



# Responsive parenting: a strategy to prevent violence



**EARLY CHILDHOOD MATTERS**



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# EARLY CHILDHOOD MATTERS



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Loreto region, Peru

Photo: Courtesy Asociación Red INNOVA

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**Responsive parenting refers to the ability of parents to meet the needs of their children mentally, emotionally and physically through the critical few years after birth. Photo • Jim Holmes/Bernard van Leer Foundation**

*'This edition explores the approaches and evidence for the effectiveness of a range of programmes that have been developed to educate and support parents in becoming more responsive to their children.'*

## Value children, cherish parents

Katelyn Hepworth, Research and Evaluation Officer, Bernard van Leer Foundation

John Bowlby, the father of attachment theory, once said: 'If a community values its children, it must cherish their parents.' There is growing evidence that responsive parenting can have lifetime effects on all aspects of children's development including their health, nutrition, learning and protection. Much of this edition of *Early Childhood Matters* is devoted to the potential of parenting programmes to reduce the incidence and impact of violence in young children's lives. Exposure to violence at an early age can be extremely detrimental to a child's development.

Responsive parenting refers to the ability of parents to meet the needs of their children mentally, emotionally and physically through the critical few years after birth, when brain development is at its peak (Engle *et al.*, 2011). As Bowlby theorised, and as science now shows, an infant's secure attachment to at least one responsive and emotionally stable adult lays the foundations for social and emotional skills later in life (Richter, 2004), and can protect against a range of other risk factors (Carpenter and Stacks, 2009).

However, many parents either are not aware of the need for responsiveness, or their capacity to parent responsively is compromised by poverty, lack of access to services or other socio-economic and environmental factors (Richter, 2004). The articles in the coming pages explore the approaches and evidence for the effectiveness of a range of programmes that have been developed to educate and support parents in becoming more responsive to their children.

Results show that the Better Parenting Programme in Jordan (page 7) and the Informed Families – Healthy Generations project in Turkey (page 12) both positively influenced parental behaviour and practices. Their methods, respectively, are providing parents with essential information about best parenting practices and development, and providing services including father programmes, mother programmes, child playgroups and parenting seminars, through a public centre that provides other social services.

The Israel Center for the Treatment of Psychotrauma developed the Parent's Place programme (page 14) in response to a study that concluded that the reaction of children to traumatic events was in direct relation to their mothers' ability to regulate emotions during the same events. Through play and therapy sessions, the programme aims to mitigate the effects of political violence.

Two contributors from Brazil, YouthBuild (page 22) and *Terra dos Homens* (page 19), demonstrate the impact of adding parenting to a broader programme agenda. The YouthBuild model originates from the USA and gives adolescents and young adults from *favelas* – poor urban areas often characterised by violence – the opportunity to develop skills in construction and more general life skills. Many of the participants are parents of young children.

As showcased by the human stories of two mothers who participated in their Local Roots programme, *Terra dos Homens* provides a range of services that holistically address the challenges faced by parents in the *favelas*.

Sometimes programmes to support families may have an unanticipated effect on reducing violence by improving parenting. An example is the *Allin Wiñanapaq* programme in Peru (page 27), which set out to improve young children's health by improving their living conditions; an evaluation also found an impact on the prevalence of violence and child maltreatment, as it seems that better living space made parents less stressed and improved the responsiveness of their parenting.

Often, programmes that say they target parents in practice target only mothers, who typically spend more time with children and are easier to reach. An article by the Fatherhood Institute (page 30) explains the importance and challenges of also reaching out to fathers, who have a significant role in reducing the risk of exposure to violence or child maltreatment.

One common problem faced by parenting programmes – whether focused on child maltreatment or not – is how

to manage the transition to scale. Dave Willis, director of the US Home Visiting and Early Childhood Systems, outlines (page 35) the challenges and explains the need for research and evaluation to better understand which components are most effective in which contexts.

In targeting different contexts, the original programme design might need to be modified to align with the contexts of new participants. The *Madres a Madres* programme (page 38) is an example of one which needed to be adapted for a distinct population: Latino immigrants in the USA. The modifications may need to go beyond linguistic translation, and also take into consideration cultural differences.

Similarly, Susan Jack and Harriet MacMillan discuss the ability to replicate the US model of the Nurse–Family Partnership programme in Canada (page 43), in the face of institutional limitations. The process highlights the need to pilot programmes before taking them to scale: although the USA and Canada are very similar, the success of the programme in the USA did not guarantee that it would be equally effective for its northern neighbour. The Nurse–Family Partnership has also been piloted and evaluated in the Netherlands, where it is in the process of being taken to scale; Klaas Kooijman (page 47) discusses the story so far.

One of the major obstacles in adapting programmes to diverse country settings has been that the majority of the evidence has been generated in the United States. Parenting for Lifelong Health in South Africa (page 49) is an important initiative to evaluate the ability to replicate programmes coming from high-income countries in low- and middle-income countries, looking at areas such as cultural differences and cost. The objective of the work is to create a toolkit of effective parenting programmes that have been piloted in a multiple low- and middle-income countries.

The Children and Violence Evaluation Challenge Fund (page 54) is also adding to the evidence base about what works in low- and middle-income countries. The fund connects NGOs with research institutions to

better understand the impact of violence prevention programmes, and will disseminate the results of the evaluations to inform policies and practices in the field.

One way to tackle the issue of cost – always important, but especially so in the current global context of fiscal austerity – is to piggyback on existing services, as with the aforementioned programmes in Turkey and Brazil. The Mobile Alliance for Maternal Action (page 57) is another group that has capitalised on existing networks and infrastructure, in this case telecommunications. The organisation has created text messages that provide pregnant and new mothers with important information on health and nutrition, eliminating some of the issues of access in rural areas.

With effective scale-up of successful programmes, the hope is that parenting programmes will influence national policy. Jamaica is one of the few countries to develop a public policy specifically for parents. On page 62, Maureen Samms-Vaughan and Rebecca Tortello discuss the evolution of Jamaican public policy supporting parents and providing parenting programmes, including the importance of evidence to inform decision makers about what types of policies are needed. She presents the current policy and examines specific challenges for implementation.

The selection of authors and programmes included in this issue provides a panorama of responsive parenting; where programmes are currently, how they need to expand and the challenges regarding expansion, and the ultimate goal of implementing government policies that support parents.

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# A randomised evaluation of the Better Parenting Programme in Jordan

Suha M. Al-Hassan, Associate Professor of early childhood and special education and Dean of the Queen Rania Faculty for Childhood, Hashemite University, Jordan, and Jennifer E. Lansford, Research Professor, Duke University Centre for Child and Family Policy, Durham, NC, USA



Parenting that is supportive, proactive, responsive and involved promotes children's positive adjustment. Photo • jcarillet/istockphoto

**Most evaluations of parenting programmes do not compare participants with a randomly assigned control group. An exception is the Better Parenting Programme (BPP) in Jordan. This article describes the background to the programme and outlines how the evaluation, conducted in 2009, found that participation in the programme had modest positive effects on parenting practices.<sup>1</sup>**

Many programmes designed to enhance children's development have attempted to alter parents' attitudes and behaviours as the mechanism to effect change in children. The importance of parenting is documented in a large body of research detailing how parenting of young children is related to children's subsequent cognitive, behavioural, and socio-emotional development, as well as how parents interact with other major socialising forces such as education systems to

promote children's optimal development. Parenting that is supportive, proactive, responsive, and involved promotes children's positive adjustment, whereas parenting that is neglectful, abusive, rejecting, and controlling predicts children's maladjustment.

When parents are struggling to parent well, they are sometimes targeted for interventions designed to improve their parenting and, in turn, their children's adjustment. Yet even parents who are not noticeably struggling can benefit from gaining new knowledge and being part of a supportive network of other parents, as evidenced by the large number of parents who join voluntary groups such as Mothers of Preschoolers<sup>2</sup> or Mothers & More<sup>3</sup>.

The key goal of parenting programmes is to enhance parents' knowledge, attitudes, and practices in relation



to caring for a child (Shannon, 2003). Optimal parenting includes a wide range of activities to ensure that children are cared for physically (for example, providing nutritious food, health care, and adequate sleep routines), cognitively (offering opportunities to learn and use language), socially (responding to the child with consistent, loving care), and emotionally (supporting the child's sense of self-worth). Because these are key challenges in parents' ability to provide optimal care for their children, parenting programmes often seek to improve one or more of these aspects of caregiving.

Given the importance of parents in promoting optimal child development and the success in other contexts of parenting programmes in promoting positive parenting and child adjustment, the Better Parenting Programme was designed to enhance parenting in Jordan.

#### **The context of parenting in Jordan**

Almost 37% of the Jordanian population is under the age of 15 and the national average of number of children per household is 5.2 (Department of Statistics, 2012). Only 35% of Jordanian children attend preschool and less than 2% attend any form of daycare (Department of Statistics, 2007). Instead, the majority of children are cared for at home, primarily by their mothers.

Over the past decade, Jordan has made remarkable achievements in the areas of child health, nutrition and education. Infant and under-5 mortality rates reflect improvements in meeting the survival rights of Jordanian children and are now low (18 and 21 per 1000, respectively, in 2011 compared to 33 and 40, respectively, in 1990 (UNICEF, 2014). This success in promoting child survival has motivated the Jordanian Government to focus more closely on child development and protection issues.

One major context for parenting in Jordan lies in the emergence of a National Plan of Action in early childhood for the years 1993–2000, and the Jordanian Plan of Action for Children 2004–2013 (Al-Hassan, 2009). The vision set forth in these plans is to create a safe environment that develops the capabilities of children

by supporting legislation, policies and programmes that cater to the physical, mental, social, and emotional well-being of children. The National Plan of Action for Children aims at providing Jordanian children with the best possible start in life by promoting a healthy life, giving them access to basic, quality education, and providing them with ample opportunities to develop their individual capacities in a safe and supportive environment protected from abuse, exploitation, and violence.

#### **The Better Parenting Programme**

A major vehicle through which child development and protection have been promoted is the Better Parenting Programme (BPP), which was designed after a national Knowledge, Attitudes and Practices Survey conducted in 1996 (Brown, 2000).

An initial evaluation of the programme was carried out in 2000. This commended the achievements of the BPP, in particular the level of coordination between the different parties and the low cost of reaching parents and their children, which amounted to only 3 dollars (US) per child. An important recommendation was the need to expand the BPP's scope to a more holistic early childhood approach, including protection of children from abuse and neglect (Brown, 2000). These recommendations were taken into consideration in the design of a revised BPP, which started in 2003.

UNICEF and other key government and civil partners have supported the BPP as a nationwide programme aimed at empowering parents and caregivers to provide a stimulating, loving and protective environment at home, through equipping parents and caregivers with skills and information to enable them to promote the psychosocial, cognitive and physical development of their children aged 0–8 years. The BPP consisted of a series of lessons (comprising a total of 16 hours) that focused on specific areas of parenting knowledge, attitudes and behaviours. The lessons were led by social workers, health workers, kindergarten teachers and paraprofessionals who had been instructed in how to deliver the lessons by centralised trainers. The



**The Better Parenting Programme in Jordan is a nationwide programme aimed at empowering parents and caregivers to provide a stimulating, loving and protective environment at home.**  
Photo • Jim Holmes /Bernard van Leer Foundation

facilitators' manuals included session guides, printed booklets, flip charts, audio-visual materials, posters, parent activity sheets, and recommended take-home reading materials for the participants. Local facilitators had the flexibility to use all or a subset of the lessons and to follow time schedules that worked best for the participants. Some facilitators implemented the programme over a period of 3–4 consecutive days, some conducted the training once a week for a month, and some conducted the training twice a week for 2 weeks.

A 2009 evaluation (Al-Hassan, 2009) investigated the effects of the Better Parenting Programme on parents' knowledge and behaviour in three domains:

- the extent to which parents obtain knowledge related to child development and parenting skills
- changes in parents' activities, expressions of contentment, and discipline with children

- changes in parents' perceptions of behaviours that would constitute child abuse or neglect as a result of participation in the programme.

A sample of 337 parents and caregivers throughout Jordan was drawn to represent the three geographical regions in which the BPP is delivered (North, Middle, and South parts of the country). Participants heard about the BPP from charitable organisations, school principals, community centres, programme staff, and the media. Because the BPP targeted children's primary caregivers, the large majority of participants were women (94%). Participants were randomly assigned to either the experimental group (which participated in the BPP) or a control group (which did not participate in the programme). Both groups completed questionnaires at two time points: once before and once after the experimental group participated in the BPP.

#### **Findings of the 2009 evaluation**

The study focused on comparing those who attended the programme (the experimental or intervention group) with those who did not (the control group). The main findings were as follows.

- There were no significant changes in the reported frequency with which the control group engaged in activities with their child. In the experimental group, after attending the programme participants reported spending significantly more time with their children playing and reading stories. Neither the control group nor the experimental group changed over time in their expressions of contentment with the child; both groups reported high levels of positive forms of expressing contentment at both time points.
- Results from both the control group and the experimental group showed an increase in the use of positive discipline methods and a decrease in using negative discipline methods over time. Specifically, participants in both groups indicated an increase in taking away privileges, and a decrease in beating the child and calling the child names.
- For both groups the behaviour of shouting at the child increased significantly, despite the fact that it is considered undesirable. Participants who attended

the programme (but not those in the control group) reported a significant increase in explaining to the child why something he or she did was wrong.

- In questions about discipline methods that would be used if the child misbehaved during a visit to a neighbour, participants in both the experimental group and control group were significantly less likely to ignore the child, give the child sweets to keep him or her quiet, and beat the child. The experimental group also showed a significant increase in positive responses on the item regarding showing the child things he or she could do.
- No significant changes were found over time in perceptions by either the control group or the experimental group of behaviours considered to be child abuse. However, after attending the programme a significantly greater percentage of the experimental group reported that they regarded leaving the child alone at home, having someone underage take care of the child, and not buying the child new clothes as neglect. Perceptions by the control group regarding behaviours concerning child neglect did not change significantly over time.

#### **Discussion: positive but small effects**

The findings provided modest support for the benefits of participating in the BPP. Over time, participants in the experimental group (but not the control group) improved on parenting knowledge, spending time playing and reading books with their children, using more explanations during the course of disciplining their child, and accurately perceiving behaviours that would constitute neglect. Because participants were randomly assigned to the intervention or control group, these differences between groups in change over time can more confidently be attributed to participation in the BPP. As in other parenting interventions (Layzer *et al.*, 2001), the effects of the BPP were positive but small.

For several constructs assessed, participants in the control group as well as the experimental group showed improvements over time. For example, participants in both groups showed an increase in using positive discipline methods and a decrease in using negative

discipline methods. This implies that, with the exception of using more explanations (which improved for the experimental group only) something besides participation in the BPP was responsible for changes in reported discipline strategies over time.

It is possible that the process of completing the pre-programme questionnaire caused participants to reflect on their discipline practices and to attempt to change those they deemed to be less desirable. The control group consisted of individuals who were interested in attending a parenting programme, so they were probably willing to improve their knowledge and practices; merely completing the first questionnaire may have alerted them to some parenting practices that they then reconsidered. It is also possible that participants in the control group interacted in community settings with participants in the experimental group and learned information being conveyed in the BPP from members of the experimental group.

Most programmes designed to improve parenting have not been evaluated rigorously through random assignment to control and intervention groups (Lansford and Bornstein, 2007). The findings from the present study suggest that the benefits of such programmes may be overestimated if they are not compared to a randomly assigned control group that did not receive the intervention.

Even at the time of completing the pre-programme questionnaires, most participants in the experimental group and the control group accurately identified behaviours that should be considered child neglect and abuse. This indicates that there is a high degree of community awareness regarding these issues, probably stemming from many sources such as the media. Many parents in both groups also were engaging in positive behaviours with their children. Thus, the BPP should be framed in terms of enhancing already positive parent-child relationships rather than as addressing deficits. In previous research, working with parents' strengths and providing support that fits their needs has been related to more positive outcomes for parenting programmes (Sanders *et al.*, 2003).

Future research experimentally manipulating key features of the programme (such as the timeframe for implementation, particular lessons offered) could determine the most effective combination of features so that future iterations of the Better Parenting Programme could implement these features consistently in all locations. Furthermore, future iterations of the BPP could offer more intensive services to at-risk families for whom the relatively brief, education-oriented focus of the current BPP may not be sufficient to meet their needs. More at-risk families often benefit from multimodal and long-term interventions.

Given the context in Jordan in which the Government is promoting child development and protection issues, it makes sense to focus on improving parenting as a way of optimising children's development. Because participants who were randomly assigned to participate in the Better Parenting Programme demonstrated modest improvements in parenting knowledge, spending time playing and reading books with their children, using more explanations during the course of disciplining their children, and perceiving particular behaviours as constituting child neglect, compared to parents who were randomly assigned not to participate in the programme, one can conclude that the programme is contributing to the promotion of positive parenting in Jordan. Because the Better Parenting Programme has been implemented widely, even small effects within individual families may amount to large effects for the country as a whole.

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## Notes

- 1 This research was supported by UNICEF and Fogarty International Center grant R03-TW008141. This article is a summary of the authors' research paper 'Evaluation of the Better Parenting Programme in Jordan' (Al-Hassan and Lansford, 2011).
- 2 Information about Mothers of Preschoolers is available at [www.mops.org](http://www.mops.org)
- 3 Information about Mothers & More is available at [www.mothersandmore.org](http://www.mothersandmore.org)

## A responsive parenting intervention in Istanbul

Gaye Uğurlu, Project Coordinator, Culture City Foundation, Istanbul, Turkey



Most of the fathers participating in the programme believed that they gained a better understanding of the importance of their role, with some speaking of creating 'memorable moments' with their children which they had not experienced in childhood with their own father.

Photo • Courtesy Culture City Foundation

**In the Beyoğlu district of Istanbul, the Bernard van Leer Foundation is funding the Informed Families – Healthy Generations project. While the project has yet to be formally evaluated for its effectiveness in reducing violence, this article describes its activities to promote responsive parenting and positive early anecdotal feedback.**

*I used to yell a lot at my children, even slapped them sometimes, but I stopped this behaviour after I attended the workshops. I mean when you yell and beat, the child begins to be worse. And the child doesn't do what you told anyway. But, when you talk, when you explain it well the child does both what you have told and you are happy and the child is happy. It is really nice. My relationships got better with my husband and child.*

These are the words of a woman who attended family seminars and group workshops to support responsive parenting, held by the Informed Families – Healthy Generations project in the Beyoğlu district<sup>1</sup> of Istanbul, Turkey. The project has been implemented since 2012, with the support of the Bernard van Leer Foundation, by the Culture City Foundation in cooperation with the Beyoğlu Municipality, Istanbul Bilgi University and the Beyoğlu Region Department of the Ministry of Education.

The project aims to reduce all forms of violence in the lives of young children, including neglect, psychological/verbal abuse, harsh physical punishment, and exposure to violence at home or in the community. It involves various activities to develop responsive parenting, such as mother support groups, father

support groups, therapeutic play groups with children, seminars about communication and childrearing, and psychological counselling. There were 158 participants in the group activities, while the seminars reached around 900 people – almost all women – and about 800 children, young people and adults consulted the psychological counselling centre.

At the end of their involvement in the mothers' groups, many participants reported that they saw themselves as better problem solvers, and noted improved capacity to cope with stress and anger and to evaluate their emotions when chastising their children. They felt more confident about differentiating between over-protective behaviour and good parenting, and realised that trying to understand how the child felt served as a big step in translating childrearing values into skills. The effect of the project was not so much to change their values about mothering, but to show them practical know-how, such as kneeling down to communicate at the child's level, or waiting until a child is developmentally ready before starting to toilet train. Many reported that they were now spending more quality time with their children rather than leaving them by themselves in front of the television.

The 8-week fatherhood programme focused on developing better communication skills and giving fathers an opportunity to practise the techniques they learned, for example in storytelling and toy-making activities. Most of the fathers participating in the programme believed that they gained a better understanding of the importance of their role, with some speaking of creating 'memorable moments' with their children which they had not experienced in childhood with their own fathers.

The counselling centre dealt with problems such as relationship difficulties, domestic violence, trauma, somatisation, attention deficit, learning disabilities, and regulation of emotions such as anxiety, worry, anger, shame and guilt. Generally, feedback from those who received counselling pointed to a significant change in communication with family members.

This qualitative feedback suggests that the project overall had a positive effect on participants – making them more confident and content, and improving family relationships and sharing of responsibilities. However, there is not yet enough data to pinpoint whether there was a decrease in violence against children. This impact is expected to become more visible in the longer term.

**Note**

- 1 Project activities targeted three neighbourhoods within the Beyoğlu Municipality: Yenışehir, Hacıahmet, and Okmeydanı.

## Parent's Place: how responsive parenting helps children exposed to violence in Israel

Ruth Pat-Horenczyk, Director, Dafna Ba-Gad, Workshop Coordinator, Liz Yung, Group Facilitator, Sarit Schramm-Yavin, Research Coordinator, and Danny Brom, General Director, Herzog: Israel Center for the Treatment of Psychotrauma, Jerusalem, Israel

**Children growing up in the Sderot area, adjacent to the Gaza strip, are exposed to the constant uncertainty and danger of missile attacks. How their parents respond can help to minimise the lasting psychological trauma. This article explores how the Israel Center for the Treatment of Psychotrauma (ICTP) works with parents to help their children through an upbringing in an environment of pervasive violence.**

In times of crisis, the human body responds with an array of behaviours defined as 'survival mode': the sympathetic nervous system is activated and the parasympathetic system is inhibited. As a temporary state this is normal and highly adaptive, as it helps humans to be alert, avoid risk, and focus their efforts on staying safe and responding efficiently to threat (Pat-Horenczyk *et al.*, 2012).

However, when the threat is recurrent and prolonged, survival mode is persistently activated, and this causes damage to individuals' mind and body (Seeman *et al.*, 1997). A study in Sderot showed that mothers and children living in the face of ongoing traumatic stress reported more post-traumatic distress and higher ratings of behaviour problems in their children than a comparison group who had experienced just one short-lived incident of political violence (Pat-Horenczyk *et al.*, 2013).

Due to a widespread belief that children under the age of 5 are impervious to traumatic events, research on children exposed to prolonged war situations and acts of terrorism has historically focused on older children or adolescents (Feldman and Vengrober, 2011). However, more recent research indicates that exposure of very young children to repeated wartime trauma can have profound and lasting effects on their mental health (Lieberman, 2011).

This is exacerbated by the way ongoing threat also has an effect on parents and their parenting capacity. Survival mode affects parental abilities: attunement, containment, the ability to play, over-worrying, and an inability to create safe space (Chemtob *et al.*, 2010). In

the aftermath of traumatic events, the mother-child relationship and the mother's adaptation and coping ability are of vast importance for children's adjustment (Cohen and Gadassi, 2009). In light of this finding, it is not surprising that the single most important factor affecting children's symptoms is a traumatic event experienced by the primary caregiver.

Others have reported a significant correlation between functional impairment of the mother, as manifested in her parenting functions, and the child's reaction to stress (Cohen, 2009). Scheeringa and Zeanah (2001) coined the term 'relational post-traumatic stress disorder (PTSD)' to describe the co-occurrence of post-traumatic distress in a mother and a young child, when the symptomatology of the mother exacerbates the symptomatology of her child. The aforementioned Sderot study reported a higher prevalence of relational trauma, measured by co-occurrence of post-traumatic distress in both mother and child, in the ongoing exposure sample compared with the past exposure sample (Pat-Horenczyk *et al.*, 2013).

### Parents, playfulness and resilience

There is widespread evidence regarding the importance of play and playfulness in the development of children under normal circumstances. It is widely accepted that play is of central importance to children's cognitive, social and emotional development (Vygotsky, 1966; Singer and Singer, 2006; Ginsburg, 2007) and it seems that the process of play itself, even without any outside intervention, may lead to important psychological transformations (Winnicott, 1971). The ability to experience a sense of agency in play may help children counteract feelings of depression, anxiety and panic often reported by traumatised children (Schonfeld, 2011), as well as give them the opportunity to create meaning in various ways. Thus, children who are able to play may be more resilient in the face of stress.

Unfortunately, in times of trauma and loss, children's ability to play is often impaired. Children might exhibit post-traumatic play (PTP), a play pattern which is distinctly different from normal play (Wershba-Gershon,





**Mothers reported dedicating more exclusive time to the child, some saying this helped to strengthen their bond.** Photo • Courtesy Israel Center for the Treatment of Psychotrauma

1996) and which is characterised as driven, serious, lacking in joy and frequently morbid. PTP tends to involve simple defences such as identification with the aggressor, identification with the victim, displacement, undoing and denial, and tends to be developmentally regressed (Terr, 1981; Cohen *et al.*, 2010).

According to Cohen (2013) there is support for the idea that playfulness developed prior to exposure to traumatic events enhances resilience for such events. Therefore, support in regaining playfulness can help children regain the use of 'playful play' to successfully process their traumatic experiences.

Parents play a major role in the development of play and playfulness. In the aftermath of a traumatic event, parents are powerful mediators of the events. They

model behaviour during the event and shape the healing environment following a traumatic event (Cohen, 2009). Parents who are willing and able to engage in and support their children's play foster children who are able to engage in complex, rich play which they are able to use for affective processing (Bronson and Bundy, 2001; Fonagy *et al.*, 2002).

However, as mentioned earlier, during stressful periods the quality of parents' caregiving and their capacity for play and playfulness are impaired. This is most unfortunate, since these are the times when the children need their parents more than ever. Therefore there is great need for interventions that aim to foster play and playfulness among parents in families who have experienced trauma. One such intervention is child-parent psychotherapy (Van Horn and Lieberman, 2009), which focuses on the parent-child relationship among young children who have been exposed to traumatic events in an individual or family format. Although this programme and its counterparts have shown positive results, there is still a need for programmes in a group setting which have the potential to reach a larger population and may be more suitable for periods of ongoing and/or collective trauma. This is one of the main approaches that guided the development of the 'Parent's Place' programme.

#### **Parent's Place and NAMAL**

Parent's Place in Sderot was built with the vision of strengthening the capacity of parents living under continuous threat of missile attacks to provide their young children with the best care. The programme was designed to address parents' needs by providing them with knowledge and practical tools for coping with stressful and traumatic experiences as parents of young children. It included five elements:

- a parent-child playgroup aimed at enhancing joint play and playfulness
- training for educational staff on coping with stress and enhancing resilience
- a parental therapy group in collaboration with the local psychological services

- bi-weekly question-and-answer sessions with the local project coordinator for parents and staff, addressing personal issues and questions regarding parenting issues
- monthly lectures provided by professionals and experts, discussing issues of parenting and child development, which are open to the general public.

The first of those elements, the parent–child playgroup programme, was developed by Dr Esther Cohen of the Hebrew University in collaboration with the ICTP team. The Hebrew name of the programme – NAMAL – reflected the acronym for ‘Let’s Make Room for Play’. NAMAL is based on ‘child–parent relationship therapy’, a filial play therapy programme conducted in a format of parent groups. It aims to bolster children’s resilience and development by providing a safe haven for playful interactions between parents and their children, while also specifically addressing themes such as post-traumatic play and attachment. These are the programme’s main principles:

- Free, imaginative play promotes cognitive, emotional and social development.
- Play promotes resilience for children undergoing traumatic events.
- Play helps to treat children with developmental and emotional problems.
- Parents’ involvement in a child’s playful activity significantly improves the parent–child relationship and the child’s adjustment and development.
- It is possible, economical and efficient to help parents become the child’s agents for change by using a group setting to train them to play with their child.
- Parents are motivated and enabled to play with their children in the setting of a symbolic, fun and emotionally significant group activity.

The NAMAL programme consists of ten afternoon group meetings for parent–child dyads. The meetings involve playful and fun music, craft, drama and movement activities suited to children aged 2–4. The theme and activities of each session are organised around a ‘saying of the day’ with a relational or developmental message; at the end of each session, parents are given handouts

which include a summary of activities, song lyrics, and a simple explanation of the content, along with a decorative magnet showing the saying of the day. The activities are followed by a small, free dinner.

### Programme evaluation and results

The programme was accompanied by qualitative evaluations and quantitative research which is still ongoing. Over 2 years, 70 mothers from ten groups completed a semi-structured questionnaire at the end of the programme. Analysis of the questionnaire revealed that its meaningful effects could be classified into three domains (Cohen *et al.*, 2013).

#### 1 Perceived changes in the child’s behaviour

Following the programme, 68% of parents reported an improvement in their child’s positive mood and expressions of excitement; 36% referred to a reduction in conflicts with their children due to greater listening and cooperating from the child; 12% mentioned increases in the child’s self-reliance and autonomy. For example, one mother stated that her daughter was ‘more independent and confident with other grown-ups’; another reported that her son ‘is more open with other children and strangers and tells members of the extended family what he does in the programme’.

#### 2 Perceived changes in the mother’s behaviour

Mothers reported dedicating more exclusive time to the child, some saying this helped to strengthen their bond. For example:

*The thing that changed most at our home is my considering everything she does. I try to really look at what she does and not just ‘by the way’ while doing other things.*

Another change involved the participants’ sense of competence in their parental role and better understanding of their child. As one parent stated:

*I understand him more when he is stressed.*

Parents felt more able to promote a sense of autonomy in the child:

*I tell him: ‘You’re a big boy, you can wash your hair yourself’.*

or:

*I, as a mother, give her more space for independence.*

### 3 Understanding and internalising the programme's messages

The parents' comments reveal the extent to which they internalised the programme's messages, notably the importance of spending exclusive time with the child, joint play, the use of imagination, and coping skills such as the use of reflective phrases and techniques of soothing and relaxation as means of enhancing emotional regulation.

In a one-year follow-up, 38 of the 53 mothers contacted by phone agreed to respond to a short, semi-structured questionnaire. Their responses indicated that the most lastingly significant aspects of the programme were their sense of competence in their role as parents, understanding the importance of identifying and talking about feelings and fears with their children, and their ability to address the child's needs.

As one mother said:

*Thanks to the programme I felt that as a new mother, I have more tools for coping with situations we don't always know how to deal with, in terms of feelings and thoughts. It gave me an opportunity to encourage my child to express herself. I can see that today she shares her feelings and fears more, especially regarding the security situation – she has questions, and I feel that I can answer her in a way that relaxes her. It seems that following the programme I manage to not silence the fear but to open it.*

### Adaptation for other populations

Following the success of the NAMAL programme, the parent-child therapeutic playgroups were culturally adapted for the Ethiopian Jews who migrated to Israel in the last two decades – an often traumatic transition.

Qualitative evaluations with mothers who participated in the programme for Ethiopian Jews revealed three main themes. First, they mentioned the importance of a variety of coping skills. For example, one mother stated she learned that:

*It is important to reflect her feelings as it reduces the tension and anxiety felt by both of us.*

*'Parent's Place programme was designed to address parents' needs by providing them with knowledge and practical tools for coping with stressful and traumatic experiences as parents of young children.'*

Another mother said:

*I learned how to deal with the security situation and to give her the feeling that I am always there for her and how to cope, even when I am most distressed.*

The second theme was the importance of spending exclusive time together with the child. For example, one mother stated:

*The most important thing for me was the time I spent with my daughter without having to be preoccupied with something else. This was the time devoted to me and her only.*

Another said:

*It was the quality time with my daughter during the activities that strengthened the bond between us.*

The third theme was the importance of joint play and the use of imagination and playfulness in the parent-child interaction. For example, some mothers reported learning from the proverb that was used in the group: *In order to play, all you need are a good imagination and a pile of junk.*

One mother stated that:

*The imaginative play activities helped me to learn about new sides in my daughter.*

Recently, another cultural and linguistic adaptation of the programme was made for the Bedouin population of Rahat. This involved a need to find parallel sayings that reflect the Bedouin culture correctly. Some of the Hebrew songs were replaced by songs in Arabic with which the Bedouin population were familiar, while others were translated and adapted. The project is now in its pilot stage, with one group currently following the course in a children's day care centre. Early anecdotal

feedback is encouraging: the day care manager has observed an increase in symbolic play among children who have been participating in the programme, while many mothers have expressed eagerness to participate in future groups.

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## Local Roots: social work in a violent community in Brazil

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The work of *Raízes Locais* can best be illustrated by exploring stories of individuals who have participated in it, such as the case of Cleo and her children (pictured here). Photo • Courtesy *Associação Brasileira Terra dos Homens*

**The *Associação Brasileira Terra dos Homens* (ABTH) works to improve parenting in Mangueirinha, an especially violent area of Rio de Janeiro. This article explores the social work approach of the *Raízes Locais* ('Local Roots') programme, illustrated through the stories of two of the mothers who participated.**

The *Raízes Locais* programme was created in 2008 by the *Associação Brasileira Terra dos Homens*. It aims to promote the development of Mangueirinha, a community with nearly 10,000 inhabitants in the Duque de Caxias municipality of Baixada Fluminense, a region of the state of Rio de Janeiro.

The programme began after an ABTH investigation showed that most of the children living on the streets in Rio de Janeiro came from Mangueirinha. The region is recognised by the public security authorities as the most violent in the area. In 2009, ABTH studied the socio-economic situation of Mangueirinha and devised the *Raízes Locais* approach, including elements of psychosocial support, street art and culture, income management, kindergarten education, social mobilisation and political advocacy.

ABTH has a house at the entrance to the community where about 200 children and 80 families meet to participate in activities. Though it started work in this

community in 2008, ABTH has carried out social work to strengthen the families of children and adolescents since 1996. Over those last 18 years, a work methodology has been developed which has proved successful in more than 80% of the cases dealt with.

The methodology understands the family as a system: when one individual seeks support, the whole family must be supported. Methods of support include interviews (both with individual members of the family and combinations of members, such as couples, parents with children, etc.), home visits, parent groups and networking with social services. The methods vary as each case develops, according to the family's specific needs. The emphasis is on dialogue, trust and the preservation of each person's autonomy.

Staff members work with families to develop tools called the genogram and the ecomap. The genogram analyses interactions among the family's different generations, and the ecomap analyses how the family interacts with systems such as the crèche, church, entertainment, friends, neighbours, medical services and housing. Graphically visualising these relationships helps to develop structured intervention measures.

The work of *Raízes Locais* can best be illustrated by exploring stories of individuals who have participated in it. Antonia and Cleo came to the programme in different ways, but both experienced the problem of difficulty in creating bonds with their children. Participating in the programme gave them a new perspective on these relationships. Antonia and Cleo's stories are just two among many which show that ABTH's social work methodology can strengthen responsive parenting and reduce the risk of violence within the family.

#### **Antonia**

Antonia joined the programme in 2008, when she was 27 years old and had two children: Caio, aged 5, and Camila, aged 1. Her relationship with her children was not good. Her own upbringing had been difficult: her biological mother died during childbirth,

and her adoptive mother was violent. She moved to Mangueirinha and met Robson, to whom she was married for 10 years. He had a drugs habit, which made him aggressive; though he wanted to give up, he lacked the strength to do so.

The ABTH team took the family in and verified their need for systematic support. To understand how Robson's drug habit affected the family, the team discussed it with Antonia on her own, with Antonia and Robson together, and with the children, both separately and together with their mother. Antonia attended income management centres, which helped her to learn new ways of managing her income and increased her self-esteem. Her relationship with her children improved, and so did their school performance.

Through support from the team, Antonia's husband began treatment and got a job. However, he relapsed. One evening when Robson was in a violent mood and looking for Antonia, Caio told his father where she was and Robson tried to kill her. Antonia escaped and took refuge outside the community. Robson sold the family's house to pay off his drug-related debts, but the team managed to get the house back for Antonia and her children.

Antonia blamed Caio for telling his father where she was that night, and Caio blamed Antonia for causing the separation from his father. Antonia became violent towards Caio. The team intervened to repair this bond through activities designed to stimulate interaction between parents and children and strengthen their relationship. During one of those meetings, Antonia and Caio each chose a musical instrument and sang a song together. Antonia confessed that it was the first time she had managed to see her son as a child.

ABTH introduced play as a technique in the meetings between parents and their children as it establishes a channel of communication between them. Through play, a child 'comes into contact with his fantasies, desires and feelings, becomes aware of the strength and limits of his own body and establishes relationships of

trust with others' (Rede Nacional Primeira Infância, 2010: 52).

Antonia's behaviour has changed. She has become calmer, more patient and more able to resolve difficulties through talking. She has created a healthy and non-violent environment for her children. In the process of working with Antonia, the team realised that she has high levels of intelligence, understanding and critical thinking skills. They invited her to be trained as a crèche assistant, and she began to work with children aged 2–6 as part of the programme.

#### **Cleo**

When Cleo joined the programme she was 37 years old and had four children (three girls and one boy) from two marriages. She earned an income by collecting materials for recycling, taking her children with her as she had nobody to leave them with. Ana, her eldest daughter, was 9 years old and had been looking after her two younger brothers since she was 5. She experienced difficulties concentrating at school and had to repeat a year. When Ana started to commit petty theft, that prompted Cleo to ask for help from the programme.

The ABTH team worked with her to make a genogram of her family – a graphic model of the relationships among family members of various generations, and 'a rich source of hypothesis in trying to understand how the problems that the family encounters can be put in context' (ABTH, 2013: 26). While drawing up the genogram, it became clear that Cleo had much better relationships with the men in her family than with the women. She mentioned that she was very attached to her father and in conflict with her mother, she was close to her brothers, and she valued her only son more than her daughters, calling him the 'prince of the house'.

Cleo was trained in an alternative way of generating income, by making and selling fruit juice lollies. Meanwhile, her younger children attended the programme's educational assistance activities for 2–6 year olds. Ana attended too, to look after her siblings, and the team observed that she was very mature for her

age. They encouraged her to read stories to the rest of the children, and gradually she improved her performance at school and stopped engaging in petty theft. But it became clear that she felt furious at her mother for having burdened her with responsibility for her siblings instead of letting her enjoy her childhood.

Through her work with the team, Cleo came to understand that the treatment she complained about from her own mother was being replicated in the way she was behaving with her daughters. Realising this, Cleo spontaneously got in touch with her mother and tried to rescue their relationship. She also became willing to work at her relationship with Ana, whose participation in programme activities such as theatre, *capoeira* and singing helped to mend their relationship. Also, as Cleo is illiterate, she felt proud of Ana because of her ability to read. When both mother and daughter rediscovered their natural roles, Ana was able to recover her childhood and to once again play her role as a daughter, strengthening the bonds with her mother.

#### **Integration with government services**

An NGO that experiments with innovative methods in its fieldwork must have a mission to pass its knowledge on to the government and promote constant communication with official decision-making structures, as only then will the accumulated experience be multiplied in an efficient and lasting way. ABTH's staff therefore work on political advocacy, requesting governmental services to act in a more integrated and participative way. There is a clear need for proactive community services which promote integration between health, education, social assistance, entertainment, work and housing activities.

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## YouthBuild in Brazil: how construction training can improve parenting

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By treasuring each young person's dreams and goals in life, YouthBuild programmes allow participants to feel more valued in their family, among their friends, and in the community at large. Photo • E. Raynes/Bernard van Leer Foundation

**In a part of Rio de Janeiro marked by poverty and a long-standing culture of violence, YouthBuild International and CEDAPS are training young people for careers in construction. The Bernard van Leer Foundation supports the programme as it also prepares the young participants to be responsive and responsible parents. This article discusses how.**

Gabriel recalls his childhood in Rio de Janeiro:

*When I turned 12, I got involved with crime, I was deluded by it.*

At that time, in 2002, his father stopped talking to him, and he would walk by his son on the street and pretend he had not seen him. Gabriel thought he had no future and one day, sooner or later, he would simply go to prison or die – he would live the intense and yet short life of those who get involved in ‘the world of crime’.

For as long as Gabriel can remember, his parents have been separated. Gabriel was raised by one of his sisters, as his mother was working and was seldom in the house. However, the sister was neither a mother nor a father to him. Gabriel says:

*She didn't have much to teach or to advise me with. Education must come from your parents.*

When he was young, his father was either living in other women's homes or working, so he could never pay much attention to his son as he grew up.

Gabriel also experienced violence within his home, as he was hit by his father. According to Gabriel:

*Whenever I got home, he came up and beat me. I never had him sit and just talk to me, as a friend, as a father.*

It was ‘always beating instead of advice’. To make matters worse, his father kept drug dealers’ weapons in the house, setting a negative example for his son.

At age 15, Gabriel met his wife and soon she became pregnant, but lost the baby. The following year, she got pregnant again and, at 16, Gabriel became a father. The pregnancy had not been planned, as they were both very young, but little by little they matured and learned to deal with the situation. Today, they are still married and have two children.

Looking for an opportunity to learn a trade at age 22, Gabriel decided to join the YouthBuild programme at the Centre for Health Promotion (*Centro do Promoção da Saúde*, CEDAPS), which started in his community of Complexo do Alemão in July 2012. Gabriel’s story suggests how YouthBuild programmes can help encourage responsive and responsible parenting by young people in communities that experience high rates of violence.

#### **YouthBuild in Rio**

Located near the commercial centre of Rio, the Complexo do Alemão consists of 13 slums, with population estimates ranging from 69,143 to 89,112, of whom 29% live below the poverty line. The community has the worst Social Development Index ranking in the city, a Human Development Index (HDI) of 0.711 (ranked 126th)<sup>1</sup>. The infant mortality rate is 40.15 per 100,000 live births, five times higher than the rate of 7.76 per 100,000 live births in the nearby, higher-income neighbourhoods of the Zona Sul (UPP Social, online). The community has the second-lowest educational level in the city, with an average of 5.36 years of study in contrast to the average of 8.29 years of study in other school districts (Carreira and Carneiro, 2008; Instituto Humanitas Unisinos, 2010, online); 14% of residents are illiterate.

Complexo do Alemão was previously controlled by drug traffickers, until the neighbourhoods were taken over by the Brazilian military and police 3 years ago as part of a broader pacification initiative underway in the city. While residents are grateful that trafficking violence has decreased and their community has opened up, they

are facing great uncertainty, because the local economy, which was fuelled by drug trafficking, essentially evaporated overnight.

During this challenging transition in the history of the Alemão *favela*, YouthBuild International and CEDAPS collaborated with a local NGO called Educap (Democratic Forum for Union, Sharing, Learning and Prevention)<sup>2</sup> to adapt and implement the YouthBuild programme. This programme was made possible with support from the Bernard van Leer Foundation, the Prudential Foundation, and *Oi Futuro*. YouthBuild has been in operation for 35 years and works with partners around the world. The adapted programme model in Alemão provides a holistic experience for young people, including applied basic education classes; counselling; programmes on self-awareness, teamwork and drug abuse prevention; technical skills training including health and safety and workers’ rights; and placement and support services (into jobs, self-employment, or continuing education and training.) For young people going into the building trades, ‘community asset building’ (CAB) offers work-based education necessary for employment, and for those focused on non-construction livelihoods it offers a rigorous and comprehensive introduction to the world of work.

CAB is central to the YouthBuild programme design. Young people transform their communities, while developing their technical and soft skills, by creating or renovating community assets such as housing, community centres and parks. These activities take place in the communities where the young people, their peers, and their families live. As a result, these young people see how their individual actions can improve the world around them, and family members and local residents witness them taking responsibility for the development of their own lives and their community.

In Rio de Janeiro, YouthBuild found a strong alignment in values with CEDAPS, whose mission is to develop the capacity of local leaders and organisations and to empower communities to seek and find solutions to their own problems. So far, outcomes include the following:

- 112 young people have participated.
- 77% of enrolled people completed the programme.
- 75% of graduates were placed in jobs, self-employment, or continuing education.
- 85% of graduates received market-recognized certifications in the construction trades.
- Through community asset-building activities in their neighbourhoods, young people renovated two homes to make them universally accessible, upgraded two community centres, and completed modest construction improvements to 46 homes.

### **Gabriel's experience**

Among the 25 young people, aged 17 to 26, who completed the programme with Gabriel, six were parents before entering the project and one was pregnant. Most of the participants had been involved with drug dealing activities and/or had prior criminal convictions. During sessions in which the young people had an opportunity to discuss the challenges they were facing in their lives, other programme participants shared stories similar to Gabriel's. Gabriel saw that he was not alone, and that some of his peers had experienced or observed violence in their homes, or in the community related to drug-trafficking activities. Many fathers had been absent from their homes for long periods of time, and traditional views of fatherhood did not include a hands-on role in parenting for men.

As part of the CAB activities, CEDAPS gave the students a small budget to improve their own homes. Gabriel recalls how much his home needed renovations and how the project allowed him to practise the new skills he had acquired in the programme. He stresses how the work earned him the respect of his mother, his own children, and his relatives. As they saw him make progress with the home renovation, they asked questions about what was being done. Gabriel says:

*As soon as I entered the programme, my mother started to respect me more, to trust me, and to believe I am prospering.*

The staff provided role models, and having a forum with his peers to discuss developing healthy relationships, as well as the importance of values such as mutual respect,

partnership and cooperation, may have played a role in Gabriel's growth as a parent. He developed a greater sense of responsibility – about himself, his family, and his community. As he noted:

*The programme changed my life, my relationship with my children. While I was working on the house, (my children) asked me what I knew to do. They were observing the improvements and we also played together. For me, it changed for the better.*

Gabriel now relates to fatherhood in a very different way from that he experienced himself. He remembers the void he felt as a child and teenager and tries to stay close to his children, providing them with the love and affection he never got. He says:

*My children are everything to me, our relationship is as good as it gets.*

Every day, he plays his role as a father actively: he helps the children with their homework, cooks, takes them out, and does anything else that might contribute towards the boys' education.

The experience even gave Gabriel's own father a second chance at caregiving. As Gabriel started renovating his home, his father began to help with tiling and flooring. As they worked together, they communicated more:

*I started cooking my father lunch. We sat and ate together. Things changed and he became closer.*

By witnessing the loving relationship between Gabriel and his children, Gabriel's father realises how different he was as a father. He tries to make up for his absence during Gabriel's childhood by being near his grandchildren, helping his son, and by showing interest in his son's work. The grandfather visits his son, plays with the children and behaves differently than the father he was many years ago. Gabriel says:

*Little by little [our relationship] is changing, or already has changed for the better. Now I know I can count on him for a few things.*

### **Lessons learned**

CEDAPS values the practical training that the YouthBuild methodology offers to young people, and has been impressed by the changes that the programme

inspires in young people and others in the community. Lucia Cabral, Executive Director of Educap, appreciates that the YouthBuild programme increases the civic engagement of young people, as she observes that the young people 'now they feel like they are citizens'. By treasuring each young person's dreams and goals in life, YouthBuild programmes allow participants to feel more valued in their family, among their friends, and in the community at large. CEDAPS feels that the changes in self-image and behaviour among young people, and their growth during the training, are the critical outcomes of the programme.

YouthBuild's CAB projects broaden the community-based impact of the programme. CEDAPS has emphasised community asset building as the central focus of their YouthBuild programmes, as staff have observed how these tangible experiences allow young people to gain confidence and self-esteem while they develop market-relevant leadership and livelihood skills.

Social projects such as YouthBuild can contribute directly to the reconstruction of young people's life trajectories, despite the patterns of concrete violence that they have faced in their family and community. The practical experiences provided by the YouthBuild programme allow for a structural transformation of concepts and feelings that, although not completely understood, trigger patterns of destructive behaviour towards self and others. The intensive support that young people receive in the programme helps them build healthier, more affectionate relationships with their spouses, children, parents, and friends.

Through the experience of shaping and implementing the adapted YouthBuild programme design in Alemão, CEDAPS learned that the following strategies encourage responsive and responsible parenting among young people who have grown up experiencing violence in their homes or communities:

- Build a dynamic youth network, to which young people refer their friends to participate in social programmes.

*'CEDAPS feels that the changes in self-image and behaviour among young people, and their growth during the training, are the critical outcomes of the programme.'*

- Provide safe spaces for young people to discuss how to develop healthy relationships with their children, family, and partners, and to share the transformations they experience during the programme.
- Offer community asset-building activities which positively affect relationships within the family and within the community.
- Develop objective strategies aimed at construction (physical or intangible), so that the feeling of achievement and 'positive power' prevails.
- Ensure continuous community outreach and dialogue, so as to strengthen community participation.
- Disseminate the project's positive achievements throughout the community.

Involving role models such as Gabriel, and other young men and women who went through similar life challenges, inspires the engagement of other young parents in similar activities. Gabriel, who is now employed at Educap and also supplements his income through construction jobs, has this message to other young men:

*Don't be angry because of how you were raised. Trust the importance of staying close to your children and never avoid doing something just because someone didn't do that for you one day. If you don't wish something for yourself, you also don't wish it for your children. That was terrible and I never wish the same to happen to my children. Otherwise it becomes a cycle.*

Through programmes such as YouthBuild, the cycle can change into a positive one.

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## Notes

- 1 Data from the 2010 Brazilian Demographic Census. More information on these results from the census is available online (UPPS, 2012). Some residents in the community did not participate in the census, leading some community organisations to calculate a higher population estimate. Further population data are available on the website of the Instituto Brasileiro de Geografia e Estatística (IBGE, online).
- 2 According to Lucia Cabral, head of Educap (Democratic Forum for Union, Sharing, Learning and Prevention), the NGO collaborates with several initiatives that deal with citizens' rights, such as health promotion, education, the environment and others. The purpose is to have people acknowledge their citizenship through rights and duties.

## Improving home environments in the Andes to prevent violence against children

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The improvement in household living conditions included having a place in the yard outside where the children could play.  
Photo • Courtesy Instituto de Estudios Peruanos

**When TADEPA<sup>1</sup> implemented a project to improve household living conditions among impoverished peasant communities in the highlands of Ayacucho, Peru, it was not explicitly targeting a reduction in violence against children. However, at the end of the project that seemed to be an unexpected but welcome impact. This article summarises further research into the possible explanations for this, which could inform the design of future projects.<sup>2</sup>**

Most kitchens in rural households of the Andes are dark and filled with smoke. Aurelia's kitchen is not. She and her husband made improvements to their household design after becoming involved in the *Allin Wiñanapaq*

project (meaning 'To grow up well' in Quechua, the region's indigenous language), implemented in Ayacucho by the non-governmental organisation TADEPA from 2009 to 2012.

They replaced their corrugated iron roof with transparent corrugated plastic, to let in more light. Their water supplies are covered. Storage devices made from local materials keep everything organised and free of dust, and food can be refrigerated. There is a place in the yard outside for the children to store their toys and play home-made games. The children also help with the organic garden, which provides fresh vegetables for their meals.

The family enjoy living in their new layout. But what does any of this have to do with violence against children?

When the project started, reducing violence was not among its explicit aims. Physical punishment was one of the topics touched on in the project's home visits and collective meetings with mothers, but the focus was more generally on child development, early stimulation, play, health and nutrition. The aim was to improve the physical and mental well-being of children under 5, who had high rates of malnutrition (33%) and delays in psychosocial development (75%).

The project worked with families, schools and local authorities to improve all the environments around young children. It guided families in areas such as kitchen design and organic gardens; separating adults' and children's beds and bedrooms; building playgrounds and playhouses for children; and creating space at home for reading and homework. It worked with preschools to improve their physical and pedagogical conditions, and with local authorities on aspects of community life such as garbage collection, and to help them take into account the needs of young children in their planning.

At the end of the project, it was observed that violence against children seemed to have reduced. Intrigued by this possibility, the Bernard van Leer Foundation commissioned the Instituto de Estudios Peruanos (Institute for Peruvian Studies, IEP) to conduct research to gather further information. Two communities which had worked with the project, Cuchucancha and Inccaracay, were selected for an in-depth, qualitative study. Two similar communities in the same district – Ccochapata and Pantin – which had not participated in the project were also selected for comparison.

In each of the four communities, the researchers conducted interviews with local authorities, women and children; they selected three families for in-depth interviews and observation and observed school lessons and community life for several days.

### **'We live better now'**

The study suggested that attitudes towards violence against children had, in general, become more ambiguous since the time when the current generation of parents were growing up. This is particularly true since 2000, when two decades of internal conflict ended: new state programmes and greater experiences of migration have exposed parents to discourses that question the use of violence as a legitimate strategy to educate children. Nonetheless, widespread fears persist that not using physical punishment will make children lazy and weak.

Various forms of violence (physical, psychological, sexual) were present in all four communities. This is not surprising, given high rates of violence against children in rural areas of Peru: the National Health Survey 2011 (ENDES, to use its Spanish acronym) suggests that almost 45% of rural mothers hit their children as a form of punishment, and 38% of women have violent partners. Nonetheless, there were three important differences between the two communities that had worked with the project and the two that had not.

#### *1 Less severe punishment*

Firstly, only relatively light and moderate forms of physical punishment were reported in the communities which had experienced the project's intervention: for example, pulling the ears or hair, spanking, and use of a whip, belt or stick. The other communities additionally reported use of more – and harsher – ways to punish, such as kicking, punching and hitting.

This suggests that participation in the intervention may have helped to speed up a change in social norms that is generally underway, by shifting opinion away from finding more severe forms of violence acceptable. As violence against children was usually attributed to a perceived lack of obedience and bad behaviour, it is also possible that the project reduced this perception by promoting greater intra-family collaboration and a changed view of the role of children in the household, along with a more comprehensive understanding of child development.



## 2 Less neglect

Secondly, child neglect was reported in both of the non-project communities but in neither of the project ones. Neglect is defined as parents' failure to respond to the physical and emotional needs of children, putting them at risk. This is likely to be attributable partly to the home visits and collective meetings imparting information on child development, but also to the way the project encouraged family members to share responsibilities for domestic tasks. It was observed that the mothers who neglected children tended to be those most overwhelmed by having to do most of the domestic work as well as caring for their children.

## 3 Less family fighting

Thirdly, some families reported that the intervention resulted in a reduction in fighting among family members. This is likely also to be related to the greater sharing of the responsibility for domestic tasks: intimate partner violence was found often to be sparked by discussions about household issues. As women felt less overwhelmed and more supported at home, they became less stressed, and there were fewer disputes that could escalate into physical violence. Alicia from Incaraccay put it this way:

*When your home is nice and clean, you come home and rest, you are calm, there are no reasons to protest or to fight, neither with children nor the husband.*

Another woman, Aurelia in Cuchucancha, said:

*Before we argued, we fought, but after they came, not any more. They explained in workshops, they say do not hit your children. There has been a change. Before it was disorder, children were untidy, they did not make the bed. Sometimes when I was angry, I treated my husband badly, I argued with him. Since TADEPA came, everything has changed. You have seen how my children react, they go nicely and there is no problem.*

TADEPA has taken up the insights gained from this research and is now working in Huancavelica, a neighbouring region, with the explicit aim of reducing violence against young children as well as improving their overall well-being.

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## Notes

- 1 TADEPA stands for *Taller de Promoción Andina* ('Workshop for Andean Promotion'); it is a partner of the Bernard van Leer Foundation in Peru.
- 2 This article is based on wider research, commissioned by the Bernard van Leer Foundation and carried out by the Instituto de Estudios Peruanos. It has been published in Spanish by the IEP (Ames, 2013), see [http://www.iep.org.pe/catalogo\\_fe.html](http://www.iep.org.pe/catalogo_fe.html)

# Reaching out to fathers: 'what works' in parenting interventions?

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**In parenting support programmes, the word 'parents' is often used interchangeably with 'mothers'. This article discusses the importance of specifically including fathers, surveys the limited evidence base on working with fathers, and identifies ten interventions of proven effectiveness.**

A review of child welfare practice in a number of countries has found systemic overlooking of fathers and father-figures in the lives of children at risk (Zanoni *et al.*, 2013). In child protection contexts this has been linked with child maltreatment and deaths (OFSTED, 2011; Brandon *et al.*, 2011).

Marginalising of fathers and father-figures in these families, as well as in families where children are not deemed to be at risk, takes place in routine practice (Raikes *et al.*, 2005; Featherstone *et al.*, 2007; Harwin *et al.*, 2014). One outcome is that few fathers are known to participate in formal parenting programmes; another is that mothers are made unfairly responsible for introducing and maintaining changes within families.

Because of low participation by fathers in parenting interventions, and because evaluations have rarely disaggregated parental outcomes by gender and have, instead, lumped mothers and fathers all together as 'parents' when presenting their findings, the evidence base on fathers' participation in formal interventions is small and methodologically weak.

In a systematic review, Panter-Brick and others (in press) identified only 92 parenting interventions worldwide that disaggregated findings by sex of parent and thus could describe outcomes in relation to fathers' participation. Most of these interventions were in developed countries, with 57 from the USA and Canada. Only 12 were found in more diverse contexts: in Turkey, Ukraine, Israel, Jordan, Iran, Mexico, Brazil, Peru, China, Niger and Pakistan. In all these cases, sample sizes of fathers were usually small, the impact of engaging with both parents was almost never measured, and outcomes (which mainly relied on fathers' self-reporting) were recorded only in the very short term.

Only 11 of 34 programmes identified by these authors as 'exemplars' benefited from evaluation in randomised controlled studies (8 of these were in the USA); and only 11 reported impacts on children (none of these was in a developing country).

## **Programme elements likely to be effective against maltreatment by fathers**

Lundahl *et al.* (2006) conducted a meta-analysis to assess the capacity of parent-training programmes to prevent physical and emotional abuse and neglect of children. Few disaggregated findings by gender. The authors conclude that programmes are more effective if they include both one-to-one and group-based elements, are delivered in more than one setting (home- and centre-based), and include both non-behavioural (attitudinal change) and behavioural (child-management) approaches. A 'systematic review of reviews' by Mikton and Butchart (2009) relevant to the prevention of child maltreatment found that home visiting, parent education, abusive head trauma prevention, and multi-component interventions all 'showed promise' in improving rates of child maltreatment by mothers.

It is likely that many of the programme elements found to be valuable in preventing child maltreatment by mothers could usefully be incorporated in work on maltreatment by fathers. This does not however suggest that a gender-neutral approach will be sufficient. For instance, a particular feature of fathers who maltreat seems to be rigid attitudes about appropriate child behaviour and parenting practices *linked to possible adherence to gender-role stereotypes*. If so, addressing such stereotypes will be an important element in intervention (Pittman and Buckley, 2006).

## **Which programmes?**

The Fatherhood Institute (for example, Burgess, 2009; McAllister *et al.*, 2012) has identified formal parenting interventions which have engaged with fathers and either been found to reduce abusive parenting or to have clear potential for doing so. Ten of these are briefly described here. Many are men-only (single-sex) interventions. However, this does not mean that

engaging with fathers separately from mothers or with men separately from women is, in most contexts, the best way of approaching them. The opposite may be the case (Cowan *et al.*, 2009; Spaulding *et al.*, 2009; Wadsworth *et al.*, 2011). Indeed, many men are extremely unwilling to attend men/father-only groups (Russell *et al.*, 1999) while from a programmatic point of view, men-only services are often an add-on to other programmes, and deemed unsustainable when resources are short.

**1 Primary prevention of Shaken Baby Syndrome**

**(USA).** In Buffalo, NY, new mothers and fathers were informed about the risks of shaking babies, given strategies to deal safely with, for example, persistent crying, and urged to sign a ‘commitment statement’ acknowledging receipt and understanding of information. A video was also produced but not widely recalled by parents, who had possibly not been shown it in some settings. Rates of abusive head injuries occurring in the first 3 years of children’s lives almost halved over the 5-year study period (Dias *et al.*, 2005).

**2 Early Head Start (EHS) (USA)** is based on a three-pronged approach: to increase economic self-sufficiency and health of families; to monitor and enhance child development; and to support and enhance parenting skills. In a sample of 3000 children and their parents, it was found that fathers who participated in EHS were significantly less likely to use harsh discipline than fathers in the control group. EHS fathers were also less intrusive and more easily engaged by their children, who were also more attentive (Vogel *et al.*, 2011).

**3 AÇEV Father Support Programme (Turkey)** aims ‘for fathers to play a more effective and positive role in the development of their children’. Topics addressed during the 13-week programme include child development, fathers’ experiences of being fathered, positive discipline, the importance of play and improving communication in families. Fathers who participated in the programme evaluation showed increased time spent with children, used less shouting and harsh discipline, became more involved in parenting and in housework (mothers’ reports) and

showed improved communication with and greater respect towards their wives (Population Council, 2009).

**4 UNICEF ‘Papa’ schools (evaluation in the Ukraine),**

groups for expectant/new fathers (2-hour sessions, six or seven times before the birth and once or twice afterwards) in UNICEF Child Development Centres. Main goals are to strengthen couple relationships and prevent violence against women and children. Fathers are encouraged to recognise their importance in children’s lives, prepare for their baby’s arrival, support breastfeeding, understand child development and children’s rights, create a safe family environment and take parental leave where this is available to them. Results include: massive increases in male attendance at birth (for example, from 4% to 75%), child morbidity down 15%, postnatal complications down 48%, childhood trauma rates down 58% (Al-Hassan, 2009; Al-Hassan and Lansford, 2011).

**5 Caring Dads (Canada),** a single-session 17-week group intervention for men who have exposed their children to violence. The programme integrates knowledge from parenting, child maltreatment, behaviour change and domestic violence perpetrator programmes. Caring Dads is successful in keeping fathers engaged: attrition rates (25%) are low when compared with established domestic violence perpetrator programmes. Evaluation found that participants had increased knowledge of child development and reported more patience with children and more positive co-parenting. Reduced risk of child maltreatment was also found, as well as positive changes in emotional unavailability, failure to respect the child’s boundaries, hostility and rejection of the child and exposure of the child to hostile interactions with mothers (Scott and Crooks, 2007; Scott and Lishak, 2012).

**6 Dads on Board (Australia).** This intervention consists of eight 2-hour weekly therapeutic groupwork sessions with a ‘therapeutic newsletter’ (reporting on each session) sent to the participating parents during the week. Two facilitators (male and female) are closely supervised. Participants were

men who had participated in a behaviour-change programme for their use of violence or who had maltreated their children. Positive impact was found on father–infant and mother–infant attachment and on fathers’ curiosity/respect for their child, ability to read infant cues, and understanding of the impact of their own behaviour on their baby or toddler (Bunston, 2013).

- 7 **Aangan, Rozan: capacity-building workshops on child sexual abuse (Pakistan).** This NGO, Rozan, appointed a child abuse specialist to set up a local committee to involve the whole community, including police, teachers and health and child protection workers. Religious leaders were offered awareness training in child sexual abuse and encouraged to publicise referral systems. Once men realised that there was a collective space to act in children’s interests, they were motivated to attend fathers and couples groups discussing early child development, and a male group leader was appointed to deliver counselling to men on positive discipline and child abuse issues (Bhandari and Karkara, 2006).
- 8 **Proyecto Papa en Acción (Peru).** This intervention consists of five workshops covering the basics of positive parenting and the importance of reading to young children, with a session on visual and verbal stimulation for early childhood development and a support session for fathers facing particular difficulties. Qualitative impact data revealed that fathers felt more involved in the family and had learned to respect family members and grow together. The men felt more connected to their children, had learned how to refrain from using violence, and shared more of the domestic and caregiving work (McAllister *et al.*, 2012).
- 9 **Family Foundations (USA),** an eight-session, 2-hour couples intervention, with four sessions pre-birth, four afterwards, and between-session homework. Programme goals are to decrease postpartum depression; improve parenting sensitivity/warmth in both parents; decrease harsh parenting; foster positive couple relations, secure attachments and positive child self-regulation; and decrease child behaviour problems. Video resources are used and

sessions are active, with exercises rather than discussion. Positive outcomes include better births, lower maternal depression, improved father–infant relationships, better co-parenting, couple relationship quality and sexual satisfaction, higher parenting quality, better infant self-regulation and better child adjustment and school adaptation. For certain outcomes, the greatest benefits were shown for families at higher levels of risk (Feinberg and Kan, 2008; Feinberg *et al.*, 2009, 2010; Feinberg *et al.*, under review, a and b).

- 10 **Siempre Papa (Spanish edition): the 24/7 Dad Curriculum (USA).** This programme consists of 12 2-hour sessions that can be implemented with groups of men or with individuals. The curriculum addresses masculinity and fatherhood, including what it means to be a man, power and control, disciplining and rewarding children and how to form emotional bonds with children. Evaluation (through fathers’ self-report) found improved parenting skills, knowledge and attitudes, more time spent with children, ability to communicate effectively with partner and children, and improved perceptions of gender roles and partner’s role as a parent. There was no change in the perception that harsh punishment shows that a father ‘is serious’ (Evans-Rhodes, 2010; Hyra, 2011).

#### **How important are formal parenting interventions?**

Most professionals’ engagement with families (and therefore, potentially, with fathers) does not involve formal parenting programmes. Support is provided, sometimes almost casually, through relationship building between the professionals and the parents (usually mothers).

Without being sent on ‘a programme’ fathers, like mothers, can be supported informally by professionals and by their partners and extended family and friends to become confident and substantial caregivers. Tamis-LeMonda *et al.* (2013), looking to support fathers’ contributions to their young children’s language development, suggest that simply encouraging verbal interactions between fathers and their young children

in the course of normal caretaking may be effective. Similarly, Pruett (2000) observed that fathers who nurture and take substantial responsibility for basic infant care (such as feeding, changing nappies) are significantly less likely to abuse their children sexually. Thus, raising awareness among the professionals who interact with families to encourage fathers' routine active caretaking and interactions with their children may be an important first step (McBride and Rane, 2001). Mothers and other female relatives, who can have important influence on fathers, can also be encouraged to facilitate fathers' confidence and sensitivity as intimate caregivers, for example by encouraging *solo* caretaking by them.

Bearing this in mind, and also bearing in mind that unless services are already in direct contact with many fathers, they will find it very difficult to recruit sufficient dads onto formal parenting courses or to meet them in substantial numbers in home visits, the Fatherhood Institute has developed a training programme for managers and frontline staff to help them 'bring fathers in'. Known as training in 'father-inclusive practice', this is delivered to whole teams before any attempt is made to deliver a formal parenting intervention.

Managers are encouraged to support practitioners to develop and implement strategies to engage with fathers routinely in their daily work. This includes reviewing letters, websites, newsletters, brochures, signage and session/course materials to ensure that these address fathers as well as mothers. For example, services often use the term 'parent' thinking that this will be inclusive and attract fathers. In fact since the word 'parent' is routinely used synonymously with 'mother', fathers *do not feel included* when that term is used. They need to be explicitly addressed and invited in, with liberal use of terms such as 'dad' and 'father'.

Another important strategy in father-inclusive practice which is also important in home visiting is for staff routinely to record fathers' and father-figures' names and contact details when a child is registered. This

requires proactive enquiry and invitation. Here again, management commitment is required: data collection 'fields' on computer systems or registration forms may need to be revised to enable such information to be collected.

Addressing staff attitudes and beliefs is another important element in training staff in father-inclusive practice. Beliefs (often unconscious) that men are less suited 'by nature' to care for children or that they 'don't love their children as much as mothers do' or 'are unwilling' or 'cannot multitask' inhibit workers from trying hard to draw them in.

Staff must be strongly motivated if they are to change their usual practice. For many, specific understanding of *why* including fathers matters for the well-being of mothers and children can be transformative, as can the realisation that delivering a parenting intervention to both parents is generally more effective than delivering it to just one (Fatherhood Institute, 2013, online).

Fathers and mothers, too, have often internalised notions of fathers as 'second-class' caretakers. Identifying their strengths and the relative contributions of nature/nurture in the capacity of human males and females for caretaking (see the downloadable resources listed below) can be an important first step in supporting fathers' involvement with young children.

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#### Free, downloadable resources

Supported by the Bernard van Leer Foundation, the Fatherhood Institute (2014) has produced a series of well-designed and accessible one-page Topic Sheets for practitioners, advocates and researchers to address the how and why of engaging better with dads and evaluating outcomes. These resources are backed up by short, high-quality research summaries, showing their evidence base: <http://www.fatherhoodinstitute.org/2014/bringing-fathers-in-resources-for-advocates-practitioners-and-researchers/>

#### Also available online

*Fathers and Parenting Interventions: What works?* by A. Burgess (2009): <http://www.fatherhoodinstitute.org/shop/fathers-and-parenting-interventions-what-works/>

*Dads Included*, free online course from the Fatherhood Institute (2013): <http://www.fatherhoodinstitute.org/training-and-consultancy/dads-included-free-online-course/>

*Engaging with Men in Social Care: A good practice guide* by the Fatherhood Institute (2014): <http://www.fatherhoodinstitute.org/wp-content/uploads/2013/03/FAT-91768-FI-SafeGuarding-A4-16pp-aw1.pdf>

*Fatherhood Institute Newsletter*, free e-newsletter: <http://www.fatherhoodinstitute.org/contact-us/sign-up-for-fi-emails/>

*Fatherhood: Parenting Programs and Policy – A critical review of best practice* by F. McAllister et al. (2012): <http://www.fatherhoodinstitute.org/wp-content/uploads/2012/07/Parenting-Programs-and-Policy-Critical-Review-Full-Report.pdf>

MenCare, a global fatherhood campaign (online): <http://men-care.org/Programs/MenCare002B.aspx>

## 'Be guided by the evidence'



The implementation of the Home Visiting Program in USA has been an exciting, rapid and heavy lift for many states and local communities.  
Photo • mlive.com/Landov

**As the Director of the Division of Home Visiting and Early Childhood Systems at the US Department of Health and Human Services, David Willis administers the Maternal, Infant and Early Childhood Home Visiting Program. The Program was created by the Patient Protection and Affordable Care Act of 2010, better known as Obamacare.**

*David, please first give us some background on what the Home Visiting Program sets out to achieve, and how it works.* The Home Visiting Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to age 5. These services have been proven to improve maternal and child health outcomes in the early years of a child's life. Although home visiting models have been around for decades, the Home Visiting Program

is the first nationwide expansion of these services. The home visiting models have a long history of compelling scientific evidence to positively impact birth outcomes, improve children's health and reduce child maltreatment, and promote long-term benefits for at-risk families and their children. Thus, evidence-based home visiting is not only a violence reduction strategy, as you're exploring with the articles this edition of *Early Childhood Matters*, but also a public health strategy, an early education strategy, a workforce development strategy, and a community-building strategy.

The Home Visiting Program promotes collaboration and partnerships among states and local communities, home visiting model developers, families and early childhood stakeholders. In March 2014, funding for the Home Visiting Program was extended through March 2015,



building upon the \$1.5 billion investment in the Home Visiting Program for fiscal years 2010 through 2014. Priority populations for the Program include pregnant women under age 21 and families who:

- live in at-risk communities
- are low-income
- have a history of child abuse, neglect, or substance abuse
- have users of tobacco in the home
- have children with low student achievement or developmental delays or disabilities
- are military families.

When the Home Visiting Program began, each state, territory and Tribal grantee developed a mandatory needs assessment to identify communities with concentrations of premature birth, low-birthweight infants and infant mortality. Then, as defined by statute, grantees chose from a list of Health and Human Services-approved, evidence-based home visiting models to promote:

- improvements in maternal and prenatal health, infant health, and child health and development
- increased school readiness
- reductions in the incidence of child maltreatment
- improved parenting related to child development outcomes
- improved family socio-economic status
- greater coordination of referrals to community resources and supports
- reductions in crime and domestic violence.

The Home Visiting Program is completely voluntary: families choose to participate and can leave the Program at any time. It is also administered with state and local flexibility and built on decades of scientific evidence demonstrating both the effectiveness and the cost benefit of home visiting. According to a recent Pew Charitable Trusts study, every dollar invested in home visiting yields a return of up to \$9.50 to society. Home visit services are conducted in the home, over time, with multiple visits and careful attention to relationship building and trust building.

*Which are the approved home visiting programmes that states can choose to implement?*

By legislation, the Home Visiting Evidence of Effectiveness review (HomVee) was designed to provide comprehensive, systematic and transparent review of the evidence<sup>1</sup>. (Seven evidence-based home visiting models were initially approved and served as a foundation for the Program. And with ongoing review of the evidence, HomVee now includes a total of 14 Health and Human Services (HHS)-approved evidence-based models. The majority of current Home Visiting Program investments are supporting the following models:

- Nurse–Family Partnership (NFP)
- Healthy Families America (HFA)
- Parents as Teachers (PAT)
- Early Head Start – Home Visiting Option (EHS).

The legislation for the Home Visiting Program also encourages innovation by allowing up to 25% of funds to support promising approaches. In addition, the legislation provides for a 3% investment in evaluation, research, and corrective action technical assistance and 3% of the funding goes specifically for grants to Indian Tribes (or consortia of Indian Tribes), Tribal organisations, and Urban Indian Organisations.

*What have been the biggest challenges with scaling up?*

The implementation of the Home Visiting Program has been an exciting, rapid and heavy lift for many states and local communities. The programmes had to conduct needs assessments, contract with local providers and home visiting models, develop data and reporting systems, create quality improvement and evaluation plans and engage many stakeholders to assure the success of the Program. For many states, the Home Visiting investment builds on decades of successful early childhood system infrastructures, allowing those states to use this nationwide expansion of home visiting to new levels of innovation and scale.

*One of the common problems with scaling up is achieving consistency across different geographical areas; how have you approached that?*

The Home Visiting Program has a keen focus on fidelity, accountability, and quality of programmes, built from

the knowledge and experience of the evidence-based home visiting models. In addition, to further address differences in grantees' capacities, Home Visiting has a comprehensive and robust technical assistance programme to assure its success.

*What has been the biggest surprise since you started the Home Visiting Program?*

The prevalence and extent of toxic stress within families and communities has been sobering and challenging. The 'big three' issues that have been most identified as challenges for the home visitors have been parental mental health (especially maternal depression), substance abuse and domestic violence. Of course, home visitors are trained to address these challenges, but the depth and severity of these risks in some communities have been challenging, especially when local resources are limited. Yet, these challenges have driven the development of new partnerships, innovations and local solutions.

*How else has the Program moved forward the evidence base on home visiting?*

The home visiting legislation mandated a national evaluation of the Program in a random assignment study of approximately 5100 families in 85 local sites across 12 states. This study, called MIHOPE (Mother and Infant Home Visiting Program Evaluation), will examine child and family outcomes, implementation and cost effectiveness. MIHOPE includes the four major evidence-based home visiting models I mentioned earlier: HFA, NFP, PAT and EHS. In addition, there is a second national evaluation called the MIHOPE-SS, which will be specifically examining the effectiveness of Healthy Families America and Nurse Family Partnership home visiting on reducing preterm birth, increasing birthweight and improving infant and maternal health outcomes.

We have also developed the Home Visiting Collaborative Improvement & Innovation Network (CoIIN), which includes Home Visiting Program state grantees and local implementing agencies to focus on developing quality improvement and rapid cycle methods to accelerate improvements in Program outcomes.

*What advice would you give to other countries that are thinking of scaling-up home visiting?*

Be guided by the evidence. Make use of multiple evidence-based home visiting models, not just one, so that flexibility and choice will address the local circumstances, local resources and the local needs of families. In addition, it is imperative to view home visiting as a key component of a continuum of services for vulnerable families within the child health and public health systems. Intentional linkage of resources, public health services and home visiting can become breakthrough strategies to address the toxic stress and generational transmission of trauma that so disrupts life course health and developmental trajectories.

In addition, it is important to be sensitive to public messaging and framing – to stress that home visiting is embedded in a public health and human capital development agenda, not just a social welfare agenda. The home visiting message must be grounded in a broad community context of building healthy communities and assuring healthy development for all children. Home visiting is intended to lift up families who seek support and need more intensive parent coaching. Home visiting must develop within the context of a continuum of services and supports for all young families.

**Note**

- 1 Information about the Home Visiting Evidence of Effectiveness review is available online from the US Department of Health and Human Services Administration for Children and Families, at: <http://homvee.acf.hhs.gov/>

## The *Madres a Madres* Programme

Nancy G. Guerra, Professor of Psychology and Associate Provost for International Programs, University of Delaware, Newark, DE, USA



The *Madres a Madres* programme was developed specifically to address adaptation of parenting programmes to Latino families.

Photo • Jon Spaul/ Bernard van Leer Foundation

**Replication of evidence-based positive parenting programmes may not be as successful as the original if their adaptation to new cultural settings is only superficial. This article describes how the *Madres a Madres* ('Mothers to Mothers') home visiting parent-training programme was based on principles of evidence-based programmes, but designed specifically for the unique cultural and contextual needs of recent Latino immigrants to the United States. Early results suggest that the programme is successful in improving parenting skills.**

Over the past two decades, there has been an increasing emphasis on building an evidence base of effective programmes to prevent childhood violence perpetration and victimisation. Although various standards of 'evidence' have been used, a commonly accepted gold

standard requires a randomised controlled trial and at least one replication study for an intervention to be recommended as effective.

Using this standard, a number of best practices have been documented in specific developmental contexts including schools, peers, families and communities (for examples, see Blueprints for Violence Prevention at the University of Colorado<sup>1</sup>). Across these multiple contexts, family intervention and parenting programmes have emerged as particularly promising targets for intervention. Indeed, early interventions that increase parenting skills can lead to lower levels of harsh punishment and parental violence against children, as well as lower levels of children's aggression towards others (Sweet and Appelbaum, 2004; Eyberg *et al.*, 2008).

However, a key challenge in implementing these programmes in different cultural and community contexts is the extent to which even the 'best' practices are relevant across different settings. A gold standard of two evaluation studies, often with recommendations that implementation follows a strict protocol, does not adequately address potentially important cultural and contextual differences when implementing programmes with different populations.

These differences also may vary within specific population groups. For instance, several parenting programmes to prevent aggression and violence have been adapted and evaluated with Latino children and families. Many of these programmes have been successful with minor adaptations, such a translation into Spanish, incorporation of Latino family values, and use of ethnically matched intervention specialists (for a review, see Leidy *et al.*, 2010). Still, within the Latino population, very few programmes have been adapted specifically for recent immigrant families, and programmes adapted broadly for Latino families have been shown to be less successful for immigrants (Martinez and Eddy, 2005).

#### **Tailored programmes for immigrant Latino families**

The *Madres a Madres* programme was developed specifically to address this gap. It was developed as part of a collaboration between the Southern California Academic Center of Excellence on Youth Violence Prevention, funded by the Centers for Disease Control and Prevention (CDC), and a community-based agency, Latino Health Access (LHA), that served recent and predominantly Mexican immigrant Latino families. The CDC was interested in implementing and evaluating evidence-based programmes to prevent violence victimisation and perpetration in high-violence communities. In a similar vein, families served by LHA were plagued by increasing community violence, and also had asked the agency to teach them effective parenting skills.

Because the CDC encouraged use of evidence-based programmes, the collaboration initially selected and

implemented a programme with strong empirical support, Families and Schools Together (FAST), that had been translated into Spanish and seemed to be a good cultural match for Latino values. However, the FAST programme yielded minimal and insignificant effects for the recent immigrant sample (Knox *et al.*, 2011).

In follow-up qualitative interviews and focus groups, families stated that they needed more specific information on parenting skills and discussed several unique challenges that were not addressed in the FAST programme. These included differences in levels of acculturation between parents and children, children speaking English and parents only speaking Spanish (leading to a reversal of the power structure), overcrowded housing, unfamiliarity with the US school system, and fear of immigration raids.

Families also had difficulty travelling to the intervention sites and arranging babysitting for other children. The cost to LHA of implementing the programme in multiple community sites also made it impossible to sustain the project without continued external funding (Guerra and Knox, 2008). Because these concerns were not adequately addressed in any of the available evidence-based parenting programmes, the next step was to tailor a programme to the specific needs of this population.

Indeed, we believed that the specific parenting skills that recent immigrant Latino families needed – coupled with the importance of feasible service delivery and implementation methods – required developing new, customised programmes. Rather than taking a 'packaged' programme and implementing it as developed, it was necessary to build on empirically supported principles of effective programmes but to tailor the programme to the unique circumstances of participants. This strategy guided the development of the *Madres a Madres* programme. Specifically, the programme was designed to build on critical components of evidence-based parent-training programmes while also incorporating identified parenting concerns of participants as well as feasibility of implementation for LHA.

We looked to the parenting literature to identify skills that were consistently associated with positive programme outcomes. Based on programme reviews and a recent meta-analysis of 77 parenting programme outcome studies (Kaminski *et al.*, 2008) we identified several, including positive communication strategies, time-out, consistent discipline skills, and regular practice of these skills in intervention sessions. In response to family concerns, we also included information on normative child development and on skills specific to immigrant families as discussed in focus groups with community residents. These skills included how to maintain authority when children speak English and parents speak only Spanish, how to interact with schools and other agencies to leverage community resources and be effective advocates for their children, and how to build social support networks.

To reduce stigmatisation commonly related to mental health care for Latinos and to increase the limited access and utilisation of services by immigrant populations, the programme was implemented in families' homes by lay community health workers (*promotoras*). Home visiting services have a long history of successful implementation in low-income and marginalised populations, and have been particularly effective in preventing child maltreatment and other health problems during infancy and early childhood (Sweet and Appelbaum, 2004). This approach is particularly useful for families who are unable to access regular transport or safe passage to clinic or agency-based services. Using lay community workers also facilitates cultural relevance and 'fit' to client needs, because the health workers are themselves parents from the same communities.

*Promotoras* were identified as coaches rather than experts. They were encouraged to spend time building rapport with mothers and connecting them with others. Overall, this method of service delivery is a cost-effective strategy for increasing engagement in underserved communities, to provide culturally sensitive intervention services, and to disseminate evidence-based practices (Perez and Martinez, 2008; Rotheram-Borus *et al.*, 2012).

### **The *Madres a Madres* programme**

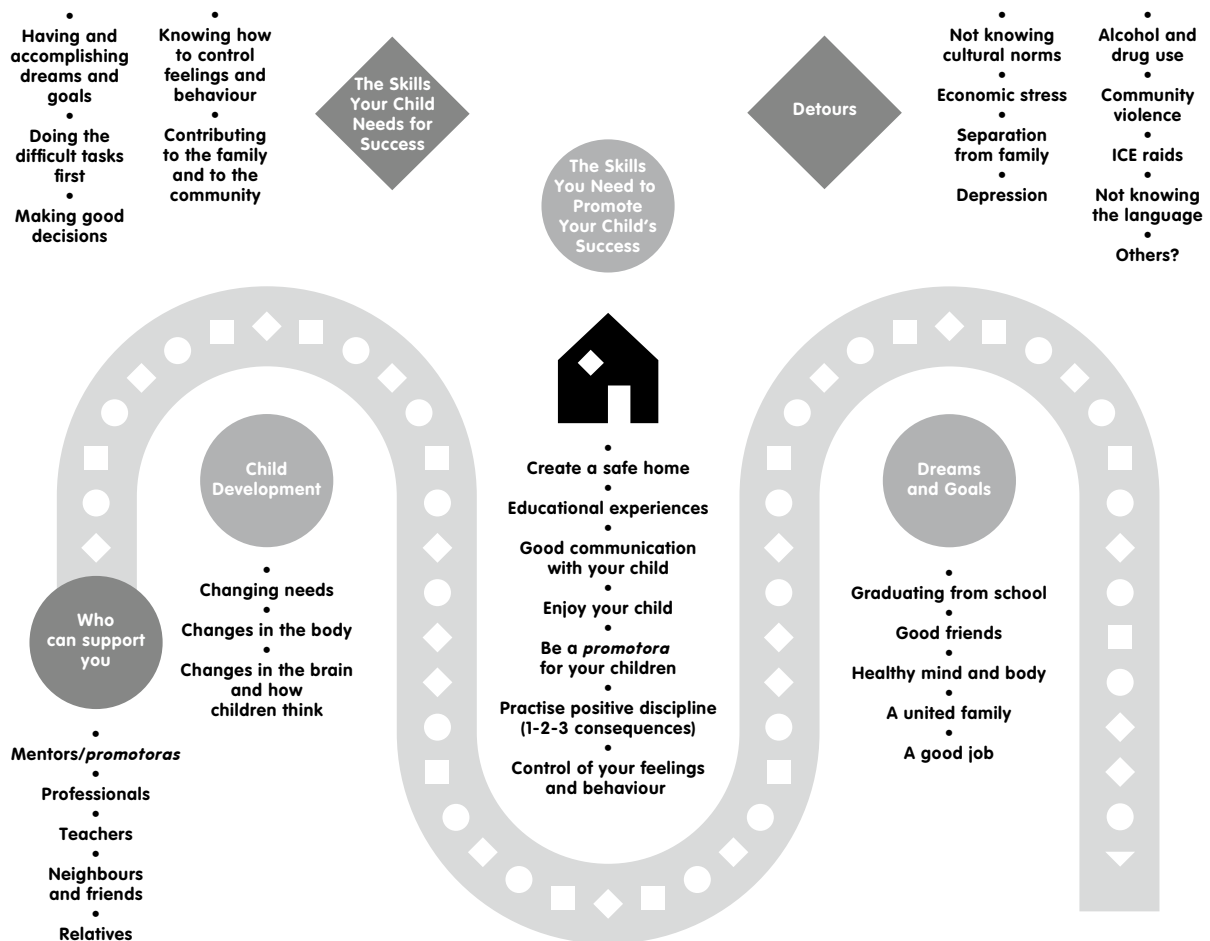
Because *Madres a Madres* was designed to be preventive in nature and feasible to implement under resource constraints, it was intentionally brief and was delivered in the home setting by lay community workers or *promotoras*. Although fathers and other family members or caregivers were invited to participate, only mothers enrolled in the initial pilot phase. Four 2-hour sessions were delivered over the course of 4 weeks. Instruction focused on specific core content areas:

- 1 normative child development and related social competencies
- 2 positive parent-child interaction techniques
- 3 positive behavioural management strategies
- 4 service navigation to support access to community resources.

Families had specifically requested information on normative child development – what to expect from their children at different ages, what behaviour was normal and what types of behaviour were cause for concern. To respond to this request, the programme taught basic concepts related to children's cognitive, physical and emotional milestones. Parent-child interaction techniques built on Parent-Child Interaction Therapy (PCIT) (McNeil and Hembree-Kigin, 2010). Mothers were taught to increase positive interactions with their child during a time-limited interaction period called '15 Magic Minutes' through the use of skills such as following the child's lead, reflective listening, and focused praise. During this period mothers spent time engaged in specialised activities and communication with their child. Skills and activities were adapted to fit the child's developmental level, including playing games with younger children (age 6–7) and making a meal for or just talking with older children (age 10–11).

During the sessions, *promotoras* taught or reviewed these skills, coached mothers, and then assigned the mothers homework to engage in the 15 Magic Minutes several times per week. Positive behaviour management strategies emphasised teaching mothers to ignore minor misbehaviour, to discuss rules with the child, and to implement a system of consequences including time-out

Figure 1 The Path of Hope



Source: Southern California Academic Center of Excellence on Youth Violence Prevention/Latino Health Access collaboration

and a contingency management system (Forgatch and Patterson, 2010). To encourage utilisation of community resources and child advocacy, *promotoras* provided mothers with relevant information about community resources (for example housing or food programmes, after school care). Mothers in the programme also were invited to take part in monthly meetings called *cafecitas* ('little cafés') or *quermes* (small charity fairs), designed to bring mothers from the same neighbourhood together to provide opportunities for social connection, support, and mobilisation around the needs of families in the community.

Visual materials, video segments, interactive role-plays, and worksheets were used as instructional aids. Materials were designed specifically for use with Spanish-speaking parents or guardians with low levels of literacy and integrated familiar, community-relevant content. Programme sessions were organised around The Path of Hope (*El Camino de Esperanza*), a visual discussion tool that oriented caregivers to the four intervention components shown in Figure 1. In the pilot phase, the mothers also developed a Personal Parenting Record (PPR) as their own strategic plan for child behaviour management goals. *Promotoras* and mothers developed

the PPR during the first session, and used it throughout the intervention to monitor goals and problem-solve any issues that arose.

### Results and conclusions

Although *Madres a Madres* is a brief intervention, mothers who participated in our pilot study reported improvements in parenting skills and family functioning that were statistically significant compared to a matched control group. Mothers' improvement in parenting skills suggests that behavioural parent-training techniques are applicable to recent immigrant Latino parents as long as the issues addressed and the format for implementation are a good cultural fit. Results also suggest that relatively complex behavioural strategies can be taught successfully by lay community health workers. Further, although the skills taught did not directly address family functioning, mothers reported improvements in family support, organisation and cohesion.

We had been interested in whether this programme would also yield improvements in children's adjustment. Although we did not find significant differences in children's aggression, children of parents who participated in the intervention demonstrated statistically significant reductions in depression and internalising behaviours compared to children in the control group (Williamson *et al.*, in press). This finding is interesting because our sample was not drawn from clinically referred young people, nor was the programme specifically designed to address depression in children. It may be that the effects on parenting skills and family functioning created a more positive home environment that spilled over into children's emotional adjustment.

Still, it is important to bear in mind that this programme was implemented with a specific sample of immigrant Latino families from Mexico living in Southern California during the mid- to late 2000s. The culture of immigrant Latino families is not homogeneous and contextual and historical circumstances may differ widely across Latino individuals and immigrant groups. As such, this study

is limited in its generalisability to Latino immigrants from different countries, as well as to immigrants in general. What it does point out, however, is that adapting programmes for different cultural groups and in different contexts requires more than surface-level modifications (such as translation into Spanish) of existing programmes. A more nuanced approach utilises principles of evidence-based practices that can be mapped on to specific needs, priorities and challenges in local cultures and settings.

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### Note

- <sup>1</sup> The Blueprints can be accessed via the website of the Center for the Study and Prevention of Violence, at the University of Colorado, Boulder, USA: <http://www.colorado.edu/cspv/effectiveprograms.html>

## Adaptation and evaluation of the Nurse–Family Partnership in Canada

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The Nurse–Family Partnership is an intensive programme for first-time, socially disadvantaged mothers. It begins prenatally and extends until the child is 2 years of age. Photo • Jon Spaul/ Bernard van Leer Foundation

**The Nurse–Family Partnership (NFP) is well known internationally as an evidence-based nurse home visiting programme that has been implemented across the United States. This article describes how the NFP was replicated in Canada, through a pilot study which highlighted necessary adaptations, and is currently being evaluated.**

The Nurse–Family Partnership is an intensive programme for first-time, socially disadvantaged mothers. It begins prenatally and extends until the child is 2 years of age. Over the past 35 years, the NFP has undergone rigorous evaluation in three US-based randomised controlled trials (RCTs) where it has shown consistent benefits for maternal and child health, including the prevention of child abuse and neglect (Olds *et al.*, 2007).

Despite these positive findings, it is unclear whether this programme would achieve similar outcomes outside the USA. Especially in a country such as Canada, where there is a publicly funded universal healthcare system and better access to social services, we cannot assume that the NFP will provide the same benefits for vulnerable mothers.

In response to extensive international interest in the NFP, Dr David Olds – who developed the NFP – and his colleagues at the Prevention Research Center for Family and Child Health at the University of Colorado developed a four-phase process to adapt, pilot, evaluate and then implement the NFP in countries other than the USA. The process is currently in the evaluation phase in Canada, Australia, the Netherlands, and the United Kingdom. We hope the following description of how the NFP has



come to Canada for evaluation might inform other replication efforts.

### **The need for a champion**

It is important to highlight that home visiting services have existed in Canadian provinces and territories for many years, typically delivered by public health units. However, there is considerable variation across such programmes and limited knowledge about the benefits for families. Through a partnership of committed investigators and one Ontario public health unit willing to reallocate resources, we were able to undertake the prerequisite steps that have led to the Canadian replication currently in progress.

What have we learned along the way? First, to move an innovation such as the NFP into a context where other home visiting programmes exist, it is important to justify the need without threatening established services. This required a senior public health administrator to champion the NFP within the unit, throughout the local community (Hamilton, Ontario) and at the more senior levels of decision making within the provincial government. It became clear to the investigators who had promoted the NFP in Ontario for many years that without this champion the NFP would not have come to Canada anytime soon.

Additionally, this champion was able to secure the political support at a provincial level to reallocate existing home visiting funds for the NFP services. Together, public health personnel and the investigators were able to galvanise funds from local agencies to conduct a pilot study to evaluate the feasibility and acceptability of the NFP in an urban Canadian context (Jack *et al.*, 2012).

In the USA, NFP nurse home visitors and supervisors are provided with guidelines on what to include and how to structure home visits, and content facilitators to guide their work with the women and their families. Content-specific guidelines have been developed for three phases: pregnancy, infancy and the toddler period. These materials required a significant amount of adaptation

for their use in Hamilton (within the Canadian context) to ensure that the content was culturally appropriate, integrated Canadian standards of clinical evidence for topics such as immunisation schedules or safety regulations, and reflected existing best practice guidelines.

The next step required preparing Hamilton's public health nurses to deliver the programme with fidelity to the 18 NFP model elements.<sup>1</sup> While all nurses working in the NFP must have a minimum of a baccalaureate degree in nursing, this is an advanced practice nursing role. Extensive professional development is required to enhance the nurses' clinical knowledge and assessment and intervention skills. The opportunity for Hamilton nurses to observe the home visiting practices of experienced NFP home visitors in the USA consolidated the core education for their work in the Canadian setting.

### **Issues raised by the pilot study**

To answer the question 'Will the NFP be feasible to deliver in an urban Canadian setting and be acceptable to socially disadvantaged mothers and their families, as well as all health and social service providers?', we recruited 108 young (under 21 years), low-income pregnant women to enrol in a pilot study of the NFP.

As part of this pilot work, we conducted a qualitative case study to identify and understand the individual, organisational and community-level factors that influence the delivery and uptake of the NFP. We completed face-to-face interviews with women enrolled in the NFP, their partners or extended family members, and community professionals responsible for referring women or providing supportive health or social service care to them while they were in the programme. Focus groups were also conducted with the NFP nurses as well as with nurses and managers in other public health home visiting programmes.

The pilot results confirmed that we have the capacity to adapt and implement the NFP in the Canadian healthcare system. The team was successful in

identifying and enrolling pregnant women into the programme, with the majority (87%) receiving their initial home visit in the first few weeks of the second trimester. Early enrolment into the programme facilitates the development of a therapeutic relationship between the nurse and the family, and also allows for sufficient time to support mothers in making healthy choices in pregnancy, such as accessing prenatal healthcare, giving up smoking, eating healthy foods and exercising.

The public health outreach services were also successful in locating a hard-to-reach group of adolescent pregnant women, with 77% of the clients being between 16 and 19 years. Professionals, including physicians and nurse practitioners in the community, perceived the NFP as an important evidence-based prevention programme to meet the needs of some of their most disadvantaged clients. More importantly, physicians identified that the NFP was meeting the needs of an underserved population of high-risk mothers and infants who typically fall through the cracks of the primary healthcare system. Their experiences with the programme were so positive that they expressed frustration with not being able to refer all pregnant women, including those already parenting a child, older than 21 years of age or further along in their pregnancy.

The content, structure and timing of the home visits were acceptable to women enrolled in the NFP, public health nurses and community professionals. There was consensus too that public health nurses had the necessary knowledge and skills to meet the social and health needs of the families, many of whom are exposed to violence, substance use and mental health challenges.

However, within the pilot study we were able to implement only 16 of the 18 required model elements with fidelity and needed to make some adaptations to the programme. The most significant change was to reduce the nurses' caseloads from 25 to 20 active clients at any one time. This was necessary after considering the working and employment conditions for nurses in the USA compared with Canada, based on issues such

as greater travel distances for nurses to reach clients and the difference in average number of work hours per week. Additionally, considerable time was required in the first year of the programme to complete the NFP education requirements, prepare the home visiting materials and develop procedures for documentation and integration of clinical supervision into their work.

The second element that was not met within the pilot study was the collection and review of data for quality improvement and to inform clinical supervision sessions. Extensive resources and local-provincial collaboration would have been required to integrate NFP data requirements into the established provincial public health databases.

This highlights the importance of conducting pilot work, and not simply assuming that an evidence-based programme is feasible or acceptable in another geographical setting. Although we were able to deliver the NFP within the Canadian context, certain adaptations were required.

### **Implementing an RCT**

Following the pilot, despite our success in Hamilton and support from several other public health units across the province, attempts to undertake the next step – an RCT that would evaluate the overall effectiveness of the NFP compared to existing services – were not successful in Ontario. Although senior policymakers and many Ontario health units were in favour of a trial, final agreement could not be reached on ensuring the necessary funds to implement the NFP within a research context. It was suggested that some funds from within the existing universal home visiting programme provided in Ontario be reallocated to a trial of the NFP, following the model of the pilot study. Despite lack of evidence for effectiveness of the existing Ontario home visiting model in improving maternal and child health outcomes, agreement could not be reached to move forward on this plan.

However, the local champion and investigators continued to work together in a strong, flexible

collaboration and were able to link with another established investigator who had strong relationships with senior policy decision makers within the British Columbia (BC) provincial government. By matching the outcomes of the NFP with BC's children's mental health strategy, an opportunity to roll out the RCT to test the NFP's effectiveness in Canada commenced in 2013. In parallel to the RCT, a mixed-methods process evaluation is being conducted to describe how the programme is implemented; to consider further adaptations required to meet the needs of families living in rural and remote communities; to measure fidelity to the NFP model elements; and to explore how NFP public health nurses collaborate with the child welfare sector, as well as meet the specific needs of families exposed to intimate partner violence or substance abuse.

Flexibility among the champion and investigators, as well as the senior BC investigator, led to the implementation of the RCT despite the aforementioned resistance at the Ontario level. Our experience underscores the importance of collaborations that allow an implementation process to proceed even when the original intended conditions are not possible, provided that such aspects as scientific rigour can be maintained.

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#### Note

- 1 The 18 model elements are set out on the website of the Nurse–Family Partnership, at: <http://www.nursefamilypartnership.org/Communities/Model-elements>

## 'This is an exciting time to be rolling out a programme nationally'

**Klaas Kooijman is a senior employee at the Nederlands Jeugdinstituut (Netherlands Youth Institute), which has spent the last decade bringing the Nurse–Family Partnership (NFP) – or VoorZorg, as it is termed in Dutch – to the Netherlands. In this interview he discusses with *Early Childhood Matters* how the programme was adapted, piloted and evaluated; results showing effects on, among other things, violence prevention; current plans for scaling-up the programme nationally; and a new initiative to test an additional early stimulation component.**

*When and why did your organisation first become interested in bringing the Nurse–Family Partnership model to the Netherlands?*

We were aware that the evidence from randomised controlled trials (RCTs) had established it as a programme of proven effectiveness in the USA. In 2003 we made contact with the NFP's creator, David Olds, who gave us permission to adapt it for the Dutch context. We translated the manuals and training materials, with minor adjustments as necessary for differences in the US and Dutch systems, such as how the programme would work alongside the role of midwives. Then we trained nurses, and the first families entered the programme in 2004.

David Olds imposed one condition: that we have the programme tested through an RCT, so that we could learn about whether it continued to be effective in a new country setting. This was carried out from 2006 to 2012 by the Free University Medical Center. In a double-blind, parallel-group trial, 237 expectant first-time mothers were assigned to the intervention group and visited by trained VoorZorg nurses 40–60 times from the second trimester of pregnancy until their child turned two, while 223 mothers were allocated to the control group and received the usual forms of care.

*What did the RCT find?*

The results were very positive. Among the effects found were that mothers who participate in the programme become about half as likely to smoke during pregnancy and when the baby is born, and they are more than twice as likely still to be breastfeeding after 6 months.

In terms of the issue which this edition of *Early Childhood Matters* is addressing, the results were also strong. It was found that by the time the children were 2 years old, the number of reports of suspected child abuse among the participants in the VoorZorg programme was almost half that in the control group. The incidence of domestic violence was also lower among programme participants.

We were very happy with the results of the RCT, which were formally published last year. It has established VoorZorg as one of the more important programmes in the Netherlands, both for abuse prevention and child development, and David Olds gave us his approval to roll out the programme nationally.

*How is that going?*

In the Netherlands at the moment, we are in a transition period towards municipalities taking over responsibility for child care policy, so we are making plans to approach municipalities to persuade them that adopting the VoorZorg programme is a good idea. Because there is such a state of flux, this is an exciting time to be rolling out a programme nationally.

Based on our experience so far – we currently have around 40 trained nurses, and about 400 families in the programme – we have calculated the cost of enrolling a mother into VoorZorg is about 13,000 euros over a period of two and a half years. More pertinently, from the point of view of municipalities who have to decide on whether to take up the programme, independent research shows a 20% payoff, when you factor in the money which the municipalities would otherwise have to spend on dealing with a greater incidence of problems such as child abuse. Apart from being an effective intervention for at-risk mothers and infants, therefore, it saves public money in the medium term.

*You are also testing an additional component for VoorZorg, on early stimulation. What is the background to this?*

When we initially adapted the NFP, there were some modules we opted not bring over because the additional training for the nurses would have been expensive and there was some overlap with existing services in the

Dutch context. We already had a way of helping parents to interact with babies up to about 9 months, by using videos, but we were missing a good component of the programme to stimulate parent–child relationships from the age of 9 months up to the end of the *VoorZorg* programme, at age 2 years.

With the financial support of the Bernard van Leer Foundation we are now testing that module, which is based on an existing Dutch programme called *Instapje*, which has been well researched and shown to be effective. We developed a manual with worksheets for the nurses to use in the home visits, to give parents some ideas about the types of play they could be engaging in, what the child will learn from that play and why it is important. There are suggestions for inventive ways to play, using cheap or everyday household objects such as toilet rolls, stackable plastic cups and ping-pong balls.

The aim of this new component is to help parents observe how their child is developing and adapt their behaviour to the child's, to promote both parent–child attachment and children's cognitive development.

*How are you evaluating the early stimulation component?*

It's a preliminary feasibility study rather than a fully fledged evaluation, so we are asking the nurses to fill in evaluation forms to give us their impressions about whether they think it is working, how they are finding the implementation and whether they are noticing any changes in the behaviour of the parents and the development of the child. Anecdotally, early experiences seem to be positive, but the pilot will continue until the end of the year.

## Parenting for Lifelong Health: from South Africa to other low- and middle-income countries

Catherine L. Ward, Associate Professor, Department of Psychology and Safety and Violence Initiative, University of Cape Town, South Africa, and Christopher Mikton, Technical Officer, Prevention of Violence Team, World Health Organization; Lucie Cluver<sup>1</sup>, Peter Cooper<sup>2</sup>, Frances Gardner<sup>3</sup>, Judy Hutchings<sup>4</sup>, Jamie McLaren Lachman<sup>5</sup>, Lynne Murray<sup>6</sup>, Mark Tomlinson<sup>7</sup> and Inge M. Wessels<sup>8</sup>



Training of paraprofessionals (community health workers) to deliver the programmes is a key component of Parenting for Lifelong Health.

Photo • Courtesy Clowns Without Borders South Africa

**At present there are no parenting programmes that are both evidence-based and affordable for low- and middle-income countries, where the need is the greatest. Parenting for Lifelong Health<sup>9</sup> aims to fill this gap. This article sets the context of violence and parenting in low- and middle-income countries, and describes the programmes currently being evaluated in South Africa.**

Although violence against children is a global problem, studies suggest that it is particularly prevalent in low- and middle-income countries (see, for example, Reza *et al.*, 2009; UNICEF, US Centers for Disease Control and Prevention and Muhimbili University of Health and Allied Sciences, 2011; UNICEF, US Centers for Disease Control and Prevention and Kenya National Board of Statistics, 2012).

South Africa, in the upper tier of middle-income countries, is no exception. A nationally representative study in 2009 found that the child homicide rate in South Africa was nearly twice the global average, and nearly half of those homicides were associated with child abuse and neglect (Mathews *et al.*, 2013).

This is not surprising given that poverty – by definition widespread in low- and middle-income countries – is a particular risk for parenting. Not only does it affect parents' ability to provide adequate nutrition and health care, it also affects the processes of parenting. Poor parents are:

- more likely to be depressed, which tends to result in harsher, more inconsistent parenting (Elder *et al.*, 1995)

- less likely to be affectionate towards and to monitor their children, and more likely to use corporal punishment (Bradley *et al.*, 2001)
- less likely to have the social support that assists better-off parents with their parenting (Duncan *et al.*, 1994).

Together, these conditions increase the likelihood of child maltreatment (Hashima and Amato, 1994). Further, these are precisely the forms of parenting that increase the likelihood of child and youth aggression (Essau *et al.*, 2006; Jackson *et al.*, 1998). Youth violence occurs at higher rates in low- and middle-income countries than in high-income ones (Mercy *et al.*, 2002).

To break this cycle of violence, interventions to support parenting in low- and middle-income countries are a priority. There is evidence that positive parenting can buffer the effects of poverty on children (Conger and Ge, 1994). Parenting programmes have been shown to be effective both in improving parenting and in improving children's cognitive and behavioural outcomes (Knerr *et al.*, 2013; Mejia *et al.*, 2012). Certain types of parenting intervention – risk assessments and behavioural interventions in paediatric clinics – have been shown to reduce child maltreatment, and there is promising evidence for the beneficial effects of home visiting and other programmes on child maltreatment (Mikton and Butchart, 2009; Peacock *et al.*, 2013; Selph *et al.*, 2013).

### **Designing and testing programmes**

Unfortunately, although the need for parenting programmes is greatest in low- and middle-income countries, almost all the evidence for their effectiveness comes from high-income countries (Knerr *et al.*, 2013; Mejia *et al.*, 2012). While there is evidence that programmes can transfer from one country to another and retain effectiveness (Gardner *et al.*, forthcoming), this cannot simply be taken for granted.

There are two prime reasons why programmes may not transfer, especially from high- to low- and middle-income settings. First, cultural differences: a host of factors – including, for instance, language, culture,

literacy, poverty, and health and social care delivery systems – may weaken or even cancel out the effects of the programme in the new setting (Mikton, 2012). Second, cost: many evidence-based programmes are proprietary, and are too expensive to roll out at scale in countries where resources are severely limited.

For these reasons, our research group (a collaboration among the World Health Organization's Department of Violence and Injury Prevention and Disability, Stellenbosch University in South Africa, the University of Cape Town in South Africa, Bangor University in Wales, and the Universities of Oxford and Reading in England) has undertaken to test a number of parenting programmes that will be appropriate for low- and middle-income countries. South Africa is serving as the cradle in which these are initially developed.

We are calling this suite of programmes Parenting for Lifelong Health. The idea is that we design programmes on the basis of evidence, test them, train partners to implement them, and then have further independent tests conducted. Our commitment to developing programmes that are suitable for low-resource contexts has several dimensions.

First, we are training paraprofessionals (community health workers) to deliver the programmes, given that there are too few professionals to deliver even clinical services to families in need, let alone carry out preventive work (Barberton, 2006). Second, the materials will be kept low-cost (for instance, the use of printed cartoons to illustrate parenting principles, rather than expensive video vignettes). Third, all the materials will be licensed through the Creative Commons and will be freely available to those interested in using them (and, in addition, prohibiting their use to make a profit).

We acknowledge that the reason why many programmes have become proprietary is at least in part to cover the costs of training and supervising those who implement them, and thus to ensure that the programme is implemented with fidelity. If programmes are not implemented so that they are true to the accompanying

manual and intentions of the programme, they are likely to be ineffective. This of course presents a problem when materials are freely available, and so our fourth commitment is to develop and seek funding for a group of trainers who can support effective implementation around the world.

At present, we are testing four programmes, across three age groups:

#### *0–2 years*

Thus far, two interventions have been developed for the infant and toddler age group and both have been tested in Khayelitsha, an informal peri-urban settlement near Cape Town which is characterised by high levels of economic deprivation.

The *Thula Sana*<sup>10</sup> programme encourages mothers in sensitive, responsive interactions with their infants. Home visits take place twice during pregnancy, and then occur weekly for 8 weeks postpartum, fortnightly for the next 2 months, and then monthly for 2 months, with 16 visits in total.

Mothers in the intervention group were found to be significantly more sensitive and less intrusive, and their infants to be significantly more secure in their attachments to their mothers, than those in the control group (Cooper *et al.*, 2009). Attachment – the bond between mother and child – is an integral part of the process by which children form a prototype for other relationships with peers, partners and their own children (Belsky, 1993; Norton *et al.*, 2012); a poor or violent relationship with a mother becomes a pattern for what the child expects from others and themselves in later relationships. Poor attachment in infancy is thus thought to be one of the pathways by which child maltreatment is transmitted from generation to generation, and one of the mechanisms via which maltreated children may become perpetrators of violence (Belsky, 1993; Norton *et al.*, 2012); there are therefore good reasons to suggest that interventions that improve attachment may prevent both child maltreatment and youth violence.

At present, the children who first received the *Thula Sana* programme are 13 years old, and a follow-up study is currently in the field that will assess, among other things, their aggressive behaviour at this stage of their development. An adapted version of the *Thula Sana* programme is currently being run by the Parent Centre in various locations in Cape Town.

Another intervention for toddlers that may both encourage responsive parenting and provide cognitive stimulation for children has also been tested in a small randomised controlled trial (Cooper *et al.*, 2014). This intervention combined group sessions and individual support in which mothers learned about ‘dialogic’ book sharing (Whitehurst *et al.*, 1988) over 6 weeks. Alongside good parenting, cognitive stimulation has been shown to reduce youth violence (Walker *et al.*, 2011).

Mothers who received the intervention were more sensitive to their infants (both during book sharing and during play), and infants’ language and attention improved. A larger-scale randomised controlled trial has recently been completed, in the same South African peri-urban context, which has confirmed these positive findings (Vally *et al.*, forthcoming). We are currently raising funds and looking for an implementation partner to take this programme further.

#### *2–9 years*

The *Sinovuyo*<sup>11</sup> Caring Families Programme for Young Children covers the 2–9 years age group, and has been tested in a small randomised controlled trial, also in Khayelitsha. The programme covers techniques intended to improve the parent–child relationship (for instance, parents spending dedicated time with their child in child-led play), emotion regulation (such as parents recognising their own and their child’s emotions), and positive behaviour management approaches (such as praising good behaviour and alternatives to harsh discipline).

The initial test found improvements in positive parenting behaviour in the group that received the programme, as compared with a group of parents who



did not receive the programme. It also achieved high attendance rates (75%), high participant satisfaction, and was found to be culturally acceptable and faithfully implemented by the paraprofessional community facilitators. The programme is now being implemented by our partner, Clowns Without Borders South Africa.

#### 10–17 years

Child maltreatment is typically thought of as a problem affecting young children, but in fact there is robust evidence that maltreatment is experienced at high levels by adolescents (Finkelhor *et al.*, 2009; Meinck *et al.*, in press). The *Sinovuyo* Caring Families Programme for Teens covers this age group and has been tested in a pre-pilot in a rural area of the Eastern Cape Province of South Africa, one of the poorest of the country's nine provinces. It is also being implemented by Clowns Without Borders, with support from UNICEF South Africa.

This group-based programme uses social learning and parent management training principles, with group-based parent, adolescent, and joint parent-adolescent sessions. It utilises a collaborative learning approach, with activity-based learning, role-play and home practice (Webster-Stratton, 1998). Sessions include establishing special time for parents and adolescents, specific and immediate praise, dealing with stress and anger, establishing rules and responsibilities and responding to crises. The preliminary test in 2013 found reductions in parents' use of violent and abusive discipline, and in adolescent rule-breaking and aggressive behaviour. Data from this have been used to develop the programme manual further, and a further test is being conducted, with the data expected to be available in late 2014.

#### Future steps

These programmes form the basis for Parenting for Lifelong Health. Future steps include testing each programme in at least two other low- or middle-income countries, and setting up a group that can assist with adaptation and high-fidelity implementation in other countries. We hope to have the programmes ready for wide-scale roll-out by 2020 – that is, by then we hope

they will have a strong evidence base and be widely available to all low- and middle-income countries.

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#### Notes

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- 9 More information on Parenting for Lifelong Health is available on the World Health Organization website at:  
[http://www.who.int/violence\\_injury\\_prevention/violence/child/plh/en/](http://www.who.int/violence_injury_prevention/violence/child/plh/en/)
- 10 'Thula Sana' means 'hush little baby' in isiXhosa, the primary indigenous African language in the Eastern and Western Cape Provinces.
- 11 'Sinovuyo' is an isiXhosa word meaning 'We have happiness' or 'We have joy'.

# Building the evidence on violence prevention against children in low- and middle-income countries

Sara Bensaude De Castro Freire, Programme Manager, and Sarah Sommer, Communications Officer, Network of European Foundations, Brussels, Belgium

**The Children and Violence Evaluation Challenge Fund is currently funding rigorous evaluations of programmes to prevent violence against children in low- and middle-income countries. These include responsive parenting programmes. With results expected in 2015–2016, this article describes the Fund's progress so far and future plans.**

In the past decade, various reports have highlighted the need for better data and research on what works in preventing violence against children in low- and middle-income countries.<sup>1</sup> Recognising this, in 2011 a group of foundations came together within the Network of European Foundations (NEF) to set up a pooled fund with the aim of filling the knowledge gap.<sup>2</sup>

The Children and Violence Evaluation Challenge Fund set out to inform and improve violence prevention and child protection programming and policies in low- and middle-income countries, in three ways:

- by generating more rigorous evidence through robust evaluations
- by enhancing the capacity of organisations working in the field to appreciate, commission and appropriately use such evaluations
- by disseminating the evidence generated to relevant stakeholders.

Funds are allocated through a competitive process of open calls for proposals. Eligible organisations submit a concept paper of their evaluation proposals, which is reviewed by an ad hoc proposal assessment team made up of global and regional experts in child protection, violence prevention and evaluation. Shortlisted applicants are then invited to follow up with a full evaluation proposal for the second phase, again reviewed by the assessment team, whose recommendations lead to the decision on the grantees.

Since the establishment of the Fund, there have been two calls for proposals, in 2011 and 2012. Both had broad scope, including physical, emotional and/or sexual violence, and young as well as older children. The first addressed reducing risks in family settings,

while the second focused on prevention. Three types of interventions were considered: large, small and innovative, and components of broader interventions that have an indirect impact on violence prevention although they are not directly designed to do so.

In total, the fund currently supports 17 evaluation projects, with varied geographical scope, areas of focus and evaluation methodology. They cover countries across three continents: Burkina Faso, Burundi, Ethiopia, Kenya, Tanzania, Uganda and South Africa; China, Indonesia, India and Jordan; and Mexico, the Dominican Republic and Ecuador.

Six of the interventions currently being evaluated specifically look at parenting programmes (see box). The others consist mainly of community-based child protection mechanisms, life skills-building programmes, home visiting approaches or interventions addressing the wider determinants of violence. The grantees include local and international NGOs and universities. The evaluation methodologies vary from randomised controlled trials through quasi-experimental designs to mixed methods.

## Strengthening evaluation capacity

As noted above, one of the Fund's objectives is to develop a culture of learning by strengthening the capacity of organisations working in violence prevention to work in partnership with research teams. It became clear during the first call for proposals that most local NGO applicants had limited evaluation capacity and often were not in a position to identify good evaluators. This was reflected in a success rate of only 2% for local NGOs, compared to 40% in the case of foreign universities.

This was partly addressed in the first call for proposals by offering six local NGOs which were not already affiliated to universities or research institutes a small cash grant (up to 5000 euros) to help them get professional assistance in developing a full evaluation proposal. Three of the six were eventually selected to receive funding for their evaluation project. Nonetheless, the process of finding external experts

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## Parenting programmes under evaluation

### *Families First Home Visiting Programme – Indonesia*

Implemented by: Save the Children Switzerland

Evaluated by: McGill University and Centre de Santé et des Services Sociaux de la Montagne; University of Indonesia, Center on Child Protection

Expected completion: November 2016

Through home visits by specially trained community health volunteers, this programme aims to prevent violence at home and the unnecessary institutionalisation of children.

### *The Faithful House – Tanzania*

Implemented by: Selian Aids Control Programme

Evaluated by: Savannas Forever

Expected completion: July 2015

The Faithful House is a 5-day, faith-based skills-building curriculum to strengthen families affected by HIV, through building communication and conflict resolution skills. It uses faith values as an entry point for addressing attitudes towards gender roles and domestic violence.

### *Junconi – Ecuador and Mexico*

Implemented by: Fundación Junto con los Niños

Evaluated by: Baylor College of Medicine

Expected completion: December 2016

Through weekly home visits that focus on parent–child attachment strategies, the programme aims to reduce family violence and the incidence of children being forced into living on the streets.

### *International Child Development Programme – Colombia*

Implemented by: International Child Development

Programme (ICDP) Colombia

Evaluated by: University of Oslo and University College London

Expected completion: August 2015

This psychosocial early childhood development programme aims to reduce the risk of harsh discipline by improving parenting skills and parent–child relationships.

### *Universal parenting education to prevent violence against children in families – China*

Implemented by: Department of Education in Fuxin, Teachers Training Institute of Fuxin

Evaluated by: Peking University, Health Science Center

Expected completion: November 2014

Based on self-administered manuals, this intervention aims to improve parenting knowledge and skills on non-violent discipline and promoting children’s development.

### *Violence Against Children in Schools and Families – Albania*

Implemented by: Save the Children, Albania Country Office and Regional Educational Authorities

Evaluated by: Maria Antonia Di Maio and Migena Buka (independent consultants)

Completed: July 2012 (dissemination strategy currently under consideration)

This programme aims to reduce the use of physical and psychological violence against children as disciplinary methods in families, schools and communities, by improving parenting and teaching skills and empowering children to recognise and report cases of abuse.

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proved to be more difficult than expected. There was a clear need for reflection on this aspect of the programme, as the difficulty faced by local researchers in accessing academic peer support posed a clear issue of equity.

In the second call for proposals, it was made a requirement for local implementers to apply in

partnership with expert evaluators. Capacity strengthening was addressed more systematically as the fund matched selected applicants with mentors. Five applicants were offered the possibility to choose from two or three mentors, who were then asked to guide the applicants in developing the full evaluation proposal and, if selected, throughout the implementation of the evaluation project.



**One of the Evaluation Challenge Fund's objectives is to develop a culture of learning by strengthening the capacity of organisations working in violence prevention to work in partnership with research teams.** Photo • Jon Spaul/ Bernard van Leer Foundation

### Dissemination and future activities

Most of the evaluation findings are expected to be available towards the end of 2015 and 2016, when the Fund will implement a systematic dissemination and communication strategy. It is a critical element of the programme to ensure that the results of the evaluations are made available to relevant practitioners and policymakers, and eventually translated into improved programmes and policies.

The Fund is currently reflecting on this knowledge transfer component. A quality review system will ensure reliability of findings, and an evidence brief will be developed for each evaluation project – a short document, presenting the context of the project and the

main findings in an accessible format and language. The Fund's current website<sup>3</sup> is also being restructured to facilitate accessibility and networking.

With the backing of its contributing foundations, the fund is currently planning for its second programme period with a further open call for proposals. This is planned to be more targeted, based on a gap analysis which looks at the existing evidence in the field and the work of other stakeholders to identify current momentum and opportunities. It is envisaged that this will identify a list of about three strategic sub-themes on which there is a particular need to increase the possibility of drawing conclusions or recommendations around what works.

Other future activities are under consideration to further develop capacity strengthening, such as regional and thematic workshops to bring together NGOs, research teams and potentially also other stakeholders, and a toolkit of practical guidelines to provide information on what to take into account when undertaking impact evaluations.

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### Notes

- These include the 2002 WHO *World Report on Violence and Health* (Krug *et al.*, 2002), the 2006 United Nations Study on Violence against Children (Pinheiro, 2006), and the 2013 *Annual Report of the Special Representative of the Secretary-General on Violence against Children* (United Nations, 2013).
- The three initial funders were the Bernard van Leer Foundation, Oak Foundation and UBS Optimus Foundation. They were joined by a fourth funder, Wellspring Advisors, in early 2013.
- Information about the Children and Violence Evaluation Challenge Fund is available on its website: <http://www.evaluationchallenge.org/>

# MAMA: use of mobile messaging to promote responsive parenting

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**The growing penetration of mobile technology in low- and middle-income countries makes it possible to raise awareness of responsive parenting practices by sending timely messages to new and expectant mothers. This article describes how the Mobile Alliance for Maternal Action (MAMA) is using mobiles to reach parents in South Africa and Bangladesh.**

MAMA is an innovative public-private partnership involving the US Agency for International Development, Johnson & Johnson, mHealth Alliance, the United Nations Foundation and the leading pregnancy and parenting website BabyCenter.com. MAMA's country programmes in Bangladesh and South Africa currently reach over 600,000 women and families with messages synchronised with a woman's stage of pregnancy or the age of her child. The messages are either free, thanks to subsidy, or at a cost affordable to users. Messages continue up to a child's first birthday, and the Bangladesh programme is in the process of extending this through the child's fifth birthday.

The messages provide information, offer support, dispel myths, highlight warning signs and connect pregnant women and new mothers with local health services. They encourage responsive parenting – that is, positive parent-child interactions and attachment – and positive discipline rather than harsh punishment. They increase parental awareness of child development, so parents can use appropriate parenting practices for their child's development level. As described below, they also address individual and family-level risk factors for child maltreatment.

Systemic violence against women and children presents large challenges in both South Africa and Bangladesh. South Africa has been described as having the highest prevalence of violence in the world (Norman *et al.*, 2010). Mothers experience extremely high rates of violence and mental health problems, and it is estimated that 50% of South Africa's children will be abused before reaching the age of 18 (Krever, 2014, online). In Bangladesh, almost two-thirds of women will experience gender-

based violence during their lifetime (MDG Achievement Fund, 2014, online).

Meanwhile, in both countries, mobile phone penetration is high and growing. More South Africans use a mobile phone than watch television or listen to the radio; there are already more mobile subscriptions than there are people, by a ratio of 131 to 100 (World Bank, 2012). While Bangladesh is not yet at this level, the mobile is still a readily available tool to reach many Bangladeshis – 63 out of every 100 people have access to mobile subscriptions (World Bank, 2012, online).

MAMA South Africa (MAMA SA) uses four mobile channels to reach women in a range of income groups through mobile phone technologies that they already use and are comfortable with. These are: a free SMS (text message) program offered through six inner-city clinics in Hillbrow, Johannesburg; a dynamic community portal at askmama.mobi; a USSD-based interactive quiz service; and a portal on Mxit – a popular mobile social network in South Africa.

The MAMA Bangladesh program is called *Aponjon* (meaning 'the close/dear one' in Bangla). *Aponjon* delivers information to subscribers twice weekly via SMS or interactive voice response (IVR). The voice messages are either dramatic mini-skits with local actors playing the roles of a doctor, pregnant woman, mother and mother-in-law, or a more direct narration. *Aponjon* also offers a counselling line to subscribers as a direct channel to communicate with a doctor.

## Responsive parenting messages

Through these services, MAMA country programmes encourage parental responsiveness – 'parenting that is prompt, contingent on the child's behaviour and appropriate to a child's needs and developmental state' (Bornstein and Tamis-LeMonda, 1989). Responsiveness is often theorised as a three-step process – observation, interpretation and action (Engle and Ricciuti, 1995). The MAMA messages address all three steps. They encourage the mother or caregiver to observe the child's cues, help the caregiver to interpret these signals correctly, and

encourage appropriate and timely action to meet the child's needs. For example:

*Take some time every day to watch your baby breathing. If it is rapid and shallow, he may be ill and need treatment at the clinic.*

The MAMA messages facilitate positive parent-child interactions and attachment: touching, talking, caring for and playing with children. As such, they promote the child's psychosocial (social, emotional, mental and physical) development, which is reliant on love, physical and verbal stimulation and play. For example:

*Play peek-a-boo with your baby today. He'll love it. He's learning how an object might still be there even if it disappears.*

*Your baby loves the sound of your voice. Talk and sing to him every day. Make eye contact and smile. He will smile back!*

In addition, the MAMA messages focus heavily on exclusive breastfeeding for the first 6 months and complementary breastfeeding through 2 years. Breastfeeding is a component of early psychosocial development as it usually occurs in a process where a child is 'held, stroked and emotionally nurtured' (Woodward and Liberty, 2005, online). Breastfeeding supports a baby's secure attachment, playing an important role in facilitating 'emotional exchanges between mother and child that contribute to the child's sense of being heard' (Epstein, 1993). This research also suggests that nursing contributes to maternal development as mothers gain experience in reading cues and interpreting feedback from children, demonstrated by this MAMA message:

*A well-fed baby will have a full belly and a sleepy smile!*

The MAMA messages provide parents with age- and stage-based advice, tips, and information, so they know what to expect and how to react appropriately. Butchart's definitions of positive strategies of discipline versus punishment highlight the problems that occur when parents have inappropriate developmental expectations of their children, which can influence how they choose to discipline them (Butchart *et al.*, 2006). The MAMA messages enhance awareness of child development and appropriate parenting practices for a child's development

level:

*Does your child do the same thing, repeatedly? This is because his memory isn't very good yet. Try to be patient, this is a phase!*

The messages also encourage positive disciplinary strategies rather than punishment. Positive strategies of discipline involve helping children develop judgement, boundaries, self-control and positive social conduct. In contrast, punishment consists of physical or emotional measures reflecting the caregiver's anger or desperation (Kağıtçıbaşı *et al.*, 2001; Aracena *et al.*, 2009; Oveisi *et al.*, 2010). Such punishment involves power and dominance and is frequently inappropriate for the child's developmental stage (Butchart, 2006). The MAMA messages provide parents with guidance on positive discipline strategies:

*Does your child hit? Don't hit him back. Make eye contact and firmly tell him that he hurt you and made you sad.*

and on positive social conduct:

*Praise your child's good behaviour, instead of punishing bad behaviour. This is a better way to teach your child rules and discipline.*

#### **Addressing family risk factors**

Finally, the MAMA messages address individual and family-level parent-related risk factors for child maltreatment, such as postnatal depression (Gilbert *et al.*, 2009):

*Are you feeling sad all the time? Talk to your health worker about this. Ask your family to help you eat well and get plenty of rest.*

difficulty bonding with a new baby (Djeddah *et al.*, 2000):

*Being a mother can be hard sometimes. Why not try talking to your mother or an elder? Don't be scared to ask for help.*

and substance abuse:

*Drinking alcohol can reduce the amount of breast milk your baby takes. Occasional, light drinking is ok. But don't drink heavily.*

Intimate partner violence is a very strong family-level risk factor for child maltreatment, as children easily get caught in the emotional and physical crossfire. The MAMA messages support positive behaviour between partners:

*Having a baby will change your relationship with your partner.*



**The MAMA messages facilitate positive parent-child interactions and attachment: touching, talking, caring for and playing with children.**  
 Photo • Courtesy Mobile Alliance for Maternal Action (MAMA)

*You can stay close by making some time for each other every day, and suggest that while disagreements are normal, having them when the child is not around is preferable:*

*Every relationship has good parts and bad parts. It's normal for you and your partner to argue, everybody does it! Try not to argue in front of your child though. He won't understand, and it could scare him. Try to go to another room, or wait until your child is asleep, before sharing your frustrations with each other.*

Another related family-level risk factor that MAMA addresses is the adherence to traditional gender roles, particularly definitions of masculinity around dominance and lack of involvement in caregiving. The messages encourage women to involve their male partners in childcare:

*Your partner may feel left out. Suggest he gives the baby his baths. That will help them both bond. It'll also be fun!*

The country programmes also address country-specific risks and opportunities. In Bangladesh, there is a specific set of messages for fathers, based on a pilot and research which found that inclusion of household decision makers such as husbands and mothers-in-law allows for better household practices in terms of nutrition, antenatal care visits, preparation for delivery and other types of care important for pregnant women. Dnet, the social enterprise which implements MAMA's *Aponjon* service, found that when husbands see the value in *Aponjon*, they are more inclined to grant their wives access to their phones (less than 60% of women had their own phones). Husbands showed a higher willingness to pay for the service than the women themselves, which is relevant considering that 97% of the phone bills are paid by the husband.



In South Africa, the dynamic features of MAMA's mobisite inspire Q&A sessions, storytelling and self-guided learning on a variety of topics central to maternal, newborn and child health. The mobisite is widely accessible due to the high penetration of feature phones (mid-level phones that can access the internet), as well as the low cost of data compared to SMS. The site targets both women and men. There is a 'Good Dad Guide' and articles that feature advice for men on responsive parenting and supporting a partner through pregnancy, birth and childrearing. The content also focuses on topics such as HIV-positive parenting, postpartum depression and domestic violence.

#### Evidence of effectiveness

In Bangladesh, the first three periodic phone surveys carried out by Dnet in 2012 and 2013 revealed that significantly higher percentages of *Aponjon* subscribers reported adoption of healthy behaviours compared with national averages captured in the 2011 Bangladesh Demographics and Health Survey (BDHS) (National Institute of Population Research and Training, Mitra and Associates and ICF International, 2013). The phone survey findings are validated by findings from Dnet's more robust annual household survey of *Aponjon*, called the Sample Survey.

As there were no baseline data on knowledge, attitudes, behaviour and practice levels prior to the service, and since the BDHS is recent and covers many maternal, newborn and child health-related practices relevant to *Aponjon*, programme managers found the BDHS to be a cost-effective comparator for the phone survey findings.

**Table 1 *Aponjon* Phone Survey 2012**

	<b><i>Aponjon</i> subscribers</b>	<b>National average (BDHS data)</b>
Attended four ante-natal care visits	63%	32%
Had a facility-based birth	45%	29%
Exclusively breastfed	83%	64%

The Phone Survey also revealed that nearly three-quarters of women and household members reported that they had the ability to take action to improve the health of the mother or baby as a result of the MAMA messages.

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is currently conducting a mixed-methods outcome evaluation of *Aponjon*/MAMA Bangladesh using a quasi-experimental design with a targeted sample of 2080 people to examine the effects of *Aponjon* on outcome-level indicators (knowledge, attitude, behaviour, service uptake).

In South Africa, qualitative feedback during user testing revealed that most users felt the service provided new knowledge on how to care for their child, such as when to introduce solid foods, how to monitor developmental milestones, and when to vaccinate.

MAMA SA, led by the Wits Reproductive Health and HIV Institute, is about to commence a scientific randomised controlled study to examine effects of the SMS service on women living with HIV. This study will assess the health impact of the messaging, particularly around prevention of mother-to-child transmission of HIV.

#### Achieving scale

Strong relationships with both governments and mobile network operators (MNOs) are necessary for 'mHealth' programmes such as MAMA's to achieve scale. MNOs offer sizeable customer bases, strong subscriber billing relationships, robust marketing capabilities and extensive distribution networks (Burchell and Smith, 2014, online). In terms of government buy-in, as UNICEF put it (2011):

*National policies serve as the necessary framework for an enabling environment where service delivery can be effective, where families and communities can genuinely care for children in early years.*

MAMA SA has a strong partnership with South Africa's biggest network operator, Vodacom. Vodacom hosts the MAMA mobisite on its operator platform, *Vodafone Live!*. Vodacom also provides 25 million customers with

zero-rated access to the MAMA content and supports 6000 women by sponsoring their MAMA SMS messages. *Aponjon* has integrated with five operators with market coverage of 98.8%, and is in talks with the sixth.

The Bangladeshi Government has been involved with *Aponjon* since the pilot phase. The Ministry of Health and Family Welfare is the official government partner of *Aponjon* and takes ownership of the initiative through an advisory board of representatives from relevant government agencies. Another important public sector contribution comes from the Bangladesh Telecommunications Regulatory Commission (BTRC), which coordinates with telecommunications operators on *Aponjon*'s behalf. BTRC approved the *Aponjon* counselling line and provides *Aponjon* with access to and help in managing shortcodes (special, short telephone numbers that can be used to address SMS and MMS messages from certain service providers' mobile phones or land lines).

MAMA SA is currently in the process of collaborating with the South African Department of Health to launch a national pregnancy registry. The registration process will adapt technology originally developed and tested for the MAMA SA programme. This registry will greatly improve the accuracy of maternal and child health statistics in South Africa as well as supporting improved quality of care.

MAMA is also set to launch a new country programme in India in 2014. It aims to continue putting responsive parenting information in caregivers' hands, empowering them to become ambassadors of responsive parenting in their real-world communities, and tackling violence against children – one well-loved and well-cared for baby at a time.

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## Jamaica's National Parenting Support Policy: origins and early implementation

Maureen Samms-Vaughan, Professor of Child Health, Child Development and Behaviour, University of the West Indies, and Chairman of the Early Childhood Commission, Jamaica; and Rebecca Tortello, parenting consultant, Jamaica



The vision of the National Parent Support Policy states that it is Jamaica's first attempt at codifying a broad national understanding of parenting issues and at stating its commitments to strengthen and improve support services nationally.

Photo • Peter de Ruiter/Bernard van Leer Foundation

**Government policy decisions often build on prior activities or actions by non-governmental stakeholders, including academia, civil society, and non-governmental organisations. The passage of Jamaica's National Parenting Support Policy in October 2012 is a case in point. This article reports on the background to the development of the policy, and early policy implementation.**

The earliest published description of Jamaican family life was Edith Clarke's *My Mother Who Fathered Me* in 1957. This detailed ethnographic study provided statistics on family structure and tremendous detail on parenting practices.

Nonetheless, at the newly independent Jamaica's fledgling University of the West Indies (UWI), studies on

the family between 1962 and 1980 focused primarily on family structure and kinship relationships, with little attention to parenting, as is evident from a review of the literature on child development during this period (Semaj, 1984).

Two factors would shift academic study to parenting practices, particularly to parenting the young child. First, the prevalence of malnutrition, and specifically kwashiorkor and marasmus, led to intensive study of malnourished children by researchers at the Tropical Medicine Research Unit at the UWI. Initially the focus was very medical and biochemical in nature. However, the noticeably impaired mental development of affected children led to efforts to improve children's development by influencing parenting practices, specifically stimulation. Preventive efforts would lead to parenting

intervention programmes to ensure stimulation of children who were not malnourished (Grantham-McGregor *et al.*, 1975), and would herald numerous publications in this area, which continue until today.

Simultaneously, in the 1960s to 1970s, the emerging early childhood movement, centred at the UWI, focused its early efforts on improving the quality of stimulation at preschools for children aged 3–6 years by providing training programmes for practitioners who had no formal training. In the late 1970s to early 1980s, concern about childrearing primarily for children aged 0–3 years led those in the early childhood movement to study parenting practices for this younger age group (Grant *et al.*, 1983).

Between the 1980s and 2000, there were many publications on childrearing practices in Jamaica (Evans, 1989; Leo-Rhynie, 1997; Brown and Chevannes, 1998). Earlier studies tended to focus almost exclusively on parents of lower socio-economic groups and often used a deficit lens, suggesting that primarily parents living in poverty needed intervention, and that among this group there were few parenting strengths to be identified. Later studies began to identify cultural and family strengths across classes as a basis for interventions to change ineffective practices. Among the parenting challenges identified were limited parent–child interaction, limited father involvement, inadequate resources to provide stimulation in the home and gender differences in expectations for boys and girls.

#### **Longitudinal studies**

Large-scale epidemiological longitudinal studies would add a new dimension to the information on parenting. The Jamaican Perinatal Mortality and Morbidity Study (1986) on the pattern of the British Birth Cohort Study of 1958, enrolled some 10,000 children and families, or 94% of those born in the 2-month period September to October 1986 (Ashley *et al.*, 1988). A large subset of these children, approximately 1700, who were living in the most urban areas of Kingston and St Andrew, were evaluated at 11–12 years and 15–16 years.

Among the main objectives of the study was the determination of factors impacting children's development and behaviour, with parenting structure and function among the factors considered important for study. Between the contacts at 11–12 and 15–16 years old, another epidemiological study of children's development, the Profiles Project, was conducted, but this time the sample was a national one of 500 children aged 5–6 (Samms-Vaughan, 2005), who were seen again at 9 years old. The methodology of these studies, using population-based samples, ensured that families of all socio-economic backgrounds and types were included. In 2004, the inclusion of a parenting module in the annual national household survey, the Jamaican Survey of Living Conditions, also provided national data on parenting. However, full information from this survey was not published until 2009 (Ricketts and Anderson, 2009).

The longitudinal studies (Samms-Vaughan, 2001, 2004) identified the changes in children's family structure as they grew. Only 55% were born within a married or common-law union. By the age of 6 years, only two-thirds of children had their biological parents as the main parenting figures and by 11–12 years, a half of parental unions had ended and marriages had increased somewhat from 18% to 26%. When parental unions ended, mothers largely continued their parenting role (82% and 86%), but for the small proportion who did not, the maternal mother-figure was typically a grandmother or another relative. When biological fathers were absent (65% and 70%) there was often no father-figure (11%) or multiple father-figures as the mother's partners changed. Migration of mothers (28% and 33%) and fathers (21% and 27%) was the main reason for parental separation from children. Physical separation was often accompanied by emotional separation, as 17% of mothers and 25% of fathers who were separated from their children did not maintain contact when children were 11–12 years old.

Parenting impacted children's outcomes in many ways. Parental stress was measured among parents of 6 year olds and was one of four factors that affected child

outcomes; the others were poverty, parental education and the quality of the home learning environment. At 11–12 years, children who lived in poverty who had the highest cognitive and academic outcomes were those whose biological parents were in stable relationships, who had their biological parents as main parenting figures and whose parenting figures had higher education and were aged between 40 and 49 years. Parental involvement, church attendance and participation in extra-curricular activities were other protective factors associated with improved school performance. The absence of the biological parents from the home and multiple mother-figures were associated with greater behaviour problems in children.

The main parenting recommendations were the need for parenting education and parental stress to become national priorities, because of their multiple impacts on children.

#### **Early state initiatives**

In 1991, the Minister of Education invited parenting groups to a meeting that aimed to strengthen the Ministry's efforts to improve parenting through Parent-Teacher Associations. With initial support from the Ministry and UNICEF, the Coalition for Better Parenting became an umbrella non-governmental organisation of parenting groups and a resource centre for parenting materials. When funding from UNICEF ceased in 2001, the coalition had limited resources to continue a wide range of activities, but has continued to exist as an organisation supporting parenting.

The Early Childhood Commission (ECC) was established by the Government of Jamaica in November 2003, in response to a strategic review of Jamaica's Early Childhood Sector. This review identified a number of activities taking place in the early childhood sector, but these were poorly coordinated. As a result, the establishment of a single entity for early childhood development (ECD) was recommended. The ECC's remit is to advance ECD through a number of legislated functions, including advising the Minister of Education on policy; facilitating, coordinating, and monitoring

and evaluating ECD plans and programmes; regulating early childhood centres; conducting research; and public education. The ECC is governed by a multi-sectoral Board of Commissioners representing government agencies and ministries and professionals trained in various aspects of ECD (education, health, nutrition). ECC activities are implemented through an operational arm.

The ECC Board, recognising the importance of parenting to ECD, took a series of actions to ensure that parenting was a central aspect of its activities. In mid-2004, a recommendation was made to the Minister of Education that a professional representing a parenting organisation be appointed to the Board and, by early 2005, a parenting policy to guide national parenting activities was recommended to the Minister of Education by the ECC.

Two important decisions were taken with regard to the parenting policy. First, it was decided that the policy would provide the support and guidance that all parents needed, and not be confined to parents at risk. Second, the policy would focus on parent education and support and would not be punitive. This led to the deliberate inclusion of the word 'support' in the name: the 'National Parenting Support Policy'. It was felt that the Child Care and Protection Act (2004) already contained sanctions for inappropriate parental acts of commission (such as harsh punishment) or omission (such as negligence). Additionally, a national parenting policy could not be limited only to the early childhood years, as parenting continued to the age of 18 years and, some would argue, beyond this. The ECC therefore sought and received permission from the Minister of Education to undertake policy development for the childhood years from birth to 18.

The Board also recommended that the ECC be structured to support and promote parenting activities. A Parenting and Community Intervention Sub-Committee was established in December 2005. This was, at the time, the only regular meeting of professionals engaged in parenting programmes. Additionally, the position of Community Intervention Co-ordinator at the ECC was



**Despite the challenges, Jamaica remains one of the few countries to have developed a national parent support policy.**  
 Photo • Peter de Ruiter/Bernard van Leer Foundation

expanded to become the Parenting and Community Intervention Co-ordinator. Research activities in parenting were also initiated to inform decisions on parenting; these included development of a parenting strategy (2005), mapping of existing parenting programmes across the country, and an audit of parenting education material (2006).

The Government of Jamaica's guidelines on policy development require multiple consultations, as the original concept paper progresses through various stages and revisions. The lengthy process culminated in the passage of the National Parent Support Policy in the Jamaican Parliament in October 2012, with strong bipartisan support.

#### **Current policy and strategy**

The vision of the National Parent Support Policy is:

*All parents in Jamaica – whether by virtue of having given birth, adopting or serving as guardians – recognize, accept and discharge their duty to ensure that the rights of children are always upheld, the best interests of children are always promoted, and their children are always loved and provided with opportunities and resources to achieve their full potential and ultimate fulfilment, within safe, caring and nurturing environments.*

(Government of Jamaica, 2012)

The policy's five goals are:

- 1 All Jamaicans make wise choices about becoming parents and make parenting a priority.

- 2 All Jamaican children are loved, nurtured and protected instinctively and unconditionally by their parents.
- 3 Each parent understands and applies positive practices in effective parenting.
- 4 An enabling institutional framework exists to support parenting.
- 5 The principles and implications of effective parenting are communicated to the public in user-friendly ways that enable comprehension of the material.

The policy document states that it is Jamaica's first attempt at codifying a broad national understanding of parenting issues and at stating its commitments to strengthen and improve support services nationally. It also states that it lays the foundation for future activities and provides guidelines to sectors and agencies for moving forward in the development of annual operational plans. Policy objectives include defining and communicating a common framework for effective parenting and parenting practices (outlined in a user-friendly Parenting Charter); identifying, mobilising and coordinating national stakeholders and resources for promoting and supporting effective parenting; providing a platform for advocacy; laying the foundation for a National Plan of Action on Parenting Support; defining a coordinated legal framework; and increasing the use of effective parenting strategies. The extensive research on parenting, mostly from local researchers, provides the background to policy development.

At the same time, the ECC developed Jamaica's first National Strategic Plan (NSP) for ECD 2008–2013 through a consultative process (Early Childhood Commission, 2008). The NSP had seven strategic objectives, placed in life cycle sequence. As such, parenting was the first of the strategic objectives, and activities to achieve this objective aimed to improve the access to and quality of early childhood parent support programmes. This was done through the development of a national parent support strategy and the establishment of parenting standards. As with the parenting policy, though initiated by the ECC, the parenting strategy and

standards were not limited to parents of children under the age of 8 years.

The National Parenting Strategy consists of parenting programmes delivered through Parents' Places. A Parents' Place is a familiar neighbourhood place which welcomes and supports all parents and families to raise their children well. The concept encourages the use of existing buildings in communities to offer variable and flexible services, rather than expending limited resources on new buildings. These buildings could be located at or linked to a wide range of public or private services, such as health clinics, schools, libraries, social service agencies or churches. There are three types of Parents' Places:

- Level I** makes information available to parents.
- Level II** also offers parenting support training programmes by trained facilitators.
- Level III** also has the facility for specialist referral services.

Six parenting programme standards were identified. These addressed the physical environment, programme design (content and duration), programme administration, human resources, programme materials and programme monitoring and evaluation. Existing parenting programmes were encouraged to apply to become Parents' Places.

#### **Implementation challenges**

Policy development must be supported by a plan for policy implementation. As the ECC could not be responsible for implementation of the policy for all age groups, the establishment of a National Parenting Support Commission (NPSC), constituted similarly to the ECC, was recommended. The NPSC's Board of Commissioners includes representatives from key ministries, the private sector, the faith-based community, the newly established National PTA of Jamaica, and NGOs. The NPSC is also legally empowered to advise the Minister on parenting matters; coordinate, monitor and evaluate existing parenting programmes; and promote the creation of new programmes to meet identified needs. The NPSC is currently establishing

Parents' Places in primary schools across the country, while the ECC is establishing Parents' Places in the early childhood sector.

Implementation of the Parents' Places strategy has been challenging, due to human resource limitations; many communities, while able to identify a physical location, have been unable to identify trained parenting facilitators functioning in a voluntary capacity and do not have the resources to pay such professionals. As a result, Parents' Places have been most successful where there are government institutions with established staff, such as schools.

Despite these challenges, Jamaica remains one of the few countries to have developed a national parent support policy. The drivers of policy development were the existence of a body of local research identifying the need for parenting support, and an institutional anchor that was supportive of policy development (ECC). Together, these also promoted policy implementation, particularly through the establishment of an institution designated to this function (NPSC). Implementation of the parenting policy is still in its early stages and will need to be evaluated over the next few years.

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## Investing in the development of young children

The Bernard van Leer Foundation funds and shares knowledge about work in early childhood development. The Foundation was established in 1949 and is based in the Netherlands. Our income is derived from the sale of Royal Packaging Industries van Leer N.V., bequeathed to the Foundation by Dutch industrialist and philanthropist Bernard van Leer (1883 to 1958).

Our mission is to improve opportunities for children up to age 8 who are growing up in socially and economically difficult circumstances. We see this both as a valuable end in itself and as a long-term means of promoting more cohesive, considerate and creative societies with equal opportunities and rights for all. We work primarily by supporting programmes implemented by local partners. These include public, private and community-based organisations. Working through partnerships is intended to build local capacity, promote innovation and flexibility, and help to ensure that the work we fund is culturally and contextually appropriate.

We also aim to leverage our impact by working with influential allies to advocate for young children. Our free publications share lessons we have learned from our own grantmaking activities and feature agenda-setting contributions from outside experts. Through our publications and advocacy, we aim to inform and influence policy and practice not only in the countries where we operate but globally.

In our current strategic plan, we are pursuing three programme goals: reducing violence in young children's lives, taking quality early education to scale, and improving young children's physical environments. We are pursuing these goals in eight countries – Peru, India, the Netherlands, Israel, Uganda, Turkey, Brazil and Tanzania – as well as undertaking a regional approach within the European Union.



**Bernard  
van Leer**  
FOUNDATION