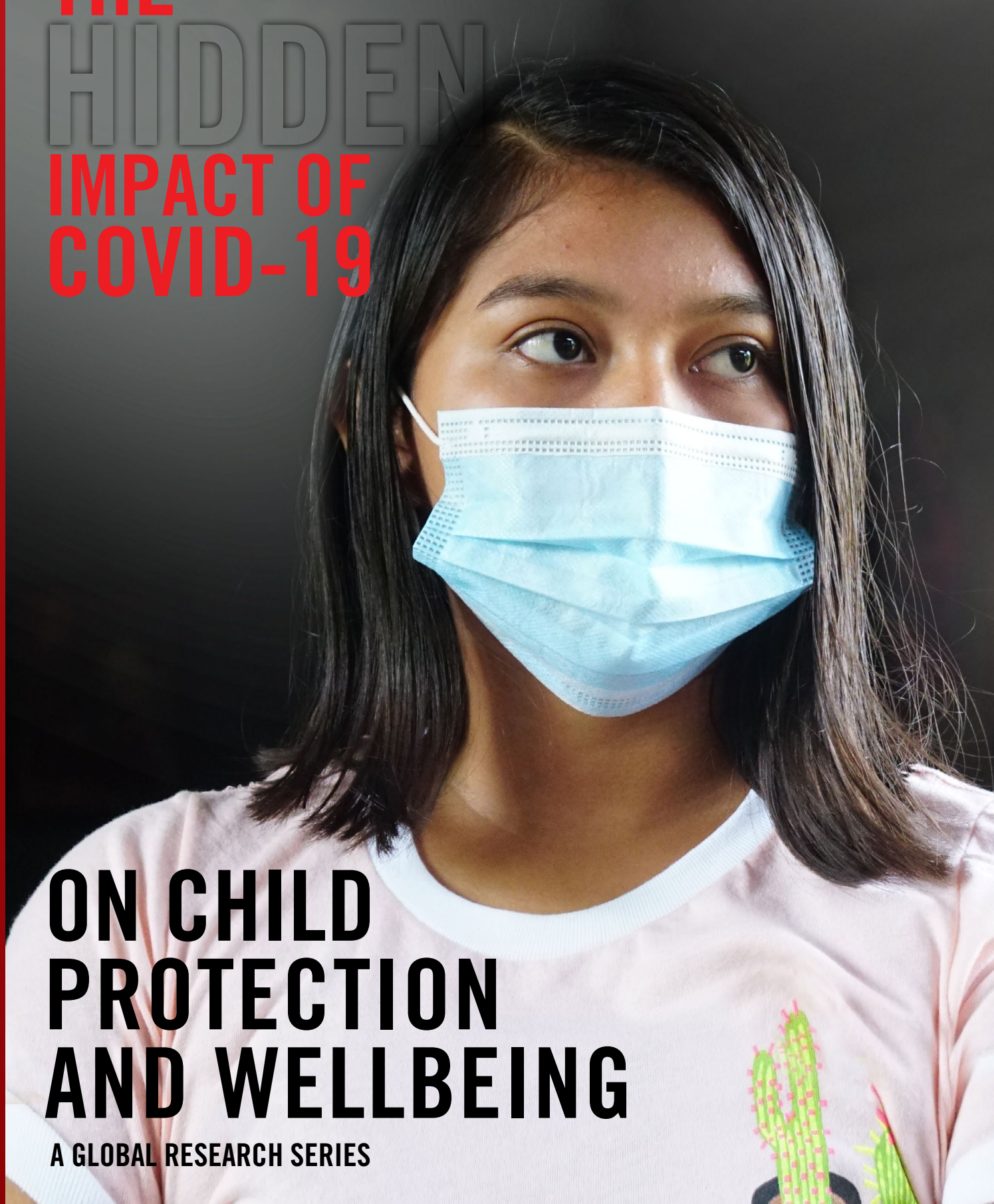




# THE HIDDEN IMPACT OF COVID-19

## ON CHILD PROTECTION AND WELLBEING

A GLOBAL RESEARCH SERIES



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# **THE HIDDEN IMPACT OF COVID-19**

## **ON CHILD PROTECTION AND WELLBEING**

**A GLOBAL RESEARCH SERIES**



# The Hidden Impact of COVID-19 on Child Protection

## Response overview

31,683

public responses including

13,477

child responses aged 11-17



The study was implemented in **46** countries and resulted in the largest and most comprehensive survey of children and families during the COVID-19 crisis to date.

## KEY FINDINGS

### Mental health and psychosocial wellbeing

The interruption of formal education means children are less able to meet friends and play, having a significant impact on their wellbeing.

More than half the children who are not in touch with their friends report feeling

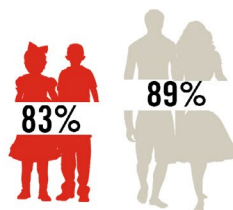
Less happy **57%** More worried **54%** Less safe **58%**

compared to only a few children who see their friends in person and interact virtually, who report feeling

Less happy **5%** More worried **5%** Less safe **6%**

The vast majority of girls and boys and parents/caregivers reported an increase in negative feelings due to the COVID-19 pandemic.

Boys/Girls Parents/Caregivers



Just under half (46%) of parents/caregivers reported observing signs of psychological distress in children.

### Family Relationships

Over 1 in 5 parents/ caregivers (22%) surveyed reported an increase in their use of negative or violent parenting methods.



Nearly one-quarter (23%) of parents/caregivers who had to move because of COVID-19 reported separation from children.

## About the research

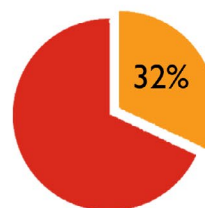
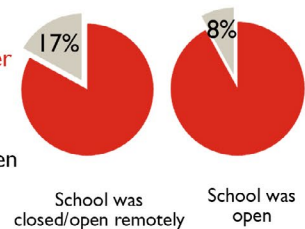
The research sampled three distinct population groups:

1. Save the Children program participants.
2. specific population groups of interest to Save the Children.
3. the general public.

A representative sample of Save the Children program participants with telephone numbers or email addresses was obtained in 37 of the 46 countries. The results presented in this report focus on data from our representative sample of 17,565 parents/caregivers and 8,069 children in our program participants group.

### Violence at Home

Violence was reported at higher rates by children when schools were closed compared to when children were attending in person.



32% of households had a child and/or parent/caregiver reporting that violence had occurred in the home, including children and/or adults being verbally or physically abused.



During this time violence against children is increased, thus please work on this issue.

Girl, 14, Ethiopia

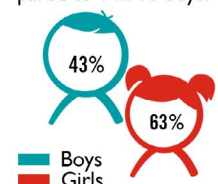
### Parenting

Over three-quarters of parent/caregiver program participants (77%) reported an increase in their use of positive parenting methods with their children.



### Child Labour

Almost two thirds of girls (63%) reported an increase in household chores, compared to less than half of boys (43%). For 1 in 5 girls this was stopping them from learning, compared to 1 in 10 boys.



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# EXECUTIVE SUMMARY

## About the study

COVID-19 has spread rapidly within and between countries across the globe. Governments worldwide have implemented measures to contain the spread of COVID-19 including school closures, home isolation/quarantine and community lockdown, all of which have secondary impacts on children and their households. Save the Children launched a global research study to generate rigorous evidence on how the COVID-19 pandemic and measures implemented to mitigate it are impacting children's health, nutrition, learning, well-being, protection, family finances and poverty, and identify children's and their family needs during these times. The research also captures children's views and messages for leaders and other children.

The research was implemented in **46 countries** and results in the largest and most comprehensive survey of children and families during the COVID-19 crisis to date, with **31,683 parents and caregivers and 13,477 children** aged between 11-17 years old participating in the research. The research sampled three distinct population groups:

1. Save the Children programme participants;
2. Specific population groups of interest to Save the Children;
3. The general public.

A representative sample of Save the Children programme participants with telephone numbers or email addresses was obtained in 37 countries.

This report is one in a series presenting findings from the Global COVID-19 Research Study. The results presented here focus on the implications for Child Protection issues, drawing on data from our **representative sample of 17,565 parents/caregivers and 8,069 children in our programme participants** group. Comparisons with our general public sample have been made in some places.

Topics investigated include violence occurring in the home, the separation of children from their caregivers, mental health and psycho-social well-being of caregivers and children, child labour, online safety and child protection support and services. Available data was analysed and presented considering the socio-ecological model in order to highlight the interconnectedness of the broader socio-ecological environment which places children within their households and communities. This enabled the detailing of the range of associated risks and protective factors in relation to these child protection issues as well as drawing attention to the complexity of their interrelationship. Differences in impact and the needs of children by region, age, gender, disability, minority group, indicators of poverty, and more, were explored.

## Key findings

### Children reported violence and risk of violence in their homes



Nearly one-third (32%) of the households had a child and/or parent/caregiver reporting that violence had occurred in the home, including children and/or adults being verbally or physically abused.



Just over three quarters of the children (77%) reported that they knew methods to keep themselves safe online, including information they should and should not share and/or how to change whom they share content with.

### Children and parents/caregivers reported changes in emotional well-being since the lockdown



The vast majority of girls and boys (83%) and parents/caregivers (89%) reported an increase in negative feelings due to the COVID-19 pandemic and just under half (46%) the parents/caregivers reported observing signs of psychological distress in children.



More than half the children who were not in touch with their friends reported feeling less happy (57%), more worried (54%) and less safe (58%). Only a few of the children who were able to interact with friends reported that they were less happy (5%), more worried (5%) and less safe (6%).



While 62% of the children and 83% of the parents/caregivers reported an increase in negative feelings when schools were closed between 1 to 4 weeks, the reports of negative feelings were higher for the vast majority of children (96%) and adults (95%) when schools had been closed for 17 to 19 weeks.



Children with disabilities were more than three times more likely to show an increase in bed-wetting (7%), and unusual crying and screaming (17%) since the outbreak of COVID-19, than children without disabilities (2% and 5% respectively).

### Boys and girls reported barriers to learning



2% of the children reported not being able to learn, because they were getting paid for work. This increased to 5% for the children of parent/caregiver respondents with a disability.



Two-thirds (63%) of the girls reported an increase in household chores, compared to less than half (43%) the boys and 1 in 5 (20%) girls compared to 1 in 10 (10%) boys reported having too many chores to be able to learn.

## Factors affecting parents'/caregivers' and children's well-being were interconnected



The disability status of a parent/caregiver had some negative association with increased use of negative or violent parenting methods with children, separation of children, feelings of hopelessness and the domestic work burden of children.



Loss of income due to COVID-19 was associated with a higher reporting of violence in the home, the separation of children from their primary caregiver(s), higher levels of increase in negative feelings of children, reduced psycho-social well-being of parents/caregivers and children's reporting getting paid for work.



When parents/caregivers reported that they had to move from where they normally lived, because of the outbreak of COVID-19, there was also significantly higher reporting of the separation of children and violence in the home.



Programme participants in urban locations reported significantly higher levels of violence in the home, separation of children, levels of increase in negative feelings of children, and lower awareness of how to ensure children's safety online.



There was a relationship between higher numbers of children in the care of a parent/caregiver and higher reporting of violence in the home, separation of children, decreased psycho-social well-being, domestic work burden of children affecting being able to learn, and higher support/service needs required by parents/caregivers.

## Key Implications and Recommendations

Government leaders, including high-level decision-makers, must step up immediate efforts to protect children from the impacts of the COVID-19 pandemic by:

1. **Listening to children of all genders**, and ensuring dialogue and further research to take the experience of the impact of COVID-19 on children and households into account in designing response plans.
2. **Prioritising child protection within COVID-19 response plans**, making child protection and social welfare provisions central components within national and local level infectious disease emergency preparedness plans.
3. **Designating the social service workforce – both formal and informal – as essential workers**, with support to adapt responses to continue safely providing essential services to children and households in the community.
4. **Providing urgently needed funding for child protection programming**, including for children and caregivers' mental health and psycho-social support, and gender-based violence response services.
5. **Ensuring that child protection services are well resourced, inclusive and supported** including through increasing the numbers and reach of trained and skilled child protection workers and addressing barriers to access for persons with disabilities and other vulnerable groups. All aspects of child protection systems – including laws and policies, law enforcement agencies and child protection services – must take into account the violence experienced by children in the home during the pandemic.



6. Ensuring that responses to COVID-19 do not exacerbate the particular vulnerability of children during this pandemic, and that of girls in particular to harmful gender norms, discriminatory practices and inequalities, while **ensuring that quality services are reaching those who are most vulnerable, including people with disabilities**. This will require
  - a. support for effective, adapted and inclusive reporting mechanisms;
  - b. further research on the impact of COVID-19 on children's protection;
  - c. **the collection of disaggregated data** to ensure that future investments are data driven, informed by gender analysis, and targeted to the most vulnerable and marginalised children and households, including those with disabilities.
7. Ensuring that child protection risk factors are understood and integrated into **social protection and child benefit programmes**, with the objective of helping prevent and mitigate violence against children, exploitation and family separation and promote adequate care.
8. Ensuring that education and child protection sectors are enabled to **proactively work together** to put child-friendly, effective protection response mechanisms in place that can function through school structures and outside them, particularly within plans to transition children back to school/education safely.
9. Integrating child protection messaging in **COVID-19 risk communication and community engagement**, training frontline health professionals in psychological first aid and detection, and referral of child protection risks.
10. Strengthening the integration of **high-quality mental health and psycho-social well-being programmes** with gender sensitive child protection systems and services to prevent and address gender-based violence.



PHOTO: SAVE THE CHILDREN

# INTRODUCTION AND AIMS

## Study background

On 30 January 2020, the World Health Organisation (WHO) Director General declared the outbreak of coronavirus disease (COVID-19) a Public Health Emergency of International Concern (PHEIC) (WHO, 2020a), and on 11 March 2020, declared the COVID-19 outbreak a global pandemic (WHO, 2020b). The PHEIC remains in place at the time of writing. The number of cases and deaths from the coronavirus outbreak continues to rise exponentially. As this report is being written, in late August, 2020, nearly 22 million people from more than 200 countries have been infected and nearly 800,000 have died (WHO, 2020d).

The global coronavirus COVID-19 outbreak is already having a serious impact on the global and national economies, health systems, education systems and more – and ultimately on the fulfilment of children's rights. A number of governments have implemented measures to contain the spread of COVID-19, ranging from social distancing and behavioural changes to home isolation/quarantine, school closures, business closures and community lockdown. Around 1.5 billion children and youth were affected by school closures in the first half of April 2020 (UNESCO, 2020a).

In addition to the immediate impacts on their health rights and those of their caregivers, the social and economic disruptions caused by the outbreak of COVID-19 present a range of other risks to children's right to education and to their wellbeing and protection. These may be derived directly from the outbreak, from measures taken to respond to it and from wider economic and other disruption. The WHO (2020c) coordinated Global Research Roadmap summarises the available literature on this topic:

*These measures all have secondary impacts. Quarantine, for instance, has impacts on the mental [5–7] and physical health [8] of populations... A rapid systematic review of publications reporting previous events of quarantine for infectious disease outbreaks, identified how knowledge of the disease, clear information regarding quarantine procedures, social norms, perceived benefits of quarantine, perceived risk of disease, and ensuring sufficient supplies of food, medicines and other essentials were important factors to promote adherence to the uncomfortable realities of quarantine measures [10]. Others have highlighted the critical role of trust, interpersonal and international cooperation that emerge in response to a collective effort in tackling a major public health crisis [11].*

*(WHO and R&D Blueprint, 2020: 60)*

## Research Purpose

This research report presents selected findings from a large-scale cross-thematic research study on the impact of the COVID-19 pandemic on children and their families. The purpose of this study is to understand:

1. The impact of school closures, home isolation/quarantine and community lockdown on children's health, nutrition, learning, well-being and protection.
2. The economic impact of the COVID-19 pandemic on households with children.
3. The health, psycho-social, learning and protection needs of children during times of school closures,

home isolation/quarantine and community lockdown.

4. Children's right to be heard when talking about COVID-19.
5. Children's messages for leaders and other children around the world.

This knowledge will be used by Save the Children and shared with governments, donors, partners and other stakeholders, to inform the development of a variety of information products, services, programmes and policies across multiple sectors.

## Research Questions

This research report presents findings addressing the following Child Protection related research questions:

- *What is the impact of the COVID-19 pandemic on violence in the home?*
- *What are the risks and protective factors associated with violence occurring in the home?*
- *What is the impact of the COVID-19 pandemic on family relationships?*
- *How has the COVID-19 pandemic impacted parents' and caregivers' parenting?*
- *Have children been separated from their parents/caregivers?*
- *What is the impact of the COVID-19 pandemic on children's psycho-social well-being?*
- *What are the risks and protective factors associated with an increase in negative feelings for children?*
- *What are the signs of distress that children are displaying since the outbreak of COVID-19?*
- *What are the risks and protective factors associated with signs of distress in children?*
- *What is the proportion of parents/caregivers reporting a negative change in their mental health and psycho-social well-being owing to the COVID-19 pandemic?*
- *What is the proportion of children currently engaged in child labour?*
- *What proportion of children know how to keep safe when learning online?*

# RESEARCH DESIGN AND METHODS

This section provides a summary of the study research design and methods. The full Study Methods Report describes the methods and sample in detail, as well as the limitations of the design and methods. The full Study Methods Report is available at: <https://resourcecentre.savethechildren.net/library/hidden-impact-covid-19-children-global-research-series>.

This study was approved by the Save the Children US Ethics Review Committee (SCUS-ERC-FY2020-33). Approval was also obtained from local Independent Review Boards in the countries where the research was undertaken, if such bodies existed.

## Study Populations and Scope

This research study was carried out among current programme participants of Save the Children-led or partner-led programmes in the 37 countries listed in Table 1. The study was implemented only in those countries where local Save the Children staff could quickly mobilise resources to carry out the study. These countries were not randomly selected and are therefore neither representative of all countries across the world, nor representative of all countries in which Save the Children operates.

Region	Countries Where the Research was Implemented among Save the Children Programme Participants
Asia	Afghanistan, Bangladesh, Cambodia, India, Indonesia, Laos, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka
East and Southern Africa (ESA)	Ethiopia, Kenya, Malawi, Mozambique, Somalia, South Sudan, Uganda
West and Central Africa (WCA)	Burkina Faso, Niger, Senegal, Sierra Leone
Middle East and Europe (MEE)	Egypt, Lebanon, Syrian Arab Republic Albania, Kosovo
Latin America and the Caribbean (LAC)	Bolivia, Brazil, Colombia, and Dominican Republic, El Salvador, Paraguay, Peru
North America	United States of America
Pacific	Papua New Guinea, Solomon Islands

The survey questionnaire and Participant Information Sheet were translated using a back-translation process into 28 languages to facilitate uptake in all the countries where the research was implemented.

## Sampling, Recruitment and Data Collection Mechanisms

The research was designed to obtain a representative sample of current Save the Children programme participants. Remote data collection methods had to be used owing to the presence of COVID-19 and the risk of contracting or transmitting COVID-19 during in-person data collection methods. The study population was therefore necessarily reduced to only those programme participants with remote contact details (phone number or email) listed at the individual or household level. For this reason, the research can only be considered as representative of Save the Children programme participants with remote contact details in those countries where the study was implemented.

A random sample of the current programme participants across all programmes (derived from a programme database of programme participants with contact details) was obtained in the majority of countries. A stratified random sample of current programme participants across all programmes (derived from a programme database of programme participants with contact details) was obtained in a few countries.

There were only two eligibility criteria for participation in the study:

1. Adult respondents (aged 18 and above) had to be parents and/or caregivers of children aged 0–17 living in the same household (Part 1 of the survey);
2. Child respondents had to be aged 11–17 (Part 2 of the survey).

Data was collected through a single online SurveyMonkey (Enterprise version) survey either directly completed by the respondents themselves or indirectly via an interviewer. The majority of programme participants, in the majority of countries, were reached by phone and invited to participate in the study. In these cases, an interviewer would talk through the survey and enter the participants' responses directly into the online survey on their behalf. Programme participants were also invited to participate in the study after being sent the survey link by email, text messaging, WhatsApp or other instant messaging platform. They could then complete the online survey in their own time using a device of their choice.

Permission for in-person interviews was granted in Papua New Guinea owing to the absence of COVID-19 cases at the time of the study. The Papua New Guinea sample therefore included all programme participants, regardless of whether or not they had remote contact details. A census of all current programme participants was obtained in the United States of America. The United States population was invited to participate in the study through a printed flyer with a QR code linking to the online survey.

The minimum requirements for participation in the study were a confidence level of 90% and a margin of error of 5%. For the majority of countries, this meant a minimum sample size of 273 adult respondents. A detailed description of the sampling approach and final response numbers per participating country is listed in the full Study Methods Report.

## Limitations of the Research Design

The sample is skewed:

- Towards programme participants with stable internet and/or phone access and who were willing to absorb the cost of receiving phone calls or using their data plan.
- Towards those who can speak or read and write in the languages that the survey has been translated into, and against those who cannot. To overcome this, an effort was made to translate the online survey into a range of languages, and to engage interviewers who could speak local languages/dialects, verbally translate the survey questions (following a written and tested translation) and then enter the participant responses into the more mainstream language in the online survey on the participant's behalf.



- Towards those with time and interest, and against those with limited time and less interest (self-selection bias).

This unfortunately biases the study sample against the most marginalised and deprived. Similarly, the sample is also skewed against those with certain disabilities. To foster inclusivity, survey respondents could engage the assistance of another when participating in the survey.

## The Survey Questionnaire

Data was collected through a single survey divided into two parts. The first part was for the adult parent or caregiver, and gathered household level information as well as information specifically about the parent/caregiver and children in their care. This part of the survey questionnaire also prompted the parent/caregiver to think about 1 particular child ('the indexed child') and answer some specific questions about them related to COVID-19. Prompts in the survey were designed to prioritise the capture of data on school-age children, while still facilitating the collection of data on an even spread of children of different ages.

If the adult parent/caregiver had a child aged 11–17, they were asked whether they consented to their child answering some additional survey questions (the second part of the survey). If the adult parent/caregiver consented, they passed the survey to their child, who then went through an assent process before being asked to answer the children's questions.

Only 1 adult and 1 child (aged 11–17) per household could complete the survey. If the adult had more than 1 child (aged 11–17), they could choose which child would complete the children's section of the survey.

There are various limitations with the questionnaire structure, and these are discussed in the full Study Methods Report. A notable limitation is that the survey questionnaire did not ask whether the child respondent was the same individual as the indexed child. This limitation of the survey prevents comparison between the adult reports on the child and the child's self-reports. The Washington Group Short Set of Questions on Disability (WG-SS) was used to disaggregate data for disability<sup>1</sup>. The WG-SS was asked of the adult respondent, and about the indexed child by proxy of the adult respondent. Child respondents did not respond to the WG-SS, preventing data disaggregation for the child respondent by disability.

Being a self-report survey, there will likely be a response bias, particularly for survey questions around parenting, family relationships, violence and income losses. Self-reporting of income bias can involve a combination of expectation bias, privacy concerns and the general challenge of accuracy of reporting income from people (mainly rural and informal sector) with multiple income sources without triangulation.

## Data collected

The survey was designed to capture information across multiple sectors or themes, including household economies, health and nutrition, child education and learning, child protection and child rights. The survey questionnaire is presented in the full Study Methods. An overview of the data collected in the survey, as relevant to this report, is as follows:

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<sup>1</sup>Person with disability is defined as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.



## HOUSEHOLD-LEVEL INFORMATION (reported by the adult parent/caregiver)

- **COVID-19 interventions**
  - o Number of weeks in schools closed
  - o Number of weeks confined at home (told not to leave)
  - o Number of weeks all shops closed (except medical and food)
- **Geography, migration & displacement**
  - o Current country and settlement type
  - o Migration and displacement owing to COVID-19
  - o Children being separated from their parents/caregivers owing to COVID-19
- **Household composition:**
  - o Number and gender of adults and children in the household
- **Household wealth and economic impact of COVID-19:**
  - o Income lost and income sources lost owing to COVID-19
  - o Whether or not household members have had trouble paying for basic needs owing to COVID-19
  - o Coping strategies employed by household members
  - o Government support and social protection
- **Children and household members' physical health and nutrition:**
  - o Whether or not household members had fallen sick since COVID-19
- **Child rights**
  - o Other items/supports needed by households to ensure child rights are upheld
  - o Space for children to play outside



## INDIVIDUAL-LEVEL INFORMATION ON THE PARENT/CAREGIVER (reported by the adult parent/caregiver)

- **Adult respondent demographic information:**
  - o Gender
  - o Age
  - o Belonging to or identifying as belonging to a minority group
  - o Disability status
  - o Relationship to child/children in care
- **Parents'/caregivers' well-being and perceptions of family relationships:**
  - o Parents' and caregivers' feelings and worries
  - o Changes in relationships with children and in the household
  - o Violence in the home



## INDIVIDUAL-LEVEL INFORMATION ON THE 'INDEXED CHILD' (reported by the adult parent/caregiver)

- **Indexed child's demographic information:**
  - o Gender
  - o Age
  - o Disability status
  - o Chronic health condition

- **Children's well-being, and family relationships:**
  - o How children feel and sleep since COVID-19
  - o Changes in children's behaviour and sleep since COVID-19
  - o Children's contact with friends and doing activities for fun
  - o Whether parents/caregivers talk to their children about COVID-19
  - o Children's safe use of the internet



### INDIVIDUAL-LEVEL INFORMATION ON THE CHILD RESPONDENT (reported by the children themselves)

- **Child respondent's demographic information:**
  - o Gender
  - o Age
- **Children's well-being:**
  - o What children do to have fun
  - o What children miss and miss out on by not attending school
  - o Children's contact with friends
  - o How children describe their home situation
  - o What children have enjoyed most about being at home
- **Children's rights:**
  - o Children's messages for leaders and other children around the world

## Measures, Indices and Specific Variables

Details on measures, indices and specific variables are included in the Full Methods Report. The following are specifically addressed here given their particular significance to this thematic report.

### Violence in the home

"Violence in the home" was measured by parents/caregivers reporting that they were resorting to yelling and/or resorting to physical punishment and/or more aggressive behavior towards children and/or there had been some violence in the home; and by children reporting that there was some violence in the home involving either children or adults being hit or verbally abused. The findings are first presented at the household level, showing the proportion of households where either an adult or a child has reported violence in the home. The findings are then presented at the individual level, as the proportion of parents/caregivers reporting violence as well as the proportion of child respondents reporting violence<sup>2</sup>.

There were a number of limitations with this approach, which is likely to have led to an under-reporting of violence. First, it is not always clear who is perpetrating violence in the household (adult or child) and whom the violence is being perpetrated against (adult or child), although witnessing intimate partner violence is considered to have a secondary impact on the children who do so. Secondly, the valid and reliable measurement of physical and humiliating punishment of children usually includes asking parents/caregivers specific questions on a range of common disciplinary practices, from different forms of psychological aggression (i.e. shouting, calling names, swearing, threatening) through to different forms of physical punishment (i.e. shaking, spanking, hitting, beating – area of body, use of objects). This specificity allows for a more accurate measurement of whether violence is being used, as well as removing an interpretation

<sup>2</sup>Household level and individual level statistics cannot be compared for various reasons. Only when both the parent/caregiver and the child completed the survey were they included in the household level statistics.

of issues on what constitutes violence, which is often impacted by the existence of social norms in which these actions are considered “discipline” and not violence. Finally, these types of measurement tools usually ask parents/caregivers to respond to the series of questions in relation to an indexed child, as physical and humiliating punishment of children can vary depending on cultural beliefs on how girls, boys, children with a disability, children of different ages, etc., should be disciplined, and/or by whom they should be disciplined. Asking this question generally of children in the household therefore creates challenges in how and whom the parent/caregiver is responding to.

## Mental Health and Psycho-Social Well-being

Aspects of mental health and psycho-social well-being in children and adults were measured through self-assessment and observational rating scales, covering a number of positive and negative feelings as well as changes in children’s behaviour. In addition, the questions posed in the survey explored children’s and adults’ thoughts, their social connectedness as well as existing coping strategies to maintain well-being. However, given the time-sensitive nature and scope of the study it was not feasible to carry out detailed assessments of child and adult mental health and psycho-social well-being using comprehensive psychometric measures, thus limiting the findings to the particular aspects researched in the study and not providing exact indications of children’s and adults’ well-being. It is also acknowledged that manifestations of mental health and psycho-social well-being issues are heavily influenced by context-specific cultural differences and locally existing social norms. This could not be reflected upon in detail in the report because of the global nature of the study itself and the global focus of the subsequent analysis of findings. While behaviours such as unusual crying or screaming and bed-wetting etc. commonly indicate distress and reduced well-being in children, children with disabilities may display such signs and behaviours owing to other reasons relating to their specific impairment, thus making them less reliable as determinants of distress for this group of children.

## Child Labour

Children’s engagement in labour was measured based on child respondents selecting ‘getting paid for work’ or ‘having too many chores to do’ as response options to the question ‘What stops you from learning at home?’ Due to the nature of the study, a full measure of the child labour situation, including distinguishing between different types of labour (including hazardous work) and the change in actual time spent working, could not be included. The findings presented in the report are therefore limited to the specific question asked in the survey and might therefore not be representative of the true scale of the child labour situation.

## Data analysis

Probability weighting was used to weigh the programme participant sample against the total programme participant population. Regression analysis was performed using the F-Statistic test in STATA. A p-value of <0.05 was used to denote statistical significance.

The quotes featured in this report were selected following a qualitative analysis of five open-ended survey questions answered by the child-respondents. The qualitative analysis employed a conceptual content approach to identify key themes that children spoke of. A framework method supported this approach, whereby a pre-emptive thematic framework, protocol and coding template were developed to support consistency in coding by numerous analysts coding for different countries and languages. The framework allowed flexibility to code inductively, and therefore new emerging themes could be added during the coding process. All of the children’s open-ended responses were examined and coded, irrespective of any perceptions on saturation point. Quotes and case studies reported as a result of the qualitative data analysis are consistent with these key themes, or are noted as particularly salient and important to the child respondent.





# STUDY SAMPLE NUMBERS AND CHARACTERISTICS

Data were collected from 17,565 adult respondents and 8,068 child respondents, from across the seven regions (Asia, ESA, WCA, LAC, MEE, Pacific, and North America) in which Save the Children operates. The detailed characteristics of the programme participant respondents are presented in the table below. More detailed breakdowns of the sample numbers and characteristics by region are presented in a separate Sample Characteristics Report available at: <https://resourcecentre.savethechildren.net/library/hidden-impact-covid-19-children-globalresearch-series>.

**Table 1: Save the Children Programme Participants, Worldwide Sample**

Variable	Adult Respondent (Parent/Caregiver)		Child Respondent (11–17)		Indexed Child	
	Number of Adult Respondents	Percentage of Adult Respondents	Number of Child Respondents	Percentage of Child Respondents	Number of Indexed Children	Percentage of Indexed Children
<b>Total</b>	<b>17,565</b>	<b>100</b>	<b>8,069</b>	<b>100</b>	<b>16,110</b>	<b>100</b>
<b>Region</b>						
Asia	6,915	39.4	3,686	45.7	6,559	40.7
ESA	3,274	18.6	1,588	19.7	3,084	19.1
WCA	1,372	7.8	646	8.0	1,282	8.0
LAC	3,047	17.3	1,129	14.0	2,716	16.9
MEE	2,166	12.3	794	9.8	1,772	11.0
Pacific	251	1.4	140	1.7	235	1.5
North America	518	2.9	81	1.0	444	2.8
Europe and others	22	0.1	5	0.1	18	0.1
<b>Gender</b>						
Female	10,554	60.1	4,336	53.7	8,075	50.1
Male	6,055	34.5	3,619	44.9	7,945	49.3
Prefer not to say/ other	62	0.4	11	0.1	90	0.6
Non-response	894	5.1	103	1.3	-	0.0
<b>Age</b>						
0–1	N/A	N/A	N/A	N/A	809	5.0
2–4	N/A	N/A	N/A	N/A	1,591	9.9

Variable	Adult Respondent (Parent/Caregiver)		Child Respondent (11–17)		Indexed Child	
	Number of Adult Respondents	Percentage of Adult Respondents	Number of Child Respondents	Percentage of Child Respondents	Number of Indexed Children	Percentage of Indexed Children
5–10	N/A	N/A	N/A	N/A	4,932	30.6
11–14	N/A	N/A	4,531	56.2	4,770	29.6
15–17	N/A	N/A	3,398	42.1	4,008	24.9
18–24	1,154	6.6	N/A	N/A	N/A	N/A
25–29	2,197	12.5	N/A	N/A	N/A	N/A
30–39	6,363	36.2	N/A	N/A	N/A	N/A
40–49	4,514	25.7	N/A	N/A	N/A	N/A
50–59	1,804	10.3	N/A	N/A	N/A	N/A
60+	744	4.2	N/A	N/A	N/A	N/A
Non-response	789	4.5	140	1.7	-	0.0
<b>Disability status</b>						
Has disability	997	5.7	N/A	N/A	623	3.9
Does not have disability	15,337	87	-	-	12,582	78
Non-response	1,231	7.0	8,069	100.0	2,905	18.0
<b>Has a chronic health condition</b>						
Has health condition	N/A	N/A	N/A	N/A	1,087	6.7
Does not have health condition	N/A	N/A	N/A	N/A	14,921	92.6
Non-response	N/A	N/A	N/A	N/A	-	0.0
<b>Family member belongs to a minority group</b>						
Yes	4,588	26.1	2,168	26.9	4,318	26.8
No	10,400	59.2	5,041	62.5	10,098	62.7
Prefer not to say	540	3.1	202	2.5	498	3.1
Non-response	2,037	11.6	658	8.2	1,196	7.4
<b>Relatively poor</b>						
Poor (below median wealth index)	6,278	35.7	3,506	43.5	6,278	39.0
Not-poor (on or above the median wealth index)	5,762	32.8	3,425	42.4	5,762	35.8
Non-response	5,525	31.5	1,138	14.1	4,070	25.3
<b>Settlement type</b>						
City	5,099	29.0	2,268	28.1	4,863	30.2
Large or small town	2,912	16.6	1,218	15.1	7,618	47.3
Village	8,593	48.9	4,364	54.1	2,755	17.1
Don't know	172	1.0	79	1.0	155	1.0
Non-response	789	4.5	140	1.7	719	4.5

# RESULTS

This report aims to present the impact of the COVID-19 pandemic on child protection issues, such as violence occurring in the home, the separation of children from their caregivers, mental health and psycho-social well-being of caregivers and children, child labour, online safety and child protection support and services. Available data was analysed and presented considering the socio-ecological model, which places children within the context of their families and communities. This enabled the detailing of the range of associated risks and protective factors in relation to child protection issues as well as drawing attention to the complexity of their interrelationship.

## Impact of the COVID-19 Pandemic on Violence in the Home

### WHAT IS THE IMPACT OF THE COVID-19 PANDEMIC ON VIOLENCE IN THE HOME?



Violence by parents/caregivers is the most common form of violence experienced by children. It is expected that stressors related to COVID-19, including concerns over restrictions, health, food security and income, could exacerbate this violence against children, both increasing the risk to children already in abusive and neglectful households, as well as increasing the potential for over-stressed parents/caregivers to become violent or abusive (The Alliance for Child Protection in Humanitarian Action et. al, 2020). The results below should be read with caution, taking into consideration the limitations outlined above. Irrespective of COVID-19, it is well documented that the accurate reporting of violence is problematic

due to the sensitive nature of the issue and risks associated with reporting (Peterman et. al, 2020).

At an individual level, approximately 1 in 6 (16%) child programme participants reported violence occurring in the home, and 1 in 5 (19%) parent/caregiver programme participants. A more accurate indication of the prevalence of violence at the household level can be given by matching parents/caregivers to their child respondent at the household level, as violence is often under-reported by both adults and children<sup>3</sup>. The following household level statistics are calculated where both an adult and a child answered the survey and these particular relevant questions. This means that households that did not have a child respondent were removed from the analysis. When this is performed, we can see that there were **only a small proportion of cases where both the child and their parent/caregiver reported violence (in 9% of the households where violence was reported)**. There were a number of cases where a child reported violence and their parent/caregiver did not (in 7% of households). Likewise, there were a much larger number of cases where a parent/caregiver reported violence and their child did not (in 15% of households).

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**In total, nearly one-third (32%) of households had a child and/or a parent/caregiver who reported that there had been violence occurring in the home, including children and/or adults being verbally or physically abused.**

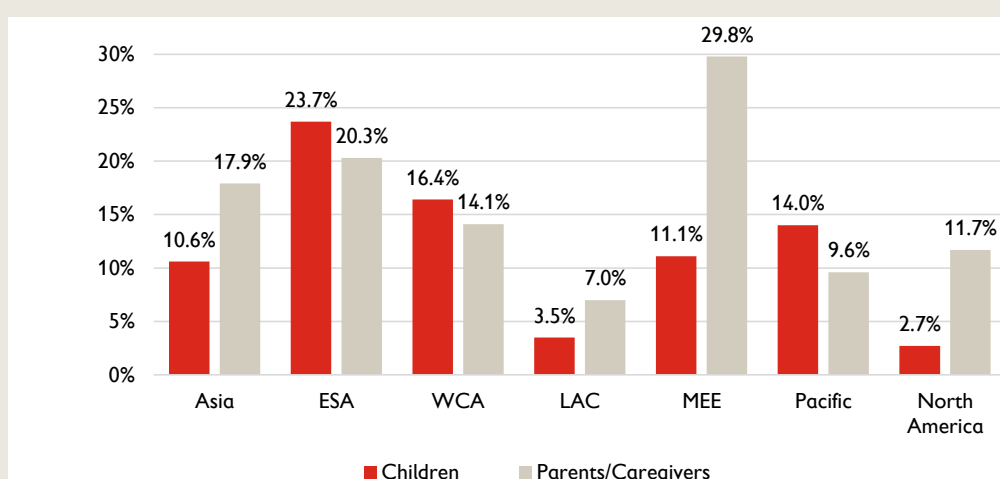
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<sup>3</sup>See methodology section "Violence in the Home" for further information on limitations in measuring violence in the home in this survey.

**"In total, nearly one-third (32%) of households had a child and/or a parent/caregiver who reported that there had been violence occurring in the home, including children and/or adults being verbally or physically abused".**

The child programme participants' reporting of violence in the home varied significantly across regions, with much higher levels reported in East and Southern Africa (ESA) (24%) compared to North America (3%). The reporting of violence in the home by parent/caregiver programme participants also varied significantly across regions – but not in line with child programme participant reporting – with much higher levels reported in the Middle East and Europe (MEE) (30%) compared to Latin America and the Caribbean (LAC) (7%).

**Figure 1: Proportion of Child and Parent/Caregiver Program Participants Reporting Violence in the Home by Region**



A similar proportion of girls and boys surveyed, 16% and 17% respectively, reported violence occurring in the home. Similarly, female parents/caregivers and male parents/caregivers surveyed reporting that there had been violence occurring in the home had similar rates (20% and 17% respectively). There was also no difference in the proportion of children reporting violence in the home across the 11-14 and 15-17 years age groups, at 16% for both.

However, at a regional level there were differences between these two age groups in terms of reported violence in the home; significantly higher in Asia for the 11-14 years age group, while significantly higher for the 15-17 years age group in ESA and West and Central Africa (WCA). When the parent/caregiver who had responded to the survey had a disability, the reporting of violence by the child was significantly higher, at one-third of the respondents (31%), compared to 16% when the parent/caregiver did not have a disability. Parents/caregivers with a disability also reported violence occurring in the home at a higher rate (27%) compared to those without a disability (19%).

Those parents/caregivers surveyed in urban locations also reported violence in the home at a higher rate (23%) compared to rural respondents (17%). At a regional level though, there was variation in this result, and in ESA and MEE, violence in the home was reported at a significantly higher rate by parents/caregivers in rural locations. Having moved from where they normally live due to the outbreak of COVID-19 also resulted in significantly higher reporting of violence in the home by parents/caregivers, at one-third (33%) for those who had moved, compared to 18% for those who had not. Children surveyed also reported higher levels of violence in the home in urban locations, and when the family had moved owing to COVID-19, with similar regional trends as outlined above in the parent/caregiver results.

**“During this time violence against children is increased, thus please work on this issue”**

**- Girl, 14 year old, Ethiopia**

Among the general public children who participated in an online survey, 10% reported that there had been violence occurring in the home, while for their parents/caregivers, 16% reported that there had been violence occurring in the home, with rates reported by female parents/caregivers 19% and male parents/caregivers 13%. For the general public children, there was no statistically significant difference across the different demographics investigated in this survey. However, for the general public parents/caregivers, there were statistically significant differences in the results based on the parents'/caregivers' age, disability status, minority status and location (rural/urban), similar to the trends for the parent/caregiver programme participant results.

**WHAT ARE  
THE RISKS AND  
PROTECTIVE  
FACTORS  
ASSOCIATED  
WITH VIOLENCE  
OCCURRING IN  
THE HOME?**



There is a significant association between child programme participants reporting violence in the home, and household income. Of households that reported no to income source loss due to COVID-19, only 5% of the children reported violence in the home, compared to 19% when there had been a loss of household income source. Further, of those households that had lost more than half their income as a result of COVID-19, they appear to also be associated with these children reporting violence, with 19% reporting violence when more than half of household income had been lost, compared to 9% when less than half their income had been lost. Parent/caregiver programme participants also reported similar

significant association between violence in the home and the loss of household income, with 22% reporting violence when more than half the household income had been lost, compared to 15% when less than half had been lost.

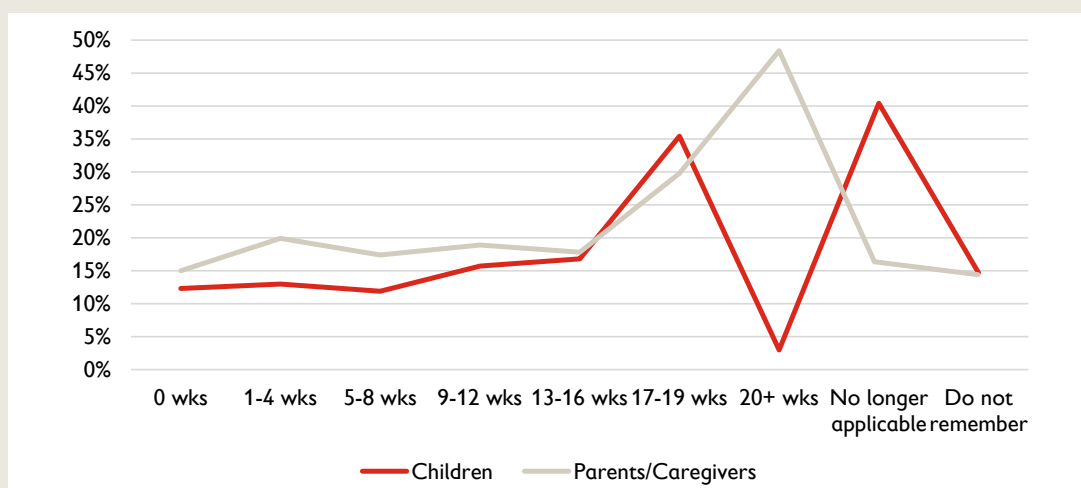
There was also a significant association between children reporting violence in the home, and whether or not their school was open. Children who reported their schools being closed also reported violence in the home at a higher rate (17%) than those who reported that their school was open and they were attending in person (8%). For those children who reported that their school was open for remote learning, they reported violence in the home at a rate of 15%.

The number of weeks confined at home due to COVID-19 and whether child and parent/caregiver programme participants reported that there had been violence occurring in the home, also had a significant association. The trend of this is unclear though, likely owing to considerable regional variation, but with violence reported by children tending to increase the longer confinement at home lasted, with 12% at 0 weeks through to 17% at 13-16 weeks, before a jump to 35% at 17-19 weeks and then a dip to only 3% at 20+ weeks. Interestingly, it was children from households for which confinement was no longer applicable which reported the highest levels of violence at 40%. For parents/caregivers, the trend was also unclear, and again likely due to the regional variation, with the reporting of violence tending to start lower at 0 weeks (15%), hovering at around 17-20% for between 1-17 weeks, before jumping to 30% at 17-19 weeks and 48% at 20+ weeks. When confinement was no longer applicable, a comparatively lower proportion of these parents/caregivers reported violence in the home (17%) than children.

**The more household income that has been lost owing to COVID-19, the higher the reporting of violence in the home by both children and parents/caregivers.**

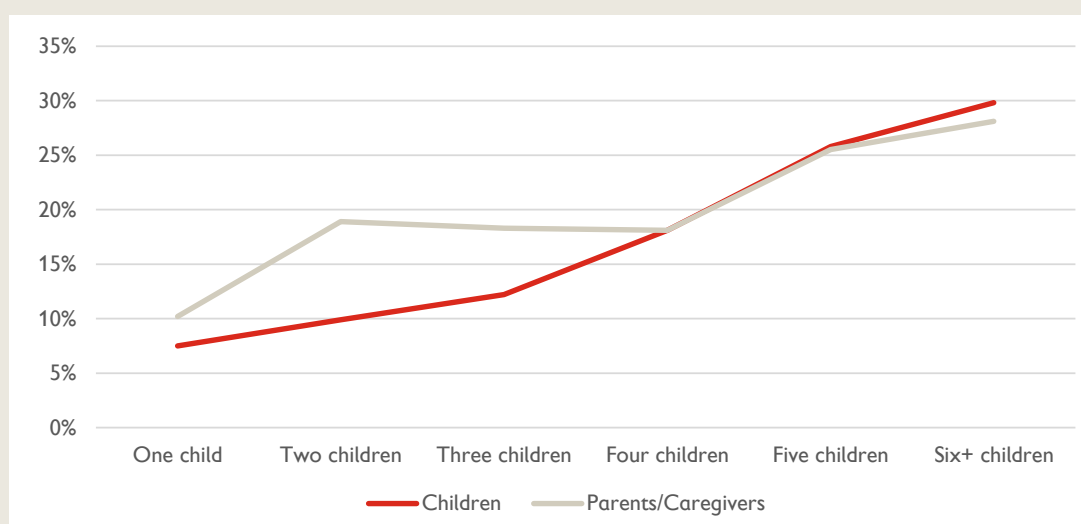


**Figure 2: Proportion of Child and Parent/Caregiver Programme Participants Reporting Violence in the Home and Weeks Confined at Home**



Both child and parent/caregiver programme participants reported significant associations between reporting of violence in the home and the number of children in the care of the parent/caregiver. This ranged from 8% of children reporting violence when there was 1 child in the care of their parent/caregiver, through to nearly one-third (30%) when there were 6+ children living in the home. Similarly, 10% of parents/caregivers reported violence when there is 1 child in their care, compared to 28% when there were 6+ children living in the home.

**Figure 3: Proportion of Child and Parent/Caregiver Programme Participants Reporting Violence in the Home and Number of Children in the Home**

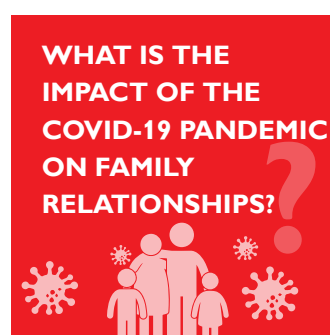


There was a significant difference in the reporting of violence in the home based on the mental health and psycho-social well-being of parent/caregiver programme participants. 1 in 5 of those with reduced mental health and psycho-social well-being (20%) reported violence in the home, compared to around 1 in 10 (11%) where reduced mental health and psycho-social well-being was not a factor. There was also a difference between the number of activities parents/caregivers reported doing together with their children, including reading, art, music, play and watching TV, and the reporting of violence in the home. The reporting of

violence in the home was significantly lower when parents/caregivers reported doing no activities with their children (14%), compared to nearly one quarter (24%) of them reporting violence when they were doing four or more activities.

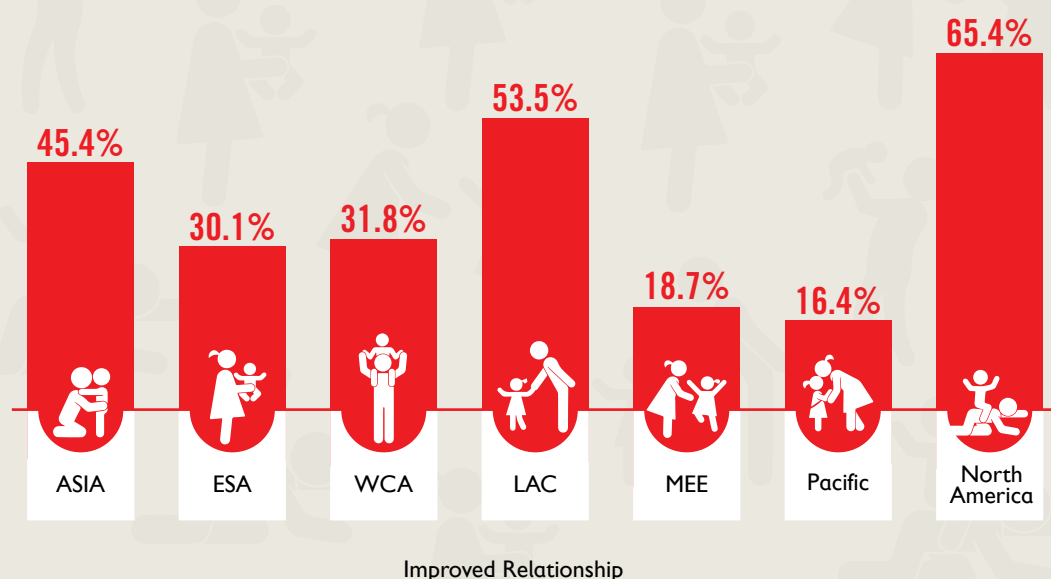
Finally, a significant proportion of child and parent/caregiver programme participants reporting violence in the home also reported a lack of access to parenting supports, including counselling, mental health services, drug and/or alcohol services, domestic violence services, money/vouchers, childcare and/or parenting advice/support. Over one quarter (26%) of the children reported violence in their home when their parents/caregivers had reported a lack of access to parenting support, compared to 12% when their parents/caregivers had not reported any lack of access to supports. Similarly, nearly one quarter (24%) of the parents/caregivers reported violence when they also reported a lack of access to parenting supports, compared to 16% when they did not report any lack of access to supports. This finding was particularly high for the ESA region, with 32% of the parents/caregivers reporting violence when they also reported a lack of access to parenting supports. Please see the last results section on service needs, for further information in this area.

For the general population children and parents/caregivers who participated in an online survey, there were similar results and trends as for the child and parent/caregiver programme participants results above. Loss of household income, reduced parent/caregiver mental health and psycho-social well-being and a lack of access to parenting supports all had associations with significantly higher reporting of violence in the home.



Over one-third of the parent/caregiver programme participants (39%) that could be reached by phone/email reported an improved relationship with their children since the outbreak of COVID-19, including that their children show more love and affection to them and/or that their children are happier spending more time with them. The reporting of improved relationships with their children by these parents/caregivers varied significantly across regions though, with greater improvements reported in North America (65%) compared to the lowest reported improvements in the Pacific (16%).

**Figure 4: Proportion of Parent/Caregiver Programme Participants Reporting Improved Relationships with Children, by Region**



**“Earlier, my mother was not at home. I like that now she is [home] with us more and that we always talk. Earlier she was always tired, and now less, although she is always very worried”**

— Girl, 12 year old, Peru

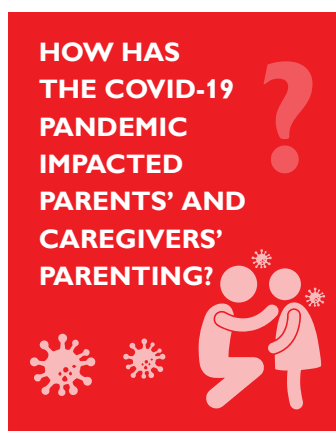
The female parents/caregivers surveyed reported slightly higher results for having an improved relationship with their children (40%) compared to male parents/caregivers (36%). However this was not statistically significant. This trend was similar across regions, with the exception of MEE in which male parents/caregivers reported an improved relationship at a higher rate (24%) than female parents/caregivers (16%). Globally, there was no statistical difference in results between parents/caregivers with (43%) and without (40%) a disability. However this varied across regions. In MEE and LAC, parents/caregivers who did not have a disability reported improved relationships with their children at a higher rate than those with a disability. Parents/caregivers in urban locations also reported improved relationships with their children at a higher rate (44%) than those in rural areas (36%).

Three variables (the loss of income, reduced mental health and psycho-social well-being, and a lack of access to parenting supports) that were shown above to have a significant, negative association with reporting of higher levels of violence, here tended to have a significant, positive association with the higher reporting of improved relationships.

1. Parent/caregiver programme participants who had lost more than half their income since the outbreak of COVID-19 tended to report improved relationships with their children at a higher rate (41%) than those who had not lost this amount of income (36%). This trend was evident across all regions, with the exception of WCA in which those parents/caregivers who had not lost more than half their income reported an improved relationship with their child at a slightly higher rate (33%) than those who had lost more than half their income (29%).
2. Parents/caregivers who had reduced mental health and well-being reported an improved relationship with their children at a higher rate (40%) than those who did not have reduced mental health and well-being (30%).
3. Nearly half (49%) the parents/caregivers reporting a lack of access to parenting supports also reported improved relationships with their children, compared to those who did not report any lack of access to supports (34%).

The number of activities parent/caregiver programme participants reported doing together with their children, including reading, art, music, playing and watching TV, was associated with both reporting of higher levels of violence in the home and improved relationships with their children. The reporting of improved relationships was significantly higher with the more activities the parent/caregiver programme participants did with their children, at 72% when four or more activities reported, compared to 22% when no activity was reported. Spending more time with parents/family and having a stronger relationship with family were also the primary themes highlighted by children when asked what they had enjoyed the most about this time [during the COVID-19 pandemic].

Among the general population parents/caregivers who participated in an online survey, over half the parents/caregivers (58%) reported an improved relationship with their children. There were some trends similar to the parent/caregiver programme participants results above - reduced mental health and psycho-social well-being and lack of access to parenting supports actually resulted in a statistically significant higher reporting of improved relationships. Similarly, the more activities reportedly undertaken with children, the higher the reporting of improved relationships with children.

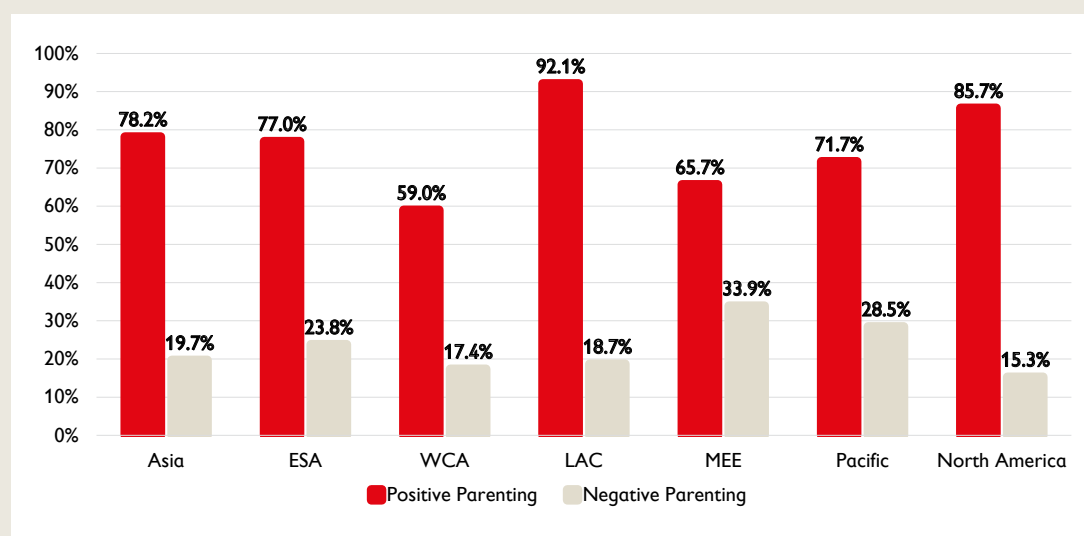


Over three-quarters of the parent/caregiver programme participants (77%) reported an increase in their use of positive parenting methods with their children, which included spending more time with them, having a greater bond with them, showing more love and affection towards them and/or being more responsive to their children's needs. Reporting of an increased use of positive parenting methods with their children by these parents/caregivers varied significantly across regions, with greater increases reported in Latin America and the Caribbean (92%) compared to West and Central Africa (59%).

Conversely, just over 1 in 5 parents/caregivers surveyed (22%) reported an increase in their use of negative or violent parenting methods, including being less patient, speaking less calmly, being more

aggressive, shouting more and/or increased use of physical punishment. Reporting of the increased use of negative or violent parenting methods with their children by these parents/caregivers also varied significantly across regions, with greater increases reported in Middle East and Eastern Europe (34%) compared to North America (15%). 17% of the parents/caregivers reported an increase in both positive and negative parenting.

**Figure 5: Proportion of Parent/Caregiver Programme Participants Reporting Positive or Negative Parenting, by Region**



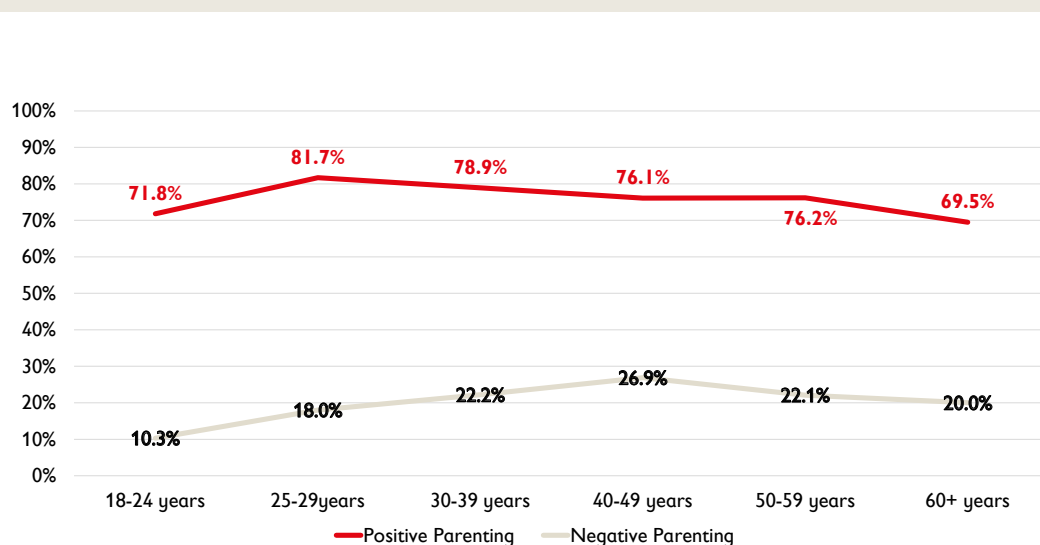
Female parent/caregiver programme participants reported greater increases in using positive parenting methods with their children (80%) compared to male parents/caregivers (74%) in all regions, with the exception of the MEE, where male parents/caregivers reported the use of positive parenting methods at a slightly higher rate (67%) than female parents/caregivers (65%). Globally, the use of negative or violent parenting methods, however, was similar, at 22% for female parents/caregivers and 21% for male parents/caregivers. This varied at a regional level though, with 22% of the females and 16% of the males in Asia reporting increased negative or violent parenting methods, while the reverse of this was seen in East and Southern Africa (27% for males and 22% for females), and the Pacific (28% for males and 17% for females).

The results for parents/caregivers according to disability status was also very similar for positive parenting, at 80% for those with a disability, and 77% for those that did not have a disability. However,

parents/caregivers with a disability reported a significantly higher use of negative or violent parenting methods with their children, at one-third (33%), compared to about one-fifth of the parents/caregivers with no disability (21%). The exception to this trend was in West and Central Africa, where parents/caregivers who do not have a disability reported the highest use of negative or violent parenting methods.

The increasing use of positive and negative or violent parenting methods reported was also significantly associated with the age of parents/caregivers surveyed. For positive parenting, there was no clear trend, with results ranging from 82% for 25-29 year olds, to 70% for 60+ year olds. Negative parenting, however, tended to increase as the parent/caregiver got older, then dipped lower for the two older age categories (see graph below).

**Figure 6: Proportion of Parent/Caregiver Programme Participants Reporting Positive or Negative Parenting, by Age of Parent/Caregiver**



Parent/caregiver programme participants in urban areas reported an increased use of positive parenting methods at a higher rate than those in rural areas, at 80% and 76% respectively. Yet parents/caregivers in urban areas also reported an increase in using negative or violent parenting methods at a higher rate than those in rural areas, 26% and 20% respectively. This was not consistent across all regions though, with parents/caregivers in rural areas in Latin America and the Caribbean reporting higher increases in the use of positive parenting methods, while in the Middle East and Eastern Europe, the respondents from rural areas reported greater use of negative or violent parenting methods.

An increase in the reported use of negative or violent parenting methods was also higher among parents/caregivers who had moved due to COVID-19 (39%) compared to those who had not (21%). Parents/caregivers in this cohort also reported comparatively lower rates of using positive parenting (71% compared to 78%), although this was not statistically significant. This relationship between moving due to COVID-19, and the higher use of negative or violent parenting methods and lower use of positive parenting methods, was not consistent across all regions though. In MEE and WCA, those who moved reported a higher use of positive parenting (77% and 72% respectively) compared to those who had not moved (65% and 59% respectively), as well as lower use of negative or violent parenting methods among parents/caregivers who had moved (24% and 15% respectively) compared to those who had not (34% and 18% respectively).



**“What can adults in your home do differently?”**

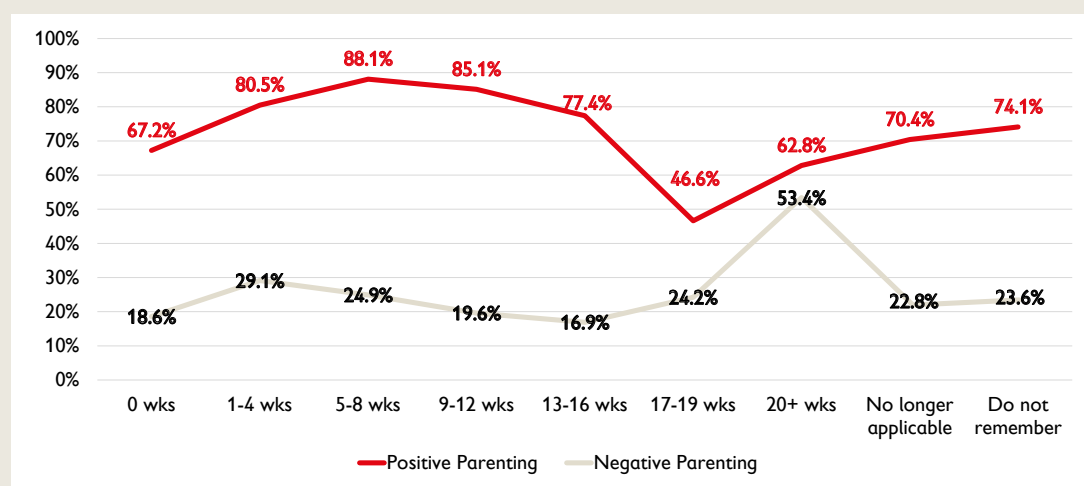
**“Maybe they should worry less. They are becoming a bit dramatic (overreacting). They are becoming very strict even inside the house”**

— Boy, 17 year old, Philippines

Parent/caregiver programme participants who had lost more than half their income since the outbreak of COVID-19 reported a significant association between this and increases in both positive parenting or negative parenting. The majority (80%) of the parents/caregivers reported an increase in their use of positive parenting methods, compared to those who had not lost this amount of income (75%). At the same time, nearly one quarter (24%) of the parents/caregivers who had lost more than half their income owing to COVID-19 reported a significant increase in the use of negative or violent parenting methods, compared to 19% of those who had not lost that amount of income.

There was also a statistically significant association between the number of weeks confined at home and whether parents/caregivers reported both an increased use of positive parenting or negative parenting methods. Trends however, are unclear, likely due to considerable regional variation. The reporting of increased use of positive parenting methods was lowest at 17-19 weeks (47%) and highest at 5-8 weeks (88%) while the reporting of increased use of negative or violent parenting was lowest at 13-16 weeks (17%), but significantly higher at 20+ weeks (53%).

**Figure 7: Proportion of Parent/Caregiver Programme Participants Reporting Positive or Negative Parenting and Weeks Confined at Home**



Again, reduced mental health and psycho-social well-being, the lack of access to parenting supports and the number of activities done with children were significantly associated with both the increased use of positive and negative or violent parenting methods:

1. Of those parent/caregiver programme participants who did not have reduced mental health and psycho-social well-being, 61% reported an increased use of positive parenting methods, compared to 80% of parents/caregivers who did have reduced mental health and psycho-social well-being. At the same time, nearly one quarter (23%) of those with reduced mental health and psycho-social well-being

- reported an increased use of negative or violent parenting methods, compared to 16% where reduced mental health and psycho-social well-being was not a factor.
2. A higher proportion of parents/caregivers reporting a lack of access to parenting supports also reported an increased use of positive parenting (81%), compared to those who did not report a lack of access to support (76%). 27% of the parents/caregivers reporting an increased use of negative or violent methods also reported a lack of access to parenting supports, compared to 19% who did not report a lack of access.
  3. The reporting of increased use of positive parenting was significantly higher with the more activities the parents/caregivers did with their children, at 92% when four or more activities reported, compared to 51% when no activities were reportedly undertaken. In contrast, however, the reported increased use of negative or violent parenting methods was significantly lower when these parents/caregivers reported doing no activities with their children (16%), compared to 29% when they shared four or more activities.

Among the general public (parents/caregivers who participated in an online survey) the majority (85%) reported an increase in using positive parenting methods, while just under one quarter (24%) reported an increase in using negative or violent parenting methods. There were some similar trends as with the parent/caregiver programme participant results above, in that reduced mental health and psycho-social well-being, lack of access to parenting supports and undertaking more activities with children were associated with higher reporting of both the use of positive and negative or violent parenting methods, as they were for programme participants.

## Children Separated from their Parents/Caregivers

It is expected that the number of children who are separated, or at the risk of being separated from their primary caretakers will increase as a result of the COVID-19 crisis. This is owing to both the short-term containment measures, illness and loss caused by the pandemic, as well as the long-term socio-economic impact of COVID-19 and the capacity of households to care for their children (Better Care Network et. al, 2020).

**HAVE CHILDREN  
BEEN SEPARATED  
FROM THEIR  
PARENTS/  
CAREGIVERS?**

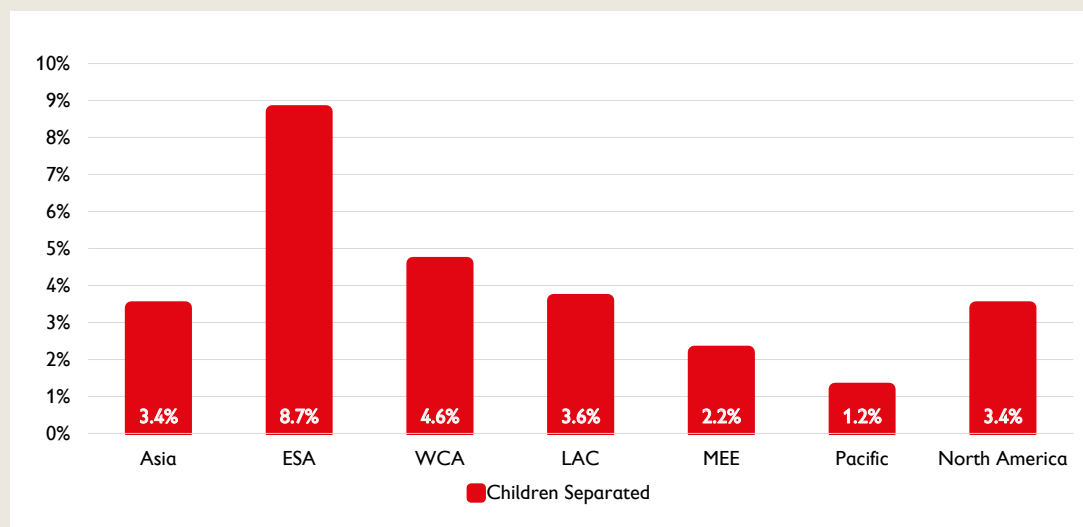


Among parent/caregiver programme participants who could be reached by phone/email, 6% reported that they had children that they had been separated from because of COVID-19. At a regional level, the proportion of children who reported having been separated from their parents/caregivers ranged from 1% in the Pacific through to 9% in East and Southern Africa.



PHOTO: LEI TAPANG / SAVE THE CHILDREN

**Figure 8: Proportion of Parent/Caregiver Programme Participants Reporting Separation of Children by Region**



Whether or not any adult in the household had fallen sick due to any illness since the outbreak of COVID-19, the age of a parent/caregiver, and disability of the parent/caregiver were associated with higher reporting of separation from a child in their care, though there was little difference in terms of the gender of the parent/caregiver (6% of male parents/caregivers compared to 5% of female parents/caregivers). A significantly higher percentage of parents/caregivers with a disability (17%) reported separation from children, compared to parents/caregivers who did not have a disability (5%). This result was particularly high in East and Southern Africa, where 27% of the parents/caregivers with a disability reporting the separation of children, compared to 7% of the parents/caregivers with no disability. The age of parents/caregivers was also significantly associated with whether children had been separated from them. Rates ranged from 4% for 25-29 year olds to 9% for 60+ year olds. The relationship between parents/caregivers reporting that they or another adult in the household had fallen sick, and the separation of children was also significant (11% for those households with illness compared to 4% for households not reporting illness).

Parents/caregivers in urban locations reported child separation at a higher rate (7%) than rural parents/caregivers (5%). This trend was statistically significant and the same across all regions. Parents/caregivers who identified as belonging to a minority group also reported separation at a higher rate (9%) than those who did not (4%).

The relationship between whether the parents/caregivers reported moving from where they normally live because of the outbreak of COVID-19 and children being separated was also significant. Nearly one quarter (23%) of the parents/caregivers reporting a move also reported the separation of children, compared to 5% of the parents/caregivers who had not moved. This association was reflected across all regions, but was particularly pronounced in East and Southern Africa where 36% of the parents/caregivers who had moved reported separation, compared to 7% who had not moved.

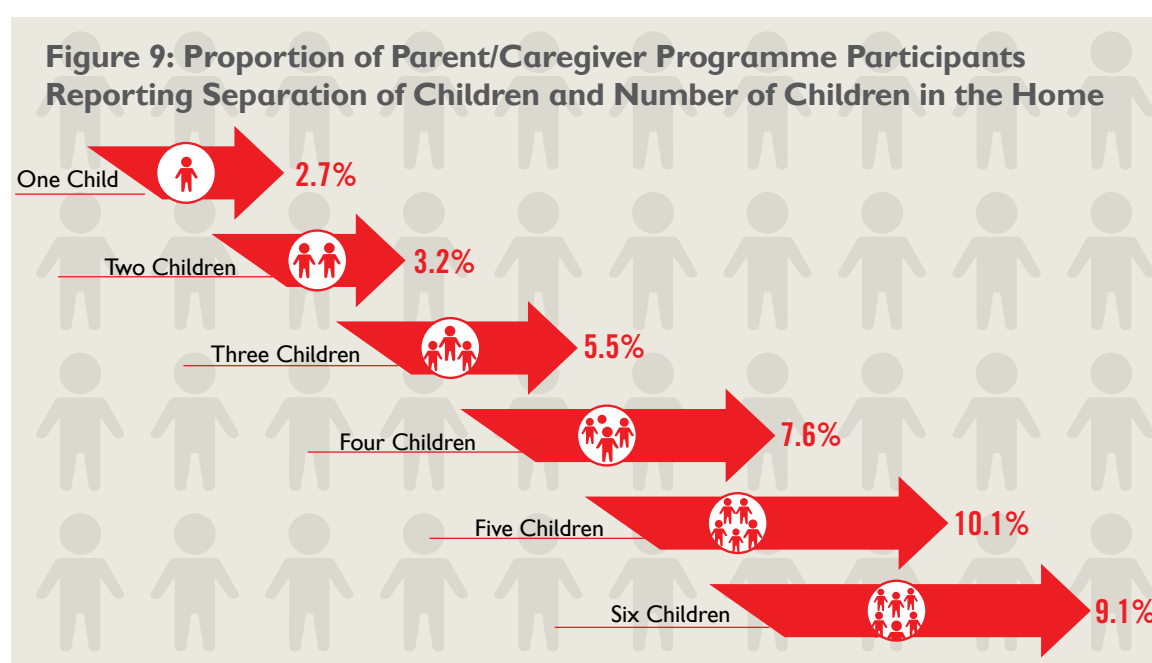
**23% of the parents/caregivers who have had to move because of COVID-19 reported children being separated.**

**“Mother has gone abroad for work. Being separated from her is worrying me.”**

— Boy, 13 year old, Sri Lanka

Among parent/caregiver programme participants, those who reported a loss of income owing to COVID-19 also reported that children had been separated from them because of COVID-19 at a higher rate than when the loss of income was not a factor. While this result was not statistically significant, the extent to which income had been lost and children separated, was. This ranged from 8% reporting separation for those who had lost all of their income, compared to 3% for those who reported they had lost less than a quarter of their income.

Parents/caregivers who reported a higher number of children in their care reported separation at higher rates than those who reported less children in their care. Parents/caregivers who reported 6 or more children in their care, reported separation at 9%. Parents/caregivers who reported 5 children in their care reported separation at 10%. Reported separation decreased for parents/caregivers who reported fewer children in their care, down to 3% for parents/caregivers with 1 or 2 children in their care.



There was a statistically significant association between the type of care relationship that parents/caregivers reported with children under their care<sup>4</sup>, and whether or not they had children who had been separated from them owing to COVID-19. Of parents/caregivers who reported their relationship as being one of a foster caregiver or caring for unrelated children, 17% reported that children had been separated, while for biological or kinship care arrangements this was 5%, and negligible (0.1%) for institutional caregivers.

Children tended to be separated in the earlier stages of home confinement. Of parents/caregivers reporting separation, reports of separation were higher for confinements of 1-4 weeks and 5-8 weeks (9% for both), and tended to decrease during longer periods of confinement to about 5% for weeks 9-12, 13-16, and 17-19, and 1% at 20+ weeks.

Finally, the relationship between parents/caregivers reporting a lack of access to parenting supports and child separation was statistically significant. Parenting supports in the survey included counselling, mental health services, drug and/or alcohol services, domestic violence services, money/vouchers, childcare and/or parenting advice/support. Child separation was reported at 7% for those with a lack of access to supports, compared to 5% for those

**Children tended to be separated in the earlier stages of home confinement.**

<sup>4</sup>Note: this is specifically children under their care and currently living with them, and may not be the same relationship as they had with the child/children who have been separated from them.

who did not report a lack of access to supports. This varied across regions though, with results in Asia, the Middle East and Eastern Europe, and West and Central Africa reporting slightly higher separation of children when parents/caregivers reported that they did not lack access to parenting supports.

Among the general population who participated in an online survey, 6% of the parents/caregivers reported that they had children that they had been separated from because of COVID-19. Some trends among this group were similar to those among the parent/caregiver programme participants' results, including the association between the reporting of children being separated and disability of the parent/caregiver, age, household illness and the parent/caregiver moving from where they normally live because of the outbreak of COVID-19.

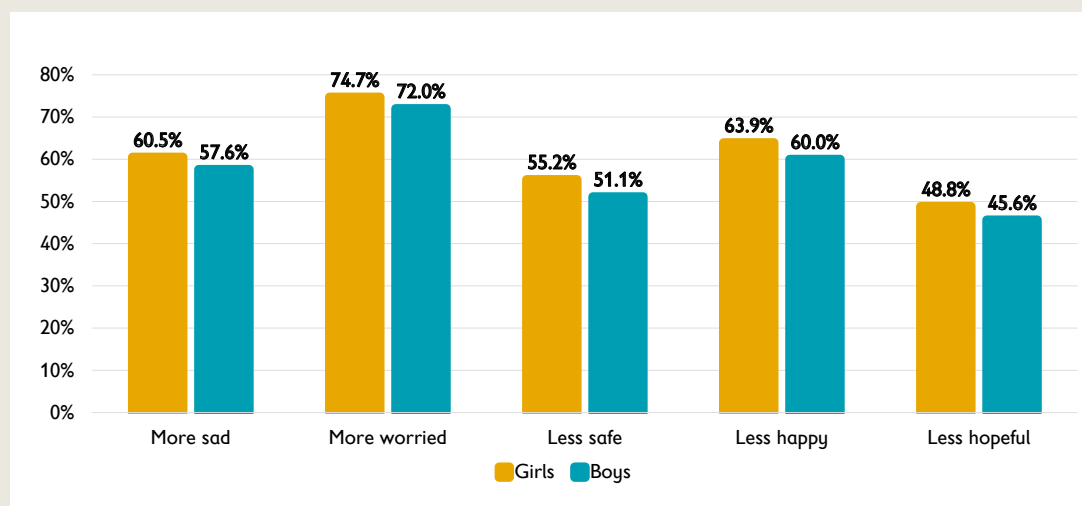
## Impact of the COVID-19 Pandemic on Children's and Parents'/Caregivers' Mental Health and Psycho-Social Well-Being

### WHAT IS THE IMPACT OF THE COVID-19 PANDEMIC ON CHILDREN'S PSYCHO-SOCIAL WELL-BEING?



The vast majority (83%) of the children whose households had programme participants and could be reached by phone/email reported an increase in negative feelings owing to the COVID-19 pandemic. Boys and girls aged 11-17 years were asked about changes in their feelings since the COVID-19 outbreak. Around 3 in 4 (74%) boys and girls from programme participant households reported that they were more worried, while 59% were more sad and around half (53%) said that they felt less safe compared to before the outbreak. Only a quarter (25%) of the children reported feeling as happy as before, while almost 2 in 3 children (62%) said they were less happy. There is no statistical difference in changes in feelings experienced by girls and boys.

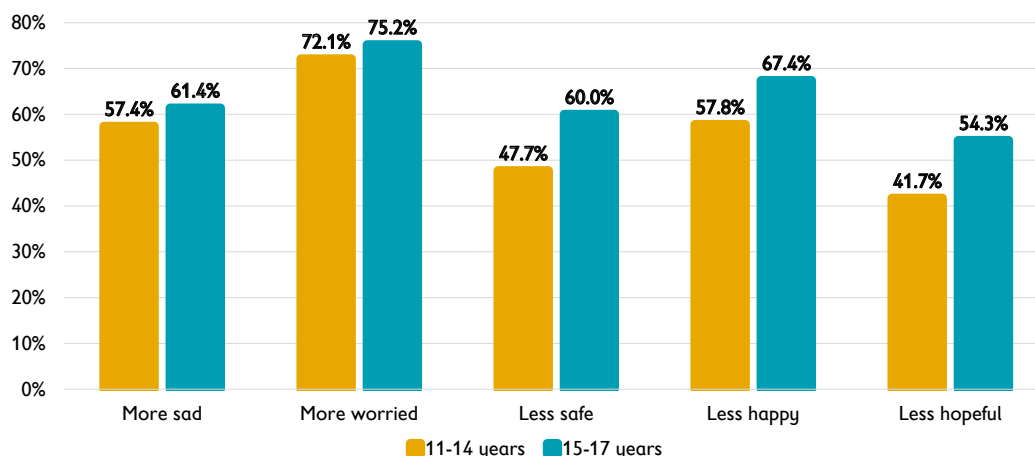
**Figure 10: Proportion of Boys and Girls Reporting Negative Feelings**



**Adolescents aged 15 to 17 years** showed higher levels of change in negative feelings across a range of feelings<sup>5</sup> and notably more than half (60%) stated that they are feeling less safe compared to just less than half (48%) the child respondents aged 11-14 years and more than half (54%) felt less hopeful compared to younger children (42%).

<sup>5</sup>The associations between children's age and the change in feeling worried ( $P=.709$ ) and sad ( $P=.441$ ) were not statistically significant.

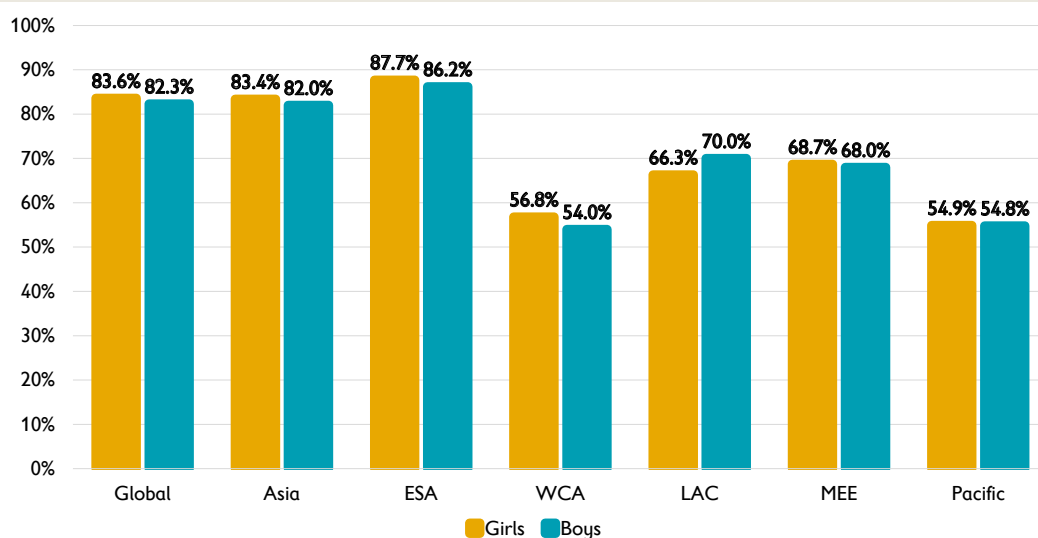
**Figure 11: Differences in Children's Age in Reporting Negative Feelings**



Children of parents/caregivers with disabilities reported positive and negative changes in feelings at higher rates, than children of parents/caregivers with no disability. Almost two-thirds (64%) of the children of adult respondents living with a disability reported feeling less hopeful, compared to less than half (47%) the children of adult respondents with no disability. Surprisingly, they also reported lower rates of feeling more worried (61%) or more sad (46%), compared to 74% and 59% respectively for children of caregiver respondents who had no disability.

Children's reporting of increases in positive and negative feelings varied widely at a regional level. The highest proportion of children reporting an increase in negative feelings were in East and Southern Africa (87%) and the lowest proportion were in the Pacific (34%). While almost two-thirds (62%) of the children in the Pacific reported being as happy as before the outbreak of COVID-19, only 12% reported the same in the East and Southern Africa Region. There are also stark regional differences for feeling worried and

**Figure 12: Proportion of Girls and Boys Reporting a Change in Negative Feelings**

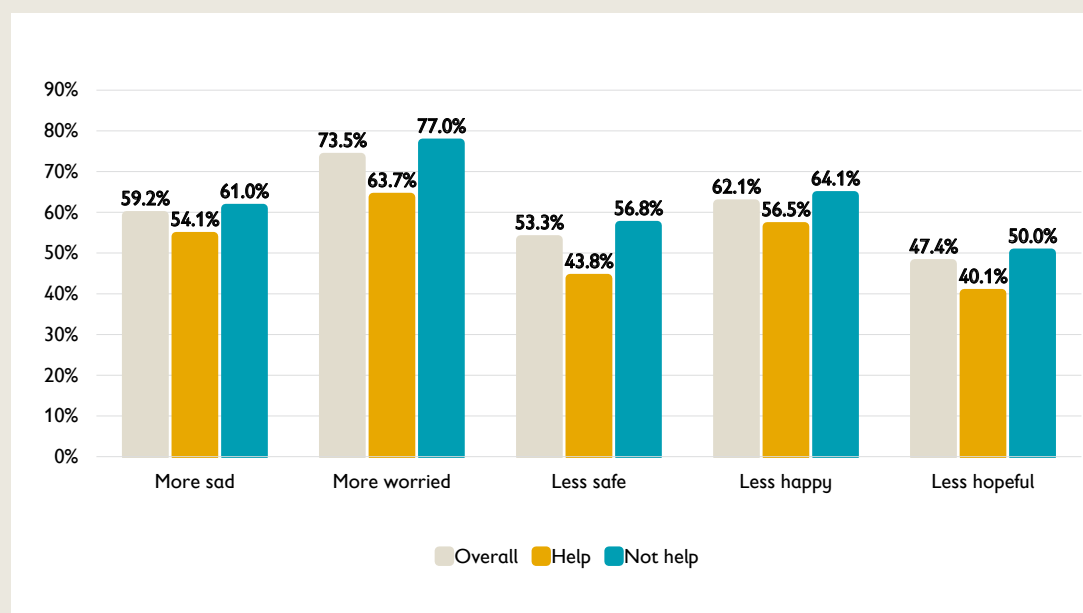




feeling less safe. Around **three quarters or more children in the Asia (73%) and Eastern and Southern Africa Region (77%) reporting they are feeling more worried** compared to only 1 in 5 (20%) children in the Pacific. Similarly, **more than three quarters (68%) of the children in East and Southern Africa reported feeling less safe** than before the outbreak of COVID-19, compared to 1 in 5 in the Pacific (22%) and Latin America and Caribbean (23%) regions (statistically significant). For a comparison of children's and caregivers' reporting of change in negative feelings, see Figure 13 below.

Notably, children's reported levels of negative feelings were even higher where they also stated that they did not have help with answering the survey<sup>6</sup>. The survey results show clear statistically significant correlations between how much children reported feeling worried, sad or safe as well as happy and hopeful, depending on whether someone helped them answer the survey questions. More than three quarters of the children surveyed reported being more worried (77%) compared to around two-thirds (64%), if they also stated that someone helped them. Similarly, more than half (57%) the children reported feeling less safe, when they did not have help with answering the survey, compared to 44% when they had help.

**Figure 13: Proportion of Children Reporting a Change in Negative Feelings Comparison**



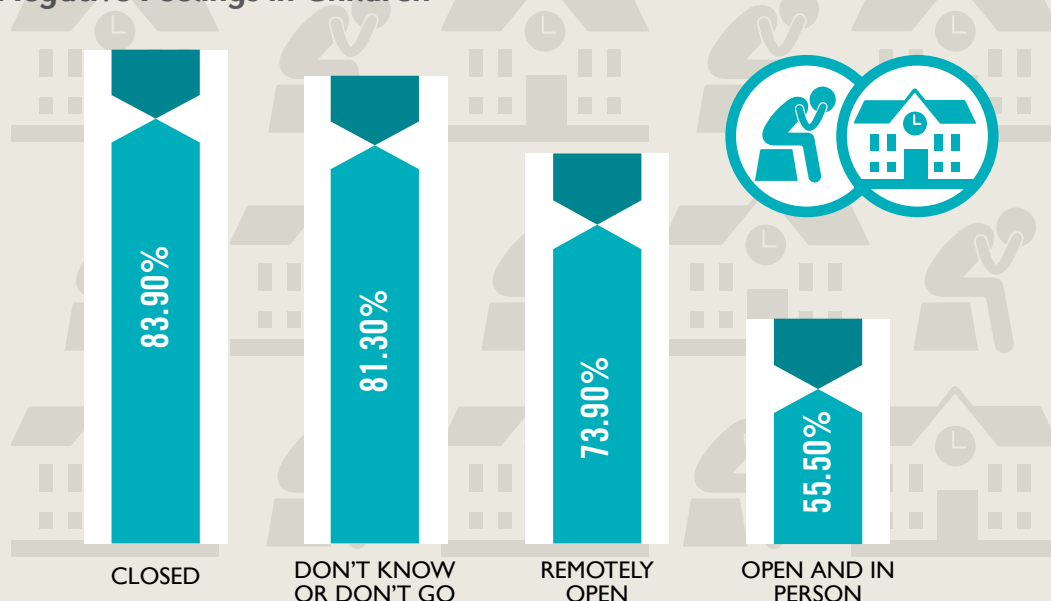
An analysis of a range of factors impacting children's feelings related to the COVID-19 pandemic revealed that in line with existing research (Burde D, et. al., 2015), the interruption of formal education and connected implications is one of the most significant stressors for children (IASC, 2020). The analysis showed **associations between children's ability to attend school, as well as the length of school closures and the levels of reported increase in negative feelings**. Children whose schools were closed for 1 to 4 weeks reported much lower levels of increase in negative feelings (62%) compared to a peak of almost all (96%) the children whose schools have been closed for 17 to 19 weeks. (For a trend line of children and parents'/caregivers' increase in negative feelings please see Figure 14).

<sup>6</sup>Children participating in the survey were asked 'Did someone help you answer these questions?', to which children could respond with a 'Yes' or 'No'.

**The longer that schools had been closed owing to COVID-19, the higher the reported increase in negative feelings in boys and girls.**

A similar trend was observed for girls and boys who reported going to school compared to children attending school remotely or reporting their schools to be closed/not going to school. The vast majority of girls and boys who stated that their schools were closed or they could not go reported an increase in negative feelings (ranging between 81% and 84%) compared to just over half (56%) the children who were going to school in person.

**Figure 14: Comparison of School Closure and Proportion of Increase in Negative Feelings in Children**



**Keeping in touch with friends makes children twice as likely to feel happier, more safe and less worried**



The survey data also shows vast differences in the proportion of boys and girls who reported feeling less happy, less safe and more worried, depending on whether they were able to connect with their friends.

**More than half the children who were not in touch with their friends reported to be less happy, more worried and less safe (ranging between 54% and 58% depending on the feeling), compared to only around a quarter (between 22% and 24%) of the children who were able to meet their friends in person.**

Even staying in touch virtually impacted on children's feelings of happiness, safety and worry. Only a minority (15% to 17%) of children reported feeling less happy, less safe and more worried, if they were in touch with their friends virtually<sup>7</sup>. This number decreased further if the children reported seeing their friends in person as well as interacting virtually, with only 5% feeling less happy and more worried and 6% feeling less safe.

Playing less often than before COVID-19 was associated with children more likely to report negative feelings. More than half (54%) the children who could play less also stated that they were less happy, less hopeful, and felt less safe. **A much lower 1 in 6 (16% to 18%) children who were able to play at about the same levels as before reported feeling less happy, less hopeful and less safe.**

<sup>7</sup>This includes 'We talk/message on the phone', 'We use social media to keep in touch' and 'We play internet games together'.

**Playing less often than before,  
makes children three times more likely  
to feel less happy, less hopeful and less safe.**



The level of activities that children and parents/caregivers reported doing together also influenced children's feelings. Programme participant parents/caregivers were asked what activities they were doing with their children<sup>8</sup>,

including telling stories, reading books, playing, dancing and other musical activities or cooking together. The amount of parental engagement (none or several activities) impacted children's reported levels of happiness, hope and worry. Two-thirds (66%) of the children reported feeling less happy since the outbreak of COVID-19 when their parents/caregivers reported doing one activity with them, compared to just over half (52%) the children when parents/caregivers engaged in four or more activities. **More than half (53%) the children reported feeling less hopeful when parents/caregivers engaged in one activity, compared to just over a third (35%) when parents/caregivers engaged in four or more activities.** Similarly, more than three quarters (76%) of the children reported feeling more worried when parents/caregivers engaged in one activity, compared to 60% of the children when parents/caregivers engaged in four or more activities.

Children reported a higher level of increase in negative feelings, if they or their parent/caregiver also reported violence in the home. **88% of the children reported an increase in negative feelings, if they also reported violence in the home, compared to 82% of the children with no reported violence.** Similarly, parents'/caregivers' reporting of violence was associated with 86% of the children reporting an increase in negative feelings, compared to 74% when no violence was reported.

#### **Girl, 11, Kosovo**

*[If you were asked to write a letter to leaders in your country, what would you say?]*

Please pay closer attention to the children. Throughout this time, we've only heard about the COVID-19 rules, and they've only increased panic. They were also only dealing with political issues. No one bothered about our mental and physical health.

The loss of income and living in urban areas was also associated with an increase in negative feelings. Children living in households that lost more than half their income since the outbreak of COVID-19 reported a higher level in the increase of negative feelings (87%) compared to children from households that didn't (79%). Similarly, children living in urban areas reported a higher level of increase in negative feelings (86%) compared to children living in rural settings (81%). Children belonging to a minority group reported slightly lower levels of increase in negative feelings (80%) compared to children from non-minority groups (85%).

#### **WHAT ARE THE SIGNS OF DISTRESS DISPLAYED BY CHILDREN SINCE THE OUTBREAK OF COVID-19?**



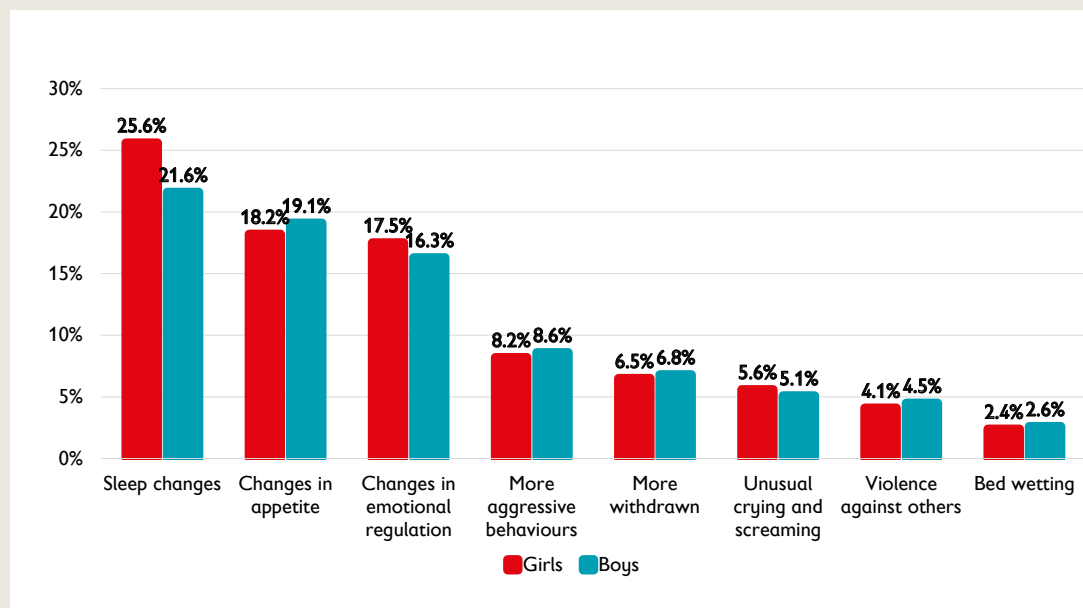
Parents and caregivers were also asked about whether they noticed any changes in their children's behaviour since the outbreak of COVID-19. In difficult and unsettling situations, children may externalise their feelings by showing signs of distress, including higher levels of unusual crying and screaming, more aggressive behaviour or violence, bed-wetting as well as changes in emotional regulation. **Just under half the parents/caregivers (46%) reported observing changes in children's behaviour** with around 1 in 5 parents/caregivers reporting changes in appetite (19%) and sleep (24%). 1 in 6 (17%) reported changes in emotional regulation in their children, 8% reported more aggressive behaviour and 4% reported the use of violence against others since the outbreak.

<sup>8</sup>The reporting of parents'/caregivers' activities with their children was in relation to a particular child, which is not necessarily the child who reported on the change in their feelings. However, the assumption is that the reported level of involvement in parents'/caregivers for 1 child is a reflection of their involvement with all the children in the household.





**Figure 15: Signs of Distress in Children as Observed by Parents/ Caregivers since the Outbreak of COVID-19**



Regional differences were observed for signs of distress in children. The highest levels of changes in sleep and appetite were reported in Asia (27% and 19% respectively) and Latin America and the Caribbean (24% and 27% respectively), while parents/caregivers in East and Southern Africa reported the highest levels of changes in the way children were handling their emotions (23%) as well as unusual crying and screaming (9%). The highest levels of more aggressive behaviour and children showing violence against others were reported in the East and Southern Africa (13% and 8% respectively) and in the Middle East and Eastern Europe (12% and 6% respectively). These regions also showed higher levels of bed-wetting with 5% in the Middle East and Eastern Europe and 4% in East and Southern Africa.

**Children with disabilities and children with chronic health conditions showed higher levels of signs of distress, such as bed-wetting, changes in emotional regulation, unusual crying and screaming.**

While there were only minor differences between boys and girls displaying signs of distress, there were stark differences for children with disabilities and children with chronic health conditions. Children with disabilities and chronic health conditions showed higher levels of bed-wetting, changes in emotional regulation, unusual crying and screaming, more aggressive behaviour and violence against others. For instance, **children with disabilities were more than three times more likely to show bed-wetting (7%) and unusual crying and screaming (17%) since the outbreak** than children without disabilities (2% and 5% respectively). Similarly, children with chronic health conditions were twice as likely or more likely to show unusual crying and screaming (12%) and aggressive behaviour (16%) than children without health conditions (5% and 8% respectively)<sup>9</sup>.

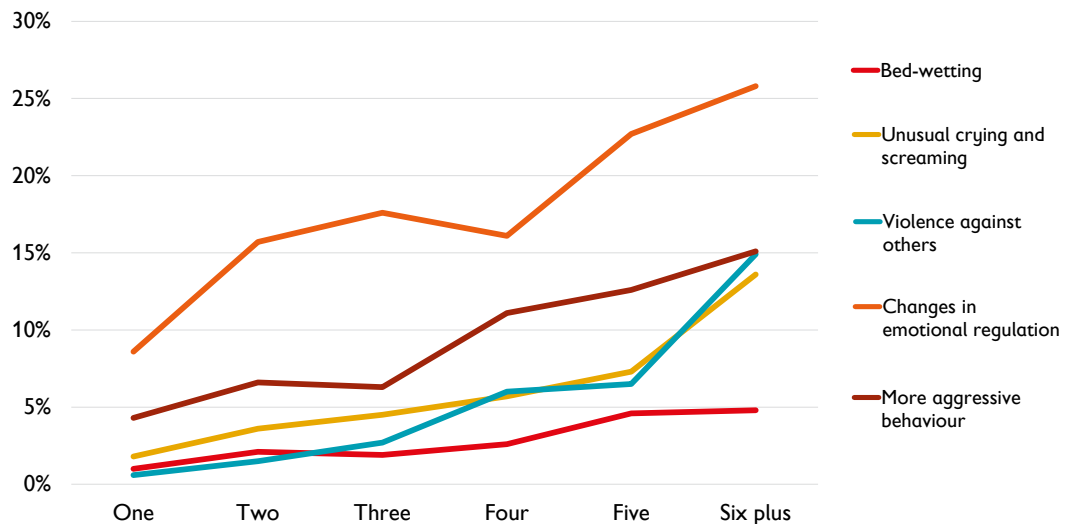
<sup>9</sup>Although these signs often are seen as signs of distress in children it is important to note that for children with disabilities they may occur for other reasons relating to their specific impairment and therefore not be as reliable when using them as determinants for wellbeing. The survey question asked parents/ caregivers specifically about 'have you noticed any of the following changes in children's behaviour since the outbreak of COVID-19', and with that relies on the respondent answering for 'changes' as denoted in the survey question.

**WHAT ARE  
THE RISK AND  
PROTECTIVE  
FACTORS  
ASSOCIATED  
WITH SIGNS  
OF DISTRESS  
IN CHILDREN?**



**Levels of change in emotional regulation, more aggressive behaviour and bedwetting in children were between three to almost five times higher in households with six or more children in the household,** compared to households with only one child. Moreover, children from households with six or more children were seven times more likely (14%) to display unusual crying and screaming compared to households with one child (2%), while violence against others increased from 1% in households with one child compared to 15% in households with six or more children.

**Figure 16: Proportion of Children with Signs of Distress versus Number of Children in the Household**

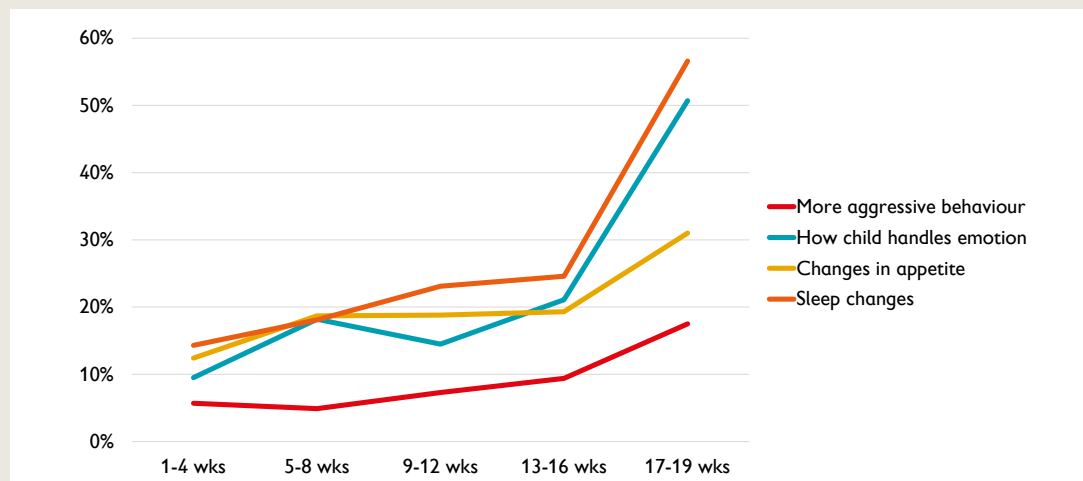


There was a correlation between the reported lack of access to support services for parents and an increase in levels of signs of distress in children. Parents/caregivers who reported a lack of access to supports, including counselling, mental health services, domestic violence services as well as parenting advice and support, were more likely to report signs of distress in their children. For instance, **12% of the parents/caregivers who reported a lack of access to supports also reported unusual crying and screaming in their children, compared to 3% of parents/caregivers who did not report lack of supports.**

Interestingly, although there were no significant trends between weeks in lockdown and signs of distress observed, there were statistically significant associations between the length of school closure and signs of distress. **There was a clear trend showing that the longer the schools were closed, the higher the rate of parents'/caregivers' reporting of sleep changes, changes in appetite, changes in children's ability to handle their emotions as well as more aggressive behaviour.**



**Figure 17: Weeks of School Closures versus Levels of Signs of Distress Observed in Children**

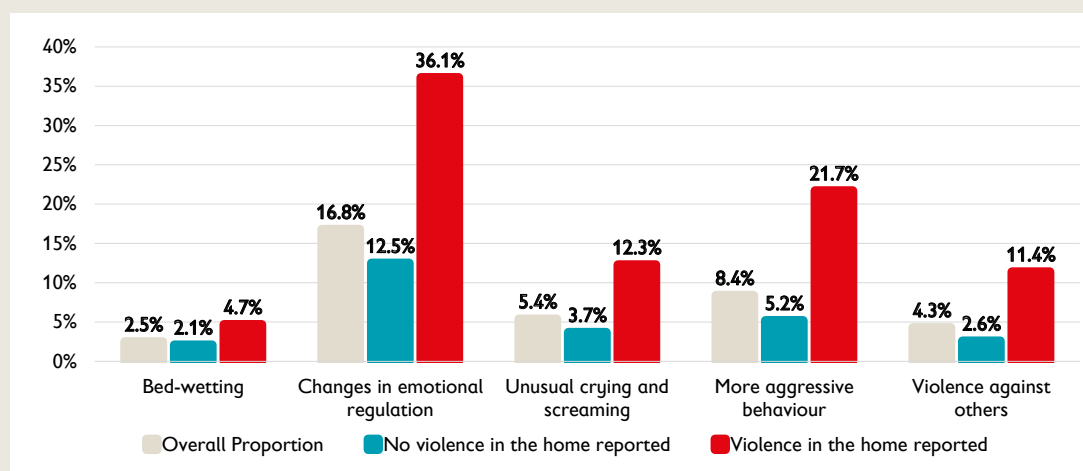


Children whose parents/caregivers reported that there was violence in the home were two to three times more likely to show signs of distress. Compared to children whose parents/caregivers had not reported violence in the home, those children were:

- more than twice (5%) as likely to be bed-wetting, compared to 2%;
- almost three times (36%) more likely to show changes in how they handle emotions, compared to (13%);
- more than three times (12%) more likely to show unusual crying and screaming, compared to 4%;
- more than four times more likely to show more aggressive behaviour (22%) or violence against others (11%), compared to 5% and 3% respectively.

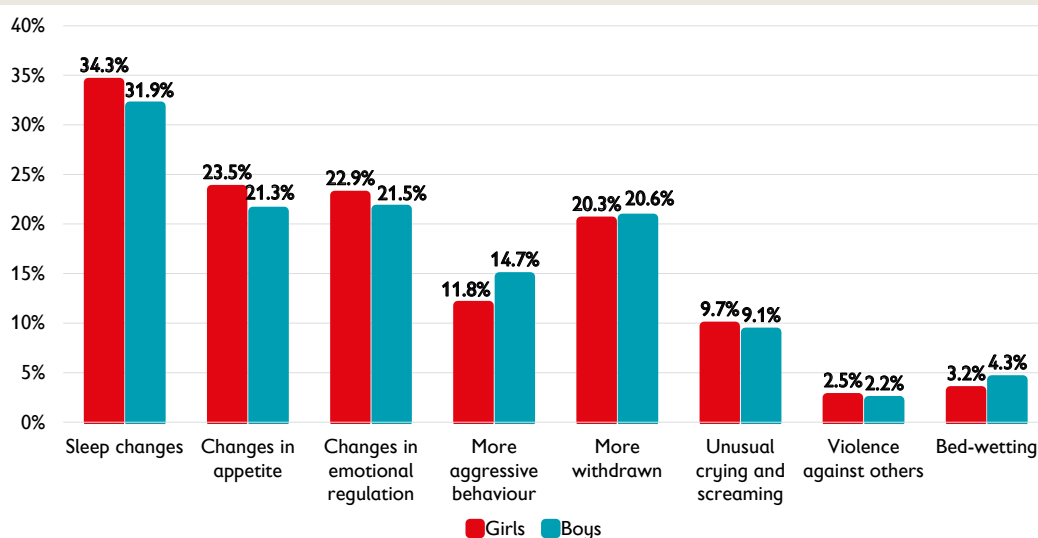
**Children whose caregivers reported violence in the home were two to three times more likely to show signs of distress.**

**Figure 18: Violence in the Home and Levels of Signs of Distress Observed in Children**



Among the general public who participated in an online survey, almost two-thirds (62%) of the parents/caregivers reported observing changes in children's behaviour/signs of distress, including a third (33%) of the children showing changes in sleep, and more than 1 in 5 children showing changes in appetite and changes in emotional regulation (22% for both).

**Figure 19: Signs of Distress Observed in Children in the General Public**



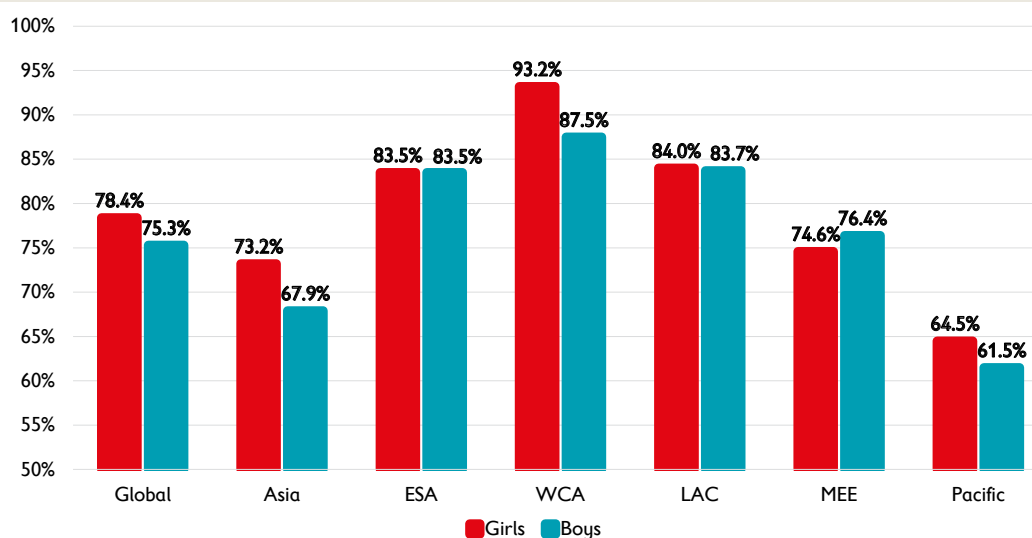
**WHAT IS THE PROPORTION OF PARENTS/CAREGIVERS REPORTING THEIR CHILDREN EXPRESSING NEGATIVE FEELINGS ABOUT COVID-19 SITUATION?**



Parent/caregiver programme participants with phone/ internet access were also asked about the feelings their children express about the COVID-19 situation. More than three quarters (77%) of the parents/caregivers reported that children expressed negative feelings, including worry, anxiety, sadness and fear about the COVID-19 situation.

Interestingly, parents/caregivers who report having a disability observe higher levels of negative feelings in their children with 85% female and 88% male caregivers reporting that their children expressed negative feelings about the COVID-19 situation. This compares to 76% female and 75% male caregivers without disabilities.

**Figure 20: Proportion of Parents/Caregivers Reporting their Children Expressing Negative Feelings about the COVID-19 Situation**

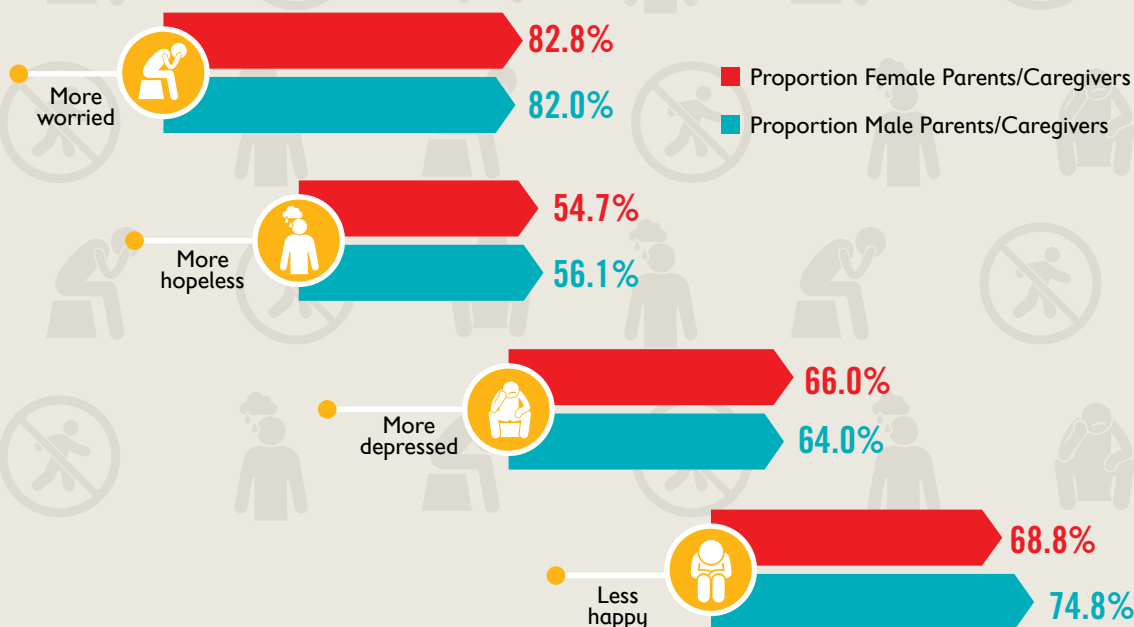


## WHAT IS THE IMPACT OF COVID-19 ON PARENTS' /CAREGIVERS' MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING?



Parents/caregivers were also asked about changes in their feelings since the outbreak of COVID-19, including feeling more worried, nervous, hopeless and depressed. **The vast majority (89%) reported reduced mental health and psycho-social well-being due to the COVID-19 pandemic.** More than half the parents/caregivers reported feeling more restless (53%) and more hopeless (55%), while 1 in 3 reported feeling more nervous (66%) and more depressed (65%) than before the outbreak. The vast majority (82%) of parents/caregivers reported feeling more worried than before.

**Figure 21: Proportion of Parents/Caregivers Reporting Change in Negative Feelings Compared to Before the Outbreak of COVID-19**

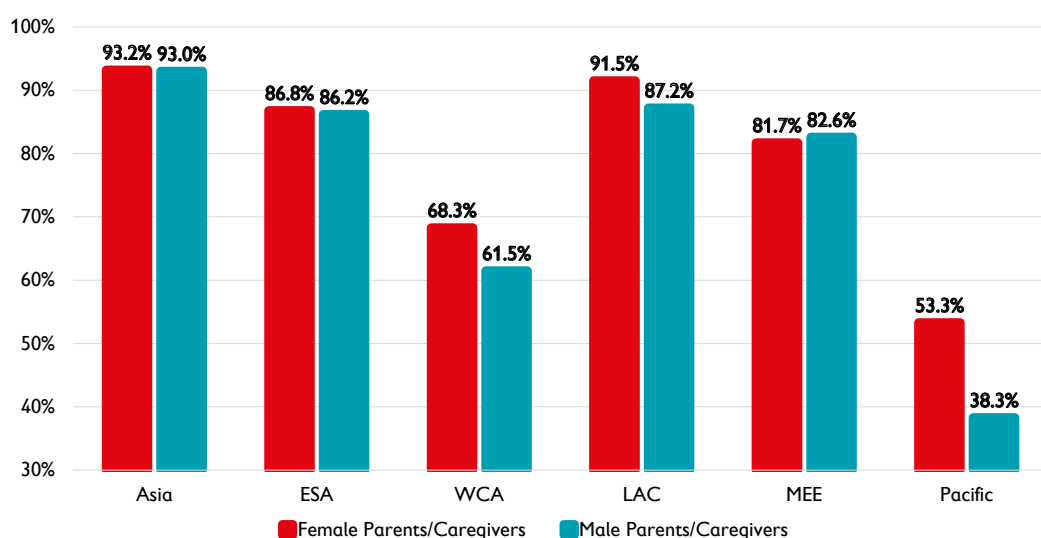


While there were only minor differences in the reporting of negative feelings between female and male parents/caregivers at a global level, slightly higher levels of increase in negative feelings were reported by female parents/caregivers in West and Central Africa (68% female compared to 62% male) and Latin America and the Caribbean (92% female compared to 87% male). Parents/caregivers from the Pacific region reported the lowest levels of increase in negative feelings, but with stark differences in female (53%) and male (38%) parents/caregivers.

Parents/caregivers with disabilities reported lower levels (82%) of increase in negative feelings compared to parents with no disability (90%). A smaller number of parents/caregivers with disabilities, around two-thirds, reported feeling more worried (68%) and less happy (64%) compared to parents/caregivers with no disability (83% and 71% respectively). **There was a stark difference in feelings of hopelessness between male and female parents/caregivers with a disability. More than half (53%) the female parents/caregivers with a disability reported feeling more hopeless compared to 1 in 3 (37%) male parents/caregivers with disabilities.**

Parents/caregivers from **minority households reported lower levels of feeling less happy (67%), more worried (78%), more depressed (62%) and more hopeless (52%)** compared to parents/caregivers from non-minority households who reported to be 73% less happy, 85% more worried,

**Figure 22: Regional Differences in Parents'/Caregivers' Reporting of Change in Negative Feelings Compared to Before the Outbreak of COVID-19**



67% more depressed and 57% more hopeless. **Parents/caregivers living in urban areas reported higher levels of feeling less happy (80%) and more depressed (74%) and more hopeless (62%),** compared to households in rural areas where 67% of the parents/caregivers felt less happy, 62% more depressed and 53% more hopeless.

**Caregivers' parenting confidence and methods used influenced their reporting of negative feelings.**

Almost all (93%) the parents/caregivers reported reduced psychosocial wellbeing when there was a reported loss of household income compared to parents/caregivers in households with no loss of household income (89%). This level increased to 96% of parents/caregivers where loss of all income was reported.

The loss of household income caused parents/caregivers to feel less happy (79% compared to 63% of the parents/caregivers with no loss of income), more hopeless (65% compared to 46% of the parents/caregivers with no loss of income) and more depressed (74% compared to 57% of the parents/caregivers with no loss of income).

Illness in the household was also associated with a reduction in psycho-social well-being. Almost all (92%) the parents/caregivers reported an increase in negative feelings when an adult in the household had fallen sick compared to 89% of the parents/caregivers where no adult had fallen sick.

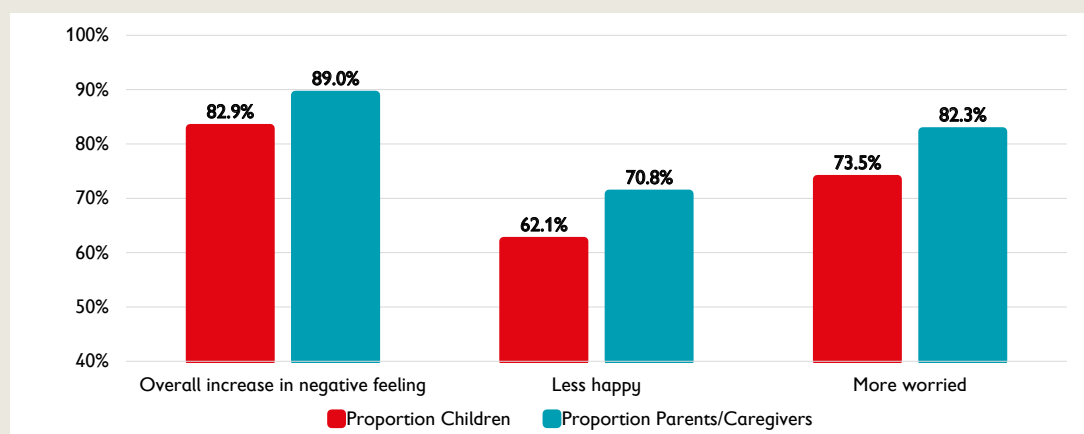
The reported use of negative parenting methods and feeling less confident in parenting was associated with an increase in negative feelings. **Around three quarters (73%) of the parents/caregivers who reported feeling less confident stated feeling less happy, compared to 60% of the parents/caregivers who did not report less confidence.** Parents/caregivers with less confidence also reported being more worried (84%) and more depressed (67%) compared to other parents who did not report feeling less confident (77% more worried and 57% more depressed). Further, parents/caregivers who reported using negative parenting methods, including physical punishment of children, showed higher levels in the increase of negative feelings. **Around two-**

**Overall, parents and caregivers reported higher levels of increases in negative feelings due to COVID-19 than children**

thirds (78%) of the parents/caregivers using negative parenting methods reported feeling less happy (78%) and more depressed (75%), compared to parents who did not report negative parenting methods (69% of those parents/caregivers felt less happy and 62% felt more depressed). Half the parents/caregivers reporting negative parenting methods also reported feeling less able to cope (51%) and more worthless (48%), compared to parents/caregivers who did not report using negative parenting methods (37% and 34% respectively).

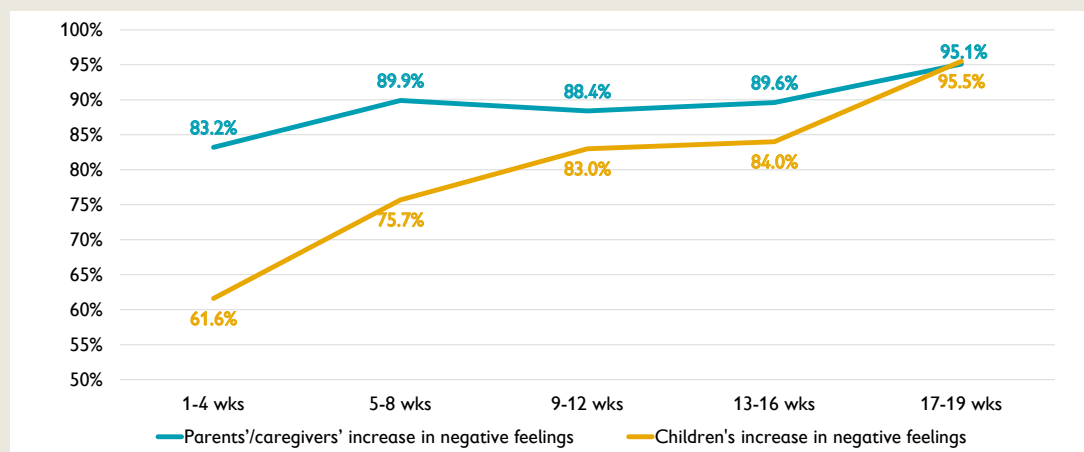
**Overall, parents and caregivers reported higher levels of increases in negative feelings due to COVID-19 than children.**

**Figure 23: Comparison of Levels of Increase in Negative Feelings Between Children and Parents/Caregivers**



Both children and their parents/caregivers reported higher levels of increase in negative feelings, the longer schools were closed. Almost two-thirds (62%) of children and a vast majority (83%) of parents/caregivers reported an increase in negative feelings when schools were closed between 1 to 4 weeks, this rose to the vast majority of children (96%) and adults (95%) reporting an increase in negative feelings in weeks 17 to 19 of school closures.

**Figure 24: Weeks of School Closure versus Children's and Parents'/Caregivers' Reporting of Increase in Negative Feelings**



Among the general public (who participated in an online survey) the vast majority of female (88%) and male (83%) parents/caregivers reported an increase in negative feelings due to the COVID-19 pandemic.

## Impact of the COVID-19 Pandemic on Child Labour

Child programme participants were asked what stops them from learning at home, including whether they have paid work to do as well as how often they have to do chores or care for siblings/others compared to before the outbreak of COVID-19.

**2.3%<sup>10</sup> of the boys and girls reported getting paid for work, with no statistically significant difference in the children's gender and age at the global level.** There were some statistically significant regional differences in the reporting of children getting paid for work<sup>11</sup>, with higher rates in the Middle East and Eastern Europe at 2.8%, and in East and Southern Africa at 2.6% of the boys and girls surveyed, compared to 1.3% of the children in West and Central Africa.

### Risk and Protective Factors Associated with Children Getting Paid for Work<sup>12</sup>

From previous pandemics and epidemics (Bakrania, S. et al., 2020) it is known that children's involvement in paid work increases due to reduction in household income. Child programme participants in this study were 1.3 times more likely (2.6%) to report getting paid for work where more than half their household income had been lost than children from households that had not experienced the same income loss (1.9%). **This difference was even greater in Latin America and the Caribbean (3.2%) and East and Southern Africa (3.8%). There children were three to four times more likely to be engaged in paid work when they lived in a household that had lost more than half their income,** than children in households that had not experienced that level of income loss (1%).

Children in Asia, and East and Southern Africa<sup>13</sup> who belong to minority groups reported higher rates of getting paid for work. **Children belonging to a minority group in East and Southern Africa were almost twice (4.1%) as likely to get paid for work than children who were not from a minority group (2.1%).** A statistically significant percentage (2.6%) of the children from a minority group in Asia reported getting paid for work, compared to 1.6% from non-minority households.

Being engaged in paid work potentially impacts children's ability to attend school or limits their ability to learn in the future. This study found a statistically significant association between children's expectations about going back to school and the proportion of children reporting to be engaged in paid work. 9% of the boys and girls who thought they would not be going back to school once COVID-19 is over reported getting paid for work. Just 2% of the children who thought they would be going back to school reported that they were getting paid for work.

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**Girls report a higher burden of domestic chores and childcare for siblings impacting their ability to learn.**

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In addition to paid work, children also carry the burden of domestic work and childcare for siblings, with some evidence (Bakrania, S. et al., 2020) that in crisis situations children are involved in doing more domestic chores than they would under normal circumstances. This impacts girls in particular, given society's perception of the respective roles of women/girls and men/boys with the consequence of prioritising boys' education over that of girls (Save the Children, 2019).

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<sup>10</sup>The findings presented are based on children selecting 'getting paid for work' as a response option to the question 'What stops you from learning at home?' Due to the nature of the study, a full measure of the child labour situation, including different types of labour (including hazardous work) and a change in time spent working, could not be included. The findings presented are therefore limited to the specific question asked in the survey.

<sup>11</sup>Due to low numbers in response to this survey question, further disaggregation for gender or age groups are not possible at regional levels

<sup>12</sup>The study also looked at correlations between the children of parents/caregivers with disabilities and the reporting of getting paid for work. However, there were no statistically significant associations at the global or regional level, mainly owing to small numbers of responses. There were only 9 child respondents globally who reported getting paid for work, whose parents/caregivers reported to have disabilities.

<sup>13</sup>Due to the low levels of respondents for this question, associations are not statistically significant at the global level ( $P=.373$ ) or other regions.



More than half (54%) the child programme participants surveyed in this study reported having more chores to do compared to before the outbreak of COVID-19, with a stark difference based on gender. **Almost two-thirds (63%) of the girls reported an increase in household chores, compared to less than half (43%) the boys and 1 in 5 (20%) girls compared to 1 in 10 (10%) boys reported having too many chores to do to be able to learn.** As expected, the percentage of younger children (11 to 14 years old) reporting too many chores stopping them from learning was slightly lower at 14%, compared to 17% for children aged 15 – 17 years.

Regionally there were stark differences, with **1 in 5 (20%) children in East and Southern Africa reporting that they could not learn because they had too many chores to do, compared to only 2% of the children in the Middle East and Eastern Europe.** A clear gender divide was also observable at the regional level. **Girls from West and Central Africa and Asia were almost three times more likely (20% and 18% respectively) to have too many chores to be able to learn than boys (7% for both).** More than 1 in 5 (23%) girls in East and Southern Africa reported that they could not learn because they had too many chores, compared to 16% of the boys.

Parents'/caregivers' age and the number of children living in a household were also associated with the proportion of girls and boys who reported too many chores to be able to learn. Only 8% of the boys and girls of parents/caregivers aged 18-24 years old reported having too many chores, while for children with parents/caregivers aged 50-59 years, 17% of the boys and girls reported too many chores. **For children from households with only 1 child, 6% reported having too many chores to be able to learn in contrast to more than a quarter (27%) of the children living in households with more than 6 children.**

The disability status of parents/caregivers respondents had different impacts in different regions. In the Asia region, 28% of the children with a parent/caregiver with a disability reported having too many chores to do, compared to 13% of the children from households where the respondent parent/caregiver did not have a disability. The opposite was found in East and Southern Africa where 9% of the children of parents/caregivers with a disability reported having too many chores to be able to learn at home, compared to 1 in 5 (22%) children of parent/caregiver respondents who did not have a disability<sup>14</sup>.

More than half (52%) the girls and less than half (42%) the boys surveyed reported having to care more for siblings or others than before the outbreak of COVID-19. The analysis revealed stark differences across the regions with the lowest levels of increased care for siblings reported in the Pacific (13%), 1 in 3 children in Latin America and the Caribbean (33%), and the highest levels in East and Southern Africa, where more than half (52%) the girls and boys reported caring more for siblings since the outbreak.

Among the general public (who participated in an online survey) 1.7% of the child respondents reported getting paid for work, while more than half (51%) the girls and less than half (40%) the boys reported an increase in their chores. 12% of the girls and 7% of the boys reported having too many chores to do, and 44% of girls and just over one-third (36%) of the boys surveyed reported taking on more care responsibilities for siblings or others than before COVID-19.



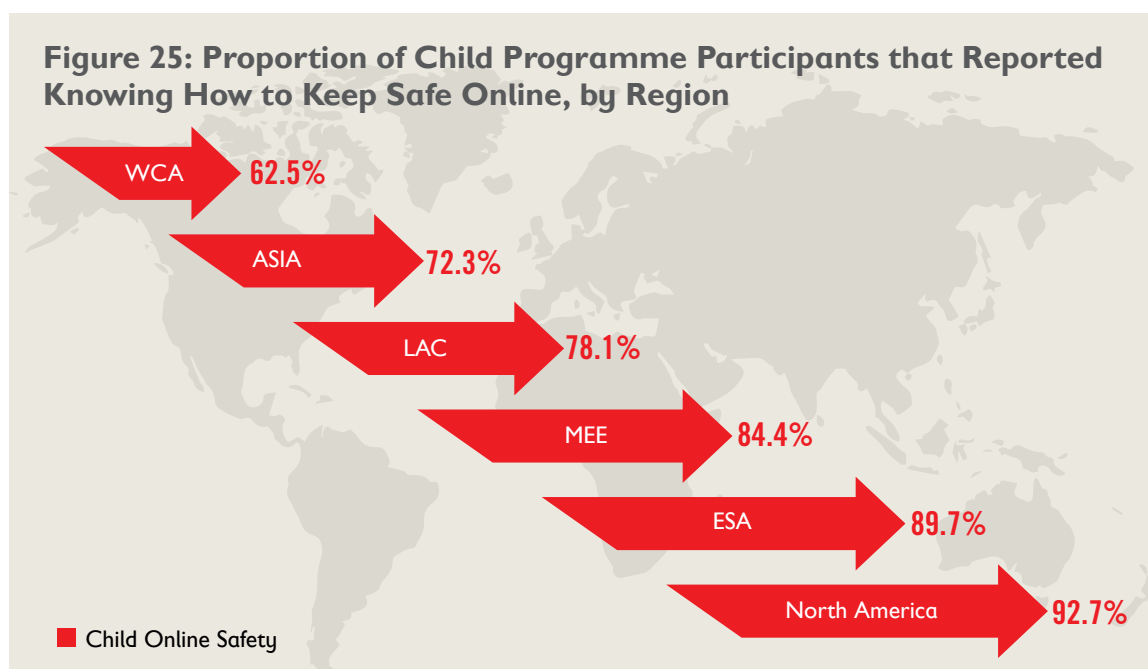
## Children's Online Safety During COVID-19

COVID-19 has resulted in many children and their households turning to digital solutions to support children's learning, socialisation and play. With the opportunity this provides, there is also an increased exposure to risk (WeProtect et. al, 2020). It is expected that the prevalence of online child sexual exploitation will increase because of COVID-19 due to a range of factors. This includes children's increased use of the internet to learn, socialise and play (often unsupervised) providing more

<sup>14</sup>Other regions could not be analysed for such associations, because of very low numbers of respondents in the respective response categories.

opportunities to perpetrators of abuse, children's increased emotional vulnerability and isolation, the inability of offenders to travel and disruptions to reporting services (WeProtect Global Alliance, 2020).

Just over three quarters of child programme participants surveyed for this study (77%) reported that they knew methods to keep themselves safe online while using the internet for learning, including information they should and should not share and/or how to change whom they share content with. At a regional level, there was considerable variations in children reporting knowing methods to keep themselves safe online, ranging from almost all (93%) in North America, compared to less than two-thirds (63%) of the children in West and Central Africa.



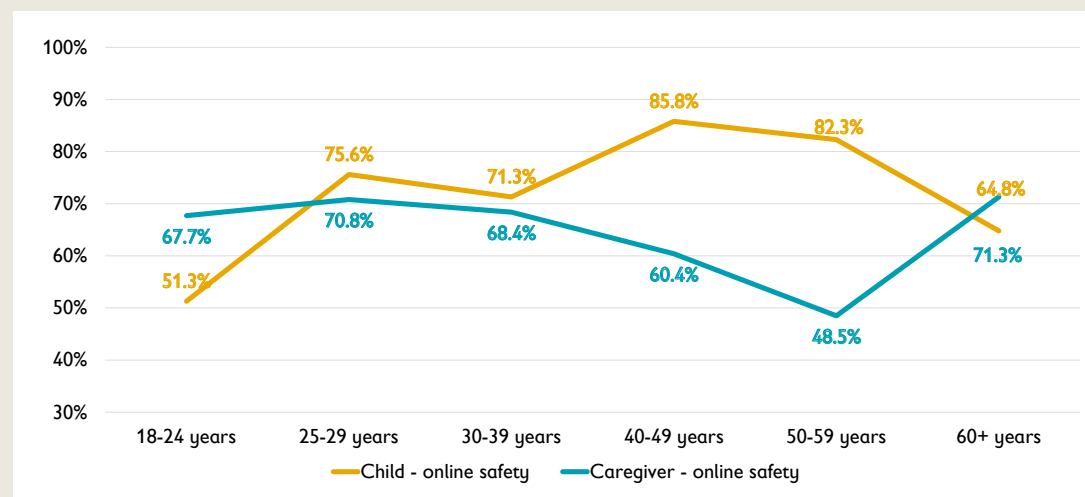
The results of this study were similar for boys and girls, with 79% of the boys reporting knowing how to keep safe online, compared to 76% of the girls. However, there was a statistically significant difference in the result depending on the age range of these children, with 72% of 11-14 year olds reporting knowing how to keep safe, compared to 82% of the 15-17 year olds. Children belonging to a minority group household were also significantly less likely to know how to keep safe online with only two-thirds (66%) reporting this, compared to the vast majority (82%) of the children who did not belong to a minority group. There was no significant difference between children based in rural or urban areas.

There were differences in children's reported knowledge of how to keep safe online depending on the gender, disability status and age of the parent/caregiver that took the survey. **The majority of child programme participants (82%) with a female parent/caregiver also completing the survey reported knowing how to keep themselves safe online, compared to almost two-thirds (64%) with male parents/caregivers completing the survey.** There was also a difference based on the disability status of the parent/caregiver, with 68% of the children with a parent/caregiver respondent with a disability reporting knowing how to keep themselves safe online compared to 78% of the children where the responding parent/caregiver did not have a disability, although this difference was not statistically significant.

Children's reporting knowing how to stay safe online increased with the age of their parent/caregiver except for children whose parents/caregivers were over 60 years old. Just over half (51%) the children with a parent/caregiver aged 18-24 years knew how to keep themselves safe online, compared to about three quarters of children with parents/caregivers aged 25-29 years and 30-39 years (76% and 71% respectively) and the vast majority of children with parents/caregivers aged 40-49 years and 50-59 years (86% and 82% respectively). For children with a parent/caregiver aged 60+ years, the knowledge of how to stay safe online lowered

again to 65%. Interestingly, the age group in which parents/caregivers reported the lowest understanding (40-49 years, 50-59 years) of child online safety was the age-group for parents/caregivers of children who generally reported the highest understanding of how to keep themselves safe online (see section below).

**Figure 26: Proportion of Child and Parent/Caregiver Programme Participants who Reported Understanding Child Online Safety, by Age-Category of Parent/Caregiver**



The proportion of child and parent/caregiver respondent pairs both reporting an understanding online safety, was lower than the separate results, at 52%.

The vast majority (83%) of the general public children (who participated in an online survey) reported that they knew ways to keep themselves safe online. There were similar results for general public boys and girls, however 11-14 year olds were significantly less likely to report knowing how to stay safe online than 15-17 year olds (80% compared to 89%). There were similar trends to those reported above on the effect of the demographics of the child's parent/caregiver on the child's reporting knowing how to keep themselves safe online.

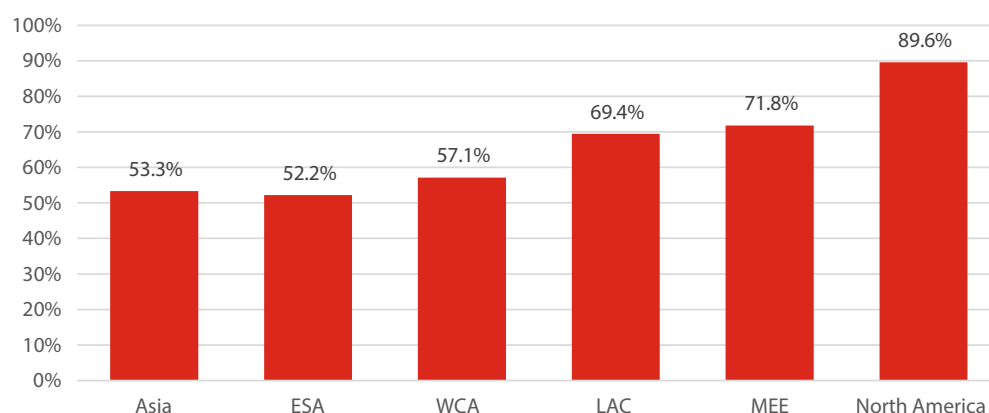


Just under two-thirds of parent/caregiver programme participants (65%) reported that they were aware of the risks and how to ensure their child's safety online when using the internet to learn. At a regional level, there was considerable variation in the reported understanding of, and the ability to ensure child online safety, ranging from almost all (90%) of the parents/caregivers in North America, to just over half (52%) in East and Southern Africa.

Just over two-thirds (67%) of the female parents/caregivers surveyed reported that they were aware of the risks and how to ensure their child's safety online, compared to 57% of the male parents/caregivers. Despite this gender result not being statistically significant, the gender composition of household members was statistically significant.

**In male-headed households, only 27% of the parents/caregivers reported knowing how to keep children safe online, compared to 71% and 76% for mixed and female-headed households respectively.** Overall, there was no difference in parents'/caregivers' reporting based on disability status, with the exception of Latin America and the Caribbean, where parents/caregivers with a disability reported an awareness of risks and ensuring child safety online at significantly lower rates than those who did not report a disability (36% compared to 72%). Differences between urban and rural areas were

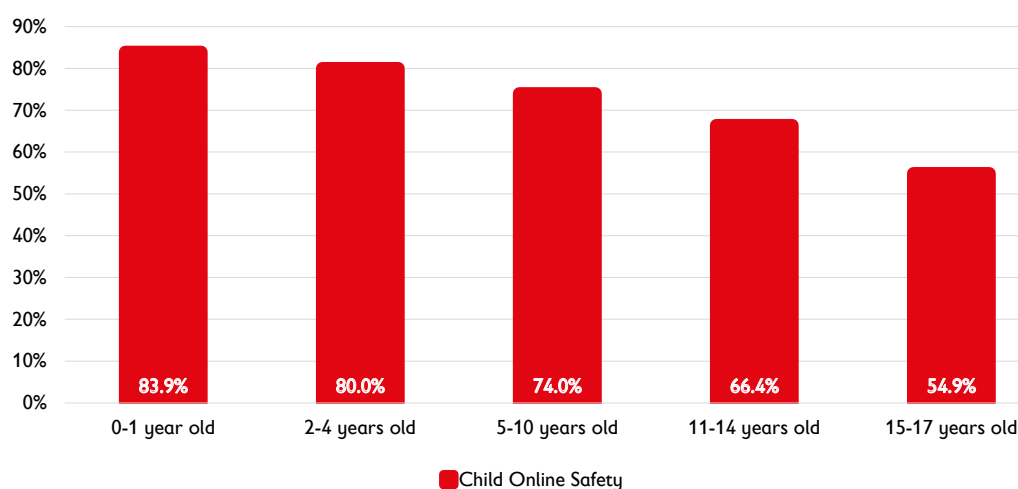
**Figure 27: Proportion of Parent/Caregiver Programme Participants Reporting Awareness of Risks and Ensuring Child's Safety Online by Region**



significant – just over half the parents/caregivers (53%) in urban areas reported that they were aware of the risks and how to ensure their child's safety online, compared to 71% of the rural parents/caregivers.

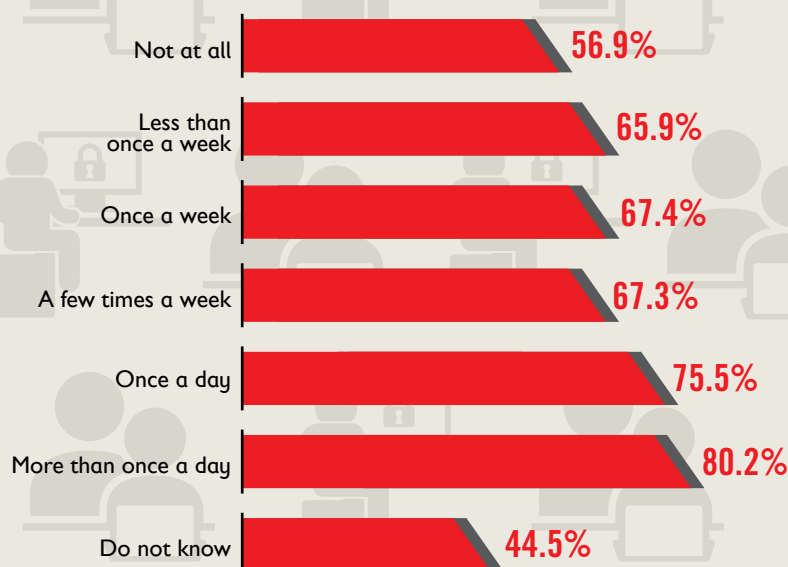
In relation to the specific responses for their indexed child, parents/caregivers reported similar awareness of risks and ensuring children's safety online for girls (66%) and boys (64%). There was no statistically significant difference in the reported awareness of parents/caregivers responding to the survey in relation to a child with a disability. There was however, a significant association between the age of the child and parents/caregivers reporting the awareness of risk and feeling able to ensure the child's safety online. The reported awareness was highest for the parents/caregivers of the youngest children at around 80% for very young children, and lowest for those with the oldest children at 55% for 15-17 year olds. This is contrary to the child programme participants' results presented above, in which the older cohort reported knowing how to keep safe online at a higher rate.

**Figure 28: Proportion of Parent/Caregiver Programme Participants Reporting an Awareness of Risks and Ensuring Child's Safety Online, by Age of the Child**



There seemed to be an association between parents/caregivers reporting an awareness of the risks and how to ensure their child's safety online, and higher frequencies of teachers checking in on the children. This ranges from 57% of the parents/caregivers reporting being able to ensure that children are safe online when teachers were not checking in at all, compared to 80% of the parents/caregivers when teachers were checking in with their child more than once a day.

**Figure 29: Proportion of Parent/Caregiver Programme Participants Reporting an Awareness of Risks and Ensuring a Child's Safety Online, by Teacher Checks-in with the Child**



For the general public (parents/caregivers who participated in an online survey) most (72%) reported that they were aware of the risks and how to ensure their child's safety online. There were no statistically significant differences in these results based on key demographic variables. There were, however, some similar trends to the parent/caregiver programme participants results above, including an association between higher frequencies of teacher check-ins and parents reporting being able to ensure that children are safe online.

## Access to Child Protection and Mental Health and Psychosocial support-related Services During COVID-19

### WHAT IS THE IMPACT OF COVID-19 ON CHILD PROTECTION AND MHPSS RELATED SERVICES FOR PARENTS/ CAREGIVERS?



Parent/caregiver programme participants reported not being able to access the counselling, mental health and domestic violence services that they needed to stay healthy and safe during COVID-19, and the need for childcare and parenting support.

More than 1 in 5 (21%) programme participant parents/caregivers reported that they could not access counselling services, while 8% could not access mental health services and 4% could not access the domestic violence services that they needed to stay healthy and safe during this time. Among the general public (who participated in an online survey) 13% of the parents/caregivers reported they could not access counselling or the mental health services that they needed, while 3% reported not being able to access domestic violence services.

Male parents/caregivers reported less access to mental health support services than female parents/caregivers. Almost a quarter (24%) of the men reported the need for counselling compared to about 1 in 5 (19%) women. Similarly, 9% of the men and 7% of the women reported that they could not access the mental health services they needed. Interestingly, reporting on not being able to access the required domestic violence services is similar between female (4.1%) and male (4.6%) parents/caregivers. In addition, 13% of the parents/caregivers reported that they needed parenting advice/support; 12% of the female parents/caregivers and 17% of the male parents/caregivers asked for childcare support. Among the general public (who participated in an online survey) 17% of the parents/caregivers reported that they needed parenting advice/support and 16% needed childcare support.

Parents/caregivers reported higher unmet service needs where more children were living in the household. If 1 child was living in the household, 17% of the parents/caregivers reported not being able to access the required counselling services (6% for mental health services), compared to more than a quarter (28%) of the parents/caregivers reporting the same (15% for mental health services) from households with 6 or more children. Similarly, 3% of the parents/caregivers reported not being able to access the required domestic violence services when 1 child was living in the household, compared to 7% in households with 6 or more children. Childcare and parenting advice/support needs were reported by 9% of the parents/caregivers living with 1 child, compared to more than 1 in 5 or more (20% for parenting advice/support, 22% for childcare) for parents/caregivers with 6 or more children living in the household.

There were stark differences in the domestic violence and mental health service needs of parents/caregivers with disabilities and parents/caregivers of children with disabilities, and their ability to access those services compared to parents/caregivers without disabilities or those of children with no reported disability<sup>15</sup>. **12% of the female and male parents/caregivers with disabilities reported not being able to access the required domestic violence services, compared to 4% of the parents/caregivers without disabilities.** 13% reported not being able to access the required mental health services, compared to 8% of the parents/caregivers without disabilities.

Similarly, a higher proportion of parents/caregivers of children with disabilities reported the need for support services that they could not access. Almost 1 in 3 (29%) parents/caregivers with at least 1 child with disabilities reported not being able to access the required counselling services, compared to just over 1 in 5 (22%) parents/caregivers who reported their child had no disabilities. 13% of the parents/caregivers of children with disabilities reported not being able to access the required mental health services, compared to 8% of the parents/caregivers who reported that their child had no disabilities. Moreover, 8% of the parents/caregivers of children with disabilities reported not being able to access the required counselling services, while this was reported by 4% of the parents/caregivers who reported that their child had no disability.

Parents/caregivers from minority groups had higher service needs than those not identifying with a minority group. 11% of the minority parents/caregivers reported needing mental health services and 7% the domestic violence services, compared to 6% of the non-minority parents/caregivers and 3% the domestic violence services.

Parents/caregivers from minority groups and those with disabilities also reported higher needs for childcare. 1 in 5 (20%) parents/caregivers with disabilities and 17% of the parents/caregivers from minority groups reported childcare needs, compared to 14% of the parents/caregivers with no disability and 12% of the non-minority parents/caregivers. **There were stark differences in the reported support needs of parents/caregivers of children with disabilities, compared to parents/caregivers of children with no reported disability.** Almost a quarter (23%) of the parents/caregivers of a child with

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<sup>15</sup>As disability was only required for the indexed child by proxy of the adult parent/caregiver, there may be other children in the household with disability that we are unable to account for in our survey.



a disability reported asking for childcare support, and almost 1 in 5 (18%) reported asking for parenting advice/support, compared to 14% and 13% respectively for parents/caregivers who reported no children living with disabilities.

**Table 2: Regional Differences in the Reported Needs for Child Protection / Mental Health and Psycho-social Support Related Services**

Region	Counselling	Mental Health Services	Domestic Violence Services	Parenting Advice/ Support	Childcare
Asia	17.0%	6.5%	4.1%	13.2%	12.7%
ESA	27.2%	8.9%	5.1%	14.4%	13.8%
WCA	13.7%	4.3%	3.8%	27.4%	34.2%
LAC	10.6%	8.4%	2.6%	8.5%	6.8%
MEE	15.4%	9.7%	2.4%	11.2%	10.0%
Pacific	6.2%	2.7%	3.6%	4.5%	10.4%
Asia	4.1%	3.9%	0.0%	14.0%	8.1%



PHOTO: SOPHIE HANANDISHE / SAVE THE CHILDREN

# CONCLUSION

## Overview

At a time when children's safety, protection and well-being is threatened by the immediate and long-term impacts of COVID-19 and efforts to contain it, never has it been more important to prioritise and collaborate on protecting children. The protection of children from harm requires the coordinated involvement of actors across sectors (such as health, education, social welfare, justice, and law enforcement) and levels (individual, family, community, subnational, and national) to guarantee children a protective environment. This requires laws, policies, budgets, a trained social service workforce, and a focus on both preventive and responsive action, tailored to the specific child protection risks detected in each context.

Child protection is however, a chronically under-funded sector, despite the economic impacts of violence against children, which erodes human and social capital and gains made in child survival, health and education. It receives 0.6% of the Overseas Development Aid (ChildFund Alliance et. al, 2017), and 0.53% humanitarian funding (Thierry, 2019). According to the latest UN Global Status Report on Preventing Violence Against Children, while 89% countries are committed to multi-sectoral action, and 80% countries have a national plan in at least one sector, only 20% countries have funded those plans (WHO, 2020).

This study is important as it brings us closer to children's experience of the impacts of COVID-19 and signals important considerations for their protection and well-being. The study shows that during the COVID-19 pandemic, children and caregivers have overwhelmingly been affected by negative feelings (more worried, more hopeless, more depressed, less happy). This has increased with the number of weeks of school closure, with almost all children and caregivers impacted at 17-19 weeks.

## Disability

- Parent/caregiver programme participants with a disability reported significantly higher use of negative or violent parenting methods with their children, at one-third (33%), compared to about one-fifth of the parents/caregivers with no disability (21%).
- For parents/caregivers with a disability, a significantly higher percentage of respondents (17%) reported the separation of children, compared to parents/caregivers who did not have a disability (5%).
- Children with disabilities showed higher levels of signs commonly indicating distress. They were more than three times more likely to show bed-wetting (7%) and unusual crying and screaming (17%) since the outbreak of COVID-19, than children without disabilities (2% and 5% respectively).
- More than half (53%) the female parents/caregivers with disabilities reported feeling more hopeless compared to 1 in 3 (37%) of the male parents/caregivers with disabilities.
- The disability status of parents/caregivers had a great impact on children in the Asia region, where 28% of the children from households with reported disability in caregivers reported having too many chores to do, compared to 13% of the children from households with caregivers with no disability.



Almost half the caregivers reported children showing specific signs of distress, and this increased with violence in the home. Children not attending school were almost twice as likely to have an increase in negative feelings than those whose schools were open and where they were able to attend in person.

School closures were also relevant to violence occurring in the home. Children with schools closed reported violence occurring in the home at over double the rate of those whose schools were open and where they were attending in person. The length of confinement also impacted the experience of violence in the home, with parents/caregivers reporting much higher levels of violence (48%) at 20+weeks versus at 0 weeks (15%).

The loss of family income has been a major stressor, with nearly 1 in 5 children reporting violence in the home when there had been a loss of household income owing to COVID-19, compared to 1 in 20 when no loss of income was reported. Almost one-third of the children with caregivers with a disability reported higher violence in the home and this was almost double of that in households where the parent/caregiver respondent did not have a disability. Parents/caregivers with a disability also reported violence occurring in the home at a higher rate compared to those without a disability.

Caregivers' own mental health and psychosocial wellbeing was also relevant, with 20% of the caregivers with reduced mental health and psychosocial wellbeing reporting violence in the home, compared to 11% who did not report mental health concerns. Parents reporting negative parenting methods including the physical punishment of children, also showed higher levels of increased negative feelings. One-third of the parents/caregivers who had moved because of COVID-19 reported violence in the home, which was significantly higher than for those who had not moved (18%). The reporting of violence was higher from urban respondents than those in rural areas and the size of households was also relevant. Violence was reported by nearly one-third of the children in homes where 6 or more children were living, compared to less than one-tenth where only 1 child was in the care of their parent/caregiver.



## Gender

- Female parent/caregiver programme participants reported greater increase in using positive parenting methods with their children (80%) compared to male parents/caregivers (74%).
- In male-only headed households, only 27% of the parents/caregivers reported knowing how to keep children safe online, compared to 71% and 76% for mixed and female adult households respectively.
- Girls carry an increased burden of domestic work and childcare for siblings. Almost two-thirds (63%) reported an increase in household chores, compared to less than half (43%) the boys and 1 in 5 (20%) girls compared to 1 in 10 (10%) boys reported having too many chores to do to be able to learn at home. More than half (52%) the girls compared to 42% boys surveyed reported having to care more for siblings or others than before the outbreak of COVID-19.

Girls and boys reported experiencing violence in the home – including children being hit or verbally abused and adults being hit or verbally abused – in equal measure. The survey revealed significant differences in the assigning of gender roles, affecting the use of time and girls' ability to study. Almost two-thirds of the girls reported an increase in household chores, compared to less than half the boys, and 1 in 5 girls reported having too many chores to do to be able to learn at home, compared to 1 in 10 boys.

2% of the child participants reported being engaged in paid work. Children in households suffering loss of income were more likely to be engaged in paid work, with this being significant in Latin America and East and Southern Africa, in cases of total loss of household income. Among children who did not think that they would be going back to school, being in paid work was stated as the reason for this by nearly one-tenth of them; whereas paid work was relevant for only 2% of the children who thought they would return to school.

The separation of children from caregivers was greatest in households that moved because of COVID-19, occurring in almost a quarter of the households that had moved. Separation was also more likely to happen in the first 8 weeks, and was more common in households with caregivers that had a disability, were from a minority group, were foster caregivers, had sickness in the home or were over 60 years old.

On the positive side, in relation to protective factors, over three-quarters of the caregivers reported an increase in their use of positive parenting methods, including spending more time with their children, having a greater bond with them, showing more love and affection and being more responsive to children's needs. Well over one-third of the caregivers reported an improved relationship with their children since the outbreak of COVID-19, that their children showed more love and affection to them, and/ or that their children were happier spending more time with them. The fact that this was also often accompanied by reporting on the use of negative parenting and violence, indicates caregivers' needs for a range of parenting supports to assist in challenging times.

Access to a range of parenting supports (including counselling, mental health services, drug and/or alcohol services, domestic violence services, money/vouchers, childcare and or parenting advice and support), or the lack of it, was cited as a significant factor in relation to violence in the home. Over double the number of children reported violence in their home when the parents/caregivers also reported the lack of access to parenting support (26%), compared to when parent/caregivers had not reported this unmet need (12%). Parents/caregivers from minority groups and those with disabilities also reported higher needs for childcare. 1 in 5 (20%) parents/caregivers with disabilities and 17% of the parents/caregivers from minority groups reported childcare needs, compared to 14% of the parents/caregivers with no disability and 12% of the non-minority parents/caregivers.

An important factor in reducing girls' and boy's sadness and hopelessness, was whether they had contact with their friends and could play. More than half the children who were not in touch with their friends reported being less happy, more worried and less safe, compared to only 1 in 20 children who felt less happy, more worried and less safe when they were able to meet their friends in person as well as interact with them virtually. More than half the surveyed children stated that they were less happy, less hopeful and felt less safe than before, if they were also less able to play compared to before COVID-19.

Positively, over three-quarters of children, and about two-thirds of caregivers, reported having sufficient knowledge of online safety. Caregivers' confidence in knowing how to protect children online, was least in households headed by men, less in urban compared to rural areas, and diminished as children grew older. The frequency of check-ins from teachers were cited as a positive factor in increasing confidence in online safety, with 57% of the parents reporting being able to ensure that children were safe online when teachers were not checking in at all, compared to 80% when teachers were checking in with their child more than once a day. These findings draw our attention to the importance of positive relationships, nurturing care, friendships and play to children's well-being and development.

The data and its regional variations merit further study. Additional research is also recommended to understand:

- The co-occurrence of both positive and negative changes in parenting methods, and the overlap of risk and protective factors.
- The gender dimensions of violence against children in the home.
- How and why children are being separated from family members and whether new care placements are appropriate and temporary, especially in families when either parents/caregivers or children have a disability.
- The extent and nature of children's engagement in child labour and its relation to their ability to study and learn.
- Barriers and enablers to access to family or domestic violence and mental health services for marginalised groups, specifically parents with disabilities or parents of children with disabilities.

All this must also lead to improved preparedness and response measures to ensure that children are safe and protected in households and communities.

# RECOMMENDATIONS

Children's right to protection from all forms of physical or mental violence, abuse, exploitation and neglect, is enshrined in Article 19 of the Convention of the rights of the child. State parties are obliged to take appropriate legislative, administrative, social and educational measures to achieve this, including establishing social programmes to provide support to children and caregivers, and setting up necessary mechanisms for identifying, reporting, referring, investigating, treating and following up the maltreatment of children, including through the courts.

The findings of this study indicate specific vulnerability factors linked to absence from school, to loss of household income, to displacement, belonging to a minority group, and to the gender, disability, and mental health status of children and their parents/caregivers. This informs the following specific and tangible recommendations for governments, policy makers, donors, and civil society organisations to inform policies, programmes strategies and investment to keep children (both girls and boys) safe from harm in homes and communities.

The recommendations arising from these study findings sit within broader calls to prioritise child protection within COVID-19 pandemic responses made by the UN Secretary General and agreed on by states, multilateral and civil society organisations<sup>16,17,18,19,20</sup>. These are also informed by the Child Protection Minimum Standards in Humanitarian Action (Alliance 2019), which have been adapted to address the COVID-19 pandemic in a series of technical notes (Alliance, 2020), providing clear and practical guidance to address the range of child protection risks and challenges arising from the COVID-19 pandemic.

## Critical Elements for Action

Key recommendations to protect children from the impacts of COVID-19 include:



1. **Listening to children** of all genders, ensuring dialogue and further research, to take the experience of the impact of COVID-19 on children and households into account in designing response plans.



2. Committing to **prioritise child protection within COVID-19 response plans**, placing child protection and social welfare provisions as central components within national and local level infectious disease emergency preparedness plans.

<sup>16</sup>UN Secretary General's Statement on the Effect of the COVID-19 Pandemic on Children. <https://www.un.org/sg/en/content/sg/statement/2020-04-16/secretary-generals-statement-the-effect-of-the-covid-19-pandemic-children-scroll-down-for-french-version>









<sup>17</sup>UN Policy Brief on the Impacts of COVID-19 Pandemic on Children [https://unsdg.un.org/sites/default/files/2020-04/160420\\_Covid\\_Children\\_Policy\\_Brief.pdf](https://unsdg.un.org/sites/default/files/2020-04/160420_Covid_Children_Policy_Brief.pdf)

<sup>18</sup>Group of Friends response to UN Secretary General's Statement <https://www.unicef.org/sdgs/protect-our-children-during-covid-19>

<sup>19</sup>Global Partnership to End Violence Against Children, Leaders Statement, April 2020 <https://www.end-violence.org/sites/default/files/paragraphs/download/Ending%20Violence%20in%20a%20time%20of%20COVID-19%20-%20Join%20Statement%20FINAL2.pdf>

<sup>20</sup>Open Letter from International Civil Society Organisations and Child Focused Agencies. COVID-19 and the Impact of Pandemic Response Plans Threaten Immediate and Long-Term Risks to Public Health and Child Protection.



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 3. Designating the **social service workforce** – both formal and informal – as essential workers, with support to adapt responses to continue safely providing essential services to children and households in the community.
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 4. **Providing urgently needed funding for child protection programming**, including for children's and caregivers' mental health and psycho-social support, and gender-based violence response services.
- 
 5. Ensuring that child protection services are well resourced, inclusive and supported including through increasing the numbers and reach of trained and skilled child protection workers and addressing barriers to access for persons with disabilities and other vulnerable groups, and that all aspects of child protection systems – including laws and policies, law enforcement agencies and child protection services – take into account the violence experienced by children in the home during the pandemic.
- 
 6. Ensuring that responses to COVID-19 do not exacerbate the particular vulnerability of children during this pandemic, and that of girls in particular to harmful gender norms, discriminatory practices and inequalities, while **ensuring that quality services are reaching those who are most vulnerable, including people with disabilities**. This will require
  - a. support for effective, adapted and inclusive reporting mechanisms;
  - b. further research on the impact of COVID-19 on children's protection;
  - c. **the collection of disaggregated data** to ensure that future investments are data driven, informed by gender analysis, and targeted to the most vulnerable and marginalised children and households, including those with disabilities.
- 
 7. Ensuring that child protection risk factors are understood and integrated into **social protection and child benefit programmes**, with the objective of helping prevent and mitigate violence against children, exploitation and family separation and promote adequate care.
- 
 8. Ensuring that education and child protection sectors are enabled to proactively work together to put child-friendly, effective protection response mechanisms in place that can function through school structures and outside them, particularly within plans to **transition children back to school/education safely**.
- 
 9. Integrating child protection messaging in COVID-19 risk communication and community engagement, training frontline **health professionals in psychological first aid and detection and referral of child protection risks**
- 
 10. Strengthening integration of high-quality **mental health and psycho-social well-being programmes** with gender sensitive child protection systems and services to prevent and address gender-based violence.

## Sub-Thematic Recommendations

### Protection of Children from Violence in the Home

Preventing violence in the home requires an increase in the access to positive parenting programming and other parenting supports and services for parents/caregivers, taking into consideration the particular risks and protective factors identified in this report. Further, the impact of COVID-19 on livelihoods and household income, and the related economic stressors this creates, requires a focus on social protection to reduce violence. Specifically, it is recommended that:

1. There should be an uplift and investment in positive parenting programming – including Parenting without Violence (PwV), training of all staff<sup>21</sup> and investment in continuing to build the evidence base for parenting programming.

<sup>21</sup>Including encouragement for all Save the Children staff to complete relevant in-house positive parenting courses





2. The accessibility of positive parenting/PwV programmes/messaging needs to increase for parents/caregivers generally, but in particular for parents/caregivers with a disability, parents/caregivers in urban areas and parents/caregivers on the move.
3. Multi-sectoral programming that addresses MHPSS, health and livelihoods issues alongside violence in the home, should be prioritised given the interconnectedness of these issues.
4. Social protection programming, including cash and voucher assistance, needs to be linked with programming that addresses violence in the home. This includes ensuring that child protection risk factors are integrated into universal social protection, including the relationship between economic stressors in households and violence against children in the home, and that child protection outcome indicators are systematically monitored within child-sensitive social protection provision.
5. Referral and reporting systems in the community must be reviewed and updated for children to report violence safely, including when schools are closed. This should also be part of preparedness and contingency planning for subsequent 'waves' of the pandemic should these occur.
6. Further consideration, including through programming and research, needs to be given to the co-occurrence of both positive and negative changes in parenting methods, as well as the overlap in risk and protective factors, to ensure to build on positive practices and protective factors, while also addressing negative practices and risk factors.

## The Separation of Children

Preventing the separation of children from their primary caregiver(s), both in the short, medium and long-term due to the impact of COVID-19, requires prevention and response actions that consider the particular risk factors for separation identified in this report. Specifically, it is recommended that:

1. Tailored programming should be created to identify and support parents/caregivers in whom disability, age (60+) or illness are a factor, as these lead to higher rates of child separation.
2. Cash and social protection programming needs be linked with child protection programming to address income/livelihoods issues where this is a root cause of family separation. Furthermore, child protection outcome indicators need to be systematically monitored within child-sensitive social protection provision.
3. Prevention and response programming support is provided for households to stay together when they are on the move because of COVID-19, given the high rate of separation in this context. This could also include further research to understand the cause of separation during mobility.
4. Contingency plans should be developed, with clear trigger points to respond to family separation within the first 8 weeks of a pandemic, as this is when the majority of family separation occurs. This could include the consideration of community monitoring and support of households at-risk of separation (for example, through existing community-level groups, existing school absence management records) as well as referral and access to parenting support services.
5. Specific follow-up and support should be provided to foster caregivers to reduce the risk of separation where this may exist.
6. Government-level infectious disease emergency preparedness plans should include emergency alternative care plans that include safe and appropriate care for unaccompanied and separated children, the establishment of referral pathways that are linked to the health sector, and appropriate levels of child protection social welfare staff capacity.
7. Strong child protection links should be made within health sector responses to support identification, referral to appropriate care, and follow-up of children separated by households. This should include

capacity-building of community health staff in the identification and referral of unaccompanied minors and/or children without appropriate care, as well as a better understanding of the importance of family-based alternative care options and the risks that need to be mitigated in quarantine and isolation treatment facilities.

8. Further research is conducted on where, what and why children are being separated from their family. This could show how appropriate new care placements are for children, and how and if they are temporary – leading to improved preparedness and response measures to ensure that children are safe and can be reunited with their primary caregivers as appropriate, as well as tailored response interventions to prevent unnecessary separations.

## **Child Protection Services**

Much needed child protection, mental health and psycho-social well-being services such as counselling, mental health support, domestic violence as well as childcare and parenting support services are not available due to the COVID-19 outbreak and its related government measures, contributing to violence in the home and decreased mental health and psycho-social well-being. It is therefore recommended that:

1. Remote ways of working are explored and enabled, including remote communication, follow-up and support using phones, digital tools and online platforms to ensure continued service provision to support the protection, safety and well-being of children.
2. Social services and child protection systems are in place and accessible to all children and their caregivers seeking help, but particularly to minority parents/caregivers and parents/caregivers with disabilities as well as households that care for a larger number of children.
3. Governments should prioritise child protection and social welfare provisions within national and local level infectious disease emergency preparedness plans. This must include reviewing social welfare staff capacity for infectious disease response (or working in a COVID-19 outbreak), PPE provision, child protection staff placements within health response and safe and appropriate care plans for children separated from their primary caregivers.

## **Mental Health and Psycho-Social Support (MHPSS)**

Effectively addressing the impact of the COVID-19 pandemic and its related measures on children and their parents'/caregivers' mental health and psycho-social well-being requires a high quality, holistic and inclusive response from governments, humanitarian actors, and donors alike. Specifically, it is recommended that:

1. Investment is needed in the scale-up and integration of high quality MHPSS programmes across sectors in the COVID-19 response. A collective responsibility to protect children and the unique capacities of the health, nutrition, education, child protection, sexual and gender-based violence and WASH sectors to promote their safety, mental health and psycho-social well-being, should be acknowledged. This includes ensuring an awareness of basic mental health and psycho-social aspects of COVID-19, within these sectors.
2. Connection between children, and the strengthening of a supportive peer environment be increased, including through the resumption of schooling and other related activities.
3. Joint activities for caregivers and children leading to strengthened relationships and improved psycho-social well-being for both should be supported.
4. Support is needed for parents/caregivers for their own mental health and psycho-social well-being, and in support of their care for children. Parents/caregivers should receive support to be able to maintain a structure and routine for their children, and to keep children engaged in play and learning activities

in school and at home. This should include ensuring a focus on caregivers' psycho-social well-being within positive parenting programmes.<sup>22</sup>

5. MHPSS interventions for children and their caregivers should be provided across the 'continuum of care' by responding across the different layers of support, providing for those who need for basic services with social considerations and those with mental health conditions who need referral, and focused and specialised services by skilled and supervised personnel who know how to address the specific needs of children<sup>23</sup>.
6. Schools should be supported to ensure age-appropriate, gender-sensitive, inclusive, accessible messages on psycho-social well-being and stress prevention messages are conveyed to children and their caregivers and teachers in a way that reassures rather than distresses. Schools may need support to identify and refer children in high distress and/or showing signs of a mental health condition<sup>24</sup>.
7. Access to mental health and psycho-social support services should be made available to children of all ages and their parents/caregivers without discrimination: all MHPSS interventions in the COVID-19 response need to reach all children and their caregivers without risk of discrimination, marginalisation or stigma, including but not limited to, children living with pre-existing mental health conditions or disabilities; refugees, displaced and migrant children; children separated from their caregivers; children exposed to violence, including gender-based violence. The response must reach those severely affected by the intersectionality of these determinants.
8. The long-term impacts of the COVID-19 outbreak need recognition, advocacy to governments to strengthen links and referral mechanisms between education, health and social services and to ensure the integration of mental health services in Universal Health Coverage. In addition, mechanisms should be put in place for an early detection of signs, such as sudden changes in behaviour, unusual persistent sadness, excessive worry, a lack of concentration, trouble sleeping, or exhaustion, which could point towards looming mental health issues such as depression.
9. Advocacy to government is undertaken to promote investment in children's mental health and well-being as part of their response to the outbreak of COVID-19, and a response to the needs of all vulnerable children by ensuring that response plans provide equitable access to effective, adequately resourced and rights-based child protection, education, health and mental health services.
10. Governments, donors and aid agencies finance and support the employment, training and staff care of national public service workforce and humanitarian workers to respond to the mental health and psycho-social needs of affected children and households.

## Online Safety

While the internet has provided many children with the ability to continue learning, socialising and playing during COVID-19, this comes with its own risks. Ensuring that all children, parents/caregivers and teachers know how to keep children safe online is critical, and it is therefore recommended that:

1. Programming that supports children with the knowledge to stay safe online is prioritised, with the specific targeting of children belonging to a minority and younger children (for this survey, this was children in the 11-14 years cohort, but vulnerabilities of children younger than this should also be considered).

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<sup>22</sup>For key messages on parenting without violence, see <https://resourcecentre.savethechildren.net/library/parenting-without-violence-key-messages>

<sup>23</sup>ASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

<sup>24</sup>For further details see Safe Back to School Practitioners Guide, Global Education Cluster and Child Protection Global Cluster <https://resourcecentre.savethechildren.net/library/safe-back-school-practitioners-guide>.

2. Programming that supports caregivers with keeping their children safe online is prioritised, with specific targeting of older adults (40-59 years in particular), male parents/caregivers, and parents/caregivers in urban households. Keeping children safe at different ages should also be a focus, including addressing particular concerns that parents/caregivers have as children get older.
3. Gender and social inclusion analyses should be included in programme designs to gather more information on how to target caregivers where children and caregiver identify a low understanding of how children can stay safe, including male parents/caregivers and older caregivers.
4. Schools providing remote learning should be supported with online safety information, including protocols for teachers' communicating directly with students through remote learning.

## Child Labour

To address children's involvement in paid work and the increased burden, particularly on girls, of domestic work and childcare for siblings due to the COVID-19 situation, which impacts their ability to learn at home, it is recommended that:

1. Programming efforts addressing child labour should be linked with social protection programming, in particular targeting parents/caregivers from minority groups and parents/caregivers with disabilities or those of children with disabilities.
2. Support is provided to parents/caregivers in their efforts to send boys and girls back to school, and to strengthen community-based child protection mechanisms to identify children vulnerable to dropping out of school and child labour.
3. The operation of schools' overall performance measurement systems and targets should be examined and adapted to ensure that they do not deter the working children's return to school.
4. Programming addressing child labour should be linked to safe back-to-school initiatives as well as other educational alternatives for adolescents, including adolescent and youth life skills and employment programming.
5. Case management processes and care plans should be facilitated through a multi-sectoral approach that promotes children's access to health, education and social protection services to prevent and address their engagement in child labour.
6. Households, particularly with higher numbers of children in the home, should be provided with childcare and other parenting supports.
7. There should be an increase in investment in programming to address the gender differences for children engaged in domestic work and care, particularly addressing the impact on girls.



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Your candid responses and honesty in expressing your concerns, fears, hope for the future were beneficial & will prove invaluable to develop Save the Children COVID response and advocacy work further.

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