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THE POWER OF CAREGIVING

MENTAL HEALTH AND EARLY CHILDHOOD DEVELOPMENT IN SUB-SAHARAN AFRICA: A REVIEW OF PARENTING PROGRAMMES

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Henriette Risvoll
Oslo, februar 2021

EXECUTIVE SUMMARY

Mental health and early childhood development (ECD) are crucial to individual and societal development, but are both neglected fields, especially in low- and middle-income countries. The two are linked in that early childhood development is important to mental health, and mental health is important for children's development.

Parents, or other caregivers, can support and protect the development of children, and moderate risk factors. Therefore, enabling guardians to care for their children should be a priority. This desk study addresses how to support early childhood and mental health through parents and caregivers in three of the poorest countries in the world: Eswatini (formerly Swaziland), Malawi and Zambia.

This literature review investigates relevant effective parenting programmes, dating back to 2010. Hundreds of studies and reports were reviewed, of which 15 studies were selected for in-depth information.

The results showed a lack of high-quality research from the selected countries, as only two studies (from Zambia) were identified. There is, however, relevant evidence from other contexts in sub-Sahara Africa (SSA), which we included. Typically, the interventions consisted of 10-12 group sessions and home visits with some elements of education and skill-based practice for caregivers. Most studies assessed both parental behaviour and child outcome, including nutrition, cognition, and psychosocial wellbeing. However, there was relatively little emphasis on mental health. All studies reported some positive effects, but also little or no effect in some domains, such as health.

Despite the selected studies providing some evidence of positive effects, the wide range of programme content and implementation make comparisons difficult. The results indicate that relatively low-cost community-based interventions targeting different domains of child development (mainly health, learning, nutrition, safety, and responsive caregiving), can promote child development. Yet, few studies demonstrated improvement in parents' mental health and children's physical health. In general, we have limited understanding of why interventions worked, which highlights the need for more thorough investigation into the efficacious components in interventions for future development and implementation of effective programmes. Further shortcomings include that there is little information of unintended harm caused by interventions; a lack of longitudinal studies, and of large scale-interventions; a lack of knowledge of why some efforts do not work in SSA contexts, and of the process of bringing interventions to scale.

As we were able to identify relatively little research in SSA, the findings in the 15 studies were interpreted in view of the wider literature on parenting from other regions. Interventions seem to work best and give more synergy when they are integrated and multi-sectorial, where parenting content is part of other interventions (e.g., nutrition and social protection). Mental health of parents is important for ECD, but

mental health problems may need to be targeted explicitly. Further, not all interventions work. Quality, sufficient frequency of group sessions or home visits, and a structured curriculum appear necessary. Existing paraprofessional community workers seem to be able to deliver interventions, also in large village groups, and ECD interventions seem to lend themselves well to up-scaling of programmes. Participation of local communities is important for success and sustainability, as well as for evaluation and research. Context and culture are crucial, and may be barriers, so adaptation of programmes and delivery is necessary, but building on evidence-based programmes may be better than creating new ones.

A recent holistic framework of *nurturing care* adopted by several agencies seems to be useful for understanding needs and resources, as well as for what and how to provide support. Overall, the evidence is strong that parent- and family-focused interventions may be valuable to people in low- and middle-income settings, and that mental health and ECD are linked. The focused review of studies conducted in sub-Saharan Africa supports that such interventions also can be effective in these contexts. We also suggest that efforts to support ECD and mental health could be better linked.

This report also includes recommendations for promotion of mental health and ECD, using the findings in this study in the context of Norwegian development policy, in the work of SOS Children's Villages, and for research.

INTRODUCTION

Background and aim of the study

The aim of this study is to provide knowledge that will be useful for supporting young children in vulnerable situations in low- and middle- income countries. We will try to compile, review and share information about major threats to young children's development, and how to support them through supporting their parents and caregivers, focussing particularly on psychosocial support and psychosocial outcomes.

Child mortality has been significantly reduced over the past three decades, and the advances in child health and education have been unprecedented. Despite this progress, many children suffer from lack of care and protection. Malnutrition remains a serious challenge. An estimated 250 million children under the age of 5 in low- and middle-income countries (LMIC) are at risk of not reaching their developmental potential, which could have long-term negative consequences on health and productivity *(Black et al., 2017)*.

It is now widely recognised that children need to thrive, not only survive *(Black, Trude, & Lutter, 2020)*. Meeting the health and nutritional needs of children adequately is important to promote the development and growth of children. However, nutrition and physical health are not enough on their own to foster good and healthy early childhood development *(Black et al., 2020)*. Emotional, cognitive and social aspects of development are equally important *(Black et al., 2017; Britto et al., 2017)*. **One in every three children of pre-school age in LMICs is at risk of failing to meet basic milestones in either their socioemotional or cognitive development, together with an additional 16 percent risking setbacks in their physical growth *(McCoy et al., 2016b)*.**

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Mental conditions, such as depression and anxiety, and substance use disorders, affect millions of people. Globally, depression is one of the leading causes of illness and disability among adolescents. Suicide is amongst the leading causes of death in many countries, including the third leading cause of death in 15-19- year-olds *(World Health Organization, 2019)*. Half of all mental health conditions start by 14 years of age. Mental conditions impose an enormous global disease burden that leads to premature mortality and affects functioning and quality of life. Adversity in early childhood is a risk

factor for poor mental health, and therefore another reason why early childhood development is important.

Many factors threaten and hinder children's development. Adversities create stressors in families and pose major threats to children's rights. Adversities include poverty, lack of protection, malnutrition and poor health *(Jeong, Pitchik, & Yousafzai, 2018)*. Poverty, conflict, and violence are widespread in low-income contexts and can compromise parenting and good care, and increase the risk of abuse *(Lachman et al., 2016).* Mental health problems pose an enormous burden to societies and people, and affect both parents and children. This is particularly true in low- and middle-income countries, and in crises, disasters and conflicts. Parents' poor mental health often make caring for children harder. Maternal depression is a global concern, and does not only affects women's health, but is also associated with adverse outcomes in children, including their health.

Adversities are likely to rise during and after the COVID-19 era, risking an increase of inequalities in society and making more children vulnerable *(Yousafzai, 2020)*. The pandemic has economic consequences and an increase in stress, all of which may deteriorate mental health and wellbeing for parents and for children. These are examples of factors that may make it harder for parents to provide children with sufficient care *(Shumba et al., 2020)*. UNICEF and partners have recognised this, and also that parents and families are the greatest source of resilience for children, and have therefore provided recent guidance for frontline workers to be able to promote caregivers' mental health and capacity to take care of themselves and their children *(UNICEF, 2020a)*.

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Parents, or other primary caregivers, are particularly important to children because of the role they play in providing many elements of good care. Being in adverse conditions can make it challenging for parents to provide such good care. Parents in stressful situations, e.g., suffering from mental health conditions, may need additional support to care for their children. From high income countries, there are many solid studies evaluating effectiveness of parenting programmes. These studies show that parenting programmes are effective in improving parents' mental health and psychosocial functioning such as depression, anxiety, stress, anger, guilt, and confidence in the short-term. Psychotherapeutic group interventions for parents (of children between 3 and 12 years) have been shown to be effective for parental mental health, improving child conduct problems, and parental skills in the short term *(Barlow, 2016)*.

There is less evidence on effect and cost-effectiveness of parenting programmes on parents' mental health and psychosocial wellbeing in low- and middle-income countries. However, some evidence exists. A classical and ground-breaking study in Jamaica showed how early psychosocial interventions

can improve outcomes for disadvantaged children in the long term *(World Bank, 2015)*. By delivering interventions to families with stunted children in low-income communities over a two-year period, it helped to close the gaps in relation to education and earning, relative to a better-off group *(Gertler et al., 2014)*. **The Jamaica study showed improvements both in children's early cognitive outcomes and gains in adult outcomes 20 years *later (Walker, Chang, Vera-Hernández, & Grantham-McGregor, 2011)*, and have inspired other parenting programmes around the *world (Weber, Fernald, & Diop, 2017).***

SOS Children's Villages support parents and caregivers around the world. For this support to be as useful as possible, one should build on previous experiences and evidence. With the many types of adverse conditions that exist, what should such support entail? What framework can we use so that we see children's needs and development, rather than health, learning and protection only as separate sectors? Recognising mental health as an important resource, and the enormous challenges posed by mental conditions, what role does mental health play in parenting programmes? What type of interventions have been evaluated, and how strong is the evidence? In this study, we attempt to address these questions so that existing knowledge can be used for planning and implementation of support to children through their caregivers.

1.1 Mental health and early childhood development as foundations for sustainable development

For countries to be productive and compete successfully in a global economy, they will need people to be healthy, able to work, cooperate and adapt. Sustainable development depends on human capital. Therefore, the World Bank emphasises the urgency to protect people and invest in people *(van Trotsenburg, 2020)*. With the devastating impact of COVID-19, investment in people is more important than ever. Two of the areas that are crucial to human capital, are mental health and early childhood development.

Mental health is about people's wellbeing, ability to handle challenges and to work productively, and therefore necessary to reach the Sustainability Development Goals (SDGs). Mental health and psychosocial wellbeing are recognised and explicitly targeted in the SDGs, not least in SDG number 3: "Ensure healthy lives and wellbeing for all at all ages". One of the targets of this third goal, target 3.4, is especially relevant for mental health: "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" *(Sustainable Development Goals Knowledge Platform, 2019)*.

Mental illness is one of the largest and fastest growing categories of burden of disease worldwide *(Patel et al., 2018)*, and therefore a major threat to growth and poverty eradication.

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Mental disorders can have devastating effects on individuals, families and communities. By 2030 it is predicted that mental health problems will be the leading cause of illness and mortality globally *(James et al., 2018)*. The economic burden of mental illness is vast, but treatment of common mental disorders leads to improvements in health outcomes and economic production. The returns on investment in treatment far outweigh the costs *(Chisholm et al., 2016)*

The wellbeing of children is a right in itself. Creating an opportunity for children to have the best chance in life is essential, and enshrined in Article 6 of the Convention on the Rights of the Child, on the right to life, survival, and development *(UN General Assembly, 1989)*.

Early childhood development has also been recognised in the SDGs *(Lake & Chan, 2015)*, and is linked to health and nutrition, education, social protection, reducing inequality, and ending poverty *(Saran, White, Albright, & Adona, 2020)*. Target 4.2 of the SDGs describes "access to quality early childhood development" *(Sustainable Development Goals Knowledge Platform, 2019)*, and highlights the increasing focus on the early years as a means of improving societal and individual wellbeing *(McCoy et al., 2018a; Richter et al., 2017)*.

1.2 Justification for this study

The two topics of this report - mental health and early childhood development - are linked in that early childhood development is important to mental health, and mental health is important for children's development. The reasons for focussing on mental health and ECD are to some extent the same: The challenges in both areas are enormous, the problems affect many people, the consequences are often in important domains of life, and are severe and long-term for the individual as well as for communities, and both areas have been neglected.

Although the negative impacts on children growing up under difficult conditions are profound, the mediating or buffering effect of caregiving can be powerful. **Nurturing parents and caregivers**

constitute an important, perhaps *the* most important, protection a young child can have. Parents, or other caregivers, can support and protect the development of children, and moderate risk factors. Therefore, enabling guardians to care for their children should be a priority because early childhood is a foundation for lifelong health, learning, and behaviour.

There is a long tradition of supporting parents and caregivers. Studies over several decades, especially from the US and other high-income countries, have shown that psychosocial and other types of support to parents and caregivers together with stimulating and safe environments, have long-term positive effects that pay off. However, is there equally strong evidence from LMICs, especially from the poorest countries?

This report will go through studies and reviews, aiming to give an overview of what works in parenting programmes and interventions for young children's development, including mental health and psychosocial wellbeing.

1.3 Limitations

There are many issues that we could have included or studied in more detail, but, as an attempt to limit the scope, we did not. This study does not give an exhaustive overview of all aspects of early childhood development, nor all potential stressors children and families may face. We could have highlighted resilience and focussed even more on strengths-based approaches. We have not focussed on groups who may be at risk, such as adolescent mothers, people with disabilities, or refugees, nor on particular situations that render many people vulnerable, such as natural disasters, conflict or migration. The report is not a comprehensive synopsis of mental health. We have not focussed on different caregivers, such as mothers, fathers, relatives, or caregivers in institutions.

Although we have selected a specific context, this report is not an analysis or study of the social, cultural, economic or other contexts in Eswatini, Malawi and Zambia, nor in sub-Saharan Africa. There are many interventions that support families that we have not studied, such as cash transfers, income generating activities or literacy courses for parents.

2 OBJECTIVES

The main aim of this study is to identify effective approaches and delivery mechanisms of parenting programmes and family strengthening interventions, focusing on sub-Saharan Africa, and Malawi, Zambia and Eswatini in particular. To achieve this, we conducted a narrative review based on a systematic literature study. We also used a wider range of literature and previous reviews.

However, in order to understand what aspects of children's wellbeing parenting programmes target, and how the programmes can be implemented, we also wanted to systemise the needs of children, what constitute the greatest threats to young children's development, and ways to provide for these needs. We were also interested in exploring the role of mental health within parenting programmes.

Research questions

1. What are young children's needs and what threaten children's development?
2. What types of interventions are used in parenting programmes in (mainly sub-Saharan African) low- and middle-income countries? How is the Nurturing Care framework utilised in these interventions? Do we know what works, i.e., how strong is the evidence? To what extent is mental health integrated in parenting programmes?
3. How should such programmes and interventions be implemented, e.g., how should interventions be designed, adapted, delivered and evaluated? Do we know what works, i.e., how strong is the evidence?

3 CONTEXT OF THIS STUDY

3.1 SOS Children's Villages

SOS Children's Villages International work in more than 130 countries and territories, providing a wide range of support to children. Examples of this work are supporting and strengthening families for them to stay together, and providing quality care according to the unique needs of children *(SOS* CVI, 2020). The ambition of SOS Children's Villages is to improve care for children at risk and help them succeed in life *(SOS CVI, 2019)*. Improving precarious conditions for families and children is a major task. Priority is given to strengthen and support families to enable them to take good care of their children, trying to avoid removing children from their families and placing them in alternative care *(SOS CVI, 2019)*. However, in some cases, alternative care is necessary, for instance when parents and close family members are deceased, or if none of the family members or other primary caregivers can take adequate care of the child.

Family strengthening programmes are carried out in 112 countries, and include support in accessing services, economic empowerment, parenting workshops, working with the communities, and rights education *(SOS CVI, 2020)*. According to SOS Children's Villages annual report 2019 (2020), the family strengthening programmes aim to stabilise and strengthen families and their social networks in order to provide better care and protection for children. The programmes link families to available services, such as assistance with accessing food, clothes, school supplies and educational support for children, as well as providing parents and caregivers with vocational training to find a job or provide financing for starting a small business. The family strengthening programmes have a community-based approach in many of the countries, for example, projects are anchored in the local communities. Several of the family strengthening programmes offer parenting workshops and classes to families at risk. The classes offer a vast range of content, spanning from nutrition to positive discipline, all aiming to support the development of children and build safe and nurturing homes *(SOS CVI, 2020)*.

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3.2 Malawi, Zambia and Eswatini

SOS Children's Villages Norway support programmes in Malawi, Zambia and Eswatini. Information on parenting programmes and accompanying studies from these settings are therefore particularly relevant for this study.

Zambia: There are high levels of poverty and malnutrition in Zambia. As this is combined with inadequate access to quality healthcare services, it prevents many children from surviving and thriving *(UNICEF Zambia, 2019)*. According to the Zambia Demographic and Health Survey, many Zambians have either no formal education or only some primary education, and only 26 % of children have access to early childhood education *(Zambia Statistics Agency, Ministry of Health Zambia, & ICF, 2019)*. 78 % of young children in Zambia are at risk of poor development *(Countdown to 2030, 2020)*. The recent country profile further shows that 35 % of Zambian children under the age of 5 are stunted (meaning short for age, associated with malnutrition and poor development), 66 % of children live in income poverty, and the under-5 mortality rate is 62 per 1000 live births *(Countdown to 2030, 2020)*. 4 in 10 children suffer from three or more deprivations in areas of wellbeing (child protection, education, nutrition, health, housing, information, sanitation and water), and this rises to 6 in 10 children in rural areas, where levels of deprivation and poverty are markedly higher *(Countdown to 2030, 2020;* UNICEF Zambia, 2019). There are challenges, including a considerable funding gap, to achieving a well-implemented and coherent ECD sector in Zambia *(Baboo & Walker, 2020)*. Historically, mental health care has received little attention in the health system, with services concentrated at provincial government hospitals and not at the primary care level *(Munakampe, 2020)*. There is a lack of qualified personnel working with mental health, especially in rural *areas (World Health Organization, 2018)*. A new Mental Health Bill is underway, but has not been operationalised yet *(Munakampe, 2020)*.

Malawi is one of the poorest countries in the world, with high rates of food-insecurity and malnutrition *(UNICEF Malawi, 2020)*. Most households, especially in the many rural provinces, rely on subsistence farming to earn a living, which is often insecure due to uncertain access and *availability (Soni et al., 2020)*. Finding time and resources for childcare in such a setting is difficult, and early childhood care institutions or parent support programmes are mostly unavailable or inaccessible in rural areas *(Kim, Lee, Park, Choi, & Han, 2020)*. However, there have been programmes that largely targeted the mother-child dyad and promoted development and growth of young children in terms of nutritional information and physical health interventions – although the need for additional psychosocial interventions has been indicated *(Kim et al., 2020)*. 83 % of young children in Malawi are at risk of

poor development *(Countdown to 2030, 2020)*. The country profile further shows that 39 % of Malawian children under the age of 5 are stunted, 73 % of children live in income poverty *(Countdown to 2030, 2020)*. Due to the high prevalence of HIV/AIDS, infants and those under five are particularly vulnerable, although the under-5 mortality rate is declining with recent numbers being 42 per 1000 live births *(Countdown to 2030, 2020; Kim et al., 2020)*.

The government of Malawi has a focus on early childhood development and was one of the initial countries to join the global Scaling Up Nutrition movement in 2011 *(UNICEF, 2020b)*. The National ECD policy launched in 2018 provides guidance on integrated ECD interventions. However, there are challenges to the implementation of these laws and policies, due to the lack of capacity and resources *(Murphy et al., 2020)*. There is large potential in this ECD policy, as it includes recognition of the need to improve infrastructure of community-based childcare centres, improved monitoring systems, and training for caregivers *(Soni et al., 2020)*.

Eswatini (formerly known as Swaziland) has a very young population, and the country is struggling with widespread poverty. Over half of the children are lacking sufficient dimensions of wellbeing (e.g., health; nutrition; protection; education; water; child development) *(World Food Programme, 2019)*. The under-five mortality rate is 49 per 1000 live births, 26 % of children under the age of five are stunted, and 49 % of children in Eswatini live in income poverty *(Countdown to 2030, 2020)*. About 60 percent of all children are classified as vulnerable *(Central Statistical Office, 2015)*.

However, the literacy rate in Eswatini is high, which suggest an effective primary education system *(World Food Programme, 2019)*. The results from the Multiple Indicator Cluster Surveys (MICS) in 2014, show that 30 percent of children age 36-59 months are attending an organised early childhood education programme *(Central Statistical Office, 2015)*. Other relevant findings from MICS are that over 85 % of children were subjected to at least one form of physical or psychological punishment by household members in the last month *(Central Statistical Office, 2015)*. Although there is an increased awareness of ECD in Eswatini, certain components are still licking behind (e.g., early learning, caring practices, child protection), and ECD is not viewed as a national priority that needs resources and attention in all sectors *(UNICEF, 2019)*. Eswatini has been hard hit by COVID-19, and the impact is expected to be profound.

3.3 Sub-Saharan Africa

We quickly discovered that there was a shortage of quality studies on parenting programmes and mental health conducted in Malawi, Zambia and Eswatini, so we decided to expand our search for literature to also include studies conducted in countries in sub-Saharan Africa. Although the settings and contexts vary tremendously across the African continent, there are some relevant characteristics that many countries have in common, broadly speaking. Several of the sub-Saharan African countries are classified as low-income countries, with all the challenges that follow. Many have experiences with adversities such as poverty, war, disasters, droughts, and conflict, as well as psychosocial deprivations *(Black et al., 2017)*. Often health systems are weak, with a low coverage of specialists such as psychologists and psychiatrists. There is a shortage of operationalised policies on childhood development and mental health. However, resources and strengths are many, and should be explored and built on in each specific context.

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4 KEY CONCEPTS AND USEFUL FRAMEWORKS

4.1 Mental health and psychosocial wellbeing

The World Health Organization defines mental health as a "state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*" (World Health Organization, 2014)*. Mental health is perceived as a spectrum from wellbeing and coping in everyday life, via common mental problems to serious conditions that cause long term disability. Mental health efforts and interventions will therefore also span from promoting positive health, to preventing poor health, to treatment and rehabilitation.

The environment in which people live is important for their health. Structural, economic, and social factors are now recognised as playing major roles in terms of posing risks or protection to people's mental health and wellbeing. The social, physical and economic surroundings can contribute to several common mental disorders *(Wahlbeck, Cresswell-Smith, Haaramo, & Parkkonen, 2017)*.

People who have experienced armed conflict are at risk of a broad range of negative impacts on their mental health and psychosocial wellbeing. Most people will have normal reactions to abnormal situations, while others have struggles that develop into mental conditions, i.e. a range from heightened psychological distress to increased prevalence rates of mental disorders *(Tol, Song, & Jordans, 2013)*. Social determinants of mental health and wellbeing tend to be severely affected by armed conflict, with a decrease of access to basic needs and security, and family and community care networks *(Tol et al., 2013)*.

Despite the increased attention to mental health, there are major gaps in treatment around the world, with around 80 percent of people not getting the appropriate services they need in low- and middle-

income countries *(Epping-Jordan et al., 2015)*. **Although reported prevalence of mental health disorders vary considerably, recent figures indicate a prevalence of 22.1% at any point in time in the conflict-affected populations assessed, estimating that approximately one in five is suffering from depressions, PTSD, anxiety disorders, bipolar disorders, or schizophrenia *(Charlson et al., 2019).*** For people who have experienced conflict, disasters or live in a situation of great adversity, many suffer from ongoing social and material conditions that impact on mental health and psychosocial wellbeing (Silove, Ventevogel, & Rees, 2017). The consequences of armed conflicts include increased mortality, systematic human rights violations, destruction of natural environments, and mass displacement. Furthermore, humanitarian crises may lead to increased poverty, violence and the disruption of health and educational systems *(Weissbecker, Hanna, El Shazly, Gao, & Ventevogel, 2019)*. The environmental conditions for mental health and wellbeing, such as social support networks, income opportunities, and respect for human rights, often deteriorate and therefore make it harder to cope *(Miller & Rasmussen, 2010; Tol et al., 2011)*.

Although reported prevalence of mental health disorders vary considerably, recent figures indicate a prevalence of 22.1% at any point in time in the conflict-affected populations assessed, estimating that approximately one in five is suffering from depressions, PTSD, anxiety disorders, bipolar disorders, or schizophrenia *(Charlson et al., 2019)*.

4.1.1 Mental health and psychosocial support (MHPSS) framework

Mental health and psychosocial support (MHPSS) is a composite term widely used to describe “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder” *(Inter-Agency Standing Committee, 2007, p. 1)*. The launch of MHPSS and the guidelines was an attempt to unite actors in the support, and the multi-layered support system is recommended by the guidelines to promote consensus *(Tol, Purgato, Bass, Galappatti, & Eaton, 2015)*. Furthermore, these standards and guidelines are based on available evidence and humanitarian experience, and present best practice *(Inter-Agency Standing Committee, 2007; Sphere Association, 2018)*.

The MHPSS guidelines’ core principles include promotion and protection of human rights and equity; avoiding risk of harm and promoting the “Do No Harm” principle; building on available resources and capacities; integration of support systems; the use of multi-layered support; and participation of affected populations *(Inter-Agency Standing Committee, 2007)*.

The guidelines provide a framework for multi-layered, integrated MHPSS interventions on each of the four levels, and all levels should ideally be implemented concurrently *(Inter-Agency Standing Committee, 2007)*. The associated pyramid (fig. 1) illustrates the four levels, and psychosocial considerations are relevant at each level.

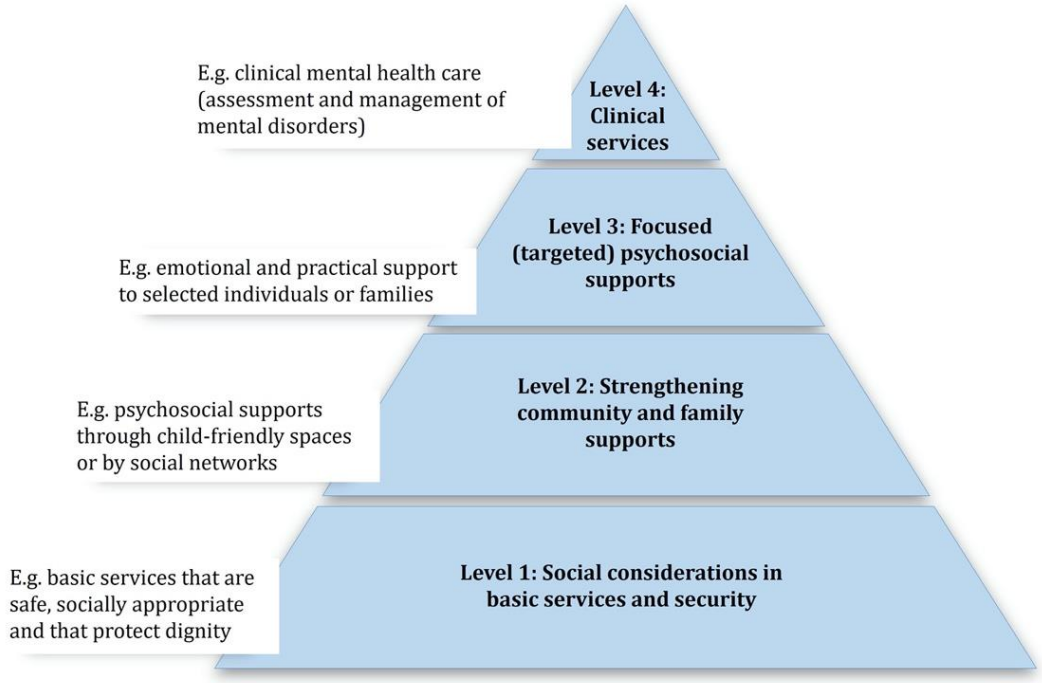

Fig. 1: Pyramid of multi-layered MHPSS services and supports (Inter-Agency Standing Committee, 2007).

4.2 Early childhood development

The period for early childhood is usually defined from the beginning of conception until 8 years of age or until transition to school is completed *(Britto, Singh, Dua, Kaur, & Yousafzai, 2018; Engle, Britto, & Super, 2013)*. However, there is often an emphasis on the first 1000 days, meaning from conception to the second birthday, as this period is of critical importance for the rest of the life-span *(Black et al., 2017)*, not least because the child's brain develops rapidly and is extremely sensitive to its environment in this period, whether enriching or adverse *(McCoy et al., 2018a)*.

The term “early childhood development” captures several concepts, such as health, protection, care, nutrition and education. The developmental progression of socioemotional, self-regulation, cognitive, language, motor, and perceptual skills are central *(Black, Gove, & Merseth, 2018)*. Early childhood development is multifaceted and concern both the characteristic of the child and the context *(Engle et al., 2013)*. The environment of a child is a central part of the child’s development, as development is a maturational process that results from a bi-directional interaction between the child and the environment *(Britto et al., 2018)*. Various academic fields are merged in early childhood development, as the focus is on different domains of development, such as cognitive, motor, language, social and emotional development, bringing social science, neuroscience and economics together *(Britto et al., 2018)*.

There are several factors that make early childhood development unique. It is the period in human development when brain development is at its most rapid, and when humans are the most sensitive to environmental influence, so the developing brain is exquisitely sensitive to both enriching environments and adverse environments *(McCoy et al., 2018a)*. Because of that, the foundations of lifelong health, learning, and behaviour are really laid down in early childhood *(Shonkoff, Richter, van der Gaag, & Bhutta, 2012b)*. There has been an upsurge in scientific evidence in support of early childhood development as critical to individuals and societies *(Britto et al., 2018)*.

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Being exposed to risk factors and adversities at a young age, can affect the socioemotional, cognitive, and sensory-motor development of children in a harmful manner *(Grantham-McGregor et al., 2007)*. It might obstruct their ability to be mentally and physically healthy, thrive, and become productive adults *(Yousafzai, 2020)*. To avoid, and possibly counteract, harmful childhood development, it is critical to address such adversities and risk factors early, while neural development makes the brain plastic to environmental interventions and influences *(Betancourt et al., 2020)*.

Children’s early years do not only provide a risk of vulnerability, but are also a critical window of opportunity *(Britto, Ponguta, Reyes, & Karnati, 2015)*. The rapid and extensive early brain development is a reason for giving particular attention to children under the age of three *(Black et al., 2017)*. The development is driven not only by biology and genes, but also by a child’s environment which shapes the developmental process *(Britto et al., 2018)*. This development establishes capacities

such as learning, socioemotional regulation, and resilience, and works as building blocks that enable the child to think, express emotions, communicate, solve problems, create, and form relationships, i.e., foundation for later health and wellbeing *(Britto et al., 2018; Yousafzai, 2020)*. Should the building of these foundations be obstructed, it can have major consequences for a child's development trajectory.

From relying largely on health-related and economic assessment factors such as birthweight, stunting, mortality, and poverty for estimating children's wellbeing *(Grantham-McGregor et al., 2007)*, there is a shift towards initiatives for populations-level indicators of child development *(McCoy, Black, Daelmans, & Dua, 2016a)*. There is not yet a complete agreement on an assessment measure, but this work is underway *(McCoy, Waldman, & Fink, 2018b)*.

The proximal environment, particularly the immediate home- and care setting, is a powerful context for the care of children *(Britto et al., 2017)*. However, a child's development is not only influenced by its immediate social context, but also by broader social arrangements and institutions like health care systems and educational services *(Pierce, 2020)*. Enabling environments are part of activating nurturing care, spanning from families to communities, services, and policies, all of which are prone to further influences from ideological, political and economic forces *(Black et al., 2020)*. The influences from these settings and environments can function as compensatory mechanisms as they enable environments to alter the developmental pathways of children *(Black et al., 2020)*.

4.3 Nurturing care

In order to conceptualise the promotion of early childhood development, the Nurturing Care Framework was launched in 2018. It is a collaboration between the World Health organization, UNICEF, and the World Bank group. The Nurturing Care framework for early childhood development offers a roadmap for the action of multiple sectors in order to enable a world where families and communities can help and support the developmental needs of *children (Banerjee, Britto, Daelmans, Goh, & Peterson, 2019)*. The framework identifies threats to early childhood development, such as poor mental health, poverty, violence, environmental toxins, insecurities, and gender equities. These factors might affect caregivers and reduce their capacity to support, protect and promote the development of young children.

The framework is used for helping children survive and thrive using five strategic actions with the aim of transforming health and human potential. Ensuring that every child gets the best start in

life includes support in health, safety and security, responsive care, nutrition, and opportunities for early learning *(World Health Organization, United Nations Children's Fund, & World Bank Group, 2018)*, as seen in figure 2 below.

Fig. 2: Nurturing Care components (World Health Organization et al., 2018).

The aims for outcomes can differ between parenting programmes, but the ones that acknowledge the nurturing care framework and aim for healthy early childhood development often have things in common *(Knerr, Gardner, & Cluver, 2013)*. The framework serves as a model for the care, support and services that foster healthy growth and development of young children (Black et al., 2020). Some of the essence of the Nurturing Care Framework is to create an enabling environment for families and communities to make sure that the children are safe and secure, receive responsive caregiving, health care, opportunities for early learning, and adequate nutrition *(Black et al., 2017)*.

There is some likelihood of transferring the care received as a child onto one's own children. Nurturing care will likely strengthen the intergenerational transfer of positive parent-child interactions and relationships, as well as healthy child development, which is another point that speaks to the importance of healthy early childhood development and nurturing care *(Lachman et al., 2016)*.

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4.4 Parenting programmes

Parenting is one of the strongest influences on children and their development *(Britto et al., 2015)*, reflected in scientific evidence and strategies that spring from the SDGs. In this report, we have chosen to use the term 'parents' to refer to all significant or primary caregivers of children. However, we would like to emphasise that the primary caregiver of the child, here often referred to as parent, does not have to be the mother. Moreover, it does not have to be a biological relative, as it includes people who are directly responsible for the child at home. The term 'parent' refers to people who are closely attached to the child and provide daily support and care.

We define parenting programmes as a programme, activity or intervention (often programmes consisting of various interventions) that involves a parent/caregiver and aims to improve outcomes (e.g., mental health, cognitive, social and emotional wellbeing, physical health beyond survival) for children 0-8 years of age and their parents – as a way of educating and supporting parents in promoting positive interactions, coping with stressors, and encouraging healthy child development *(Britto et al., 2015; Mihelic, Morawska, & Filus, 2017; Pedersen et al., 2019)*.

4.5 Implementation of programmes

Implementation is understood as actions to bridge the gap from research to practice. Effective implementations of interventions are central for achieving positive developmental outcomes for young children *(Britto et al., 2018)*. Research on implementation will often address the processes that are used in the implementation of initiatives, in addition to the contextual factors affecting these processes *(Britto et al., 2018)*. Furthermore, implementation research encompasses evaluation of "real world" impact of interventions (e.g., on health outcomes such as illness, survival, physical growth, and cognitive development), as well as acceptability, adoption, appropriateness, coverage, and scalability. The mode of delivery of a parenting programme is informed by a theory of change, which should be consistent with the context and programme environment, and the needs of the identified target population – which often is found to be a key determinant in a programme's success *(Britto et al., 2018)*.

5 METHODS – WHAT DID WE DO?

We used a two-tier approach. We reviewed existing systematic reviews and meta-analyses to get a comprehensive overview of the field of early childhood development and parenting programmes. We tried to systematize and compile evidence and recommendations from numerous studies, reports and guidelines. This information is the basis for our presentation of risks to children's development, for the choice of frameworks, and summaries of early childhood and mental health. In addition, the information from these sources is used to interpret the findings from the second tier.

The second tier of our approach is a systematic literature search that comprise our narrative review in the results chapter. Studies that examined different programs for improving early childhood development in African low- and middle-income countries were screened for potential inclusion. Studies were identified through systematic searches of bibliographic databases in November-December 2020. The findings of the included studies are narratively described. In addition to the selected studies, this narrative review will focus on existing systematic reviews and empirical studies, as well as grey literature. The aim is to provide a general knowledge base, as well as answering the research questions.

5.1 Search strategy for literature review

This literature search made use of both systematic searching and supplementary search methods. The systematic search used the following databases: PsychINFO (Ovid), Medline (Ovid), Global health (Ovid), ERIC via EbscoHost, Web of Science, Scopus, and Cochrane Library. We primarily looked for peer-reviewed studies. Reference lists were also searched for additional literature, as well as citation searches for particularly relevant articles. Furthermore, we searched relevant grey literature, various manuals, reports, book chapters, external evaluations, policies and policy support documents. Stakeholders in the countries of interest were in some cases contacted, as well as scholars working with relevant matters. Publications from 2010 until 2020 were included in the search.

The Boolean operator “OR” was be used to find search terms within one concept, and “AND” to combine the different concepts. The index databases searched in titles, abstracts and keywords; those searches comprised the main results. Supplementary searches were conducted in Google Scholar, where full text searches are possible. Truncation and wildcards were be used to account for UK and US spelling and terminology, as well as for including inflections of words as for instance child*.

Search strings and terms:

"parent* program*" OR "parent* intervention*" OR "parent* support" OR "famil* program*" OR "famil* intervention" OR "famil* support" OR "famil* strengthening" OR "caregiver program*" OR "caregiver intervention" OR "caregiver support" OR (parent* OR famil* OR caregiver) ADJ3 (program* OR intervention* OR strengthening OR support*)

AND

"low income countries" OR "middle income countries" OR LMIC OR LMICS OR Africa OR "sub-Saharan Africa" OR "subsaharan Africa" OR Malawi OR Eswatini OR Swaziland OR Zambia

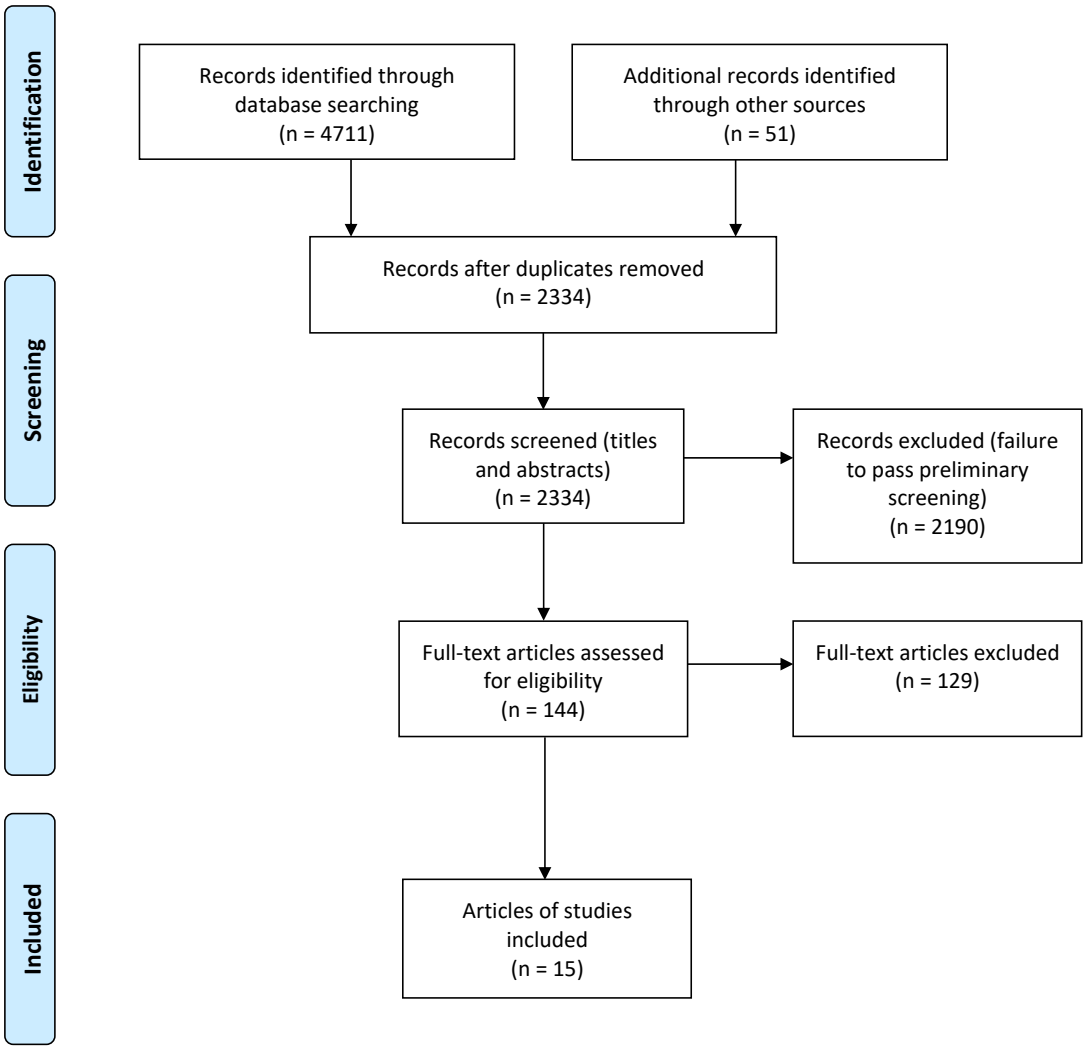
5.2 Inclusion and exclusion criteria

	Population	Intervention	Outcome
Inclusion criteria	Children up till the age of 8 years, together with family/parent/caregiver in low or middle-income African countries, particularly Zambia, Malawi and Eswatini. This will include, but is not limited to, children and families living in conflict-affected settings and humanitarian crises.	Any psychosocial-related intervention or programme that involves the parent and the child, and/or the entire family member/unit; Multi-component (/sectorial) programmes with focus on family strengthening interventions.	Relevant psychosocial outcomes for children and families / caregivers, such as psychosocial wellbeing, connectedness and communication. In addition to outcomes that are explicitly focused on mental health, we will include nutrition, learning, violence prevention, and holistic outcomes.
Exclusion criteria	Parents or family with members aged (1)9 years or older; Families living in high-income countries; Refugee families who have moved from a low-income country to a high-income country and the intervention is delivered in a high-income country.	Programmes that solely focus on parent training skills for irreversible disability or psychopathology only; Programmes that target caregivers during the prenatal period only.	Only physical outcomes (not linked to psychosocial outcomes); Outcomes that assess psychopathology only

5.3 Study selection for literature review

From more than 4700 studies identified initially, 144 potentially eligible studies were scanned, 129 of which were excluded. Reasons for exclusion of the studies include not being conducted in African low- and middle-income countries, papers published before 2010, papers written in other languages than English, studies assessed only growth outcomes, no interventions related to parenting programmes or the interventions listed in the eligibility criteria.

The PRISMA diagram (fig. 3) below illustrates the systematic literature search and the following selection process.



6 RESULTS – WHAT DID WE FIND?

After our initial scoping search of literature, we discovered very few studies matching our eligibility criteria that were conducted in Malawi, Zambia or Eswatini. We therefore decided to expand our search to also include studies conducted in countries in sub-Saharan Africa, and ended up with 15 studies. An important part of the results of this desk study consists of these 15 studies. We decided to make use of additional literature, in order to interpret the 15 studies from SSA in view of the wider literature on parenting from other regions. This includes studies conducted in low- and middle-income countries more broadly, and existing systematic reviews and meta-analysis. This broader literature provides a basis of much of this report.

Attempting to present the many findings as clearly as possible, we will first summarise

1) risks to child development, before 2) going in-depth into the 15 studies from SSA; first going through the characteristics of the studies, before giving a narrative synthesis.

Then 3) we will give a condensed presentation of some findings from selected systematic reviews of parenting programmes from other LMICs, which will also be used to make a general discussion and summary of what is known about parenting programmes. Afterwards we present what we found on 4) implementation, and finally we present findings on 5) the relationship between mental health, caregiving and early child development.

6.1. What are the major risks to young children's development?

There are many factors that may constitute risks to healthy development for children in low- and middle-income countries. Growing up in adversity such as poverty, disasters, and social deprivation, threaten the development of children, and hinder their ability to thrive, build positive relationships, and be mentally and physically healthy *(Yousafzai, 2020)*. It is estimated that 386 million children were

living in extreme poverty in 2019 *(United Nations, 2020)*. For children living in poverty, compared to children living in advantaged circumstances, the mental growth trajectories begin to diverge early in life *(World Bank, 2015)*. Children are exposed to risks ranging from infectious diseases and malnutrition to lack of appropriate stimulation and learning opportunities in their home environment and community *(Rockers et al., 2018)*. Prevalence of serious health concerns such as positive HIV status has been found to be associated with higher rates of common mental disorders *(Pedersen et al., 2019)*.

Malnutrition, and the associated stunting and wasting (severe acute malnutrition), are serious challenges in low- and middle-income countries as it undermines the survival, development, and growth of children *(Britto et al., 2017)*. Children that are undernourished or repeatedly ill are at risk for developmental problems, which emphasises the urgency for the development of coordinated early childhood development programmes that collaborate and are integrated with aspects form the health and nutrition sectors *(Black et al., 2017)*.

There are many stressors that affect people in post-conflict settings where there can be exposure to community-based violence and other risk factors for mental health problems and family stress. Living in such circumstances seem to provide a higher risk for conflict, abuse and a range of poor developmental outcomes *(Puffer et al., 2015)*. Living in a post-conflict setting comes with several daily stressors, which might have equally negative effects, or potentially more, on mental health as war-related stress *(Miller & Rasmussen, 2010)*. The context and life situation can have a major impact on people's mental health and their capacity to provide nurturing care. Higher rates of family conflict and abuse are found in conflict and post-conflict settings *(Puffer et al., 2015)*.

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Intimate partner violence is a significant global health issue, and is negatively associated with the developmental outcomes of young children in low- and middle-income countries *(Jeong, Adhia, Bhatia, McCoy, & Yousafzai, 2020)*. For children between one and four years old, more than three-quarters experience violent discipline by their caregivers in almost half of countries worldwide *(Richter et al., 2020)*. Child maltreatment is a salient risk factor, and includes physical and psychological violence, sexual abuse, and neglect *(Efevbera, McCoy, Wuermli, & Betancourt, 2018)*. Violence and maltreatment can have severe negative consequences for children and may have potentially permanent effects on cognitive, emotional and social development, as well as on children's health

(Britto et al., 2017; Shonkoff et al., 2012a). Parents that mistreat their child typically show few positive interactions with the child, a low tolerance for misbehaviour, poor understanding of child development, and ineffective strategies for discipline *(Puffer et al., 2015)*. Inconsistent or overly harsh parenting has been associated with lower social skills and self-esteem, and higher rates of disruptive behaviour and anxiety *(Puffer et al., 2015)*. There is considerable scientific evidence that toxic stress alters brain architecture, brain chemistry and functioning, increasing the risk of negative development in many areas of life, including cognition, learning, education, mental and physical health *(Child Welfare Information Gateway, 2015)*.

Having experienced cumulative trauma and abuse are also risk factors for negative parenting *(Banyard, 1997)*. Parents who experienced abuse as children are more likely to maltreat their own children *(Thornberry & Henry, 2013)*. This shows the potential negative power of parenting, as parents can mistreat and harm their children, which can lead to both immediate and long-term negative consequences. **Young children are not able to protect themselves and healthy development is less likely under high stress conditions and insecurity *(Pierce, 2020)*. Preventing violence is an essential part of positive parenting and crucial for healthy child development.**

Young children are not able to protect themselves and healthy development is less likely under high stress conditions and insecurity *(Pierce, 2020)*. Preventing violence is an essential part of positive parenting and crucial for healthy child

Pandemics such as COVID-19 pose obvious risks. The increase in illness and death from the virus, means that many children are becoming orphaned or experience increased adversity. It is probable that vulnerable children bear a large burden of the impact of the pandemic, both direct and indirectly, and the potential effect on children's development is enormous *(Shumba et al., 2020)*. A recent review looked at the ongoing impacts of COVID-19 on nurturing care in Kenya, with relevance to the sub-Saharan African region *(Shumba et al., 2020)*. They concluded that multifactorial impacts fall into five key domains: direct health; health and nutrition systems; economic protection; social and child protection; and child development and early learning. A recent UNICEF guidance document on how to care for caregivers during the COVID-19 crisis, identified three important areas to prioritize when trying to mitigate the impact of COVID-19 on caregivers and children: gender and gender equity, adolescent caregivers, and child development *(UNICEF, 2020a)*. The impact of the COVID-situation on household economy, safety and access to services can increase parents' stress and emotional problems. Closure of schools, workplaces and childcare services can add to the burden. It may be harder to care for stressed children, and caregivers under stress may be less patient or attentive *(UNICEF, 2020a)*.

6.2 What do we know about parenting programmes in SSA?

The following chapter is based on 15 papers from 12 unique studies. The papers are published between 2014 and 2020. The 15 papers include a variety of interventions and assessed outcomes, several different methods and study designs, and they focus on various aspects connected to early childhood development and nurturing care.

6.2.1 Design

Several of the studies used randomised controlled designs. Betancourt et al. (2020), Luoto et al. (2020), Rockers et al. (2016), and Singla, Kumbakumba, and Aboud (2015) used a cluster-randomised design for their trials (e.g., community cluster), whereas the studies by Puffer et al. (2015), Lachman et al. (2017), and Ward et al. (2020) were randomised by individual (parent-child dyads). Two studies were follow-ups to randomised controlled trials (Atukunda et al., 2019; Rockers et al., 2018). The study by Skar, Sherr, Clucas, and von Tetzchner (2014) was a retrospective study comparing intervention with control. The study by Weber et al. (2017) was an evaluation study of an existing and already implemented programme, and the study by Borisova, Pisani, Dowd, and Lin (2017) used a quasi-experimental design to compare a family-focused approach with a pre-primary programme. The study by Betancourt et al. (2018) was an open trial of a programme. Two studies made use of qualitative methods, with the mixed-methods process evaluation by Lachman et al. (2018), and Giusto et al. (2017) qualitative study on mechanisms of change. Sample sizes of the studies ranged from N=30 *(Giusto et al., 2017)* to N=1152 *(Luoto et al., 2020)*.

6.2.2 Settings and participants

The studies are all conducted in low- and middle-income countries as defined by the World Bank List *(World Bank, 2021)*. The included studies have been carried out in the following countries: Uganda (n=2), Rwanda (n=2), Ethiopia, Liberia, South Africa (n=2), Kenya, Zambia, Mozambique, Senegal.

Many of the communities included in the various studies are in rural areas *(Giusto et al., 2017; Puffer et al., 2015; Singla et al., 2015; Weber et al., 2017)* and are characterised by high rates of poverty *(Betancourt et al., 2018; Betancourt et al., 2020; Luoto et al., 2020)*, and post-conflict *(Giusto et al., 2017; Puffer et al., 2015; Singla et al., 2015)*. Others are conducted in peri-urban settlements, with high levels of HIV and community and family violence *(Lachman et al., 2017; Lachman et al., 2018; Ward et al., 2020)*. Some of the participants are subsistence farmers or unskilled informal workers *(Luoto et al., 2020; Singla et al., 2015)*, some of the others studies reported low levels of maternal education *(Borisova et al., 2017; Singla et al., 2015)*.

Eligibility of participants was determined by: Mothers or other female primary caregivers of children *(Atukunda et al., 2019; Lachman et al., 2018; Singla et al., 2015; Weber et al., 2017)*; or Primary caregiver, which also includes fathers *(Betancourt et al., 2020; Borisova et al., 2017; Giusto et al., 2017; Lachman et al., 2017; Luoto et al., 2020; Puffer et al., 2015; Ward et al., 2020)*.

Children ranged in age from two months *(Weber et al., 2017)* to nine years *(Ward et al., 2020)*, but most studies were concerned with children either before age two or 3-7 years of age.

6.2.3 Intervention package

Many of the intervention packages were delivered through group sessions *(Atukunda et al., 2019; Giusto et al., 2017; Lachman et al., 2017; Lachman et al., 2018; Rockers et al., 2018; Ward et al., 2020)*, with typically 10-12 sessions. Additionally, several studies used group sessions combined with individual home visits *(Borisova et al., 2017; Puffer et al., 2015; Rockers et al., 2016; Singla et al., 2015; Skar et al., 2014; Weber et al., 2017).* Others again used either group sessions, home visits or a mix of both *(Luoto et al., 2020),* whereas the two studies by Betancourt et al. *(2018 and 2020)* only used home visits.

The parenting programmes in the included studies often shared these components: individual counselling or group discussion; cognitive-behavioural strategies such as role play; structured or guided parent-child play, including games and songs; educational communications materials which model or guide positive behaviours (e.g., illustrations depicting positive childrearing); and use of toys made from readily available objects or materials.

The interventions were delivered by trained community workers/facilitators/volunteers *(Betancourt et al., 2020; Weber et al., 2017; Ward et al., 2020; Puffer et al., 2015; Borisova et al., 2017; Giusto et al., 2017; Singla et al., 2015; Lachman et al., 2017, 2018; Atukunda et al., 2019; Luoto et al., 2020),* educated facilitators with experience in programme delivery *(Betancourt et al., 2018; Skar et al., 2014; Rockers et al., 2016), or local "head mothers" that participated in the programme (Rockers et al., 2018).*

6.2.4 Assessed outcomes

Most studies assessed both parental outcomes and child outcomes. The most common parental outcomes assessed in the 15 studies can be sorted into the following categories: positive parenting; parent attitude or knowledge; parenting practices or skills; harsh and abusive parenting; parental mental health; social support; help seeking behaviour for child; and parent-child interaction. The most common child outcomes were cognitive development; socioemotional wellbeing; growth; nutrition; and adaptive behaviour.

A variety of assessment measures and tools were made use of in the studies, some of which are The Observation of Mother-Child Interaction (OMCI) (Betancourt et al., 2018; Betancourt et al., 2020), Home Observation for Measurement of the Environment (HOME) inventory (Betancourt et al., 2018; Betancourt et al., 2020; Luoto et al., 2020; Singla et al., 2015), Bayley Scales of Infant Development (Atukunda et al., 2019; Luoto et al., 2020; Rockers et al., 2016; Rockers et al., 2018; Singla et al., 2015), The Strengths and Difficulties Questionnaire (SDQ) (Puffer et al., 2015), Different depression scales (Betancourt et al., 2020; Lachman et al., 2017; Rockers et al., 2018; Singla et al., 2015), International Development and Early Learning Assessment (IDELA) (Borisova et al., 2017), semi-structured interviews (Giusto et al., 2017; Lachman et al., 2018; Skar et al., 2014), self-report (Lachman et al., 2017; Lachman et al., 2018; Luoto et al., 2020; Puffer et al., 2015; Rockers et al., 2016; Rockers et al., 2018; Singla et al., 2015; Ward et al., 2020), observed parent-child practice and/or interaction (Lachman et al., 2017; Puffer et al., 2015; Ward et al., 2020), report scales (Lachman et al., 2018; Puffer et al., 2015; Ward et al., 2020; Weber et al., 2017), child growth (Atukunda et al., 2019; Betancourt et al., 2018; Betancourt et al., 2020; Luoto et al., 2020; Rockers et al., 2016; Rockers et al., 2018; Singla et al., 2015), questionnaires and surveys (Weber et al., 2017), measures of children's language and vocabulary (Rockers et al., 2016; Weber et al., 2017).

A table describing these 15 studies can be found as Appendix 1.

6.3 Narrative description of the SSA studies

We will now describe the fifteen studies narratively. They are sorted according to their focus regarding the nurturing care components, or whether they encompass several of the components in a more combined and integrated manner.

6.3.1 Learning opportunities and education

The study by Borisova et al. (2017) conducted in Ethiopia examined the effectiveness of a low-cost family-based support programme as an option to the traditional school-based early childhood care and development model (0-class). The parent education programme targeted foundational literacy and math skills through games and resources that parents (also illiterate parents) can use at home with their child, and it seeks to enhance the confidence of parents for supporting the school readiness of children *(Borisova et al., 2017)*. They found that children in both groups made comparable gains, but that they were not significantly different, for overall school readiness, socioemotional development, early literacy and early math development. Quality may have been a factor as the parent-focused interventions seemed to have high engagement in activities with children, whereas the government-supported 0-class programme had large class sizes, little support from teachers and high absence of teachers *(Borisova et al., 2017)*. As similar improvements in learning and development across key domains were found at the same rate in both the low-cost 10 session programme and in the traditional pre-primary classes that lasted for an academic year, it may imply that the programme has much potential as an effective and low-cost alternative *(Borisova et al., 2017)*.

A parenting programme in rural Senegal was designed to encourage verbal communication between parents and infants, in a society where some cultural beliefs and norms could discourage talking to babies *(Weber et al., 2017)*. Building on a parenting programme by the NGO Tostan, the evaluation study by Weber et al. (2017) examined whether the programme resulted in changes in parenting behaviour and if such changes influenced the early language development of children. The parenting programme was delivered by a trained facilitator that lived in the community and included group sessions and bimonthly home visits over a 10-month period. Topics included in sessions were brain development in infancy, and scientific evidence on how parenting practices influence children's development, language and cognitive growth, as well as beneficial and potentially harmful parenting practices, and how parents can help children succeed in school *(Weber et al., 2017)*. Weber et al.

(2017) found that parents who participated in the programme significantly increased the amount of verbal engagement with their children when observed after 1 year, and that the children showed greater improvement in vocabulary and other language outcomes compared to children in comparison villages. One of the aims of this parenting programme was to mitigate the social stigmas associated with engaging with and talking to babies, by providing participants with knowledge and alternative explanations to cultural beliefs *(Weber et al., 2017)*.

6.3.2 Safety and security

Lachman et al. (2017) conducted a randomised trial of a parenting programme to reduce the risk of child maltreatment in a low-income community in South Africa. Parents of children aged 3-8 years received either a group-based parenting programme (Sinovuyo Caring Families Program for Young Children) or were assigned to a waitlist control group. The parenting programme was based on social learning theory and its core components were content on emotional communication, child-led play, praise and reward, instruction-giving and household rules, and nonviolent discipline strategies. Mindfulness-based techniques were also incorporated in the programme to help parents manage potential stressors stemming from poverty, illness and community violence *(Lachman et al., 2017)*. The programme was delivered to the intervention group (10-14 parents per group) over 12 weekly sessions by trained community-based workers, introducing the parenting principle using traditional stories and illustrated scenarios that are typical for the context. Using self-report and observational assessments, the results indicated moderate treatment effects for increased frequency of positive parenting and parent-report, as well as observational assessments of parent-child play. The results indicate preliminary evidence of effect of reducing the risk of child maltreatment, but several limitations (e.g., low statistical power and post-test immediately after programme delivery) suggest the need for further research to strengthen the knowledge of intervention effectiveness and programme components *(Lachman et al., 2017)*.

Another paper by Lachman et al. (2018) is based on the same study, but is a mixed-methods process evaluation to determine the feasibility of such a parenting programme as the Sinovuyo Caring Families Programme, and explore e.g., participation involvement and programme implementation. Quantitative data demonstrated a high rate of overall program enrolment and participants reported a high overall satisfaction with the program. From the qualitative analyses it is gathered that the parents found weekly text message reminders useful and that the distributed handbook supported engagement and adherence to program content. Furthermore, parents reported that collective problem-solving was useful, roleplaying helped them understand the skills and the perspective of the child, the use of

traditional and cultural stories provided them with opportunities for positive parent-child interactions, and that illustrations made the content more feasible, especially for parents with low literacy levels *(Lachman et al., 2018)*. Although some initial resistance was reported when introducing new parenting skills, this often diminished when the parents understood the rationale and impact of the practice, according to the study. Examples of such practices were engaging in child-led play, using language to communicate emotions, and using non-violent discipline techniques. Explanations form the participants of the initial reluctance highlighted that the new parenting skills were not in line with what they were used to and with their cultural practice, but that they found the new skills to provide them with increased empathy for their child (talking about emotions), and more efficacy in managing problematic child behaviour (non-violent discipline) *(Lachman et al., 2018)*.

A low-cost 12-session programme aiming to increase positive parenting, and to reduce harsh parenting and conduct problems in children, was subject of the randomized controlled trial conducted in South Africa *(Ward et al., 2020)*. Using home practice, roleplay, and group discussions, the programme focused on building positive parent-child relationships, positive reinforcements, and nonviolent discipline strategies. Ward et al. (2020) found increased effects in observed positive parenting and child behaviours, as well as a possible effect on caregiver depression, but the differences between the intervention and control group were small. It is suggested that reasons for these small differences were the use of measures unvalidated in South Africa, and possible contamination between intervention and control groups *(Ward et al., 2020)*.

6.3.3 Nutrition

A cluster randomised controlled trial was conducted in Zambia by Rockers et al. (2016), to test the impact of community-based early childhood interventions. The assessed primary outcomes were child neurodevelopment and physical growth, and the households in the intervention group were visited fortnightly by a local health worker and invited to attend fortnightly group meetings, both of which lasted throughout the one-year study intervention period. The curriculum in the group meetings consisted of self-care for parents for good mental health, child nutrition and cooking practices, parenting skills, cognitive stimulation, language development and play practices, whereas the home visits consisted of screening children for acute malnutrition and infections, as well reminding parents to use routine health care services *(Rockers et al., 2016)*. Results for the intervention group showed that the interventions had a strong positive impact on parenting behaviours, as significant impact was found for behaviours such as engaging more often with their child in activities like singing, reading to the child, and playing. They also found that children in the intervention group had a more diverse diet.

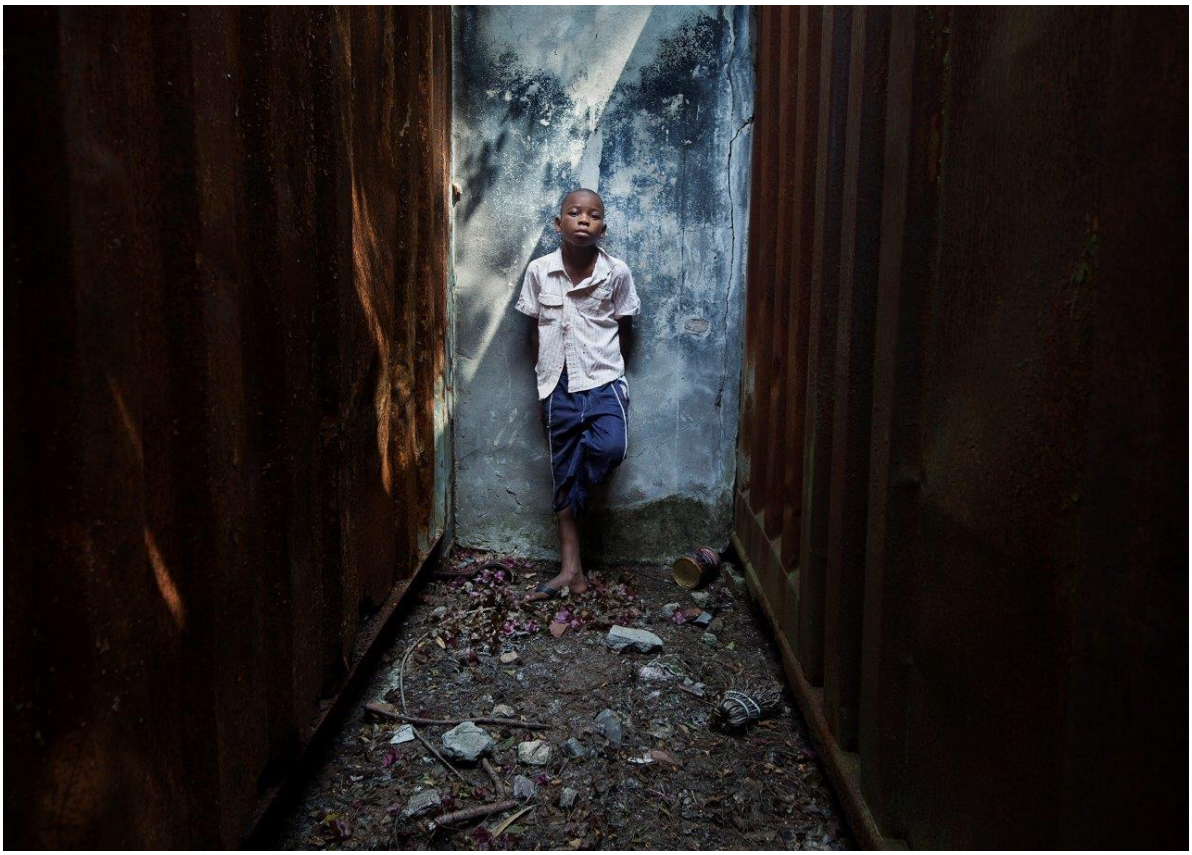
For outcomes related to child development, such as child nutrition and parent-child interaction, there was a small positive impact, but the impact was not statistically significant *(Rockers et al., 2016)*. Several limitations were noted, such as not being able to identify the independent impact of home visits and group meetings, and relying on self-reports for measuring parenting behaviour.

The parenting group meetings (but not the home visits) interventions were extended for another year, and Rockers et al. (2018) did a year two in-depth follow-up of the original study cohort. They found that interventions had significantly reduced child stunting, and had a significant positive effect on language development, and caregiver-child interactions, but not on cognition, motor skills, adaptive behaviour, or socioemotional development, or caregiver mental health *(Rockers et al., 2018)*. The significant impact on stunting reduction and positive language development was interpreted to mean that community-based early childhood interventions could be an effective platform for delivering parenting support in a low-recourse setting such as Zambia, as it seemed to be an effective means to reach a large number of households *(Rockers et al., 2018)*. Furthermore, Rockers et al. (2018) emphasised the need to consider temporal aspects of child development when designing future studies, possibly needing longer intervention periods and follow-up studies in order to realise potential impacts.

6.3.4 Responsive care

The International Child Development Programme (ICDP) is psychosocial, interactive, community-based prevention programme directed at parents and other caregivers that aims to promote psychological care competence and improved child-care services *(Skar, De Abreu, & Vaughn, 2019)*. It is a family strengthening programme used in more than 30 countries globally that works to guide parents' understanding of their children and interaction with them *(Sherr, Skar, Clucas, Tetzchner, & Hundeide, 2014)*. In a study conducted in Mozambique, Skar et al. (2014) found that the group of caregivers who completed the ICDP course reported better parenting skills, better child adjustment, and fewer conduct problem in their children than the comparison group. The intervention group was compared against a socio-geographically matched group who had not followed any parenting programme. The ICDP programme examined in the study, consisted of 10-12 weekly group sessions, in addition to follow-up visits at home for 6 weeks that allowed for ICDP facilitators to observe caregiver-child interactions. Such interactions are at the core of the programme with its focus on positive aspects of caregiver performance and interaction in order to strengthen the self-confidence *(Skar et al., 2014)*.

In a more recent study by Skar et al. (2019) from Mozambique, a health and nutritional supplement was integrated with the interventions in ICDP. Measures included weight and height scores of children, together with self-report on Strengths and Difficulties Questionnaire before and after the interventions. The children's self-report suggest increased prosocial behaviour in the intervention group, whereas height and weight measures indicate an improvement among 93 percent of the children categorised as malnourished prior to the interventions *(Skar et al., 2019)*. Both these studies have limitations, such as the lack of randomisation, longer-term follow up, and adequate comparison data, as well as the post-test only research design in the study from 2014. However, the studies suggest that parenting programmes such as ICDP are useful for strengthening parenting practices and the conditions of children and parents, as well as indicating the usefulness of a holistic approach that combine the psychosocial interventions with nutritional support *(Skar et al., 2019; Skar et al., 2014)*. The newest study by Skar et al. is not included as a stand-alone study in this section because it targets children up to age 16, which is higher than the inclusion criteria for age of children.



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6.3.5 Combined focus

The parenting programme ‘Sugira Muryango’ is examined in two different studies by Betancourt et al (2018; 2020) conducted in Rwanda. The programme has a rather broad range as it offers coaching to parents in order of promoting early stimulation, play, nutrition and hygiene to children, as well as nonviolent interaction between the members of the households, engagement from both female and male parents, and responsive caregiving. Additionally, navigating resources such as social support and more formal health and nutrition services, are also a part of the support *(Betancourt et al., 2020)*.

The study from 2018 is an open trial with a pre-post design with 6–13-month follow-up assessing the feasibility, acceptability and potential of the programme. During the trial, the intervention content and material were condensed into a 15-module version that maintained the same core content as the original 22 modules. The caregivers reported high participant satisfaction of the programme post-intervention. Significant improvement was found in the HOME Involvement and Learning Materials domains, which suggests that ‘Sugira Muryango’ is appropriate for targeting caregiver capacities to provide suitable play and learning materials and to engage children in their daily routines *(Betancourt et al., 2018)*. Small, but not significant, changes were found for child health, caregiver knowledge and attitudes about early childhood development, the effects found on reducing family violence were limited. The authors found that the initial results demonstrate feasibility and acceptability of the programme, and that more research was needed to investigate the programme more thoroughly.

The study from 2020 of ‘Sugira Muryango’ was a pre-post cluster randomised trial delivered to families in combination with a government-provided social protection programme (e.g., cash for labour and access to livestock). ‘Sugira Muryango’ now consists of 12 modules with the same core content as the 2018 study. This randomised trial examined whether the intervention group demonstrated changes in positive and responsive caregiving, care seeking, nutrition, hygiene, and father involvement, compared with the treatment as usual control group. The results indicate that the programme led to improvements in parental practices related to child development including parent-child interactions and stimulation, care seeking, nutrition, and reduced violence, although no improvements were found in child health status *(Betancourt et al., 2020)*. Significant improvements in depression and anxiety symptoms among caregivers were found, as well as decreased exposure to harsh discipline.

Another paper on this study is underway, and will explore cognitive and physical development outcomes at 12-month follow up. The ‘Sugira Muryango’ programme is still under development with

further studies underway, and small adaptions are being done in order to improve interventions or to adapt the programme to different contexts *(Betancourt et al., 2020)*. It is a programme that involves the community around the family by helping the parents navigate the resources that are available, as well as channels for conflict resolution – incorporating violence prevention in the overall support *(Betancourt et al., 2018; Betancourt et al., 2020)*.

The study by Atukunda et al. (2019) was conducted in Uganda, using a multidisciplinary approach, and examined the development of children and their growth and gut microbiota from the effects of an education package that was delivered to mothers. The education package consisted of information and practice on preparing food, stimulation of the children (play to improve cognitive, language and motor development), and a hygiene intervention (e.g., hand wash, oral hygiene), as well as emphasising the need for ill children to be taken to hospital. Atukunda et al. (2019) found that the interventions had positive effects on child growth and development, with significantly improved cognitive, language and motor developmental outcomes.

A cluster-randomised trial conducted in Kenya by Luoto et al. (2020), aimed at testing the effectiveness of two group-based models for an integrated early childhood development responsive stimulation and nutrition education intervention. The responsive stimulation and nutrition education intervention focused on responsive play, love and respect in the family, responsive communication, nutrition, and hygiene, and was delivered through demonstration and coached practice, group-based problem solving, and peer support *(Luoto et al., 2020)*. For the group that received the mixed version, they also had home visits from community health volunteers who delivered review messages identical to those in the group reviews, but the focus was tailored to that specific family. Using this purely group-based model versus a mixed-delivery model that combines home visits with group sessions, Luoto et al. (2020) found that a group-based intervention is at least as effective as a mixed-delivery model in combination with home visits, but is less burdensome to deliver. Regarding the assessed outcomes, the study found that both the group-only and mixed-delivery models significantly improved the socioemotional and cognitive development of children, as well as maternal stimulation practices and knowledge of child development *(Luoto et al., 2020)*.

The programme ‘Parents Make the Difference’ in Liberia was evaluated by Puffer et al. (2015) in an randomised controlled trial, and it focused on positive parenting and building cognitive and educational skills. The programme consisted of ten group sessions that included topics such as introduction to nurturing parenting, childhood development and appropriate expectations, discipline with dignity, and communication with children and empathetic listening. The sessions were interactive and emphasised

discussion, in-session skills practice, and model learning *(Puffer et al., 2015)*. In the randomised trial, Puffer et al. (2015) found a reduction in harsh punishment practices, with caregiver-reported decrease in whipping, beating, slapping, and shouting at their children. They also found an increase in positive behaviour management strategies such as 'time-out', as well as an increase in positive interactions between caregivers and children.

The paper by Giusto et al. (2017) builds upon the study by Puffer et al. (2015), and explored mechanisms underlying effects of parenting interventions, with findings suggesting that learning about effects of violence on child development can promote parental efforts to decrease the use of harsh discipline. Parents received interventions focusing on e.g., addressing beliefs and attitudes related to parenting, stimulating early learning, parenting skills related to positive interaction and nonviolent behaviour management, as well as caregiver stress *(Giusto et al., 2017)*. In qualitative interviews, several of the parents reported improvements in their relationships, and in the interactions between themselves and their child, of being more involved in their child's education, staying more at home and reducing substance use, as well as advocating for positive parenting in their community (Giusto et al., 2017). Giusto et al. (2017) identify pathways of change in the data and frame the change in parenting practice and parent-child interaction as a cognitive shift in identity for the parents, where they see themselves as protectors and nurtures for their children and thus reduce the use of harsh punishment.

Maternal psychological wellbeing and child development and growth was addressed by a community-based, cluster randomised trial in rural Uganda for children younger than 3 years by Singla et al. (2015). The parenting intervention group attended 14 peer-led group sessions on topics related to child care (play, love and respect, two-way talk, diverse diet, and hygiene) and maternal wellbeing (e.g., increasing father involvement, the mother's relationship with herself, her spouse, and the child). Through active and interactive activities as roleplay, group-based problem solving, games, and parent-child interactions, parents heard about the benefits and rationales of the different aspects of child care, enacted the practices with their child, and explored and dealt with relevant barriers *(Singla et al., 2015)*. For the four sessions on mother care, two were delivered to mothers and fathers separately and two were delivered to mothers and fathers together. Discussions were facilitated about potential interpersonal conflicts with the use of scenarios of mothers and fathers in supportive and unsupportive situations, in addition to using role-play for practicing appropriate conflict resolution strategies and communication *(Singla et al., 2015)*.

The primary outcome was child cognitive and receptive language development at three months after completing the programme (measured with Bayley Scales of Infant Development), the secondary

outcomes were maternal depressive symptoms and child growth. Singla et al. (2015) found significantly higher language scores for children receiving the intervention compared to control group, mothers in the intervention group reported lower depressive symptoms compared to the control group, and mothers' knowledge of perceived positive support and milestones in children's development (measured by the HOME inventory), were significantly higher among mothers in the intervention group. Although the findings indicate lower degrees of depressive symptoms compared to the control group, the interventions only prevented the worsening of depressive symptoms for mothers in the intervention group *(Singla et al., 2015)*. This suggests the need for further research into interventions that promote maternal wellbeing and reduce depressive symptoms.

6.4 Discussion of the findings from SSA: What is the evidence of effect? What do we know?

The results from the programmes explored in the 15 papers are somewhat mixed. Positive effects in some areas are reported in all studies, but most studies also report on no improvement in other areas. Overall, they provide moderate evidence of positive impact on parents' knowledge, parenting behaviours and parent-child interaction (e.g., engaging more often with their child in activities like singing, reading to the child, and playing) and cognitive and language development. There is also some evidence for improvement in child nutrition, stunting, diet, socioemotional development, harsh discipline and family violence. The studies provide less evidence on improvement in child health and parental mental health. Although some of the studies assess outcomes related to mental health and wellbeing, the link between early childhood development and mental health is not prominent in the studies. One reason that we did not find a lot of studies that demonstrated improvement in mental health, could be that it is possible that we missed these studies as they may focus on mental health specifically, rather than early childhood development.

Several of the studies in this narrative synthesis make use of parenting programmes that are relatively wide-ranging and multi-faceted, as for instance Betancourt et al. (2020), while others had a more targeted focus, such as Borisova et al. (2017). These examples are highlighted because they show some of the range in the existing studies conducted in sub-Sahara African low- and middle-income countries that concern early childhood development. There are few studies, small samples, dissimilar measurements, limitations in the studies, and some divergence in the findings. Despite these

challenges, it is possible to extract some knowledge from the reviewed papers, illustrated below with some examples from the findings.

The findings from the selected studies have a wide range, because they intervene at, and assess a range of, different aspects of early childhood development related to both the wellbeing of the child and the parents. From the studies, we gather that maternal education interventions had positive effects on child development and growth *(Atukunda et al., 2019)*. Wide-spanning parenting programmes such as 'Sugira Muryango', led to improvements in caregiver behaviours linked to child development and health, and reductions in violence, as well as an increase in parental mental wellbeing *(Betancourt et al., 2020)*. An integrated intervention can concurrently enhance both child development and maternal mental health, and therefore has a potential to be synergistic and cost effective *(Singla et al., 2015)*.

Interventions that aim (and succeed) at improving positive parenting behaviour, can contribute to reducing child abuse *(Lachman et al., 2017)*. Adding and increasing parental knowledge together with discussions and reflection around attitudes, are shown to make parents more aware of their role as a parent and the implications it may have for their children, for instance to reduce the use of harsh punishment *(Giusto et al., 2017)*. Furthermore, a low-cost parental education programme can potentially be just as effective as traditional pre-primary classes that lasted for an academic year, for strengthening literacy, language and overall school readiness for children (Borisova et al., 2017).

Several of the studies contain elements of nurturing care, such as for instance good nutrition and early learning *(Atukunda et al., 2019; Luoto et al., 2020)*. Furthermore, the component of responsive caregiving was exemplified in the interaction between parent and child in several studies *(Betancourt et al., 2020; Giusto et al., 2017; Puffer et al., 2015; Skar et al., 2014)*.

Rockers et al. (2018) investigated child development and the impact from community-based parenting groups, and found in their two-year follow-up that the odds of stunting were substantially reduced, suggesting that parenting groups hold promise for improving child development, particularly physical growth. On a somewhat different matter, Giusto et al. (2017) emphasises the importance of understanding the mechanisms underlying the interventions, so that they can be used to some extent across contexts and adapted to contexts when necessary, as well as taking culture and population needs into account.

Integrated interventions that use parenting content in other interventions such as nutrition and social protection programmes, could provide opportunities for synergistic effects on parent-child relationships and the home environment *(Richter et al., 2017)*. Examples of this are found in how education and engagement of caregivers can improve child development and health through behavioural change *(Betancourt et al., 2020)*. A recent study by Jeong et al. (2020) suggests that strategies for improving early childhood development in low- and middle-income countries may have more success by additionally integrating interventions that prevent intimate partner violence, in addition to the more commonly focused interventions for increasing the quality of mother-child interactions and early learning opportunities, which coincides with the papers of Puffer et al. (2015) and Giusto et al. (2017).

The studies presented in this chapter have given valuable insight into the status of parenting programmes concerning early childhood development in sub-Saharan Africa. Because of the variations in the studies, it has been difficult to compare them. However, it is useful to get an understanding of what is being done in terms of parenting programmes related to early childhood development and psychosocial wellbeing in sub-Saharan Africa, through these studies. Moreover, they highlight the need for even more information and knowledge about the needs and recourses in the different settings and contexts across the countries.

The studies presented in this chapter have given valuable insight into the status of parenting programmes concerning early childhood development in sub-Saharan Africa.

In the following, we will give a brief overview of a selection of previous reviews from the broader literature. The broader literature will then be used to interpret and discuss the findings from the 15 main papers.

6.5 What did we find from parenting studies in other regions?

We identified several systematic reviews on parenting programme. *For a more detailed overview, see the table in Appendix 2.* Some of these reviews of parenting programmes found positive effects on direct measures of children's cognitive and language development across service delivery and social contexts *(Aboud & Yousafzai, 2015; Britto et al., 2015; Rao et al., 2014)*. The systematic review by Knerr et al. (2013) focused on improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries. From the twelve studies that they examined, they discovered that parenting interventions may be effective and feasible in improving interactions between parent and child, and for improving parental knowledge on child development. However, there was a lack of high-quality studies and there was high heterogeneity among the included studies,

therefore it is recommended that interventions are more rigorously evaluated in the future *(Knerr et al., 2013)*.

In their review, Rao et al. (2014) found that a large high-quality evidence base shows that early childhood development interventions that focus on parental support, early stimulation and education, nutrition and health, income supplementation, and comprehensive and integrated programmes have positive effects on children's cognitive development, especially comprehensive programmes. A meta-analysis by Jeong et al. (2018) explored effectiveness of early childhood stimulation interventions on caregiving outcomes, by examining fifteen papers on studies conducted in low- and middle-income countries. They found medium-to-large effects of stimulation interventions on observed mother-child interactions, on improving the home caregiving environment, and maternal knowledge of early childhood development *(Jeong et al., 2018)*.

The review by Pedersen et al. (2019) showed that parent- and family-focused interventions may be valuable to people in low- and middle-income settings. This includes e.g., parent skills training, psychoeducation, trauma-focused-CBT, and psychosocial and behavioural interventions. This discovery is supported by 28 studies (88%) that showed a significant positive effect in the intervention group on numerous outcomes including child and youth mental health and wellbeing, as well as family functioning and parenting behaviours *(Pedersen et al., 2019)*. A recent systematic review by Khatib, Gaidhane, Ahmed, Saxena, and Syed (2020), found that early stimulation interventions can prevent inequalities and encourage socioemotional and cognitive development in young children, as well as improving maternal outcomes. The mutual bond between parent and child was emphasised as important to strengthen, which may entail strengthening the emotional availability of parents as that affects their parenting ability *(Khatib et al., 2020)*.

Saran et al. (2020) conducted a mega-map of systematic reviews on interventions to improve child well-being in low- and middle-income countries. They discovered 333 systematic reviews, but 231 of them were assessed to be of low or medium quality thus highlighting clear gaps in quality in evidence of interventions for child wellbeing *(Saran et al., 2020)*. Although there was quite a large number of reviews, the evidence was unevenly distributed across categories of interventions *(Saran et al., 2020)*. They found many reviews that examined health and nutrition as part of early childhood development, and striking gaps in evidence on areas such as social protection and child abuse.

Meta-analyses have reported consistent medium-to high effect sizes on early childhood development and learning outcomes, stemming from interventions such as parenting, early childhood education, and stimulation *(Yousafzai, Aboud, Nores, & Kaur, 2018)*. Parental actions that are nurturing and caring might act as a buffer and contribute to protecting children from hardship, deprivation and chaos *(Miller et al., 2020)*. This shows the importance of adequate parenting, no matter the context and setting. Promoting responsive parenting, nutrition, hygiene, early stimulation, play, and nonviolent interactions, are aspects of parenting programmes and interventions that contribute to healthy child development *(World Health Organization et al., 2018)*.

There is still a consensus that adjusting parenting approaches to modelling positive and prosocial behaviour, is the better measure for preventing unwanted behaviour in children, over child focused therapy or medication *(Thompson & Thompson, 2020)*. Modifying and boosting parental activities can be done in various ways and some examples are counselling, encouraging, and coaching parents as a way of enhancing knowledge, practices, and attitudes, as well as promoting positive interactions between the child and parent *(Jeong et al., 2018)*.

Several parenting programmes centre around fostering knowledge about children, skills-training, attitude promotion, providing good nutrition, supporting families, and aiding healthy development and wellbeing *(Jeong et al., 2018; Khatib et al., 2020)*. A variety of outcomes are monitored in studies of different parenting programmes. Some outcomes are related to the child, such as internalising and externalising symptoms. Others relate to parents, for instance parental self-efficacy or parenting behaviour. Others again concern both children and parents, such as child-parent interaction.

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6.6 What did we find on implementation of parenting programmes?

6.6.1 Design

Many interventions in parenting programmes centre around psychoeducation, skills-training, knowledge and attitude promotion. Coaching parents is a central aspect in many parentings programmes, focusing on for instance how to interact with their child in order to enhance sensitivity to the developmental needs of their child *(Jeong et al., 2018)*. The systematic review by Britto et al. (2015), found that for example in improving child protection, it was useful and effective to provide demonstrations or examples of alternative approaches in order to inform parental practices. Furthermore, they found that programmes that applied more than one modality consistently achieved better results than programmes that only used one *(Britto et al., 2015)*.

Many interventions in parenting programmes centre around psychoeducation, skills-training, knowledge and attitude promotion.

A recent study by Kim et al. (2020) highlighted home visits as a powerful part of parenting programmes, as it allows for assessing and engaging the families in question and makes it easier to reach parents that are unable to attend services regularly, as well as fostering more culturally sensitive services. Although home visiting may be a powerful tool, the study by Luoto et al. (2020) compared and tested the effectiveness of group-based models for delivery of parenting programmes with a mixed-delivery model that combined group sessions with home visits. They found that a group-based intervention is at least as effective as a mixed-delivery model, and is less burdensome to deliver *(Luoto et al., 2020)*.

These findings are interesting for task-shifting and the up-scaling of programmes, as they found that early childhood development interventions can be effectively delivered in large village group settings using existing paraprofessional community workers, without losing effects compared with a more personalised model of delivery that entails home visits, which may be more time-consuming and expensive *(Luoto et al., 2020)*. These are interesting findings, and can be interpreted as linking to the important connection between outcome and type of modality. Britto et al. (2015) showed in their systematic review that child cognitive outcomes were significantly improved across both and centre-

based programmes that used group settings and home-based modalities, but importantly; the active engagement between the parent and the child was key to improving the cognitive development of children.

The modality and the techniques used in such programmes should be influenced by the outcomes. There are several platforms for early childhood development services, spanning from home visits, community-based groups, and clinical contacts, to new and emerging approaches, such as media and digital deliverances *(Black et al., 2017)*.

The dosage and delivery of the programmes are important factors for programme effectiveness (Britto et al., 2018). The dosage of a programme concerns the amount of the programme delivered, and the duration, frequency, and intensity of the programme.

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In addition to the intensity and duration of programmes, the timing of when the interventions are delivered is also important. The study by Luoto et al. (2020), found that children who attended more session showed greater benefits from the programme, and that maternal stimulation practices also improved with attendance. Yet, there is still a lack of certain knowledge on what works best when it comes to dosage, much because specific interventions may differ in what is the most effective dosage for just that type of intervention and outcome *(Britto et al., 2015)*.

The early development of children is characterised by critical and sensitive periods for development, accordingly will the effects of interventions vary based on these sensitive periods and the delivery of the interventions *(Black et al., 2017)*. Interventions aimed at preventing child and parenting problems should ideally start before any significant problems occur *(Mihelic et al., 2017)*.

6.6.2 Participation

Attendance and engagement by parents as participants in parenting programmes are essential for children and parents benefiting from the interventions. An exploratory study from South-Africa that

looked at what effected engagement and attendance, found that on average caregivers attended 50 percent of sessions *(Shenderovich et al., 2018)*. There was an ongoing fluctuation in attendance, and the authors observed dips in attendance that corresponded to the beginning of a new month, which was potentially connected to families travelling to receive disbursed social grants. They found that caregivers in peri-urban areas attended fewer sessions than caregivers in villages, caregivers with one deviation higher alcohol and substance abuse reported attending fewer sessions than others, and caregivers that had a job attended fewer sessions compared to unemployed caregivers *(Shenderovich et al., 2018)*.

Some of the most common ways of delivering parenting programmes and interventions are community-based group sessions with or without home visits, health centre visits, and separate home visits *(Khatib et al., 2020)*. Most parenting programmes last over a period of time, with weekly meetings. This gives the group members and the parents and trainer, time to get to know each other which can promote a feeling of togetherness, emotional security and social support. Furthermore, it makes it possible to develop new skills and acquire new knowledge together as a group, and at the same time have the opportunity to practice and try out the interventions between meetings and give and get feedback on the progress.

These forms for peer support can be valuable during the programmes, and even more so when the sessions are completed. In the parenting programme in South Africa that Lachman et al. (2018) explored, participants were encouraged to form relationships with other parents in the programme in order to create a peer support network outside the group sessions. By participating and being involved with peers and in group networks, the group dynamics may make the parents recognise their strengths, while solving daily problems, reducing stress, and discussing strategies that help them to cope and to avoiding harsh self-judgment *(World Bank, 2015)*. Support networks may contribute to improved parental effectiveness that can be sustained after the intervention ends. This is a way of involving the community in the parenting programmes, an involvement that can cause the essence of the programmes to trickle down onto members of the community that did not participate in the programmes.

Using community health workers in delivery of interventions programmes is a much-used strategy in low- and middle-income countries that enable more families to receive support as task-shifting and adequate training helps to reach a larger audience *(Singla et al., 2015)*. Findings by Giusto et al. (2017) are in line with this, as they discovered that some participants spontaneously assumed a role as leaders and passed on programme content to their communities, perhaps indicating that such

participants can hold more formal roles when the programmes are expanded. These factors are extremely important to consider when designing and implementing a programme, and show the necessity of having a proper theory of change.

6.6.3 Context and culture

An important point with regards to parenting programmes and implementation, is the cultural and contextual considerations. In line with having a beneficial theory of change, the interventions and delivery should be in line with the context and the needs of the population *(Britto et al., 2018)*. To effectively and feasibly adapt interventions for new settings, requires an acknowledgement of the context. Knowing the context and culture is important in order to tailor the interventions, which often is needed in at least some degree, as to make sure the content and examples make sense for the participants.

An important point with regards to parenting programmes and implementation, is the cultural and contextual considerations.

Another important point is the contextual environment and particularly the mindset, state, and the situation of the parent. It is of course possible that a parent knows everything that the programme will teach, but is still not able to take care of the child because of poverty, war or the distress of being on the run or living in a refugee camp setting. This speaks to the potential benefit of having an integrated and multi-sectorial approach, as it may contribute to an appropriate programme that has an impact and effect regardless of life domains *(Miller et al., 2020).*

Previous reviews have found that parenting programmes can be transported from one context to another, often without major adaptions *(Gardner, 2017)*, concluding that parenting programmes should be chosen based on evidence and documented effect, rather than cultural context. However, most of these programmes were transported within high income countries, and none to or from sub-Saharan Africa. A paper by *(Aboud, Yousafzai, & Nores, 2018)* present a different approach and argues that when taking programmes into a new culture or setting, principles of flexibilities and adaptation are more important than exact replication, and it is often beneficial to follow the adaptation with a feasibility study. The extent the service providers and participant regard the contextual and cultural relevance of a programme, is related to the acceptability of the programme *(Lachman et al., 2018)*.

Findings from Malawi underline the need for an understanding of the core ingredients of interventions, together with participatory approaches for enhancing local relevance, in order to make them effective *(Britto et al., 2018; Gladstone et al., 2018b)*. The involvement of local people and communities is recognisably important for adapting and delivering impactful and effective programmes, but involvement is additionally essential in the evaluation and research *(Baumann et al., 2019)*.

Conducting qualitative research may give a peak into cultural and contextual manners. A qualitative study from Malawi that explored maternal depression, found that stressors such as being financially dependent on their husbands, little social support or being abused, was linked by the women to a condition of “nganisyo” or “thinking too much”, with some of the symptoms being unhappiness, worrying, loss of interest, suicidal thoughts, being irritable, self-neglect, or inadequately caring for the child *(Stewart, Umar, Gleadow-Ware, Creed, & Bristow, 2015)*. Although “nganisyo”/”thinking too much” have several similarities with depression, it may be better to stick to such local conceptualisations as the way people make sense of mental distress can vary greatly and therefore would be lost by using the term ‘depression’, as well as mitigating the potential stigmatisation of using a diagnostic term *(Ventevogel, Jordans, Reis, & de Jong, 2013)*. In the study by Stewart et al. (2015), some women reported that they were vulnerable to harm during pregnancy through witchcraft, others attributed behavioural disturbances to possession by “Jinns”, all of which can indicate a society in transition as well as emphasising the importance of knowledge and understanding about cultural beliefs and norms.

A study by Ng'oma, Meltzer-Brody, Chirwa, and Stewart (2019) on maternal depression in Malawi, found that all participants in the study acknowledged the need for support and interventions to address challenges with depression, indicating a need for family focused interventions that address psychosocial challenges during pregnancy and after, as well as empowering the women in problem solving. Several women in the study used spirituality, religious counselling and prayer as a coping mechanism, and many viewed their symptoms as social problems related to difficulties in their life situation *(Ng'oma et al., 2019)*. These studies from Malawi emphasise the need for a strengthened primary health care system, as well as family focused interventions that can address the challenges for children, mothers and fathers connected to maternal *depression (Ng'oma et al., 2019; Stewart et al., 2015)*.

Taking such contextual factors into account, shows the possible differences in people’s situations, and works as an example of why we not automatically can use programmes from a peaceful and high-resource setting, everywhere.

6.6.4 Measurements

There is not enough data and therefore not enough knowledge on the situation for children and their development, as many countries do not have such assessments and measures in place. A lot of effort is going into establishing a global monitoring system for early childhood development, but there are still major gaps in the data such as on child poverty, attendance of early education, or the state of children's diets *(Richter et al., 2020)*. The newly updated country profiles by Countdown to 2030 (2020) indicate progress towards establishing monitoring and accountability measures. Nonetheless, there is still a daunting shortage on crucial indicators from many of the countries, as well as much variations in the indicators for data collection and therefore a challenge for international comparability (Richter et al., 2020). Additional progress is underway for measurement tools that hopefully will contribute to bridging this gap in information on early childhood development and its indicators. An example is the ECDI2030 (Early Childhood Development Index) that captures the achievement of key milestones by children aged between 24 and 59 months, addressing the need for internationally comparable and nationally representative data *(UNICEF Data, 2021)*. Another example of positive supplements to the field is the IMPACT Measures Tool, which is a repository of early childhood measures that makes it easy to search, compare, and access measurement tools *(EC PRISM, 2021)*.

Regarding implementation, there is a lack of internationally validated tools that are easy to use, interpret and compare across cultures *(McCoy et al., 2018b)*. Without such tools, the monitoring of global progress towards developmental equity and wellbeing is hard (McCoy et al., 2018b). However, work is underway to change this with CREDI (Caregiver Reported Early Development Instruments), which is a tool for measuring mental health, socioemotional, cognitive, language, and motor skills of children younger than three years in culturally diverse settings *(McCoy et al., 2018b)*.

6.7 What did we find on the relationship between mental health, caregiving and early child development?

The mental health and psychosocial wellbeing of parents are important for early childhood development. There seems to potentially be corresponding benefits of parenting interventions,

which not only improve child development and the bond between parent and child, but also the psychosocial wellbeing and mental health for both children and parents *(Mejia, Ulph, & Calam, 2016)*.

There is a robust finding of a connection between daily stressors and war exposure, and comprised parenting *(Jordans, Tol, Ndayisaba, & Komproe, 2013; Puffer et al., 2015)*. This has contributed to the interest in strengthening caregiving for families that face daily stressors and lives in adversities, or has experienced war, loss, or disasters. Improving the wellbeing of parents is seen as a way to improve parenting and promoting healthy development and child wellbeing. It is suggested that some of the less-than-optimal parenting that occurs owes to the impact of the continuous high levels of stress that many parents have in their lives. These stressors interfere with many parents' ability to make proper use of the knowledge and skills that they already possess on parenting *(Miller et al., 2020)*.

Poverty, lacking basic resources, unemployment, and losing social support networks are major stressors that potentially impact negatively on mental health *(Eltanamly, Leijten, Jak, & Overbeek, 2019; Miller et al., 2020)*. Struggling with such stressors will often take its toll on psychosocial wellbeing and might make it difficult to be an attentive parent, as such strain can decrease nurturing and supporting parenting and instead perhaps increase harsh and emotionally distant parenting *(Biglan, Flay, Embry, & Sandler, 2012)*. The inability of the parent to respond in a sensitive manner to the needs of the child may be because of the challenging context and not a shortcoming as a parent, indicating the need of appropriate parental support *(Kim et al., 2020)*. This highlights the importance of focusing on not only boosting and improving parenting practices, but also on the mental health and psychosocial wellbeing of the parents.

Parenting programmes in conflict-affected communities have shown moderate effects on parenting outcomes *(Puffer et al., 2015)*, as well as on child mental health, which may suggest that parenting can be strengthened some without primarily targeting the wellbeing of parents *(Miller et al., 2020; Pedersen et al., 2019)*.

Having a mental illness can have a major impact on parenting. Taking depression and depressive symptoms as an example, it can be very challenging to be an attentive and responsive parent while struggling with feelings of sadness and despair, low energy, loss of interest, possible suicide thoughts, and a lack of hope. The consequences of parental depression on children and particularly their socioemotional development is underscored by a robust body of evidence *(Jeong & Li, 2020).* Parents suffering from depression may struggle with the interaction with their child, as it can become difficult to perceive and interpret the emotional states of the child and regulate their own responses accordingly *(Jeong & Li, 2020)*. Getting help and support to cope with difficult feelings, lowering stress, and strengthening wellbeing, is helpful and useful for most people that struggle. Learning techniques for managing stress and regulating feelings is a much-used approach in 'first-line psychotherapy' that is also used in several parenting programmes. Focusing on this in parenting programmes can help parents understand how stress can affect parenting, and exploring this together as a group can be effective. **Children need stable and secure adults that can make them feel safe and help them make sense of the world and regulate themselves when facing and experiencing new impulses.** Being this important adult is difficult when you are having trouble with understanding and regulating your own emotions, coping with circumstances and stress that takes a major toll. Following this, it may therefore be useful to support parents in regulating affect and cognition *(World Bank, 2015)*.

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Mental health can be promoted and improved without interventions that specifically or explicitly target mental health. However, several studies on parenting programmes from low- and middle-income settings find that people with a mental illness in most cases also need treatment that is targeted towards their struggles *(Singla et al., 2015)*. However, some programmes have interventions that predominantly target psychosocial wellbeing by providing for instance trauma-focused cognitive therapy. Such interventions will however take us to the upper levels of the MHPSS intervention pyramid *(Inter-Agency Standing Committee, 2007)*. This is compared to most parenting programmes that are placed at the lower levels of the pyramid, and include low-cost mechanisms that have shown to be effectively implemented in a low- and middle-income context of adversity *(Knerr et al., 2013; Pedersen et al., 2019)*.

The study by Singla et al. (2015) found positive effects of community-based responsive stimulation interventions on maternal depressive symptoms, but the overall evidence from studies is not conclusive when it comes to reducing maternal depression *(Jeong et al., 2018)*. A recent cluster-randomized controlled study conducted in Tanzania set out to evaluate the effect of responsive

stimulation, nutrition and health interventions together with conditional cash transfers for antenatal care on maternal depressive symptoms *(Bliznashka, Yousafzai, Asheri, Masanja, & Sudfeld, 2020)*. They found that these interventions, which did not explicitly aim to improve mental health, significantly reduced maternal depressive symptoms as compared with control *(Bliznashka et al., 2020)*. It is interesting to note that the reductions in depressive symptoms were even greater among women without depressive symptoms at baseline, although the interventions did also reduce symptoms among women with depressive symptoms at baseline. Bliznashka et al. (2020) view this as an indicator for the interventions being a promising strategy for improving and promoting the broader mental health of women by addressing several risk factors and providing multiple coping mechanisms. Although studies show that interventions were effective in reducing maternal depressive symptoms, they did not appear adequate for meeting the needs of clinically depressed women *(Bliznashka et al., 2020)*. However, there might be a need to offer a separate support option for people with clinical diagnoses, for instance using parenting programmes or community-support networks as a way of identifying such needs and referring (i.e., higher levels of the pyramid by IASC, 2007) or treating them in a more targeted and specialised manner.

One important issue is perinatal depression, i.e., mothers' depression in pregnancy and within one year after birth. Perinatal depression affects around 20-25% of women in LMICs, and is a serious concern because associated with disability and suicide in women, and negative outcomes for children's health, insecure attachment, and cognitive and socioemotional development *(Howard & Challacombe, 2018)*. Maternal depression is mainly untreated in low- and middle-income countries. One promising intervention, however, is the Thinking Healthy Programme (THP) for mothers designed to be simple and scalable for low resource settings. It is based on principles of cognitive behaviour therapy, and includes collaboration with the family *(World Health Organization, 2015)*. A qualitative study conducted in Malawi explored local perceptions of stressors that women experienced in the prenatal period, and found that pregnancy was a time of uncertainty and that the women saw their husbands as both a support and stressor *(Stewart et al., 2015)*. Thus, building on the relationship between the mother and father, and other significant people, as THP does, might be helpful for combatting maternal depression.

7 DISCUSSION: IMPACT OF PARENTING PROGRAMMES

Globally and generally, we know quite a lot about which interventions are effective, and what kinds of implementations that have success, so why is the access to support still so scarce? Part of the answer is the lack of access to early childhood interventions, especially for children that are disadvantaged in the first place as they live in adverse contexts with cumulative challenges *(Britto et al., 2018)*. Although knowledge about what works is increasing, and we know more about what the developing child and brain need in order to achieve their potential, the quality of interventions and programmes vary, and there are major gaps in knowledge *(Britto et al., 2017)*.

7.1 What are the implications of these findings?

This review indicates that relatively low-cost community-based interventions targeting different domains of child development, such as health, learning, nutrition, safety, and responsive caregiving, can promote child development, be locally acceptable, and feasible. Support to parents, families and caregivers can contain many elements, but it seems that important factors are active engagement between the parent and the child, influencing the way the parent thinks about the child and what may be labelled “positive parenting”, strengthening the bond between the child and caregiver, and the caregivers’ perception of his/her ability to care for the child.

The fact that many interventions have positive effect, does not mean that all interventions work. Studies that do not demonstrate significant results, are less likely to be published, and poorer quality interventions may not be included in research. **There is considerable evidence that quality, quantity (sufficient number of sessions or home visits), and a structured curriculum is necessary. There is also evidence that longer-term interventions have better effect, and that some positive outcomes will get stronger over time.**

7.1.1 The value of integrated interventions

The body of evidence from controlled trials is growing, and repeatedly indicating that combined interventions that include support for developmental stimulation of young children, together with advice on nutrition, feeding, and health, can have substantial effects on early childhood development *(Gladstone et al., 2018b)*. Additionally, it seems to influence later life-course outcomes such as educational achievements, earnings, and mental health, all of which continue into adulthood together with the economic returns *(Gladstone et al., 2018b)*.

There are complex contextual factors associated with childhood malnutrition. Our findings indicate the need to take a multi-faceted view of support, and take the wider family and social contexts into account, as one type of intervention (e.g., nutrition) alone is not sufficient as early childhood development is influenced by several other factors. The feeding of children can be used as an example of a broad and holistic way of thinking, in that the social context of how the feeding happens is just as important as the nutritional content of what the child is fed, since it is a simultaneous chance for responsive caregiving *(Panter-Brick & Leckman, 2013)*.

Combined or integrated interventions are not only necessary for fostering healthy early childhood development, they promote improved outcomes for parents as well. Interventions to improve learning through play, together with interventions to improve mother-child communications, improved child development, and the combining of interventions were found to concurrently improve the mental health of mothers *(Khatib et al., 2020; Singla et al., 2015)*. Programmes consisting of health and nutrition interventions, together with responsive stimulation that targets a range of risks and promotes multiple coping strategies, can successfully support women at risk of depression *(Bliznashka et al., 2020)*.

Combined or integrated interventions are not only necessary for fostering healthy early childhood development, they promote improved outcomes for parents as well.

Parenting programmes can help parents acquire skill sets, adapt attitudes, and cooperate with and learn from other parents, as a way of enhancing positive parenting, feeling confident, empowered, and bonding with the child – skills that relate to warmth, love and responsiveness. Responsive caregiving is a recurring component in the parenting programmes and affiliated studies that are explored in this report. In addition to being an outcome in its own, it is also incorporated into interventions targeting other outcomes *(Betancourt et al., 2020; Luoto et al., 2020; Skar et al., 2014)*.

Intervention that focus on improving parent-child interactions seem to have considerable effect on the socioemotional and cognitive development of young children *(Radner, Ferrer, McMahon, Shankar, & Silver, 2018)*. There is strong evidence that responsive parenting improves cognitive and language development, regardless of cultural differences *(Khatib et al., 2020)*. As responsive caregiving is intertwined with positive parenting, it is possible to integrate it into other interventions, such as directly instruct and support parents to conjointly practice and build skills such as emotional warmth, responsivity, and sensitivity, together with, for example, the increased frequency of play and communication *(Jeong, Siyal, & Yousafzai, 2019)*.

However, there is some debate in the field revolving around seeing interventions as holistic and encompassing several targets, as opposed to only one *(Aboud & Yousafzai, 2019; Hamadani, Baker-Henningham, Tofail, Mehrin, & Grantham-McGregor, 2019)*. Such frictions show that the field of early childhood development is not set, and there is a way to go before agreeing on the substance and characteristics of components and interventions, perhaps particularly so for responsive caregiving. Richter et al. (2020) have recently emphasised the need for an operational definition of component of responsive caregiving and a clarification of its contents, as it is difficult to measure and define responsive caregiving across contexts and cultures in a comparable manner.

7.1.2 Multi-sectorial efforts

Our findings highlighted that evidence suggests the need for a multi-sectorial take on interventions for healthy early childhood development and related outcomes. Using multi-sectorial approaches means having coordinated services across sectors that ideally are unified in a common goal. The multi-sectorial coordination is, together with integrated interventions, a part of a holistic approach to early childhood development. Integrated interventions entail services that address multiple issues using shared messages, as well as using shared or existing platforms *(Black et al., 2018)*.

The positive impact of interventions to promote play, responsiveness, stimulation, and early communication is increasingly demonstrated, not only for child development, but for long-term gains in economic growth and education as well *(Betancourt et al., 2020; Gladstone et al., 2018a; Pedersen et al., 2019).* Our review showed the shift from survive to thrive *(Black et al., 2020)* to be promoted in the Nurturing Care Framework *(World Health Organization et al., 2018)*, and that this framework is

increasingly applied, for example in guidance to caregivers during COVID-19 *(UNICEF, 2020a)*. **Integrating and combining interventions, as well as incorporating interventions into other sectors, are all a part of a holistic approach to parenting programmes and early childhood development.**

It can be argued that some of the essence of the Nurturing Care Framework is its holistic nature. The five components are inter-related, and if any one of the components should be out of alignment, will pose a risk to the entire system *(Black et al., 2020)*. Still, that does not imply that each one of the components must be spearheaded in every single intervention, but nurturing care should be incorporated into the core of parenting programmes and the foundation of interventions. There may be interventions that target specific outcomes like cognitive development, that ends up with making an impact on other outcomes as well, such as maternal mental health *(Khatib et al., 2020)*.

Lacking multi-sectorial implementation of parenting programmes, can often make them fragmented and disjointed, leading to unattended gaps in the provision of services *(Black et al., 2017)*. Bridges must be made between the different sectors, such as health and nutrition, child protection, and education, in order to address and meet the multiple needs of young children *(Richter et al., 2017)*. **Although it may be challenging, our review supports the need for holistic programmes that embrace numerous outcomes contributing to a healthy childhood development. In order to achieve this, there must be integrated programmes with a holistic approach, together with a multi-sectorial effort.**

Although it may be challenging, our review supports the need for holistic programmes that embrace numerous outcomes contributing to a healthy childhood development. In order to achieve this, there must be integrated programmes with a holistic approach, together with a multi-sectorial effort.

7.2 The importance of implementation

This review has shown that there is a range of content, techniques and platforms used in parenting programmes, such as psychoeducation, roleplay, videos, modelling, homework and discussion groups. Furthermore, there are many ways to deliver the content.

In terms of challenges to implementation, it is likely that contextual and cultural factors can present barriers to larger scale implementation and sustainability. These could be (i) cultural differences in explanations of, and attitudes towards, young children and mental health; (ii) social context and infrastructure of the country or community (e.g., social protection and health systems); (iii) recruiting and retaining group leaders or providing supervision over time; and (iv) the larger political context.

Scaling-up parenting programmes for early childhood development is a challenge. Our review indicates that a shortage of verified implementation strategies, and a lack of validated tools. The core of this challenge centres around the fact that clear evidence still is missing for the total package of "why", "what" and "how" early childhood development programmes have an impact and are effective (Murphy, Yoshikawa, & Wuermli, 2018).

The review showed an increase in the interest, development, execution, and evaluation of parenting programmes related to early childhood development. Implementation reports on the status of the scaling up of effective small-scale programmes at regional and national levels are valuable sources of information for further programme planning *(Aboud et al., 2018)*. Obtaining rigorous data at all stages of intervention development and implementation can provide answers to the "why", "what" and "how" questions, as well as offer insight into differential effects with a goal of improving impact *(Radner et al., 2018)*.

7.3 Knowledge gaps

Although much is known about which interventions and parenting programmes are effective for strengthening early childhood development, there is still a lack of knowledge on how to put them into practice. Few of the effective interventions that promote early childhood development have achieved scale, and more knowledge is needed from implementation research *(Yousafzai et al., 2018)*. **There are several obstacles that complicate the implementation of parenting programmes in low-and middle-income countries, such as limited funding to maintain and operate the programmes and related services, systems for service delivery are often weak and unstable, thus making it hard to integrate interventions, as well as a dearth of human resources to deliver the services *(Janowski et al., 2020; Knerr et al., 2013)*.** Additionally, there might be inefficient flows of resources from central to local levels of government, as well as across sectors, all of which can challenge a programme *(Richter et al., 2017)*. More research is needed to better understand how early childhood

interventions can be integrated into existing public service systems to ensure sustainability *(Rockers et al., 2018)*. What is known, however, is the value of including context and culture, and involving local stakeholders.

Previous reviews *(Britto et al., 2015; Jordans, Pigott, & Tol, 2016; Knerr et al., 2013; Tol et al., 2013)* have identified several parenting interventions that are effective in low-and middle-income countries for early childhood development. However, **the heterogeneity of identified interventions show the need for a clearer understanding of the active ingredients of effective interventions, which would provide essential information for implementation and further development of efficient programmes *(Pedersen et al., 2019)*.** There are several different programmes with different curricula and interventions, but we still lack evidence on common ingredients and the association to specific outcomes for a child's development *(Britto et al., 2018)*, as well as what works under what conditions. There are moderate effect sizes for psychosocial stimulation in parenting programmes, but there is still a lack of knowledge about why some are more effective than others *(Luoto et al., 2020)*.

This literature review has shown that many of the programmes for early childhood development are wide-ranging with several components, which makes it difficult for individual studies to identify the specific components that are responsible for the negative or positive outcome *(Aboud et al., 2018)*. In order to address this, future research may investigate which of the components of interventions and implementation characteristics that are individually effective, all of which require the dismantling of studies and mechanisms of change *(Pedersen et al., 2019)*. Furthermore, it requires continuous dialogue at global, national, and community level, on-the-ground adaption, and platforms for learning across diverse domains *(Shonkoff, Radner, & Foote, 2017)*.

Knowledge about what works for early childhood development, psychosocial wellbeing, and parenting programmes is growing, and frameworks such as Nurturing Care are contributing to healthy development. We need more information and research on how to best implement and scale these programmes, how to best integrate into existing systems, and how to most effectively make use of integrative interventions across sectors. We do know that holistic approaches and multi-sectoral efforts where both children, mothers, fathers and others are provided with knowledge and supported through parenting programmes that are mindful of contextual factors, are working and must be further expanded. And we know that lived experience and participation of users and communities are necessary.

8 CONCLUSION

This study has provided knowledge on how to support young children's development through parenting programmes. This knowledge can be used to promote mental health and early childhood development in low- and middle-income countries. The nurturing care concept provides a promising model for integrating a variety of needs, risks, protective factors and intervention options. This framework serves as a model for care and services, showing how multiple sectors are needed for families and communities to support children *(Banerjee et al., 2019)*.

To a large extent we know how to support children. The aim is to create an enabling environment for families and communities to make sure that the children are safe, receive responsive care, adequate nutrition, health care, and opportunities for learning *(Black et al., 2017)*. Thus, what to do will vary according to the needs and available resources in each context, but each component of the nurturing care framework can be used as an entry point. This does not mean that structural and environmental factors are not important. For example, the laws and regulations on violence against children, economic hardship, natural disasters, working conditions for parents, and available services in health and education obviously play major roles, and therefore multi-sectorial efforts are needed. However, good parenting can moderate risk and protect children from chaos, fear, uncertainty, and deprivation *(Miller et al., 2020)*.

To a large extent we know how to support children. The aim is to create an enabling environment for families and communities to make sure that the children are safe, receive responsive care, adequate nutrition, health care, and opportunities for learning *(Black et al., 2017)*.

The 15 studies provide encouraging results in terms of content, delivery and outcome. Although the evidence is not strong, the general evidence-base from other regions is useful for interpretation, and provides support for conclusions. Interventions to support ECD and mental health are needed in all three countries, and parenting programmes are likely to be good investments in all three countries.

The mental health of parents is important for ECD, but may need particular attention in programmes. There seems to be a potential for a better link between the two in programmes to support ECD and mental health. Moreover, there is potential for further exploiting this link when it

comes to prevention and treatment. It is possible that interventions need to target parental, and especially maternal mental health, more directly. Scalable programmes exist, and could be part of an integrated approach. It is also possible that there should be a clearer division between universal promotion and preventative interventions, and between those that target specific populations in need of treatment, such as those who suffer from physical or mental problems or malnutrition.

The overall evidence suggests that interventions that provide holistic support in several domains have better effect, although these may be more expensive and demand more cooperation. **Where possible, one should build on existing preventive and promotive structures and systems, such as integrating nurturing care components into strategies for e.g., maternal health, education, humanitarian, and non-communicable disease policies – ensuring multi-sectorial efforts and a holistic approach.**

Integrated and multi-sectorial interventions where parenting content is part of other interventions (e.g., nutrition and social protection), seem to work better and give synergy. This means that interventions to support early childhood development and mental health can be good investments also across sectors. Investment in mental health may pay off also in other sectors than health. Similarly, investments in ECD may pay off in terms of education, physical health, less adult crime, and better employment productivity.

Although the focussed review shows a lack of research on parenting programmes in the countries that were selected, they provide some evidence for the effectiveness of parenting programmes in sub-Saharan Africa. There is a robust body of evidence suggesting that early interventions in parenting and nurturing care together with stimulating and safe environments pay off. The potential is great for low-cost and high-impact support for children in LMIC through the strong influences of parents and family for child mental health outcomes, and in combining them with scalable non-specialist approaches.

The time to act is now. Falling behind in children's early years can often mean that they are left behind forever. Based on the findings in this report it is clear that funding for essential services for early childhood development must not be diverted or stopped, rather the opposite. This is especially the case in the present times because of the COVID-19 pandemic, as it increases the adversities for children. It is essential that we do not forget about the children and the ripple of effects that many of them suffer from the pandemic. Therefore, it is recommended to enhance the

support and protection of children and their families, by investing and taking the lead in supporting the mental and physical health and development of children and their caregivers.

9 RECOMMENDATIONS

General recommendations on ECD and mental health

- Better understand and exploit the link between ECD and mental health
- Stakeholders should request analyses on poor results, and use these for learning
- Actors and donors should request that evidence-based interventions are used
- Stakeholders should make room for action research and other types of high-quality research

Recommendations to civil society organisations on ECD and mental health

- Organisations (such as SOS Children's Villages) should use available research and experience in-country or in the region, as well as global knowledge in programming and implementation
- Stronger focus on the fundamental role of families in ECD and mental health
- Consider how to support young children's development and promote mental health in programmes and advocacy

Recommendations to the Norwegian Government on ECD and mental health

- Monitor and share results from the WHO special initiative on mental health
- Use available evidence to promote early child development and mental health globally, building on existing partnerships and activities, as well as strategies in maternal health, human rights, non-communicable diseases, education efforts, and humanitarian assistance
- Use the concept of nurturing care in documents and policies
- Use the Security Council role to strengthen care for women and children in war and conflict
- Relevant Norwegian missions could report on progress in early childhood development and mental health, both in the context of development cooperation and humanitarian effort

Recommendations for research

- Quality of research should be prioritised in low resource settings, paying attention to context, long-term effects, scaling up, implementation, cost, ethics, lived experience and participatory research
- More diverse and innovative research approaches and methods are needed, together with the development and use of culturally appropriate and validated measures

- The underlying theoretical model of an intervention should be clear in order to investigate working ingredients
- Studies with larger number of participants are needed, as is the inclusion of invisible populations such as children and parents with disabilities

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APPENDICES

Table (1): Description of included studies conducted in sub-Saharan Africa

Study	Location	Populati-ons; age group children	Sample size; comparison	Intervention type; setting; therapist type	Number of sessions; session format	Type of study	Assessed parent/family outcomes	Assessed child outcomes
Atukunda et al. (2019)	South-Western Uganda	Mothers of children (20-24 months)	Intervention n=77; control n=78	Education on nutrition, stimulation and hygiene; impoverished households; trained education team	3 group meetings over 6 months and monthly discussion meetings of mothers	Follow-up of a randomised education trial		Cognitive, language, motor development; growth; gut microbiota;
Betancourt et al. (2018)	Kayonza and Nyarugeng districts, Rwanda	Families with children (36 months or younger)	N=35 (20 households):	“Sugira Muryango” – family home visiting intervention; impoverished	22 or 15 modules - condensed version given to Kayonza district	Open trial	Responsiveness of caregiver-child interactions; harsh punishment, child discipline	Child nutrition and health status

			Families-22 module intervention n=10; Families-15 module intervention: n=10	households; trained local coaches	population; home visits		practices and beliefs; knowledge and attitudes about ECD	
Betancourt et al. (2020)	Nyanza, Ngoma, and Rubavu districts, Rwanda	Families with children (6-36 months)	Intervention n=541; Usual care n=508	"Sugira Muryango" - family home visiting intervention; vulnerable families; community-based coaches	12 modules (1 per week)	Cluster randomised trial	Parents' behaviours towards the child including responsive care and play; family violence; care seeking for child health problems; shared decision-making among parents; caregiver mental health	Child nutrition and health status
Borisova et al. (2016)	Ethiopia	Parents and children in preschool-age (5-6 years)	N=357 children from 18 villages. Parenting programme: 9 villages;	"ELM at Home" – parenting programme; community setting; trained	10 group sessions (ELM programme)	Comparison study	Parental engagement with child; support for learning	Children's learning and development gains

			Government-supported 0-class programme: 9 villages.	local facilitators				
Giusto et al. (2017)	Lofa county, Liberia	Caregivers of children aged 3-7 years	N=30	"Parents Make the Difference" -Parenting interventions; community setting; lay health worker	10 group sessions	Qualitative study on mechanisms of change	Harsh treatment; Experienced changes in parenting; parent-child interactions	Socioemotional wellbeing; cognitive development
Lachman et al. (2017)	Cape Town, South Africa	Parents of children (aged 3-8)	Intervention n=68; Waitlist n=34	The Sinovuyo Caring Families Program; low income suburb; community-based workers	12 group sessions	Randomised controlled trial	Harsh parenting; positive parenting; parental depression; parenting stress; social support;	Child behaviour problems; observed child behaviour, child-led play
Lachman et al. (2018)	Cape Town, South Africa	Families (female caregivers) with children aged 3-8 years	Intervention n=68; Waitlist n=34	The Sinovuyo Caring Families Program; Low-income families;	12 group sessions	Mixed-methods process evaluation	Levels of participant involvement, implementation, and acceptability	

				Community facilitators				
Luoto et al. (2020)	3 sub-counties in western Kenya	Mothers or female primary caregivers with children aged 6–24 months	Group only intervention n=376; mixed-delivery intervention n=400; comparison group n=376	Integrated parenting intervention; Village setting; Community health volunteers	Group-only delivery with 16 fortnightly sessions *or* mixed delivery combining 12 group sessions with 4 home visits	Cluster-randomised community effectiveness trial	Maternal stimulation practices	Child cognitive and language development; socioemotional development; child stunting; child dietary diversity
Puffer et al. (2015)	Lofa county, Liberia	Caregivers of children aged 3-7 years	Intervention n=135; Waitlist n=135	"Parents Make the Difference" – parent skills building; community setting; lay health workers	10 sessions; combination of groups and individual caregivers	Randomised-controlled trial	Harsh discipline; positive behaviour management; caregiver-child interactions – caregiver report, child report; caregiver-child communication	Cognition; emotional symptoms, conduct problems, hyperactivity/inattention
Rockers et al. (2016)	Southern Province, Zambia	Caregivers with children aged 6–12 months baseline	Intervention n=268; Control n=258	Psychoeducational programme and health screening of children; rural community; community-based health	Household visits and fortnightly group meetings	Cluster-randomised controlled trial	Caregiver–child interactions; caregiver mental health	Stunting; neurodevelopmental assessment; child illness symptoms; dietary intake

				workers and trained local "head mothers"				
Rockers et al. (2018)	Southern Province, Zambia	Caregivers with children aged 6–12 months baseline	Intervention n=268; Control n=258	Psychoeducational programme and health screening of children; rural community; trained local "head mothers"	Fortnightly group meetings	Follow-up to RCT, two-year impact	Caregiver-child interactions; caregiver mental health,	Stunting; cognitive development, language, motor, socioemotional development, adaptive behaviour
Singla et al. (2015)	Lira, Uganda	Mothers of children aged 12–36 months	Intervention n=171; Waitlist n=148	Parenting interventions; community-based; non-professional community members	12 fortnightly group sessions and 1-2 home visits; peer-led	Community-based cluster randomised controlled trial	Maternal wellbeing; parenting practices: preventive health practices, dietary diversity, psychosocial stimulation, mother's knowledge of ECD	Cognitive and language development;

Skar et al. (2014)	Maputo area, Mozambique	Caregivers with children close to age 4.	Intervention n=75; No-intervention comparison group n=62	Psychosocial support intervention (ICDP); local facilitators	10-12 weekly ICDP group sessions with follow-up home visits (6)	Retrospective study comparing intervention with control	Harsh discipline; parenting behaviour; self-efficacy; mental wellbeing	Prosocial behaviour and conduct problems
Ward et al. (2020)	Cape Town, South Africa	Caregivers of children aged 2-9	Intervention n=148; Control group n=148	"Parenting for Lifelong Health" – parenting intervention; peri-urban settlements; paraprofessional community members	12 group sessions	Randomized controlled trial	Positive parenting; harsh discipline; parenting stress; caregiver depression; supervision; social support	Child behaviour; conduct problems
Weber et al. (2017)	Kaolack region, Senegal	Caregivers of children aged 4-31 months	Intervention n=443	Parent-child engagement intervention; rural villages; facilitator from local community	43 group sessions and bimonthly home visits over a 9- to 10-month period	Evaluation study	Parenting skills: caregiver-child interaction, knowledge of ECD	Language proficiency

Table (2): Description of selected systematic reviews from LMIC

Review article	Number of studies	Findings	Notes
Global Health and Development in Early Childhood. Aboud & Yousafzai (2015)	21 articles with a stimulation intervention and 18 with a nutrition intervention (several had both)	Interventions that provide or promote psychosocial stimulation have a medium effect on children's cognitive and language development. Interventions that provide or promote nutrition have a very small effect on children's cognitive and language development. Interventions that include multiple techniques of behaviour change, especially those related to performance, problem solving, and the provision of small media, are effective in changing parents' stimulation behaviour.	The hypothesized mediators linking nutrition interventions to mental development need to be clarified and tested; at this point it is not clear whether brain function, height, gross motor development, or environmental stimulation are influenced by nutrition and in turn improve mental development.
A Systematic Review of Parenting Programmes for Young Children in low- and middle-income countries. Britto et al. (2015)	105	Psychosocial stimulation programmes are effective in improving a child's cognitive development, and caregiver practices. Child nutrition and growth were improved through several types of parenting programmes focusing on micronutrient supplementation and nutrition education. The multi-sectoral health and child developmental programme is efficient and	In sum, 36 countries in 7 regions of the world were represented in this systematic review, with 29.5% from low-income countries, 33.3% from lower-middle-income countries, and 37.1%, from upper-middle-income countries.

		effective in improving a host of child outcomes.	
Integrating Early Child Development and Violence Prevention Programs: A Systematic Review. Efevbera et al. (2018)	6	All but one study reported improvements in both child development and maltreatment outcomes. The findings of this study reveal an opportunity to improve development and reduce maltreatment against children through early interventions by using a combined ECD+VP approach.	The dearth of evidence on ECD + violence prevention interventions suggest additional research is needed.
Stimulation Interventions and Parenting in Low- and Middle-Income Countries: A Meta-analysis. Jeong, Pitchik & Yousafzai (2018)	15	They found medium-to-large effects of stimulation interventions on observed mother-child interactions, on improving the home caregiving environment, and maternal knowledge of early childhood development.	Limitations include heterogeneity across interventions, lack of standardized measures, and different time points of assessments across studies.
Interventions for children affected by armed conflict: a systematic review of mental health and psychosocial support in low-and middle-income countries. Jordans, Pigott & Tol (2016)	24	Interventions appeared to show promising results demonstrating mostly moderate effect sizes on mental health and psychosocial wellbeing. CBT-based interventions, and the school as the delivery platform, are the most commonly reported.	This systematic review replicates an earlier study, aiming to provide a comprehensive update of the most current developments in interventions for children affected by armed conflict. Interventions involve data from 4858 children.

Early Childhood Development Programs in Low Middle-Income Countries for Rearing Healthy Children: A Systematic Review. Khatib et al. (2020)	17	Found that early stimulation interventions can prevent inequalities and encourage socioemotional and cognitive development in young children, as well as improving maternal outcomes. The mutual bond between parent and child was emphasised as important to strengthen, which may entail strengthening the emotional availability of parents as that affects their parenting ability.	Observational and randomised controlled trials that examined the efficacy of different programs for improving ECD in LMICs were included.
Improving Positive Parenting Skills and Reducing Harsh and Abusive Parenting in Low- and Middle-Income Countries: A Systematic Review. Knerr, Gardner & Cluver (2013)	12	Focused on improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries. From the twelve studies that they examined, they discovered that parenting interventions may be effective and feasible in improving interactions between parent and child, and for improving parental knowledge on child development.	There was a lack of high-quality studies and there was high heterogeneity among the included studies, therefore it is recommended that interventions are more rigorously evaluated in the future.
A Systematic Review of the Evidence for Family and Parenting Interventions in Low- and Middle-Income Countries: Child and Youth Mental Health Outcomes. Pedersen et al. (2019)	36	The majority of interventions showed positive outcomes for child and youth mental health and wellbeing. Parent- and family-focused interventions may be valuable to people in low- and middle-	Study designs covered: RCTs (50% of studies), pre-to-post studies (38%), and other (12%).

		income settings. This includes interventions such as parent skills training, psychoeducation, psychosocial, behavioural, and trauma-focused-CBT. This discovery is supported by 28 studies (88%) that showed a significant positive effect in the intervention group on numerous outcomes including child and youth mental health and wellbeing, as well as family functioning and parenting behaviours.	The review is characterised by the heterogeneity of interventions and low quality of studies.
Early childhood development and cognitive development in developing countries: A rigorous literature review. Rao et al. (2014)	111 (in 40 developing countries)	A large high-quality evidence base shows that ECD interventions that focus on parental support, early stimulation and education, nutrition and health, and income supplementation, and comprehensive and integrated programmes have positive effects on children's cognitive development, especially comprehensive programmes.	Findings from 70 of the 111 studies were combined in a meta-analysis. Only 38 of the 70 studies investigated effects longer than 6 months after completion of intervention.
Mega-map of systematic reviews and evidence and gap maps on the interventions to improve child well-being in low- and middle-income countries.	333	Although there was quite a large number of reviews, the evidence was unevenly distributed across categories of interventions (Saran, 2020). They found	Mega-map of systematic reviews on interventions to improve child well-being in low- and middle-income countries.

Saran et al. (2020)		many reviews that examined health and nutrition as part of early childhood development, and striking gaps in evidence on areas such as social protection and child abuse.	About 69% (231) of the reviews are assessed to be of low and medium quality.
Annual Research Review: Resilience and mental health in children and adolescents living in areas of armed conflict – a systematic review of findings in low- and middle-income countries. Tol, Song & Jordans (2013)	53	Development of interventions in areas of armed conflict should start with a detailed contextual (qualitative) assessment to select appropriate resilience outcomes that may be targeted. Intervention development should focus on how to augment the possible family-level predictors that may contribute to promotion of these outcomes, particularly parental support and monitoring. In addition, practitioners may build on peer-, school- and community-level resources.	Of the 53 studies 15 were qualitative and mixed methods studies, and 38 quantitative, mostly cross-sectional studies focused on school-aged children and adolescents.

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