Primary caregivers perceptions of the role of fathers in the provision of nutritional care in a resource constrained environment in Cape Town, South Africa

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Abstract

Background : The role of fathers has traditionally been defined as a breadwinner or provider, with men generally having lower levels of engagement in childcare tasks, especially with young children. The involvement of fathers has important consequences for child well-being, especially with regards to issues of diet/nutrition, exercise, play, and parenting behaviours. This paper seeks to explore the perceptions and limitations that primary caregivers have on fathers' provision of care in a resource constrained community in South Africa. **Methods :** Data was collected through in-depth face to face interviews, with a sample of 10 primary caregivers in a resource constrained community in Cape Town, South Africa. **Results :** The findings reveal that there is a lack of involvement from fathers in the provision of nutritional care and that this affects mothers and grandmothers who then need to provide both the physical and emotional care to their children. These findings are based on the perspective of mothers and grandmothers and their perceived roles in the family. **Conclusion :** The level of lack of financial involvement from fathers has dramatically affected the participating family's food security due to only one member in the household earning below minimum wage. This has therefore meant that the dietary needs of the family are not being met with nutritional foods, but instead by high fat and high sugar content foods. The findings also highlighted that primary caregivers want to be taught about health and nutritional food choices for a limited budget.

Background

The role of fathers has traditionally been defined as breadwinner or provider with men generally found to have lower levels of engagement in childcare tasks, especially with young children (1). However, the involvement of fathers has important consequences for a child's well-being, especially with regards to issues of diet/nutrition, exercise, play, and parenting behaviours (eg, reading, discipline) (2).

Predominantly, family studies concentrate on maternal influences or combined data of both parents, (3) which precludes an understanding of the independent effects of fathers on young children's health behaviours. This is likely the result of traditional views of parental roles where mothers are considered family caretakers and fathers the breadwinner (3). Fathers' involvement in parenting has been associated with positive outcomes in cognitive, developmental, and socio-behaviour of the child, leading to improved weight gain in preterm infants, improved breastfeeding rates, higher receptive language skills, and higher academic achievement (4). However, it is important to note that there is a global increase in the decline of the father's presence (1).

In 2013, in South Africa, the estimated 14.3 million households consisted of 18.6 million children and 34.4 million adults (Statistics South Africa, 2014). Of these children, 7.3 million (39.5%) lived only with their mothers, while 3.3% of children resided only with their fathers (5). Statistics South Africa (2016) indicated that the number of present fathers who do not reside in the same household as their children is estimated to be about 46.22%. 4.1 million (22%) of children in South Africa did not live with either parent. Unemployment, poverty, income inequality, gender power, consequences of intimate partner violence,

masculinity ideologies, migration and abandonment were reported as factors that children were unable to live with their fathers (6). Globally, it is estimated that the time women spend daily in caring for the home and children is, on average, three times what men spend, but this varies dramatically across settings (7). A recent analysis of data from around the world found that the ratio of women's time spent on unpaid work (family caregiving) to men's is also much greater in low- and lower-middle income countries. This difference shows that poverty exacerbates gender inequalities in unpaid care, with the poorest women who spend the most time on unpaid care (7). The provision of care from fathers needs to be seen in the context of unpaid care as well.

The provision of childcare in South Africa has been described quantitatively using data collected in Time Use Surveys (TUS). To date, two Time Use Surveys have been conducted, in 2000 and 2010. Both surveys showed that women spent considerably more time on childcare than men. The 2000 TUS found that among adults (aged 21–55) who live with at least one child, women spend an average of 5.9 hours per week on childcare compared with 0.6 hours by men (8). Similar gender differences are identified in the more recent 2010 survey, where the average amount of time that women spend on childcare is more than eight-fold larger than the time spent by men (9).

South Africa has the lowest marriage rate on the continent, the second highest rate of father absence in Africa, after Namibia (10), low rates of paternal maintenance for children, and very high rates of abuse and neglect of children by men (11). There are also racial dynamics when it comes to fathers' presence in the household. Across South Africa, black African fathers have the highest rate of not being present in their households at 41.92% (9). Within the Western Cape specifically, coloured fathers are most affected, (due to the higher coloured population), with 20.91% of fathers not being present in their household (12). Black African fathers were second with 14.46% fathers not present and 2.21% of white fathers aren't present (12). Absent fathers generate problems such as broken families, aggressive behaviour among children, financial and social problems and poverty (5). The effect therefore of absent fathers means that most households are run by single mothers (13), who are often reliant on social security. South Africa has an extensive social security system that includes a monthly Child Support Grant (10). The number of social grants in South Africa has increased exponentially over the past twenty three years: from an estimated 4-million in 1994 to [17,443,994 by October 2017](#)(14).

Socioeconomic inequalities in childhood are linked to both childhood and adult health inequalities (15). They are particularly closely associated with inequalities in nutritional and health status based on diet quality (16). Diet quality is consistently linked to problems in health such as obesity, type II diabetes, cardiovascular disease, and several cancers (17). Recent research highlights the high cost of nutrient-rich foods and the low cost of nutrient-poor foods, which impacts diet quality and health, and which leads parents to have to negotiate food purchases on a limited budget (16). This in turn lays the foundation for the feeding practices parents then adopt.

The relationship between parental feeding practices and children's eating patterns described in the literature largely pertains to the practices and attitudes of mothers, focusing less on fathers (18). Mothers

usually have a greater impact on the development of children's eating behaviour as they tend to be more involved in food-related decisions and the preparation of meals (18). Unhealthy food preferences in mothers (e.g., consuming fast foods, sweets and higher-energy fluids), as well as the availability of un-nutritional foods at home, were found to be responsible for children's preferences when it came to the consumption of these types of foods (18). As might be expected, this does indicate that maternal obesity is a substantial predictor of childhood obesity, but it is crucial to acknowledge that fathers' attitudes and practices may also contribute to a child's health and the development of eating habits, although mothers and fathers may differ in their strategies (18).

Approaches to feeding used by mothers and fathers vary depending on a variety of factors, such as their own weight-related experiences, perception of their child's BMI, or the parent's beliefs about gender differences regarding dieting and physical attractiveness (18). The intense focus on mothers and mothering in childhood obesity research has exposed a conspicuous lack of attention to the influence, roles and responsibilities of fathers in the provision of the family's food (19). The latest data from the South African National Health and Nutrition Examination Survey (SANHANES) indicates that 28% of South African households are at risk of hunger and 26% experienced hunger in 2012. Undernutrition among children is high, with the prevalence of stunting sitting at 27% of children under three. About 6% of children under 14 are underweight, about one in a hundred severely so (20). On the other end of the scale, 19% of children aged between two to five were classified as overweight and 5% were classified as obese in 2012. At six to nine years these results dropped slightly, but at ten to 14 years 17% of children in the survey were overweight and nearly 6% were obese (20). Pivotal to this research, the SANHANES study found that it is mostly women who shop for groceries and that the most important factor for women when purchasing food was the price. Health was a lesser consideration for most shoppers, especially when men shop (20). The current study therefore focused on the perceptions of mothers and grandmothers on the provision of nutritional care provided by fathers to their children in a resource constrained community.

Methodology

This research aimed to develop parental nutritional guidelines to improve nutritional knowledge and feeding practices for children. In this study we selected a qualitative approach to gain a deeper insight into the lives of our target group. This study used a qualitative interpretivist research method (21) to explore how the mothers and primary caregivers experience fathers' provision of nutritional care in a resource constrained environment. This allowing for understanding and interpretation, with which the researcher's personal experiences and knowledge could be applied. The interpretations of the researcher were vital to bring "such objectivity to the fore as well as quality of arguments instead of statistical exactness" (1).

2.1 Participants

Study participants were mothers and primary caregivers in Manenberg, in the Western Cape Province, South Africa, who care for children between the ages of 3 - 18 years old. The township of Manenberg was chosen because it was a resource constrained environment. It was established in 1966 at the height of the apartheid regime's forced removal programme. Located 20km from Cape Town city centre, Manenberg struggles with gangs, drugs and high unemployment (22). The 2011 census shows its population at over 61 000, of whom 85% were identified as Coloured and 10% as African. Of this population, 40 452 are 'working age' (15–64). Amongst this working age group, 35% (13 962) were classified as employed, 20% (7 923) as unemployed, and 46% (18 567) as 'not economically active.' 61% of households have a monthly income of less than R3200, and 38% a monthly income of R1600 or less (23). With regards to Coloured men, who were the target population of this study due to the mothers and grandmothers interviewed, there is limited contemporary research. Research that has been undertaken has focused on Coloured masculinity as violent, uncaring, and absent (24–27).

In order to recruit participants for the study, letters were sent to three local schools, regarded as safe zones by the community, with less likelihood of gang related violence. Of these, one school reported back in the required time period that mothers and caregivers were willing to attend interviews. On the day, 15 mothers/ caregivers (grandmothers) arrived, however, five participants had to leave early, and three mothers that had confirmed did not participate due to gang violence the night before. A total of six grandmothers and two mothers were interviewed.

Table 1 provides a breakdown of the participants, showing the employment status of the mothers and primary caregivers. The households consist of a minimum of eight and a maximum of 11 occupants, including family and extended family. Of the ten interviewees, only three fathers were currently providing financial care to their children.

Family composition, living arrangements and parental practices did not vary significantly across the participant sample. Many of the families consisted of more than eight living in one house (5 - 7 children, plus the primary caregivers and extended family).

Table 1. Sample Characteristics

Interviewees (n = 10)	
Gender	Female: 10
Grandmothers	6
Mothers	4
Mean age	45.5
Participants highest qualification	Grade 11
Participants lowest qualification	Grade 9
Employment status of mother/caregiver	7
Fathers living at home	3
Fathers employment status	3
Fathers providing financial care	3
Maximum number of people living in the home	>8 , <11 occupants family and extended family.

2.2 Data collection

Interviews included open-ended questions about respondents' perception of care, difficulties and barriers to parenting, grocery shopping and meal patterns, food-provisioning priorities, fathers constraints and ideals; and the role of fathers in their children's lives. Questions focused on, but were not limited to, the children in the target age range (3- 18 years old). If children fell outside this range, questions centred on the child closest to it (this happened 3 times). An interview schedule was used to guide the interview process. The questionnaire included a set of questions on parent/caregiver–child relationships and parental/caregiver involvement in personal matters and saturation was reached. The interviews were conducted in a mix of English and Afrikaans and were recorded and later transcribed verbatim by the interviewer.

2.4 Data analysis

A thematic analysis was carried out on the transcribed interviews to identify patterns or themes (28), with the findings sorted according to their themes. A table was used for the grouping of main themes and the sub – sequent breakdown of sub – themes. Additional information was presented using direct quotes from the participants and from supporting literature.

Results

The results in this study focus on mothers and grandmothers' perceptions of fathers' provision of care in relation to nutritional care. There were five themes identified, with each having either two to three sub-themes. Key parts of these findings focused on parental care in general - how mothers perceived care by fathers, healthy diets, as well as resources for nutritional support for mothers. The participants were vocal in the interviews, with some highlighting the effect of gangsterism and drugs on their family environment. Through their participation in the current study, two primary caregivers received information for social services in the area that could provide support to the families.

The perception of care

The results show that all 10 participants were able to provide a thorough understanding of what constitutes adequate care for children. Two mothers reported:

"I provide the children with attention, food and clothing. I ask them questions about their day and what is happening in their lives. Take care of them when they are sick, sing songs with them. Do activities with them."

(Mother: age 39, Participant 3, three children - ages 7, 10, 16 years old, father unemployed but at home.)

"Supporting him on different levels: financial support, social support, emotional support, listening to him, sitting down when he needs to talk to me. Not just him, but all my children. One also needs to build trust with your children so that they are able to have freedom to come and speak to you."

(Mother: age 48, Participant 9, five children - ages 14, 19, 21, 25, and 28 years old.)

Similar responses were received from all participants. It was commonly stated that food, shelter and clothing was part of care. However, only one mother expressed that love was part of caring for their child. Barriers to the provision of good care were also noted, including money, the environment, or needing to raise the children alone.

"Stress about money, them getting into drugs or the wrong friends. All these things keep you awake at night."

(Caregiver (grandmother): age 65, Participant 5, six children - ages 7, 10, 12, 15, 17, and 21 years old, different fathers who are drug addicts, only one mother of 2 of the children is present but she is unemployed, all other mothers are not in the household.)

"Difficulty is not letting them play outside because of the area in which they stay, allowing them to have the freedom to walk to the shop and not to have to worry about them getting hurt, and shot or into gangsterism."

(Grandmother: age 57, Diabetic, Participant 10, seven children - ages 5, 7, 10, 12, 15, 17, and 21 years old, parents drug addicts, only one mother of 2 of the children is present)

"Since her father has passed, she does not want to really focus on her schoolwork - almost like she has become lazy with her school work which has made it a little difficult. We shout and argue all the time. Shame she is also very big for her age, she is even heavier than me. Her father used to spoil her a lot as the baby and give her a lot of luxuries."

(Mother: age 48, Participant 9, five children - ages 14, 19, 21, 25, and 28 years old.)

Father's involvement in care and nutritional provision

Participants reported that fathers' involvement in providing nutritional care and support for their children was limited. This is due to many of the fathers being unemployed or not living with the children. When this occurred, they did not make any provisions for financial support. This lack of financial support often means that mothers and grandmothers need to borrow money or go to bed hungry, which had occurred more than once in the last 6 months of the interviews being conducted. Some participants highlighted food insecurity in the communities as an everyday reality. Other participants became emotional and angry when speaking of the lack of support from the fathers.

"No child support. There is no role of the father being fulfilled. He is not there where the son stays. The son lives with his grandmother, so I send money to her. He just left us all and I couldn't have all the children, so I sent my son to live with his grandmother. But I still send money for his food."

(Mother: age 30, Participant 4, two children - ages 5 and 10 years old.)

"There is no money at times, he is not working so we have gone to other family members or somebody, we try and make a plan. Sometimes if there is not enough, we will go without as long as the children eat something and not go to bed hungry. But there were times when we had nothing to eat because we did not have any work and we couldn't ask any more people. I felt bad. The children eat at school in the morning at the feeding scheme. I just eat what I get, or eat a packet of cheap biscuits with tea, as long as the children eat a meal.

But everyone is suffering and always saying there is no food or just a little in the house, there are so many people in the area borrowing money and food that at the end of the month you have to pay so much back to those you borrowed you have to borrow again. I do not even know where some of the children's fathers are. So maybe they do not care."

(Grandmother: age 57, diabetic, Participant 10, seven children - ages 7, 10, 12, 15, 17 and 21 years old.)

One mother noted that her husband, although unemployed, cooked and did the household shopping while she went to work as a street cleaner.

"My husband is not working so it is almost like he is standing in for me at home. I feel like I need to emotionally support everyone in the house, as they all come to me for everything. He takes care of the house work and cleaning while I go to work so it is like we changed roles for the last few months but you

can see it is taking its effect on him, as he always used to provide for the family. Now my husband buys the food, but not really a big shop, not a monthly shop. Just when there is something that is needed at the corner shop. There is not really money for a big shop.”

(Mother: age 39, Participant 6, three children - ages 7, 10 and 16 years old.)

Another mother noted that the father was unemployed but did make an effort to find food and care for them if the monthly contribution she brought home was not enough for their basic nutritional needs.

“Their father is in the house, but he does not work now. And so I am the only one who is working. I make about R750 a month which does not stretch very far into the month. The father makes sure that if there is no food in the house that he goes out and looks to borrow or ask somebody else so that the children can eat. He enforces the discipline in the house. He is caring to the needs of the family and I think at this point he is a little depressed as he has been trying to find work.”

(Mother: age 39, diabetic, Participant 2 , seven children - ages 3, 6, 10, 13, 19, and 22 years old, all living at home.)

Father's present but not involved

The notion that fathers need to be supportive and discipline their children in order to instil work ethic and provide encouragement for their children to function well at school was commonly highlighted by mothers and grandmothers.

“Not really supportive fathering or loving at times. Don't recall the father sitting with his son many times, as he would get very angry with him for not being able to grasp things quickly. My husband is at home, he is a father but, provides the money for physical things. He just orders the children around to do things he wants them to do. Our son is forever in trouble at school and then I always have to go.”

(Mother: age 42, Participant 1, two children - ages 10 and 16 years old.)

“There is no role of the father being fulfilled he is not there where the son stays. The son lives with his grandmother, so I send money to her.”

(Mother: age 30, Participant 4, two children - ages 5 and 10 years old.)

Capacity building and nutritional understanding of mothers and primary caregivers

With respect to what food the mothers and grandmothers provide for their children, many indicated there was a need to understand what is healthy. Participants wanted to know how to cook on a limited budget while still make sure their children are getting enough nutrients. The majority of the women interviewed claimed to assume a primary, if not complete responsibility, for managing their family's diet. This included budgeting meals, shopping, preparing and serving meals. Within the participant group, the children's weight seemed to be within the healthy range. However, the mothers and caregivers were

suffering from diseases and many were obese. As research has indicated, this could have a future effect on their children, who may end up with similar weight and health problems. Some of the challenges the parents and caregivers face when it comes to eating healthily are shown below:

“How to feed children, because you can make the food but then they do not want to eat what is healthy. I am diabetic and the hospital they gave me a list of what to eat. I cannot buy all those things. It will be too expensive so I try to buy some of the things, then we can all eat healthy but they do not want to eat a lot of veg. They say it doesn't taste nice. Maybe I need to know how to make it differently. Classes where you learn, not just pieces of paper that you throw away. How do I as a diabetic buy good food if it is so expensive.”

(Grandmother: age 57, diabetic, Participant 10, seven children - ages 7, 10, 12, 15, 17 and 21 years old.)

“How to make good healthy food choices and why. But also a course for everyone in the family so the children also understand why they are being given the food they are given. It is maybe important to know when to buy foods in season and the quantity of food to buy for a family and how then to make sure they are eating enough or too little”

(Mother: age 30, Participant 4, two children - ages 5 and 10 years old).

“Yes, I dish the food and also say they can have a little first and if they finish it and want more, they can have so that we do not waste. I eat whatever there is left or just a lot of white bread and coffee, but I take my medication for my diabetes.

(Mother: age 39, diabetic, Participant 2, seven children - ages 3, 6, 10, 12, 14, 19, and 22 years old, all living at home).

Given that women are the primary managers of children's diets, health and weight, their articulations of men's contributions to food provision offer crucial insights into the power dynamics that produce and sustain the gendered responsibilities of nutritional care work in the family (29).

Discussion

Many parents in South Africa face considerable barriers to fulfil the tasks of parenting. Poverty increases parents' difficulties in providing for and protecting their children, and makes emotionally distant, harsh and inconsistent parenting more likely. Parents living in poverty are also likely to be poorly educated and thus less able to support their children's educational development (16). This is the case with the participants where the highest qualification in the group was Grade 11.

Poverty also reduces the ability of parents to provide adequate nutrition and access to good educational opportunities for children, on a consistent basis necessary for healthy development (16). Low education levels coupled with the presence of food insecurity may impact not only the quantity of available food but also diet intake patterns (30). According to available data, the number of people who suffer from

hunger has increased over the past three years, returning to levels from a decade ago. The absolute number of people in the world affected by undernourishment, or chronic food deprivation, is now estimated to have increased from around 804 million in 2016 to nearly 821 million in 2017 (31). Many resource-constrained communities have been found to eat less suitable food, to limit portion sizes, to skip meals or even skip eating altogether for full days at a time, to deal with food and nutrition insecurity (32). There is a psychosocial link between food insecurity and obesity and malnutrition, and further metabolic diseases such as diabetes. Physiological adaptations in response to “feast-and-famine” cycles have been associated with an increase in body fat, decrease in lean muscle mass, and more rapid weight gain when food becomes plentiful (33). Furthermore, for many in impoverished communities, the experience of not having certain or adequate access to food often causes feelings of anxiety, stress and depression, which in turn leads to behaviours that increase the risk of becoming overweight and obese. These include patterns of bingeing or overeating when food is available (and continued availability uncertain), or choosing low-cost, energy-dense “comfort foods” rich in fat, sugar and salt. This is evident in the current study, with primary caregivers filling up on high sugar snacks, white bread and black coffee so their children and grandchildren have enough to eat. Some of these primary caregivers are already diabetic and on medication to control their blood sugar. This finding aligns with studies by indicating that low income will contribute to low dietary diversity, which will in turn lead to poor dietary intake and micronutrient deficiencies (32,34).

The women's perception of fathers provision for their children's dietary needs were significantly similar - either the father was not present or present but unemployed. Mothers also stated that they were responsible for everyone's care in the house. Yet, despite women being breadwinners, the provision of emotional support to children remained their responsibility. Emotional support was a space where the men had very little involvement, thereby reaffirming women's role as caregivers (5). If fathers were not present, mothers provided for the nutrition and dietary needs both financially and physically.

Mothers' descriptions of their daily routines of nutritional care reflected an ethic of care imbued with a very strong ‘morality of responsibility’ that starkly contrasted with descriptions of fathers' approaches (29). These findings accord with what is already known about the gendered division of family food work in Western societies, that is, that ‘the purchase and preparation of food for the family is the major responsibility of women’ (29). Domestic involvement in children's diets and health remains more peripheral to contemporary fatherhood (35). Men's fulfilments of fatherhood do not necessitate participation in either feeding the family or managing children's routines, and broad conventional masculinity norms discourage fathers from engaging in healthy behaviors, including healthy eating (36,37).

Research has demonstrated the benefit of parental nutrition education in improving children's health outcomes (38). Furthermore, evidence shows that information on healthy eating practices can support communities to alleviate poor health and fight against household food and nutrition insecurity in South Africa (39). Members of the community involved in this study needed specific guidance with regard to food-related practices, which could be provided through workshops or practical demonstrations. Existing

literature notes that workshops and demonstrations can benefit communities in pursuit of healthy diets, (40). Additionally, they require guidance in understanding how to provide healthy meals on a budget, and ways to encourage children to eat the healthy meals provided.

This study found that fathers had a very limited influence on the nutritional provision of their families. This concurs with other studies, although as mentioned, limited research exists in South Africa on the role of fathers on the provision of specific nutritional care, precluding an understanding of the independent effects of fathers on young children's health behaviours (3). Additionally, there has not been a large focus placed on the resource constrained environment. While mothers and female primary caregivers may continue to largely structure these practices, fathers nonetheless help shape what families eat by providing financially and by the meals they prefer to eat.

This study clearly provides evidence that highlights the limitations of nutritional and dietary care fathers play in a low resource family setting. It also raises the express need that mothers, and caregivers have in wanting to provide nutritional meals for their families, as part of their understanding of their care responsibility. Limitations of the study include a small sample size only focused on coloured mothers and grandmothers, which could present just one viewpoint on food choice and selection. Fathers were also not interviewed as to understanding their point of view. Future research should have a bigger sample size, explore these practices across geographies, and with diverse socio-demographics and family characteristics.

Declarations

Ethics approval and consent to participate

Ethical clearance was received for this study from the University of the Western Cape, Senate ethics committee with clearance number 14/10/34. Informed written consent was obtained from all participants in the study.

Consent for publication

Not applicable

Availability of data and materials

All data generated or analysed during this study are included in this published article

Competing interests

The authors declare that they have no financial or personal relationship that may have influenced them writing this article

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