost reported case.

**Extreme Weather Events**

The unique health, behavioral, and psychosocial needs of children place them at unique risk from extreme weather events. The frequency of reported natural disasters has increased in recent decades. Three times as many extreme weather events occurred between 2000 and 2009 as did between 1980 and 1989. The scale of natural disasters has also increased because of deforestation, environmental degradation, urbanization, and intensified climate variables. Increased extreme events are predicted to increase the number of children affected by disasters from an estimated 66.5 million yearly in the 1990s to as many as 175 million per year in the upcoming decade. The greatest burden of these disasters will be borne by the world’s poorest children, who are up to 10 times more likely to be affected by climate change–associated disasters than children in higher-income families.

**Direct Effects**

Extreme weather events directly harm children through injury and death. The most common injuries after hurricanes include lacerations, puncture wounds, and blunt trauma. In the 24 hours after Hurricane Ike, there were more than 500 emergency cases presented to the Children’s Hospital in Camaguey, Cuba. Ninety-six of these patients needed admission, and 4 needed surgery.

**Indirect Effects**

The indirect effects of weather disasters on children are far reaching. Children’s biological and cognitive development occurs in the context of family, school, neighborhoods, and communities. Disasters can cause irrevocable harm to children through devastation of this broader social context.
Extreme weather events of the past decade have illustrated this potential for long-lasting harm to children through devastation of communities, institutions, and family stability. After hurricanes Katrina and Rita, more than 5000 children were separated from their families. More than 34 000 calls were made to a special hotline that the National Center for Missing and Exploited Children established after the storms, and the last missing child was reunited with her family after 6 months.133 It is estimated that 400 children and adolescents were rescued from flooded homes and that 11 000 children were placed in the New Orleans Convention Center and Superdome at some time. Between 200 000 and 300 000 children were evacuated and relocated, temporarily or permanently.140

Children displaced by Hurricane Katrina experienced an average of 3 moves per child. Some believe that a child needs 4 to 6 months for academic recovery after a move that results in a change in schools. In the year after Hurricane Katrina, displaced students in Louisiana public schools, on average, performed worse in all subjects and grades compared with other students. In addition, displaced students experienced a variety of problems related to attendance, academic performance, behavior, and mental health.133

Hurricane Sandy, the largest storm ever recorded in the Atlantic Ocean, caused a record high storm surge, damaged or destroyed more than 375 000 housing units, and resulted in an estimated $75 billion in damages. In New York City, 46.2 square miles had flooding, affecting more than 28 300 children younger than 5 years old.141 Mold growth in affected homes was a significant problem after the storm, placing inhabitants at risk for asthma exacerbations, cough, and wheeze.142

Recent weather events outside the United States have exposed the unique vulnerability of children, particularly in poor countries. In 2010, an unprecedented monsoon flood disaster in Pakistan affected more than 20% of the land area, killing more than 1700 and affecting more than 20 million people.143 The flood left more than 10 million people homeless, caused massive disruption to crop systems and health care, and placed more than 100 000 children more than 5 years old at risk for death from malnutrition.144 Children may be affected by infectious disease outbreaks that follow severe weather events. Measles, diarrheal illness, respiratory infections, and malaria can affect large numbers of survivors and displaced people.145 After Hurricane Katrina, 20 clusters of diarrheal illness were reported in evacuation centers in Louisiana, and approximately 1000 cases of diarrhea and vomiting were reported in Mississippi and Texas. Norovirus, *Vibrio, Salmonella,* and other pathogens were identified. Skin infections were also a problem. A cluster of 30 pediatric and adult patients with methicillin-resistant *Staphylococcus aureus* was reported at a Texas evacuation facility after Hurricane Katrina, as well as 24 cases of hurricane-associated *Vibrio* wound infections, with 6 deaths.146 Exposure to weather disasters, including hurricanes and flooding, has also been associated with adverse birth outcomes, including low birth weight and preterm delivery.147,148

**Food Security**

Agriculture has always faced the challenge of weather variability. However, altered agricultural conditions attributable to climate change challenge farmers’ ability to adapt. These include extreme heat and increased water demands; increased frequency of severe weather events, including drought and flood; sea level rise and flooding of coastal lands; beneficial impact of CO₂ fertilization of crops; and changes in crop nutrient content. Changes are also likely to occur in the number and type of pathogens and pests affecting plants and livestock, altered use of pesticides, damage to fisheries and aquaculture, and mycotoxin contamination.149-152

Elevated atmospheric CO₂ acts as a fertilizer and has been demonstrated to increase plant growth and water use efficiency in a wide range of crop species. However, these positive effects may not compensate for losses associated with heat stress, decreased water availability, weather extremes, increased tropospheric ozone, and changes in weed, insect, and disease dynamics.153 Extreme temperatures and rising ozone have been demonstrated historically as well as experimentally to cause severe losses in a range of crops, including wheat, maize, soybean, rice, and fruit.153-156 Changes in the yield of these major crops have significant implications for food pricing and availability for families across the world, including in developed nations.157

An emerging concern is the effect of increased atmospheric CO₂ on grain quality. Lowered protein content of the edible portions of wheat, rice, and barley has been demonstrated for plants grown under elevated CO₂ conditions. Decreases of 10% to 15% have been found in these grains when grown in CO₂ levels likely for year 2100 as compared with current levels.158 Nitrogen fertilization compensates for some but not all of this decrease. CO₂ enrichment has also been shown to lower concentrations of zinc and iron in wheat, rice, soybeans, and field peas. Roughly 4 billion people live in countries where 60% to 70% of dietary zinc or iron comes from these crops.159 Although understanding of these interactions remains limited, they carry serious implications for child growth and nutrition.151,160
Seafood availability and safety are also at risk from climate change. Marine ecosystems are changing rapidly, with warming of the ocean’s upper layers, ocean acidification, and declining oxygen concentrations.\textsuperscript{161} Many coastal communities depend on seafood as a protein source and a vital part of the economy. Projected changes in seafood production, including declines in tropical regions and increases in high-latitude seas,\textsuperscript{162} have significant implications for communities that have depended on seafood availability for generations. As marine ecosystems change in response to climate change, emerging infections are also a threat. For example, a 2004 outbreak of \textit{Vibrio parahaemolyticus} gastroenteritis was traced to Alaskan oysters, extending the northernmost documented source of this infection by 1,000 km.\textsuperscript{163} Climate also affects food safety. Mycotoxin-producing fungal contamination of legume and grain crops carries health risks for both humans and livestock.\textsuperscript{25} Climate is the most important factor affecting food contamination by these fungi. Industrialized nations with temperate climates, including the United States and Europe, may be at greatest risk from these toxins, because they will reach temperatures close to optimal for aflatoxin production. However, tropical countries may become too hot for fungal growth.\textsuperscript{164} Exposure to aflatoxin is associated with hepatocellular carcinoma, growth stunting, and underweight.\textsuperscript{165} Food safety may be affected by an increased need for pesticide use. Pesticide needs may increase as pest populations expand and migrate to new habitats because of temperature and precipitation changes.\textsuperscript{166} Additionally, the half-life of pesticides in soil has been shown to decrease with increased temperature.\textsuperscript{167} Increased exposure to these products could negatively affect children’s health.\textsuperscript{25}

The effects of these climate changes, and farmers’ ability to adapt, will vary greatly by region. Moderate warming (1°C–3°C by 2050) may benefit crop and pasture yields in temperate regions, and even small local temperature rise could decrease yields in tropical and semiarid regions. However, warming greater than 2.5°C, as projected for after 2050, would decrease yields in all regions.\textsuperscript{168–170} These effects on crops will occur simultaneously with an increased world population to 9.2 billion people by 2050 and the need to increase global food production by 50% to meet projected demand.\textsuperscript{171} Climate changes will cause substantial negative effects on childhood undernutrition and related child deaths in developing countries.\textsuperscript{24} Currently, undernutrition underlies nearly 3.1 million deaths of children younger than 5 years old worldwide and is responsible for 45% of the disease burden in this age group.\textsuperscript{172} Studies have projected a 7% to 20% increase in the number of malnourished children globally because of climate change.\textsuperscript{157,173,174} The regions with the greatest risk of child malnutrition are also those most vulnerable to crop losses attributable to climate change.\textsuperscript{175} Compared with a future with no climate change, an additional 95,000 child deaths attributable to malnutrition and an additional 7.5 million moderately or severely growth-stunted children have been projected for the year 2030.\textsuperscript{108}

It should be noted that the agriculture sector is itself responsible for approximately 22% of total global greenhouse gas emissions, 80% of which comes from livestock production.\textsuperscript{176} It has been recommended that animal food consumption in industrialized countries decrease to cut emissions to the level necessary to limit global temperature increase to 2°C.\textsuperscript{177} Animal food is a major source of vitamin D, calcium, iron, and protein intake for children in the United States. Recommendations regarding changes in intake to mitigate greenhouse gas emissions would need to account for child nutritional needs to prevent deficiencies.

### Mental Health

To date, literature on the effects of climate change and children’s mental health has focused on psychological aspects.### TABLE 1 Case Vignettes From 2007 Mental Health Patients

<table>
<thead>
<tr>
<th>Case Vignette</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>An 8-year-old boy was evacuated from floodwaters where he witnessed dead bodies floating by. He had persistent school problems while living in a Texas homeless shelter. After resettling in New Orleans, he was referred because of disruptive behavior in school. A 4-year-old girl who had been evacuated from New Orleans before the storm was separated from her parents for several weeks, during which details of her situation were unclear. She was referred from her preschool as an alternative to expulsion after she was reunited with her homeless family. It emerged that she recently had been prevented from setting her doll on fire. Mental health referrals from pediatricians included a 5-year-old with sleep disorder and panic attacks whose apartment and possessions were destroyed in the hurricane and a 4-year-old whose mother had died the year before the hurricane. After Katrina, she had nightmares and regressed functioning, and she was diagnosed with PTSD. A 7-year-old girl was rescued from the floodwaters by boat and placed in a shelter apart from her family. She had multiple cigarette burns when reunited with her family. In the first 2 years after the storm, she attended 5 different schools. Her symptoms included enuresis, hyperventilation, and self-injurious behavior. She was diagnosed with PTSD. A 7-year-old previously diagnosed with PTSD after an automobile accident spent 5 days after the hurricane in a hospital building without adequate food and water. He was evacuated to 2 different states. When he returned to New Orleans, he presented with nightmares and a depressive disorder. Other features of this referred population included animal cruelty, multiple school expulsions, and fighting that necessitated police intervention.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Olteanu et al (2011).\textsuperscript{187}
trauma related to weather disasters. High rates of posttraumatic stress disorder (PTSD) symptoms in children have been described after a number of natural disasters that may or may not be climate related. These disasters include hurricanes, floods, earthquakes, and other disasters. Providing immediate psychological support and family reunion, as well as rapidly restoring safety and security, are probably effective means of preventing traumatic stress reactions.

Hurricane Katrina had a profound effect on the mental health of children in New Orleans. Stories of children referred for mental health services in 2007 illustrate what children endured in that event and the lasting psychological harm that resulted (see Table 1).

Although child posttraumatic mental health problems typically decrease substantially within 1 year after disasters, the high rates of forced relocation and prolonged community disruption years after Hurricane Katrina probably delayed the typical pattern of recovery. In 1 study, serious emotional disturbance persisted in 11.5% of children and adolescents 3 years after the hurricane, compared with an estimated 4.2% prehurricane prevalence. Another study found PTSD symptoms in 46% of fourth through sixth graders 33 months after Hurricane Katrina.

In addition to PTSD, the indirect effects of climate change on children’s mental health should be considered. Economic security, social inclusion, and freedom from violence and discrimination are all crucial to mental health and well-being. These factors are uniquely important for children, whose lifelong health may be affected by early adverse social stressors. Through effects on the economic viability of communities dependent on agriculture and tourism, population displacement attributable to sea level rise and extreme weather, resource scarcity, and potentially increased violent conflict, the social foundations of children’s mental and physical health and well-being are threatened by climate change. These effects will probably be greatest for communities already experiencing socioeconomic disadvantage.

**SUMMARY**

“Climate change is the biggest global health threat of the 21st century.” This is the conclusion reached by The Lancet and University College London Commission on Climate Change in 2009. Climate change is not about a distant, unforeseeable future. It is about the world in which our children live today and the future in which they will raise their own children.

A new public health movement is needed to educate, advocate, and collaborate with local and national leaders regarding the risks climate change poses to children and the major health benefits associated with mitigation policy. In addition, ongoing research into the links between climate and health outcomes and the development of medical and public health interventions to protect individuals and communities from inevitable changes is needed. Pediatricians, as advocates for the population most vulnerable to climate change health effects, have a valuable role to play in this movement.

**LEAD AUTHORS**

Samantha Ahdoot, MD, FAAP
Susan E. Pacheco, MD, FAAP

**COUNCIL ON ENVIRONMENTAL HEALTH EXECUTIVE COMMITTEE, 2014–2015**

Jerome A. Paulson, MD, FAAP, Chairperson
Samantha Ahdoot, MD, FAAP
Carl R. Baum, MD, FAAP
Aparna Bole, MD, FAAP
Heather L. Brumberg, MD, MPH, FAAP
Carla C. Campbell, MD, FAAP
Bruce P. Langhein, MD, MPH, FAAP
Jennifer A. Lowry, MD, FAAP
Susan E. Pacheco, MD, FAAP
Adam J. Spanier, MD, PhD, MPH, FAAP
Leonardo Trasande, MD, MPP, FAAP

**REFERENCES**

2. Doran PT, Zimmerman MK. Examining the scientific consensus on climate change. Eos Trans AGU. 2009;90(3):22–23
overwhelming the great forces of Nature? Ambio. 2007;36(8):614–621


21. Arrhenius S. On the influence of carbonic acid in the air upon the temperature of the ground. Philosophical Magazine and Journal of the Sciences. 1896;41:237–276


40. Knobel R, Holditch-Davis D. Thermoregulation and heat loss prevention after birth and during neonatal intensive-care unit stabilization of extremely low-birthweight


73. Dennekamp M, Abramson MJ. The effects of bushfire smoke on


121. Morin CW, Comrie AC. Regional and seasonal response of the West Nile virus vector to climate change. *Proc Natl Acad Sci USA*. 2013;110(39):15620–15625


124. Morin CW, Comrie AC. Modeled response of the West Nile virus vector *Culex quinquefasciatus* to changing climate using the dynamic mosquito simulation model. *Int J Biometeorol*. 2010;54(3):517–529


128. Jaensson TG, Lindgren E. The range of *Ixodes ricinus* and the risk of contracting Lyme borreliosis will increase northwards when the vegetation period becomes longer. *Ticks Tickborne Dis*. 2011;21(1):44–49


135. Guha-Sapir D, Below R, Hoyois P. Natural disasters reported. EM-DAT: International Disaster Database,


144. Mooney H. More than 100,000 children under 5 are at risk of death in Pakistan. *BMJ*. 2010;341:c5288


168. Tubiello FN, Rosenzweig C. Developing climate change impact metrics for


# Global Climate Change and Children's Health

Samantha Ahdoot, Susan E. Pacheco and THE COUNCIL ON ENVIRONMENTAL HEALTH

*Pediatrics* 2015;136;e1468

DOI: 10.1542/peds.2015-3233 originally published online October 26, 2015;

<table>
<thead>
<tr>
<th>Updated Information &amp; Services</th>
<th>including high resolution figures, can be found at: <a href="http://pediatrics.aappublications.org/content/136/5/e1468">http://pediatrics.aappublications.org/content/136/5/e1468</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>References</td>
<td>This article cites 156 articles, 23 of which you can access for free at: <a href="http://pediatrics.aappublications.org/content/136/5/e1468#BIBL">http://pediatrics.aappublications.org/content/136/5/e1468#BIBL</a></td>
</tr>
<tr>
<td>Subspecialty Collections</td>
<td>This article, along with others on similar topics, appears in the following collection(s):</td>
</tr>
<tr>
<td></td>
<td><strong>Current Policy</strong> <a href="http://www.aappublications.org/cgi/collection/current_policy">http://www.aappublications.org/cgi/collection/current_policy</a></td>
</tr>
<tr>
<td></td>
<td><strong>Council on Environmental Health</strong> <a href="http://www.aappublications.org/cgi/collection/council_on_environmental_health">http://www.aappublications.org/cgi/collection/council_on_environmental_health</a></td>
</tr>
<tr>
<td></td>
<td><strong>Environmental Health</strong> <a href="http://www.aappublications.org/cgi/collection/environmental_health_sub">http://www.aappublications.org/cgi/collection/environmental_health_sub</a></td>
</tr>
<tr>
<td>Permissions &amp; Licensing</td>
<td>Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: <a href="http://www.aappublications.org/site/misc/Permissions.xhtml">http://www.aappublications.org/site/misc/Permissions.xhtml</a></td>
</tr>
<tr>
<td>Reprints</td>
<td>Information about ordering reprints can be found online: <a href="http://www.aappublications.org/site/misc/reprints.xhtml">http://www.aappublications.org/site/misc/reprints.xhtml</a></td>
</tr>
</tbody>
</table>