

Parenting amid COVID-19: Challenges and supports for families with young children in South Africa.

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Background. National response mechanisms, including lockdown regulations and financial and food aid, have exacerbated adversity and provided support. They have also exposed existing inequalities, with individuals and families able to cope and recover to varying degrees. Families with young children, specifically those under the age of 5, are rarely the focus of outreach, although they care for the most vulnerable group in our society.

Objective. To rapidly gather as much nationally representative information as possible on the challenges experienced by families with children under 5 years of age and the support they most urgently require.

Methods. A short online survey was launched in late 2020 on a zero-cost mobile application reaching over 2 million users. A total of 15 912 individuals were eligible for participation and 13 224 parents (caring for 18 858 children under 5 years) were included in the analytic sample. Outcomes were grouped by (a) negative impacts of the pandemic, including disruptions in childcare, missed clinic visits, feeding challenges, difficulties in showing affection, behavioural challenges, and violence in the home; and (b) support received and required by the family. Chi-squared tests examined outcomes across the socio-demographic variables and standardised adjusted residuals were calculated to measure strength of differences.

Results. Fathers made up 30% of the sample. Just over half of parents cared for one child under 5 and 41% for 2 - 3 children under 5. More than three-quarters (82%) of parents reported experiencing at least one challenge, with the most common being disruptions in childcare (69%), difficulties feeding their child (50%) and showing affection (41%). The main underlying factors were fear of infection, lack of money and negative affect in the household including stress, tension and a sense of hopelessness and depression. Fathers and families living in rural areas reported the most challenges. They were more likely to report difficulties showing affection, struggles in providing meals for young children, and higher levels of violence towards children in the home. Although needs considerably outweighed support received, government compared with civil society organisations and communities had the highest penetration of support to families, reaching between a quarter and a third of families.

Conclusion. Families with young children face many challenges with little outside support for their material and psychosocial needs. It is essential that those mandated with ensuring the wellbeing of young children understand the needs of families and have the capacity to reach them in general, and particularly during times of crisis.

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The COVID-19 pandemic presents direct and indirect threats to individuals, families and communities globally, with far-reaching consequences to their financial security, health and wellbeing. National response mechanisms, including lockdown regulations and financial and food aid, have exacerbated adversity and provided support. They have also further exposed existing inequalities, with individuals and families able to cope and recover to varying degrees.^[1] Compared with the elderly or chronically ill, children are not at as high a risk for morbidity and mortality from COVID-19,^[2] but they bear a considerable burden of missed opportunities, trauma and economic fallout during and in the aftermath of the pandemic.^[3] Global statistics have shown that most COVID-19-positive children eventually recover. But the impact of the social and other correlates of COVID-19 will have far-reaching and potentially permanent consequences, particularly for the youngest children.^[4-6]

The main aim of the present study was to rapidly gather as much nationally representative information as possible on the challenges experienced by families with children under the age of 5 years and the support they most urgently require. Some surveys have explored the impact of COVID-19 on households but none has been targeted

for the specific needs and challenges associated with caring for young children.

Methods

Study design

A short survey of up to 30 questions depending on response options was developed in English and translated into Sepedi, isiZulu, Afrikaans and Sesotho. The questions were programmed into RedCap,^[7,8] an online data collection platform managed by the researchers. A multinational technology company, biNu,^[9] which supports a data-free messaging platform, Moya, was contracted to reverse-bill the survey url to enable zero-rated data content. This ensured that participants carried no cost for the use of airtime to submit responses. The survey URL was posted to the Moya platform for a period of 96 hours. Responses to the survey were automatically uploaded to the Redcap's secure server for analysis by the research team. The study was approved by the University of Witwatersrand's Human Research Ethics Committee (ref. no. H20/06/38). More detailed information on the study methodology is available in a separate publication.^[10]

Participants

The Moya messaging application hosts 2.3 million daily active users across South Africa (SA). A notification for the survey was pinned on the app's interface and, once clicked, the user was directed to the survey's webpage. Moya's audience reach is 53% female, 69% aged between 18 - 35 years old, with 80% of members falling between deciles 3 and 7 on the living standards measure (LSM).^[11] Most members earn less than R15 000 per month, falling into low- and lower-middle-class groups.

A total of 44 292 participants clicked on the URL to the survey in 96 hours. Eligible participants were over the age of 18 years, cared for 1 or more children under the age of 5 years and agreed to participate. A small proportion of respondents who indicated that they cared for groups of children ($n=270$) were ineligible and 15 912 respondents were eligible.

The overall item completion rate was 52% with item non-response rates ranging from 25 - 50%. The analytic sample comprised all participants who answered each of the three demographic questions ($n=13 224$). The analysis was conducted per item for all participants who completed that specific item.

Main outcome measures

Outcomes were grouped by (i) negative impacts of COVID-19 and lockdown measures on caring for young children; and (ii) support received and required by families with young children. Negative impacts included missed clinic visits, disruptions in early childhood care and education services, feeding challenges, difficulties in showing affection to young children, child behavioural challenges, and violence towards children. Each outcome was indicated by a *yes* or *no* response, followed by a set of questions about reasons for an affirmative response.

Support received was assessed by asking participants to indicate whether they had received different forms of assistance from three sources – their family, neighbours and community, non-governmental organisations, and government agencies or departments. Options asking the type of help received followed each affirmative response. The final question asked what participants most needed from a list of material and non-material support to best take care of their young children and families.

Data analysis

Outcomes were compared across characteristics of parents and children to test for significant differences between and within groups using χ^2 tests. Standardised adjusted residuals (z) significant at Bonferroni-corrected levels are reported to interpret the significance between categorical variables.^[12] Standardised adjusted residuals are a measure of the strength of the difference between observed and expected values with those greater than ± 2 indicating significance and the size of the value indicating the relative contribution to the χ^2 value.

Results

Table 1 shows the characteristics of the sample which included 13 224 parents. Less than two-thirds (61.9%) of participants were mothers and 29.7% fathers. Moreover, a third of participants (32.7%) reported living in a city or suburb, 19.7% in a rural area, and the majority of participants in informal settlements or townships. More than half of participants (51.4%) reported caring for one child under the age of 5 years and 41% for 2 – 3 children under the age of 5 years. Overall, the sample represents 18 858 children evenly distributed between boys and girls, and between children under and over 3 years.

Adverse impacts and reported reasons

Less than a fifth (18%) of parents reported not experiencing any of the challenges assessed (Table 2). However, more than a third (47%) of parents reported one or two challenges, 29% reported either three or four, and 6.5% reported experiencing five or more of the challenges assessed.

The most common challenges were disruptions in childcare or preschool arrangements (69%), difficulties in being able to feed their child (50%), and difficulties in showing affection towards their child (41%). A third of parents (33%) reported difficulties in breastfeeding and 30% of parents had missed a clinic or healthcare visit. More than a quarter (28%) of parents found their young child more difficult to deal with and responded in various ways. Less than a third (31.2%) of parents perceived the behaviour change

Table 1. Sample description (N=13 224)

Characteristic	n (%)
Area of residence	
City or suburb	4 325 (32.7)
Township, informal settlement	5 824 (44.0)
Rural settlement, village, farm or tribal area	2 608 (19.7)
Other	467 (3.5)
Parent type	
Mother	8 189 (61.9)
Father	3 931 (29.7)
Caregiver [†]	1 104 (8.4)
Number of children under 5	
1	6 799 (51.4)
2 - 3	5 425 (41.1)
4 or more	1 000 (7.5)
Child age ($n=18 423$)	
0 - 6 months	2 101 (11.4)
>6 months and <1 year	2 269 (12.3)
>1 year and <3 years	4 994 (27.1)
>3 years and <5 years	9 059 (49.2)
Child gender (N=18 858)	
Boys	9 378 (49.7)
Girls	9 480 (50.3)

*Townships were created as segregated dormitory suburbs in urban areas to house African workers under apartheid and remain primarily under-served black areas.

[†]Biological or non-biological primary caregiver of the child.

Table 2. Frequency of adverse impacts reported

Adverse impact	n (%)
Missed a clinic appointment	3 920 (29.6)
Disruption in childcare or preschool arrangements	7 313 (68.7)
Difficulties in breastfeeding	510 (33.1)
Difficulties in feeding a young child	4 963 (49.9)
Difficulties in being affectionate to my child	3 831 (41.2)
Anger or violence towards a child	1 070 (11.9)
Child is more difficult to deal with	2 390 (27.6)
Number of adverse impacts reported	
None	2 110 (17.7)
1 - 2	5 594 (47.0)
3 - 4	3 421 (28.8)
5 or more	780 (6.5)

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as the child being naughty and responded with punishment, 52% tried to comfort their child or get someone else in the household to distract their child, and 32% said that they did not know what to do. More than a tenth (12%) of parents said that someone in the home had been angry and violent towards their child, most often another adult (64.1%), followed by another child (21.9%), and themselves (14%).

Reasons for reported challenges were condensed into three categories: fear of infection, shortage or lack of money and negative emotional states (Fig. 1). Fear of children being infected with COVID-19 was a substantial factor in the challenges experienced by families, with more than 40% of parents citing this as the reason for disruptions in their child's usual childcare or preschool (40.4%), missing a clinic appointment (46.6%), and difficulties in breastfeeding (42%). A fifth of participants reported being advised to stop breastfeeding their infant during COVID-19 by a family member (11.4%) or a doctor or healthcare professional (9%). A lack of finances was also a substantial driver for challenges, with 79% of parents reporting that they did not have money for enough food, 39% could not afford to maintain their child's childcare or preschool attendance, and 30% of parents could not afford to keep up with clinic appointments. Stress contributed to conflict in the home and this was the reported reason for difficulties in being affectionate towards a child. More than a third (38%) of parents cited feeling stressed and irritable, or hopeless and withdrawn (11%), 29% cited tension in the home, and 14% said it was a reaction to increases in their child's crying. The most common reasons for anger and violence towards a child were someone losing their temper and hitting their child (43.8%), the child breaking or touching something they were not supposed to touch (32.7%), and their child getting close to danger such as fire, poison or an open water source (16.2%).

Support received and support needed

The proportion of participants who reported receiving a specific category of support from various sources such as family/community, NGO and government are illustrated in Fig. 2. Family needs are plotted on the same chart. The largest unmet needs were financial support (35.1%), food aid (32.4%), masks, soap and sanitisers (17.9%), clothing and blankets (17.5%), and medicine (13.9%). Government support received was primarily financial (9.6%) and food aid (5.4%), and NGO support was largely food aid (5.1%). Families and communities were reported to provide a broader range of support to families including being the largest provider of food aid (6.8%), medicine (1.5%), masks, soap and sanitisers (3.8%), information (3.8%), and psychosocial support (3.5%). A small proportion of the participants surveyed (4.7%) indicated that they did not require any support.

Differences by area of location, parent type and child age

Table 3 shows the differences in reported experiences of challenges and Table 4 shows the differences in support received, both by area of location, parent type and child age. Families living in township areas ($z=8.493$) were significantly more likely to experience disruptions in their child's childcare or early child development (ECD) attendance compared with families living in cities/suburbs ($z=-5.668$) or rural areas ($z=-6.283$). Families in rural areas were significantly more likely to experience difficulties in showing affection to their young children ($z=2.764$) compared with families in cities/suburbs ($z=-3.697$) and townships ($z=1.932$), struggled with feeding their young children ($z=5.283$) compared with those in cities/suburbs ($z=-5.587$) and townships ($z=0.961$), and were more likely to have had someone in the household be violent towards

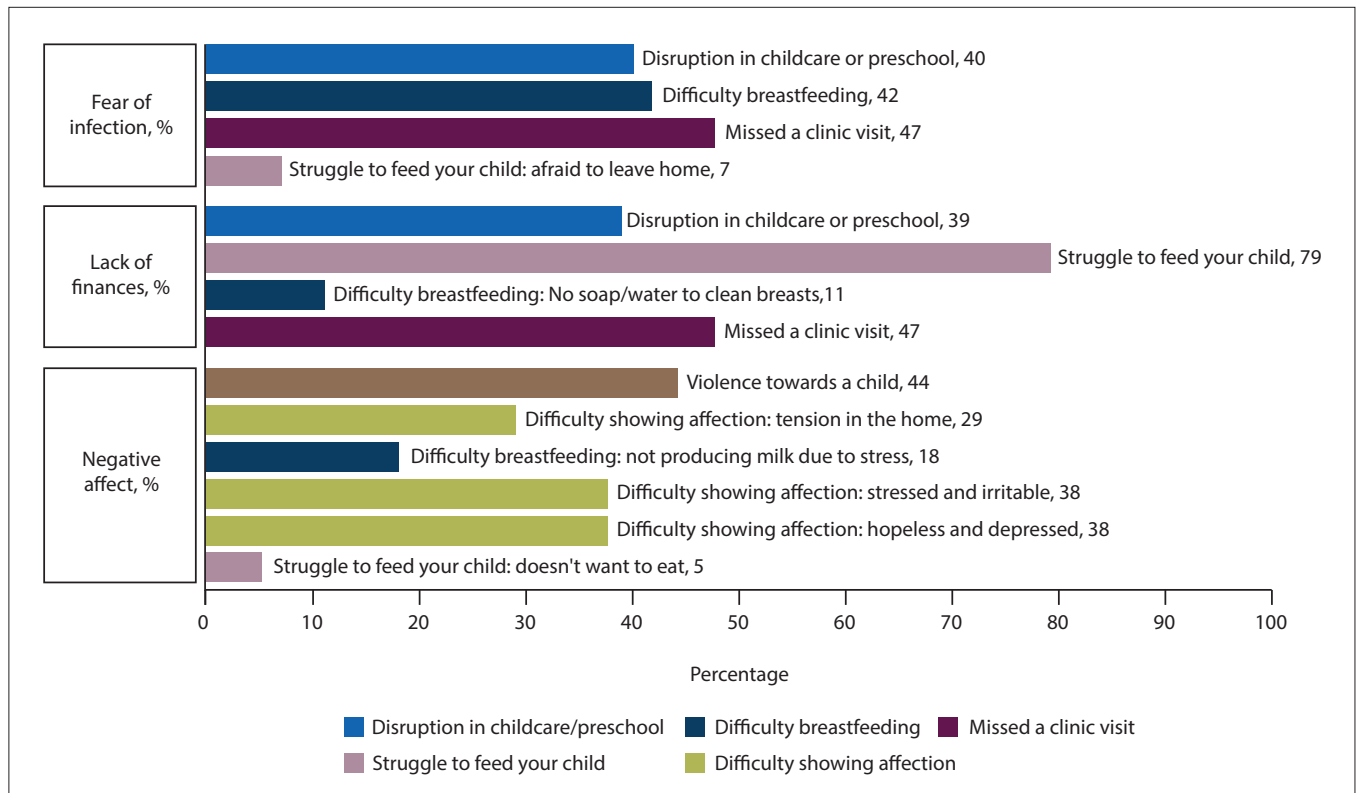


Fig. 1. Percentage of participants who attribute either fear of infection, lack of finances or negative affect as the reason for experiencing a particular challenge. Respondents may provide more than one reason for each challenge.

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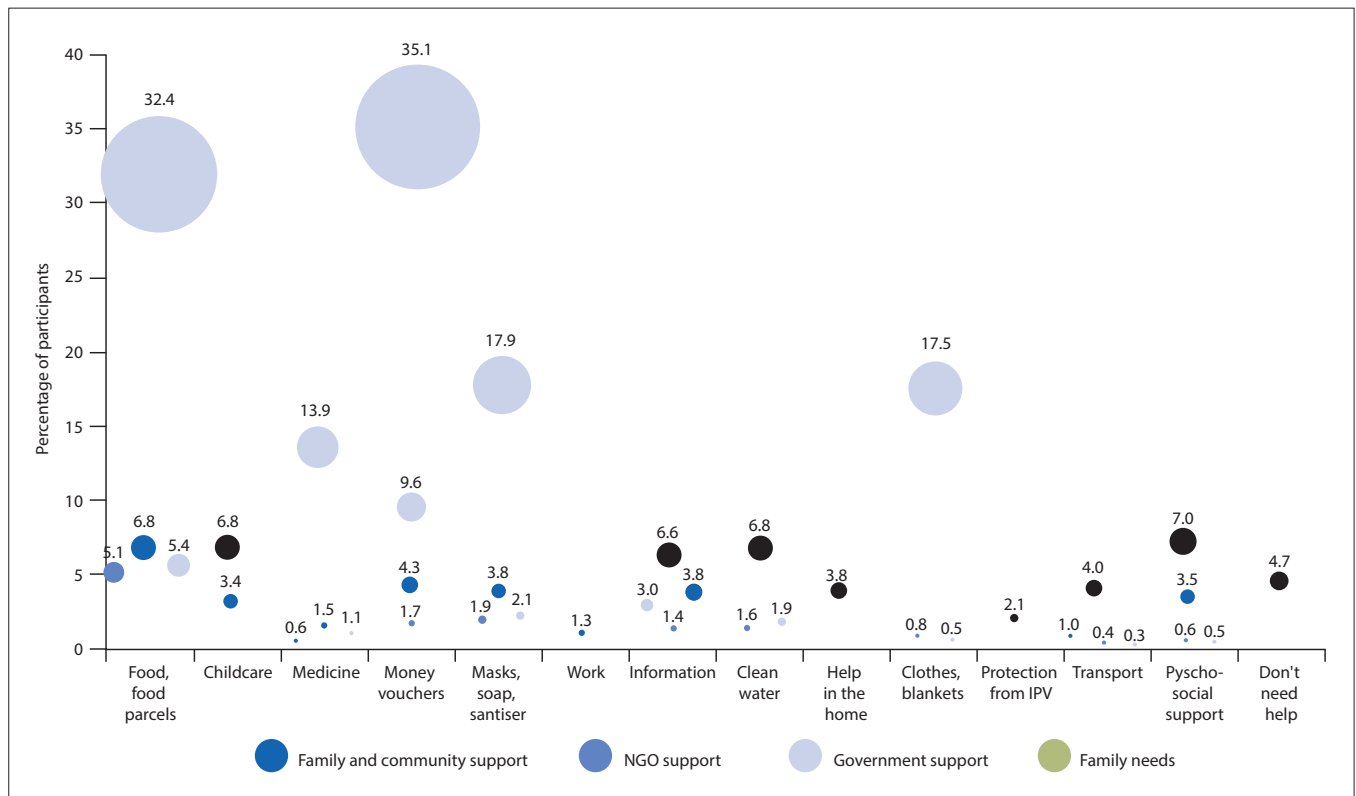


Fig. 2. Percentage of participants who report receiving support from each of the three sources – families/communities, NGOs, and government by category of support; compared with the percentage of participants who report a specific need. (IPV = intimate partner violence; NGO = non-governmental organisation).

Table 3. Differences in challenges experiences by area of residence, parent type, child age and child gender

	Missed a clinic visit n(%)	Disruption in childcare/ ECD attendance n(%)	Breastfeeding challenges n(%)	Feeding challenges n(%)	Difficulties in showing affection n(%)	Violence towards child n(%)	Child behavioural challenges n(%)
Area of residence	<i>p</i> =0.355	<i>p</i> =0.000**	<i>p</i> =0.031*	<i>p</i> =0.000**	<i>p</i> =0.000**	<i>p</i> =0.000**	<i>p</i> =0.053
City or suburb	1 271 (32.9)	2 238 (65.0)	152 (31.6)	1 472 (45.8)	1 155 (38.4)	334 (11.5)	812 (29.0)
Township	1 700 (32.3)	3 480 (72.9)	215 (31.2)	2 255 (50.4)	1 777 (42.2)	438 (10.7)	1 065 (26.9)
Rural area	807 (34.3)	1 394 (67.7)	115 (36.6)	1 062 (55.3)	785 (44.1)	238 (13.9)	425 (26.1)
Other	142 (33.57)	201 (53.9)	28 (47.5)	174 (50.6)	114 (36.3)	60 (20.3)	88 (31.4)
Parent type	<i>p</i> =0.013*	<i>p</i> =0.011*	<i>p</i> =0.072	<i>p</i> =0.000**	<i>p</i> =0.000**	<i>p</i> =0.001**	<i>p</i> =0.000**
Mother	2 464 (32.8)	4 665 (67.8)	369 (34.9)	3 200 (49.1)	2 385 (38.7)	664 (11.1)	1 671 (28.9)
Father	1 181 (34.2)	2 054 (69.8)	119 (29.2)	1 424 (53.5)	1 168 (47.8)	327 (14.0)	538 (24.1)
Caregiver [†]	275 (29.2)	594 (72.2)	22 (28.2)	339 (44.0)	278 (39.5)	79 (11.9)	181 (27.8)
Child age	<i>p</i> =0.000**	<i>p</i> =0.000**	<i>p</i> =0.477	<i>p</i> =0.000**	<i>p</i> =0.000**	<i>p</i> =0.166	<i>p</i> =0.000**
0 - 6 mo	383 (26.7)	708 (55.5)	386 (32.7)	454 (40.2)	355 (33.6)	102 (10.1)	188 (19.4)
≥6 mo - <1 yr	471 (32.2)	789 (59.7)	10 (35.7)	602 (47.9)	477 (40.7)	129 (11.4)	259 (23.7)
≥1 - <3 yr	1 131 (35.3)	1 950 (66.6)	37 (40.2)	1 393 (50.0)	1 058 (40.5)	279 (11.0)	707 (28.7)
≥3 - <5 yr	1 679 (33.0)	3 511 (77.2)	77 (31.7)	2 226 (52.1)	1 737 (43.3)	478 (12.3)	1 121 (29.9)
Child gender	<i>p</i> =0.247	<i>p</i> =0.334	<i>p</i> =0.783	<i>p</i> =0.017*	<i>p</i> =0.984	<i>p</i> =0.958	<i>p</i> =0.240
Boys	1 826 (32.2)	3 505 (69.2)	253 (33.4)	2 416 (50.9)	1 812 (40.7)	505 (11.7)	1 168 (28.1)
Girls	1 832 (33.2)	3 401 (68.3)	243 (33.0)	2 264 (48.5)	1 784 (40.8)	497 (11.7)	1 100 (27.0)

*Significant at *p*<0.05 level, and **significant at *p*<0.001 level.

[†]Biological or non-biological primary caregiver of the child.

For post-hoc tests, standardised adjusted residuals (*z*) significant at Bonferroni corrected levels were calculated for significant effects and are reported in text; in the table, blue cells show significantly greater than expected frequencies and grey cells show significantly smaller than expected frequencies.

their child (*z*=2.860) compared with families in cities/suburbs (*z*=-0.743) and townships (*z*=-3.179). Comparison between areas of residence and breastfeeding challenges was not significant in post-

hoc analysis regardless of where parents lived. Almost a third of mothers experienced problems with breastfeeding their infant under 6 months of age.

Table 4. Differences in support received by area of residence, parent type, child age and child gender

	Support received from family and community			Support received from NGOs			Support received from government		
	Yes	No	Do not need help	Yes	No	Do not need help	Yes	No	Do not need help
Area of residence	<i>p</i> =0.032*			<i>p</i> =0.000*			<i>p</i> =0.000*		
City or suburb	701 (25.8)	1 247 (45.9)	767 (28.3)	389 (15.2)	1 863 (72.9)	304 (11.9)	689 (25.9)	1 643 (61.8)	325 (12.2)
Township	884 (22.8)	1 913 (49.4)	1 076 (27.8)	469 (12.7)	2 889 (78.2)	337 (9.1)	1 336 (35.3)	2 134 (56.4)	314 (8.3)
Rural area	381 (24.1)	793 (50.2)	407 (25.7)	202 (13.5)	1 173 (78.2)	125 (8.3)	495 (32.1)	927 (60.1)	120 (7.8)
Other	62 (23.0)	132 (48.9)	76 (28.2)	46 (18.0)	172 (67.5)	37 (10.0)	60 (22.9)	163 (62.2)	39 (14.9)
Parent type	<i>p</i> =0.044*			<i>p</i> =0.000*			<i>p</i> =0.000*		
Mother	1 339 (23.7)	2 765 (49.0)	1 543 (27.3)	691 (12.8)	4 150 (77.4)	522 (9.7)	1 854 (33.6)	3 151 (54.1)	517 (9.4)
Father	537 (24.9)	1 042 (43.3)	578 (26.8)	323 (15.8)	1 523 (74.6)	194 (9.5)	542 (25.8)	1 371 (65.2)	189 (9.0)
Caregiver [†]	152 (23.9)	278 (43.8)	205 (32.28)	92 (15.3)	424 (70.3)	87 (14.4)	184 (29.6)	345 (55.6)	92 (14.8)
Child age	<i>p</i> =0.017*			<i>p</i> =0.104			<i>p</i> =0.121		
0 - 6 mo	229 (24.4)	411 (43.9)	297 (31.7)	104 (11.7)	700 (78.4)	89 (10.0)	272 (29.7)	560 (61.1)	85 (9.3)
≥6 mo - 1 yr	258 (24.2)	516 (48.3)	294 (27.5)	134 (13.2)	769 (75.8)	111 (11.0)	310 (29.7)	616 (59.0)	119 (11.4)
≥1 - <3 yr	540 (22.5)	1 203 (50.1)	660 (27.5)	295 (12.8)	1 780 (77.5)	222 (9.7)	774 (32.9)	1 375 (58.4)	205 (8.7)
≥3 - <5 yr	903 (24.7)	1 775 (48.6)	974 (26.7)	514 (14.9)	2 594 (75.2)	340 (9.9)	1 126 (31.6)	2 086 (58.6)	349 (9.8)
Child gender	<i>p</i> =0.268			<i>p</i> =0.354			<i>p</i> =0.072		
Boys	963 (23.7)	2 005 (49.4)	1 089 (26.8)	536 (13.9)	2 962 (76.6)	369 (9.5)	1 254 (31.6)	2 360 (59.5)	354 (8.9)
Girls	947 (23.9)	1 894 (47.8)	1 121 (28.3)	516 (13.8)	2 831 (75.7)	394 (10.5)	1 201 (31.1)	2 259 (58.5)	404 (10.5)

*Significant at *p*<0.05 level, and **significant at *p*<0.001 level

[†]Biological or non-biological primary caregiver of the child.

For post-hoc tests, standardised adjusted residuals (*z*) significant at Bonferroni corrected levels were calculated for significant effects and are reported in text; in the table blue cells show significantly greater than expected frequencies and grey cells show significantly smaller than expected frequencies.

There were significant differences in the sources of support received by area of residence. Families living in cities/suburbs were more likely to receive help from their family and community (*z*=-3.135), to report not needing support from NGOs (*z*=3.801), and to report not needing help from government (*z*=5.407) compared with families in townships and rural areas. Families in townships were significantly more likely to report not receiving NGO support (*z*=3.949) but were more likely to report receiving support from government (*z*=7.241) than families in cities/suburbs and rural areas.

Participants who were not a biological parent of the child (e.g. grandmother or aunt) were significantly less likely to report missing clinic visits (*z*=-2.564) compared with mothers (*z*=-0.357) and fathers (*z*=1.906). Mothers were less likely to report a disruption in their child’s childcare or ECD attendance (*z*=-2.708) compared with fathers (*z*=1.560) and other caregivers (*z*=2.235), but more likely to report that their child showed an increase in behavioural problems (*z*=3.878) compared with fathers (*z*=-4.245) and caregivers (*z*=0.110). Fathers were more likely to have problems feeding their young children (*z*=4.393) compared with mothers (*z*= 2.171) and caregivers (*z*=3.412), had difficulties showing affection to their young children (*z*=7.785) compared with mothers (*z*=-6.373) and caregivers (*z*=-0.902), and to report someone in the household showing violence towards their young child (*z*=3.651) compared with mothers (*z*=-3.298) and caregivers (*z*=-0.169).

Fathers were more likely to receive help from an NGO (*z*=3.061) compared with mothers (*z*=-0.435) and primary caregivers (*z*=1.067) but were less likely to report having received support from government agencies (*z*=-5.172). Families with children under the age of 6 months were marginally but still significantly more likely to report not needing family or community support than families with older children (*z*=2.980).

Families with children under the age of 6 months were significantly less likely to miss clinic visits (*z*=-5.268) and experience feeding

problems (*z*=-6.690) compared with older children. Families with children between the ages of 1 and 3 years old were significantly more likely to miss a clinic visit (*z*=3.714). Families with children aged 3 - 5 years old were significantly more likely to have disruptions in their childcare or ECD attendance (*z*=15.967), experience trouble with feeding (*z*=4.603), report an increase in child behavioural problems (*z*=4.467), and have a parent report difficulty in showing affection (*z*=3.980) compared with younger children. The comparison between child gender and feeding challenges is not significant in post-hoc analysis, and parents of boys and girls experience similar levels of feeding challenges.

There were no other differences between child gender in challenges experienced or support received. Parents of children under the age of 6 months were less likely to report receiving help from neighbours and community (*z*=-2,988) compared with other age groups, but were also more likely to report not needing help from their neighbours and community (*z*=2.980)

Discussion

The most prominent response to the COVID-19 pandemic has been the confinement of families to their homes for extended periods of time. The implications of this have been a disruption in the routines of families, shifts in roles and responsibilities, and changes in relationships, all in the context of increasing economic hardship for many. Data from the United Kingdom^[13] has linked worsening parental mental health to financial insecurity and the additional resource burden of childcare and home schooling. Less than half of the parents surveyed are caring for one child under the age of 5 years, not including any additional children over the age of 5 years in the household.

More than three-quarters (82%) of parents reported experiencing at least one challenge, with the most common being disruptions in childcare (69%), difficulties feeding their child (50%), and showing

affection (41%). Almost a third (30%) of parents in this present study reported that their child had missed healthcare or clinic visits. This is comparable to a nationally representative household survey in the United States^[14] where a third of parents reported delayed health visits for their children under 6 years, and a study in rural KwaZulu-Natal^[15] found >50% reduction in clinic visits for children 0 - 5 years of age during the lockdown period, although visits returned to pre-lockdown levels after three months of lifting some lockdown measures.^[15] The main reasons in the present study for missed healthcare visits were fear of infection, lack of money, and negative affect in the household, including stress, tension and a sense of hopelessness and depression.

A substantial proportion of parents and children experienced emotional distress yet only a fraction received any psychosocial support. Interestingly, 38% of parents indicated that they had been feeling hopeless, withdrawn and depressed as well as irritable and stressed, but only 7% indicated a need for support for mental distress. This suggests that parents prioritise material needs over psychosocial needs and perhaps view mental distress as stemming from financial stress. Parental mental distress is most likely to be exacerbated as the pandemic continues and may be linked to harsher punishment of children, difficulties in showing affection and children's behaviour problems as found in recent studies.^[5,16,17] It is likely that the mental health effects of the pandemic in SA are detrimental at both the individual (the parent) and dyadic (the interaction between parent and child) levels, similar to a study in Italy.^[18]

Characteristics linked to increased vulnerability were living in a rural area, having children in the older category (aged between 3 - 5 years) and being a father. Families living in cities and suburbs rated themselves as faring better than families in townships and rural areas across a range of outcomes. They reported receiving more help from their own family and communities and not needing support from other sources. Families living in townships were less likely to be reached by NGOs but experienced greater coverage of government assistance than families in rural areas. Families in rural areas, and particularly their young children, are bearing a disproportionate level of both the material and psychosocial burden of COVID-19. Parents in rural areas are having greater trouble in showing affection to their children, report more violence towards children in the household, and are more likely to struggle to feed their children. Only about a third of the families with urgent needs are receiving assistance from government sources, and far fewer from NGOs. Health resources are often scarce in rural areas, distances to clinics and other service points are greater and governance systems are multi-layered. Strong partnerships between civil society, government bodies and communities in rural areas are essential to supporting the needs of families in rural areas.

Fathers reported experiencing more challenges with their young children than mothers or other primary caregivers. They were more likely to struggle with feeding, showing affection, and more likely to report someone in the home showing violence towards their child, while mothers were more likely to report difficult behaviour from their young children. Little literature has explored the differences in mothers' and fathers' experiences of caregiving challenges. One qualitative study found that developmental and behavioural concerns were common sources of stress for mothers and fathers, but fathers reported greater difficulty and less perceived competence in caring for their young children than mothers.^[19] Findings such as these highlight the importance of extending parenting support to fathers.

Fathers indicated that they received significantly more NGO support than mothers while mothers received significantly more government support than fathers. In terms of the type of support, fathers report receiving more of all types of NGO support than mothers did, both parents reported similar levels of all other support apart from financial aid, with 11% of mothers and 7% of fathers receiving money/vouchers. Fathers are less likely to interact with government social protection mechanisms, particularly those that are child-focused, for example; despite the child support grant being gender neutral, only about 2% of fathers are recipients.^[20,21]

Families with children in the older age category report more challenges, including making sure their children had enough to eat, maintaining affection, and dealing with difficult behaviour. Given national estimates, about 69% of children aged 3 - 5 years would be attending an early learning programme or Grade R, which would provide multiple benefits, including stimulation, childcare, and for a large proportion of vulnerable children, subsidised meals.^[22] Closure of schools and ECD centres contributed largely to these parental challenges.

Nutrition and food support were consistently raised issues for families and young children. Although children under 6 months were less likely to miss a clinic appointment or have feeding problems, a third of parents were having problems with breastfeeding, 48% felt they were not producing enough milk, 42% were concerned about infecting their baby, and 20% of parents had been advised by a doctor, friend or family member to stop breastfeeding. Concerted efforts should be made to circulate accurate messaging around the continuation of breastfeeding during the pandemic and support for mothers who are breastfeeding.

Study strengths and limitations

The survey was designed as a nationally representative cross-sectional analysis of the experiences of families with young children 6 - 7 months into SA's national lockdown. The greatest strength of the survey was the size of the response, overwhelmingly greater than many studies of parental and family challenges under COVID-19 generally, as well as the participation of a proportionately large number of men. The authors discuss in more detail the strengths and weaknesses of this study design in a recent publication,^[10] but it is worth emphasising that repeat surveys in the same sample would be valuable to estimate both the cumulative and long-term consequences of the pandemic. Because the survey was designed to be a rapid assessment of challenges and support to families, a trade-off was made between length of survey and the number of socio-demographic variables included, which could have enabled more fine-grained analysis.

Although government had the highest penetration for support, reaching up to a third of needy families in rural areas and townships and a quarter of families in cities and suburbs, the extent of the needs of families far outweighed what many families received. It remains clear that vulnerable families need financial and food aid to survive in this pandemic. These are the two most common responses from both government and NGOs, but other provisions such as clothes, blankets, PPE, soap and medicine are also needed. The reach and capacity of the government and NGOs in providing this range of support needs to be addressed urgently.

One of the most interesting findings of the present study was the consequences of stress and tension in the home on parents' ability to both cope with their young child's behaviour and maintain affectionate relationships. Further research, which is being undertaken with this data, could give an indication of whether

parents who reported difficulties in showing affection and increases in child behaviour problems were also more likely to report higher levels of violence towards children in households. This would also lead to more work examining clusters of negative impacts on families to identify those most vulnerable.

Conclusions

Families with young children are facing severe challenges such as ensuring their young children's health, nutrition, care and safety. Of the broad range of challenges facing families, from material to psychosocial, none is reported to be anywhere near met. Almost one third of the families surveyed are finding it difficult to feed the youngest in their households because they do not have enough food. The pandemic has exposed the extent to which many families in SA live with few safety nets and those mandated to provide support are not capacitated to sufficiently respond to those who need it. For young children, the effects of the pandemic will depend on their family and community environment as well as government and non-governmental responses to protect their mental and physical wellbeing. Better coordination between these different role players should be more effective than a silo approach and any responses supporting and protecting children should include support for the family, and at the very least parents, extending beyond material resources to psychosocial support and guidance.

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Conflicts of interest. None.

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