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WHO guidelines on parenting interventions to prevent maltreatment and enhance parent–child relationships with children aged 0–17 years: Report of the reviews for the WHO-INTEGRATE framework

Gardner, F.; Shenderovich, Y.; McCoy, A.; Schafer, M.; Martin, M.; Janowski, R.; Varadan, S.; Backhaus, S.; Barlow, J.; Ward, C.

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WHO guidelines on parenting interventions to prevent maltreatment and enhance parent–child relationships with children aged 0–17 years: Report of the reviews for the WHO-INTEGRATE framework

Frances Gardner, Yulia Shenderovich, Amalee McCoy, Moa Schafer, Mackenzie Martin, Roselinde Janowski, Sheila Varadan, Sophia Backhaus, Jane Barlow, & Catherine Ward, Universities of Oxford, Cardiff and Cape Town

Centre for Evidence-Based Intervention
Department of Social Policy and Intervention
University of Oxford

26th January 2023

Contact information:
Frances Gardner, DPhil
Professor of Child and Family Psychology
Department of Social Policy and Intervention
32 Wellington Square,
Oxford, OX1 2ER, United Kingdom

E-mail: frances.gardner@spi.ox.ac.uk

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Introduction

This set of reviews addresses questions about the societal implications of parenting interventions, based on the WHO-INTEGRATE evidence to decision framework (Rehfuess et al., 2019). This evidence, will inform the WHO Guideline on Parenting Programmes to Prevent Child Maltreatment and Promote Positive Development in Children aged 0-17 Years. It will allow the Guideline Group to contextualise the main evidence of effectiveness from the systematic reviews, in the light of broader questions about acceptability, balance of benefit and harms, feasibility, and societal, economic, equity and human rights implications of parenting interventions. We use a combination of approaches to review the evidence including systematic, mixed-methods, qualitative, and narrative reviews of quantitative and qualitative primary studies, human rights based-analysis, and overviews of existing reviews.

The question areas suggested by WHO are as follows

1. Balance of health benefits and harms
2. What feasibility and system considerations must be addressed?
3. What financial and economic considerations must be taken into account?
4. What societal implications should be considered?
5. Health equity, equality and non-discrimination
6. Human rights and socio-cultural acceptability

Due the substantial material on human rights, we have separated the rights chapter from socio-cultural acceptability to make two chapters.

Table 1 overleaf summarises the sources of evidence that are used in these reviews

Reference

Rehfuess, E. A., Stratil, J. M., Scheel, I. B., Portela, A., Norris, S. L., & Baltussen, R. (2019). The WHO-INTEGRATE evidence to decision framework version 1.0: integrating WHO norms and values and a complexity perspective. *BMJ Global Health*, *4*(Suppl 1), e000844.

Table 1: Evidence sources for INTEGRATE reviews

Short title to be used in Evidence to Decision (EtD) tables	Description of type of study of parenting interventions	Child age group	N of studies	Notes
LMIC effectiveness review	SR of RCTs in LMICs	2-17 years	131	SR = systematic review
Global effectiveness review	SR of RCTs in HICs & LMICs	2-10 years	278	HIC = high-income country
LMIC adolescent effectiveness review	SR of RCTs in LMICs for parents of adolescents	10-17 years	30	LMIC = low & middle income country
LMIC humanitarian effectiveness review	SR of RCTs in LMICs for families in humanitarian settings	2-17 years	18	RCT= randomised controlled trial
'Jeong ECD review'	SR of RCTs in LMICs conducted for WHO Guideline on Nurturing Care / ECD	0-3 years	YY	ECD- early child development
LMIC ECD effectiveness review	SR update of Jeong review, to include maltreatment outcomes (no meta-analysis)	0-2	45?	
Qualitative review of perceptions	Review of qualitative primary studies & qualitative reviews of the perceptions of parents, delivery staff and other stakeholders in HICs and LMICs	0-17 years	217 primary studies; 8 reviews	Used to derives data on perceptions of harm, intrusion, socio-cultural acceptability, societal impact, feasibility.
LMIC review of intervention moderators	Review of within-trial moderator studies in LMICs	2-17 years	8 studies	
Review of economic studies	Review based on searches for i) reviews of cost, cost effectiveness, cost benefit; ii) economic studies associated with the 131 trials in LMIC effectiveness review	0-17 years	8 reviews --- 7 primary LMIC studies	
EGM review of effectiveness reviews	Review for EGM, 2020	0-17 years	76 reviews	EGM = evidence gap map
Human rights review	Review of human rights aspects, based on a combination of searches for studies & programs, any methodological approach (e.g. legal analyses, 'think-pieces', qualitative studies)	0-17 years	17	
Implementation review	Review of implementation aspects, based on a combination of searches (e.g. implementation, fidelity, scaling, participant engagement, leadership, oversight).	0-17 years	N/A	Search terms related to parenting programs and scale legislation, sustain, dissemination, leadership, barrier oversight, facilitator

WHO-INTEGRATE Chapter 1: The Balance of Benefits and Harms

WHO questions:

- Which adverse health effects are associated with parenting interventions, including potentially increased intimate partner conflict or violence, reduced safeguarding of children, increased stigmatisation of parents?
- Which broader positive or negative health-related impacts, such as impact on other diseases (e.g. maternal mental health, youth-to-youth violence) and spill-over effects beyond beneficiaries, are associated with parenting programmes?

Introduction

There is extensive research evidence demonstrating the benefits of parenting interventions in terms of outcomes for both parents and children, with studies showing positive effects, such as increases in positive parenting and decreases in harsh parenting (Barlow et al., 2010; Furlong et al., 2012). The research also shows that parenting interventions have the potential to have positive impacts on child outcomes in both the short and the long term including emotional and behavioural adjustment, and cognitive development (Jeong et al., 2021; Leijten et al., 2019). While these findings are very encouraging in terms of their contribution to the scale-up and dissemination of parenting interventions, it is also important to consider potential adverse effects. The aim of this chapter is, therefore, to examine the balance between health benefits and harms associated with parenting interventions. More specifically, this chapter seeks to address the questions outlined above:

Since the broader health-related impacts associated with parenting interventions (Question 2 above) are discussed in Chapter 4 (Equity), and Chapter 6 (Socio-cultural acceptability) the majority of this chapter will focus on the adverse health effects associated with parenting interventions, examples of which could include increases in intimate partner violence or conflict, or increases in stress or stigmatization of parents (Question 1 above).

Overview of current knowledge and definitions of harms

The benefits of parenting interventions in relation to a broad range of outcomes (including intimate partner violence, and parent and child mental health) are covered by the main systematic reviews for this Guideline, and the focus of this section is as such primarily on harms, and on evidence which seeks to inform the consideration of the balance of benefits and harms. There are, however, a number of different classifications of harms. For example, some researchers distinguish between 'adverse effects' with a likely and plausible causal relation to the intervention versus 'adverse events' that might occur in the context of an intervention but are unlikely to be caused by the intervention itself (Peryer, Golder, Junqueira, Vohra, & Loke, 2021). They can also be classified in terms of whether they are systematically or not systematically assessed in a trial. The former of these two approaches will be considered first.

In addition, two broad types of harm assessment have been identified in the literature (Mayo-Wilson et al. 2019; Lorenc & Oliver, 2014). First, harms can be systematically assessed in an intervention trial,

either as recognised potential harms or as unintended adverse effects in relation to the intended outcomes. These are also termed 'negative', 'iatrogenic' and 'harmful' effects. An example of an unexpected harm is provided by a trial of a group-based youth intervention that aimed to reduce a range of adolescent risky behaviours, but in which researchers found an unintended increase in substance use (Dishion et al., 1999). The researchers went on to elucidate the mechanisms of harm through the conduct of mediation analyses, thereby contributing to a shift in both understanding about and the evaluation of youth interventions. In the parenting field, recognised potential harms appear rarely to be explicitly assessed and reported (Leijten et al, 2018), and neither is it common for unintended harms to be reported and further investigated. For example, a Cochrane review of parenting interventions that explicitly sought to synthesize adverse outcomes on partner conflict or family burden, found no such data reported (Furlong et al., 2012).

The second type of harm assessment is where unintended effects are not systematically measured but are reported in response to open-ended questions – for example, in a process evaluation of a parenting intervention, where a parent reports that they experienced increased conflict with their partner, related to disagreements about parenting practices. Such effects may also be assessed routinely via trial adverse event reporting.

Although the authors' prior knowledge and their searches for the WHO Evidence Gap Map suggest that relatively few harms are reported in the parenting field (Leijten et al., 2018), either as part of qualitative or quantitative studies, it is of course vital to test this systematically. Thus this chapter reports the results of an evaluation of the literature using multiple methods to determine if this is the case, and to consider the extent to which limited reporting might represent a failure to report or detect harms, or a lack of harmful effects, as well as taking into account the balance of benefit and harm. Accordingly, this chapter aims to systematically examine the existing literature to date, with a particular focus on LMICs, to provide an overview of the evidence regarding the harms associated with parenting interventions.

Methods

We used a range of approaches to search for and identify the reporting of harms in qualitative or quantitative primary studies or syntheses. The search terms that were used, and a summary of the overall methods, are outlined below:

Search terms used for harms:

When conducting searches in databases and within study full texts, we used the following 'harm-related' terms: Harm OR Benefit OR Adverse Events OR adverse effects OR Iatrogenic OR Unintended Consequences OR Paradoxical Effects OR Unexpected OR Paradox OR Negative effect OR Unintentionally OR Anticipate OR Exception OR Deteriorate.

Methods for approach 1 (systematic review, LMICs, quantitative)

Outcomes in the direction of harm as detected in our systematic review of trials of parenting interventions in LMICs

- At trial aggregate level: We examined meta-analytic data from 131 randomized trials in the main LMIC systematic review, for evidence of harms on any of the wider, secondary outcomes assessed. We drew on findings from qualitative studies to suggest adverse outcomes that might potentially result from parenting interventions, including partner conflict, parental stress or an undermining of confidence.

- At individual trial level: Using the 131 randomized trials in our main LMIC systematic review, we inspected the forest plots for all key outcomes to catalogue adverse effects within individual trials, and planned to follow up on moderate effect sizes found in the adverse direction, examining where possible how these were reported and interpreted in the trial papers.
- We supplemented inspection of individual trial outcome data with searches for harm-related terms within the full texts of the included trial papers, and recorded how many papers report harms or related terms for adverse or unintended effects.

Methods for approach 2 (review of reviews, global, quantitative)
Overview of harms reported in recent systematic reviews of parenting interventions
We searched the full texts of the 100+ systematic reviews of parenting interventions in our Evidence Gap Map (created for WHO in July 2020) for 'harm-related' terms, and extracted data and discussion points relevant to any kinds of adverse or unwanted effects. When reviews highlighted specific individual studies that had demonstrated iatrogenic or adverse effects, these were then further examined. Few of these reviews had a focus on LMICs, thus this section covers mostly studies from HICs.

Methods for approach 3 (qualitative, primary studies)
Qualitative synthesis of harms perceived by participants in parenting programmes in primary qualitative studies
We aimed to focus on retrieving and reviewing studies from LMICs, especially given that most prior qualitative reviews have focused primarily on (and retrieved studies from) HICs. We used several strategies to locate relevant qualitative studies. To optimise the search terms across different databases, a combination of truncations and asterisks were used in the search strategy. See Appendix A1 for an example of the search strategy used and details with regard to the inclusion and exclusion criteria.

We searched seven electronic databases and retrieved 217 qualitative studies of parent, child and staff perceptions of parenting programmes globally. We extracted basic data from these studies, including any explicit reference to harms. Eighteen of the 217 studies were conducted in LMICs, mostly in Latin America, but also Kenya, South Africa, Palestine, Turkey and Thailand. The remainder were conducted primarily in the USA, with many studies also in the UK, Canada, Australia and Sweden. We supplemented these LMIC-focused searches by conducting additional searches for qualitative studies associated with the randomized trials in our main LMIC review, and by consulting experts. Given that we expected data on harms to be limited, we also synthesized relevant data from HIC studies.

Methods for approach 4 (review of reviews, global, qualitative)
Overview of harms as reported by parents in syntheses of qualitative data
We searched for systematic reviews of qualitative studies of parent and staff perceptions of parenting programmes, both within the studies retrieved as part of the searches for primary qualitative studies and using extensive Google Scholar searches. Our searches retrieved eight qualitative reviews, all of which have a primary focus on HICs. We examined these to identify any explicit reference to harms or their absence, and extracted data relevant to harms from the results of these studies.

Quality appraisal tools and synthesis and reporting guidelines for harms
We completed a quality assessment of the 131 trials included in our review using the Cochrane Risk of Bias Assessment (see Gardner et al., 2021, LMIC review for this Guideline). We have, where possible, drawn on guidance from PRISMA Harms to aid in conducting syntheses, and from Bougioukas et al.

(2018) on balanced reporting of harms and benefits in overviews. The sample sizes of the qualitative studies included in this review were also assessed and data saturation considered.

Approach 5: Other harms discussed in the literature
We also review potential harms of parenting interventions discussed in the wider literature that resulted from the searches but that were not explicitly reported in the trials, qualitative studies and systematic reviews that we retrieved.

Results

Quantitative studies of harms

Results for approach 1: Evidence of harms as identified by the systematic review and meta-analysis of randomized controlled trials of parenting interventions in LMICs

Summary of findings
Preliminary data found a very low proportion of trials explicitly reporting any harms or discussing issues about adverse effects. Only 9 out of 120 trials (8%) reported on whether harms or adverse events occurred. Of these nine trials, six reported no adverse effects, and the remaining three discussed possible adverse effects found in terms of secondary outcomes. The next section provides a short summary of the findings of these nine trials that report on the presence or absence of harmful effects.

Five out of the nine above trials reported an absence of adverse effects or harmful effects (Cluver et al., 2018; Foxcroft et al., 2017; Ponguta et al., 2020; Ruiz-Casares et al., unpublished; Villarruel et al., 2008). Miller et al. (2020) reported that there were no serious adverse events during the study; however, the authors did note that there were some adverse events that were not connected with the study (e.g. illness and eviction), which led the researchers to refer participants to medical or social services. There were also two studies that reported a potential harmful effect at post-test. Salari et al. (2018) reported that the children in the study scored higher on worry/oversensitivity and social concern/concentration at post-test. Lachman et al. (2017) found a reduction in frequency of observed positive child behaviour in the parenting intervention group compared to controls at post-test, in a small trial in South Africa. A potential iatrogenic effect was also observed by Lachman et al. (2020) in the economic intervention arm of a study investigating the combined and separate effects of parenting and economic strengthening interventions on reducing violence against children in rural Tanzania. Interestingly, Lachman and colleagues (2020) found an increase in physical abuse and reduced positive parenting reported by children (but not adults) in the villages that had only received the economic strengthening intervention. Thus, while the parent training intervention did not have any iatrogenic effects, the authors suggest that the delivery of an economic strengthening intervention without parent training appeared to have a potentially harmful effect, or seemed to be associated with an increase in child-reported child (Lachman et al., 2020).

The second approach, in which we inspected the forest plots for outcomes in the direction of harm in individual randomized trials in our main LMIC systematic review, proved challenging. There were a few additional examples of significant adverse effects other than those described in the trial reports cited above; however, we found that some of these appeared to be due to there being substantial baseline differences in the outcomes, often in very small trials, where the authors had used a different analytic strategy from that in our meta-analysis (e.g. using change scores). This could explain why authors may

not have perceived or reported there to be any harmful effects. At this point we took advice from experts on meta-analysis and on harms, including Professor GJ Melendez-Torres, our data analyst, and Dr Evan Mayo-Wilson. From these discussions, we concluded that the number of potentially adverse effects is no more than might be expected by chance. Of course, the picture is complicated because we would also expect there to be reporting bias in the direction of under-reporting of harms (Mayo-Wilson et al., 2019; Welsh et al., 2020).

Results for approach 2: Overview of harms as reported in recent systematic reviews of parenting interventions

Summary of findings
While systematic reviews of the effectiveness of parenting programmes do not devote significant attention to discussing harms and adverse or unintended effects, a small proportion of the reviews in our Evidence Gap Map discuss at least one individual study that has reported issues relating to adverse effects. These outcomes and related considerations are summarized below.

Predominantly beneficial findings
In general, most of the studies included in the reviews found beneficial effects with no adverse effects, with only a small minority reporting adverse or unintended outcomes. It is worth noting that while some reviews explicitly mention harmful or adverse effects or report the absence of adverse outcomes, such as a Cochrane review of group-based parenting interventions by Furlong et al. (2012), the majority do not report the presence or absence of adverse effects at all. As an example of beneficial findings, Furlong et al.'s (2012) review included 13 trials, indicating that parent training led to a significant reduction in negative or harsh parenting based on both parent reports and independent assessors. The authors also found a significant improvement in parent mental health and positive parenting skills. Notably, however, some of the secondary outcomes in their review indicated less robust findings and yielded more mixed results (Furlong et al., 2012). Meta-analyses in their review of the secondary outcome of child emotional problems, for example, found a very small, statistically non-significant effect size, with very wide confidence intervals, with the authors commenting that this indicated both a large possible benefit and also a large possible harm. Of note, however, this meta-analysis was only based on two studies, and as such these findings should be interpreted with caution. Both included studies were assessed as having a high risk of bias, and a high level of heterogeneity between studies was identified, warranting further caution in the interpretation of the results.

This absence of harmful effects has also been reported by a number of other reviews in the field. A review by Barlow et al. (2016) on group-based parent training programmes for improving emotional and behavioural adjustment in young children aged 0–3 years, for example, found no evidence of adverse effects in relation to deterioration in any of the key outcomes. Notably, however, in their review, Barlow et al. (2016) make note of a qualitative study associated with one of the trials in their review where participants expressed that they at times found it difficult to adopt new parenting techniques at home (Mockford & Barlow, 2004). In particular, this study found that some parents reported that a change in one parent's parenting technique could increase couple differences in caregiving approaches, thereby resulting in couple conflict (Mockford & Barlow, 2004). The unintended consequences of increased parental tension and parental conflict is discussed further in the results for approach 4.

Reporting and outcome measurements

Another important consideration highlighted by reviews in the parenting literature is the outcome measures and measurement scales used. One example of this is highlighted in a review by Colalillo & Johnston (2016), where the authors discuss the effect of Parent Management Training (PMT) on affective and parenting cognition outcomes. In particular, the authors suggest it is possible that the measures used in some parenting studies may occasionally be too broad to capture more specific or subtle improvement or deterioration. This raises other important methodological questions and implications, which are also noted by Colalillo and Johnston (2016). Indeed, these questions concerning the importance of better measurement of parent outcomes underscore the need not only for improved specificity and sensitivity but also for greater transparency and emphasis surrounding the rationale behind the parent variables measured. This discussion has important implications in relation to both the balance between benefits and harms, as well as the application of this existing evidence in policy and practice.

Qualitative studies of harms

Results for approach 3: Qualitative synthesis of harms perceived by participants in primary qualitative studies

Summary of findings
In common with the other approaches, our full-text word searches revealed that a very low percentage of studies use explicit 'harms' terms, but that a few discuss issues of stigma and unintended consequences such as parental conflict. We focus where possible on data from LMICs, but include studies from HICs to supplement examples of the themes.

Based on the searches we conducted, the unintended consequences and harmful effects identified and discussed by studies have been collated into the following seven themes: *1) parental conflict; 2) family conflict; 3) privacy and distrust; 4) stigma; 5) implementation fidelity and programme interpretation; 6) negativity and stress;* and *7) lack of support and consideration*. These seven themes associated with harms and unintended effects are discussed below, using quotes drawn from the primary studies.

Parental conflict
One particular unintended consequence highlighted by various studies was that of parental conflict. Notably, this seems to be one of the primary iatrogenic effects discussed in the parenting intervention literature. One study in Panama, for example, discussed how, following the parenting intervention, parents expressed that:

> *"[. . .] one day I asked, 'What do I do if you are teaching me something and my husband comes up with a contradictory idea?'" (Participant #1)* (Mejia et al., 2015, p.62)

This unintended consequence was also noted by various other studies. In one study in Ireland, for example, a mother shared the tension she experienced with her partner when trying to share the parenting strategies she was learning:

> *"We had several rows about it … It's hard to teach your partner the techniques you've learned in the class without sounding like you're the 'know-it-all' … But now he sees the difference hugely with the kids and I find now that he's copying everything I'm doing and it's*

> *all happier all round. I got him onside … eventually (laughs)." (Mother of five-year-old boy)* (Furlong & McGilloway, 2012, p.624)

This type of tension arising between couples when one parent attempted to adopt new parenting techniques was also highlighted by parents in other studies:

> *"Their dad is large and in charge... And he will come in here and say, 'Oh how stupid this is' ...any time I build something he wants to tear it down."* (Wolford and Holtrop, 2020, p.454)

An increase in conflict between partners or ex-partners because of the introduction of new parenting skills in the home was also found in a study by Furlong & McGilloway (2012), where almost half of the parents (11/25) who participated in the programme reported an increase in parental conflict due to the introduction of new parenting strategies. While many participants expressed that these conflicts were resolved as the programme progressed, an increase in parental conflict following an intervention due to differences in parenting techniques is a concern that has been highlighted by multiple studies in the parenting field.

Interestingly, the majority (20/25) of the parents in the study by Furlong & McGilloway (2012) expressed that they would have preferred their partner to have attended the intervention; however, most were unable to do so due to child-care and work commitments. Participants in this study also highlighted that even when partners were not resistant to the intervention, they sometimes unintentionally caused confusion for the children when not implementing the new parenting techniques (Furlong & McGilloway, 2012):

> *"He often bulldozes through my system of rewards and consequences. He doesn't mean to, but it's annoying."* (Furlong & McGilloway, 2012 p.624)

This highlights broader issues that have been raised in relation to the importance of engaging fathers in parenting programmes, and is a topic that is elaborated later in more detail, in the discussion.

Family conflict and escalated difficulties

Another potential harm that was noted in various studies was that of increased familial tension following the programme and a deterioration of family difficulties. For instance, attendance at a parenting programme sometimes triggered child-rearing conflict with other family members and relatives:

> *"My mother told my son, 'If your mother spanks you, tell her that I am going to spank her!' I tell my mother, 'Don't tell him that because that is wrong.' That is why he will not respect me."* (Calzada, Basil, & Fernandez, 2013, p.367*)*

Conversely, however, a number of studies found contrasting findings, whereby attending a parenting programme improved couple and family relations, and enhanced family relations and communication:

> *"The whole process, it was definitely a family type of thing, Ron and I were taking this course, but we'd always discuss it with the kids and told them what we did this week and the kids loved it, like I think. . . they really liked the attention, they really liked the fact that we were wanting to work to make family communication better."* (Levac et al., 2008, p.86)

> *“I think I became calmer when managing conflicts. Not only with my daughter but also with the remaining family members” (M10)* (Ramos et al., 2019, p.292)

> *"The number of conflicts in my family has diminished. There is now more affection being expressed, and everyone is a lot more relaxed and happier."* (Coleman & Collins, 1997, p.273)

In light of these contrasting findings regarding family relations, it is important to bear in mind differences that may exist in relation to the type and quantity of family content incorporated in parenting programmes. For example, some programmes may specifically include sessions and content on interparental communication and problem-solving (Ireland, Sanders & Markie-Dadds, 2003). Consequently, these types of programmes may help improve not only child–parent relationships but also broader family communication and relationships.

It is also worth noting that differences in family outcomes may also arise depending on whether one or both parents of two-parent households attend the intervention. Indeed, as highlighted in the previous section, this focus on promoting the engagement of fathers in parenting programmes is a growing area of research (Hayward et al., 2020).

While much less common, some families also noted an increase in behavioural difficulties following the programme, with behavioural difficulties and parent–child relations appearing to have worsened:

> *"They [problems] exploded. There was a lot of resentment because the children were forced into the program. . . major yelling, screaming, and more runaways."* (Coleman & Collins, 1997, p.274)

As discussed in more detail under the section ‘Readiness for change’, this deterioration of behaviour likely reflects a lack of compatibility between the type of support needed by the particular family and the difficulties they were facing, rather than the programme itself, and highlights the need for appropriate treatment and prevention options in relation to the type and extent of difficulties a family experiences.

Privacy and exposure

Another unintended consequence highlighted by various studies concerned issues of privacy and mistrust experienced by participants. Indeed, intrusion of privacy was highlighted in some studies in instances in which parents and caregivers lived in the same region:

> *“I didn’t like that talking about personal stuff … It was too confidential … Everyone knows everyone here.” (Mother of five-year-old boy)* (Furlong & McGilloway, 2012, p.625)

This type of concern about the exposure of problems experienced by participating parents was also noted by facilitators in some studies:

> *“Obviously, they just want to fix [adolescent’s presenting problem], but they don’t want people to know that there are even issues.” [Facilitator] (HSS #11)* (Finan et al., 2020, p.717)

While these concerns do not indicate iatrogenic effects as such, they highlight broader issues surrounding the importance of ensuring that parents feel safe when attending parenting programmes,

and potential barriers that may prevent parents from attending or continuing to attend a parenting programme in the first place – a topic that is further discussed under the theme of 'Stigma' below.

Stigma

Another concern highlighted by various studies was that associated with the stigma of attending a parenting programme. The implications of attending a parenting programme was a concern raised by participants in multiple studies:

> *"The stigma of a program coming into your home is, like, indicative of you needing some type of help. You know, people have pride, and, um, you know, they want to be respected."* (Happy Family Center transcript, p.13 in Glasgow, 2014, p.132)

> *"I don't need to go to a parenting program. It sort of implies that I'm doing something wrong or I'm a bad parent." (Parent #3)* (Finan et al., 2020, p.717)

Conversely, however, other studies found that participation in the intervention actually helped relieve and reduce stigma. One parent, for example, explained the impact that the intervention had had on her life, and the role of the programme in relieving the stigma she felt, while legitimizing some of the grief and challenges she had faced:

> *"It means a lot to me. I have realised, it is not until now that I have realised that I have the right to be angry, I have the right to cry, I have the right to feel sorry for myself." (IP3)*
> (Shanks & Weitz, 2020, p.356)

These contrasting findings point to broader considerations in the field relating, for example, to the type of terminology used to ensure that interventions empower families, rather than perpetuate harmful stereotypes and stigmatization surrounding challenges in parenting. One example that highlights the importance of adopting appropriate terminology to avoid stigmatization is the previously named 'Troubled Families' programme in the UK which has been newly renamed 'Supporting Families' (Ministry of Housing, Communities & Local Government, 2021).

Implementation fidelity and programme interpretation

Other unintended consequences noted in the literature arise when participants misinterpret the content of a programme. While implementation fidelity is examined in more depth in Chapter 2, mixed views and interpretation of programme content can sometimes lead to harmful and unintended consequences. For instance, one study by Mejia et al. (2015) found that participants reported mixed interpretations in relation to the use of physical punishment following the programme. While some caregivers reported that the intervention reinforced using physical punishment, others expressed the view that they had learned to use communication strategies instead of spanking (Mejia et al., 2015). Consider, for example, the extracts below which are experiences of mothers who participated in the same parenting group and were part of the same low-income community in Panama:

> *"They taught us to correct the children and, if necessary, spank them because nothing will happen to them." (Participant #2)* (Mejia et al., 2015, p.679)

> *"However, they also taught us to not spank them immediately but instead try to figure out what is happening." (Participant #7)* (Mejia et al., 2015, p.679)

The differences in the above interpretations and experiences indicate how differently programme information may be interpreted by participants, and how this may sometimes lead to unintended outcomes.

Negativity and stress

Another unintended consequence noted in some of the studies included feelings of stress and frustration following participation in the programme. Some studies discussed how these feelings emerged due to the obstacles some parents faced in relation to attending the programme, while others arose due to needs or expectations not being met. Some participants, for example, expressed feeling frustrated and downhearted after attending the programme:

> *"I felt really cranky after those sessions. It took a lot of effort to get to the place, to get the kids up … People were sitting around moaning and crying, talking all around the place, and I was getting no tips or advice about how to deal with my child … They were looking down on you, like they were looking at you if you said that you'd slap him sometimes because he was so bold." (Mother of four-year-old boy)* (Furlong & McGilloway, 2012, p.625)

Some parents also expressed that they felt that participation in the parenting programme increased their levels of stress rather than helped reduce it:

> *"I found it very inflexible in terms of the time that we saw her [the clinician]. It was a real problem and this is why we had to stop in the end because we were finding it difficult to continue with the meetings because of work schedules (...) I know that you could say well this is your child and you should give, but … at the end of the day if we lost our jobs because we were going to this, would that be beneficial to the children in the long run?" (Gloria 7:22–23)* (Attride-Stirling et al., 2004, p.355)

The above participants dropped out of the parenting programme due to the heightened stress they experienced and the obstacles they faced in terms of attending the programme (Attride-Stirling et al., 2004). Notably, this raises questions regarding barriers associated with attending parenting programmes, and equity effects which may arise when participants who face particular disadvantages drop out of programmes while others remain. This issue surrounding the barriers related to attending a parenting programme was also raised in another study where a single mother dropped out of the study due to the financial stressors she faced as a result of attending the group:

> *"I just didn't have the money to get petrol"* (Friars and Mellor, 2009, p.32)

Another concern raised by a few parents was related to how the parenting intervention brought up difficult emotions related to their own upbringing. A few mothers (2/20) in Furlong & McGilloway (2012, p.623), for example, reported becoming upset by the intervention because learning positive parenting strategies drew attention to their own abusive and non-loving upbringing, making them feel sad and angry and leading to their seeking counselling to address their unresolved childhood difficulties.

Lack of support and consideration

While not an iatrogenic effect as such, concerns regarding the brevity of some parenting programmes was an issue raised by some participants. This echoed concerns expressed by parents who did not feel listened to during the interventions:

> *"I disliked the shortness of it. We're quite dysfunctional. In order to get a [better] habit established, we needed long-term."* (Coleman & Collins, 1997, p.268)

> *"We are not machines; we are people. [Worker] had established an excellent rapport, she was trusted, she was effective, and when they (italics added) thought she was done, she was pulled out without consultation by the family and someone was put in her place, again without consultation. Not any consideration to the workability of the dynamic. These are intimate, profoundly personal issues.., if I don't like them, I don't want them in my family... I want to accept help, but I'm not simply a case; I'm a human being . . . . It's really detrimental to take out someone who is working so well with a family.., if [worker] had stayed six months, [child] would never have been in [placement] for a year and it would have saved [the Department] thousands of dollars!"* (Coleman & Collins, 1997, p.268)

In addition to concerns regarding brevity, some studies highlighted participants' experience of loss of support after the end of the parenting programme:

> *"At the end of the 9 weeks, I wasn't ready for it to be over."* (Owens et al., 2007, p.188)

Some participants also highlighted a lack of consideration for single mothers attending the programme and how this in some instances increased the feelings of isolation experienced by this group of mothers:

> *"A lot of them had husbands, and I think maybe [that's] why I felt left out was because I was sort of the only one who was on my own, and that made me feel sort of isolated because they were sort of talking about their partners and the sort of things they would do to try and help." (Mother of a six-year-old boy with co-morbid ADHD and ODD)* (Friars & Mellor, 2009, p.32)

Another issue related to lack of support and inclusion in the programme was the exclusion of fathers and the barriers that appeared to prevent many fathers from participating. One participant, for example, highlighted this concern very clearly:

> *"There's nothing there for the dads. It was during the day … my husband works. It is only the mothers who turn up to these groups, not the dads, and they suffer just as much as the mums. They have gone out to work all day and then they come home to the mums going 'rah, rah, rah' and the kids going absolutely spastic and everything." (Mother of a seven-year-old girl with co-morbid ADHD and ODD)* (Friars & Mellor, 2009, p.32)

Results for approach 4: Overview of harms as reported by parents in syntheses of qualitative data

Summary of findings

Similar to the other approaches, our full-text word searches revealed that few reviews use explicit 'harms' terms, but that a few discuss issues surrounding suitability, or unsuitability, of certain interventions for families experiencing particular difficulties, or concerns associated with increases in family tension and parental conflict following programme participation. In summary, the harms or

unintended effects discussed in these studies can be summarized in two additional main themes (over and above those identified in primary studies in approach 3), namely: cumulative disadvantage and readiness for change.

Cumulative disadvantage

One unintended consequence noted in some studies was that of cumulative disadvantage. Vella et al. (2015), for example, noted that following participation in the Solihull Approach parenting group, parents with advantaged baseline characteristics described further improvement, while parents with disadvantaged baseline characteristics tended to describe further deterioration. Notably, the two parents who reported a deterioration at follow-up were the only parents who had a child who scored in the abnormal difficulty range on the Strengths and Difficulties Questionnaire (SDQ) (Vella et al., 2015). This deterioration was thus attributed to the fact that the more serious behaviour problems experienced by these participants were beyond the remit of the universal version of the parenting group. Indeed, these two participants expressed that they felt the group was insufficient for the level of difficulties they were experiencing, which highlights the importance of matching parenting programme to participant level of need.

These findings underscore the importance of considering the suitability of some intervention formats in relation to the levels of difficulties experienced by a family. Indeed, in some cases, families that face particular challenges may require more intense or more individually oriented support than others. It should be noted, however, that some of the findings of these small qualitative (e.g. Vella et al. 2015) do not concur with multiple, much larger quantitative studies of moderators (see Chapter 4, Equity), which generally find few differences in outcomes by socio-economic status (Leijten et al, 2015) and repeatedly find that children with higher levels of behaviour problems benefit more, at least from social learning theory-based parenting programmes (Leijten et al., 2019, 2020). For instance, an Individual Participant Data (IPD) meta-analysis of the Incredible Years parenting programme pooled across trials in Europe (Gardner et al. 2019) found that there were no differential effects by social disadvantage (poverty, teenage parenthood, lone parenthood, joblessness or low education) on intervention outcomes. Similarly, findings from a further study (Dishion et al. 2008) on the Family Check-Up (FCU) intervention found that the intervention was especially beneficial for children with more conduct problems at baseline.

Readiness for change

Another concern highlighted by studies in the field is related to the topic of readiness for change among participants. This issue overlaps with the aforementioned concern associated with cases where parenting interventions have led to increases in family or partner conflict, in particular in cases of two-parent households where one partner may not have attended the intervention.

O'Doherty et al. (2014), for example, highlight that readiness for change should be an outcome that is more regularly measured in trials of interventions, which involve survivors of domestic violence, as this may help shed light on the causal mechanisms of a programme that may lead to benefits or potential harms (Howarth et al., 2019). Indeed, increased parental tension and conflict with a partner at home while implementing new skills is an outcome and concern that has been identified by various qualitative studies in the field (Furlong & McGilloway, 2012). We note though, as discussed in approach 4, that several trials have found the opposite, namely, that parenting interventions have led to reduced partner conflict and violence (e.g., Lachman et al., 2021). Overall, our LMIC systematic review showed some weak evidence of benefit across eight trials that reported on partner violence. There was a small-sized

effect, with borderline significance, in reducing partner violence, and substantial variation between studies (*d*=-0.24; 95% CI=-0.50, 0.016; p=0.06; I^2=70%).

An example of a case where differences in readiness for change appears to have led to partner conflict is highlighted in a study by Miller et al. (2020), which examines a Caregiver Support Intervention (CSI). In this study, the authors found a prominent reluctance among the male caregivers to try stress management exercises in the intervention (Miller et al., 2020), in contrast to the female caregivers. While various men in the intervention used the exercises regularly and found them helpful for their parenting and well-being, a majority reported that they wanted to see the evidence behind the stress management techniques before adopting them, and had their own ways of dealing with stress (Miller et al., 2020):

> *"I don't really need the exercises. I can just go out of the house. I pay more attention to myself and my health. I go see a friend." (Male participant)* (Miller et al., 2020, p.7)

> *"Personally, I go for a walk when I'm angry, and I feel better." (Male participant)* (Miller et al., 2020, p.7)

> *"I would have liked more scientific research." (Male participant)* (Miller et al., 2020, p.7)

The female caregivers, on the other hand, expressed that they regularly used the stress management techniques and found them beneficial for their parenting and family relationships (Miller et al., 2020):

> *"The relaxation exercises helped me manage my reaction to things, slowed my thinking and gave me comfort. Comfort to me alone. It gave me emotional and physical comfort at the same time. It was a boost forward for me." (Female participant)* (Miller et al., 2020, p.7)

> *"The counting method and taking the other's perspective helped me with my children and husband. Now I am able to be in control and my husband's behavior also changed. When he used to get angry, he refused to talk about his perspective. But now when I count to 10, I opened the space for him to relax and start talking in a calmer manner." (Female participant)* (Miller et al., 2020, p.7)

As highlighted by these extracts, these differences in readiness for change may lead to differences in outcomes or unintended consequences such as increases in parental tension.

Approach 5: Other harms discussed in the literature

A number of other potential harms of parenting interventions are discussed in the literature, but which did not arise in the trials, qualitative studies, and systematic reviews that we retrieved.

The first is that some practitioners, mainly coming from an attachment theory perspective, have raised the concern that 'time-out', a common component in social learning theory-based parenting programmes, may lead to children being left to manage their own dysregulated state when they need parental input to do so, and potentially more insecure in their relationship with parents. This warrants some discussion, as time-out was included as a component in the interventions in some 40% of trials in our LMIC review, and in 93% of trials in our global parenting components review, which included only social learning theory-based programmes (Leijten et al., 2019). Dadds & Tully (2019) discuss this issue at

length, and attempt to integrate attachment theory and social learning theory perspectives on time-out. They point out that the principles and practice of time-out are designed to reduce child distress and fear, provided they are used as intended – that is, as part of a structured positive parenting programme. This means that, before using time-out, parents will have set out clear expectations for children's behaviour, and learned to enhance positive attention and praise. As a result, time-out is used as part of a calm, brief, planned and predictable approach to discipline. It is also important to note that time-out is recommended to be used sparingly as an alternative to harsh discipline, such as shouting and hitting – parental actions which, in contrast, tend to be unplanned and done in anger or frustration. Dadds & Tully (2019) could find no evidence of harms from time-out; on the contrary, they point to the known beneficial effects of programmes containing a time-out component, from numerous randomized trials.

The second focuses on concerns that come from the critical social policy field, with authors suggesting that when political discourse and decision-making place a strong emphasis on investment in parenting programmes, various negative consequences at societal level may follow – especially when targeting low-income families. Gillies et al. (2017), for example, have argued that parenting interventions stigmatize, blame, and even de-skill, working class parents by placing the onus on parents to change, whilst detracting policymakers from mobilizing other, more important, structural-level, anti-poverty and pro-family measures.

A third concern relates to parent engagement in parenting programmes. To date, parenting programmes have predominantly involved mothers, which researchers note may unintentionally perpetuate harmful gender norms and reinforce a gender divide in family caregiving responsibilities (Panter-Brick et al., 2014). While this is changing, with the field seeing a recent increase in fatherhood parenting programmes and engagement of male caregivers (see e.g. Ashburn et al., 2016; Lachman et al., 2020), in most parenting programmes to date, fathers tend to be markedly under-represented (Panter-Brick et al., 2014). Indeed, some studies have also noted that maternal gatekeeping, in which mothers' restrict or control fathers' involvement in parenting and family tasks (Fagan & Cherson, 2017), is more likely to occur when mothers believe men are not competent or committed fathers (Randles, 2020). Notably, high-quality involvement of fathers in parenting has been found to positively contribute to the well-being and development of children (Flouri & Buchanan, 2004; Stahlschmidt et al., 2013). Accordingly, enhancing fathers' parenting skills may not only help prevent interparental conflict and address harmful gender norms but may also help reduce the occurrence of maternal gatekeeping and encourage greater paternal involvement (Randles, 2020).

Wider impacts

Since the broader positive or negative health-related impacts associated with parenting interventions are examined in Chapter 4 (Equity), and Chapter 6 (Socio-cultural acceptability), the discussion regarding these effects will be limited in this chapter. The preceding findings, however, suggest that adverse health-related spillover effects and impacts are seldom discussed in research studies. Conversely, health-related impacts that are beneficial are much more frequently reported and discussed. This is closely linked to selective outcome reporting and publication bias, where outcomes and studies with significant and favourable results are more likely to be reported or published than those without such findings.

Discussion: Harms and balance of harms and benefits

Summary

This chapter has sought to examine which adverse health effects are related to parenting interventions, such as potentially increases of intimate partner conflict or violence, reductions in safeguarding of children, or increases of stigmatization of parents. Additionally, this chapter has also aimed to consider broader positive or negative health-related impacts of parenting programmes, such as the effect on other diseases and spillover effects beyond beneficiaries. In summary, the results of this chapter suggest that while some studies have noted some adverse effects related to parenting interventions, such as instances of increased conflict between parents or experiences of stigmatization of parents, as a whole the literature to date indicates that the evidence underscoring the benefits and positive outcomes of parenting interventions outweigh the potential harms noted in a few studies. Indeed, it is worth highlighting that the majority of the unintended effects and concerns discussed in the results section of this chapter are a reflection of challenges experienced by some parents in parenting programmes, rather than a reflection of iatrogenic effects or harms that are caused by parenting programmes. What the present review highlights, however, is the need for an increase in the systematic reporting of adverse and unintended effects, as well as an increase in transparency in the reporting of outcome measures – a point that is further elaborated in the discussion section below.

Quality appraisal

In terms of the sample sizes of the qualitative studies included in the review, this varied quite substantially, with the study sample sizes ranging from 3 participants to 822 participants. Overall, approximately 20% of the studies included samples with fewer than 10 participants, with the great majority of studies having between 10 and 30 participants. For the nine trials in the main LMIC systematic review which reported on the absence or presence of harms, approximately 30% of the studies included samples with 40–72 participants, approximately 30% of the studies had samples with around 100 participants, and 40% had samples with around 248–720 participants. In terms of risk of bias, five of the studies were rated as low risk of bias, and four of the studies were rated as high risk of bias. Data saturation was reached, with data analysis being carried out until the point of data saturation, whereby no new themes appeared to be identified from the data (Given, 2008).

Reporting of harms and publication bias

The findings of this review reveal that systematic reviews of the effectiveness of parenting programmes do not provide significant attention to discussing potential harms and adverse or unintended effects. While it appears that qualitative studies devote slightly more attention to both the advantages as well as the disadvantages and challenges (including potential harms) associated with parenting interventions, even in the qualitative literature, there is a lack of systematic reporting of iatrogenic effects. This under-reporting of harms is also closely related to the broader issue of reporting bias in the intervention field, whereby null effects, as well as adverse effects, are less likely to be reported (Harrison & Mayo-Wilson, 2014; Mayo-Wilson et al., 2019). In addition to reporting bias, it is also important to consider the related issue of publication bias, whereby entire studies with non-significant findings or null effects are less likely to be published, which leads to a bias in the evidence available, and consequently may lead to less than optimal decisions made by decision- and policymakers (Ayorinde et al., 2020).

Balancing harms and benefits

The large body of literature highlighting the large number of positive outcomes and beneficial effects associated with parenting interventions provides a strong basis for suggesting that the benefits of parenting interventions outweigh any potential harms that may arise. Of course, the requirement to 'do no harm' is a vital ethical imperative in the field of public health interventions (Bonell et al., 2015, p.95), and the findings of the current review suggest that the potential harms identified need to be addressed

going forward. The critiques raised by Gillies et al., point to the complexity of assessing and understanding potential harms, if they were indeed to operate at a broader system or societal level, whereas researchers in this field are better able to investigate individual level effects. Overall, however, the available research approaches suggest that parenting programmes are likely to be an important prevention and treatment strategy in which potential harms are significantly outweighed by the benefits.

Co-parenting, fatherhood policies and father engagement

The findings of this review also have important implications in relation to supporting fathers. As noted by Randles (2020), responsible fatherhood programmes may have beneficial, indirect effects for co-parenting, parental well-being, and parenting outcomes. This review also highlights the importance of engaging fathers more in parenting programmes, particularly in terms of the finding that parenting programmes can lead to increases in partner conflict due to the introduction of new parenting techniques (Furlong et al., 2012), especially in two-parent families where only one parent attended the programme. We note also that even where harms are reported in qualitative studies, such as through increased partner conflict, these are not necessarily borne out in average effects seen in systematic reviews, where there was a tendency towards beneficial effects in terms of partner conflict/violence across the small number of studies assessing this outcome in our LMIC review.

Conclusions

In conclusion, this chapter has revealed that the parenting intervention literature to date provides little evidence of harms and adverse effects. Notably, the results of this review highlight the need for more systematic reporting and transparent publication practices, particularly in relation to the measurement and reporting of iatrogenic and adverse effects. As the prevention science field and parenting literature move towards approaches that adopt more transparent, reproducible and open research and publication practices (Grant et al., 2020), and the dissemination and scale-up of parenting interventions grow (Ward et al., 2016; Shenderovich et al., 2021), the importance of ensuring that the benefits outweigh any potential adverse effects is vital. The findings of this review suggest that while there is some evidence of adverse effects associated with parenting interventions that need addressing for what is likely to be a small number of parents, these appear to be limited compared to the overall benefits. This is reassuring given the growing implementation of evidence-based parenting programmes as a global strategy for improving child well-being and family outcomes (Ward et al., 2016).

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WHO-INTEGRATE Chapter 2, Feasibility and system considerations

Introduction & WHO-INTEGRATE questions:
There is substantial evidence underpinning the effectiveness of parenting programmes. However, evidence that a programme can achieve its intended parent and child outcomes does not necessarily mean that the programme is easy to translate into practice. This chapter will explore the feasibility of parenting programmes by answering the larger question, 'What feasibility and system considerations must be addressed [for successful implementation]?'. This question will be unpacked by exploring the following sub-questions, posed in the original request for proposals, which we have groups under three themes:

Theme 1: Sustainability and scale-up; governance and institutions, policy barriers and facilitators to delivery of parenting programmes

- How can parenting programmes be scaled up?
- How can parenting programmes be made sustainable?
- What factors are associated with programme replicability and transferability?
- What are the legal barriers or facilitators to the implementation of parenting programmes?
- Might governance aspects, such as past decisions and strategic considerations, positively or negatively impact the implementation of parenting programmes?
- Are formal or informal institutions available to provide effective leadership, oversight and accountability in implementing parenting programmes?

Theme 2: Implementation: human resources for programme delivery; quality of implementation, and factors associated with variation in implementation

- What are best practices to ensure quality implementation of a parenting programme?
- What considerations should be taken into account around the recruitment, training, retention, supervision, transport, and monitoring of parenting programme implementers?
- What factors are associated with quality implementation and implementation fidelity, and how do implementation factors affect the effectiveness of parenting programmes?
- How do parenting programmes interact with the existing system of service providers across sectors? Is it likely to fit well or not, is it likely to impact on it in positive or negative ways?
- How do parenting programmes interact with the need for and usage of the existing workforce and broader human resources (in the health sector and/or other sectors), at national and sub-national levels? Are parenting programmes likely to impact on these in positive or negative ways, for example by affecting the number or distribution of staff, their skills, responsiveness or productivity?

Theme 3: Caregiver and family participation in parenting programmes

- What are the factors increasing parent/key caregiver attendance and engagement in parenting programmes (e.g. transport, child care)?

We will summarize the evidence and provide some answers to these sub-questions by grouping the evidence into three sections: theme 1: scale-up; theme 2: implementation; and theme 3: participant engagement.

Further, this chapter will make important links to other sections of the review, including the chapters on: equity (with respect to participant engagement); social acceptability (in respect to participant engagement); human rights (in respect to confidentiality, family recruitment and participation incentives, legal barriers/facilitators to implementation); and harms (in respect to confidentiality during recruitment and intervention and involving multiple family members.

In summarizing the evidence, we will focus on feasibility issues to consider with in-person interventions but have also included feasibility considerations for remote and hybrid programmes, made especially relevant by the COVID-19 pandemic.

Methods

We have drawn on the following literature. (full searches are described in the Appendix).

Overarching:

- We reviewed all studies based in low- and middle-income countries (LMICs) judged relevant to implementation during the screening process from the new qualitative study searches conducted for this project. In addition, we drew on a number of more topic-specific searches, described below.

Theme 1 (search 1):

- Our first line of searches was based on a search for terms related to scale-up and social interventions conducted by members of our team in 2019. Searches were conducted in Scopus, Google Scholar and the International Bibliography of the Social Sciences (IBSS) databases.
- In addition, we searched for relevant reviews and studies in 2021 on Google Scholar with relevant keywords (parenting programmes and legislation, law, sustain, scale, dissemination, leadership, oversight, barrier, facilitator and review), as well as employing backward and forward citation tracking for key references.
- We also drew on the key documents and reviews with which our team was already familiar, such as the ExpandNET guidance and bibliography on scale-up. Where literature on parenting programmes is scarce, we have also drawn on examples from related fields, such as early childhood education programmes.

Theme 2 (searches 2 and 3):
A number of searches were drawn on to draft this section.

- First, we drew on recent ongoing work on quality and fidelity of delivery by members of our team (Martin, Steele, Lachman, & Gardner, 2021). This search was conducted in 12 electronic bibliographic databases and supplemented by contacting authors, as well as forward and backward citation tracking (see Appendix 2).
- Second, we based our section on facilitator characteristics on a recent rapid search of facilitator characteristics in EMBASE and PsycINFO. This search was the basis for uncovering other key terms not included in the search strategy (e.g. therapist) to fuel new Google Scholar searches. Forward and backward citation tracking was also employed.
- We also used search results from ongoing work (Martin et al., 2021) on approaches to measuring quality of delivery, associations between quality of delivery and outcomes, and on facilitator characteristics and outcomes.

Theme 3 (searches 4, 5 and 6):
In April 2021 we conducted searches for reviews on parenting engagement, and on engagement in digital parenting interventions, on Google Scholar. We searched for terms related to engagement and related to digital interventions (including online, mhealth, ehealth, remote, digital, online and internet):

- Search results in 2021 on engagement in digital parenting interventions from searching "digital + mhealth + online + internet + self lead + web based + remote + parent training + parenting program + parenting intervention + engagement + adherence + compliance + involvement + participation + dropout + retention + attrition + review" in Google Scholar.
- Search results in 2021 from searching "parent training + parenting program + parenting intervention + recruitment + enrolment + attendance + engagement + adherence + compliance + involvement + participation + dropout + drop out + retention + attrition + systematic + review" on Google Scholar.

Given the broad scope of the topics addressed by these sub-questions, it is not possible to systematically review and synthesize the evidence for each question. We draw on systematic reviews and other types of reviews, where relevant reviews are available. We also emphasize findings reported in multiple studies, and provide some reflection on the overall quantity and quality of existing evidence, and findings from LMICs. We also draw on the review team's experience as it relates to the implementation of parenting programmes, and highlight key existing resources.

Theme 1: Sustainability and scale-up; governance and institutions, policy barriers and facilitators to delivery of parenting programmes

Introduction

Scale-up is often defined as "deliberate efforts to increase the impact of health innovations successfully tested…so as to benefit more people and foster the development of sustainable policies and programs" (World Health Organization & ExpandNet, 2009). The term 'scale-up' is sometimes used to refer to the large-scale dissemination of a programme to reach more families and geographical areas. Other terms for reaching more people and areas include programme dissemination, expansion, replication and horizontal scale-up.

Increasingly, scale-up also encompasses embedding programmes in existing service structures to increase the chances of sustained delivery (sustainment) over the long term (Greenhalgh & Papoutsi, 2019). The embedding of programmes in existing health and social systems has also been called vertical scale-up or institutionalization. The latter perspective on scale-up also speaks to the growing emphasis on the complexity of systems within which interventions are delivered (Hawe, Shiell, & Riley, 2009). From this perspective, new interventions are seen as events within complex systems, rather than simply an installation of something new (Moore et al., 2019).

We are not aware of a comprehensive systematic review on factors related to scaling up and sustaining parenting programmes – however, we have identified several relevant qualitative studies, narrative reviews and reflection pieces looking at dissemination and scaling of parenting programmes (Axford et al., 2017; Hutchings, 2012; McLennan, 2010; Sanders et al., 2021; Shenderovich et al., 2021; Skeen and

Tomlinson, 2013; Ward et al., 2016). Furthermore, looking beyond literature specifically on parenting, the ExpandNet set of scale-up guidance documents and literature reviews (World Health Organization & ExpandNet, 2009) provides an overview of relevant considerations for scaling health and social prevention programmes.

In addition, we draw on relevant insights from the scale-up of similar interventions, including qualitative studies, reflection pieces and reviews on scaling early childhood interventions (Aboud & Yousafzai, 2019; Cavallera et al., 2019; Tomlinson, Hunt, & Rotheram-Borus, 2018), systematic (Hodge & Turner, 2016; Wiltsey Stirman et al., 2012a) and narrative (Shelton, Cooper, & Stirman, 2018) reviews on sustained implementation of evidence-based programmes, a review of reviews (Birken et al., 2020) on frameworks used to study sustainment in health-care settings, a systematic review on delivering child and adolescent mental health services in LMICs (Babatunde, van Rensburg, Bhana, & Petersen, 2019), interviews and a systematic review on scaling mental health services (Eaton et al., 2011), a series of case studies on scaling gender-based violence norms change programmes (Goldmann et al., 2019), and a systematic review with reflections, based on examples of scaling health interventions in LMICs (Barker, Reid, & Schall, 2016).

We organize the findings in the literature related to this theme following the categories in Wiltsey Stirman et al. (2012a), as follows:

- The programme itself (programme selection)
- Organizational and external context (organizational factors, leadership, programme champions, community ownership, local and national support, multisectoral collaborations)
- Processes and interactions (monitoring and evaluation; reporting)
- Capacity to sustain (programme funding; replication and transferability).

Findings and recommendations in the literature

Programme selection and set-up

Programme characteristics are identified among the factors influencing programme sustainability in many reviews (Hodge & Turner, 2016; Wiltsey Stirman et al., 2012a). A key principle emphasized in the scale-up literature is 'beginning with the end in mind' (Barker et al., 2016; World Health Organization & ExpandNet, 2009). This principle is stressed, as it is recommended that researchers and practitioners consider the sustainability of a programme from the start to give the programme the best possible chance of long-term impact.

Gottfredson and colleagues (2015) provide guidance on the necessary conditions for programmes to be selected for scale-up, including: a programme should have evidence underpinning its effectiveness; interested partners should assess local readiness for implementation and potential barriers to implementation; and programme manuals and materials for delivery should be available, such as programme manuals, staff training materials and implementation tools. Advice on selecting parenting programmes is also provided in several reports (Hardcastle, Bellis, Hughes, & Sethi, 2015; UNICEF, 2021), similarly emphasizing the importance of identifying programmes with an evidence base which also have sufficient documentation and support for implementation and can fit the local context. An important consideration in selecting which parenting programmes to implement is the age group of children being targeted, since different programmes include content and approaches appropriate for different developmental stages (UNICEF, 2021)

Parenting intervention models can also be classified into universal (engaging with a broad target group to change prevalence of child maltreatment at population level) and targeted or selective (engaging with families most at risk). Parenting programmes can also be used with families that already have issues related to violence against children – for example, cases of child maltreatment – also known as indicated targeting (Hardcastle et al., 2015). An approach knowns as 'proportionate universalism', also used in the nurturing care framework (Sanders et al., 2021; World Health Organization, UNICEF, & World Bank Group, 2018), suggests that a range of responses is needed to address different levels of need in the population, so a programme roll-out can include approaches with different intensity levels.

Many of the aspects of implementing a parenting programme will be influenced by which model of programme targeting and delivery is selected. Parenting programmes may be delivered on their own or in combination with other existing programmes and services. If a programme is delivered within an existing service or package of services, this will, in turn, likely shape staffing and participant recruitment, based on existing systems. For instance, in the context of a research study, Parenting for Lifelong Health (PLH) for Young Children has been delivered within the health-care system in Thailand. That, in turn, influenced various aspects of the programme, such as delivery being carried out by community-based nurses, public health officers and medical social workers who were already respected and trusted in the community. Integration within existing services also carries potential challenges – for instance, in terms of the conflicting demands on programme staff (see Theme 2 for more details on staff experiences).

In selecting the intervention, reviews looking at sustainment of evidence-based interventions have found that it is important to align the selection with organizational priorities (Hodge & Turner, 2016; Wiltsey Stirman et al., 2012b). In the studies included in these reviews, the organizations adopting programmes would often be local or regional non-governmental or public agencies. Similar conclusions have also been drawn in respect to wider system changes (Shelton et al., 2018). Similarly, a study looking at the adoption of parenting programmes by agencies in Canada suggested that fit with mission was seen as important by implementers in the process of programme selection (McLennan, 2010). The importance of fit was also highlighted in interviews with stakeholders and implementers in South Africa in the context of delivery of Parenting for Lifelong Health (Loening-Voysey et al., 2018), and in disadvantaged areas of Ireland where Incredible Years was implemented (Furlong & McGilloway, 2015). Related, several studies and reviews have emphasized the advantage of the programme being adaptable or able to be adapted where needed (Hodge & Turner, 2016; Wiltsey Stirman et al., 2012a).

Organizational factors; leadership and programme champions

The next cluster of factors we consider comprises contextual factors, which include both the inner context of the implementing organizations and the outer context of local and national policies. First, we will consider the inner, organizational context. Parenting interventions are delivered by a variety of organizations, including non-governmental and governmental agencies in the health, education and social care sectors.

Reviews of qualitative studies have revealed that organizations play a critical role in programme delivery and outcomes. In particular, workplace trust, stability, support for new programmes, provision of supervision and peer support, and effective leadership have been identified as supportive organizational factors for sustained delivery of evidence-based innovations (Hodge & Turner, 2016). We will discuss staff support and supervision further in Theme 2 below.

Effective leadership has been defined as "respected, respectful, empowering, creative and able to negotiate and resolve conflict" (Livet, Courser, & Wandersman, 2008). The critical nature of supportive leadership has also been discussed in the ExpandNet guidance on scale-up (World Health Organization, Expand Net, & Management Systems International, 2007) and examples from gender norm (Goldmann et al., 2019), maternal health (Smith, de Graft-Johnson, Zyaee, Ricca, & Fullerton, 2015) and early childhood (Cavallera et al., 2019) programmes. For example, consistent and committed leadership was identified as critical in sustaining delivery of an early years maternal and child health home visiting intervention in South Africa (Tomlinson et al., 2018). Leaders can also enable effective communication about the new programmes. The key figures who advocate for the programme and provide support are often referred to as programme champions, and the presence of one or multiple champions within organizations and communities has been qualitatively linked to programme sustainment in individual studies and reviews (Hodge & Turner, 2016). The creation of a task force or resource team to promote and facilitate wider use of the programme is also recommended (WHO, 2010).

Many parenting programmes use an organizational readiness checklist to guide organizational preparation prior to starting programme delivery. As described in respect to the Incredible Years programme, this process is seen to help evaluate the fit of the intervention with the organization, and to guide the organization through reviewing the necessary financial, human and other resources needed for implementation (Webster-Stratton & McCoy, 2015). In the broader implementation science field, research is ongoing on how organizational readiness can be enhanced, and promising approaches include the strategies listed in this chapter, such as identifying and preparing programme champions, and developing implementation plans (Vax, Farkas, Russinova, & Mueser, 2021).

Cultivating support for delivery nationally and locally; community ownership

We will now consider some of the aspects of the outer context. In addition to communicating about the intervention within the professional and implementing organizations, reviews of qualitative studies also emphasize the importance of engaging community members (Barker et al., 2016; Hodge & Turner, 2016). Community engagement is an essential part of the process of adapting, where needed, and preparing the programme for delivery in a new setting or a new delivery system (Miller et al., 2020). The process should include community leaders, potential families and staff that would be involved in delivery (Suchman et al., 2020). Strong community ties were also identified as critical in sustaining delivery of an early years maternal and child health intervention in South Africa (Tomlinson et al., 2018). We will also come back to community engagement under Theme 3, discussing family engagement in the programme.

Some of the approaches suggested to support community engagement and community ownership of programmes include:

- reaching out to stakeholders and conducting consultations to involve stakeholders in planning and decision-making for programme delivery as early as possible;
- building long-term trusting relationships;
- setting up systems to allow policymakers, communities or providers to choose from a range of options the evidence-based programmes that best suit their context (Scott, 2010);
- providing information about the motivation for the programme (e.g. the importance of violence against children and parenting programmes) and communicating results of programme evaluations; and

- adapting the programme to suit communities better, where needed and consistent with programme evidence (Barker et al., 2016; Hodge & Turner, 2016).

As an example of the importance of communicating about the programme and its benefits to policymakers and stakeholders, in 2015 the Queensland Government funded the state-wide implementation of the full five-level Triple P system, free of charge for all parents of children from birth to age 16, reaching an estimated 400,000 parents (Sofronoff et al., 2018). This funding decision was seen as a result of the state government being convinced by the strength of the evidence on programme outcomes (Sanders et al., 2021).

An additional perspective on organizational motivation to sustain programmes is provided by institutional theory, highlighted by a review of reviews on programme sustainment conducted by Birken and colleagues (2020). This theory argues that organizations sustain programmes in response to the following pressures: mimicking the behaviour of other organizations, meeting expectations from organizations providing critical resources, such as funding, and acting in accordance with professional norms.

In addition to local and organizational support, reviews of literature emphasize the importance of ensuring national stakeholder involvement and political commitment to the programmes (Hodge & Turner, 2016; World Health Organization & ExpandNet, 2009; Hardcastle, 2015). A report commissioned by UNICEF Montenegro has outlined a number of specific steps that could be taken to create an infrastructure for the national support of parenting programmes, such as creating a national committee or task force, developing a national action plan, issuing national guidelines and setting a national parenting strategy (McCoy, 2021). In advancing such steps, technical support could be acquired from a variety of United Nations agencies and international organizations, such as the INSPIRE working group. The Global Partnership to End Violence Against Children provides some support to Pathfinder countries with the implementation of violence prevention.

Examples of countries with national parenting strategies that have served to encourage or fund the implementation of evidence-based parenting programmes include Scotland (UK), previously England (Scott, 2010), Ireland, Malta, Norway, Slovenia, Estonia (World Health Organization, 2019) and South Africa. For example, in South Africa, both government policy and funding allocation highlight the importance of preventing violence against children through parenting interventions (South African Government, Children's Act 2005). In its integrated parenting framework, the Department of Social Development indicates the need to build capacity of service providers to develop parenting skills (DSD, 2013). Nevertheless, there remain gaps between government policy and the capacity for policy application, with a review showing that few parenting programmes implemented in South Africa are based on theoretical components common to evidence-based interventions or that incorporate strategies shown to be scalable (Wessels & Ward, 2015).

The importance of gathering widespread support for programme implementation and scale-up is exemplified by efforts to ratify human rights law. To illustrate, the United Nations Convention on the Rights of the Child (CRC) is a key piece of human rights law that has been ratified by 196 countries. It is believed that ratification of the CRC can help build support for parenting programmes by marshalling attention to the important role parents play in the advancement of child health and well-being. The CRC also obliges ratifying states to provide parenting education and support (see Chapter 5 for more on human rights).

Multisectoral collaborations

Scale-up and sustainability of parenting programmes are considered to require collaboration across sectors (Hardcastle et al., 2015). This is also consistent with the scale-up and sustainment literature that calls for collaborative partnerships (Hodge & Turner, 2016). An example from recent guidance on parenting programmes for adolescents (UNICEF, 2021) describes opportunities for involvement for the fields of health, education, child protection/social development, labour, communications, justice and law enforcement, finance and civil society/non-governmental organizations by providing entry points for the programmes, creating a supportive context and pooling resources. Some barriers to multisectoral collaboration were identified in a study looking at scaling PLH in Montenegro (McCoy 2021). The study found that barriers included difficulties in providing consistent facilitator training and accreditation across sectors, as well as coordinating and sharing responsibilities and information about families across sectors. A qualitative synthesis of studies of parents' and professionals' perceptions (Koerting et al., 2013a) identified other challenges in inter-agency collaboration, such as in referring families to the parenting programmes that suit them and are geographically accessible.

An important role of collaborations in delivering parenting programmes is to create systems for referrals to other services, where needed. In particular, many cases of violence against children are unreported. For example, in a South African cohort only 20% of 10–17-year-olds who had experienced abuse disclosed being abused to someone, and only a fraction of these young people received any support services (Meinck et al., 2017). The interactions between families and facilitators within parenting programmes are likely to lead to cases of disclosure of violence against children and other child protection issues. Programme delivery can be particularly stressful for facilitators when few other services are available and the facilitators are uncertain if families can obtain all the help they need (Wall, Kaiser, Friis-Healy, Ayuku, & Puffer, 2020) (see more on facilitator experiences in Theme 2). Therefore, implementers of parenting programmes need to make use of existing referral strategies, together with relevant government agencies or non-governmental organizations, or design new referral pathways and services, if needed (Child, Naker, Horton, Walakira, & Devries, 2014).

Monitoring and evaluation; reporting and accountability

Next, we consider monitoring and evaluation as one of the key processes supporting programme sustainment. In many cases, it is not feasible or necessary to conduct another outcome evaluation (Goldmann et al., 2019; Gugerty & Karlan, 2018). However, it is recommended as a best practice to continue to monitor the implementation of parenting programmes (Frantz, Stemmler, Hahlweg, Plück, & Heinrichs, 2015; Marryat, Thompson, & Wilson, 2017). The Hodge and Turner (2016) review on sustainment of evidence-based practices in low-resource settings provides several perspectives from individual studies on the benefits of collecting monitoring data and supporting ongoing learning. Monitoring and evaluation can provide opportunities for consultation and communicating with implementation staff and other organizational and community stakeholders, including caregivers and families. Monitoring can also demonstrate if parts of the programme are not being implemented or are not being implemented well (see Theme 2 for more on quality of delivery). A qualitative study of PLH in South Africa suggested that monitoring in and of itself can improve the quality of implementation by bringing staff attention to the quality of programme delivery (Lachman et al., 2016).

Where the parenting programmes are offered or overseen by government bodies, they can be built into existing monitoring systems, if they are available. For example, the Ministry of Education in New Zealand

has provided reporting guidelines for collecting data on programme implementation and impact linked to the Incredible Years programme for implementing organizations (New Zealand Ministry of Education, 2014).

There are a number of indicators that researchers, practitioners and policymakers might choose to monitor. If monitoring is focused only on 'quantity' indicators, such as the number of families reached by a parenting programme, this may mean that the quality of delivery suffers because implementation staff focus on reaching more families, while paying less attention to quality. Relatedly, if funding is conditional on a particular indicator, it may lead to distortions in reporting and even implementation to privilege that indicator. Therefore, if possible, monitoring results should not directly determine the continuation of programme funding, to encourage learning from both mistakes and successes, rather than creating incentives to only report successes.

Mapping a theory of change or key programme assumptions is a helpful way to identify relevant indicators, which can then be monitored. Indicators that could be used by funders include quality training of new facilitators and quality of delivery (see Theme 2). The quality indicators chosen do not need to be monitored among all individuals and organizations involved in implementation; they can be assessed in a sample of parenting sessions or locations (Araujo, Dormal, & Rubio-Codina, 2018).

It is also important to acknowledge that data collection takes time, and it is necessary to plan for it in terms of staff workload and budgets – for example, a study of PLH in Tanzania found that programme facilitators felt they were often short on time to facilitate data collection (Wamoyi et al., forthcoming).

Long-term funding mechanisms

The final area we consider under this theme is the capacity to sustain and replicate the programme. The reviews on scale-up (Hodge & Turner, 2016; Wiltsey Stirman et al., 2012a) emphasize the importance of core funding to ensure successful long-term delivery. Hodge (2016) refers to an example from Hodgins, Crigler, & Simon (2013), suggesting that large-scale programmes should be planned within at least a 10-year time -frame. Although long-term commitments are ideal, they may not be feasible for many governments, and may change with shifting political pressures or changes of government.

Goldmann et al. (2019) give an example of the dangers of expecting immediate outcomes from the scale-up of IMAGE, a programme to reduce intimate partner violence. The authors outline how for one year, in preparation for delivery of the programme, implementers in South Africa were involved in activities such as engaging stakeholders, conducting a feasibility assessment, adapting the curriculum, training staff and designing a monitoring and evaluation system. When preparation was completed, following a change in the donor personnel, the programme funding was withdrawn due to a lack of recognition for this foundational work and the pressure to get the project 'off the ground' quickly and see measurable results (CUSP, 2018; Goldmann et al., 2019). We can also hypothesize that, beyond wasted money and effort, short-term funding without follow-up may be demoralizing and lead to loss of confidence in future programmes. This example illustrates that investing in the development of community support and programme delivery systems requires substantial time, resources and effort. The security of consistent and long-term funding is thus essential. Further, as discussed above, long-term funding is favourable, as short-term funding may create incentives for the selective reporting of positive programme results to ensure the longevity of the programme.

Replication and transferability

An important consideration when scaling up an evidence-based programme is the expansion of programme delivery to new contexts. However, a key concern with such expansion is whether programmes remain culturally relevant so as to maintain family engagement and programme effectiveness (Baumann et al., 2015). A recent systematic review found that parenting programmes may have comparable or even greater effectiveness when implemented in regions and with populations different from where they were developed, with relatively minimal content adaptation (Gardner, 2017; Leijten, Melendez-Torres, Knerr, & Gardner, 2016). Yet not all transported family programmes show effects (Eisner, Nagin, Ribeaud, & Malti, 2012; Fonagy et al., 2018).

The recent ADAPT guidance on adapting social intervention programmes (Moore et al., 2020) provides advice on systematically examining whether programmes need to be adapted for a new context. Furthermore, within the same location as the original evaluation, a change of circumstances over time (for instance, changes in social norms around parenting) may warrant considering programme adaptations.

Even within a similar cultural and policy context, positive programme effects achieved in research trials or other programme pilots are not always replicated (Axford, Berry, Lloyd, Hobbs, & Wyatt, 2020; Nagin & Sampson, 2019). For instance, in several studies, the parenting programmes that had shown positive results in a number of randomized evaluations did not show the same effects when delivered within routine services or at a larger scale, such as Triple P in England and Scotland (Glasgow) (Little et al., 2012; Marryat et al., 2017) and in Switzerland (Malti, Ribeaud, & Eisner, 2011). The reduction in programme effects as interventions are scaled has also been described in respect to early childhood interventions (Araujo, Rubio-Codina, & Schady, 2021). The decrease of programme effects at scale for various types of prevention interventions is sometimes known as the ‘scale-up penalty’ (Welsh, Sullivan, & Olds, 2010).

One of several potential explanations suggested for this difference is the lower quality of implementation than in the context of highly controlled research studies (Little et al., 2012). In routine practice, fewer resources for implementation are often available than in research studies (Welsh et al., 2010). (We discuss issues of implementation quality below. See also Chapter 6 for more information on the acceptability, transferability and cultural adaptation of parenting programmes.) Other potential reasons for why programme results may not replicate, particularly on a large scale, include a wider and perhaps less motivated set of programme participants; a greater share of participants without existing challenges; and different analytical approaches. The considerations of potential bias may also explain some of the variation in reported programme replication results. It is important to learn carefully from cases where null programme effects are identified, and there are a number of steps that can be taken in commissioning and planning evaluations to maximize the learning from any result, as outlined by Axford et al. (2020).

A related issue in the broader field of social interventions is that evaluations conducted without the involvement of the original programme developers often find fewer programme effects (Eisner, Humphreys, Wilson, & Gardner, 2015; Olds, 2009). On the one hand, programme developers and related purveyor organizations are often very well placed to provide technical assistance in programme delivery to ensure high-quality implementation. For instance, the series of case studies on scaling programming on changing gender norms in LMICs points out that the involvement of the organizations and individuals

who had originally developed the programmes can support the quality and the consistency with the original model (Goldmann et al., 2019). At the same time, it is also important to be transparent about any potential conflicts of interest in such cases, particularly in the evaluations of such projects and where financial interests may be involved (Eisner et al., 2015). A potential solution is for developers to provide technical assistance for programme delivery, but not to be involved in the evaluation.

Conclusion

Overall, while there is a lot of variation in the terminology used, and important gaps remain, the existing literature reveals that researchers from a variety of fields highlight many of the same considerations regarding effective programme implementation and scale-up. The literature suggests that implementing and scaling up a parenting programme programme may involve:

- selecting a programme or multiple programmes with an evidence base and implementation resources to implement and adapt them, if needed;
- identifying organizations and structures for sustainable programme delivery, and assessing and supporting readiness for implementation;
- mapping how the parenting programme fits with any other relevant services and systems;
- building national and local support and ensuring sufficient resources for delivery;
- identifying and supporting organizational and community intervention champions;
- linking to existing referral systems for additional support where children are at risk; where systems are not available, designing and implementing such systems; and
- putting in place systems for ongoing programme monitoring, ongoing feedback and learning.

This chapter relies on reviews and primary qualitative studies, as well as commentaries and other published expert reflections, examining scale-up and sustainment. A review of reviews on sustainment found a lack of studies using theories, models and frameworks to causally examine mechanisms of sustainment (Birken et al., 2020). It is also likely that there is interplay between different contextual and intervention factors in terms of the likelihood of sustainment (Wiltsey Stirman et al., 2012a).

The following two themes in this chapter will discuss further recruiting or identifying and training and supporting programme service providers to ensure high-quality delivery, and promoting family engagement in the programmes.

Theme 2: Implementation: quality of implementation and human resources for programme delivery

Introduction

While a substantial amount of research on parenting programmes has focused on family outcomes, it is also increasingly recognized that the quality with which parenting programmes are delivered is important. Quality implementation is commonly understood to include several components, including the extent to which the target population is reached by the programme (reach); the level at which participating families engage in the programme (engagement); and the degree to which the facilitators follow the programme and its principles to a high level of quality (competent adherence) (Berkel, Mauricio, Schoenfelder, & Sandler, 2011; Forgatch, Patterson, & DeGarmo, 2005).

In this theme, we discuss the available evidence and best practices regarding the latter aspect of quality implementation – how facilitators deliver parenting programmes. We define facilitator as someone who is responsible for directly implementing the programme and working with families. In particular, we will discuss the role of fidelity, competent adherence and programme adaptation, the considerations in selection, training, support, supervision and retention of programme facilitators and impacts of programme delivery on the facilitators. (The final, third, theme of this chapter will then discuss the issues of reach and family engagement with parenting programmes.)

Findings and recommendations in the literature

Defining competent adherence

Implementation fidelity or adherence can be defined as the extent to which an intervention is implemented as intended by programme developers and as outlined in a logic model or programme manual (Bumbarger, Perkins, Bumbarger, & Perkins, n.d.; Dane & Schneider, 1998; Dusenbury, Brannigan, Hansen, Walsh, & Falco, 2005; Fagan, Hanson, Hawkins, & Arthur, 2008). Furthermore, as facilitators are the medium through which programmes are delivered, some researchers have argued that 'the facilitator is the intervention', pointing to the importance of facilitator skill and competence. Facilitator competencies can include the extent to which facilitators are responsive to family needs, non-judgemental and non-intrusive, and able to engage caregivers and children in the programme.

The importance of facilitator competence is supported by findings from a recent systematic review on parents' perceptions and experiences of parenting programmes (Butler, Gregg, Calam, & Wittkowski, 2020), which highlighted a common finding across included qualitative studies, in which parents stated that it was important for them that programme facilitators were supportive and non-judgemental. An overview of 20 systematic reviews, combined with a focus group with practitioners in the UK (Law, Plunkett, Taylor, & Gunning, 2009), emphasized the importance of facilitators being mindful of different family contexts for families participating in parenting programmes. The combination of adherence and competence, or facilitator competent adherence, is the skill with which a facilitator delivers intervention components and the strictness with which they implement the programme manual (Forgatch et al., 2005).

Relationship between implementation and outcomes; programme adaptation

Examining adherence can demonstrate the extent to which the programme theory was implemented in practice (Breitenstein et al., 2010) and can provide insight into the mechanisms through which programmes achieve their outcomes (Astbury & Leeuw, 2010; Fixsen, Blase, & Fixsen, 2017). To assess facilitator competent adherence, many parenting programmes have designed assessment tools. A recent systematic review by Martin and colleagues (2021) provides an overview of such measures and their psychometric properties in parenting programmes aiming to reduce child behaviour problems and maltreatment. In sum, most measures used are observational (completed by video or live assessments), completed by facilitators (self-reports) or researchers, and used Likert-scale ratings. An assessment of the quality of these measures found them to be of reasonably high quality.

A widely cited 2008 review of prevention and health promotion programmes for children (Durlak & DuPre, 2008) found that in 45 out of 59 studies there was a statistically significant positive relationship between implementation level and at least half of the intervention effects measured. An ongoing

systematic review by Martin and colleagues is looking at the relationship between competent adherence and family outcomes in parenting programmes aiming to reduce child behaviour problems and maltreatment. The findings in the parenting literature are mixed. For instance, a study of the Parent Management Training-Oregon (PMTO) parenting programme, implemented and examined at scale in Norway, found that higher levels of facilitator fidelity were correlated with greater improvement in parenting skills among programme participants (Askeland, Forgatch, Apeland, Reer, & Grønlie, 2019). However, while this and other research on parenting interventions has found that higher facilitator competent adherence is associated with better intervention outcomes (Eames et al., 2010, 2009; Forgatch & DeGarmo, 2011; Hogue et al., 2008; Huey, Henggeler, Brondino, & Pickrel, 2000), other research has found the relationship was not present (Breitenstein et al., 2010; Cantu, Hill, & Becker, 2010; Shenderovich et al., 2019).

There are a variety of potential reasons for the inconsistent findings regarding the association between implementation and outcomes. One potential reason for inconsistent findings is that aspects of implementation fidelity (such as facilitator competent adherence and dose) may interact with each other and not be reflective of their true relationship with outcomes when examined in isolation (Berkel et al., 2011). There are also tensions regarding facilitator competent adherence. For one, high levels of facilitator competent adherence may jeopardize participant satisfaction and engagement, as facilitators may prioritize strictly following their programme manual over reacting to and supporting the families in front of them (Byrnes, Miller, Aalborg, Plasencia, & Keagy, 2010; Stern, Alaggia, Watson, & Morton, 2008). For example, parents may experience literacy difficulties that affect the way in which the programme is delivered. Therefore, staff must have appropriate skills to customize programmes accordingly, without reducing the desired impact of the programme. The issue of acceptability also relates to the importance of initial piloting and thoughtful programme selection, described under Theme 1.

A study by Hogue et al. (2008), reporting on the Multidimensional Family Therapy programme, found evidence of a curvilinear relationship between facilitator adherence and parent-reported child internalizing behaviours. In their analysis, low levels of facilitator adherence were associated with lower levels of improvements in internalizing behaviours, medium levels of adherence were associated with higher levels of improvements, and high levels of adherence were associated with lower levels of improvements. This finding may suggest that some degree of adaptation or modification of programme components may be beneficial so that facilitators can tailor the programme to suit the actual participants in front of them (Kemp, 2016). A simple example of adaptation is when changes are made to the language and terminology used in the delivery of the programme. As research on PLH in Tanzania found, in a multilingual setting, facilitators and participants may prefer to discuss the sessions in their local language, so the manual translated into the national languages (English and Swahili) was further interpreted by facilitators and participants during the programme to help reach participants more conversant in other local languages (Wamoyi, forthcoming).

A related concept emphasized by the ADAPT guidance on programme adaptations is functional fidelity, also known as integrity. Functional fidelity speaks to maintaining core programme functions while changing the form in which the programme is delivered. However, both pre-planned and ad hoc adaptations are rarely recorded and reported, and more research in this area is needed.

Facilitator selection

One of the first steps in implementing a parenting programme is making decisions about the selection of organizations and facilitators who will deliver the programme. Factors examined in the literature in respect to programme facilitator selection include the personal and professional characteristics of facilitators, the degree to which facilitators are congruent with and connected to the communities where the programme is delivered, and the existing workload of the potential facilitators.

Professional characteristics

A recent systematic review of facilitator characteristics in parenting interventions directed at children's behaviour problems (Leitão, Seabra-Santos, & Gaspar, 2021) found that research has been limited on the impact of facilitator characteristics on programme outcomes. Historically, in many of the research studies of parenting programmes delivered and tested in high-income countries (HICs), the majority of facilitators delivering parenting programmes have been highly trained professionals with a relevant professional background, such as child care or psychology.

However, there is increasing evidence of examples where parenting programmes have been successfully delivered in a number of settings by lay health workers and other non-specialist workers with training and support, such as in the evaluations of PLH programmes in South Africa (Cluver et al., 2018; Ward et al., 2020). An ongoing systematic review found that examples of randomized trials of parenting programmes delivered by lay staff are still rare (Gardner et al., forthcoming) – only 12% of the 120 included trials looked at delivery by lay staff. A study in Kenya focused on recruiting individuals who had already been informally providing advice on personal and family issues in their communities into the roles of volunteer counsellors for a family therapy programme. The study found qualitatively in interviews with facilitators that their existing interest in spending time on helping was seen as helpful for sustaining their motivation (Wall et al., 2020).

In the broader health and social intervention literature, there have been a number of studies on associations between facilitator professional backgrounds and parent and child outcomes. For instance, a systematic review by Singla and colleagues (2017), including 27 quantitative evaluations of mental health interventions delivered by lay health workers in LMICs, found moderate to large effects on participants, suggesting the way in which the interventions were delivered was effective. On the other hand, in a study comparing the family benefits across the treatment arms of a randomized trial of a home visiting programme in the USA, researchers found that families who received the programme delivered by nurses reported substantially higher benefits than those who received it delivered by paraprofessionals (Olds et al., 2004, 2002).

The ongoing systematic review of parenting programmes by our team has looked at programme outcomes by the background of programme facilitator, comparing outcomes in studies where the parenting programme was delivered by professionals (e.g. psychologists, researchers, nurses), semi-professionals (e.g. counsellors) or lay persons (Gardner et al., forthcoming). The results indicated that for the outcome of negative parenting, delivery by professionals may be more effective than by lay staff. However, there was no difference in the negative parenting outcomes from trials of programmes delivered by semi-professionals compared to professionals, and no differences across types of facilitators for child outcomes. Small numbers of studies in each group make these comparisons across studies not very reliable.

Other research has examined associations between facilitator professional backgrounds and the quality with which they deliver programmes. To illustrate, a cluster trial of the Mothers and Babies programme in the USA, focusing on prevention of perinatal depression, found that professional and paraprofessional facilitators had similar levels of competent adherence (Diebold et al., 2020). Thus, there is emerging evidence that paraprofessional facilitators can be an effective alternative to professional facilitators with respect to achieving high-quality delivery and parent and child outcomes, although this may vary by type of intervention and other contextual factors, and further research is needed.

Existing facilitator workload

Another consideration regarding staff selection is examining the amount of work facilitators have to complete and whether the amount of work is feasible along with their other existing commitments. Studies of parenting and early childhood interventions, both in relatively high-resource settings such as the USA and the UK, and in LMICs, have shown that establishing and maintaining quality delivery is a challenge if programmes are delivered by overburdened volunteers or staff (Hutchings, 2012; Klingberg, van Sluijs, Jong, & Draper, 2021; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009; Stevens, 2014; Walker et al., 2017). For example, in a study of a home visiting and health centre-based early childhood intervention in Jamaica, delivered by paraprofessional community health workers as well as nurses, staff workload was the main challenge in programme implementation reported by nurses (Walker et al., 2017). Existing qualitative evidence in primary studies (Seng, Prinz, and Sanders 2006; Wamoyi, forthcoming) and reviews (Hodge & Turner, 2016) consistently indicates that interventions need to be well integrated and feasible alongside any existing staff responsibilities.

Personal characteristics

In addition to facilitator professional characteristics, a segment of the intervention literature has examined the role of a variety of personal characteristics in achieving parent and child outcomes and high quality of delivery. Factors explored in this literature include facilitator attitudes to the intervention; facilitator confidence in their ability to deliver the intervention; and characteristics such as facilitator age, sex, race and ethnicity. The recent systematic review on facilitator characteristics in parenting interventions directed at children's behaviour problems (Leitão et al., 2021) suggests that there is mixed evidence in terms of whether and which personal facilitator characteristics may be associated with implementation or family outcomes. Furthermore, most of the studies examining facilitator personal characteristics have been conducted in HICs.

Regarding facilitator attitudes, there is some evidence that facilitator satisfaction with the intervention is associated with higher-quality facilitator delivery and better programme outcomes. A study by Tommeraas and Ogden (2017) of PMTO in Norway found that higher levels of facilitator satisfaction were associated with larger improvements in child externalizing behaviours. Another study on the Early Risers programme found that better facilitator attitudes to the intervention were associated with better implementation quality (Klimes-Dougan et al., 2009). However, this finding is not consistent (Schoenwald, Letourneau, & Halliday-Boykins, 2005).

Another dimension of facilitator attitudes might be facilitator views regarding how programmes should be delivered. For instance, some of the more participatory and experiential parenting intervention activities may be at odds with staff and organizational use of didactic approaches in working with families. As it relates to facilitator confidence (also called self-efficacy), there is some evidence that this

is an important factor in the broader intervention literature. However, evidence on this facilitator characteristic is lacking in the parenting intervention literature. One study that examined facilitator self-efficacy, by Turner, Nicholson and Sanders (2011), found that higher levels of facilitator self-efficacy were associated with better programme implementation.

There is also a small amount of research on the role of factors such as facilitator age, sex and race/ethnicity. A number of studies have found that these factors do not play a significant role. For instance, a study by Scott, Carby and Rendu (2008) found that facilitator gender and age were not associated with the quality of delivery in studies of the Incredible Years in the UK.

Other research on staff factors examines the role of the degree to which facilitators are embedded within the same community as their participants and the extent to which facilitators are culturally similar to their participants. Among the limited research on this topic in the parenting literature, the findings are inconsistent. However, several qualitative studies and reviews emphasize the perceived benefits of leveraging existing relationships between parents and intervention providers (Doubt, Blanc, et al., 2017; Mytton, Ingram, Manns, Hons, & Thomas, 2014).

In addition to community connectedness, some research has examined whether the degree of cultural and ethnic similarity between facilitators and participants contributes to high-quality delivery and enhanced outcomes. The evidence on such cultural congruence is mixed. For instance, a study by Orrell-Valente, Pinderhughes, Valente and Laird (1999) in the USA did not find such similarities to be an important factor in enhancing programme participation among parents. In contrast, a study of a parenting programme aiming to support military families in the USA found that facilitators with some connection to or knowledge of the military contribute to better parent attendance rates (Pinna et al., 2017). There is similarly mixed evidence regarding the contribution of cultural congruence to achieving high-quality facilitator delivery.

Facilitator training

Since parenting programmes require a high level of skill to implement with fidelity, prior to delivering a parenting programme, many facilitators are provided with training on the intervention's theories, objectives, components and delivery approaches. Although parenting programmes have different approaches to training, many follow the same general format. For example, a facilitator training programme has been described for Parent-Child Interaction Therapy (PCIT). In PCIT, facilitators received approximately 40 hours of training, which includes receiving didactic instruction from a master trainer, watching and discussing videos of programme delivery, reviewing case study examples and role-playing programme delivery (Christian et al., 2014). This is similar to the training provided by a number of other parenting programmes, including PMTO, Incredible Years, Brief Strategic Family Therapy and PLH. It is also often recommended by researchers that, as part of training, facilitators and supervisors complete the parenting intervention as participants (Gevers & Dartnall, 2015).

Facilitator training is often a prerequisite for certification, as in the case of Incredible Years (Hutchings, 2012), PMTO (Forgatch & DeGarmo, 2011), Triple P, PLH (Lachman et al., 2018) and other parenting programmes. In the case of PLH, once facilitators have received facilitator training and delivered the programme, they receive an assessment using a tool to rate their competent adherence. If facilitators receive above 60%, they are certified to continue delivering the programme. In Montenegro, training in

PLH facilitation was recognized as a formal accreditation (Hutchings, forthcoming; McCoy 2021), which can be an additional motivational factor to become a facilitator, as discussed below.

After some time delivering the programme, a facilitator may be asked to become a trainer and/or a coach. This approach, cascade training, also known as 'train-the-trainers', is often used in programme scale-up (Cavallera et al., 2019). Cascade training can support local capacity for supervision and training (Gask, Coupe, & Green, 2019). In practice, this can mean that a group of facilitators is trained to deliver the programme, and some of them are additionally trained as supervisors and trainers, to enable them to later train others.

Facilitator supervision

Many researchers have noted that the provision of training alone is not sufficient to maintain high-quality delivery (Herschell et al., 2009). For instance, programme drift can occur after the initial training, with facilitator competent adherence decreasing over time (Mowbray, Holter, Gregory, & Bybee, 2003). As a result, once facilitators are trained and delivering a parenting programme, many interventions provide them with ongoing support and feedback in the form of supervision sessions. In a review on sustainment of evidence-based programmes in low-resource settings, including LMICs (Hodge & Turner, 2016), many of the included qualitative studies pointed to the importance of workplace support, including supervision, alongside time for training, financial support and other measures, discussed below.

Supervision frequently consists of live or video observation of the facilitator delivering the programme and a discussion of the challenges the facilitator is facing and how they might improve in future. In a qualitative study of PCIT in the USA, facilitators indicated that they appreciated the opportunity to receive constructive feedback on their delivery and preferred that these conversations occur in person rather than over the phone (Christian et al., 2014). Similarly, both facilitators and supervisors perceived regular supervision as vital for high-quality implementation of an early stimulation intervention for mothers of young children in Uganda (Singla & Kumbakumba, 2015). Also pointing to the importance of supervision, a lack of adequate supervision has been noted in a number of qualitative studies as a challenge in ongoing programme delivery. For example, practitioners in the USA identified insufficient access to supervision among the major obstacles to Triple P intervention delivery in routine practice (Sanders, Prinz, & Shapiro, 2009).

While the qualitative data consistently suggest that supervision is an important aspect of programme delivery, research is lacking on more nuanced questions, such as the minimum necessary level of supervision and the effects of different supervision modalities (Lachman et al., 2019). A potential reason for inadequate supervision is cost. Researchers and implementers point out that supervision costs need to be factored into programme budgets from the start (Forgatch & DeGarmo, 2011; Stern et al., 2008).

Remote implementation support

The COVID-19 pandemic has resulted in an increase in the number of digital and remote-delivery adaptations of parenting programmes, as well as a shift to remote training and supervision of programme facilitators. This transition had begun prior to the pandemic. An example of an in-person programme 'going digital' in LMICs is PLH. For instance, remote supervision of public health workers was provided through videoconferencing as part of a randomized controlled trial of PLH for Young Children in Thailand (Gardner et al., in submission).

COVID-19 restrictions in Southeastern Europe led to the adaptation of PLH for Young Children from in-person to videoconference delivery as part of a three-country trial in Moldova, North Macedonia and Romania. Online training was provided to programme facilitators, with adaptations made to delivery including reducing the number of parents per group to allow for supportive role plays (Taut et al., protocol in review). Remote training and supervision of facilitators has also been provided as part of ongoing USAID-funded delivery of PLH for Teens in sub-Saharan Africa.

Lastly, PLH has adapted its programmes for children and adolescents into a version delivered via online chat groups (e.g. ParentChat) which includes remote training and support for facilitators and coaches across five countries (Malaysia, Montenegro, North Macedonia, Philippines and South Africa). Although role plays and practising skills were not possible in this modality, the shift to online chat groups could potentially increase accessibility for parents who do not have the time or ability to attend in-person or live sessions (Eagling-Peche, protocol in submission). Findings from these studies will be available in 2022. These developments have implications for a more cost-efficient scale-up of programmes, though further research is required to determine whether remote training and support are effective.

Facilitator retention; payment and non-monetary benefits for facilitators; effects on facilitators

Delivering parenting programmes can be practically and emotionally demanding for programme facilitators, which can lead to facilitator burnout and turnover (Wall et al., 2020). Turnover is a particularly important challenge in the context of long-term delivery and scale-up (Hodge & Turner, 2016). For example, challenges with facilitator retention were reported as a key barrier to sustained scale-up in a study of Cuna Mas, a Peruvian national home visiting programme (Araujo et al., 2018).

Parenting programmes have been delivered by both paid and volunteer facilitators. The latter are sometimes provided with minimum remuneration (e.g. an honorarium). Related to the discussion of facilitator professional backgrounds above, volunteer facilitators tend to have fewer professional qualifications. A series of interviews with facilitators delivering early childhood development programmes found that they viewed some form of compensation as necessary to be both effective and fair; the interviews suggested that compensation could include salaries and non-monetary incentives, such as capacity-building or training, and community recognition (Cavallera et al., 2019).

A systematic review of 82 child and maternal health interventions found that overall both paid and unpaid lay health workers delivered programmes with a similar degree of quality (Lewin et al., 2010). However, some evidence seems to suggest that it is important for staff to receive a salary. While to our knowledge this has not been examined directly in parenting programmes, an observational quantitative study comparing child outcomes achieved by paid and unpaid staff delivering a community-based programme in Malawi and South Africa found better child outcomes when staff were paid (Tomlinson, Sherr, Macedo, Hunt, & Skeen, 2017).

Ongoing research on the dissemination of PLH in South Africa pointed to challenges with long-term retention of volunteer facilitators, given the demanding nature of the facilitator tasks and the need to receive an income through other means (Sacolo-Gwebu, Shenderovich, et al., forthcoming). A quantitative study of multisystemic therapy in the USA found that lower salary and higher perceived emotional demands were predictors of turnover among the facilitators (mental health clinicians) delivering the programme (Sheidow, Schoenwald, Wagner, Allred, & Burns, 2007). Furthermore, where

facilitators are volunteers, if programme delivery is demanding, it may interfere with facilitators' ability to provide for themselves and their families from other sources (Wall et al., 2020).

Where either stipends or salary payments are provided, qualitative studies have found that it is important for them to be timely and reliable. A study of an early childhood intervention in South Africa (Klingberg et al., 2021) and a study of a parenting programme for families with adolescent girls in Tanzania – an adapted version of PLH for Teens (Wamoyi et al., forthcoming) – both found that late payments to facilitators can negatively affect facilitator motivation and programme delivery, especially in the context where programmes are delivered by staff with other substantial work responsibilities.

In respect to professional development, the value of receiving facilitator certification has also been found in qualitative interviews stemming from the large-scale implementation of PLH for Teens in Tanzania, wherein facilitators have stressed the importance of receiving certification for their career development and future prospects (Wamoyi et al., forthcoming). In Wales, the parenting training centre at Bangor University has created a register of all professionals who have been trained to deliver the Incredible Years programme, to keep in contact with the facilitators and communicate further training opportunities (Hutchings, 2012). The centre has also been organizing annual workshops with parenting programme coordinators/managers to communicate about research findings and future research opportunities, support organizational planning and facilitate knowledge exchange.

In addition to the benefits of payment and professional development, research from the early childhood intervention literature has brought attention to the perceived benefits of social status and prestige for programme staff in some contexts associated with delivering the programme (Cavallera et al., 2019). Facilitators may also benefit by being intrinsically motivated to help children and families in their community and achieving fulfilment through their work (Wall et al., 2020). In the delivery of an early childhood intervention in Jamaica, both community health workers and nurses reported programme benefits they experienced in terms of better interpersonal skills and increased knowledge, and increased job satisfaction, as a result of observing the benefits to the participants from the programme they delivered (Powell, Baker-Henningham, Walker, Grantham-Mcgregor, & Gernay, 2004).

Additional benefits related to programme delivery have been noted in respect to facilitators' personal use of the programme learning. Across several qualitative studies of PLH in South Africa and Tanzania, facilitators reported perceived improvements in their own family relationships as a result of their experience of delivering parenting programmes (Loening-Voysey et al. 2018; Wamoyi et al., forthcoming). Similar findings were reported by lay counsellors delivering a family support programme in Kenya (Wall et al., 2020).

Conclusion

While the terminology used in respect to fidelity and adherence varies, facilitator skill in following the programme principles is considered essential for programme outcomes, as parenting programmes rely on facilitators delivering programmes as intended while also applying their judgement and skills effectively in working with families. Therefore, human resources are a key factor in delivering parenting programmes well. As Tomlinson, Hunt and Rotheram-Borus (2018) articulated to emphasize the importance of well-trained and well-supported staff, "First who then what".

The evidence on the role of staff professional and personal characteristics is not conclusive. Studies of programme facilitators from varied professional backgrounds indicate that different types of facilitators can successfully deliver programmes, although some studies have found better results for facilitators from specific professional backgrounds or with specific personal characteristics. The literature suggests that ensuring facilitators receive training, are not over-burdened and are adequately supported – for instance, through supervision as well as salary and other benefits – can contribute to quality delivery, facilitator retention, and positive outcomes for families.

Under this theme, we were able to draw on several systematic reviews. However, not all relevant questions have been explored in reviews. Furthermore, in some of the cited reviews, many of the included studies come from HICs and examine implementation within research settings, which may not always generalize to routine implementation.

Furthermore, little research is available comparing different parenting programme implementation structures or different models of facilitator recruitment, training and supervision. In the future, comparative qualitative research within different settings and factorial trials testing different delivery models may be able to provide more nuanced insights, such as a minimum sufficient level of competent adherence. Next, we consider the issues of family participation in parenting programmes.

Theme 3: Caregiver and family participation in parenting programmes

Underlying question

- What are the factors increasing parent/key caregiver attendance and engagement in parenting programmes (e.g. transport, child care)?

Introduction

Family participation is an essential component of programme implementation and a pathway to family outcomes. If families are unable to engage with an intervention, it is unlikely to make an impact. Participant attendance and engagement can be conceptualized and monitored at multiple stages of programme delivery, such as:

- programme recruitment/enrolment at the start;
- attendance at the first session (some programmes consider this to be a part of a complete enrolment);
- continued attendance and retention (not missing multiple sessions in a row);
- active engagement with the programme materials and principles during the programme sessions and at home (participating in discussions, completing homework);
- understanding, remembering and applying the ideas and behaviours introduced in the programme in practice; and
- programme completion (attending a certain total proportion of the course or the final session(s)).

Many studies report insufficient family participation as a barrier to programme effectiveness (Butler et al., 2020). As with any human behaviour, family participation has multiple simultaneous causes. To simplify, we could think about factors affecting attendance that can be assessed at: (1) individual and

family levels (practical barriers, perceptions of the programme, motivation, family economic and educational level, social and health status, parenting and child behaviour, and socio-demographic characteristics) and community level (e.g. the level of community violence, norms and cultural practices around parenting, available infrastructure and service capacity etc.); and (2) programme level (content, delivery staff skills and relationship with families, other services delivered alongside parenting support etc.). Much existing quantitative research has looked at caregiver and family characteristics to test whether these characteristics are linked to programme attendance. There is less quantitative research reporting on the impact of community-level (Hackworth et al., 2018; Rutter, 2006) and programme-level factors (Wessels, 2017). However, there is substantial qualitative research on programme-level factors and how they may interact with family and community characteristics. These levels are inherently linked because, for example, programme features, such as providing transport and child care, are designed to address the potential impact of family experiences, such as limited access to transport and child care during the parenting programme sessions.

Several narrative and systematic reviews of qualitative and quantitative studies have looked at factors associated with parenting programme enrolment, attendance and engagement, as well as attrition, primarily drawing on studies from HICs (Chacko et al., 2016; Koerting et al., 2013b; Levert, 2017; McCurdy & Daro, 2001; Michael, 2018), and we are aware of one systematic review of experimental studies looking at effects of engagement strategies (Gonzalez, Morawska, & Haslam, 2018). Furthermore, wider reviews of qualitative studies with parents and facilitators provide an insight into family participation (Axford et al., 2017; Axford, Lehtonen, Kaoukji, Tobin, & Berry, 2012; Butler et al., 2020; Koerting et al., 2013a; Morawska & Sanders, 2006; Mytton, Ingram, Manns, Hons, et al., 2014; Snell-Johns, Mendez, & Smith, 2004; Whittaker & Cowley, 2012). While many reviews have drawn on studies in HICs, there is also an emerging body of research on family attendance and engagement in parenting programmes in LMICs (Lachman et al., 2016; Martins et al., 2020; Shenderovich et al., 2018; Wessels, 2017), but as yet, to our knowledge, no systematic review of quantitative or qualitative research on engagement focusing on LMICs. This section will provide a summary of the existing evidence and recommendations from the qualitative and quantitative literature on family participation.

Findings and recommendations in the literature

Individual, family and community characteristics associated with family engagement in in-person programmes

Overall, findings have been mixed in quantitative research for many of the potential factors associated with attendance and engagement. We group the evidence here into two categories: family and community resources and well-being factors (economic, educational, social and health), including the baseline levels of parenting and child behaviour problems, and family demographic factors.

Family and community resources and well-being

To explore family factors associated with family participation in parenting programmes, it may be beneficial to draw on family theory. Frameworks such as family stress theory suggest that families experiencing multiple stressors are at higher risk of strained family relationships (Smith, Dishion, et al., 2016), which is also supported by findings that violence against children often especially affects the most disadvantaged families (Cerna-Turoff et al., 2021). At the same time, we may expect that families experiencing more stressors and demands on their time will also find it more difficult to engage with parenting programmes. This could happen because the families who experience multiple stressors and

competing demands on their time may be, for example, facing the most pressure to spend time on income-generating activities, such as working. Families with limited social support may also have access to fewer alternative caregivers who can look after other children in the household or care for ill family members, which may also prevent them from participating.

Among the family characteristics, socio-economic status is perhaps the most examined predictor of participation in parenting interventions. Several reviews have looked across multiple studies to see if certain characteristics were associated with the rates of attendance or engagement in the study (meta-analytic moderation). While these analyses can be useful, it is worth noting that such comparisons between studies are often limited in terms of statistical power and may be confounded by other study characteristics. The findings from reviews bringing together quantitative studies to examine the role of socio-economic factors have been mixed. For example, a review of 262 behavioural parenting programmes in HICs found no significant association between socio-economic status and attendance (Chacko et al., 2016). However, a recent meta-analysis of school-based parenting programmes found that studies with disadvantaged families had lower attrition (Livert, 2017), while a meta-analysis of behavioural parent training programmes in clinical and community settings found no relationship between socio-economic status and attrition (Michael, 2018). An older meta-analysis of just six studies found that higher occupational prestige was associated with increased dropout (Reyno & McGrath, 2006).

The research included in these reviews has taken place primarily in HICs. Several recent studies in LMICs did not identify a relationship of indicators such as poverty with participation in parenting programmes (Janowski, 2020; Shenderovich, 2018). A few studies in HICs have also demonstrated lower attendance among families with lower socio-economic standing (e.g. Peters, Calam, & Harrington, 2005). While most studies have focused on family-level indicators, a team in Australia explored the predictors of engagement in an early-intervention family programme, finding that enrolment was lower in communities with higher long-term unemployment and socio-economic disadvantage (Hackworth et al., 2018).

Other social and health resources and barriers studied in parenting interventions include parental depression, substance use and social support (Morawska, Dyah Ramadewi, & Sanders, 2014). Some evaluations have identified equal or higher engagement among families with more mental health problems (Baydar, Reid, & Webster-Stratton, 2003; J. D. Smith, Berkel, et al., 2016), while others showed that caregiver depression and parenting stress were associated with higher levels of dropout (Calam, Bolton, & Roberts, 2002).

Recent findings from a study nested in a randomized controlled trial of PLH for children in the Philippines indicated that caregivers who experienced higher rates of intimate partner violence attended fewer sessions (Janowski, 2020). Similarly, a study of the same programme in North Macedonia, Romania and Moldova found that greater levels of intimate partner violence were associated with programme dropout (Williams, forthcoming). Interestingly, in the same study, parents with **better** mental well-being were also more likely to drop out.

Examining the effect of pre-intervention parenting practices and child behaviour, we may expect that families with greater difficulties may find it more difficult to engage in parenting programmes. Conversely, according to the Health Belief Model, parents may be more likely to participate if they perceive their family problems to be more serious. Similar to other characteristics, there are mixed

results on the associations between family participation and parenting and child behaviour. For instance, some research has found that more baseline family problems in terms of parenting or child behaviour predicted greater attendance (Salari and Filus 2017; Baydar et al., 2016; Gorman-Smith et al., 2002), while other studies did not find a similar relationship (Eisner & Meidert, 2011; Martins et al., 2020; Salari & Filus, 2017; Shenderovich et al., 2018).

Caregiver and children demographic characteristics

Within a large, low-income US Head Start sample taking part in Incredible Years parenting groups, Reid, Webster-Stratton and Beauchaine (2001) found no differences in attendance (or outcomes) by ethnicity. Regarding child and parent age, reviews found no association between attendance and child age (e.g. Chacko et al., 2016), while others found that families with younger children were more likely to attend sessions (Livert, 2017). Reviews have also demonstrated that older parental age was associated with higher attrition rates (Livert, 2017; Reyno & McGrath, 2006).

Some parenting interventions have focused exclusively on mothers/female caregivers. In programmes open to all caregivers, enrolment, attendance and engagement are often substantially lower among male caregivers (Shenderovich et al., 2018) – a topic we discuss in more detail below.

Furthermore, most interventions described in the literature we reviewed focused on parents of young children and, therefore, delivered training to caregivers only. As a result, these studies have focused on predictors of caregiver participation, and predictors of child participation have been rarely examined in parenting research. However, increasingly, many programmes for parents/caregivers of older children also include sessions for the children, and studies have shown that child involvement can boost parental engagement and lead to more sustainable changes in the family (Fleming et al., 2015).

Conflicting findings in the quantitative studies on factors associated with caregiver enrolment, attendance and engagement may be explained by variation in study design and measures used, heterogeneous populations (including a mix of universal and high-risk samples), how the families were recruited and whether they saw the programmes as relevant to their needs, diverse locations/settings and other contextual factors.

Programme delivery and design features associated with family engagement in in-person programmes

While many of the quantitative findings on the family and community factors that may affect family engagement have been mixed, the reviews of qualitative research with caregivers and providers in a variety of settings rather consistently indicate the perceived importance of several programme-level factors that may affect family attendance and engagement (Axford et al., 2012, 2017; Butler et al., 2020; Koerting et al., 2013a; Morawska & Sanders, 2006; Mytton, Ingram, Manns, Hons, et al., 2014; Snell-Johns et al., 2004; Whittaker & Cowley, 2012).

Based on these reviews, we list below the programme features considered to promote family participation, and provide more details on them below.

- Communicating clearly about the programme and building trust from the recruitment stage
- Considering group composition and dynamics, and developing a social network among participating families in a group intervention
- Thoughtfully selecting the delivery location and times, considering home visits/home-based delivery

- Providing transportation, child care and meals for participants
- Reminders (e.g. initial and/or follow-up messages or phone calls from the facilitator)
- Delivery by facilitators skilled in the programme content, as well as in building relationships with families and supporting positive group dynamics
- Flexible intervention content and delivery to accommodate the needs of specific families (e.g. the priority issues they would like to address), and culturally appropriate content and delivery.

Communicating about the programme and building trust; facilitator skills

Global qualitative reviews (Butler et al., 2020) and studies in LMICs (Errázuriz, Cerfogli, Moreno, & Soto, 2016) emphasize the importance of clear communication, particularly during family recruitment, to set appropriate expectations about the programme among families and other community stakeholders. Qualitative reviews also suggest that families may distrust whether the programme staff will respect their confidentiality, may experience discomfort about needing help, and may have concerns about protecting their family's privacy or about a potential involvement of social services (Furlong & McGilloway, 2012; Koerting et al., 2013a; Stahlschmidt, Threlfall, Seay, Lewis, & Kohl, 2013; Zeedyk, Werritty, & Riach, 2003). Thus, it is important to form realistic expectations in terms of what the programme can offer and achieve, and to build trusting relationships with participants.

To build participant trust, it has been recommended that recruitment involve trusted individuals, such as local health professionals or community members who already have existing relationships with families (Brand & Jungmann, 2014; Mytton et al., 2014). Programme recruiters may also use the support of parents who already have experience with the intervention (Ainbinder et al., 1998). However, such an approach needs to be balanced with maintaining confidentiality (Hoeft et al,, 2018). Thus, both family recruitment and family engagement in parenting programmes require careful maintenance of family privacy, as breaching it could be a potential harm.

Quality of delivery (e.g. competent adherence by the facilitator) has been shown to be associated with family engagement in some quantitative research (Shenderovich et al., 2019). Facilitators' professional knowledge and qualifications, as well as parents' positive impression of the services, have also been qualitatively linked to programme enrolment (Houle, Besnard, Bérubé, & Dagenais, 2018). See Theme 2 in this chapter for more on facilitator skills and quality of delivery.

Location and times of delivery

A lack of time to engage with attending the parenting programme and to try out the strategies recommended in the programme is one of the most commonly cited challenges in reviews and primary studies (Koerting et al., 2013; Snell-Johns et al., 2004; Whittaker & Cowley, 2012). For instance, a lack of time was the most widely reported barrier to using Triple P strategies reported by women in three battered women's shelters in South Africa (Wessels & Ward, 2016).

The literature has found that having sessions at times when parents are not working and in locations close to their homes is critical. These findings are also supported by some quantitative data. For instance, a study nested within a randomized controlled trial in South Africa found lower programme attendance among employed caregivers, as programme sessions took place during the working day (Shenderovich et al., 2018). The study also found lower attendance rates during days when social grants were disbursed, and qualitative findings suggested avoiding scheduling sessions on important days such as funerals or celebrations in the community (Shenderovich et al., 2018). Based on qualitative research

with families in the study sites, the Happy Families programme in Thailand, delivered by the International Rescue Committee, was delivered in the evenings and weekends and near participants' homes to reduce time and safety concerns (Sim et al., 2014).

Delivery outside regular working hours may create a trade-off between engaging families and finding facilitators willing and able to work in the evenings and at weekends (Miller et al., 2020). Similarly, engaging other/multiple family members per household can potentially promote family engagement but is more demanding for facilitators, so it is likely that greater engagement and family benefits may require greater investment in the programme, although detailed research on the cost vs. benefit of different programme features is lacking. Factorial trials may also be necessary to provide more confidence about specific elements of engagement (Lachman et al., 2019).

Delivering some intervention components at home can also reduce barriers to participation and allow multiple people in a household to be reached at once (Betancourt et al., 2014). A systematic review of quantitative research, focusing on HICs and examining the impact of intervention engagement strategies with underrepresented families taking part in child intervention services, found that lower attrition (dropout) was predicted by interventions that were community- or home-based (rather than clinic-based), suggesting that delivery in community settings or in the home is more accessible to families (Pellecchia et al., 2018). However, it is important to note that the cultural acceptability of home delivery may vary by context. For instance, a study of the PLH programme in Southeastern Europe discovered that it was not culturally acceptable for facilitators to visit the homes of families in Romania and Moldova – a practice that is culturally acceptable in many other contexts (Williams, forthcoming).

A related consideration is whether the programme targeting is universal or selective (see Theme 1 in this chapter). Particularly for programmes with selective targeting, such as vulnerable households, it is important to avoid stigmatizing the participants. It is good practice to always use non-judgemental language to present the programme. For this reason, in addition to accessibility, parenting programmes can be promoted and delivered in settings that are often visited by families and do not carry stigma, such as schools and primary health-care and community care centres. For instance, the Triple P programme in Australia has been delivered in schools, community centres and the workplace (Sanders, 2017), and the READY family programme in Kenya has been delivered in churches (Puffer et al., 2016).

The timing and location of delivery may also be affected by the delivery context, such as the delivery of parenting programmes in combination with other social services. To better understand what participants and implementers are comfortable with, researchers and practitioners can conduct community consultations to incorporate community preferences.

Transport, child care, incentives

To ensure equitable access, many parenting programmes routinely provide transportation and child-care support to improve participant access, and offer small support or incentives for attending sessions, such as snacks or meals (Axford, Lehtonen et al., 2012). This is widely supported by findings from qualitative reviews that highlight that transport and child care are seen as major barriers to participation (Law et al., 2009). In contexts where food insecurity is common, providing food during programmes sessions may also be essential to help participants focus and fully engage with the programme content.

A recent systematic review of experimental studies, which tested different strategies to enhance initial engagement in interventions for parents of young children, found eight relevant studies in HICs (Gonzalez et al., 2018). The strategies tested in these studies included monetary incentives, individual vs. group delivery setting, seeing a testimonial about the programme, advertisements, and an engagement package with multiple components (the package included a family testimonial flyer, teacher endorsement, a group leader call to engagement and a brochure). Positive impacts were shown for advertisements on recruitment, monetary incentives on enrolment, and engagement packages on first attendance. All remaining strategies showed no effects. (Recruitment was defined as attracting parents to engage in the intervention; enrolment as parents' decision to engage; and first attendance as parents' actual behaviour of completing the first session.) However, these results should be interpreted with caution, given a variety of methodological limitations pointed out by review authors, including a lack of published protocols, power calculations and information on randomization processes.

Group composition and dynamics

Getting to know other parents and sharing with them is a core part of many parenting programmes. A systematic review of quantitative studies on strategies to engage underrepresented parents in child intervention services found that interventions which used more peer pairing were associated with less attrition, which highlights the potential importance of learning from parents with similar experiences (Pellecchia et al., 2018). However, group dynamics can also pose challenges to participation – in one qualitative systematic review on parenting programmes (Mytton et al., 2014), 14 out of 26 qualitative studies identified at least one concern that caregivers had with being in a group, such as reluctance to talk in a group setting, suspicion of others, and large differences between participants. Being able to share problems with other caregivers in the group has been reported as a valued programme component for parents, despite initial reservations (Williams et al., forthcoming). Programme guidance and facilitator skills can support productive group dynamics.

Several other potential barriers to participation have not been explored much in the existing research. For instance, a lack of information on what might prevent the participation of families with children who have a disability is notable. Some of the existing recommendations on access may benefit their participation as well.

Reminders and other technology enhancement

There is a growing interest in using the internet (e.g. participants receive content or reminders through social networks) and mobile phones (via SMS messages and mobile applications) to improve the reach and participation of in-person parenting interventions (Breitenstein, Gross, & Christophersen, 2014; McGaron & Ondersma, 2015). A systematic review of technology-enhanced parenting programmes for children and adolescents with disruptive behaviour, focusing on studies from HICs, demonstrates that technology enhancements, such as smartphone messages and reminders, may increase engagement and outcomes of traditional delivery methods (Baumel, Pawar, Mathur, Kane, & Correll, 2017).

For instance, SMS messages were used as weekly reminders about the weekly core skills and home practice in a study of PLH for Young Children in South Africa for participants who had phones, and this addition received positive feedback from participants (Lachman et al., 2016). This programme component is now being tested in Southeastern Europe (Williams et al., forthcoming), and the quantitative results suggest that calls and text messages from facilitators, as well as facilitator fidelity to

the programme, were associated with parent engagement – a finding that was also supported by the qualitative data.

Engagement in digital interventions

Besides technology enhancements to in-person programmes, there is also growing attention to the development of fully digital or blended parenting support, particularly in the context of the COVID-19 pandemic (Harris et al., 2020; McGoron & Ondersma, 2015; Rauschenberg et al., 2020). Research has shown that in-person parenting programmes can successfully be adapted for fully digital and blended delivery. In high- and middle-income countries, meta-analyses and systematic reviews have demonstrated that digital parenting interventions have similar effect sizes to in-person programmes (Baumel et al., 2016; Corralejo & Domenech Rodríguez, 2018; Florean et al., 2020; Flujas-Contreras et al., 2019; Hansen et al., 2019; Harris et al., 2020; Thongseiratch et al., 2020).

In addition, qualitative interviews with participants and implementing staff support the premise that digital parenting interventions may help overcome some of the structural barriers (e.g. high cost of interventions and geographical location of delivery) faced by in-person programmes (Metzler et al., 2012; Tully et al., 2017). Indeed, some research suggests that engagement rates in digital programmes can be as high as or even higher than in in-person programmes. For example, module completion in a self-administered tablet-based version of the Chicago Parent Program (known as ezParent) was 85.4%, whereas the in-person version only achieved 50.6% session completion (Breitenstein et al., 2017). Similarly, participation in an online version of the Familias Unidas parenting programme was, in most cases, higher than in previous in-person versions of the intervention (Perrino et al., 2018).

While these findings are encouraging, they should be interpreted with caution, as digital parenting programmes have so far primarily been studied in HICs, with white, higher-income families and often lack adaptation that make them more accessible to at-risk populations (Corralejo & Domenech Rodriguez, 2018). High attrition has also often been reported as a problem for digital parenting interventions. A study of Triple P Online found that 95% of enrolled parents completed the first session of the intervention, while only 47% finished all eight sessions (Sanders et al., 2012). Thus, while digitalization may facilitate the widespread implementation and use of parenting interventions, it is an emerging field, and research on how to recruit, engage and retain parents, particularly in resource-poor settings, is lacking. Most reviews in the area of digital interventions have focused on family outcomes rather than engagement.

Individual, family and community characteristics associated with family engagement in digital programmes

Overall, only a few quantitative studies (and no reviews, to our knowledge) have investigated the potential factors associated with engagement in digital parenting programmes. Studies of digital parenting interventions have found that more positive parenting pre-intervention (Perrino et al., 2018) and fewer child behavioural problems (Dadds et al., 2019; Perrino et al., 2018) were associated with lower parental engagement. Higher family stress (Perrino et al., 2018) and lower maternal education level (Fossum et al., 2018) have also been found to be related to lower participation. Younger child age (Baker & Sanders, 2017; Dadds et al., 2019), lower disagreement over parenting before the start of the intervention (Baker & Sanders, 2017), and single parent status (Dadds et al., 2019) have been associated with greater participation and programme completion.

Programme delivery and design features associated with family engagement in digital programmes

To date, studies on digital parenting interventions have used a wide range of recruitment approaches to enrol families. These include online (emails, advertising on websites, and online forums) and traditional methods of recruitment (flyers, newspaper advertisements, posters and TV/radio advertisements) (e.g. Baggett et al., 2017; Breitenstein et al., 2016; Irvine et al., 2015). However, it remains unclear which of these strategies are the most effective, and how different recruitment strategies (e.g. in-person vs. online) affect retention and engagement in digital parenting interventions. A recent systematic review of technology-assisted parenting programmes for youth affected by mental health issues in Australia found that the development and recruitment strategies used to engage historically underserved parents – such as fathers, low-income families, and families living in rural areas – were underutilized (Hansen et al., 2019). Investigating how to recruit and engage participants may be particularly useful for informing retention strategies for minority and underserved populations. This is highlighted in the context of LMICs, where low levels of internet access and technological literacy among older caregivers may inhibit enrolment and ongoing engagement in digital interventions.

Similar to in-person programmes, one of the engagement strategies used in digital parenting programmes is sending reminders. A systematic review of internet-based parenting interventions for children's behavioural problems found that programmes that included sending parents reminders to practise programme content improved child behavioural problems, whereas including phone calls in online parenting programmes did not increase programme effectiveness (Thonseiratch, Leijten, & Melendez-Torres, 2020). This indicates that sending parents regular digital reminders could be an important way to achieve higher engagement and, in turn, higher effectiveness of digital parenting interventions. This is a promising direction, given the extensive use of mobile phones for various activities, such as banking and communication, in many LMICs. Besides sending mobile reminders or providing ongoing telephone support, offering engagement boosters such as gift vouchers (Ehrensaft et al., 2016; Hudson et al., 2012) and monetary incentives (Deitz et al., 2008) is a fairly common engagement strategy. Some qualitative and quantitative studies have also looked at strategies such as gamification, and its effects on enhancing participation (e.g. Breitenstein et al., 2016).

Engaging male caregivers and other family members

Although it might often be the case that a child's primary caregiver is the mother or another female primary caregiver, research suggests multiple benefits of fathers' engagement in child-rearing for both fathers and children (Pfitzner, Humphreys, & Hegarty, 2017). There has also been research on the benefits of engaging fathers in interventions to address both intimate partner violence and child maltreatment (Bacchus et al., 2017). For instance, parenting programmes can tackle gender inequity by promoting more equitable gender norms, joint decision-making and open communication between the caregivers (Bacchus et al., 2017).

Involving other household members – such as fathers or grandparents – in a parenting intervention has been suggested by families participating in qualitative studies as a potential way to increase the primary caregiver's engagement in the parenting intervention and support the sustainability of behaviour change within the family (Doubt, Bray, et al., 2017; Errázuriz et al., 2016). These benefits might be observed because it may be challenging to alter family dynamics if only one family member adopts new views or practices stemming from attendance at a parenting programme (Mockford & Barlow, 2004). Further, engaging more than one caregiver might prevent disagreement among family members on parenting practices. For example, a participant in Triple P in Chile reported that she could not implement

new practices without her own mother's approval, as they lived together (Errázuriz et al., 2016). However, to keep the number of participants manageable, parenting programmes often include only one caregiver per household in the group sessions. As discussed above, home visits can be one of the ways to include multiple family members, even if only one caregiver per family attends the group sessions.

Parenting programmes often fail to reach fathers and other male caregivers (Lachman et al., 2020; Panter-Brick et al., 2014; Stahlschmidt et al., 2013). Traditionally, most programmes reported around the world are attended by mothers and other female caregivers such as grandmothers. The attendance of mothers, grandmothers and other female caregivers is likely linked to existing social norms about child-rearing. Studies of parenting intervention in LMICs have reported on a wide range of father recruitment rates, including 3% in Panama (Mejia, Calam, & Sanders, 2015), 14% in China (Guo, Morawska, & Sanders, 2016), 39% in Liberia (Puffer et al., 2015) and 43% in Thailand (Annan, Sim, Puffer, Salhi, & Betancourt, 2017).

Several strategies have been offered to engage men (see Lechowicz et al., 2019; Panter-Brick et al., 2014 for reviews, mainly of studies in HICs), including the following.

- **Identifying entry points for programme delivery that harness existing social groups.** This approach is illustrated in a study in Tanzania that delivers parenting support via farmer groups, wherein existing groups were used as a basis for delivering a new parenting intervention (Lachman et al., 2020). These groups tended to be predominately male, yet did not exclude women, with the result that 60% of the participants in the parenting programmes conducted within these groups were fathers.
- **Identifying motivations and framing the programme in a way that will engage fathers.** For instance, the Parenting for Respectability programme in Uganda draws on fathers' motivation to improve their children's behaviour and enhance family respectability (Siu et al., 2017).
- **Providing content and presentation that is relevant to both male and female caregivers** (Panter-Brick et al., 2014) – for instance, giving examples including both male and female caregivers rather than only female caregivers/mothers.
- **Ensuring staff involved in recruitment and delivery, as well as other relevant stakeholders (e.g. community and institutional partners), are inclusive and non-judgemental** towards all types of caregivers (Panter-Brick et al., 2014), and include both men and women. Such an environment might be created by having former programme participants involved in recruitment.
- **Conducting separate sessions for parents and co-parents to allow open discussion before joint sessions.** A qualitative study of fathers' views in a study of parenting interventions in Australia (Sicouri et al., 2018) found that fathers who were interviewed preferred to attend a male-only parenting group. This preference has to be balanced against the likelihood that encouraging couples to work together in mixed parenting groups may be more beneficial for children, although there is a paucity of direct evidence on this question (Sicouri et al., 2018). Potentially combining both types of sessions can offer a balance. For instance, the Parenting for Respectability programme in Uganda included both initial single-sex and subsequent mixed-sex programme sessions, and the single-sex sessions were facilitated by facilitators of the same sex (Siu et al., 2017).

While engaging male caregivers remains a challenge, promising results in engaging male caregivers have been reported in a number of studies, including in conflict and post-conflict settings such as Gaza, Lebanon (Miller et al., 2020) and Liberia (Puffer et al., 2015).

Family engagement and family outcomes

In addition to the importance of participant engagement in the logic models of parenting programmes, there is also some empirical indication that participant engagement is indeed associated with family outcomes. For example, a meta-analytic moderator analysis of 51 studies of Incredible Years programmes found that higher attendance at sessions was positively related to programme effects when controlling for severity of child problem behaviour (Menting et al., 2013). Similarly, in an earlier meta-analysis, Reyno and McGrath (2006) found that attendance at sessions was significantly associated with intervention outcomes, although the effects were small.

The relationship between family participation and outcomes may also be nuanced. For instance, two studies of parenting programmes based in the USA have found that active engagement in sessions – but not session attendance – predicted parenting outcomes (Garvey, Julion, Fogg, Kratovil, & Gross, 2006; Nix, Bierman, & McMahon, 2009). These findings suggested that attending without actively engaging may not be sufficient to impact outcomes. A recent study of Incredible Years in the Netherlands found that more sessions attended by parents predicted better parenting behaviour, but not better child behaviour (Weeland et al., 2017).

While few studies looking at the relationship between participant engagement and outcomes have been conducted in LMICs, recent research on PLH for Young Children in Thailand, Philippines and South Africa has demonstrated links between greater caregiver engagement (e.g. more sessions attended) and better intervention outcomes (Wessels, 2017; Janowski, 2020). In contrast, in the study of PLH for Adolescents in South Africa neither attendance nor active engagement in sessions were associated with programme outcomes (Shenderovich et al., 2019).

Most parenting programmes do not yet have empirical evidence on the lowest sufficient level of participant engagement – or quality of delivery – necessary to achieve programme outcomes. As such, many programmes use rules of thumb based on expert perception and experience to determine the suggested level of programme attendance and engagement for families to 'graduate'.

Conclusion

There are many possible explanations for the variation in the findings around whether family or community characteristics, such as socio-economic status, measurably affect engagement in parenting programmes, as discussed above. As noted throughout this chapter, there are challenges in extrapolating implementation experiences from research studies – for instance, because participants within studies may be more motivated and engaged than the general population (Araujo et al., 2021). It can be challenging to investigate variation in caregiver engagement within research studies if the participants are relatively homogenous and support to reduce barriers to attendance is provided to everyone. Implementation at scale often includes fewer supports; therefore, inequities may be more likely to emerge, unless support, such as transport and child care, is provided.

There are also other limitations to consider in reviewing the research on participation in parenting programmes, similar to the research reviewed throughout this chapter. For instance, with qualitative research, there may be social desirability bias in the reasons given for not participating. Quantitative studies have primarily been observational, and often drawing on fairly small samples, meaning that there is limited statistical power to detect differences, and spurious results are also possible. It is hard to

measure participant engagement beyond attendance and to understand how much families are using the skills they are learning – although some studies have looked at home practice completion and observations of participation in sessions. There is potential to measure engagement beyond attendance in digital delivery, but there is limited research on this to date.

The literature on family participation is diverse, with studies reporting on a variety of strategies. Overall, there is a lot of agreement in the qualitative research with families and staff about the value of measures to ensure equitable access, such as providing transport, child care and food for participants in parenting programmes. Strategies such as clear communication, maintenance of family confidentiality, use of trusted community members or professionals for recruitment, high-quality facilitation and support for positive group dynamics are seen as valuable in recruiting and retaining participants in parenting programmes. This is also consistent with wider literature on health inequities and global health that points to the importance of factors such as distance to facilities in improving health outcomes and health equity. Digital components or digital-based delivery of parenting programmes may provide further avenues for increasing access.

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WHO-INTEGRATE Chapter 3: Financial and economic considerations

WHO-INTEGRATE questions:

What financial and economic considerations must be taken into account?

- What is the cost of parenting programmes (including costs to the programme providers)? What is the overall budget impact of implementing a parenting programme? Do cost and budget impacts vary in the short versus the longer term, and are they sustainable?
- How affordable are parenting programmes for individuals, households or communities (e.g. time, transport cost)? How will parenting programmes impact household health expenditures, including risk of catastrophic health expenditures and health-related financial risks?
- What is the overall economic impact of parenting programmes? How are different types of economic impact distributed, and how do parenting programmes influence different sectors at different organizational levels? Do parenting programmes contribute to or limit the achievement of broader development and poverty reduction goals? How do parenting programmes impact the working population – for example, in terms of who participates in the workforce and their level of engagement?
- What is the value for money of parenting programmes, based on an appropriate choice of method (e.g. cost-effectiveness, cost–benefit or cost-utility)?

Introduction

There is substantial evidence of the effectiveness of parenting programmes that aim to reduce family violence and its associated risk factors. However, as the global burden of violence against children (VAC) is substantial, and there is often scarce time and financial resources available for intervention, it is essential that we have an evidence-based understanding of the economics of parenting programmes. In this regard, it is critical to study and understand the economic cost of VAC; how much it costs to deliver parenting programmes; how programme costs vary based on contextual, beneficiary and programme factors and characteristics; the economic impact that parenting programmes have on families and society; and whether programmes represent good value for money, and if so, which ones. In this chapter, these topics will be explored to answer the broad question: what financial and economic considerations must be taken into account in terms of the delivery of parenting programmes?

Method

A number of steps were taken to perform an efficient and thorough review of the evidence:

1. A series of search strings was constructed and employed in Google Scholar (e.g. economic*, cost*, evaluation*, parent*, program*).
2. A keyword search within our database of 131 trials of parenting programmes in low- and middle-income countries (LMICs) was conducted to find relevant studies associated with the included trials.
3. The findings and overarching themes that emerged from the relevant studies were synthesized. We draw on literature on parenting programmes aiming both to reduce VAC and child behaviour problems, since these problems are closely interconnected, and both are prioritized outcomes for the WHO Guideline.

Economic burden of violence against children

It is well established that VAC and its associated risk factors, including child behaviour problems, are detrimental to child health and well-being. The serious short- and long-term consequences of child maltreatment prevent many children from enjoying healthy lives and from fully participating in and contributing to society (World Health Organization, 2010). Thus, VAC is harmful to the approximately one in two children around the world who are maltreated each year (Hillis et al., 2016; Stoltenborgh et al., 2013).

The economic consequences of child maltreatment are also considerable because violence creates huge costs to society. Worldwide, child abuse is estimated to cost between US$1,953 billion and US$7,116 billion annually, which equates to approximately 2–8% of global gross domestic product (Pereznieto et al., 2014). The US Centers for Disease Control estimates that the consequences of child maltreatment cost US$124 billion each year in the USA alone (CDC, 2015). Child maltreatment is thought to be even more costly across the life course than common, chronic health conditions such as diabetes (Wildeman et al., 2014).

The ramifications of VAC are felt across key public sectors, including the education, criminal justice, health and social service systems, as child maltreatment often has negative implications for children's academic achievement, participation in criminal activities, mental and physical health, and use of social services (DiLillo et al., 2005). The costs associated with involvement in and use of these systems and services are expensive on an annual basis as well as across the life course. That is, the problems experienced by those subjected to violence in childhood and their cost implications do not end in their childhood. One analysis found that adults who had conduct problems as children (a problem strongly linked to harsh and abusive parenting) cost the health, educational and justice systems 10 times more by the time they reached 28 years of age than adults who had not had such problems as children (Scott et al., 2001). Conduct problems, for instance, are associated with delinquency and crime in later life; for prolific offenders who had conduct problems as children, it is estimated that they have a lifetime cost of GBP1.1 million to GBP1.9 million to the UK public sector (Sainsbury Centre for Mental Health, 2009; Richardson & Joughin, 2002). One study estimated that overall, child behaviour problems cost the UK public sector approximately EUR2,300 per child per year (Romeo et al., 2006). Another study in the UK estimated that externalizing behaviours cost up to EUR3,650 per child per year (Snell et al., 2013). Thus, the economic burden of VAC is substantial.

Economic evaluation of parenting programmes

As mentioned, there is significant evidence that indicates the effectiveness of parenting programmes in reducing harsh and abusive parenting. But at what cost? Economic evaluations of parenting programmes can help answer this question; they allow researchers and practitioners to ascertain what it costs to deliver parenting interventions and can reveal what it costs to improve outcomes for children, their families and communities (Sohn et al., 2020). In turn, this information supports assessment of the feasibility of allocating resources to parenting programmes, as well as assessing whether and which programmes are worth the investment (Charles et al., 2013). Cost-effectiveness analyses can reveal how much it costs to improve a child's outcome by a point on a relevant, validated measurement scale (e.g. Eyberg Child Behaviour Inventory). Overall, knowledge of what it costs to improve child outcomes can provide organizations and governments with a sense of how much money might be needed to achieve their desired outcomes. Additionally, economic evaluations enable comparisons between programmes, allowing practitioners and policymakers to make decisions regarding which programmes to fund (Evans & Popova, 2014; Sampaio, Feldman, et al., 2018). As programmes have different components, participants and contextual factors and are conducted and reported on in a variety of ways and using a

variety of currencies, programme costs can be difficult to compare. Nevertheless, cost evaluations are an important piece of the decision-making puzzle about evidence-based parenting programmes.

Economic evaluations of programmes – the basics

A variety of key economic terms and approaches are used in cost evaluations of parenting programmes. The following summarizes some of the terms and approaches referred to throughout the chapter.

Cost analysis

The simplest economic evaluation of an intervention involves determining how much the programme costs to deliver. In a recent paper, Sohn and colleagues (2020) describe a framework they developed to conceptualize and compile information about intervention costs. Using this framework, the authors outline three phases of programme implementation that need to be considered during the costing process: design, initiation and maintenance (Sohn et al., 2020). The design phase refers to activities included in the development of the intervention and creation of its administrative systems. The initiation phase includes the aspects of the programme associated with start-up, including training staff and developing ways to measure implementation quality. The maintenance phase refers to components of the programme related to ongoing implementation, including monitoring and evaluation, as well as resolving unexpected challenges that arise.

The framework described by Sohn et al. (2020) is essentially an ingredients method, which suggests that to capture the cost of a programme, all programme components ('ingredients') should be outlined, the cost of each ingredient should be determined, and all costs should be totalled (Dhailiwal et al., 2013).

The ingredients method can be put into practice using the micro-costing framework by Charles and colleagues (2013) which defines the key steps that should be taken to collect and analyse programme costs. The first step involves the development of cost diaries for programme staff to complete. The diaries typically include questions on how much time and money staff spend on various aspects of programme implementation, such as programme-related travel. The next step involves gathering any other cost data not captured by the diaries, including costs delineated in programme budgets. The cost information is then summarized in tabular format and totalled (the micro-costing analysis), after which it can be presented as a total cost to deliver an intervention and/or a total cost to deliver a programme per participant. The final step calls for sensitivity analyses to explore assumptions and calculate the costs of various possible iterations of a programme. These analyses might include calculating how much the intervention would cost to deliver with a larger number of participants or in a city with different pay rates. In reporting intervention costs, the currency used in the programme and year of calculation would typically be specified (e.g. 2013 US$). At times, the results might be converted to purchasing power parity-adjusted dollars to enable costs in different countries to be compared (Sampaio, Barendregt, et al., 2018). An example of a micro-costing analysis is provided in Case Study 1.

Case Study 1: Micro-costing of the Incredible Years in Wales

In outlining the micro-costing framework, Charles et al. (2013) provide detailed information on the costs of the implementation of the Incredible Years (IY) Toddler programme in Wales. The programme was delivered to groups of 10 parents who attended 12 weekly sessions of 2.0–2.5 hours in length.

Cost diaries

To develop cost diaries, focus groups were held with the IY Wales training centre and IY facilitators. From these discussions and other sources, a list of set-up and delivery activities/items was created for each week of programme delivery (e.g. supplies, incentives, meetings, venue preparation).

Cost gathering
The cost of each activity/item listed in the cost diaries was compiled by phoning each facilitator and asking them how much each activity/item in the diary cost. Attempts were made to gather information from all facilitators each week. The study also collected data on other activities/items from service managers and the IY training centre (e.g. supervision costs). The costs for staff were calculated based on their time and average hourly wage, including any money facilitators received for participation in cost data collection. Using these data, an average cost for each activity/item by group was generated.

Cost data compilation and analysis
The cost data were compiled in tables by type of cost (e.g. set-up, delivery), and a micro-costing analysis was conducted. The micro-costing analysis ascertained that the total cost to deliver the programme was GBP9,326.73, and the average cost of the programme per child was GBP752.63 in 2008/2009.

Sensitivity analyses
Sensitivity analyses were conducted to estimate the costs of programme delivery based on different scenarios. For instance, the paper by Charles et al. (2013) estimated that to deliver the programme to groups of ten instead of eight parents would reduce the programme cost to GBP633.61 per child. They also analysed how much it would cost to deliver extra programme components such as home visits. Finally, the researchers estimated how much it would cost to deliver the programme in London (GBP10,560), rather than in rural Wales.

Summary
This micro-analysis of the IY Toddler programme in Wales found that it cost GBP752.63 per child in 2008/2009, with variations on this estimate based on a range of different scenarios.

Cost-effectiveness analyses
In addition to calculating how much it costs to deliver an intervention, it is also valuable to understand how much it costs to achieve various degrees of positive programme outcomes. This information can be generated by performing a cost-effectiveness analysis typically reported as an incremental cost-effectiveness ratio (ICER). These analyses are often completed in the context of randomized controlled trials (RCTs), as the analyses allow for a comparison of outcomes between the intervention and control groups. As defined by Peterson et al. (2021), a cost-effectiveness analysis "compares non-monetary per-unit effect and per-unit cost" (p. 2); these analyses indicate how much it costs to improve a given outcome by one unit (Dhailiwal et al., 2013; Morris et al., 2007). For instance, parenting programme providers might be interested to know how much it costs to improve child outcomes by one point, or by its clinically significant equivalent, on a child behaviour problem scale such as the Eyberg Child Behaviour Inventory (ECBI).

Other cost analyses
There are a number of other types of cost analyses used in the intervention literature:

- A cost–benefit analysis is in some ways similar to a cost-effectiveness analysis but asks whether the economic benefits of a potential investment decision outweigh the economic costs. To do

this it, includes multiple outcomes (Dhailiwal et al., 2013), "measuring both costs and health outcome benefits in monetary units (money saved compared with money invested)" (Peterson & Kearns, 2021, p. 2).

- A cost-utility analysis is a type of cost-effectiveness analysis which is typically represented as a quality of adjusted life year (QUALY) (Charles et al., 2011; Peterson & Kearns, 2021). QUALYs reflects morbidity and quality of life impacts of an intervention (Sampaio et al., 2018), and, importantly, is used to compare interventions whose outcomes are different.
- Cost minimization analyses "compare the cost of alternative interventions that have proven equal effects" (Charles et al., 2011, p. 464). Thus, this approach aims to provide information about which intervention costs less.
- Return on investment analyses "calculate the ratio of money saved to the money invested" (Charles et al., 2011, p. 464). This approach provides information about how much money was saved or could be saved, or the return on an investment as a percentage of the original amount invested. These savings may be found, for example, in the public, social, health, criminal justice and education sectors. Return on investment analyses are preferred and often used in economic evaluations in the USA (Charles et al., 2011).
- Other approaches involve the use of modelling to estimate how much an intervention might cost to deliver under certain conditions (Stevens, 2014). For instance, the Markov method can be used to model costs based on the typical components of a generic intervention (e.g. Bonin et al., 2011).

Guidance on the reporting of cost data

A number of guidelines in the intervention literature outline what information should be provided when reporting cost evaluations. Guidelines by Drummond and Jefferson (1996) for the *British Medical Journal* state that studies should provide information on: study design (e.g. costing perspective chosen such as that of the health system or implementing organization), form of evaluation (e.g. approach used such as cost-effectiveness analysis or cost–benefit analysis), selection of alternatives (e.g. comparator programme), costing information (e.g. currency and year), benefit measurement and valuation (e.g. primary outcome measure of interest), effectiveness data (e.g. results, including a confidence interval), modelling (e.g. justification of model choice), adjustments for timing of costs and benefits (e.g. length of time over which costs were considered), and allowance for uncertainty (e.g. assumptions and limitations) (Drummond et al., 2015). Another reporting guideline is the Consolidated Health Economic Evaluation Reporting Standards (CHEERS), which outlines 24 items to consider in conducting and reporting on economic evaluations (Husereau et al., 2013). This checklist puts the items into a number of general categories on which to report: title and abstract (e.g. justification of the need for an economic evaluation), methods (e.g. model choice and justification), results (e.g. description of differences among subgroups of participants), discussion (e.g. generalizability of results) and other (e.g. conflicts and funding). Building on the above, violence researchers recommend that cost evaluations report on the estimated number of violent incidents prevented by the programme and the average programme cost to avoid a violent incident (Peterson & Kearns, 2021).

Economic evidence

This section summarizes the evidence identified on economic evaluations of parenting programmes. As there have been relatively few economic evaluations of parenting programmes in LMICs, then we draw on review evidence from HICs, including studies relevant to any of the child and parent outcomes prioritized for the Guideline (Gardner et al., 2021), as well as considering broader, related programmes,

including home visiting. Thus we review findings from or about: programmes delivered in HICs; (the paucity of) evidence from programmes delivered in LMICs; costing vis-à-vis individual and group characteristics; participant costs; staff costs; costs associated with universal and targeted delivery, research and practice contexts, and delivery to individuals and groups; and long-term cost implications.

Evidence syntheses from HICs

A number of evidence syntheses have been conducted on the costs of parenting interventions, some of which are systematic reviews or reviews of economic evaluations of various parenting programmes, and some of which are reviews of the economic evaluations conducted on a single parenting programme (e.g. Triple P or Incredible Years). Eight syntheses are summarized as follows:

1. The earliest systematic review found was published by Charles and colleagues (2011) on economic evaluations of parenting programmes aimed at reducing conduct disorders. The systematic review included six papers from HICs that found interventions cost between GBP629 and GBP3,839 per child at 2008/2009 rates (Charles et al., 2011).
2. A systematic review by Stevens (2014) of parenting programmes aimed at reducing child conduct disorders in the UK included three economic evaluations (Edwards et al., 2007; Harrington et al., 2000; Muntz et al., 2004), although it should be noted that some involved multi-component interventions that were not purely parenting interventions. They found the interventions cost between GBP189.09 per child in 1999/2000 (Muntz et al., 2004) and GBP1,934 per child in 2003/2004 (Edwards et al., 2007). Harrington et al. (2000) found that the costs of delivering a programme to parents in community versus hospital settings were comparable (GBP374 and GBP488, respectively, on average per child at 1998/1999 prices). Edwards et al. (2007) found that the Incredible Years programme cost GBP1,344 per child at 2003/2004 rates to move the average child's conduct problem score below the cut-off point for clinically significant behavioural difficulties.
3. A systematic review by Dalziel and Segal (2012) of 33 home visiting programmes aimed at preventing child maltreatment found that intervention incremental cost-effectiveness was between AUD1,800 and AUD30,000 per family at 2010 rates. The cost saved per case of child maltreatment prevented ranged widely from AUD22,000 to several million AUD (Dalziel & Segal, 2012). All of the studies included in the review were from HICs and were conducted within the context of an RCT (Dalziel & Segal, 2012).
4. In a systematic review looking at studies of the costs of parenting programmes in HICs that were aimed at improving parent–child interaction, 10 studies reported on targeted and/or universal programmes (Duncan et al., 2017). The authors found that per participant costs ranged from GBP700 to GBP1,200, with total programme costs ranging from GBP11,000 to GBP115,000 (based on groups of eight parents) at 2012 rates, with universal programmes at the lower end of the range. In addition, the parenting interventions were estimated to save the health sector GBP2,500 per family over the 25 years post-intervention and save the criminal justice system GBP145,000 over each child's life course (at 2012 rates) (Duncan et al., 2017).
5. A synthesis of economic evaluations of Triple P delivered in Australia found that group-based programmes had an incremental cost-effectiveness ratio of AUS1,013 per disability-adjusted life year (DALY), and individual programmes had an incremental cost effectiveness ratio of AUD20,498 per DALY (at 2013 rates) (Sampaio, Barendregt, et al., 2018). For reference, interventions are typically considered cost-effective below a threshold of AUD50,000 per DALY (Sampaio, Barendregt, et al., 2018). Using this threshold, both the individual- and group-based programmes studied in Sampaio's analysis were found to be cost-effective.

6. In a synthesis of 14 trials of the Incredible Years programme in Europe, the authors concluded that the average cost per participant was GBP2,414 at 2014 rates, with some costs being as high as GBP4,675 per participant (Gardner et al., 2017). The programme was estimated to produce cost savings of between GBP1,000 and GBP8,400 per child 20 years post-intervention, and through modelling, was calculated to be cost-effective when programme costs were equal to or less than GBP145 per unit improvement on the ECBI-Intensity scale (Gardner et al., 2017).
7. A review of parenting interventions targeting child mental health and behaviour problems by Sampaio et al. (2018) summarized 22 studies from HICs, finding the interventions "likely to be cost-effective" (p. 817).
8. A systematic review of economic evaluations of violence prevention programmes included six studies of programmes in HICs aiming to prevent child abuse and neglect (Peterson & Kearns, 2021). These six studies examined the cost of avoiding each incident of violence, which ranged from GBP1,691 to GBP54,370 at 2004 prices.

It is important to note how difficult it is to compare the costs of the different programmes referred to above as a result of numerous factors (e.g. different cost analyses reported, different numbers of participants, group versus individual delivery). These variations aside, in HICs the syntheses generally found parenting programmes: to be cost-effective; demonstrated a range in costs between group-based and individual programmes and between standard and intensive treatment, with universal programmes costing at the lower end of a range of costs; and demonstrated a substantial range in costs per participant, per family, and per violent incident avoided. With regard to the variation in costs per participant, the costs found in HICs ranged from approximately GBP169 per participant to deliver the Common Sense Parenting programme in the UK to GBP3,839 per participant to deliver more intensive programmes targeting conduct disorder (at 2008/2009 rates) (Charles et al., 2011). Within the range, a behavioural parent training programme in the UK cost GBP189 per child at 2008/2009 prices (Muntz et al., 2004); the Caring in Chaos programme in Denmark cost US$1,179 per family at 2015 prices (Scavenius et al., 2020); the Incredible Years group-based programme in Ireland cost GBP1,200 at 2013 prices (O'Neill et al., 2013), and in Wales cost GBP1,344 per child at 2003/2004 prices (Edwards et al., 2007), and in Slovenia a considerably lower EUR964 at 2018/2019 prices (Ponikvar et al., 2021). In a pooled analysis of five trials in the UK and Ireland, Incredible Years was found to cost on average GBP2,414 per person at 2014 prices (Gardner et al., 2017). Although not an exhaustive list of all cost analyses in HICs, this range of costs provides a general sense of what interventions cost to deliver, albeit with some variation in costing models in different studies.

In terms of programme costs in relation to savings on violent incidents avoided, a study of a home visiting programme for new mothers in the USA found that it cost US$1 to avoid US$6 due to violent incidents (at 2013 prices) (Peterson et al., 2018), whereas a Multisystemic Therapy programme for families involved with child protection in the USA found that it cost US$1 to avoid US$3 in violent incidents (at 2015 prices) (Dopp et al., 2018). In terms of programme incremental effectiveness in HICs, for a one-point improvement in child conduct problems (ECBI), as a result of taking part in the Incredible Years programme, the cost was variously found to be EUR72 (in 2008/2009) in Ireland (O'Neill et al., 2010), GBP73 (in 2003/2004) in Wales (Edwards et al., 2007), and GBP145 per unit (in 2014) in the pooled UK and Ireland dataset (Gardner et al., 2017). For a more intensive parenting programme in Wales for treating conduct problems in more specialist services, a GBP224 cost was estimated per unit of improvement in externalizing behaviour on the Child Behaviour Checklist at 1999/2000 prices (Muntz et al., 2004).

Costs and cost-effectiveness in LMICs

Although there are relatively few cost analyses of parenting programmes in LMICs, some research has found (not surprisingly) that it is more expensive to deliver parenting programmes in HICs than in LMICs (Norman et al., 2012). Further, based on additional studies found outside the above eight syntheses, average per participant and per family costs range from US$3 per child to deliver the Better Parenting Programme in Jordan (2000 prices) (Brown, 2000) to US$504 per family to deliver the 14-session Parenting for Lifelong Health for Teens programme in South Africa at 2015 prices (Redfern et al., 2019). Other examples of programmes in LMICs falling within this range include the following:

- Carneiro et al. (2019) studied two versions of a parenting programme in Chile called Nobody is Perfect – a basic eight-session group intervention, and an intensive group intervention involving an additional two sessions with children. Their analysis found that each session of the basic group programme cost US$1.59 per family, each session of the intensive group programme cost US$2.12 per family, and each individual home visit cost US$9.15 per family (2019 rates). The study also found that the intervention cost an average of US$22 per family for staff labour costs at 2019 rates (Carneiro et al., 2019).
- A study of the Child Home Activities and Materials Packet (CHAMP) and Mother Literacy-CHAMP programmes aimed at supporting families with their child's at-home learning found that the intervention cost between US$17 and US$50 per family at 2011 rates (Banerji et al., 2013).
- A cost analysis of the SOS (Help for Parents) programme aiming to reduce parent–child conflict in Iran found that it cost US$20 per family (year prices not provided, but likely to be in mid-2000s) to deliver this two-session programme (Oveisi et al., 2010).
- A parenting programme to advance child development and parenting skills for families in Mexico found that the programme cost MXN1,100.97 per child (or approximately US$70) at 2015 prices (Cardenas et al., 2017).
- A study of a parenting programme to improve family finances, child well-being and parenting skills among ultra-poor families in Burkina Faso found that this five-session programme cost US$228 per household to deliver (year prices not provided) (Ismayilova & Karimli, 2020).

While there are some cost analyses of parenting programmes in LMICs, many more studies articulate that the programmes are low-cost without providing a cost analysis. For example, a study by Lin and colleagues (2016) describes the costs of a parenting intervention to reduce unhealthy eating among children in China as being minimal, but does not provide the costs associated with "the card design, material printing and minimal human work" (p. 902). Only one study was found with regard to programme costs per violent incident avoided in LMICs. This study of the Parenting for Lifelong Health Teens programme found that each incident of physical or emotional abuse prevented cost US$1,837 and estimated the cost to be US$972 at scale (2015 prices) (Redfern et al., 2019). A couple of other studies examined incremental cost-effectiveness. A study by Cardenas et al. (2017) of a parenting programme in Mexico found that it cost US$23.85 for each 0.1 point of improvement on the Parenting Practices Index, with an average participant improvement of 0.34 (2015 prices). A study of the CHAMP and Mother Literacy-CHAMP programmes in India found that it cost US$2.06 per standard deviation improvement in child literacy and mathematics in CHAMP and US$3.64 per standard deviation improvement in child literacy and mathematics in Mother Literacy-CHAMP (Banerji et al., 2013). Thus, with the dearth of cost evaluation evidence from LMICs, there is much work to do.

Case Study 2: Costing of Parenting for Lifelong Health in LMICs

As there is substantially less cost evidence for parenting programmes in LMICs, this case study explores one completed and a number of ongoing cost analyses of the Parenting for Lifelong Health Teens (PLH-Teens) and Kids (PLH-Kids) programmes across LMICs on three continents. Regarding PLH-Teens, there is a published paper on a cost analysis conducted on the delivery of the programme in South Africa in the context of an RCT (Redfern et al., 2019). There is also an ongoing cost analysis being conducted of the delivery of PLH-Teens at scale in Tanzania. With regard to PLH-Kids, there are two ongoing analyses: one in Thailand and one in Southeast Europe (North Macedonia, Moldova and Romania).

South Africa (Redfern et al., 2019)
The first and only published cost analysis of a PLH programme is on the implementation of PLH-Teens, locally known as Sinovuyo Teens. The treatment group consisted of 270 families. The cost analysis compiled retrospective costs of programme delivery from the perspective of the programme provider. The study calculated the cost to deliver the programme, the number of violent incidents prevented, the cost per violent incident prevented, the potential long-term savings of the intervention, and the estimated cost to deliver at scale. All costs are in 2015 US$. To calculate the overall cost to deliver the programme, the researchers collected three types of cost data: set-up costs (e.g. facilitator recruitment and training), delivery costs (e.g. staff salaries, participant transportation costs) and overhead costs (e.g. office expenses). The study found that the intervention cost a total of $135,954, or $504 per family. Set-up costs totalled 10% of the budget ($13,664). Of this, $6,511 was spent on programme preparation (e.g. recruitment activities), and $7,153 was spent on programme training (e.g. facilitators). Programme delivery costs totalled $112,591 (83% of overall costs). Of this, $79,108 was for staff costs, and $33,483 was for material costs (e.g. food). Overhead costs totalled $9,700 (7% of overall costs). Using this information and modelling differences at scale, the researchers estimated the costs of delivering the programme to 1,000 families. A number of assumptions were made to estimate the costs at scale, including that there would be economies of scale related to programme materials and management support. The estimated total cost at scale was $266,380, with $32,288 in set-up costs (12%), $219,212 in programme delivery costs (82%) and $14,880 in overhead costs (6%).

Using information on DALYs lost due to VAC as well as the incidence of VAC in South Africa, it was estimated that 73 violent incidents of emotional and physical abuse were prevented among the 270 parents in the treatment group. Based on this estimate, the programme cost $1,837 per incident prevented, or $972 per incident prevented if delivered at scale. Using information on costs of VAC to the health care, social science and justice systems, it was estimated that the intervention would result in long-term savings of $2,724 per incident of abuse prevented.

Tanzania (Martin et al., forthcoming)
An ongoing cost analysis of the PLH-Teens programme taking place in Tanzania, locally known as Furaha Teens, is being delivered to 50,000 parent–child dyads (N=100,000 participants) in schools (by teachers) and community centres (by community health workers) across eight districts of Tanzania by Pact Tanzania and a number of local implementing partners, including the Tanzania Red Cross Society and the Integrated Rural Development Organization (Martin et al., 2021). The scale-up of the programme is the largest implementation of PLH-Teens to date. The cost analysis is using budget records from Pact Tanzania, as well as retrospective cost estimates from programme staff. In particular, a number of cost forms were created by PLH team members to capture elements of the programme and its management. These forms were then used by facilitators, coaches and local implementing partner coordinators to estimate how much time (in minutes) or how much money an average instance of each task took. To analyse the data, the amounts provided by staff will be multiplied by the number of times each task was

performed by each staff member and then multiplied by the number of times each staff member was involved in programme delivery. To date, 306 forms have been collected. The cost data collected will be analysed using the micro-costing framework model and broken down by cost per district, local implementing partner, facilitator type, family and programme component. Such a breakdown will provide the basis for comparing the costs of delivering PLH-Teens at scale with the actual costs of the trial in South Africa and the estimated costs of programme delivery at scale conducted by Redfern et al. (2019).

Individual and group characteristics

A minority of studies found in the literature report on cost differences based on factors related to individual, group or population characteristics (e.g. gender, number of participants). Regarding participant number, Evans and Popova (2014) observed that programmes with fewer participants tended to have higher costs, and cautioned that these higher costs per participant might lead to overestimates about how much such programmes cost at scale. Similarly, a study by Charles and colleagues (2013) of the Incredible Years intervention found it cost GBP752.63 per participant in 2008/2009 to deliver to a group of eight parents and estimated it would cost GBP633.61 per participant at 2008/2009 rates to deliver to a group of ten parents. The finding suggests that there is potential for parenting programmes to benefit from economies of scale (e.g. the number of staff required to deliver a programme to a group of participants may remain the same even with more participants in the group). At the same time, there is likely to be a marked limit on the quality of discussion and learning if groups are too large.

With regard to the gender of child beneficiaries, a synthesis of Incredible Years studies conducted by Gardner and colleagues (2017) found that, on average, it cost GBP340 more to deliver the programme to boys than girls (2014 rates). A study by Romeo et al. (2006) also found that it cost more to deliver a programme aimed at reducing antisocial behaviour to boys (2006), whereas Knapp et al. (2015) found it cost more to deliver other mental health interventions to girls. A number of other participant characteristics have also been examined in relation to programme costs. In the study by Gardner et al. (2017) the authors found no differences in cost based on participant socio-economic status, ethnicity, ADHD status or baseline emotional problems but found some decrease in costs and a suggestion of increased cost-effectiveness with older children. The latter finding is similar to the results of other studies (Beecham et al., 2009; Dorrington et al., 2014). Estimates of cost variation by group are likely to be more useful for decision makers if they are combined with cost-effectiveness analysis by group. For example, the implications of the finding that costs are greater for boys alter, if interventions are also more effective for boys, as has been found in some trials and meta-analyses (Shelleby & Shaw, 2014).

Participant costs

A critical factor when considering the cost of parenting interventions is the cost – financial and time – incurred by parent participants. A cost analysis by Scavenius et al. (2020) of the Behavioural Parent Training Programme in Denmark found that families invested an average of 35 hours in the programme. Some studies have found that parent commute time and transportation costs to attend programme sessions are significant, and sometimes even a barrier to participation. For example, a qualitative analysis of a programme in Mexico found that transportation time and cost were barriers to attendance; in a further iteration of programme delivery, participants' transportation costs were reimbursed – which increased attendance (Martínez-Andrade et al., 2014). As this additional feature cost the programme an average of US$1.27 per participant (Martínez-Andrade et al., 2014), it was a good investment – one that could be considered when setting other programme budgets. Other ways to reduce parent

transportation burdens are also being studied. Mejia et al.'s (2015) study on implementation of Triple P in Panama City tested delivery of a single-session version of the programme to address participant financial and time barriers and found that the programme had moderate effects on child behaviour in the short term and larger effects in the long term. Online programme delivery may be another way to reduce commute time and financial costs to participants. For example, Mohamadi et al. (2014) found that online delivery of a programme to mothers of Grade 1 students in Iran was a good way to improve parental outcomes and ensure low-cost participation. Aside from commute time being a potential barrier, the length of various programme components has also been considered. In a number of qualitative studies, including one in Canada involving semi-structured interviews with 30 caregivers who participated in SafeCare to reduce child neglect, parents indicated that programme sessions were too long or that modules took too long to complete (Gallitto et al., 2018).

While in some studies parents indicated that the amount of time necessary to participate in parenting programmes was a barrier to their attendance, a number of qualitative studies indicate that parents believed that the investment was worthwhile. For instance, a study of the ACT-Raising Safe Kids programme aimed at reducing child maltreatment in Portugal found that parents believed the two-hour session was appropriate in length and worth the time they invested (Ramos et al., 2019). However, many of the same parents also indicated that finding sufficient time to attend the sessions was an obstacle.

Staff costs

Some economic evaluations of parenting programmes examine the costs of different intervention components. The focus of the limited literature in this area is on the biggest cost to parenting programme budgets: staff salaries and other staff-related costs. In a study of Incredible Years by Charles and colleagues (2013), staff wages were the biggest programme cost, and staff salaries and training were identified as the biggest cost in an earlier review by Charles et al. (2011). An analysis of a child behavioural intervention for first and second grade students in Colombia found that during the intervention, teachers invested 40 hours in workshops in addition to spending an unreported amount of time on 10 coaching sessions (Klevens et al., 2009). Additionally, the authors suggested that overall, participating in the intervention saved the teachers time by reducing children's disruptive behaviours in the classroom. A study of the Parenting for Lifelong Health-Teens programme found that staff costs made up 58% of the intervention budget (Redfern et al., 2019). A study of the CHAMP and Mother Literacy-CHAMP programmes in India found that staff costs made up approximately 84–87% of their intervention budgets (Banerji et al., 2013). Some researchers and practitioners have attempted to minimize this cost by using volunteer facilitators. For instance, the implementation of the Behavioural Parent Training in Denmark used volunteer facilitators (Scavenius et al., 2020). The study found that the volunteer facilitators donated 45.6 hours to their training and 49.5 hours to programme implementation per parenting group. However, the long-term sustainability of such a 'staffing' training and delivery model is debatable. While staff appear to be the biggest cost in parenting interventions regardless of the country income context, the costs of workers in LMICs may be lower for equivalent professionals, plus many of programmes in LMICs employ community health workers with less training and education.

Universal and targeted delivery

A small number of cost evaluations of parenting programmes examine and compare costs based on whether programmes are delivered via universal or targeted approaches. The systematic review conducted by Duncan and colleagues (2017) found that for universal programmes, costs per participant ranged between GBP290 and GBP3,900 at 2012 rates, and for targeted programmes ranged between

GBP1,400 and GBP9,500 at 2012 rates. The fact that universal interventions are generally less costly than targeted interventions is a result of the latter being more intensive and often requiring more highly skilled staff. However, it is unclear whether lower-cost universal delivery approaches can improve outcomes sufficiently to be cost-effective. Many trials and systematic reviews have found that universal programmes have considerably lower effect sizes, especially with regard to child behaviour problem outcomes (Leijten et al., 2019), meaning that lower cost per family might not justify the choice of a universal intervention if it is not cost-effective.

The workplace is one potential setting for the delivery of universal programmes. For example, a South African programme aimed at preventing HIV and enhancing parent–child education with regard to sexual health was delivered through the workplace (Bogart et al., 2013). Although a cost analysis was not performed, implementation of programmes at the parental workplace may encourage participation in programme sessions and enhance productivity at work by addressing challenges experienced at home (Bogart et al., 2013). However, there is little evidence available regarding workplace interventions, their costs, and their impact on families and the workforce.

Costs in research and practice

Economic evaluations of parenting programmes can be conducted both within the context of routine service delivery or as part of more formal evaluations such as RCTs. One take-away from the findings appears to be that programme delivery in the context of a research study is associated with increased programme cost. For instance, in a study by Charles and colleagues (2013), it cost GBP9,326.73 to deliver Incredible Years to a group of eight parents in a real-world context, whereas it cost GBP12,074.25 to deliver it in a research context (2008/2009 rates). Other contextual factors also impact costs – such as geographic location of programme delivery (e.g. country or rural versus urban). For instance, Charles et al. (2013) conducted a sensitivity analysis of the delivery of Incredible Years and found it would cost an extra GBP1,695.38 (at 2008/2009 rates) to deliver the same programme in London than where it was delivered in Wales.

Delivery to individuals and groups

Another line of inquiry in the literature on the economics of parenting interventions concerns whether there are differences in costs between interventions delivered to individuals or groups. A number of recent studies suggest that group-based programmes are less costly than individual-level programmes. There is also evidence that group-based programmes are just as effective in improving family outcomes. A cost analysis of parenting programmes delivered at scale in routine services in the UK (Puig-Peiro et al., 2010) found that the median cost of group programmes was GBP952 per parent (range in costs from GBP282 to GBP1,486) whereas the median cost of individual programmes was GBP2,078 per parent (range in costs from GBP769 to GBP5,642). A study in Canada similarly found that individual-based parenting programmes were six times more expensive than group-based programmes but were similarly effective (Cunningham et al., 1995). A modelling study of parenting programmes to address child conduct problems in the UK found mean incremental costs of GBP90 for group programmes, GBP1,380 for individual programmes delivered at home, and GBP2,400 for individual programmes delivered in a clinic (2004 prices) (McCabe et al., 2005). Further, the synthesis by Sampaio, Barendregt, et al. (2018) previously referred to found group-based programmes to be more cost-effective. However, the literature is not entirely consistent. Although studies show that group-based programmes are less costly and tend to be equally effective, it is important to note that, depending of course on the basis for the cost analysis, the difference in costs between individual and group programming may not be as

substantial as they appear, as larger groups require more preparation and longer sessions to allow everyone to participate.

Long-term cost implications

While there is emerging evidence to indicate that parenting programmes are cost-saving in the long term, these findings should be interpreted with caution, as it is difficult to estimate the long-term benefits of parenting programmes, especially as these estimates rely on numerous assumptions. A study of a group-based programme aiming to reduce child conduct problems in the UK by McCabe and colleagues (2005) estimated long-term cost savings of GBP70 per family (2004 prices). The synthesis by Gardner et al. (2017) of Incredible Years in Europe estimated the savings to be GBP1,000 to GBP8,400 per child over 20 years post-intervention at 2014 rates. A study of Triple P in Australia estimated total cost savings of AUD40.5 million at 2002/2003 rates (Mihalopoulos et al., 2007). A modelling study of a generic parenting programme aimed at reducing child conduct problems in the UK estimated a public sector savings of 2.8 to 6.1 times the intervention cost over the 25 years post-intervention, or approximately GBP14 in savings for every GBP1 invested in the intervention (2008/2009 rates) (Bonin et al., 2011). Further, a review of parenting programmes aimed at improving parent–child interaction estimated savings of GBP30 to GBP3,500 per child in the special education sector post-intervention, savings of GBP16,000 (over five years post-intervention) to GBP145,000 (over a lifetime) in the criminal justice sector, and savings of GBP1.60 per person (at one-year follow-up) to GBP92,000 per person (over a lifetime) in the social sector (2012 rates) (Duncan et al., 2017).

Thus, although a variety of studies estimate long-term savings, potential savings are hard to estimate, due to the possibility that impacts of a programme may develop over time (Stevens, 2014) or potentially fade out (van Aar et al., 2017). Systematic reviews have tended to show reasonable maintenance of effects over time in the subset of studies assessing longer-term effects (van Aar, et al., 2017; Backhaus et al., 2021, Global review for this Guideline). We caution, however, that the evidence that parenting programmes impact harder outcomes (e.g. intergenerational abuse, violent offending, school failure) over time is relatively more limited (Piquero et al., 2012). Nevertheless, the possibility of long-term benefits stemming from parenting programmes highlights the potential contribution that these programmes could have with regard to broader poverty reduction and developmental goals, since by addressing child behaviour problems, VAC and their associated disadvantages (e.g. poverty, low levels of education), such programmes may contribute positively to families and society.

Key issues, insights and gaps

Issues

It is important to acknowledge a number of key issues and considerations in reviewing and weighing the economic evidence with regard to parenting programmes. First and most significantly, the available evidence should be treated with caution, because the overall reporting quality of economic evaluations of parenting and violence prevention programmes, as found by Peterson & Kearns (2021), tends to be poor. Further, some studies have insufficient statistical power to elucidate cost differences (Gardner et al., 2017).

Second, it is worth bearing in mind that all cost analyses require assumptions and are influenced by bias. Assumptions need to be appropriately justified and suitable for the programme being evaluated (Dhailiwal et al., 2013). An important form of bias in many cost evaluations is recall bias, which arises when costs are based on recollections of past events and can thereby lead to inaccurate reporting

(Evans & Popova, 2014). Many evaluations of parenting programmes, including the cost analyses of PLH described in Case Study 2, use retrospective cost estimates.

Third, as the evidence presented in this document illustrates, programme costs are difficult to compare, as there are considerable differences in which costs are included, how they are calculated, and the perspective from which costs are reported (e.g. the government, participants, the community, the implementation organization) (Dhailiwal et al., 2013). Further, evaluators tend to study different outcomes and programmes with differing components (Stevens, 2014). Poor reporting quality heightens these comparability issues, as insufficient information is typically provided to make informed decisions about how to harmonize data from different studies. This was the experience of Gardner et al. (2017) in pooling cost data from several trials of the Incredible Years programme in Europe. For these and other reasons, it is difficult to use the findings of a cost evaluation of one programme to estimate the cost of implementing the same or similar programme in different contexts and under different conditions.

Fourth, as can be seen from the studies cited herein, most economic evaluations of parenting programmes are from high-income contexts. This is yet another limitation on the generalizability of the economic evaluation results – particularly to LMICs.

Fifth, cost evaluations require transparency about resources that were provided for free, as these resources may need to be paid for in other ways which, if not considered, could potentially make an intervention unsustainable in the long term (Dhailiwal et al., 2013). Examples of resources that might be provided at no-cost include venues (e.g. use of a classroom or workplace), management or administrative services (e.g. programme administration services provided by a non-profit organization), and human resources (e.g. volunteer facilitators). Therefore, the cost of such resources should be factored into economic evaluations (Scavenius et al., 2020); if they are not, the estimates provided should be treated with caution.

Sixth, when conducting cost evaluations, there is a risk of underestimating the value of violence reduction and prevention programmes by failing to take their spillover effects into account (Redfern et al., 2019). Typically, evaluations of parenting programmes focus on a single parent–child dyad and measure the outcomes for one child. However, parent participants may have more than one child, and recent systematic review evidence suggests that the functioning of siblings of the target child also improves as a result of the parent's participation in the programme (Leijten et al., 2021). When these spillover effects are not incorporated into cost analyses, potential benefits of the intervention are undervalued (Redfern et al., 2019). Put another way, some cost evaluations may understate the value of interventions by putting insufficient weight onto the benefits parenting programmes can provide to families (Dalziel & Segal, 2012). This may be the case in particular where evaluations of parenting programmes are often focused on short-term rather than long-term outcomes (Gardner et al., 2017). Conversely, it is also possible that benefits stemming from parenting interventions are overestimated due to generous assumptions regarding programme impact – for example, related to outcome reporting bias, common in trials in many fields, or to use of unblinded outcome reporting by parents, which is common and somewhat unavoidable in trials in this field.

Insights

A review of the economic evaluation evidence with respect to parenting programmes has resulted in the following general insights:

- Programme costs appear to vary, based on the country in which they are conducted. Some research has found that it is more expensive to deliver parenting programmes in HICs than LMICs. Cost evaluations from HIC contexts demonstrate a very wide range in costs per programme, per participant, per family, and per violent incident avoided. While there are some cost analyses of parenting programmes in LMICs, many studies from these settings simply assume that programme costs are minimal.
- Despite the cost of programme delivery, studies from HICs typically find parenting programmes to be cost-effective. While the estimates ranged widely, studies from HICs predicted that programmes would result in long-term savings for the public sector.
- Programmes delivered to individuals tend to be costlier than those delivered to groups, and programmes delivered to groups with fewer participants tend to be costlier per participant than those delivered to groups with more participants.
- There is evidence that targeted programmes tend to be costlier than universal programmes; programmes delivered in urban contexts may be costlier than those delivered in rural contexts; and programmes conducted in the context of RCTs tend to be costlier than those conducted in the context of routine service delivery.
- Most of the evidence indicates that programmes cost more to deliver to boys than girls, but this finding was not consistent. Further, one study found some decrease in costs for programmes with older children.
- The most significant programme costs are for staff training and other labour costs. In LMICs, these costs may be less, as many programmes employ community health workers with less training and education.
- Time (commute time, session time and length of modules) was a barrier to participant attendance. However, parents viewed the time investment in the programme as being worthwhile.
- Transportation costs were also a barrier to participant attendance. Potential solutions to this obstacle included online delivery, fewer sessions and paying for parent transportation costs, the latter appearing to be a cost-effective solution.

Gaps

Aside from those gaps stemming from the issues described above under 'Issues' (poor overall reporting quality; limited comparability of cost evaluations; insufficient evidence from LMICs), a number of other gaps in our understanding of the costs associated with parenting programme were identified, and these should inform future research and practice concerning the economics of parenting interventions:

- Most cost evaluations focus on parenting programmes aimed at addressing child behaviour problems rather than child maltreatment. This issue could be rectified by making the collection of cost data a routine component of programme evaluations (Peterson et al., 2021; Charles et al., 2011).
- Most studies on interventions do not collect information on costs or provide enough information to calculate costs (Dhaliwal et al., 2013). Of those studies that do, there is frequently insufficient detail provided about how the cost data were collected and the cost perspective taken (Stevens et al., 2014). For instance, very few studies indicate the perspective chosen when reporting costs, which is an important detail, as the perspective chosen influences the costs actually collected (Charles et al., 2011).
- There is little information on differences in cost-effectiveness based on participant characteristics/status or potential programme moderators (see Gardner et al., 2017 for an exception). These sorts of analyses would provide practical information about whether costs

differ based on the characteristics of programme participants or contextual factors related to programme delivery.
- There is little information on the full economic benefit of parenting programmes vis-à-vis the impact on the child, their family and society.

Conclusion

Ultimately, to improve the lives of vulnerable children and their families, programme providers need to be able implement interventions with the available resources. Although there is some evidence regarding the costs of parenting programmes and their potential benefit to children, families and society, substantially more information is needed to understand their costs in LMICs, and in particular their long-term value

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WHO-INTEGRATE Chapter 4, Health equity, equality and non-discrimination

WHO-INTEGRATE questions:

- How are the prevalence of family-level risk factors for and determinants of child maltreatment distributed across different population groups? Are parenting programmes likely to reduce or increase existing health inequalities and/or health inequities? Do parenting programmes prioritize and/or aid those furthest behind? How do such impacts on health inequalities and/or inequities vary over time? For instance, are initial increases likely to balance out over time, as parenting programmes are scaled up?
- How are the benefits and harms of parenting programmes distributed across the population? Who carries the burden (e.g. all), and who benefits (e.g. a small subgroup)?
- How accessible – in terms of physical as well as informational access – are parenting programmes across different population groups?

Introduction: Overview of equity concepts, methods and current knowledge

Violence against children is not evenly distributed across societies and social groups. It is more common in families affected by social disadvantages such as poverty, migration, food insecurity and community violence (Akmatov, 2011; Hillis et al., 2016, Meinck et al., 2015; Stoltenborgh et al., 2013). Globally, there is much variation by country, culture, region and across time (UNICEF, 2014). For example, corporal punishment of children in the home tends to be more common in LMICs, and is correlated inversely with country-level human development indices (Cuartas et al., 2019). Notwithstanding the large variation between and within countries and regions, many surveys have found overall higher prevalence of corporal punishment and physical abuse in South Asia, South America and Africa (Moody et al., 2018; Cuartas et al., 2019; Lansford & Deater-Deckard, 2012; Straus, 2010).

Moreover, the adverse consequences of child maltreatment disproportionally affect families and communities already suffering the effects of poverty and violence, compounding social and health inequalities across generations. Hence, it is vital to assess the role of parenting interventions in contributing to equity, by assessing if these interventions are likely to reduce rather than widen existing inequalities.

Approaches to equity

We define inequity as unfair or avoidable differences in health status or in the distribution of health determinants between different population groups, such as, for example, racial, ethnic, sexual orientation or socio-economic groups (O'Neill et al., 2014; Welch et al., 2010). We draw on the PROGRESS-Plus framework which applies an equity lens to interventions by considering factors such as place of residence, race/ethnicity/culture/language, occupation, gender/sex, religion, education, socio-economic status, and individual factors such as age or disability (O'Neill et al., 2014; Higgins et al., 2019).

We use Jull et al.'s (2017) framework to consider the extent to which the parenting intervention trials in our reviews are 'equity relevant'. Their framework was developed using a consensus process, drawing on PROGRESS-Plus factors. It suggests that randomized trials are equity relevant if they either focus on a population experiencing social disadvantage or use trial data to assess whether the intervention has differential effects by levels of disadvantage as defined by PROGRESS-Plus factors (e.g. race, poverty,

gender). By this definition, many of the trials in our reviews, and the evidence gleaned from other methods, as listed below, provide useful equity-relevant evidence.

Inequity of access
For many health and social interventions, there is inequity of access, due to financial, time, informational or discrimination-based barriers faced by disadvantaged groups (Strauss et al., 2015; Mathews et al., 2015). Many parenting programmes attempt to overcome these barriers in various ways, including by targeting and engaging the communities and families most in need, and providing support to increase accessibility (e.g. food, transport, convenient location) and reduce disparities. Although this may help to reduce inequity of access, targeting may cause problems in terms of the stigma that can, in some contexts, be attached to attending a parenting programme.

To help inform considerations of access, we use data from trials in our LMIC review (Gardner et al., 2021, conducted for the WHO Guideline) to conduct a descriptive analysis of ethnicity and levels of poverty of families taking part in parenting programmes that show evidence of effectiveness. Of course, access to interventions that are tested as part of a trial is not the same as access to interventions as part of routine services, but data on routine access are more limited in LMICs. We also summarize evidence from Chapter 2, 'Feasibility and systems considerations', comparing levels of poverty of families enrolled vs. families who declined or did not attend parenting programmes. These issues, including barriers to access, are discussed further in Chapter 2; stigma is discussed in Chapter 1, harms.

Inequity of outcome
We focus where possible on LMICs in this chapter, and on the issue of equity of outcome, as this has been extensively investigated in the context of effectiveness studies, within multiple designs and contexts, albeit the majority of these in HICs. We focus on questions of whether there are differential outcomes of parenting interventions for disadvantaged groups, such as, for instance, families affected by higher levels of poverty or violence, or low levels of education. It is unclear whether *a priori*, we would expect parenting interventions to be likely to generate inequities or not. Lorenc et al's (2013) review suggests that behavioural, rather than structural interventions might be more likely to generate inequities, a conclusion based on a small set of trials in the public health field.

There is a body of evidence from HICs relevant to equity questions, based on studies of moderators of parenting intervention effects, that assesses whether there are differential outcomes for different subgroups of families taking part in intervention trials. These findings, based on older (e.g. Lundahl et al., 2006; Reyno & McGrath, 2006) and newer (Leijten et al., 2013) meta-analyses, trials of varying sizes (Gardner et al., 2009, 2010) and reviews of individual trials (e.g. Shelleby & Shaw, 2014) have yielded somewhat mixed conclusions about whether disadvantaged and distressed groups are likely to benefit more than, less than or the same as families not experiencing such disadvantage (Gardner et al., 2019a). This lack of clarity may be due to contextual differences or to methodological limitations (van Hoorn et al., 2017). For example, many studies are based on secondary analyses that were not pre-registered, of individual-level data in underpowered trials; others conduct meta-analysis of cruder trial-level data across heterogeneous studies, leading to problems in terms of inadequate power and confounding between moderators.

The accepted optimal solution to these problems (Cooper & Patal, 2009; Riley et al., 2010) is to pool data across trials using Individual Participant Data (IPD) meta-analysis, greatly increasing power and precision, and yielding greater ability to control for confounders compared to aggregate-level meta-

analysis of moderators. Although studies using IPD meta-analysis represent in many ways a 'gold standard' for assessing moderator effects, they can have limitations in terms of generalizability. First, they are very labour-intensive, and so may focus only on homogenous sets of studies – for example, Gardner et al.'s (2019a, 2019b) IPD meta-analysis of a near-complete set of 14 trials of the Incredible Years parenting programme in Europe – albeit an intervention that has many components in common with other programmes implemented around the world. Other IPD meta-analyses are designed to be more inclusive, but there may be trade-offs in terms of the proportion of includable trials for which it is feasible to obtain and process data. For example, a recent IPD meta-analysis of trials of parenting and other behavioural interventions for children with ADHD found 62 eligible trials but only obtained data from 23 (37%) of them (Groenman et al., 2021). Second, to date, parenting IPD studies include trials only from HICs, although these may include high numbers of ethnic minority families. Generally, although there have been many trials of parenting interventions in LMICs, there have been relatively few moderator investigations, and no comprehensive reviews of moderators in these countries or IPD meta-analyses of parenting interventions.

Given the paucity of the highest-quality IPD studies, especially in LMICs, to maximize information about moderator effects, balancing rigour and generalizability obtained from different approaches (Gardner et al., 2019a), we use data from multiple complementary methods, including aggregate, trial-level analyses from systematic reviews, individual-level data drawn from single trials, and IPD meta-analysis from HICs.

Methods

We used the following three methods/approaches to address the question of whether parenting programmes show differential effects for those facing the greatest disadvantage. We then draw together these findings to address the question of whether these interventions are likely to reduce or increase existing health inequalities, with a primary focus on LMICs.

1. Moderators in the LMIC systematic review

We drew on data from the systematic review of randomized trials of parenting interventions in LMICs conducted as part of the WHO Guideline process (Gardner et al., 2021), to describe the populations reached by the interventions delivered in the 131 included trials. Although trial reporting quality was highly variable, we were able to extract descriptive data from many of the trials for a number of PROGRESS-Plus factors (O'Neill et al., 2014), including country-level income, race/ethnicity, gender, educational level of parent, socio-economic status (family-level poverty), and age of parents and children. We were also able to extract data on another source of inequality and family stress: level of child behavioural difficulties.

We then conducted planned meta-analyses of moderators at trial level, as part of this LMIC review, using data from 131 randomized trials. We also summarize briefly moderator findings from a second review for the Guideline, a global systematic review of 278 trials of social learning theory-based parenting programmes, mostly in HICs (Backhaus et al., 2021). Full results can be found in the report on the systematic reviews, and pre-registrations on PROSPERO (Backhaus et al., 2019; Wight et al., 2018). Here, we summarize the results from these two reviews, with a particular focus on the LMIC trials, and draw out their implications for equity effects.

Our moderator analyses test whether intervention effects are greater or smaller in trials that target families in greatest need due to poverty, low education, risk of maltreatment or risk of child behavioural

problems. We interpret these analyses with caution (Cooper & Patal, 2009), given that the sample of trials is often small for some outcomes and moderators – much smaller than the total sample size of 131 trials – and that hypothesized moderators operate only at trial level and may be confounded with other unmeasured, trial-level factors.

2. Rapid review of within-trial moderator studies in LMICs

We supplemented our data on between-trial moderator analyses with a complementary review of within-trial moderator studies of parenting programmes conducted in LMICs. We used two main approaches for retrieving analyses of moderators within randomized trials:

- Searching the full texts of the 131 trials in our LMIC review, using the term moderator and a number of related terms: moderat*, differential, interaction, heterog*, subgroup, stratified.
- Conducting targeted Google Scholar searches, including forward citation searches, to track down papers reporting on secondary analyses of trial data from trials included in our review. In both cases, we focused primarily on larger trials with sample sizes of 100+ (50 of the 131 trials), as smaller trials are more likely to be underpowered for these analyses.

- We draw on van Hoorn et al.'s (2017) checklist for critical appraisal of moderator studies, for appraising the quality of the evidence in these trials.

3. Other specific studies on equity effects of parenting interventions

We conducted searches for further studies of equity effects of parenting interventions, and reviews of moderators, including IPD meta-analyses, studies of equity at scale, and of how inequities vary over time. We report on the findings of these studies and their implications for equity questions.

Results

1. Moderators in the LMIC and global systematic reviews

First we discuss and summarize equity-relevant findings from our systematic review of parenting interventions in LMICs, for children aged 2–17, drawing on the PROGRESS-Plus framework. We included 131 trials in the LMIC review of parenting programmes for children aged 2–17. They were conducted in all regions of the world, with most in upper middle-income countries (86%), the largest number of trials being in Iran and China. Relatively few trials took place in low-income (6%) or lower-middle-income (8%) countries. Most trials, however, targeted low-income communities or families (57% of trials that reported family socio-economic status). A wide range of education levels were represented, with 38% educated only to primary level. Religion and occupation were rarely reported. Most trials were in urban areas, with a few trials in rural communities. Ethnicity was not reported in many studies, and where it was, most families were from the majority group in the country. Girls and boys were well represented in the studies, with most trials (93%) including both. Male caregivers were poorly represented, as caregivers were mostly women (range 37–100% female, mean percentage female 88%), and in half of trials, all caregivers were female. Only one trial, in rural farming communities in Tanzania (Lachman et al., 2020), had a majority of male participants (63%). If we consider that for a programme to be at least somewhat inclusive of fathers and mothers, in terms of attendance, then it might be desirable for (say) at least 30% of participants to be fathers in a group-based intervention. Just 18 trials reached this

criterion, out of 100 trials reporting numbers of male and female participants. If we required that groups averaged close to 50% of both genders (say, 45–55% fathers), then only seven trials met this standard.

Some trials (10%) reported including grandparents, almost all female, alongside parents and other caregivers. A few trials had high percentages of grandmothers attending as primary carers, including trials of Parenting for Lifelong Health in rural Thailand and urban South Africa (52% and 32%, respectively). Reporting was insufficient and numbers too small to test for differential effects by proportion of grandparents in the moderator analyses.

On average, caregivers were 35 years old. Mean age is elevated somewhat by the inclusion of grandparents in some trials. The mean age of children in the studies ranged from 2 to 17, but 47 (36%) studies did not report mean child age. Most studies, however (all but five), reported or indicated the age range of the children, with 40% of studies involving children of primary school age (age 5–10), 30% preschoolers (age 2–5), and 22% of studies involving teenagers (age 11–17).

Moderator analyses were based around all PROGRESS-Plus factors for which data were available. Where sufficient data were available for meta-analysis, we note that findings should be interpreted with caution, since there were high levels of missing data in some or many of the trials. In no cases do our analyses involve a high proportion of the 131 included trials. In some cases, analyses were 'untrustworthy' due to a lack of sufficient trials reporting on outcome and moderator for that analysis. Full details of the analyses and the numbers for each can be found in the LMIC review in the WHO Guideline Systematic Reviews report.

Summarizing the moderator analyses in the LMIC review, we found very little evidence of differential effects by PROGRESS-Plus factors. Thus, the effect of parenting interventions on child maltreatment and harsh or negative parenting outcomes did not vary by poverty level of the country, gender of the child, education level of the parent, family-level poverty, or child or parent age. For most trials, family ethnicity was either not reported or was the same as the majority for the country. Thus, there were insufficient data to test whether there were differential effects by minority status. For child behavioural and emotional problem outcomes, there were similarly no differential effects by parent education level or poverty, or child or parent age. However, intervention effects on child behaviour problems were somewhat lower in trials in the lowest-income countries, and somewhat higher in trials with a higher percentage of girls (i.e. girls were the target child for the outcome assessments). There were no trials focusing purely on fathers, hence trials were classified by whether the participants were all mothers or a mix of mothers and fathers; data on the percentage of female caregiver participants were also analysed. No differential effects were found by gender composition of the group.

Examining the 'Plus' factors from PROGRESS-Plus as moderators, parent and child age were unrelated to beneficial effects; thus, programme benefits on all outcomes from trials with more very young or many older caregivers were no different from those with more average-aged participants. Trials testing programmes in the preschool age group, ages 2–5, were no more or less effective than those in the primary school age group, and the same was found for programmes for teenagers. Few trials reported data on parent disability, although in a few studies there were high rates of parent chronic health and disabling conditions, particularly in communities in Africa affected by HIV, and studies including high percentages of grandparents. We can also consider maltreatment in the family or marked child behaviour problems as factors contributing to ill health or disability. There was also little evidence of these family stressors moderating child and parent outcomes. The exception was for high levels of child

behavioural problems at baseline: where trials focused on children showing these problems (i.e. indicated prevention or treatment trials), intervention effects were stronger for child emotional and behavioural problem outcomes. This replicates a finding reported in many reviews and trial moderator analyses in HICs (Leijten et al., 2020; Shelleby & Shaw, 2014).

Second, we briefly summarize equity-relevant findings from our large global review of parenting interventions for children aged 2–10. We included 278 trials in the global review, mainly from HICs. It focused on a more homogeneous group of studies, those involving parents of younger, pre-teen children participating in social learning theory-based programmes. Most trials were conducted in the USA (107), with many from Australia (39), the UK (20), Netherlands (14) and Hong Kong (8), with 28 trials from 10 different LMICs. Descriptive data showed that a third of trials involved mainly or entirely parents from an ethnic minority. On average 80% of caregivers taking part were female, and despite most trials taking place in wealthy countries, most parents in half the trials had a low level of education or were from a disadvantaged socio-economic background.

Moderator findings partly echoed those in the LMIC review, in that there was no evidence of differential effects on any outcomes by family socio-economic status. There was evidence of some differential effects by ethnicity, with trials that included mostly ethnic minority families showing smaller improvements in negative parenting and child behaviour problem outcomes, compared to trials including mostly majority families. Trials that focused on children with higher levels of behaviour problems showed stronger effects on improving behaviour problems, and positive parenting, post-intervention.

2. Rapid review of within-trial moderator studies in LMICs

Full text searches within our 131 included trials revealed that, of trials with 100 or more participants, 7 trials included moderator analyses in the trial report examining differential effects of the intervention on different subgroups. One further study analysing data from one included trial was found from Google Scholar searches. The eight moderator studies (see Table 1) were based on data from trials in South Africa (2), Burkina Faso, Liberia, Mexico, Chile, Indonesia and Thailand. Sample sizes ranged from 270 to 791, with a mean of 488 and a median of 435.

In terms of PROGRESS-Plus factors, most studies examined moderation by child gender (seven out of eight studies) and age (six studies), but few by place (one study) or poverty level (two studies). Some examined effects by baseline levels of harsh parenting or behaviour problems. None examined race or parent educational level. Two examined parent HIV symptoms or status. One examined moderation by child disability, and one by polygamous vs. non-polygamous family. Findings are organized by key outcomes for the Guideline, including harsh/maltreating parenting, and child behaviour problems.

Study quality appraisal: Table 2 provides details of the quality appraisal of the studies, using van Hoorn et al.'s (2017) checklist for critical appraisal of moderator studies. In summary, all studies showed good quality on some criteria, thus all moderators tested were plausible based on prior literature, despite not all authors explaining this; all were assessed at baseline, and tested interaction rather than predictor effects. For all studies, the intervention and context were highly relevant to the goals of the Guideline, however, many had limited or partial relevance to equity questions about the moderating effects of social disadvantage- only two studies assessed these factors (see Table 2), the others mainly assessed child age and gender. Several of the studies were judged to be of overall adequate quality, based on

presence of most of the other key criteria for good quality, including predominantly low risk of bias with respect to the trial main effects (as assessed in the LMIC systematic review); analyses pre-registered and justified empirically or theoretically; sample sizes high for this field, and adequate for the number of moderator tests- or with correction for multiple testing.

Table 1: Moderator analyses associated with randomized trials in the LMIC review

Author of trial	**Country**	**Intervention age group**	**N of families**	**Moderators tested, results**	**Outcomes**
Ismayilova 2020	Burkina Faso	Economic intervention + parenting, 3 arm cluster-RCT. Age 10–15	360 – in 12 village clusters	***Child gender:*** mixed depending on outcome and group comparison ***Age:*** no clear pattern *Non-biological parent:* improved more on parent–child relationship *Polygamous:* improved less on **harsh parenting**	Harsh parenting, parent–child relationship
Ruiz-Casares 2021 (unpub)	Indonesia	*PDEP (Save)* Age 0–7	736	No moderation found by child **gender or age**, or disability; many were prespecified	Harsh parenting – corporal punishment
Rincón 2018	Chile	*Dia a dia* Age 3–6	332 – in 10 preschool centres	**Child age, gender:** Ns too small. Parents with higher levels of some negative parenting variables benefited more, but not for **harsh parenting**	Harsh parenting – other negative parenting
Villarruel 2008	Mexico	*Cuidate!* – Sexual health focus	791	No moderation of parent–child communication outcomes by child or parent **gender**; nor by religiosity or familialism	Parent–child communicati-on
Shenderovich 2018 Trial: Cluver 2018	South Africa	*PLH Teen* Age 10–18	552	No moderation found on 7 tested: e.g. **poverty**, rural vs. urban, HIV status, harsh parenting. Most trends were towards more **disadvantaged** families benefiting more	Multiple outcomes on maltreatment and parenting
Annan, Puffer et al., 2017	Thailand – border zone refugees	*Happy Families* Age 7–15	479	No moderation by child **age, gender**, caregiver legal status, **household income**, parent employed, housing quality	Child behaviour problems
Puffer 2015	Liberia	*Parents Make the Difference* Age 3–7	270	Harsh parenting moderated by higher **harsh punishment** at baseline; child younger **age**, more behaviour problems. No	Harsh & Positive parenting, Positive discipline

				moderation by **gender** or other outcomes	
Eloff 2014	South Africa	HIV-affected families Age 6–10	390	No moderation by child **age** (<8 vs. >8 years), mother HIV-related illness; Moderation by **gender:** boys improved more	Child behaviour problems

Moderators of harsh parenting: Five studies examined moderators of changes in harsh parenting or maltreatment following intervention, with one trial examining parent–adolescent communication outcomes (Villarruel et al., 2008). Ismayilova et al.'s (2020) trial in Burkina Faso examined child age and gender and family polygamy as moderators of harsh parenting outcomes and found that polygamous families benefited less on this outcome than non-polygamous families. There were inconsistent patterns of age and gender effects on harsh parenting, depending on the outcomes and group comparisons used. The four remaining studies found few other moderators of harsh parenting; none found effects of child gender; and two found no effects of child age (Rincón et al., 2018; Ruiz-Casares et al., 2021, unpublished). Puffer et al.'s (2015) trial in Liberia found that harsh parenting reduced more in parents with younger children, and in parents who engaged in more harsh discipline at baseline. Shenderovich et al. (2018) tested the effects of seven moderators (e.g. poverty, rural residence, HIV status, baseline level of harsh parenting) on multiple maltreatment and parenting outcomes in a trial of Parenting for Lifelong Health for Teens in South Africa. In a very high quality study, they found no significant moderation after correcting for multiple testing, although most of the trends in the data were towards more disadvantaged families benefiting more from the intervention. Another high quality study, Annan et al. (2017) also found no moderation by poverty level. Villarruel et al.'s (2008) trial in Mexico found no moderation of parent–adolescent communication outcomes by child or parent gender, or by family levels of religiosity or familialism.

Moderators of child behaviour problems: Two studies examined moderators of change in child behaviour problems following intervention. One high quality study in northern Thailand (Annan et al., 2017) assessed the effects of poverty and refugee status on child outcomes, finding no moderation by these vulnerability factors. Two assessed child gender, with one finding more benefit for boys (Eloff et al., 2014), and one no moderation effects. Both studies assessed age effects, finding no differential benefit for older or younger children. One study in South Africa (Eloff et al., 2014) found no differential effect by HIV status of the mother.

Together this group of eight trials in LMICs assessing moderators of parenting (primarily harsh parenting and maltreatment) and child behaviour problem outcomes finds little evidence to suggest that interventions have differential effects on these outcomes for children of different ages or gender. Two large, high quality studies assessing moderation by poverty found no differential effects of poverty level on harsh parenting (Shenderovich et al., 2018) or on child behaviour (Annan et al., 2017). Although the group of trials assessing moderators of parenting intervention outcomes is small, the quality is high in many studies, and the settings are diverse, spanning young children and teens, and three continents.

Table 2. Critical appraisal of moderators in trials in LMICs

Author of RCT	**Confidence in findings? Y/N**	**CHAMP appraisal of moderators**

Ismayilova 2020	YES	Empirical support presented for two of the moderators examined. Analyses not pre-specified in protocol. Moderators measured at baseline. Number of moderators tested was reasonable in relation to sample size, but sample may be too small to draw firm conclusions. Effects tested using three-way interactions, accounting for clustering. A large number of tests were performed, with Bonferroni correction. Results presented with 95% CI and p-values. No clear pattern identified of moderators across outcomes and time points.
Ruiz-Casares 2021, un-published	NO	No theoretical support was presented for the moderators, but analyses were pre-specified in the published protocol. Moderators were collected before the start of the intervention as part of the demographic data. Effects appeared to be investigated using subgroup analyses. All pre-specified moderators reported with statistical significance. No moderating effects identified. Analyses may be underpowered due to low baseline harsh parenting rates.
Rincon 2018	NO	Theoretical support was not presented for the moderators tested, nor was the analysis pre-specified in the registered protocol. Moderators were measured at baseline using validated tools and were examined by testing interactions between the effects of the treatment and the baseline values, accounting for clustering. Results were presented with p-values reported. It remained unclear how many moderators were analysed. The sample size may potentially be too small to identify any moderating effects.
Villarruel 2008	NO	Empirical support was presented for the moderators that were examined. There was no protocol to show if the analyses were pre-specified. Moderators measured at baseline were familialism and religiosity, using questionnaires with good reliability. Moderator effects were tested by interactions between group assignment and potential moderators, controlling for covariates. The number of moderators tested was reasonable in relation to the total sample size. No significant interactions were identified. Results of analyses were not presented in detail.
Shender-ovich 2018 Trial: Cluver, 2018	YES	The study presented a strong empirical foundation for the moderator analysis. Moderator analyses were pre-specified in the published study protocol. All moderators were measured at baseline using validated tools. Effects were investigated by testing interactions in mixed effect models, accounting for clustering. The number of moderators examined was reasonable given the large sample size. All candidate moderators were reported in the results tables, with presenting confidence intervals. The results were generally consistent between related moderators and across outcomes.
Annan, Puffer et al., 2017	YES	The study did not present the empirical evidence for the moderator analyses, and they were not pre-specified in the protocol. All moderators were measured at baseline using reliable tools. The number of moderators tested was reasonable in relation to the sample size. Effects were detected by testing interactions in regression models, with correcting for multiple comparisons. Only the result with statistical significance was presented, with the p-value reported.
Puffer 2015	YES	Empirical support for the moderator analysis was not presented, but the analysis was reported to be guided by prior work. Registered protocol did not pre-specify moderators. All moderators measured at baseline using a mix of validated and unvalidated tools. Moderators examined using interactions. Unclear if covariates were adjusted for. The number of moderators was reasonable, but the analysis might be underpowered by the relatively small total sample size. All candidate moderators were reported. P-values were presented. Effects were generally consistent between related moderators for the outcome of harsh parenting. No effects identified for other outcomes of interest.

Eloff, 2014	UNSURE	The study did not present empirical evidence for the moderators examined, & they were not pre-specified. All moderators were measured at baseline using reliable tools. Three-way interaction tests were performed to investigate moderator effects. Number of moderators was reasonable in relation to sample size. Statistical significance was reported. Moderator effects generally consistent across outcomes and time points.

3. Specific studies on equity effects of parenting interventions

Our searches retrieved only three moderator studies in the parenting field using pooled IPD meta-analysis, including one that explicitly addressed equity questions (Gardner et al., 2019a; Leijten et al., 2020). The second study pooled data from trials of the US Familias Unidas programme for Latino teenagers (Perrino et al., 2014) but focused only on youth internalizing outcomes, and on effects by gender, but not other PROGRESS-Plus equity factors. The third study focused on behavioural interventions for children with ADHD (Groenman et al., 2021), only half of which involved parenting. We were able to find one potentially relevant LMIC study – an IPD meta-analysis of psychosocial programmes in humanitarian settings for youth trauma – but none of the included interventions focused on parenting (Purgato et al., 2018). Hence these last three studies are not included in our analyses.

The study that explicitly focused on equity effects of parenting interventions tested differential effects by various PROGRESS-Plus factors (Gardner et al., 2017; 2019a). The authors used IPD meta-analysis, pooling data on 1,800 families from 14 trials of the Incredible Years programme in 6 countries across Europe, aimed at reducing or preventing child conduct problems and decreasing harsh parenting. The study was equity relevant in that high proportions of the families had a low socio-economic status or were unemployed, lone parent families or from an ethnic minority. High proportions of families were also disadvantaged by mental health problems, including parent depression and child conduct problems. Moderator analyses of 13 trials (1,700 families) examined differential effects on child conduct problem outcomes, finding that none of the PROGRESS factors moderated child outcomes. Thus, families with a low-income or who were unemployed, from an ethnic minority group or teenage parents were just as likely to benefit as families not in these groups (Gardner et al., 2019a). Child age ranged from 2 to 10 years, and no differential effects by age were found (Gardner et al., 2019b). Families suffering mental health problems were more likely to benefit from the intervention. Specifically, where parents were more depressed, or the child showed higher levels of behaviour problems, children showed differentially more benefit from the intervention (Leijten et al., 2020). These analyses only covered one primary outcome: child behaviour problems; moderators of harsh parenting outcomes were not examined, and we do not know yet if similar patterns would be found for these outcomes.

We retrieved one study addressing equity questions through a very different approach, a simulation study, using longitudinal birth cohort data, rather than an intervention study. Simulations of interventions provide an opportunity to address the limitations of trial-level data by modelling different policy options in terms of the potential impact of targeting, intensity and uptake of parenting programmes on population prevalence and inequalities in child mental health problems (Hope et al., 2021). Using data from the UK Millennium Cohort Study (18,000 children born in 2000–2002), Hope and colleagues (2021) simulated the population impact of scale-up of seven parenting programmes with different levels of intensity and target populations. Predicted probabilities of child mental health problems (using a brief parent screening instrument, the Strengths and Difficulties Questionnaire) by household income quintile were estimated from logistic marginal structural models, adjusting for

parenting quality scores (Child–Parent Relationship Scale at 3 years) and confounders. Based on data from 14,399 children, the impact of scaling up parenting programmes was simulated by re-estimating predicted probabilities of child mental health problems using scores that were based on intervention intensity, targeting mechanisms and programme uptake levels. The results suggested that both universal non-intensive and targeted intensive approaches have the potential to reduce child mental health problems at population level, and that they could also play a role in reducing but not eliminating inequalities in mental health problems.

Equity and scale up: The question of whether equity effects are likely to change or balance out as parenting programmes are scaled up is a vital one, and can potentially be addressed by comparing moderator effects across trials of scaled up programmes vs. trials of more routine implementation. Given that there are very few high-quality evaluations of parenting interventions at scale, especially in LMICs, then not surprisingly, we were unable to find studies assessing equity effects at scale. We found one study from Norway of parenting interventions that have been scaled up, showing that there was no diminution of effects on child behaviour problems at scale (Tømmerås & Odgen, 2015), and that families that were highly disadvantaged compared to the national average were reached by these successful programmes. A further study of equity effects of these scaled programmes (Tømmerås & Kjøbli, 2017), however, drew on data from families included in trials, rather than routine services. Like the other European studies cited, they found no evidence that parenting interventions increased inequity; on the contrary, children in disadvantaged families, as assessed by a cumulative index of factors related to poverty, immigration and poor health, showed better response to the interventions, especially in a longer, 10-session version of the programme. For shorter programmes, there were no differential effects on child behaviour problems.

How equity effects vary over time: Our searches and our team's knowledge of the field have not yet revealed any data addressing the question of how such impacts on health inequalities and/or health inequities vary over time. Given that there are few studies explicitly focusing on equity effects of parenting interventions, it is perhaps unsurprising that there would not be any studies of how inequalities vary over time. Studies of moderators are more common, but our searches have not so far found studies of how these vary across time.

Equity of access: Issues of access are discussed further in Chapter 2. In brief, findings are mixed about differential access to parenting programmes by different groups, and patterns of access of course vary greatly by service context and policies. Many programmes target families experiencing disadvantage, and hence those served by the programmes are likely to be more disadvantaged than the population average, and more likely to be from ethnic minorities. For example, this was the case in pooled data from trials of parenting interventions in the UK (Gardner et al., 2019a), and in routine delivery of interventions that have been scaled up in Norway (Tømmerås et al., 2016). In our LMIC review, the majority of the programmes tested were accessed by low-income families. However, these data do not answer the more specific question of whether, within the groups of disadvantaged families targeted by many programmes, those with higher levels of disadvantage are more or less likely to engage in the intervention.

Discussion

Summary and discussion of results: Most trials in our systematic review of parenting intervention effects in LMICs are highly relevant to equity questions, as they are informative both about main effects

in many very poor and vulnerable families, and about differential effects by PROGRESS-Plus factors. We used two complementary approaches to examine differential effects, based on the 131 parenting trials in our review. Thus, we conducted between-trial moderator analyses to test if trial characteristics (concerning individuals, families or country characteristics) were associated with better or worse outcomes, and we searched for within-trial moderator data associated with these trials, testing if individual-level characteristics (child, parent) were associated with better or worse outcomes. We also searched for and summarized data from existing IPD meta-analyses and other equity-relevant studies.

Descriptive data from our systematic review of parenting interventions show that a large percentage of trials are equity relevant, in that, in addition to all coming from LMICs, a high percent involved low-income families or parents with low educational levels. There were several large trials showing beneficial effects on harsh parenting for extremely poor families in low-income countries, such as Liberia, Burkina Faso, Tanzania and Rwanda. Our humanitarian review conducted for the WHO Guideline found many trials in conflict and post-conflict settings, where children are at particularly high risk of violence and other poor outcomes. In these high-need settings, parenting interventions were also successful at reducing harsh and negative parenting and improving positive parenting. These findings suggest that parenting interventions, as delivered in trials, can successfully target and engage families from low socio-economic backgrounds in LMICs, and reduce levels of maltreatment, harsh parenting and child behaviour problems in these often highly disadvantaged populations. It should be noted, however, that most trials took place in upper-middle-income countries, with the largest numbers of trials in Iran, China, South Africa, Brazil and Turkey.

Findings from two complementary methods, our between-trial moderator analyses conducted as part of the review, and our rapid review of existing within-trial moderator studies, concur in finding very few differential effects of parenting programmes in LMICs. Particularly relevant to equity questions, we found no evidence that families disadvantaged by poverty or lower levels of education are any less likely to benefit from parenting interventions. This applied both to harsh parenting-related outcomes and to child emotional and behavioural problems. The same was found in trials in HICs, based on our global systematic review for the WHO Guideline and on a high-quality IPD meta-analytic study based in Europe. We also found no evidence that families troubled by maltreatment in the family or marked child behaviour were any less likely to benefit; on the contrary, families experiencing child problem behaviour were more likely to benefit. There were few studies addressing problems of illness or disability in the family, although the few moderator studies addressing these issues found no differential effects by these factors. A notable gap was that no studies examined differential effects by parent mental health problems in LMICs, although our IPD meta-analysis of parenting interventions in Europe found that children of depressed mothers benefited more from interventions (Leijten et al., 2020). There was also very little evidence of moderation by age or gender of the child or age of the parent. Findings on differential effects for ethnic minorities were more mixed, and there was a notable lack of evidence from LMICs. Our large global systematic review showed evidence of diminished effects on behaviour problems in trials that included larger numbers of families from ethnic minorities. On the other hand, large studies utilizing gold-standard individual-level data show no diminished effects on behaviour problems for children from ethnic minorities. Yet these better-powered, high-quality studies also suffer from lower generalizability, with a more limited range of countries and programmes covered.

Strengths, limitations and gaps in the evidence: There are many strengths in the evidence presented. We use multiple, complementary approaches to address differential effects, including moderators assessed using up-to-date systematic reviews and meta-analyses conducted of parenting intervention

effects – by far the largest to date in the field. We draw on high-quality IPD meta-analyses designed specifically to address equity effects, albeit in high-income European countries. There are also a number of limitations to our data that lead us to be cautious about the findings, including the relatively small number of trials included in each meta-analysis of moderators in the LMIC review, the high levels of heterogeneity for all outcomes, and a number of trials with high risk of bias. There were also relatively few trials in low-income countries, and relatively few trials that assessed moderators at individual level.

These limitations help point to some of the gaps in the evidence base and recommendations for the field. Only a few trials have analysed moderators of outcomes at individual level in LMICs, and there is a need for analyses from large trials and/or pooled individual-level data across trials to fully understand moderators, and hence potential equity effects. More studies need to examine differential effects on harsh parenting and maltreatment, given that the predominance of evidence to date, especially the large pooled datasets, has focused on child behaviour problem outcomes. Reporting standards of trials need to improve, including reporting of equity factors such as ethnicity, poverty and education level, as this affected the number of trials that could be included in different moderator analyses. Just as little is known about the effectiveness of parenting interventions at scale (see Chapter 2), then little is known about equity of access or equity of outcome when programmes are taken to scale.

In conclusion, the data from a range of countries, including the largest dataset to date from LMICs, suggests that very poor and vulnerable families can be reached by these programmes and obtain good outcomes in terms of changes in harsh parenting and child behaviour problems. Studies analysing differential effects by PROGRESS-Plus factors that index social inequality have generally found very little evidence that factors such as family poverty, low educational level and gender are linked to poorer outcomes. Thus, it is unlikely that parenting programmes would contribute to widening existing inequities. By targeting families, communities and countries most in need, they have good potential for narrowing disparities between groups in terms of harsh and violent parenting, and child behaviour difficulties.

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WHO-INTEGRATE Chapter 5, Human Rights: Reflection of standards and principles of human rights and child rights in parenting programmes

Authors: Amalee McCoy & Sheila Varadan

WHO-INTEGRATE question:

- Are parenting programmes in accordance with the standards and principles of universal human rights and children's rights in particular?

Introduction

The adoption of the Convention on the Rights of the Child (CRC) by the UN General Assembly in 1989 marked a watershed moment for the global community. Children (persons under the age of 18 years) were reconceptualized from 'human becomings' (Qvortrup, 2009) – passive objects of charity and the chattels of their parents – to 'human beings', active subjects of rights, to whom public authorities are accountable (David, 2002). The idea that children are rights holders with individual entitlements was and remains a transformative notion, which demands a reconfiguration of the power relationship between children, adults, and the state (Tobin, 2011). Since that time, advocacy for international children's rights has been labelled "one of the most powerful social movements of the twentieth century" – with such efforts contributing to almost universal ratification of the CRC (Fernando, 2001, p. 10). To date, 196 States have agreed to be legally bound by the CRC, making it the most widely ratified human rights treaty in history (Freeman, 2020).

The CRC is not the only international instrument to delineate human rights for children, and as such, should be situated within the wider framework of international human rights law. In 1948, the UN General Assembly unanimously adopted the Universal Declaration of Human Rights, recognizing that all human beings – children and adults alike – hold rights and freedoms under international law. The principles espoused in the Declaration provided the basis for nine, core international human rights treaties, which constitute the present-day international human rights legal framework. The CRC was developed with the specific aim of protecting and promoting the rights of the child, and thus provides an international legal framework to guide laws, policies, and programmes relating to children (Tobin, 2011). It embodies civil and political rights, as well as economic, social and cultural rights of children, and elements of international humanitarian law, making it the most complete human rights treaty (Tobin, 2019).

From the mid-1990s onward, the concept of a 'rights-based approach' emerged, and were promptly embraced and promoted by a range of development organizations, including UN agencies (e.g., UNHCHR, UNICEF, UNDP, UNIFEM), bilateral donors (e.g., DFID, SIDA, NZAID), international non-governmental organizations (e.g., Save the Children, Oxfam, CARE, ActionAid), and local grassroots NGOs (Hannah Miller & Redhead, 2019). These 'rights-based approaches' were intended to embody universal principles espoused in international human rights treaties, providing a framework of core values that were widely (if not universally) accepted. However, the absence of any common definition for 'rights-based approaches' coupled with a growing currency yielded inconsistencies in both its content and application, raising concerns surrounding its overuse and misuse across sectors (Tobin 2011). (Miller, 2010).

In 2003, an interagency Workshop was convened to promote a shared frame of reference and convergent strategies for development programming by UN agencies. The 2003 UN Common Understanding on Human Rights-Based Approach to Development, identified four key elements in a *human rights-based approach*: 1) the identification of the human rights claims of rights-holders (for instance, children), human rights obligations of duty bearers (state and non-state actors with obligations under human rights law, for instance, parents), and the causes of non-realization of rights; 2) capacity assessment and capacity building of rights holders to claim their rights, and of duty bearers to fulfill their obligations; 3) the monitoring and evaluation of both outcomes and processes guided by human rights standards and principles; and 4) programming informed by the recommendations of international human rights bodies and mechanisms.

Alongside the UN Common Understanding, there are a set of general principles within the CRC, which will also be relevant to rights-based programming and policies for children: the best interests of the child (art. 3(1)), the right to be heard (art. 12), the right to life, survival and development (art. 6), and the right to non-discrimination (art. 2). The principle of 'best interests' concerns all decisions affecting children and must be a primary consideration relative to other factors. The right to be heard assures children a right to not only express their views freely in all matters affecting them, but also an entitlement to have those views given due weight in accordance with age and maturity. The right to life, survival and development affirms that all children have the inherent right to life and are entitled to inputs and provisions that will allow them to develop to their full potential. Finally, the right of non-discrimination requires States to take measures to respect and ensure children's enjoyment of all of the rights enumerated under the UNCRC without discrimination of any kind (Peleg, 2018; Save the Children, 2005). These four general principles supplement the core human rights principles, providing a child rights-based framework that not only informs programme outcomes, but all processes of the programming cycle, including assessment, analysis, planning, implementation, monitoring and evaluation (UNOHCHR, 2006).

In addition to these human rights and child rights principles, the relationship between rights holders and the State as a primary duty bearer is a central feature of a child rights-based approach. The State's tripartite obligations under international human rights law – to 'respect,' 'protect,' and 'promote' or 'fulfil' – provide a typology for framing the role of the primary duty bearer that is relevant to all human rights treaties. The obligation to respect is described as a passive or 'negative' duty, requiring States to refrain from violating from violating or interfering with any of the rights described in the CRC. The obligations to protect and fulfill are 'positive' duties, involving the protection of child rights from interference by third parties, as well as the promotion or fulfilment of rights through services or other provisions (Besson & Kleber, 2019).[1]

A child rights-based approach to parenting has a number of implications for the provision of parenting programmes that aim to improve the quality of parent-child interactions. Given that children are born in a state of dependency, relying almost entirely on their parents and primary caregivers to protect and enable their realization of rights, it would follow that governments, relevant donors, and implementing

[1] See also the UN Committee on the Rights of the Child 'General Comment No. 5 (2003): General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42, 44, para 6) 27 November 2003, CRC/GC/2003/5, para 5; UN Human Rights Committee, 'General Comment No 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant,' 26 May 2004, CCPR/C/21/Rev.1/Add.13, para 6, 8, 10.

bodies hold legal obligations to ensure these carers are fully supported in this role. To this end, the UNCRC recognises parents and family (those legally responsible for the child) as primarily responsible for the care, development, and upbringing of the child [arts. 18 and 5]States to "render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities" (UNGA, 1989). Using a child rights-based lens, States are therefore required to provide parenting support to carers, as part of its legal obligations to ensure children's effective enjoyment of rights, ensuring non-discrimination, inclusiveness, and meaningful beneficiary participation at all stages. In turn, parents and carers are responsible for providing appropriate direction and guidance to the child, in a manner which is non-violent; supportive of the child's physical, mental, spiritual, moral, and social development; and pursuant to the child's best interests.

Despite the relevance of the CRC to parenting programmes, and the high importance placed by many UN agencies and development actors on human rights and child rights-based approaches, the research project team is not aware of any reviews focused on parenting interventions that have adopted such approaches. Broadening the scope, we are aware of only one review by Porsdam Mann et al. (2016) on the use of explicitly human rights-based approaches in mental health care settings. This study included interventions that aimed to improve mental health outcomes, with findings published and available in English; however, only 10 papers met inclusion criteria and were included in the analysis. None of these interventions were parenting programmes.

Given the paucity in the evidence base, we have addressed this gap by conducting a phased literature review. The overall aim of this review is to examine whether **rights-based** parenting programmes aiming to improve the quality of parent-child relationships explicitly or implicitly reflect the standards and principles of human rights and children's rights. As a starting point, we focused on the legal basis for these 'rights-based' approaches to parenting, by reviewing the writings and commentary of the Committee on the Rights of the Child. For this purpose, we developed a proposed Guiding Framework for assessing parenting programmes through a child rights-based lens.

Methods

We conducted this literature review in two stages. The first stage involved an assessment of the writings and commentary of the United Nations Committee on the Rights of the Child (CRC Committee), with the aim of identifying States party obligations to support and assist parents and others responsible for the care of the child in a manner that recognises the child as an individual rights-holder, with voice and agency within the family. The CRC Committee writings included:

1. **General Comments**: 25 General Comments issued between 2001 and 2021;
2. **Concluding Observations**: Concluding Observations issued between 1993 and 2021, as analysed in the draft doctoral thesis by Varadan (2021);
3. **Written Statements**: Written statements issued by the CRC Committee during its 23 Days of General Discussion between 1992 and 2018 and four CRC Anniversary events.

During this review, we assessed how the CRC Committee interpreted two provisions related to parenting (arts. 5 and 18) and the scope and content of States' legal obligations to implement parenting interventions. We also took into account the four general principles of the CRC - the best interests of the child (art. 3(1)), the right to be heard (art. 12), the right to life, survival and development (art. 6), the right to non-discrimination (art. 2) – as well as the protection of children's rights (from interference of parents and third parties), notably arts. 9, 19, 20, 22, 23, 24, 27, 30 and 31.

In assessing each of the three areas of CRC Committee writings and commentary, a search was conducted to identify content regarding:

a. **Articles 5 and 18**: Responsibilities of parents and States' obligations to render appropriate assistance to parents, legal guardians, extended family, and community (in accordance with local custom);
b. **Article 5**: Rights, responsibilities, and duties of parents, and other caregivers to provide appropriate direction and guidance to children;
c. **Principle of evolving capacities**: States' obligations to enable children's evolving capacities in the exercise of rights and to support parents in providing appropriate direction and guidance; and
d. **The terms 'Family', 'Parent', 'Legal Guardian', 'Extended family'**: Manner in which these terms were used and understood with respect to States' obligations under articles 5 and 18.

Themes identified during this search were then organized according to States' general implementing obligations to *respect*, *protect*, and *fulfil* the rights of every child under articles 2(1) and 4 of the UNCRC and the four general principles of the UNCRC, which provided the basis for a Guiding Framework for assessing parenting programmes through a child rights-based lens. This Guiding Framework is regarded as the review output for the first stage, and was used as a basis for data extraction during the subsequent stage.

During this second stage of the literature review, we developed search terms and conducted searches of three journal databases (EMBASE, PsycInfo, and MEDLINE), a University of Oxford maintained database on parenting programmes, and six grey literature (development agency) databases. We aimed to identify parenting programmes that explicitly incorporated human rights-based approaches and/or child rights principles, described in terms of programme aims or purpose.

A specific search was conducted through 31 May 2021, with search terms including a combination of entries and synonyms for: a) child (e.g., child*, adolescent*, infant) b) parenting (e.g., parent* education, parent* skills), and c) human rights (e.g., rights based, child* rights). The specific search strings used for each database are listed in the results section (Tables 3-5).

We included parenting programmes (see Table 1) that aimed to improve parent-child interaction, the overall quality of parenting that a child receives, and/or reduce child maltreatment through improved parenting. Such programmes included a focus on the learning or development of new skills, behaviours, parental knowledge, parental attitudes, or beliefs. We included studies or study protocols of parenting programmes that utilized any qualitative or quantitative method, with any study design or comparison. We also included any programme manuals or materials, including those targeting facilitators or parents and primary caregivers. Exclusion criteria are described in Table 2.

Table 1: Inclusion criteria

Area	
P = Population	Parents of children living in either HICs or LMICs
I = Intervention	• Parenting programmes directed at parents or other key caregivers designed to improve parent-child interaction, overall parenting quality, and/or reduce child maltreatment

	• Any parenting intervention where a human rights-based or child rights-based approach has been explicitly mentioned, adopted or otherwise promoted (in terms of programme aims or justification) • Title and abstract in English. Non-English language papers will be reviewed if title and abstract utilize HRBA or CRBA terminology.
C = Comparison	Any
O = Outcomes	Any
S = Study designs	Any qualitative or quantitative method; any programme manuals; study protocols
Type of paper	Published papers, grey literature

Table 2: Exclusion criteria

Area	
I = Intervention	• Designed for parents of children with specific health concerns (e.g., HIV, malnutrition, breastfeeding) or clinical diagnoses, disabilities, and developmental disorders (e.g., autism, cerebral palsy, cancer, child anxiety, OCD, PTSD, depression, self-harm) • Parental involvement in education, reading, school, or family therapy • Antenatal parenting interventions or programmes supporting the transition to parenthood • Programmes that comprised multiple components, of which parenting was only a minor component

From each included parenting programme, for which programme manuals and materials were available, or from studies in which the intervention was described in detail, we extracted information on whether the four CRC general principles (best interests of the child, right to be heard, right to survival and development, and right to non-discrimination) were explicitly or implicitly addressed. We then used the Guiding Framework to extract details on whether child-centred parenting support was incorporated into the programme, through the explicit promotion of parental and family awareness of child rights. In addition, we utilized the Framework's respect, protect, fulfil categories to extract information on whether programme content or approaches specifically addressed aspects under each of these areas.

We also extracted the following data from each included study: participant target group (country, child age group, parent risk group); intervention characteristics (aims, delivery methods, country of implementation, dosage, adaptation); programme development or implementing partners; and effects on primary and secondary outcomes. Measures of treatment effect were recorded as provided by study authors. Raw data were not accessed or analyzed.

Following the database searches and data extraction, we sought to supplement published papers, reports, and programme materials with additional information on programme approaches and content by contacting three authors. We next used the Guiding Framework categories to explore common themes across included parenting programmes, which allowed us to assess both shared strengths as well as aspects that were commonly excluded or weakly incorporated.

Data analysis

We used the Guiding Framework to conduct a rapid assessment of the extent to which the included parenting programmes had reflected child rights-based approaches and respect, protect, and fulfill obligations. We also utilized the Quality Standards for Ethics Analyses (Q-SEA) framework, the first instrument developed for quality assessment of ethics analyses, to guide our analysis (Scott et al., 2017).

Findings

Stage 1 results: Child Rights-Based Guiding Framework for Parenting Programmes

Through our assessment of the writings of the CRC Committee during stage one, we identified the key dimensions for adopting and implementing a child rights-based approach to parenting support (see Appendix). The first dimension related to the four general principles of the CRC, as previously described. These principles should be explicitly or implicitly incorporated into the programme aims, conveyed to parents as part of programme content, and/or otherwise incorporated into delivery methods or training for programme facilitators.

Secondly, programmes should reflect **child-centred parenting support**, which ensures that parents, children, and communities are aware of and understand the CRC and its implications, including the Convention's affirmation of children as subjects of rights. This implies that child rights-based parenting programmes should incorporate child-rights awareness raising as part of programme content.

Thirdly, the obligations to respect, protect, and fulfill child rights should be reflected in programme aims, as part of programme content, and/or incorporated into delivery methods or training for programme facilitators. Based on our assessment of the writings of the CRC Committee, we defined the parameters of these obligations as follows:

1. **Rights-respecting parenting support** (obligation to respect): States must respect and recognise the responsibilities, rights, and duties of parents, members of the extended family, community, legal guardians, or other persons legally responsible in the care and upbringing of the child (articles 5 and 18);
2. **Rights-protecting parenting support** (obligation to protect): Parenting support and assistance must be provided in a manner that aligns with the rights and principles of the UNCRC, meaning that the programme does not condone conduct that interferes with, undermines, or violates CRC provisions. This particularly applies to the general principles (articles 3(1), 2, 6, 12), and ensures the protection of children's rights to grow up in a rights-respecting family environment (articles 9, 19, 20, 23, 24, 27, 30); and
3. **Rights-enabling parenting support** (obligation to fulfil): Parenting support and assistance must recognise the child's status as a rights-holder with evolving capacities in the exercise of rights under the UNCRC (arts 5 and 14(2)).

Under 1) **rights-respecting parenting support**, we found four main themes: i) Respect for parents and family, including the role of parents and the importance of the wider family environment; ii) The responsibility of both parents for the child, with parental support targeting both mothers and fathers; iii) Flexible and culturally sensitive approaches to family, recognizing a variety of family arrangements and respecting the values of ethnic and other minorities; and iv) Implementation of parenting support in a

rights-based and culturally sensitive manner, encouraging the fostering of parent-child mutual respect and providing ways of dealing with family conflict that are rights-respecting.

Under 2) **rights-protecting parenting support**, we identified a total of 12 themes that we grouped into four categories. For the first category on *rights at different developmental stages*, there were two themes: i) Parenting to protect and support adolescent rights, including in relation to sexuality, sexual behaviours, adolescent violence, and high-risk behaviours; and ii) Parenting to support rights in early childhood, including through positive and sensitive relationship-building. The second category, on *supporting rights to positive child outcomes*, we identified three themes: i) Parenting to support child rights to play; ii) Parenting in digital environments, including encouragement of children's social, creative, and learning activities; and iii) Parenting to support child health, including prevention of injuries, violence, and high-risk behaviours, as well as to promote child development and socialization. Under the third category, on the *prevention of harm and negative outcomes*, we found three themes: i) Non-violent parenting and a focus on parental engagement and education over punishment; ii) Parenting to prevent family separation or support reintegration; and iii) Parenting to prevent child offending. Further, we grouped four themes under the fourth category on *rights protection for especially vulnerable groups*, including: i) Parenting support for children with disabilities; ii) Parenting to support rights as result of migration,; iii) Parenting to support indigenous child rights; and iv) Parenting to prevent children at risk of living in street situations, and to strengthen family reunification for children already on the streets.

Finally, under 3) **rights-enabling parenting support**, we identified three themes. These were: i) Support for parents to provide direction and guidance that attributes increasing weight to children's views and agency in decision making, enabling the child evolving capacities as they develop and mature; ii) Support for parents to provide direction and guidance relevant to child developmental stages, according to the principle of evolving capacities; and iii) Support for parents to offer direction and guidance in a child-centred way through dialogue and example, which enhances child capacities to exercise their rights.

Stage 2 results: Literature review of human rights-based and child rights-based parenting programmes

During the stage two literature review, our electronic database search retrieved 1,950 records. Following the removal of duplicates, 1,898 records remained. After screening titles and abstracts, 1,876 records were excluded for failure to meet inclusion criteria. The full text of 22 remaining records were then assessed for eligibility, which resulted in the exclusion of 15 studies. The search resulted in a pool of six included parenting programmes, drawn from seven records (see Tables 3-5). After adding hand and web searching, as well as additional materials from the lead author of one paper (Cook et al., 2017) and one NGO (Save the Children), we identified a total of 18 records describing six programmes.

Table 3: Results from journal databases (EMBASE, PsycINFO, MEDLINE) (search date 31 May 2021):

Search terms	**Hits**
1. (child* or adolescent* OR infant OR teen* OR toddler OR child).ab	4,060,189
2. parent-child* OR parent* education OR parent* training OR parental sensitivity OR parent* skills OR parent* program* OR parent* intervention	145,685
3. human rights OR rights based OR rights-based OR right to health OR child* rights	69,317
4. #1 AND #2 AND #3	**248**

Duplicates	43
Total results after removal of duplicates	**205**
Included	**0**

Table 4: Results from University of Oxford managed databases (search date 31 May 2021):

Search terms	**Total results**		
	Pre-2018 RCTs	**2018 and later RCTs**	**Qualitative studies**
1. human rights OR rights based OR rights-based OR right to health OR child rights OR children's rights)	659	107	217
Duplicates	**5**	**4**	**0**
Total results after removal of duplicates	**654**	**103**	**217**
Included	**1**	**1**	**1**

Table 5: Results from grey literature databases (search date 31 May 2021):

Database	**Search terms**	**Total results**	**Reports/ manuals requiring full text review**	**Included**
Child Rights Information Network (CRIN) https://home.crin.org/search?q=parenting https://archive.crin.org	parenting	459	1	1
Alliance for Child Protection in Humanitarian Action https://alliancecpha.org/en/library-solr	parenting	126	5	1
Save the Children https://resourcecentre.savethechildren.net/keyword/parents-and-caretakers	parents as caretakers (drop down menu)	87	9	2
World Vision International https://www.wvi.org/resources	parenting	25	0	0
UNICEF Innocenti https://www.unicef-irc.org/publications/	parenting	8	0	0
International Rescue Committee (IRC) https://www.rescue.org/reports-and-resources	parenting	14	4	0

Included parenting programmes

The six included parenting programmes in our review comprised (see Table 6): 1) the International Child Development Programme (ICDP) in Colombia; 2) the Ladnaan programme in Sweden; 3) Better Parenting Nigeria; 4) the Families First Programme (based on Positive Discipline in Everyday Parenting) in Indonesia; 5) Parenting on the Move in Syria; and 6) Program P. Four programmes were adaptations that were transported from two high-income countries (Canada and Norway) (Hundeide, 2013; Osman, 2017) and one low-income country (Ethiopia) (USAID & 4Children Nigeria, 2018b), while the remaining one was adapted from an international programme with no specific origin country (Durrant, 2016).

Table 6 provides details on the aims of the included programmes. All of the programmes aimed to strengthen child-caregiver attachment, interactions, communications, and relationships, while one programme had a specific, additional objective of providing an introduction to child rights (Osman, Salari, et al., 2017). Another programme also aimed to promote gender equality and the prevention of violence against women (Promundo et al., 2013).

Programme target populations were variable, with three targeting early childhood (Hundeide & Armstrong, 2011; Ruiz-Casares et al., 2019), one targeting early and middle childhood (0-12 years) (CIP & Save the Children, 2021), one targeting middle childhood and adolescence (11-16 years) (Osman, 2017), and one targeting children under age 18 years (USAID & 4Children Nigeria, 2018b). Three programmes targeted families or communities with particular vulnerabilities, such as migrant and refugee populations (CIP & Save the Children, 2021; Osman, 2017) and communities with high levels of civil conflict (Cook et al., 2017), while one was designed specifically for fathers and male caregivers (Promundo et al., 2013).

Included studies

Seven of the included records were studies of three parenting programmes (see Table 7). Two RCT papers (presenting different results from the same trial) (Osman, Flacking, et al., 2017; Osman, Salari, et al., 2017; Ruiz-Casares et al., 2021), one qualitative study (Osman et al., 2019), and one mixed-methods process evaluation (Osman et al., 2020) focused on the Ladnaan programme. The Ladnaan RCT included Somali immigrant parents (N=120) of children aged 11-16 years in Sweden using a waitlisted control, with primary outcome measures on child emotional and behavioural problems (Osman, Flacking et al, 2017). The study found significant improvements in child behavioural problems in the intervention group compared with the control at two-month follow-up, with the largest effect sizes for aggressive behaviour (*d* = 0.76, 95% CI 1.06 to 3.07, p <.001), social problems (*d* = 0.83, 95% CI 0.64 to 1.70), and externalizing problems (*d* = 0.60, 95% CI 0.96 to 3.53, p <.001). There were no significant reductions in measures of child emotional problems (Osman, Flacking et al., 2017). Finally, there were positive, significant improvements on all secondary outcomes, including parental mental health (B = 3.62, 95% CI 2.01 to 5.18, p<0.001), parental efficacy (B = −6.72, 95% CI −8.15 to −5.28, p<0.001), and parental satisfaction (B = −4.48, 95% CI −6.27 to −2.69, p<0.001) (Osman, Salari, et al., 2017). The qualitative study with parents who had participated in the Ladnaan programme supported these quantitative results, with parents reporting that they had improved parenting confidence; in addition, parents shared that they had gained knowledge on available child services and the legal rights of parents and children in Sweden (Osman et al., 2019). The mixed methods process evaluation found high levels of programme reach and engagement, a perceived high level of fidelity and group leader satisfaction, as well as a perception that the societal information sessions (on parenting styles, child rights, and the legal system) contributed to programme retention (Osman et al., 2020).

Two records included a draft manuscript on study findings as well as the study protocol for a cluster RCT of the Families First Programme in Indonesia (Ruiz-Casares et al., 2019; Ruiz-Casares et al., 2021). The study found no significant improvements in caregiver reported physical and emotional punishment at immediate or six months post-intervention; moreover, there were no significant improvements in positive and involved parenting, setting limits, parent opinion on discipline, child social and emotional well-being, attitudes toward the institutionalization of children, or child monitoring and supervision. However, intervention group caregivers had significantly higher odds of using positive discipline (OR = 1.51, 95% CI 1.19-1.93).

The remaining paper presented findings from a case study of the International Child Development Programme (ICDP) (Cook et al., 2017). The study situated ICDP within a 3-year community-based project to prevent violence in early childhood, combining parent training on empathy and attachment strengthening with local child rights and child protection capacity building.

Reflection of the CRC general principles and child-centred parenting support

In our assessment of whether included programmes reflected child-centred parenting support (see Table 8), we found that although all programmes incorporated child rights into programme aims or principles, only four appeared to explicitly include content intended for parents to learn about the CRC and its implications for parenting (CIP & Save the Children, 2021; Durrant, 2016; Osman, 2017; USAID & 4Children Nigeria, 2018b). For those programmes where information on themes for each session was available, two included specific sessions that focused on raising parental awareness on the CRC (Osman et al., 2019; USAID & 4Children Nigeria, 2018a, 2018b). One programme that did not explicitly incorporate such content for parents included a session titled 'Needs and Rights of Children.' While background information in the manual intended for the facilitator did include information on the CRC and framed positive discipline according to child rights principles, the manual did not describe the CRC or any specific rights in the guidance for delivery of session content (Promundo et al., 2013).

Based on available information, all of the programmes included in our review explicitly or implicitly reflected at least two of the four general principles of the CRC (see Table 8). In particular, two programmes explicitly reflected all four principles (CIP & Save the Children, 2021; USAID & 4Children Nigeria, 2018b), although Better Parenting Nigeria incorporated these principles as part of session content for parents, while Parenting on the Move describes these principles and their relevance to the programme in background information in the manual intended for moderators, trainers, and mentors rather than for parents themselves. Another programme explicitly includes information on three principles (best interests of the child, right to be heard, and right to survival and development) in the parent handbook, quoting the relevant articles from the CRC (Durrant, 2016). Other programmes mainly made implicit references to the core principles, either through programme aims or parental skills building. For example, in ICDP, parents practice reciprocal exchanges with their children during home practice, with an emphasis on listening to the child and making sure he/she is heard, which reflects the principle on the right to be heard (Hundeide & Armstrong, 2011). Further, Program P manual frames gender discrimination and traditional genders norms as negatively affecting children's ability to fulfill their full potential, which reinforces the principle of the right to non-discrimination (Promundo et al., 2013). The right to survival and development was reflected either explicitly or implicitly in all programmes, while the right to non-discrimination was least referenced.

Reflection of obligations to respect, protect, and fulfil

The findings from our assessment on reflections of obligations to respect, protect, and fulfil in the included parenting programmes are shown in Table 9. In terms of promoting **rights-respecting parenting support**, we found that three programmes incorporated the responsibilities of parents of both sexes or otherwise recognized the potential participation of both men and women in the programme (CIP & Save the Children, 2021; Promundo et al., 2013; USAID & 4Children Nigeria, 2018b). In particular, Program P aims to normalize men's involvement in maternal health and caregiving, as well as encourage a teamwork approach to parenting (Promundo et al., 2013). Two programmes purposively promoted a culturally

sensitive approach to parenting support (Hundeide & Armstrong, 2011; USAID & 4Children Nigeria, 2018b). ICDP claims to respect the values and norms of the local community by situating the programme within community-based psychosocial care (Hundeide & Armstrong, 2011), while Better Parenting Nigeria has a specific session on 'Culture and Social Norms,' which encourages parents to reflect on positive and negative local practices (USAID & 4Children Nigeria, 2018b). Further, all programmes reflected aims or content that encouraged the fostering of mutual respect between children and caregivers, as shown through qualitative research with parent participants (Hundeide & Armstrong, 2011; Osman et al., 2019), or through the description of parental skills or guidance for relationship-building and problem solving (CIP & Save the Children, 2021; Durrant, 2016; Promundo et al., 2013; USAID & 4Children Nigeria, 2018b). Finally, available materials from five programmes provided strategies for dealing with family violence, mainly through constructive resolution of problems and communication on equal terms (CIP & Save the Children, 2021; Durrant, 2016; Osman, 2017; Promundo et al., 2013; USAID & 4Children Nigeria, 2018b).

We also identified various ways in which the programmes promoted **rights-protecting parenting support,** according to the four categories of our Guiding Framework. First, we assessed ways in which programmes reflected child rights at different developmental stages. All programmes recognized the varying needs of children at different ages, but two programmes in particular offered specific sessions structured around developmental stages. Better Parenting Nigeria contains four supplemental sessions each on early childhood development and adolescent development (USAID & 4Children Nigeria, 2018b), while there are four Families First sessions on different development stages and age-specific information in the PDEP parent handbook on understanding how children think and feel, problem solving, and responding with positive discipline (CIP & Save the Children, 2021; Durrant, 2016). For those programmes that covered the early childhood years, session content invariably promoted positive and sensitive relationship-building. However, three out of the four programmes that covered adolescence included a few concerns relating to teen problem behaviour, sexuality, sexual behaviours, or other high-risk behaviours (Durrant, 2016; Osman, 2017; USAID & 4Children Nigeria, 2018b).

Second, we identified how the included programmes supported child rights to positive outcomes. Four programmes promoted parental awareness and understanding on the importance of play for child development (CIP & Save the Children, 2021; Durrant, 2016; Promundo et al., 2013; USAID & 4Children Nigeria, 2018b), although only two included interactive games to play with children (Save the Children, 2021b) or offered tips on how to engage in play with children at different developmental stages (USAID & 4Children Nigeria, 2018b). Only two programmes made reference to parenting in digital environments. Better Parenting Nigeria has a specific session on '21st Century Parenting Realities and Challenges,' which includes discussions on the Internet, social media, and online safety (USAID & 4Children Nigeria, 2018b), while Parenting on the Move briefly mentions that parents should support their children to learn different technologies (CIP & Save the Children, 2021). Concerning parenting to support child health, five programmes promoted the use of non-violent discipline (CIP & Save the Children, 2021; Durrant, 2016; Hundeide & Armstrong, 2011; Promundo et al., 2013; USAID & 4Children Nigeria, 2018b), with the PDEP, POM, and Program P interventions in particular framing corporal punishment as unacceptable from a child rights perspective. Four programmes incorporated information or case scenarios on a wider range of child health concerns, including nutrition, breastfeeding, accidental injury prevention, and HIV/AIDS (CIP & Save the Children, 2021; Durrant, 2016; Promundo et al., 2013; USAID & 4Children Nigeria, 2018b), while one specifically aimed to promote child mental health (Osman, 2017).

Third, under the category of prevention of harm and negative outcomes, we identified that all programmes either directly or indirectly promoted non-violent parenting, with one programme (Ladnaan)

applying an indirect approach by addressing risk factors for violent discipline, such as parental mental health and child problem behaviour. The Ladnaan programme was also the only included intervention for which evidence of the effective reduction of violence was available from the papers included in our review (Osman, Flacking, et al., 2017). In addition, three programmes supported parenting to prevent family separation, although through different approaches. One programme offered guidance to parents receiving children back from formal care (USAID & 4Children Nigeria, 2018b); one study identified eligible programme participants as needing to have at least one risk factor associated with child placement into residential care (Ruiz-Casares et al., 2019); and one provided information for moderators in the manual that migrant and refugee children were at increased risk of separation as well as more likely to experience harm (CIP & Save the Children, 2021). None of the included programmes explicitly promoted parenting to prevent child offending, although the Ladnaan programme, in common with many other programmes generally (Furlong et al., 2012; Piquero et al., 2016), demonstrated effectiveness in reducing child externalizing behaviour – a risk factor for juvenile delinquency (Cohn et al., 2012; Osman, 2017).

Under the fourth category on rights protection for especially vulnerable groups, two programmes target parenting to support rights as a result of migration. One programme is designed for immigrant families from Somalia who are living in Sweden, and has been adapted to respond to needs and challenges that parents have expressed during formative research regarding parenting in their new home context (Osman, 2017). The second programme was developed through research with 700 Roma families in Serbia, and was intended as a service to be integrated within a system of comprehensive support to refugee and migrant families accommodated in collective centres (CIP & Save the Children, 2021). Only one programme provided parenting support for children with disabilities, with one session focused on 'Children with Special Needs.' This session mentions the different types of potential child disabilities, as well as encourages the mapping of local support services and the provision of referrals for eligible families (USAID & 4Children Nigeria, 2018b). None of the included programmes explicitly targeted or incorporated parenting to support indigenous child rights or parenting to prevent children from ending up in or returning from street situations.

Finally, we assessed the different ways in which the included programmes reflected rights-enabling parenting support through fulfilling or promoting child agency. First, we identified content in five programmes that included support for parents to provide direction and guidance that takes into account the child's view (Centre for Interactive Pedagogy & Save the Children, 2021; Durrant, 2016; Hundeide & Armstrong, 2011; Osman, 2017; USAID & 4Children Nigeria, 2018b). These programmes commonly underscored the importance of parental flexibility and due consideration for the child's views and feelings. The Ladnaan programme contains a session titled 'Autonomy Includes Connection' – which helps parents develop skills to recognize that adolescents need autonomy while maintaining connections to their parents (Osman et al., 2019), while Better Parenting Nigeria and PDEP encourage parents to discuss with and involve children in setting household rules (Durrant, 2016; USAID & 4Children Nigeria, 2018b). Second, we identified aspects from five programmes that indicated support for parents to provide direction and guidance relevant to child developmental stages according to the principle of evolving capacities (CIP & Save the Children, 2021; Durrant, 2016; Osman, 2017; Promundo et al., 2013; USAID & 4Children Nigeria, 2018b). Two of these programmes provided quite detailed information: Better Parenting Nigeria focuses one session, 'Changing Needs as Children Grow,' on child needs, common behaviours, and appropriate parental responses according to five different stages of development, while PDEP uses case scenarios according to eight different age groups to encourage parents to consider a hypothetical child's needs, views, and capacities (Durrant, 2016; USAID & 4Children Nigeria, 2018b). Finally, we also identified content from five programmes which indicated support for parents to offer

direction and guidance in a child-centred way through dialogue and example (Centre for Interactive Pedagogy & Save the Children, 2021; Durrant, 2016; Hundeide & Armstrong, 2011; Osman, 2017; USAID & 4Children Nigeria, 2018b). All five programmes strongly emphasized the importance of reciprocal and empathetic parent-child communication, with ICDP in particular providing specific guidelines for three types of parent-child dialogue with guidelines for interaction depending on each type (Hundeide & Armstrong, 2011). Three programmes place a particular focus on the importance of positive role modelling in the parent-child relationship (Centre for Interactive Pedagogy & Save the Children, 2021; Durrant, 2016; USAID & 4Children Nigeria, 2018b).

DISCUSSION

Summary of main results

Findings from Stage 1 of our review suggest that there are three dimensions to consider when gauging whether a parenting programme is in accordance with principles of human rights, and child rights in particular. The first dimension relates to the reflection of the four CRC general principles: the best interests of the child, the rights to be heard, the right to survival and development, and the right to non-discrimination. The second dimension pertains to child-centred parenting support, which concerns the inclusion of child rights awareness or education in parenting programme content. The third dimension involves state obligations to respect, protect, and fulfil child rights, which can be grouped into themes under rights-respecting parenting support (respect for the role of parents and family in the upbringing of the child), rights-protecting parenting support (protects the rights of the child through support for parents), and rights-enabling parenting support (fulfilling child evolving capacities in the exercise of rights).

Our results from Stage 2 suggest that despite a large body of published and grey literature on parenting programmes, few have adopted or otherwise promoted an explicit human rights-based or child rights-based approach. All programmes in our review included child rights into programme aims or principles, although not all reflect child-centred parenting support by including programme content for parents on the CRC and implications of child rights for parenting. While all programmes explicitly or implicitly reflected at least half of the CRC general principles, only two – Better Parenting Nigeria and Parenting on the Move - explicitly described all four principles. The most commonly reflected principle was the right to life, survival, and development, which is expected, indeed for most parenting programmes, given that such programmes tend to promote parental knowledge of and appropriate parenting expectations and interactions during different child development stages. The principle of non-discrimination was the most weakly reflected; it was explicitly mentioned in only one programme (Better Parenting Nigeria), despite the targeting of vulnerable and stigmatized groups in two other programmes (Ladnaan and Parenting on the Move).

Obligations to respect, protect, and fulfill child rights were reflected in multiple ways. Rights-respecting parenting support, as indicated through respect for the role of parents and the family, was reflected by all programmes through aims or content that encouraged the fostering of mutual respect between children and caregivers. Even though four of the programmes were implemented in LMIC settings, only two described processes or content that clearly depicted a culturally sensitive approach to parenting support. Further, rights-protecting parenting support was strongly upheld in some aspects but not others. All programmes recognized the importance of tailoring parenting support according to different developmental stages. However, programmes that covered the adolescent years – with the exception of

Better Parenting Nigeria – included limited content regarding the full range of concerns addressed by the CRC committee, particularly sexuality and sexual behaviour. In terms of rights-protecting parenting support through the promotion of positive outcomes, almost all programmes supported good child health; however, programmes were weakest in relation to parenting in digital environments, with only two (Better Parenting Nigeria and Parenting on the Move) providing guidance in this regard. Concerning rights-protecting parenting support through the prevention of harm and negative outcomes, all programmes promoted non-violent parenting, either indirectly by addressing associated risk factors or directly by framing corporal punishment as incongruent with child rights. The explicit promotion of parenting to prevent child offending was absent from programmes in our review, although this is a goal in some parenting programmes in HICs (e.g., Stop Now and Plan, Helping the Noncompliant Child) (Piquero et al., 2016; UNODC, 2017). As a final category, rights-protecting parenting support for especially vulnerable groups was weakly reflected. While two programmes were tailored to meet the needs of parents in the context of migration, only one included parenting support for children with disabilities, and none included content on indigenous populations or children at risk of working and/or living on the streets. Finally, the provision of rights-enabling parenting support – through the promotion or fulfilment of child agency – was widely reflected in our review. Most programmes demonstrated the principle of evolving capacities by supporting parents to provide direction and guidance according to child developmental stages; further, most encouraged parenting by means of dialogue and example. In addition, most programmes incorporated parenting skills on taking into account the views of the child, including during early childhood as well as through adolescence.

Overall completeness and applicability

The six programmes included in the review represented diverse country contexts, origin countries, and target populations. They were implemented in four middle-income countries (Colombia, Indonesia, Nigeria, and Serbia) in four different regions of the world, as well as one high-income country (Sweden). Four programmes originated in two high-income countries (Canada and Norway) and one low-income country (Ethiopia). Half the programmes targeted vulnerable communities such as migrants, refugees, and communities facing intense civil conflict. Further, parents of varying child age groups were included, with half targeting the early years, while others included middle childhood and adolescence. Such characteristics may indicate that parenting programmes can reflect human rights- or child rights standards or principles while remaining adaptable and relevant to a wide range of cultural settings and community needs.

The aims and formats were similar across programmes with all including aims to strengthen child-caregiver attachment, interactions, communications, and relationships, and mainly designed for delivery in weekly, group-based sessions. It is also worth highlighting that with the exception of the Ladnaan programme in Sweden, all were implemented through international development organizations as part of broader projects or campaigns relating to violence prevention, father engagement, or health and well-being for vulnerable children. This suggests that organizational and donor mandates pertaining to human rights and child rights favoured the incorporation of rights-based standards and principles into these programmes. Given that available information is incomplete, this raises the question of the extent to which LMIC governments, local organizations, and community representatives were involved in developing or adapting rights-based content. It also underscores the issue of sustainability, and whether these programmes were or will be embedded into existing service delivery systems, whether through government or non-government providers.

Finally, our review identified only two RCTs (Osman, Flacking, et al., 2017; Osman, Salari, et al., 2017; Ruiz-Casares et al., 2021). The RCT of the Ladnaan programme found that it was effective in significantly improving parental mental health, parental competence (efficacy), parental competence (satisfaction), child aggressive behaviour, child social problems, and child externalizing problems, all with medium-large effect sizes ranging from $d = 0.60$ to 1.81, and p values < 0.001. However, findings from the RCT of Families First revealed no significant effects on the primary outcome of physical and emotional punishment nor on most other measures, with the exception of positive discipline. This provides a preliminary indication that the effectiveness of rights-based parenting programmes may be mixed.

Limitations

Our review contains several limitations that warrant consideration. First, given time constraints, our Stage 2 literature search was a rapid search that was deliberately specific and only included three major electronic databases and six grey literature databases, with search terms including those relating to human rights or child rights. We may have missed records published elsewhere; moreover, we know that many parenting programmes reflect multiple rights-based standards and principles, as described in our Guiding Framework, but without specifically using these terms. For example, Parenting for Lifelong Health programmes (see https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health) reflect many child rights standards and principles, but do not incorporate human rights or child rights language or awareness raising in its aims, purpose, or programme content for parents. Second, the records included in this review were of varying types and study designs, including facilitator/moderator manuals, a parent handbook, two RCTs, qualitative research with programme participants, a mixed methods process evaluation, and a project case study. This resulted in multiple gaps in information regarding programme theories of change, methods of delivery, adaptations, and session content, which prevented a more complete assessment of rights-based standards and principles. Third, this review is susceptible to publication bias, as many international development organizations may have kept their reports, studies, and programme manuals as internal documents, or issued them as grey literature materials that were overlooked by this review (Rudasill, 2009). Finally, we acknowledge the risk of language bias, as we did not include foreign language or regional bibliographic databases, which may be especially relevant to reviews of parenting programmes from LMICs (McCoy et al., 2020).

Strengths

This review is notable in several respects. First, it constitutes the first known review of whether parenting programmes aiming to improve parent-child interaction and overall parenting quality make explicit reference to rights, and when they do so, if they are conducted in accordance with the standards and principles of human rights and child rights. Second, it proposes an initial Guiding Framework for conducting such reviews, based on the CRC and official guidance to States parties from the CRC Committee. There is no known precedent for such a framework in existing published or grey literature. Third, our review brings together the disciplines of international law and social intervention science, which draws from the respective strengths of each field. By using legal standards that States are already obligated to uphold, this review informs a new approach to the critical appraisal of parenting programmes that heretofore appears to be lacking in the literature. Finally, the inclusion of grey literature strengthened our review, with half of the included programmes identified through NGO databases.

Conclusion

Implications for practice

This review suggests that the CRC offers an important and relevant framework for developing and adapting parenting programmes in both LMICs and HICs. Child rights are not abstract principles or lofty aspirations but represent minimum legal standards for interventions affecting children that can guide the development, adaptation, and evaluation of parenting programmes (Reading et al., 2009). While many parenting programmes do incorporate aspects of child rights, they do not explicitly adopt rights-based approaches and could do more to reflect a wider range of child rights standards and principles. In addition, given the responsibilities that States parties – and other duty bearers – hold to respect, protect, and fulfil child rights, those who deliver interventions for children or their families should be familiar with and understand how to apply child rights standards and principles (Waterston & Davies, 2006). In this vein, committed professionals involved in the design of and policy advocacy for parenting programmes should make greater use of *both* the evidence base underpinning these programmes, as well as the justification for their implementation under international law. Finally, the predominance of rights-based programmes in LMICs suggests that HICs – whose governments are also equally obligated to uphold the CRC – may benefit from South-to-North sharing of experiences and expertise in this area.

Implications for research

The novelty of this study suggests the importance of conducting a broader and more intensive review of parenting programmes, ideally comprising greater access to parenting programme materials (e.g., facilitator manuals, parent handbooks and handouts, facilitator training manuals), related published and unpublished reports (e.g., organizational documents concerning programme development, monitoring, evaluation, and advocacy), and relevant peer reviewed and non-peer reviewed studies (e.g., formative research, impact and process evaluations, qualitative research with participants and facilitators). Such a review should include regional bibliographic databases, as well as deliberately seek out non-English language materials, reports, and studies. Further, it would be crucial to appraise included studies for risk of bias (Higgins & Green, 2008), especially given the inclusion of grey literature and the involvement of many international development agencies in both the development and evaluation of their parenting programmes. Second, the inclusion of only two RCTs (Osman, Flacking, et al., 2017; Osman, Salari, et al., 2017; Ruiz-Casares et al., 2021) points to the need for further robust evaluations of the effectiveness of rights-based parenting programmes. The conduct of multi-arm trials or randomized factorial trials could also permit the differential examination of programmes that include or exclude particular rights-based components, such as sessions for parents on child rights awareness (Collins et al., 2015; Sundell et al., 2014). Finally, similar to the studies conducted on the Ladnaan programme (Osman, 2017), further peer-reviewed formative evaluations and qualitative research with programme participants is needed. Such studies should assess the relevance and acceptability of rights-based parenting programme content and approaches and seek to involve beneficiaries in their design and adaptation from the start.

Please see Appendix 3 and 4 for tables

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WHO-INTEGRATE Chapter 6, Socio-cultural acceptability, participant sensitivity, and intrusiveness of parenting programmes

Introduction and WHO-INTEGRATE questions:

An in-depth understanding of the socio-cultural acceptability, participant sensitivity, and intrusiveness of parenting programmes is crucial to informing how such interventions fit diverse local needs, expectations, priorities, and delivery capacities. These nuances can assist in the identification and transportation of interventions, cultural and contextual adaptations to ensure programme appropriateness and relevance, the incorporation of flexibility in delivery to tailor to individual needs and preferences, as well as the development of strategies to engage parents living in restrictive environments or who have been court ordered to participate.

Socio-cultural acceptability, as defined by the WHO INTEGRATE framework, pertains to the extent to which an intervention is experienced or expected to be appropriate to beneficiaries, implementers, or other relevant stakeholder groups, according to cognitive and emotional reactions to the programme (Rehfuess et al., 2019). Whether an intervention is regarded as appropriate can be related to perceptions of cultural and contextual relevance, in terms of language, concepts, methods, and delivery settings (Bernal, 2006; Kazdin, 2000; Lachman et al., 2016). At a structural level, acceptability can also be related to perceptions of scalability or "maintenance" in the intervention environment, described in the RE-AIM framework as the extent to which an intervention can become a routine part of an organization's everyday culture and norms (Glasgow et al., 1999).

Sensitivity of parenting programmes on the basis of participant characteristics can be described as the extent to which programmes have differential impacts according to individual and family-level variables. Such variables may include participant's sex or age, target child's sex or age, ethnicity, language, sexual orientation, gender identity, disability status, education, socio-economic status, and place of residence. Understanding for whom and to what extent parenting programmes result in greater or lesser effects is important for guiding the design, targeting, recruitment, and implementation of interventions, especially when they are scaled-up and delivered under real-world conditions (Weersing & Weisz, 2002). As discussed in Chapter 4 on equity, existing reviews and meta-analysis (Lundahl et al., 2006; Reyno & McGrath, 2006; Shelleby & Shaw, 2014) have thus far suggested mixed conclusions concerned whether parenting programme effects vary by of disadvantage or marginalization.

Finally, the intrusiveness of parenting programmes and effects on personal autonomy can be understood vis-à-vis international human rights law, which presents human rights as those rights necessary for the development and exercise of autonomy (Talbott, 2005). The Universal Declaration of Human Rights recognizes that individuals possess special worth and dignity, and have a right to life, which encompasses the right to private life and privacy (Gumbis et al., 2011). Intrusiveness can also be further understood within the 'stewardship model' developed by the Nuffield Council on Bioethics (2007). This framework, which depicts the role of the state in relation to public health, recognizes that the state should minimize interventions perceived an unnecessarily intrusive and in conflict with personal values, as well as limit those interventions that are imposed on individuals without their consent or without procedural justice arrangements. It thus follows that parents should not be coerced to attend or otherwise engage in parenting programmes by the state, private organizations or individuals, nor should they interfere with

parental privacy or dignity, unless the justice system fairly makes such a determination. Whether court ordered, delivered in a restrictive environment, pressured due to the nature of organizational or personal relationships, or induced due to appealing programme incentives (e.g., money, meals, children's toys), parent participation in parenting interventions may potentially exist along a spectrum of intrusiveness.

For the purpose of examining the socio-cultural acceptability, participant sensitivity, and intrusiveness of parenting programmes, we aimed to review the qualitative and mixed methods literature from both LMICs and HICs in responding to the below thematic groups of questions:

Theme 1: Socio-cultural acceptability of parenting programmes

- How are parenting programmes socio-culturally received by beneficiaries and deliverers?
- How are parenting programmes socio-culturally perceived by the public and other stakeholder groups (e.g., government actors, professional groups, NGOs)?
- Does socio-cultural acceptability vary over time (short versus long-term)?
- To what extent do programme beneficiaries value different health and non-health outcomes?

Theme 2: Sensitivity of parenting programmes to participant characteristics

- Are parenting programmes sensitive to relevant participant characteristics, such as sex, age, ethnicity, culture or language, sexual orientation or gender identity, disability status, education, socio-economic status, or place of residence?

Theme 3: Parenting programme intrusiveness and effects on autonomy

- How do parenting programmes affect the autonomy of an individual, population group or organization?
- How intrusive are parenting programmes (e.g., low, intermediate, or high)?
- Is it justifiable to deliver programmes that are highly intrusive or that negatively affect the privacy or dignity of concerned stakeholders?

Methods

We conducted this literature review by developing relevant search strategies as follows:

Theme 1: Socio-cultural acceptability of parenting programmes

For this theme, we searched the University of Oxford database on qualitative studies of parenting programmes in LMICs and HICs, which contains 217 records. We used a sensitive set of search terms, which are listed in the results section along with the number of hits. In addition, from a list of four qualitative systematic reviews of parenting interventions that was compiled separately by Oxford, we identified one review (Mytton et al., 2014) that was not yet included in the database and screened this separately.

The inclusion criteria are listed in Table 1. We did not adopt additional exclusion criteria, given that the database already included pre-screened studies that excluded target groups and interventions unrelated to our area of interest. We included a variety of sample populations from both LMICs and HICs, including

parents and other caregivers as existing or potential programme beneficiaries, parenting programme service providers, the general public, and other stakeholder groups (e.g., government officials, community-based organizations, professional groups). We also included parenting programmes that aimed to improve parent-child interaction, the overall quality of parenting that a child receives, and/or reduce child maltreatment through improved parenting. Such programmes included a focus on the learning or development of new skills, behaviours, parental knowledge, parental attitudes or beliefs. For study designs, we included qualitative and mixed methods primary research papers, as well as reviews of qualitative or mixed methods studies.

Table 1: Inclusion criteria

Area	
S = Sample	• Parents or other caregivers attending or potentially attending parenting programmes • Service providers of parenting programmes • General public • Key stakeholder groups (e.g., government officials, community-based organizations, professional groups)
PI = Phenomenon of Interest	• Parenting programmes directed at parents or other key caregivers designed to improve parent-child interaction, overall parenting quality, and/or reduce child maltreatment
D = Study designs	• Any qualitative or mixed methods papers • Reviews of qualitative or mixed methods studies
E = Evaluation	• Views on programme social and cultural acceptability and relevance • Views on value or importance placed on health and non-health outcomes • Variation in views over time
R = Research type	Published qualitative or mixed methods primary studies or reviews

For each included study, we extracted information on study country, child age group, study participants (e.g. programme beneficiaries, potential beneficiaries, service providers, general public, other stakeholder groups), parent/participant risk group, sample size, qualitative method, and findings relating to: 1) *socio-cultural relevance or acceptability* of a) programme content, b) recruitment and delivery methods, c) service providers, d) training and supervision, e) organizational management and administration, and f) variations over time; and 2) *value or importance* placed on a) health outcomes and b) non-health outcomes. We then presented our findings in a narrative synthesis. We did not include findings related to acceptability concerning programme access, as this is explored further in Chapter 2 and 6.

Theme 2: Sensitivity of parenting programmes to participant characteristics

For this theme, we did not undertake a new search of the literature, given that this topic is discussed more in-depth in Chapter 4, Equity. The team is conducting two large reviews for the Parenting Guideline that include questions related to the sensitivity of programmes to participant characteristics: a systematic review and meta-analysis of parenting programmes for reducing child maltreatment and harsh parenting in LMICs, and a large global review on parenting interventions for children aged 2-10 years. Both studies,

while still in draft form, include moderator analyses on whether individual and family characteristics are associated with the effectiveness of interventions. We summarized the relevant initial findings from these reviews for the purpose of this chapter.

Theme 3: Parenting programme intrusiveness and effects on autonomy

For this theme, we searched the University of Oxford database on qualitative studies of parenting programmes in LMICs and HICs, which contains 217 records. We used a sensitive set of search terms, which are listed in the results section along with the number of hits. Also, from a list of four qualitative systematic reviews of parenting interventions that was compiled separately by Oxford, we identified one review (Mytton et al., 2014) that was not yet included in the database and screened this separately. In addition, we supplemented our search by identifying qualitative studies on parenting programmes that target particularly vulnerable populations in potentially restrictive contexts, such as: families with children in or returning from foster care or other forms of alternative care, families in shelters (e.g., for victims of violence, displaced/refugee or homeless families), parents who have previously or are currently experiencing intimate partner violence, families in contact with child welfare services, parents with mental health difficulties, parents receiving cash transfers alongside participation in a parenting programme, parents in incarceration, and parents of children who are at risk of or known to be engaged in offending.

The inclusion criteria are listed in Table 2. As before, we did not adopt additional exclusion criteria, given that the database already included pre-screened studies that excluded target groups and interventions unrelated to our area of interest. We included particularly vulnerable sample populations (as aforementioned) from both LMICs and HICs, including parents and other caregivers as existing or potential programme beneficiaries and parenting programme service providers. We also included parenting programmes that aimed to improve parent-child interaction, the overall quality of parenting that a child received, and/or reduce child maltreatment through improved parenting. Such programmes included a focus on the learning or development of new skills, behaviours, parental knowledge, parental attitudes, or beliefs. For study designs, we included qualitative and mixed methods primary research papers, reviews of qualitative or mixed-methods studies, and institutional reports.

Table 2: Inclusion criteria

Area	
S = Sample	• Parents or other caregivers attending or potentially attending parenting programmes targeting particularly vulnerable populations, including families with children in or returning from foster care or other forms of alternative care, families in shelters (e.g. for victims of violence, displaced/refugee or homeless families), parents who have previously or are currently experiencing intimate partner violence, families in contact with child welfare services, parents with mental health difficulties, parents receiving cash transfers, parents in incarceration, and parents at risk of or known to be engaged in offending • Service providers of parenting programmes targeting particularly vulnerable populations

PI = Phenomenon of Interest	• Parenting programmes directed at parents or other key caregivers designed to improve parent-child interaction, overall parenting quality, and/or reduce child maltreatment
D = Study designs	• Any qualitative or mixed methods papers • Reviews of qualitative or mixed methods studies
E = Evaluation	• Views on programme effects on individual, group, or organizational autonomy, privacy, dignity, or independence • Views on programme intrusiveness, coerciveness, or restrictions • Views on justification of parent participation for the benefits experienced by families
R = Research type	Published qualitative or mixed methods primary studies, reviews, or institutional reports

For each included study, we extracted information on study country, child age group, study participants (e.g., programme beneficiaries, potential beneficiaries, service providers), parent/participant risk group and context for programme delivery, programme name, sample size, qualitative method, and findings relating to 1) parent autonomy, privacy, dignity, or independence; and 2) intrusiveness, coerciveness, or restrictions. We then presented our findings in a narrative synthesis.

Results

Theme 1: Socio-cultural acceptability of parenting programmes

Our search of the University of Oxford database on qualitative studies retrieved 90 records. After screening all titles and abstracts, 18 records were excluded for failure to meet inclusion criteria. The full text of 72 remaining records were then assessed for eligibility, which resulted in the inclusion of 68 records. Handsearching led to the inclusion of the systematic review by Mytton et al. (2014) as well as a mixed methods feasibility pilot and two unpublished manuscripts by the primary author of this chapter (McCoy, Lachman, Sim, et al., 2020; McCoy, Lachman, Tapanya, et al., 2020; McCoy et al., 2021), resulting in a total of 69 records. In total, we included 69 qualitative or mixed methods studies and three systematic reviews.

Table 3: Search results (search date 31 May 2021):

Search terms for University of Oxford qualitative study database	**Hits**
1. accept* OR relevan* OR cultur*	90
Titles and/or abstracts screened	90
Full text screened	72
Included	68
Handsearching of other studies and reviews	**4**
Total included	**72**

We organized our assessment according to different perspectives (parents who have already participated in a parenting programme, parents who are potential participants, service providers, public and other) as well as the themes that guided our data extraction: 1) socio-cultural relevance or acceptability, and 2) value placed on health and non-health outcomes. Most studies (50) collected data from parents who

recently participated in a programme, while 27 gathered data from service providers, 10 from potential parent participants, and one from the wider community.

1. Socio-cultural relevance or acceptability

Programme content

Parents who participated in parenting programmes. Almost all studies that collected qualitative data from parent participants indicated that programme content was well received, containing relevant skills building techniques and information on child development and parent-child relationships (Bradley et al., 2020; Buston, O'Brien, et al., 2020; Butler et al., 2020a; Coughlin et al., 2018; Edwards et al., 2010; Fogarty et al., 2020b; Furlong & McGilloway, 2012; Gallitto et al., 2018; Garza et al., 2009; Kohl & Seay, 2015; Kohlhoff et al., 2019; Kotzky et al., 2020; Leckey et al., 2021; Matos, Torres, Santiago, et al., 2006; McCoy et al., 2021; Michelson et al., 2014; Miller et al., 2020; Onyskiw et al., 1999; Fatumo Osman et al., 2019; Paris, 2008; J. R. Parra-Cardona et al., 2016; Ruben Parra-Cardona et al., 2018). Positive parenting techniques were more favoured over limit setting. Those most positively referenced were spending quality time with one's child and engaging in play, as well as praise, active listening, positive communications, giving positive attention, and using social rewards. Techniques focused on stress management, emotional regulation, improving emotional awareness, and self-care were also frequently mentioned by parents as the most useful and relevant. Parents also referred to positive discipline techniques as acceptable in several studies, although less frequently. These skills included the use of ignore, warnings, rules and limit setting, and planned consequences such as the removal of privileges. Parents also noted that they appreciated learning about different child developmental stages, as it helped them to be aware of child attachment needs at various ages, as well to understand that children are sensitive to their environment even at young ages.

Regarding overall impressions of content, Puerto Rican and Somali immigrant parents from two different studies, as well as Thai parents in Thailand and aboriginal parents in Canada, expressed that the content was not in conflict with their own cultural values (Houlding et al., 2012; Matos, Torres, Rocheli, et al., 2006; McCoy, Lachman, Tapanya, et al., 2020; Osman et al., 2019). Parents positively referred to the cultural sensitivity of the programmes, especially the use of culturally relevant examples, jokes, and metaphors (Osman et al., 2019). Two studies with Somali and Latina immigrants noted that parents appreciated learning about cultural parenting practices in Sweden and the US respectively, in addition to information about navigating locally available services (Osman et al., 2019; Paris, 2008).

A few studies noted that some parents were not comfortable with several techniques or indicated that desirable content was missing from programmes. In the systematic review by Butler et al. (2020a), the use of 'time out' was often mentioned as a strategy that parents disliked. Parents in two studies indicated that praise felt unnatural or that pointing out misbehaviour should be prioritized (Draxler et al., 2020; S. L. Parry et al., 2018). Fathers in one study wanted more Islamic content (Scourfield & Nasiruddin, 2015), while mothers in another requested more quality time activities that they could undertake with their young children – preferably in a recorded format (Miller et al., 2020). Video vignettes were criticized by parents in two studies as culturally distant, with one perceived as "too American" and another as presenting trivial scenarios that did not feature extended family members (Furlong & McGilloway, 2012; Houlding et al., 2012). Parents in two studies wanted content that was more relevant to the challenges they faced in raising adolescents, including techniques on how to discuss topics such as sex, sexuality, and drugs (Leckey et al., 2021; Parra-Cardona et al., 2018).

Potential parent participants. Several studies interviewed potential parent participants by sharing descriptions of existing programme content, or by asking them more broadly what they would prefer to learn or experience in a programme yet to be selected or designed. Many parents responded favourably to descriptions of skills such as praise, given attention to or rewarding positive behaviours, and modelling positive behaviours (Calzada et al., 2013; Wessels & Ward, 2016).

Parents also expressed that some content was socio-culturally unacceptable, particularly the use of time-out, ignoring negative behaviours in public situations, and the elimination of spanking as a discipline strategy (Calzada et al., 2013; Wessels & Ward, 2016). Fathers in one study indicated that positive parenting was too passive for use in disadvantaged communities, and that they could not identify with the non-urban setting in video vignettes, and the absence of men and African Americans (Kohl & Seay, 2015). Another study with American parents who participated in a programme from Australia, shared that workbook examples were not relevant to their daily lives (Lewis et al., 2016).

In terms of desired content, parents also shared that they wanted parenting programmes to promote family cohesion and respect from children towards their parents (Parra Cardona et al., 2009). Two studies with immigrant parents found that some wanted to avoid using physical punishment and learn effective positive discipline strategies that were culturally and legally appropriate in their host country (Osman et al., 2016; Parra Cardona et al., 2009). Other parents noted that they were interested in learning about how to better monitor adolescent behaviour (due to concerns about alcohol and drug use), as well as how to discuss sensitive issues such as contraception and sexually transmitted infections (Parra Cardona et al., 2009; Powwattana et al., 2018).

Service providers. Practitioners who delivered a parenting programme in Uganda shared that all programme content was important, and no programme messages should be omitted, indicating that the themes of "love and respect" were most widely embraced by parents (Singla & Kumbakumba, 2015). A programme for Muslim fathers in England was described as very compatible with Islamic beliefs (Scourfield & Nasiruddin, 2015), while all therapists in a qualitative study in the Netherlands reported that they agreed or strongly agreed that the programme was appropriate for Dutch families with young children (Niec et al., 2018).

Many practitioners expressed discomfort with, disliked, or had difficulty using time-out with parents (Draxler et al., 2020; Matos, Torres, Rocheli, et al., 2006; McCoy, Lachman, Sim, et al., 2020; Niec et al., 2018; Woodfield & Cartwright, 2020). Practitioners working with Puerto Rican families shared that it was too emotionally demanding, although some parents in the programme recommended the technique (Matos, Torres, Rocheli, et al., 2006), while in New Zealand it had poor acceptability amongst both families and therapists (Woodfield & Cartwright, 2020). In Sweden, counsellors expressed that the use of time-out was unethical, in conflict with the UN Convention on the Rights of the Child, and against their own cultural values. Fidelity checks showed that they did not practise this and other restricting parenting skills that are used in response to child negative behaviours (Draxler et al., 2020).

Recruitment and delivery methods

Parents who participated in parenting programmes. Concerning socio-cultural acceptability of programme recruitment and delivery methods, the predominant themes shared by many parent participants related to the appreciation of collaborative group methods, the opportunities to share experiences and engage

in mutual and non-judgmental support, as well as the sentiment of peer acceptance and shared group identity (Aspoas & Amod, 2014; Lana O. Beasley et al., 2021; Bradley et al., 2020; Buston, O'Brien, et al., 2020; Butler et al., 2020a; Coughlin et al., 2018; Furlong & McGilloway, 2012; Garcia et al., 2018; Garcia-Huidobro et al., 2016; Garza et al., 2009; Houlding et al., 2012; Leckey et al., 2021; Levac et al., 2008; Michelson et al., 2014; Onyskiw et al., 1999; Shorey & Ng, 2019; So et al., 2020; Solheim et al., 2014; Wong et al., 2011). One qualitative systematic review that included 26 studies found that the group experience was an important theme in 60% of papers; however, it also noted that 14 papers mentioned participant constraints relating to group dynamics, such as fear of attending group sessions and feeling a reluctance to talk (Mytton et al., 2014). Within this collaborative dynamic, parents also shared that the use of role plays during programme sessions were relevant and beneficial, as they helped them to gain empathy and master new skills (Parra-Cardona et al., 2016; Parra-Cardona et al., 2018).

In addition, parent participants shared that they appreciated the individualized nature of some parenting programmes, such as the use of home visits, which allow for participants and facilitators to develop positive, one-on-one relationships (Butler et al., 2020a; Christian et al., 2014; Leckey et al., 2021; Paris, 2008; Singla & Kumbakumba, 2015); phone calls by facilitators which were perceived as an expression of 'caring' (Garcia-Huidobro et al., 2019); and the embedding of programmes within a multi-disciplinary or case management service with access to referrals or immigrant advocacy (Onyskiw et al., 1999; Paris, 2008).

Parents also shared positive feedback in relation to digital programme formats and various audio-visual materials for participants. Indigenous parents who participated in a group-based programme in Canada expressed that they liked the visual learning methods, although they preferred the original DVDs over the indigenous adaptation (Houlding et al., 2012). In a study with parents who participated in a tablet-provided digital programme, over two-thirds reported that the videos showing parenting skills being effectively (and not effectively) utilized in different vignettes were one of their favourite programme components, while half appreciated the convenience of tablet use (Brager et al., 2021). Finally, all parents participating in a post-treatment interview regarding an internet-delivered programme appreciated the benefits of the medium, such as convenience and versatility, and shared that their families would not have been able to participate otherwise given the scarcity of professional support in their rural hometowns (Kohlhoff et al., 2020).

Parent participants also shared their negative perceptions of programmes, as well as offering suggestions on how socio-cultural acceptability could be improved. The systematic review by Mytton et al. (2014) found that the frequency and timing of sessions was a constraint, which compounded competing demands on parents' time and resources, with overly lengthy programmes and the onerous time commitment also referred to by parents in other studies (Gallitto et al., 2018; Lewis et al., 2016; Woods-Jaeger et al., 2018). However, in the review by Butler et al. (2020a), parents suggested longer programme duration or additional sessions in order to explore content in more detail and allow more time for child behaviour change. In other studies, parents also shared that access to participant resources should be improved, including requests for a written manual including all parenting activities and skills (Miller et al., 2020), as well as access to live chats with facilitators and extended access to the parenting application even after completion of the digital programme (Shorey & Ng, 2019). Finally, ethnic minority parents in several studies shared that cultural sensitivity and social influence could be strengthened through the engagement of respected professions and community influencers, such as teachers, church leaders, health professionals, grandparents, and local elders (Garza et al., 2009; Javier, 2018; McCoy, Lachman, Sim, et al., 2020; Woods-Jaeger et al., 2018).

Service providers. Findings from the systematic review by Mytton et al. (2014), as well as two other studies (Houlding et al., 2012; Suchman et al., 2020), emphasized that practitioners valued programme flexibility and the ability to tailor content to the needs of participants. Studies also found that practitioners particularly appreciated the multiple modalities of presenting programme information; in particular, through role plays, DVDs, presentations, facilitator manuals, and parent resources (Houlding et al., 2012; Turner et al., 2014).

There was little mention in the literature regarding recruitment or delivery methods that practitioners did not find relevant or acceptable. However, one study noted that they perceived that the programme was not long enough for families with multiple problems (Baumann et al., 2019), while another found that practitioners wanted smaller parenting groups (of 3-4 parents) for mothers with mental health concerns (Suchman et al., 2020).

Community stakeholders. Only one included study included a range of community stakeholders as participants. In this study, a community action board was formed that included representatives from education, social services, health care, and parents with histories of adverse childhood experiences. The board offered suggestions to promote programme socio-cultural acceptability by diversifying delivery methods, including the offering of alternative delivery modes (such as an evening group) and reductions in programme dosage (Woods-Jaeger et al., 2018).

Role of programme providers

Parents who participated in parenting programmes. Concerning the socio-cultural acceptability of programme providers, the predominant finding from studies reporting the views of parent participants was that it was important for them to be non-judgmental, empathetic, trusting, friendly, supportive, interactive, genuine, and approachable (Aspoas & Amod, 2014; Lana O. Beasley et al., 2021; Lana O. Beasley et al., 2018; Fogarty et al., 2020a; Garcia et al., 2018; Garcia-Huidobro et al., 2016; Kohlhoff et al., 2020; Kohlhoff et al., 2019; Leckey et al., 2021; Matos, Torres, Rocheli, et al., 2006; Paris, 2008; Parra-Cardona et al., 2016; Parra-Cardona et al., 2018; So et al., 2020). The systematic review by Mytton et al. (2014) emphasized this point in half of the included papers reporting participant perspectives; moreover, the review by Butler et al. (2020a) also highlighted that having a supportive and non-judgmental approach was the most frequently cited valuable characteristic for facilitators. Parents expressed that they appreciated facilitators who fostered a welcoming and safe environment within parenting groups, especially when sensitive issues such as violence were discussed (Fogarty et al., 2020a).

Parents also shared that they appreciated practitioners who were adept at working with families in a culturally appropriate manner. This was described as those who were: able to develop effective relationships with families by providing communicative and culturally relevant client support; adept at framing parenting skills within relevant cultural experiences and values; able to deliver the programme in the local or immigrant language and utilize culturally appropriate metaphors, proverbs, examples, and expressions to enhance understanding; and who were well respected within the immigrant community (Munns et al., 2018; Osman et al., 2019; Parra-Cardona et al., 2016).

Parents also described how they valued practitioners who were perceived as knowledgeable. Parents shared that having access to practitioner expertise was essential to overcoming their initial feelings of uncertainty and contributed to their positive experience of the programme (Kohlhoff et al., 2020). They

also appreciated that the practitioners were well educated and demonstrated satisfactory pedagogical skills (Osman et al., 2019).

Parent participants also disclosed those aspects relating to practitioner roles or characteristics that they either disliked or should be improved. In one programme, some mothers shared that practitioners struggled to keep the group focused on topic and were unable to cover all session content (So et al., 2020). In another programme targeting families of maltreated children, parents expressed that they wanted access to other professional staff in addition to the existing multi-disciplinary team, specifically a legal expert to discuss divorce, custody, spousal abuse, and stalking concerns, as well as a child psychologist who could provide counselling services specifically for adolescents (Onyskiw et al., 1999).

Potential parent participants. Several studies reported on the expertise and qualities of parenting programme practitioners that they perceived would be desirable. Low-income Latina mothers in every focus group and in most individual interviews in one study shared that they would defer to a mental health professional regardless of their own values and beliefs (Calzada et al., 2013), while Latino immigrant parents in another study repeatedly stressed that facilitators should be respectful and collaborative (Parra Cardona et al., 2009). Somali immigrant parents in Sweden emphasized the importance of facilitators who were culturally competent in both cultures and able to deliver the intervention in Somali language (Osman et al., 2016).

Service providers. In several studies, parenting programme practitioners also divulged their views on the importance and suitable qualities of programme deliverers. Almost one-half of nurses in one study emphasized that nurse provider characteristics were a crucial aspect of engaging mothers (Lana O. Beasley et al., 2018), while in another study, all practitioners believed in the importance of building rapport and developing constructive relationships in order to maintain parent engagement (Klatte et al., 2019).

Training and supervision

Service providers. Several included studies reported findings relating to practitioner socio-cultural acceptability of programme training and supervision. One commonly mentioned aspect was the relevance and importance of high-quality coaching and supervision. Practitioners appreciated regular, frequent, consistent, directive, timely, and specific feedback, noting that it was essential for them to learn intervention content and improve delivery skills (Akin et al., 2014; Shapiro et al., 2015; Singla & Kumbakumba, 2015; Woodfield & Cartwright, 2020). Some practitioners emphasized that site coaches played a critical role when the programme transitioned to real world settings (Baumann et al., 2019). In one study, preferences varied regarding whether ongoing supervision should be live or via teleconference (Christian et al., 2014), while several others in another study noted that the availability of specialist support – such as from a mental health expert or nurse – was helpful to them (West et al., 2017). A second aspect was the availability of practitioner peer support to promote mentoring and strengthen skill acquisition was also discussed in three studies (Singla & Kumbakumba, 2015; Turner et al., 2014; Woodfield & Cartwright, 2020). In particular, one study noted that peer support was one of the most desired supports requested to help practitioners deliver the programme after training (Turner et al., 2014). Third, practitioners spoke of the experience of participating in programme training as positive and satisfying, as it allowed them to learn innovative approaches, understand what parents feel like when they participate in the programme, and to acquire new skills and knowledge that had a positive impact on their role as parents themselves (Baumann et al., 2019; Cooper & Coyne, 2020; Shapiro et al., 2015; Singla & Kumbakumba, 2015).

Practitioners also shared those aspects of training and supervision which they disliked or could be improved. In three studies, some practitioners expressed that they required additional and more timely training, supervision, or ongoing consultation (Niec et al., 2018; Ruben Parra-Cardona et al., 2018; Singla & Kumbakumba, 2015), with a preference for live feedback rather than phone consultation (Niec et al., 2018). In addition, practitioners in two other studies indicated that programme materials and protocols should be improved by rectifying a lack of clarity in the manual, providing additional guidance regarding families struggling to master programme content, and including pictorial rather than text-based resources and adopting simplified language (Christian et al., 2014; Turner et al., 2014).

Programme management and administration

Participating parents. In a few studies, parents shared their views on aspects of programme management and administration that they found either strengthen or limit their engagement. Parents noted that opportunities for direct and consistent contact with a practitioner via text or email between sessions was desirable (Fogarty et al., 2020a). However, in two studies, parents expressed their dissatisfaction with the consistency of staffing and service delivery. Parents in one programme for child-maltreating families often discontinued contact due to changes in practitioners (Onyskiw et al., 1999), while some mothers in a home visiting programme experienced distress when transferred to new practitioners or when home visits were inconsistent (Paris, 2008).

Service providers. Most studies with findings on practitioner socio-cultural acceptability of programme management and administration, conveyed challenges or negative feedback. Practitioners expressed difficulties in establishing the intervention within their organization due to a lack of support by managers, colleagues, and collaborators (Draxler et al., 2020). In another study, practitioners presented contrasting experiences: one group pointed to difficulties in implementation due to an incongruence with organizational values and a lack of executive support, while the other group disclosed positive implementation experiences owing to engaged, enthusiastic, and knowledgeable leaders (Akin et al., 2014). A third study found that providers noted the absence of infrastructure to support the referral process, with success dependent solely on their own abilities to complete requisite tasks on top of their other professional responsibilities (Suchman et al., 2020).

Variations in socio-cultural relevance or acceptability over time

Participating parents. Several studies included in our review presented findings regarding variations in socio-cultural relevance or acceptability over time (Draxler et al., 2020; Fogarty et al., 2020a; Garcia et al., 2018; Kane et al., 2007; Kohlhoff et al., 2020; Leckey et al., 2021; Shapiro et al., 2015; Singla & Kumbakumba, 2015), although most were retrospective in nature; only one study gathered qualitative data during both pre- and post-intervention (Kohlhoff et al., 2020). These variations were mainly due to improved attitudes and levels of understanding regarding the management of child problem behaviour, positive changes in perceptions toward service providers and service delivery systems, and more favourable perspectives regarding the sharing of personal difficulties with others.

First, several studies found that changed attitudes toward and improved understanding regarding child problem behaviour led to greater programme socio-cultural relevance and acceptability. The systematic review by Kane et al. (2007) showed that parents initially felt loss of control in managing child behaviour, as well as harboured feelings of anger, guilt, and self-blame. However, after the programme, these

attitudes gradually changed to increased empathy, understanding the factors that contributed to child problem behaviours, and reported increased competencies in positive discipline strategies. In another study, several parents shared in interviews prior to programme participation that they had a lack of knowledge about developmentally appropriate child behaviour prior to programme participation, which impeded them from seeking services. During post-intervention interviews, some parents shared that access to expert knowledge and an evidence-based programme helped them overcome barriers to treatment and was essential to their positive experience (Kohlhoff et al., 2020). In a third study, mothers shared that prior to the programme they felt insecure about the way that parenting skills were taught and were unsure of how their children would respond; following programme participation, they regarded the programme as having a large impact, with changes in child behaviour occurring surprisingly quickly (Draxler et al., 2020).

Second, two studies referred to changes in parent perceptions of service providers and service delivery systems. One study noted that parents held negative perceptions of helpers, caseworkers, and service systems prior to the intervention, which altered over the course of the programme due to practitioners' abilities to praise parent progress and cultivate positive therapeutic alliances (Garcia et al., 2018). Another study found that parents initially expressed difficulties in trusting services, but eventually overcame this barrier due to clinician factors (e.g., welcoming approach, addressing concerns, promotion of comfort and safety), consistent and direct communication with practitioners, flexible service delivery, application of a strengths-based approach, and support from family and friends (Fogarty et al., 2020a).

Finally, one study identified changes in participating parents over time with regards to the willingness to share personal difficulties with others. Some mothers were initially apprehensive about such openness, out of concern for being perceived as an incompetent parent. However, they were able to disclose their parenting challenges following immersion in a comfortable and non-judgmental programme environment, as well as after learning techniques to manage stress and anxiety (Leckey et al., 2021).

Service providers. Improvements in practitioner socio-cultural relevance and acceptability over time were also found in a few studies (Draxler et al., 2020; Shapiro et al., 2015; Singla & Kumbakumba, 2015). Findings focused on increases in practitioner self-efficacy as well as improvements in programme tailoring. Two studies highlighted that practitioners expressed uncertainty in adopting skills-training approaches involving behavioural practice, as well as difficulties in using requisite materials during activities and feeling unprepared to deliver sessions without reading the manual (Draxler et al., 2020; Singla & Kumbakumba, 2015). After gaining experience in facilitating role plays and becoming more comfortable with the material, their self-confidence and trust in the programme methods increased. In addition, practitioners in another study noted that they felt better able to tailor the programme to individual families over time, reporting that training experiences and post-training support from trainers, supervisors, and peers were important determinants (Shapiro et al., 2015).

2. Value placed on health and non-health outcomes

Health outcomes

Several studies included in our review reported how parents valued various health outcomes, as expressed through their needs and expectations for engaging in a parenting programme, as well as aspects that they felt were particularly valuable and impactful during and after the intervention. Such health

outcomes centred on physical health and safety, mental health, and non-physical child discipline. One study noted that parents specifically referred to the importance of medical advice, activities, and referrals (e.g., check-ups, general child and maternal health information) (Lana O. Beasley et al., 2018), while another found that parents identified the health module (designed to help detect and respond to signs of illness and injury) as the most useful (Gallitto et al., 2018). Concerning mental health outcomes, six studies found that stress and anger management were widely appreciated by parent participants, which were linked to improved parental well-being and self-care, feelings of greater self-awareness and control, and improvements in positive parenting (Bradley et al., 2020; Leckey et al., 2021; Levac et al., 2008; Lewis et al., 2016; Miller et al., 2020; Woods-Jaeger et al., 2018). Finally, with regards to non-physical child discipline, Latino immigrant parents who had not yet participated in a parenting programme shared that their goals were to implement effective yet safe discipline practices that would not culminate in legal consequences in the US (Parra-Cardona et al., 2009; Parra-Cardona et al., 2020).

Non-health outcomes

In our review, parents more strongly emphasized the value that they placed on various non-health outcomes over health outcomes. We identified five key types of non-health outcomes across included studies: feelings of support from practitioners and other parents, improvements in child difficult behaviours, strengthening of parent-child communication and relationships, improvements in parent-child cultural gaps, and the strengthening of spousal and wider family relations.

Firstly, ten studies highlighted that many parents appreciated engaging in group support and in benefiting from positive therapeutic relationships with practitioners (Aspoas & Amod, 2014; Lana O. Beasley et al., 2021; Lana O. Beasley et al., 2018; Bradley et al., 2020; Buston, O'Brien, et al., 2020; Coughlin et al., 2018; Levac et al., 2008; Onyskiw et al., 1999; Paris, 2008; Y. K. Parry et al., 2020). Parents referenced that group sessions allowed for a strengthening in social connections between parents, opportunities to learn from and help others, and a sharing of problems and frustrations that alleviated loneliness. Further, the development of practitioner-parent relationships permitted opportunities to receive tailored advice, reassurance, and appropriate referrals.

Secondly, many parents shared that they were motivated to participate in a parenting programme due to concerns regarding their children's behavioural problems (e.g., aggression, emotional dysregulation, non-compliance, violence toward self and others), with the acquisition of new parenting knowledge and skills mediating reductions in child negative behaviours (Edwards et al., 2010; Houlding et al., 2012; Kohlhoff et al., 2020; Kohlhoff et al., 2019). In two studies, parents noted that they valued seeing improvements in child behaviour at both home and school, with some parents receiving fewer calls from schools to report child misbehaviour, and even improvements in grades (Edwards et al., 2010; Houlding et al., 2012).

Thirdly, many parents expressed that they aimed to strengthen parent-child communication and relationships by enrolling in a parenting programme, or that they found these improvements to be the most relevant following their participation (Javier, 2018; Michelson et al., 2014; Mytton et al., 2014; Osman et al., 2016; J. R. Parra-Cardona et al., 2016). Parents were enthusiastic about spending more quality time with their child, modelling positive parent-child interactions, developing parent-child mutual respect, and fostering warmth and nurturing within these relationships.

Fourthly, parents in three included studies raised the importance of improving parent-child cultural gaps, particularly within immigrant communities (JParra-Cardona et al., 2016; 2020; Wong et al., 2011). Parents

shared that contrasting cultural values and traditions, as well as language barriers and preferences, had provoked parent-youth conflicts. Programme content that fostered improved parent-child communication on these issues, addressed the challenges of biculturalism, and helped parents acknowledge the need to modify their parenting styles were valued by these participants.

Finally, several families appreciated that parenting programmes fostered the strengthening of spousal and wider family relations (Javier, 2018; Kohlhoff et al., 2019; Parra-Cardona et al., 2016; Solheim et al., 2014). Parents expressed that they were able to synchronize parenting strategies with their partner, which resulted in improved relationships; moreover, some noted an enhanced quality in family connections due to new ways of communicating and relating to children.

Theme 2: Sensitivity of parenting programmes to participant characteristics

Our summary of key findings of moderator analyses from the two University of Oxford reviews on associations according to participant characteristics provides only limited insights for this theme. The systematic review and meta-analysis of parenting programmes for reducing child maltreatment and harsh parenting in LMICs focuses on children aged 2-17 years, with an outcome focus on child maltreatment in the family, associated harsh and positive parenting behaviours, and child and parent mental health and child behaviour problems (Gardner et al., 2021). Currently in draft form, it is the most comprehensive review of this kind to date, including 131 RCTs and comprising 22,375 families from 36 countries in all geographic regions. The draft global review on parenting interventions for children aged 2-10 years focuses on social learning theory-based programmes and their effectiveness in reducing child maltreatment, including evidence from 278 RCTs in 30 countries (Backhaus et al., 2021).

Systematic review and meta-analysis of parenting programmes in LMICs

The Oxford LMIC review includes moderator analyses from meta-regression on whether parenting interventions have differential effects in studies that focus on the most vulnerable families, on the basis of income and education levels, beneficiary and child target group age and sex, child maltreatment risks, and child behavioural problems. Participant characteristics that were examined in these analyses included family socio-economic status (SES), parent education level, and child and parent age and sex.

For the categorical variable of **family SES**, the authors included two levels: 1) disadvantaged, and 2) non-disadvantaged. Across outcomes, the authors found no evidence that intervention effects were moderated by family SES level; however, many studies did not report data on family income level, and some analyses were unreliable. For the **parent education level** variable, three levels were included in the analysis: 1) primary, 2) secondary, and 3) higher than secondary. Again, across these outcomes, the authors found no evidence that effects were moderated by this variable; they also noted that there were gaps in data on participant education levels, with some analyses being unreliable. Regarding **child age**, three levels were considered as categorical variables: 1) preschool, 2) primary school age, and 3) teenage. There was no evidence of differentials in intervention effect by child age. Finally, the characteristics of **parent age**, **parent sex** (proportion of female caregivers), and **child sex** (proportion of female children) were analysed as continuous variables. For all outcomes, the authors also found no evidence that intervention effects were moderated by average age and proportion of male and female caregivers at the trial level. However, trials with a higher proportion of target female children did show stronger effects on

positive parenting and child emotional and behavioural problems (Change per SD = -0.01, CI -0.02, -0.00; τ^2=0.28), although distributions were skewed and findings difficult to interpret.

Global review on parenting interventions

The Oxford global review also included moderator analyses from meta-regression on whether parenting interventions have varying levels of impact on the basis of prevention strategy, country income status, programme delivery format, socio-economic status, and ethnicity. For the purpose of the present review, we summarize here the findings concerning the latter two categorical variables.

For the categorical variable of **family SES**, the authors examined two levels: 1) high, upper-middle, and middle-income status, and 2) low and low-middle income status. There was a medium mean effect size for the first level reference group [d = -0.53 (N = 57, k = 210)], a small mean effect size for the second level [d = -0.41 (N = with a small difference in coefficients [N = 27, k = 223)], and a non-significant difference in coefficients [d = 0.10, 95% CI (-0.08, 0.27)]. These findings thus suggest that there is no evidence that intervention effects are moderated by SES levels.

For the categorical variable of **ethnicity**, two levels were also assessed: 1) ethnic majority parents, and 2) ethnic minority parents. There was a small mean effect size for the first level reference group [d = -0.29 (N = 40, k = 96)], a medium mean effect size for the second level [d = -0.51 (N = 56, k = 217)], and a significant difference in coefficients [d = 0.22, 95% CI (0.05, 0.39)]. The review findings thus suggest that trials which mostly included ethnic minority parents showed less improvements in negative parenting after participating in the intervention, and fewer reductions in child externalizing behaviours. However, most trials did not report the ethnicities of participants, and where such information was available, almost all were from the ethnic majority of the country.

Theme 3: Parenting programme intrusiveness and effects on autonomy

Our search of the University of Oxford database on qualitative studies retrieved 48 records. One duplicate was removed. After screening all titles and abstracts, 14 records were excluded for failure to meet inclusion criteria. The full text of 41 remaining records were then assessed for eligibility, which resulted in the inclusion of 31 records. Handsearching led to the inclusion of the systematic review by Mytton et al. (2014), a qualitative study on the adaptation of PLH Young Children for integration within a conditional cash transfer programme in the Philippines (Mamauag et al., 2021), an institutional report by Ghate & Ramella (2002) on the Parenting Order programme for parents of young children at risk or engaged in offending in the UK, and a feasibility study on the Strong Families parenting programme for refugees in reception centres in Serbia (El-Khani et al., 2021). This resulted in a total of 35 records, encompassing 32 qualitative or mixed methods studies and three systematic reviews.

Table 4: Search results (search date 5 September 2021):

Search terms for University of Oxford qualitative study database	**Hits**
1. cash OR stigma* OR camp* OR shelter* OR court OR child protection OR child welfare OR incentive* OR privacy OR coerc* OR prison*	48
Duplicates removed	1
Titles and/or abstracts screened	47
Full text screened	41

Included	31
Handsearching of other studies and reviews	**4**
Total included	**35**

We organized our assessment according to the different contexts in which parents have been or may potentially be engaged in a parenting programme: 1) families in contact with the child welfare system; 2) parents with children in or recently returned from alternative care; 3) foster parents; 4) families in shelters; 5) families in refugee settlements or reception centres; 6) parents in incarceration; 7) parents of children at risk of or known to be engaged in offending; 8) parents beneficiaries of conditional cash transfers; and 9) families experiencing various types of adversity and vulnerability. Twenty-five studies collected data from parents who recently participated in a programme, while 12 gathered data from service providers, and four from potential parent participants.

1. Families in contact with the child welfare system

Seven included studies from the US (Akin et al., 2018; Gallitto et al., 2018; Lipman et al., 2010; Rizo et al., 2016), Canada (Coleman & Collins, 1997; Garcia-Huidobro et al., 2016), and Ireland (Lewis et al., 2016) interviewed parent participants or practitioners in the child welfare system regarding their perceptions of participating in or delivering parenting programmes. In the two studies concerning Triple-P (Lipman et al., 2010; Rizo et al., 2016), the majority of parents and practitioners had positive feedback regarding the programme, finding it to be effective and beneficial. Parents expressed that more parents should enrol in Triple-P, and practitioners expressed that it was standard agency practice to refer families to the programme when a parenting need was identified. Negative feedback in both studies focused on structural barriers to referrals and attendance, with only one caseworker having reservations about Triple-P after one participating parent failed a parenting capacity evaluation.

The remaining five studies encompassed a variety of programmes. The study by Akin et al. (2018) gathered views from families (N = 10) in the Strengthening Families Program affected by substance use. Parents spoke highly of group facilitators, but also shared suggestions for improving parent engagement with regard to group dynamics, individual factors, programme timing and transportation. One parent expressed defiance in participating in a mandatory programme, indicating that she disliked not having options, while several others felt that the programme content was not relevant to their needs. In the study by Coleman et al. (1997), 75 parents of maltreated children and children with behaviour difficulties shared their views on a family preservation programme. The majority of parents in both groups believed that their family problems were about the same as before treatment. Parents were sensitive to power imbalance vis-à-vis practitioners, with some feeling that workers sabotaged parental authority within practitioner-child relationships. Parents of children with behaviour problems in particular resented that target children were given too much power within the family, and were disappointed and resentful when practitioners did not support or validate the enforcement of family rules. In the study by Estefan et al. (2013), 21 parents in the Nurturing Parents Programme mainly shared positive feedback, especially with regards to changing their disciplinary practice, communications with their partner, and anger management. Parents shared that they learned new skills, regardless of whether or not they initially felt that they required parenting assistance. Negative comments concerning intrusion or effects on privacy or autonomy were not cited. The majority of parents (N = 26, 87%) in the study by Gallitto et al. (Gallitto et al., 2018) rated the SafeCare programme as a positive and valuable learning experience, with 90% sharing that they would recommend it to other families. However, two parents (7%) conveyed concerns regarding the power imbalance between parents and practitioners, who were child welfare system workers with a

duty to report. Several parents also noted that they were concerned about the way information shared during the programme could be used, such as for the potential removal of the child from their care. Finally, the study by Leckey et al. (2021) concerning parent views on a multi-component preventative programme to reduce child maltreatment (N = 12) noted that parents reported strong parent-child relationships, as well as improvements in communication and discipline strategies. Negative feedback regarding the programme centred on developmental appropriateness, vignette content, programme advertising, and the meeting venue; perceptions regarding intrusiveness or other restrictions were not reported by the authors.

2. Parents with children in or recently returned from alternative care

Two included studies from the US focused on the views of parents and child welfare practitioners regarding the parenting of children currently in or recently returned from alternative care. The study by Akin et al. (2014) with 28 practitioners concerning implementation of PMTO found that most families responded positively to the intervention, with perceived rapid improvements in parenting skills. Practitioners noted that parents often felt anger and guilt at the start of the programme, expressing shock that their children were in the child welfare system, and were initially sceptical of the intervention; however, parents demonstrated increased confidence as they applied newly learned skills. In addition, practitioners shared that delivering PMTO to parents with mental health and substance abuse issues was more difficult, and they were more likely to drop out. Finally, a mismatch was described between timeframes set by the child welfare system and the time available to support the family in learning new parenting skills. Views on parent opinions relating to programme intrusion, restricted autonomy, or incursions on privacy were not expressed by practitioners.

The study by Garcia et al. (2018) included 35 parents with children in kinship care, foster care, or other settings who were referred to child welfare agencies and had participated in Triple P Level 3 (Group Sessions). Several barriers to engagement were identified by parents, including lack of immediate programme acceptability, lack of feasibility to implement new parenting skills, lack of intrinsic motivation, lack of relevance of programme materials, and negative perceptions of caseworkers, systems, and policies. These barriers were reduced over time due to the cultivation of positive group dynamics and cohesion, therapeutic alliances, case study adaptations, and bonding amongst peers, ultimately resulting in improved parent-child communication, knowledge of child developmental needs, and recognition of previous negative parenting practices and positive child behaviours.

3. Foster parents

There was only one included study that examined the perceptions of foster parents with regards to a parenting intervention. In the study by Spielfogel et al. (2011) in the US, 38 parents participated in focus group discussions to inform the development of a foster home intervention using parent management training and an academically-focused intervention. The foster parents expressed a desire for more training to address child disruptive behaviours, including lying, stealing, and sexualized behaviours, and indicated that they were already using several parenting techniques being proposed in the programme. Parents also noted that strategies that they used with their own children were not necessarily effective with the foster children in their care, due to child histories of maltreatment and difficulties in forming secure attachments. Despite the expressed interest in the parenting programme, parents shared concerns about whether the child welfare agency would support their use of parent management training. Interactions with agency staff were often described as alienating or contributing to a sense of discord, as parents

perceived that staff were at times antagonistic toward or overly scrutinized their efforts to help the child in their care. Perceptions of potential intrusion, restricted autonomy, or incursions on privacy due to the planned intervention itself were not expressed by parents.

4. Families in shelters

Three included studies reported findings regarding programmes for parents staying in homeless shelters or shelters for victims of intimate partner violence. The first was a qualitative systematic review of 12 studies of parenting interventions in homeless shelter settings, with varying levels of methodological quality and most based on small samples and pre-post designs (Haskett et al., 2016). Results indicated that parents generally viewed the interventions as enjoyable and informative, with good rates of attendance. Retention was particularly strong for programmes that included incentives to promote attendance; however, some evaluations were conducted with non-random samples. The review did not describe any negative parental feedback.

The two remaining studies by Haskett et al. (2018) and Wessels et al. (Wessels & Ward, 2016) respectively involved samples from the US (N = 284) and South Africa (N = 32), who participated or would potentially participate in Triple-P. The US-based study included parents from across nine different shelters or transitional housing programmes, some of which required parents to attend Triple-P sessions regardless of whether the content was relevant to their children's ages. While parents generally had positive views of the programme, there were mixed views on content relevance, as well as suggestions for revisions to content and methods of delivery. Most recommendations were related to the difficulties faced in parenting within a crowded and highly structured environment. In the South African study, mothers staying in three shelters for victims of intimate partner violence, who were potential programme participants, were asked for their views regarding Triple-P. They shared that they generally found the parenting strategies described to be acceptable and useful, with many expressing that they would be likely to implement them. Parents noted several barriers to effective implementation of Triple-P strategies in a shelter context, including limited space (as other mothers and children were often in close proximity), and a tension between parents' own parenting rules and rules imposed by the shelter. Four participants (13%) reported that they would be uncomfortable accessing a parenting programme.

5. Families in refugee settlements or reception centres

Only one study was identified which focused on a parenting programme for refugee families in restricted settings. The feasibility study of the Strong Families programme by El-Khani et al. (2021) focused on the experiences of refugee families residing in reception centres in Serbia. The parent participants (N = 25) expressed that the programme was culturally appropriate and contributed to reductions in the use of physical punishment, a greater prioritization of caring for children, and improved communication with their children and between couples. The authors described a 100% engagement rate, as well as noted that while the motivation for parental voluntary participation in the intervention was not quite clear, caregivers noted that they experienced boredom and did not have other daily activities to engage with, and that they needed help in caring for their children. No negative feedback on the programme was provided.

6. Parents in incarceration

Three included studies focused on the experiences of families in incarceration. One study by Buston et al. (Buston, O'Brien, et al., 2020) included various target groups, including incarcerated fathers, but is incorporated in the below section on families experiencing adversity and vulnerability. Two studies focused on incarcerated parents in the UK. The study by Baradon et al. (2008) presented observations from a pilot of the New Beginnings programme for mothers and infants (N = 27 dyads) in two prisons, finding that the intervention does benefit some women and babies by building on parent strengths, develop parent-infant relationships, and enhancing parenting knowledge. Most mothers expressed anger mainly directed at the prison system and officers, as well as guilt associated with depriving the baby or normal activities and contacts through being in prison. The study by Buston (2018) assessed the implementation of the *Being a Young Dad* parenting programme for fathers (N = 16) in Young Offender Institutions. The author found that the voluntary programme had high levels of recruitment, retention, and engagement, with most expressing a desire to continue attendance even after programme completion. The study noted that some fathers were motivated to participate at the outset due to perceptions that it may be viewed favourably by social workers, or could assist in an early release; however, fathers did not seem to continue to attend solely for these reasons. Programme intrusiveness or negative effects on autonomy were not mentioned.

The third study focused on the views of developers and implementers of various parenting programmes (N = 19) concerning delivery and outcomes for incarcerated mothers and fathers in Australia (Fowler et al., 2018). Interviewed participants reported that parents experienced enhanced parenting knowledge, changed attitudes, and improved parenting behaviours; perceptions of negative programme experiences were not found. However, participants perceived that there were major limitations, as it was challenging to practise parenting skills in a context of limited or no access visits between parents and their children, or that the environment was uncomfortable or forbidding when such visits did occur.

7. Parents of children at risk of or known to be engaged in offending

Given the lack of studies targeting parents of children at risk of or in contact with youth justice systems in the Oxford qualitative study database, we identified one institutional report on a national evaluation of the Youth Justice Board's parenting programme in the UK (Ghate & Ramella, 2002). Drawing from a large sample size (approximately 800 parents, 500 young people, and 800 service providers), the study includes an exploration of programme impact depending on the referral route for participating parents (i.e., court ordered or voluntarily). The evaluators concluded that referral route did not make a difference to the level of parent-reported effects on outcomes. Differences between mandatory and voluntary participants were found at the outset, with voluntary referred parents being significantly more likely to expect the programme to be helpful (94% compared with 78% on court orders), as well as during exit ratings, which were somewhat more positive for voluntary participants (96% compared with 90%). However, parent feedback was largely highly positive irrespective of referral route, with many initially reserved or even hostile parents conveying positive feedback by programme cessation.

8. Parent beneficiaries of a conditional cash transfers

Only one included study focused on a parenting intervention delivered to caregivers participating in a national conditional cash transfer (CCT) programme. The study by Mamauag et al. (Mamauag et al., 2021) involved a sample of 47 low-income families in the Philippines who were beneficiaries of a monthly cash benefit, subject to their compliance with several social development conditions – including participation in PLH-YC. Parents shared that the learned parenting skills helped them to achieve their goals of improving

child behaviour, as well as regulated their anger and stress through mindfulness-based stress reduction techniques. While the home visits made some parents feel embarrassed, they appreciated the personalized attention by facilitators. The study did not report any other negative feedback regarding the intervention.

9. Families experiencing various types of adversity and vulnerability

Finally, 12 studies encompassed a range of programme target populations, including low-income and marginalized parents, single mothers, parents with mental health difficulties, and parents who have experienced intimate partner violence living in the US (L. O. Beasley et al., 2021; L. O. Beasley et al., 2018; Garcia-Huidobro et al., 2016; Rizo et al., 2016; Stahlschmidt et al., 2013), Scotland (Buston, O'Brien, et al., 2020), England (Butler et al., 2021), Canada (Lipman et al., 2010), Uganda (Singla & Kumbakumba, 2015), across four HICs (K. Taylor, 2018). Two studies were systematic reviews from various HICs (Mytton et al., 2014), as well as a mix of HICs and LMICs (Butler et al., 2020b).

The review by Butler et al. (2020b) included 26 qualitative studies involving 822 parents who had participated and may potentially participate in parenting programmes. Thematic analysis identified themes including new parenting skill acquisition, strengthened parent-child communication and relationships, and improvements in child behaviour and quality of family life. Parents who were mandated to attend programmes as part of child welfare processes shared that they were initially reluctant and pessimistic, although this commonly shifted to a greater willingness to engage once they began attending sessions. Some parents also shared concerns about privacy, distrust, as well as fear of being reported to child protection authorities, while others expressed feeling pressured to take part in group discussions. The other qualitative review by Mytton et al. (2014) included a total of 26 studies involving parent participants and parenting programme practitioners. Parents expressed that they valued skills that improved their confidence, parenting competence, goal setting, and personal development. They also identified several participant constraints, especially regarding group dynamics, such as the fear of attending group sessions, reluctance to speak in a group setting, suspicions of others, and differentials between participants.

Six studies focused on programmes targeting low-income or marginalized families in HICs, with participant sample sizes ranging from 11 to 67 (L. O. Beasley et al., 2021; L. O. Beasley et al., 2018; Buston, O'Brien, et al., 2020; Garcia-Huidobro et al., 2016; Stahlschmidt et al., 2013; M. B. Taylor & Hill, 2016). Across the studies, participants frequently referenced a variety of programme benefits, with findings indicating that the programmes were generally acceptable to them as well as worthwhile. Even amongst parents attending a court ordered programme, who expressed strongly negative emotions toward the social welfare system (and were potentially at risk of losing child custody), the authors found that participants had a positive and transformative learning experience (M. B. Taylor & Hill, 2016). Negative feedback from parent participants in these studies mainly centred on logistics, competing demands, and individual and family factors, rather than referral and recruitment processes or characteristics of the programme itself. However, the study by Beasley et al. (L. O. Beasley et al., 2018) did find that some parents perceived that practitioner attributes were sometimes a barrier to programme completion; namely, home visitors who were forceful, pushy, invasive, rude, and judgmental.

Three studies targeted particular groups experiencing parenting challenges and adversity, including lone mothers (N = 8) (Lipman et al., 2010), victims of intimate partner violence (N = 38) (Rizo et al., 2016), and parents with mental health problems (N = 12) (Butler et al., 2021). Across these studies, participants

identified the benefits of programme participation, noting in particular that the interventions helped parents avoid isolation (Butler et al., 2021; Lipman et al., 2010) and promote independence and empowerment (Butler et al., 2021; Rizo et al., 2016). The study by Rizo et al. (2016), which focused on the MOVE mandated parenting and safety programme, described that some women were initially wary about attending, but expressed appreciation of the intervention one-year post-completion. The study by Butler et al. (Butler et al., 2021) also noted that practitioners at times made judgements on behalf of parents regarding the appropriateness of an intervention – thus acting as gatekeepers. Despite these concerns, there were no other reported findings in relation to intrusiveness or effects on privacy and autonomy.

Finally, one study by Singla et al. (2015), which described the development and implementation of a parenting programme for rural low-income families in Uganda (N = 46), noted that parents widely viewed their participation to be beneficial. Low irregular father attendance was perceived by practitioners as attributable to male expectations for receipt of incentives or assumptions that the programme was only for mothers. Negative findings related to intrusiveness, privacy, and autonomy were not cited.

Summary of results and conclusions

Socio-cultural acceptability of parenting programmes

Findings from this review in relation to the socio-cultural acceptability of parenting programmes indicate that parent participants were generally positive toward and receptive of programme content, methods for recruitment and delivery, programme practitioners, and programme management and administration. Most parents shared that programme content was not in conflict with their cultural values, although in a few studies, some parents disliked vignettes or case examples that appeared culturally distant. Overall, they preferred positive parenting techniques over limit setting, with some parents disliking 'time out' and expressing that praise felt unnatural. Techniques relating to stress management, emotional awareness and regulation, and self-care were also found to be relevant to many parents. Some parents shared that they wanted additional content relevant to raising adolescents (e.g., sex, sexuality, drugs). Parents also frequently emphasized that practitioner characteristics were highly important, with attitudes that were non-judgmental, empathetic, friendly, interactive, genuine, and supportive being most valued. Aspects relating to programme management and administration did invoke negative reactions by some parents in two studies, who disliked inconsistencies in staffing and home visits (Onyskiw et al., 1999; Paris, 2008). In terms of variations in parent socio-cultural acceptability over time, there were few studies that gathered parent feedback at more than one time point; however, parental attitudes and levels of understanding toward the management of child problem behaviour, perceptions of service providers and service delivery systems, and perspectives regarding the sharing of personal difficulties with others did generally improve over the course of the programme.

Potential parent participants, who were exposed to the experience of the programme content and could only provide initial impressions, also at times did not perceive 'time out' to be acceptable. In addition, and in contrast to parents who had already participated, some were opposed to the elimination of spanking as a disciplinary method. Potential participants also reiterated views expressed by actual parent participants regarding the importance of practitioner character traits, beliefs, and approaches.

Perceptions shared by practitioners frequently mirrored the views of parent participants. Overall, they found programme content to be culturally appropriate and relevant, appreciated programmes that were flexible and allowed them to tailor the intervention to parent needs, and emphasized the importance of

practitioner abilities to build rapport and develop constructive relationships. In addition, practitioners frequently mentioned that they valued high quality coaching and supervision, emphasizing that it was essential to their ability to learn intervention content and improve delivery skills. In relation to programme management and administration, many practitioners shared negative perceptions or highlighted considerable problems, including a lack of support by managers and colleagues, a lack of sufficient infrastructure to support referrals, and difficulties in completing programme tasks on top of existing work demands. Concerning variations in practitioner socio-cultural acceptability over time, practitioners who shared retrospective feedback noted that they experienced increases in self-efficacy as well as improved abilities to tailor programmes to individual families.

With regards to the respective value that beneficiaries placed on health and non-health outcomes, the studies included in our review emphasized the latter. However, this depends on the categorization of outcomes, as many 'non-health' benefits often pertained to parent emotional well-being and reductions in child difficult behaviours – a key risk factor for child maltreatment. Parents frequently highly valued group support and the sharing of experiences, as well as the benefits they received from positive therapeutic relationships with practitioners.

Sensitivity of parenting programmes to participant characteristics

Overall, our summary of findings from the global and LMIC systematic reviews for the Guideline reiterate the key points and conclusions already noted in Chapter 4, Equity. Across both reviews, there was no evidence that parenting programme effects were moderated by family SES, parent education level, child age, parent age, or parent sex. However, trials with a higher proportion of target female children tentatively showed stronger effects on the outcomes of positive parenting and child emotional and behavioural problems, which may indicate that girls may benefit somewhat more than boys in these respects. In addition, trials in high-income countries with higher proportions of ethnic minority parents tended to show fewer reductions in negative parenting and child externalizing behaviours, suggesting that these families may benefit less in comparison to those in the ethnic majority. However, we interpret these findings with caution, as they do not assess outcome by ethnicity directly, but are based on trial aggregate-level data (see Chapter 4). Moreover, this finding does not concur with a recent individual participant data meta-analysis addressing this question (Gardner et al., 2019), based on pooled data from in trials in Europe.

Parenting programme intrusiveness and effects on autonomy

Findings from this review in relation to parenting programme intrusiveness and effects on autonomy support the notion that families living in restricted environments, or who are mandated to participate in a parenting programme, may experience intrusion, loss of privacy, and negative effects on independence and dignity along a spectrum. In almost all included studies, the environment and conditions under which such families participated in programmes were not well described, and the criteria for fulfilling court ordered programme participation were not reported. However, a common theme across studies was that most families initially reticent to participate in a programme experienced a change in attitudes and perceptions over time, with most expressing positive feedback on programme effects and recommending the interventions to others by the time of programme cessation. Importantly, some families that shared negative feedback indicated that practitioner attributes were a barrier to programme attendance and completion, particularly if they were judgmental, invasive, forceful, rude, and did not support parental attempts to enforce family rules. Especially for those families in contact with the child welfare system or

who were incarcerated, a power imbalance between parents and system workers was frequently directly or indirectly referenced, with fears of being viewed unfavourably or being reported to child protection authorities placing pressure on these parents to acquiesce or conform. Parents in restrictive environments such as shelters and prisons also experienced difficulties and frustration in practicing learned parenting skills with their children, which may not have allowed them to fully benefit from the intervention.

Such findings indicate that practitioners supporting families in these contexts should be sensitive to parental potential feelings of fear, anger, alienation, and relative powerlessness, which may be directed at the overarching welfare or justice systems, but perhaps projected onto programme practitioners themselves. Despite these challenges, families attending both on a voluntary and a mandated basis do appear to experience the benefits of participation over time, provided that practitioners are empathetic, supportive, and consistently apply strengths-based approaches.

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WHO-INTEGRATE Chapter 7, Societal Impact

WHO questions:

What is the social impact of parenting programme? Are there features of parenting programmes that increase or reduce stigma and that lead to social consequences? Do parenting programmes enhance or limit social goals, such as education, social cohesion and the attainment of various human rights beyond health? Do parenting programmes change social norms at individual or population level? Do parenting programmes impact research and innovation?

Introduction

A holistic and systems-based understanding of parenting, and the many complexities that influence, inhibit, and otherwise affect parent-child dynamics, should take into account the varied ecological levels in which parenting is nested (Bronfenbrenner, 1979). Beyond the individual child and parent, as well as the bi-directional parent-child relationship, parenting is affected by other family relationships, such as with siblings and extended family members; social relationships, support, and services at the community level, such as with schools, employers, neighbours, health workers; and the broader societal level, comprising factors such as laws, social norms, and poverty and inequity (Belsky, 1993). The complicated interplay of risks, protective factors, and risk and resilience interactions that take place at the individual, relational, community, and societal levels emphasize the importance of recognizing that parenting, as well as parenting interventions, do not take place in isolation. As such, the widespread delivery of parenting programmes may culminate in bolstering or inhibiting wider social dynamics and goals. In addition, population-level parenting interventions may directly target system-level rather than individual-level changes, with the aim of affecting societal level risk and protective factors or reaching greater numbers of families (Rehfuess et al., 2019).

While a full exploration of the societal implications of parenting programmes would be large and complex in scope, the WHO Request for Proposals for guiding reviews on the WHO-INTEGRATE Framework provides a more focused approach centred on three key themes. These themes are: 1) Impact on stigmatization; 2) Impact on social goals; and 3) Impact on social norms.

The first theme, **impact on stigmatization**, underscores the role that stigma may play as a barrier to parenting programme recruitment, access, engagement, delivery, and scale-up, potentially limiting positive effects for individuals and their respective communities. Stigma can be described as a complex social process through which individuals with a particular characteristic (e.g., race, ethnicity, gender, sexual orientation, class, occupation, ability, health condition, life experience) are marginalized due to discriminatory beliefs concerning that characteristic (Goffman, 1963; Lucksted & Drapalski, 2015).

According to the Health and Stigma Discrimination Framework – a global and cross-cutting framework applicable to a range of health conditions and based on theory, research, and practice – stigma manifests as either 'stigma experiences' (i.e., lived realities) or 'stigma practices' (i.e., beliefs, attitudes, actions). *Stigma experiences* may include 'experienced discrimination' (i.e., exposure to behaviours that are regulated by law, such as refusal of housing or employment discrimination); 'experienced stigma' (i.e. behaviours outside the purview of law, such as gossip or verbal abuse); 'self-stigma' (i.e., a group

member's internalization of negative societal beliefs and feelings associated with their stigmatized status); 'perceived stigma' (i.e., views on how stigmatized groups are treated in a particular context); 'anticipated stigma' (i.e., expectations of bias perpetrated by others if one's health condition becomes known); and 'secondary stigma' (i.e., experienced stigma via association with stigmatized groups) (Stangl et al., 2019). *Stigma practices* pertain to 'stereotypes' (i.e., beliefs concerning the characteristics of a group and its members), prejudice (i.e., negative judgments of a group and its members), 'stigmatizing behaviour' (i.e., exclusionary behaviours, including gossip), and 'discriminatory attitudes' (i.e., beliefs that those with certain characteristics or conditions, such as poor health, should not be permitted to fully participate in society) (Stangl et al., 2019). The framework calls attention to the fluid interconnections between power and vulnerability, as well as emphasizes stigma as not only imposed by individuals on others, but also transpiring due to wider social, cultural, political, and economic forces (Parker & Aggleton, 2003; Stangl et al., 2019).

The provision of services and help-seeking behaviour at the individual, service provider, and system levels are all affected by stigma (Corrigan et al., 2014). Potential repercussions include a lack of engagement with services at the individual level, in order to avoid negative labels (e.g., being a 'bad parent'); lower standards of care at the provider level; and a reduction in appropriate care and the number of services provided due to associated public stigma (e.g., physical health services provided to those with mental illness) (Corrigan, 2004; Corrigan et al., 2014; Eaton et al., 2015; Kinsler et al., 2007). However, despite this research on engagement in and provision of services more generally, research regarding how stigma affects participation in maltreatment prevention programmes more broadly and parenting programmes specifically is still nascent (Lanier et al., 2017).

The second theme, **impact on social goals**, underscores that parenting programmes can contribute to or detract from the attainment of distal social objectives beyond immediate programme aims. At a macro level and as represented through the SDGs, such social goals have been afforded a relatively high level of recognition by governments. Social goals exclusive of health and wellbeing and pertaining to education, food security, gender equality, food security, and poverty elimination are afforded 42% of all SDG Indicators, in comparison to economic goals (24%), environmental goals (12%), and governance goals (11%) (Diaz-Sarachaga et al., 2018).

For the purpose of this chapter, and as highlighted in the WHO Request for Proposals, the social goals of education and social cohesion may be particularly affected by parenting programmes. Firstly, *educational goals* can be defined as comprising the development of cognitive (e.g., vocabulary, IQ, task persistence) and academic skills (e.g., literacy development, school readiness, generalized achievement tests (Christian et al., 2000; Kaminski et al., 2008). The existing literature that parents' consistently responsive interactions with children (i.e., appropriate responses to child communications) support cognitive development in early childhood (Landry et al., 2001); moreover, cognitively stimulating interactions (e.g., interactive book reading) that are individualized and scaffold skill development also positively affect child language and literacy outcomes (Cristofaro & Tamis-LeMonda, 2011; Landry et al., 2012).

Secondly, *social cohesion* can be interpreted as connections and solidarity between groups in society, represented through a combination of strong social bonds and a deficiency of social conflict (Kawachi & Berkman, 2000; Maguire, 2015). Social cohesion is a characteristic that depends on the accumulation of social capital, which can be defined as a relational resource that can be invested in and utilized for instrumental and personal advantage (Forrest & Kearns, 2001; Cheong et al., 2007; Gillies & Edwards,

2006). Differences in access to social capital result in varying degrees of power and influence for different actors, and lead to a social capital duality of inclusivity and exclusivity (Bourdieu, 1979, 1986; Wakefield & Polnand, 2005; both in Shan et al 2012). Given that families are embedded within social groups and networks, families generate, manage, and utilize social capital, with this capital supporting family health and well-being and contributing to socially cohesive communities and neighborhoods (Furstenberg, 2005, in Hunter et al., 2019).

In addition to the social goals of education and social cohesion, we have identified *family preservation and family reintegration/reunification* as both social goals and a human right that may be affected by parenting programmes. The Convention on the Rights of the Child places a strong emphasis on the importance of children growing up in a safe, supportive, and nurturing family environment (CRC). States parties are obligated to respect the right of the child to family relations without unlawful interference (Art. 8), to provide assistance to parents in their child-rearing responsibilities (Art. 18), to protect the child from maltreatment while in the care of their parents, legal guardians, or other carers (Art. 19), and to respect the right of the child to maintain personal relations and direct contact with parents (if in the child's best interests), should family separation become necessary (e.g., in cases of maltreatment) (Art. 9). Family preservation programmes have been implemented in both HICs and LMICs where child maltreatment has been suspected, for the purpose of changing parental behaviours, fostering healthy environments for children, and reducing the risk of out-of-home placement (Patwardhan et al., 2017). Family reintegration or reunification comprises the process through which the child is returned to their family following a period of separation (e.g., placement in kinship care, foster care, youth detention), with programmes aiming to equip families with the necessary skills and guidance to so that the child can reach their full potential (Corcoran & Wakia, 2016).

The final theme, **impact on social norms**, pertains to the effects on shared beliefs or rules within a given community about what behaviour is deemed appropriate ('injunctive norms') and what behaviour is regarded as typical ('descriptive norms') (Cialdini et al., 1990). Social norms influence behaviour most commonly through a desire to obtain social rewards through norm compliance, as well as avoid social punishments incurred through non-compliance with norms (Lokot et al., 2020). Social norms also intersect with other factors in the environment (e.g., services, laws, access to resources) in a manner that may weaken their influence or increase their strength (Cislaghi & Heise, 2018; Lokot et al., 2020; Rimal & Lapinski, 2015). In relation to parenting and parent-child relationships, social norms in many contexts value parental authority and child obedience, as well as the belief that physical punishment or harsh verbal criticism is necessary for child rearing, at least in certain circumstances (e.g., deliberate misbehaviour) (Basu et al., 2017). Influencing social norms in relation to parenting and child maltreatment prevention often requires multi-level approaches. Efforts tend to be invested at the individual level through individual-focused and group-based parenting programmes, which tend to be resource intensive and often do not reach the majority parents in need; moreover, those with the most challenging and complex lives may be most unlikely to complete such programmes (Chacko et al., 2016). While research is still limited in this field, population level strategies may allow for more families to be reached in a more cost-efficient manner. At this level, evidence-supported universal media and communication strategies may alter social norms by destigmatizing parenting support, disseminating parenting tips and advice, breaking down parental isolation, and fostering community engagement (Eisner, 2014; Prinz & Sanders, 2007; Prinz et al., 2009).

In order to examine the societal implications of parenting programmes in relation to these three themes – impact of stigmatization, impact on social goals, and impact on social norms – we reviewed the

literature from both LMICs and HICs in order to respond to the below corresponding questions from the WHO Request for Proposals:

- Theme 1 - **Impact on stigmatization:** Are there features of parenting programmes that increase or reduce stigma and that lead to social consequences?
- Theme 2 - **Impact on social goals:** Do parenting programmes enhance or limit social goals, such as education, social cohesion, and the attainment of various human rights beyond health?
- Theme 3 - **Impact on social norms**: Do parenting programmes change social norms at individual or population level?

Methods

We conducted this literature review by developing relevant search strategies as follows:

Theme 1: Impact on stigmatization

For this theme, we utilized two databases on qualitative and mixed methods studies of parenting programmes compiled for Chapter 6b on human rights and socio-cultural acceptability with regards to Theme 1 (socio-cultural acceptability of parenting programmes) and Theme 3 (parenting programme intrusiveness and effects on autonomy). We selected these databases as they collectively include studies on parent and service provider socio-cultural acceptability, as well as the views of marginalized and vulnerable groups, who may be particularly prone to experiencing stigma. These databases were originally drawn from the broader set of studies included in the Qualitative review of perceptions of parenting programmes, containing 217 records. The combined databases, including duplicates, contained 96 records.

Both of these smaller databases were compiled using a sensitive set of search terms, listed in the results section, with inclusion criteria described in Table 1. We did not adopt additional exclusion criteria, given that the database already included pre-screened studies that excluded target groups and interventions unrelated to our area of interest. They include a variety of sample populations from both LMICs and HICs, including parents and other caregivers as existing or potential programme beneficiaries, parenting programme service providers, the general public, and other stakeholder groups (e.g., government officials, community-based organizations, professional groups). The addition of the database on intrusiveness and effects on autonomy also allows for a particular emphasis on vulnerable populations, including families with children in or returning from foster care or other forms of alternative care, families in shelters (e.g., for victims of violence, displaced/refugee or homeless families), parents who have previously or are currently experiencing intimate partner violence, families in contact with child welfare services, parents with mental health difficulties, parents receiving cash transfers, parents in incarceration, and parents at risk of or known to be engaged in offending.

We also included parenting programmes that aimed to improve parent-child interaction, the overall quality of parenting that a child receives, and/or reduce child maltreatment through improved parenting. Such programmes included a focus on the learning or development of new skills, behaviours, parental knowledge, parental attitudes, or beliefs. For study designs, we included qualitative and mixed methods primary research papers, as well as reviews of qualitative or mixed-methods studies.

For each included study, we had already extracted information on study country, child age group, study participants (e.g., programme beneficiaries, potential beneficiaries, service providers, evaluators), parent/participant risk group and context for programme delivery, programme name, sample size, and qualitative method. Given that we had also already extracted study findings related to socio-cultural relevance of acceptability (concerning programme content, recruitment and delivery methods, service providers, training and supervision, and organizational management and administration) as well as findings pertinent to parent autonomy (including, privacy, dignity, or independence) and intrusiveness (including coerciveness or restrictions), we searched within these extractions for data on stigmatizing, discriminatory, ostracizing, or otherwise exclusionary experiences or practices. We then presented our findings in a narrative synthesis.

Table 1: Inclusion criteria

Area	
S = Sample	• Parents or other caregivers attending or potentially attending parenting programmes, including those programmes targeting particularly vulnerable populations, including families with children in or returning from foster care or other forms of alternative care, families in shelters (e.g., for victims of violence, displaced/refugee or homeless families), parents who have previously or are currently experiencing intimate partner violence, families in contact with child welfare services, parents with mental health difficulties, parents receiving cash transfers, parents in incarceration, and parents at risk of or known to be engaged in offending • Service providers or evaluators of parenting programmes, including those targeting particularly vulnerable populations • General public • Key stakeholder groups (e.g., government officials, community-based organizations, professional groups)
PI = Phenomenon of Interest	• Parenting programmes directed at parents or other key caregivers designed to improve parent-child interaction, overall parenting quality, and/or reduce child maltreatment
D = Study designs	• Any qualitative or mixed methods papers • Reviews of qualitative or mixed methods studies
E = Evaluation	• Views of stigmatizing, discriminatory, ostracizing, or otherwise exclusionary experiences or practices in relation to programme recruitment, participation, content, delivery, or management
R = Research type	Published or unpublished qualitative or mixed methods primary studies or reviews in English language

Theme 2: Impact on social goals

Various sources were used to search for studies on these topics, including within the 217 studies included in the Qualitative review of perceptions of parenting programs; in Google scholar; we also drew on the WHO Guideline on Nurturing Care.

Theme 3: Impact on social norms:

For the final theme, given the volume of studies focused on changing parental beliefs and attitudes, especially at the individual level, we examined recent systematic reviews on the effects of parenting programmes on social norms (Lokot et al., 2020; Marcus et al., 2020). In addition, we searched the studies from the LMIC effectiveness review of parenting programme RCTs (k = 131), in order to identify those studies that measured changes in social norms. Inclusion criteria are set forth in Table 2.

Table 2: Inclusion criteria

Area	
S = Sample	• Parents or other caregivers attending parenting programmes in LMICs
PI = Phenomenon of Interest	• Parenting programmes directed at parents or other key caregivers designed to improve parent-child interaction, overall parenting quality, and/or reduce child maltreatment
D = Study designs	• Systematic reviews of RCTs • RCTs
E = Evaluation	• Effects on social norms or individual beliefs/attitudes toward corporal punishment or other forms of discipline, parenting styles, positive parenting, or other aspects of parenting
R = Research type	Published reviews or primary studies in English language

For each included study, we extracted information on study country, child age group, parent/participant risk group, programme name, sample size, outcome measure, and effect size. We then presented our findings in a narrative synthesis.

Results

Theme 1: Impact on stigmatization

The combination of the two databases resulted in a total of 83 records, excluding duplicates, of which we screened the full text. A total of 13 studies met our inclusion criteria. In addition, we screened the seven records (one systematic review and six qualitative studies) that were hand searched and included in the reviews for Theme 1 and Theme 3 of Chapter 6b (El-Khani et al., 2021; Ghate & Ramella, 2002; Mamauag et al., 2021; McCoy, Lachman, Sim, et al., 2020; McCoy, Lachman, Tapanya, et al., 2020; McCoy et al., 2021; Mytton et al., 2014). Of these, 4 were included, leading to a total inclusion of 17 records (3 systematic reviews, 14 qualitative or mixed methods studies) for this review.

Table 3: Search results (search date 2 October 2021):

Combined search terms used for University of Oxford qualitative study database	**Hits**
Database 1: Socio-cultural acceptability of parenting programmes	
accept* OR relevan* OR cultur*	90
Titles and/or abstracts screened	90
Full text screened	72

Included	67
Database 2: Parenting programme intrusiveness and effects on autonomy	
cash OR stigma* OR camp* OR shelter* OR court OR child protection OR child welfare OR incentive* OR privacy OR coerc* OR prison*	48
Duplicates removed	1
Titles and/or abstracts screened	47
Full text screened	41
Included	29
Combined databases	
Combined records	96
Duplicates removed	13
Full text screened	83
Included (from combined databases)	13
Handsearching of other studies and reviews	7
Included (hand searched studies/reviews)	4
Total included	**17**

We utilized the Health and Stigma Discrimination Framework by Stangl et al. (2019) (as earlier described) to organize our assessment according to the different types of stigma experiences. These originally included: a) experienced discrimination, b) experienced stigma, c) self-stigma, d) perceived or anticipated stigma, e) secondary stigma; however, we eliminated categories (a) and (e) as we found no data that could be labelled as such. We also aimed to organize these manifestations according to the 'programme feature' or context in which they occurred: a) programme content, b) recruitment and delivery methods, c) role of service providers, and d) management and administration; we eliminated categories (a) and (d) for the same reason. Fifteen studies collected qualitative data from parents who had participated in a parenting programme, while eight gathered data from practitioners and/or evaluators, and three gathered data from potential participants.

Perceived or anticipated stigma

A total of 17 studies, including three systematic reviews, presented findings on perceptions or anticipated stigma (i.e., views on how stigmatized groups are treated in a particular context). Most were conducted in HICs (13 studies) (Beasley et al., 2018; Bradley et al., 2020; Butler et al., 2021; Fogarty et al., 2020; Furlong & McGilloway, 2012; Garcia-Huidobro et al., 2016; Ghate & Ramella, 2002; Houlding et al., 2012; Javier, 2018; Kane et al., 2007; Leckey et al., 2021; Mytton et al., 2014; Onyskiw et al., 1999), while three were from LMICs (Aspoas & Amod, 2014; Mamauag et al., 2021; McCoy, Lachman, Sim, et al., 2020) and one from a mixture of country settings (Butler et al., 2020).

Fifteen studies reported perceived or anticipated stigma during programme recruitment or delivery (e.g., participation in a group session or home visit). A frequently expressed theme, including in two systematic reviews, was the view that parent participants would be uneasy or fear judgment of potentially being labelled as 'bad' or incompetent (Bradley et al., 2020; Butler et al., 2021; Javier, 2018; Leckey et al., 2021; Mytton et al., 2014). Respondents also shared that parent participants would be stigmatized for having various problems, including physical or mental health difficulties, having experienced IPV, or having exposed their child to IPV (Aspoas & Amod, 2014; Butler et al., 2021; Fogarty et al., 2020; Houlding et al., 2012). As an example, one parent shared: "People start wondering. They

know. I wonder what (*sic*) her problem? Why is she going there?" (Aspoas & Amod, 2014, p. 586). The location of the programme venue (e.g., hospital, shopping mall, youth justice system building) was also viewed as having the potential to increase or decrease stigma (Ghate & Ramella, 2002; McCoy et al., 2021; Onyskiw et al., 1999), while home visits in one study were perceived as potentially stigmatizing given the programme aim to prevent child maltreatment (McCoy et al., 2021). It was also shared that the programme name could stigmatize participating parents, with a preference for positive names that do not refer to child maltreatment (e.g., Happy Family for the Filipino Child) (Mamauag et al., 2021; Onyskiw et al., 1999). In addition, the systematic review by Mytton et al. (2014) and the study by Garcia-Huidobro et al. (2016) identified perceived gender-related stigma, due to fathers feeling uneasy with attending predominantly female groups and perceiving child rearing as a mother's responsibility. Further, in another review, the fear of judgment from professionals and other parents about being told 'how to parent' was an identified theme (Butler et al., 2020). Finally, the review by Kane et al. (2007) found that many parents did not enrol due to fears of potential social isolation and fear of rejection.

Self-stigma

A total of four studies presented findings on self-stigma (i.e., a group member's internalization of negative societal beliefs and feelings associated with their stigmatized status) in relation to programme recruitment and delivery. One systematic review (Kane et al., 2007) and two qualitative studies (Fogarty et al., 2020; Garcia-Huidobro et al., 2016) were from HICs, while one qualitative study was from a LMIC (Aspoas & Amod, 2014).

Parents in two studies shared that they disliked seeking help from others or outsiders to solve family-related problems, with one study finding that fathers in particular expressed this view (Aspoas & Amod, 2014; Garcia-Huidobro et al., 2016). To illustrate this point, one practitioner shared: "…The man will say 'no, my family is fine, we don't need that, I don't need that a third person tell me what I have to do with my family'" (Garcia-Huidobro et al., 2016, p. 16). One systematic review and another study also found that parents felt guilt that they were having difficulties managing their children's behaviour problems (Aspoas & Amod, 2014; Kane et al., 2007). Further, parents in one study expressed that a barrier their sustained engagement was feelings of guilt and blame for exposing their child to IPV (Fogarty et al., 2020).

Experienced stigma

A total of three studies presented findings on experienced stigma (i.e., behaviours outside the purview of law, such as gossip or verbal abuse) in relation to programme recruitment and delivery or the role of service providers, with all studies from HICs (Beasley et al., 2018; Furlong & McGilloway, 2012; Garcia-Huidobro et al., 2016; Ghate & Ramella, 2002).

Two studies reported different types of findings in relation to the parental experience of stigma during programme recruitment and delivery. Parents in one study shared feeling isolated from others in the group, who they perceived as having fewer problems (Furlong & McGilloway, 2012). In another study, evaluators expressed that parents who were required to attend the programme on a mandatory basis experienced anger and stigmatization (Ghate & Ramella, 2002).

Only one study reported the experience of stigmatization from service providers, with parents expressing that judgmental or rude behaviour by practitioners was a barrier to their engagement

(Beasley et al., 2018). However, it was unclear whether all parents experienced this behaviour or were mainly speculating about its potential impact.

Theme 2: Impact on social goals

There was limited evidence on effects on social cohesion, apart from parents commenting positively on the improved social networks and support they experienced due to attending a group-based program. Similarly, these interventions if scaled up, might have potential to enhance this sense of support and shared values about parenting across a community. We found one study using social network analysis across a village in South Africa (Kleyn et al, 2021) that bore this out: social networks appeared to be strengthened by attending a community-based parenting program- and in turn, positive parenting information and strategies appeared to spread partly through these networks.

Parenting programs, especially in the early years, also have positive effects on education-related outcomes, such as children's language, literacy and cognitive skills, as summarized in the WHO Guideline on Nurturing Care.

Environment: We do not know if parenting intervention have any implications for ecological sustainability, although we would expect healthy parent child relationships to help promote resilience in the face of major stresses on families and communities, including those brought about by climate change.

Theme 3: Impact on social norms

As aforementioned, we included two systematic reviews in our analysis. The review by Lokot et al. (2020) focused on three different research questions, including on the impact of interventions on social norms sustaining corporal punishment and/or discipline. While there were a wide range of countries (N = 59) and studies (k = 37) included in the wider review, only four varied interventions (e.g., parenting programmes, couples' programmes, school-based programmes) were included, of which only two studies and two programmes were relevant: the Responsible, Engaged, and Loving (REAL) Fathers Initiative in Uganda (Ashburn et al., 2017) and the Creating Opportunities through Mentorship, Parental Involvement, and Safe Spaces (COMPASS) caregiver plus girls' curriculum in the Democratic Republic of Congo (DRC) (Stark et al., 2018). Findings from the RCT of REAL indicated that the programme had no effect on gender norms in the intervention group in comparison with the control but led to changes in attitudes related to using physical punishment at four months post-intervention [1.6 adjusted odds ratio (AOR), 95% CI (1.09, 2.49)] and 8-12 months long-term follow-up [2.2 AOR, 95% CI (1.43, 3.47)] (Ashburn et al., 2017). The cluster RCT by Stark et al. (2018) of the COMPASS caregiver plus girls' curriculum compared the provision of a 13-session parenting programme combined with a 32-session life skills programme for adolescent girls in the treatment arm, to a control arm that only received the life skills intervention. There were no statistically significant changes in attitudes toward gender role norms or parental acceptability of physical discipline in the intervention group compared to control at one year-follow up.

The second review by Marcus et al. (2020) focused on assessing the impact and change in social norms of parenting programmes aiming to reduce violence against adolescents and child marriage. A diverse set of countries (N = 23) and a large number of studies (k = 58) were included in this review; however,

there were only four papers with findings from three RCTs: Happy Families programme in Thailand (Annan et al., 2017; Puffer et al., 2017), PLH Sinovuyo Teen in South Africa (Cluver et al., 2018), and the COMPASS caregiver plus girls' curriculum in the DRC (as included in the previous review; Stark et al., 2018). The Happy Families RCT focused on behavioural changes and did not include outcome measures on beliefs, attitudes, or social norms. The PLH Sinovuyo Teen RCT, also identified in our review of the Oxford LMIC database, is discussed in the below section on attitudes toward corporal and harsh punishment.

In addition to these reviews, we included in our analysis nine studies that were identified from the LMIC effectiveness review of parenting programme (Cluver et al., 2018; Gulirmak & Orak, 2020; Ismayilova & Karimli, 2020; Lachman et al., 2020; Lachman et al., 2021; Ofoha et al., 2019; Sawasdipanich et al., 2010; Sener & Cimete, 2016; Yusuf et al., 2019). As indicated in Table 6, these studies comprised nine different programmes evaluated in seven countries, that included some social norm outcomes. With the exception of Burkina Faso, all were middle-income. Sample sizes ranged from 60 to 552 and included 21 outcome measures using 16 different scales and sub-scales, which we grouped into seven outcome categories as below:

1. Attitudes toward corporal and harsh punishment

We identified nine outcome measures in six studies relating to attitudes toward corporal and harsh punishment – the most commonly assessed outcome type in our review (Cluver et al., 2018; Gulirmak & Orak, 2020; Lachman et al., 2020; Lachman et al., 2021; Ofoha et al., 2019; Yusuf et al., 2019). Using the ICAST-Trial sub-scale on attitudes to corporal punishment, only one study on PLH Sinovuyo Teen found small-medium effects [d= -0.46, 95% CI(-0.69 to -0.24), p < .001] at 5-9 months post-intervention in comparison to control (Cluver et al., 2018), while the other of PLH-YC in the Philippines found no significant effect at either one month or 12 months post-intervention (Lachman et al., 2021). Using one item from MICS on endorsement of corporal punishment, neither study of a skillful parenting/agribusiness programme in Tanzania or PLH-YC in the Philippines found significant effects at six, 12-, or 18-months post-baseline (Lachman et al., 2020; Lachman et al., 2021). Further, according to the Parental Attitude Research Instrument (PARI) sub-scale on strict discipline, both the web-based distance education programme in Turkey and the Triple P Level 4 programme in Turkey were found to have large [d = -1.57, 95% CI (-2.15, -0.99), p = <0.001] (Gulirmak & Orak, 2020) and medium [d = -0.61, 95% CI (-1.13, -0.09), p = 0.08] (Yusuf et al., 2019) effects, respectively. Finally, the trial on the web-based programme also found large effects using the PARI sub-scale on positive attitudes associated with emotional abuse, [d = 1.48, 95% CI (0.91, 2.06), p = 0.059] (Gulirmak & Orak, 2020), while a trial on the Parenting Education Programme for Corporal Punishment Prevention (PEP) in Nigeria found large effects on parental attitudes [d = -0.85[b] (-1.08, -0.61) at 8 weeks, d = -0.82[b] (-1.06, -0.58) at 12 weeks] toward corporal punishment and parental beliefs about the value of corporal punishment [d = -0.93, 95% CI (-1.17, -0.69) at 8 weeks, d = -0.94, 95% CI (-1.18, -0.70) at 12 weeks] in the short and long-term (Ofoha et al., 2019).

2. Democratic parenting

We identified three outcome measures relating to democratic parenting from three studies (Gulirmak & Orak, 2020; Sener & Cimete, 2016; Yusuf et al., 2019). Two studies utilized the PARI sub-scale on democratic attitudes, with the Triple P trial finding large effects [d = 0.92, 95% CI (0.39, 1.46), p = 0.008] (Yusuf et al., 2019), and the study on the web-paged programme showing no significant changes

(Gulirmak & Orak, 2020). The RCT of a programme based on social cognitive theory and Smith's Model of Health and Illness (SMHI) in Turkey, which used the Parent Attitude Scale (PAS) democratic attitude sub-scale found large effects at both immediate [d = 0.84, 95% CI (0.37, 1.31)] and three-months post-intervention [d = 1.20, 95% (0.71, 1.68)] (Sener & Cimete, 2016).

3. Overprotective parenting

In relation to overprotective parenting, we found three relevant outcome measures from three studies (Gulirmak & Orak, 2020; Sener & Cimete, 2016; Yusuf et al., 2019). Of the two studies using the PARI sub-scale on overprotective attitudes (e.g., the web-based programme trial and the Triple P trial), only the former demonstrated a significant effect [d = -0.72, 95% CI (-1.24, -0.20), p = 0.007] (Gulirmak & Orak, 2020; Yusuf et al., 2019). The social cognitive theory and SMHI programme, utilizing the PAS sub-scale on overprotective attitudes, also showed large effects at immediate post- [d = -0.77, 95% CI (-1.23, -0.30)] and three months-post intervention [d = -1.37, 95% CI (-1.87, -0.88)] (Sener & Cimete, 2016).

4. Overall parenting attitudes

Two outcome measures in two studies appeared to be related to a broad range of parenting attitudes. The RCT of a parental cognitive adjustment programme in Thailand, utilizing the Adult-Adolescent Parenting Inventory, measured attitudes such as the value of corporal punishment, child independence, and parental expectations. The study found a medium effect at 16 weeks post-baseline [d = 0.60, 95% CI (0.23, 0.97)] (Sawasdipanich et al., 2010). However, the Trickle Up plus (economic intervention plus family coaching) programme in Burkina Faso was found to have a small effect on a range of child protective attitudes (e.g., education, child marriage, physical punishment) at 12 months [d = 0.39, AMD = 0.55, 95% CI (0.08, 1.01), p = 0.022] but not at 24 months post-baseline (Ismayilova & Karimli, 2020).

5. Authoritarian parenting

There was only one outcome measure on authoritarian attitudes, using the PAS sub-scale. The RCT on the social cognitive theory-based and SMHI programme found large effects at both immediate [d = -0.81, 95% CI (-1.27, -0.34)] and three-months post-intervention [d = -0.99, 95% CI (-1.46, -0.51)] (Sener & Cimete, 2016).

6. Permissive parenting

There was also only one outcome measure on permissive attitudes, using the PAS sub-scale. The RCT on the social cognitive theory-based and SMHI programme found a medium effect at immediate post-intervention [d = -0.54, 95% CI (-0.99, -0.08)] and a medium-large effect at three-months post-intervention [d = -0.78, 95% CI (-1.24, -0.32)] (Sener & Cimete, 2016).

7. Domestic roles and relationships

Finally, two outcome measures were related to domestic roles and relationships, as assessed in one trial (Yusuf et al., 2019). Triple P was found to have a medium effect on the rejection of homemaking attitudes, as measured by the PARI sub-scale, at eight weeks post-baseline [d = -0.64, 95% CI (-1.16, -0.12), p = 0.069]. However, there was no effect on marital conflict in child rearing, also a PARI sub-scale, during the same period.

Summary of key results and conclusions

Impact on stigmatization

Overall, our review on features of parenting programmes that increase or reduce stigma confirms findings from existing literature, underscoring that a lack of parental engagement can be driven in part by negative stigma, and that researchers and parenting programme stakeholders require a stronger understanding of the role that stigma plays as a barrier to help seeking, programme enrolment, participation, and completion (Damashek et al., 2011; Eisner & Meidert, 2011). The main findings from our review indicate: 1) an emphasis on perceived or anticipated stigma during recruitment and delivery; 2) importance of empathetic practitioners and non-judgmental support; 3) the need for sensitivity to the challenges facing court ordered families and those in adversity; 4) the relevance of gender-related stigma; and 5) the potential stigmatization of programme name and venue.

Fifteen out of the 17 included studies in our review presented findings related to perceived or anticipated stigma in the context of programme recruitment or delivery. Many of these stigma experiences occurred prior to programme exposure and point to an emphasis on parental fear of stigma without actually enduring it. It is notable that across these studies, the authors found that the programmes were widely relevant and acceptable to those who were initially distrustful and afraid of peer judgment, perhaps indicating a change in attitudes and perceptions over the course of the programme. This suggests that the most important window for reducing stigmatization may be at the first point of contact, prior to enrolment. Further, this underscores the importance of further research and investment in the positive promotion of help seeking and parenting programmes by service providers and the media with the general public.

Secondly, our findings reinforce existing literature on the importance of practitioner attitudes and relationship-building skills. Many of the included studies repeatedly highlighted that highly valued practitioner characteristics and approaches included being non-judgmental, empathetic, flexible, and positive, and that the development of therapeutic and supportive practitioner-parent relationships was instrumental in making parents feel accepted and welcome. The recognition that most parents do want to 'do better,' and that they are often doing the best they can in very challenging circumstances, should be acknowledged by parenting programme practitioners (Allen, 2011; Hartwig et al., 2017). Developing these relationship-building skills during facilitator training, as well as including programme graduates on facilitator interview panels, may help to ensure that these characteristics receive due attention (Beasley et al., 2018; Mytton et al., 2014).

Thirdly, authors of included studies that focused on families who face particular challenges (e.g., homelessness, IPV experiences, mental health difficulties, court ordered programme participation) emphasized the need for sensitivity to parental context, including potential feelings of fear of judgment (Bradley et al., 2020; Fogarty et al., 2020; Ghate & Ramella, 2002). Reinforcement of the message that the parenting programme is a form of support rather than punishment may be a helpful approach to recruiting and retaining parents mandated to participate; moreover, media and social marketing strategies, such as those utilized by Triple P, may assist in destigmatizing and normalizing the shame that is associated with programme attendance (Ghate & Ramella, 2002; Sanders et al., 2003).

A fourth finding is that men may face gender-related to stigma in relation to parenting programme attendance. This underscores the social norm in many contexts that parenting is not a gender-neutral or gender-equal role, with parenting programmes highly oriented to and organized for mothers (Edwards & Gillies, 2005). As noted in Chapter 2, existing reviews have offered several strategies for male engagement, including the identification of entry points for programme delivery, the pinpointing of male motivations for engagement, the provision of content relevant to both male and female caregivers, and the conduct of both separate and joint sessions for men and women (Lechowicz et al., 2019; Panter-Brick et al, 2014).

Finally, our review found that programme name and venue may potentially contribute to stigmatization, although such concerns were mainly raised by service providers rather than parents themselves (Mamauag et al., 2020; McCoy et al., 2020). Using a positive programme name that does not refer to child maltreatment may potentially reduce stigma for potential parent participants (Mamauag et al., 2020; Onyskiw et al., 1999). However, concerns over the programme setting in two countries did not appear to be substantiated, with a programme based in youth justice system buildings reportedly thriving in the UK (Ghate & Ramella, 2002) and parents in a hospital-based programme pilot in Thailand attending 93% of all sessions (McCoy et al., 2021).

Limitations

Our review has many limitations that bear consideration. We relied mainly on a University of Oxford database of qualitative research (k = 217), as well as selective hard searching that may have excluded other studies that could have been identified through a more extensive search. We ultimately included only 17 studies, including three systematic reviews, with mostly very small samples, the smallest including only 11 participants (Aspoas & Zaytoon, 2014). HICs were also overrepresented in the included studies, with only three studies focused on LMICs and one systematic review including LMIC research. Moreover, these included studies did not have an exploration of stigma as a research objective, which led to limited data and analyses of potential and experienced stigmatization. Finally, given that the included studies focused on stigma experiences rather than stigma practices (i.e., beliefs, attitudes, actions), this review provides only an initial and partial assessment of stigma manifestations in the context of parenting programmes. It would be important for further research to explore aspects of practitioner training, supervision, delivery; programme management and administration; as well as local laws and policies regarding the provision of and access to parenting programmes that increase or potentially increase stigma experiences for parents.

Impact on social norms

Overall, our review on whether parenting programmes change social norms at the individual or population levels found that eight out of 10 programmes did result in changes to at least one measurement of parental attitudes or beliefs (Ashburn et al., 2017; Cluver et al., 2018; Gulirmak & Orak, 2020; Ismayilova & Karimli, 2020; Ofoha et al., 2019; Sawasdipanich et al., 2010; Sener & Cimete, 2016; Yusuf et al., 2019), with two out of three programmes demonstrating ongoing effects when measured at follow-up (Ofoha et al., 2019; Sener & Cimete, 2016). In our analysis of primary studies, 15 out of 21 outcome measures demonstrated significant effects on parental attitudes and beliefs, including attitudes condoning harsh punishment, attitudes toward corporal punishment, beliefs about the value

of corporal punishment, strict discipline, overprotective parenting, democratic parenting, authoritarian parenting, permissive parenting, positive attitudes associated with emotional abuse, child protective attitudes, attitudes toward child rearing, and rejection of homemaking attitudes. With the exception of effects of the web-based education programme on democratic attitudes (Gulirmak & Orak, 2020), and effects of PLH-YC on the endorsement of corporal punishment at 18 months post-baseline (J. M. Lachman et al., 2021), the remaining outcome measures all showed improvements despite not demonstrating significance.

None of the studies included in our review measured changes in social norms at the population level, indicating that this is an area that requires greater attention and research in LMICs. The widespread dissemination of evidence-based parenting programmes in LMICs may allow for the use of population-based household surveys such as MICS to suggest impacts on social norms, utilizing data on location-specific programme coverage and the geographic disaggregation of MICS data. However, such programme coverage would need to be universal or nearly universal, at least in certain geographic areas, to suggest these correlations. Further, beyond the aggregate impact of individual and group-based programmes, interventions that aim to change social norms through universal media campaigns should be implemented and evaluated. However, according to the review by Poole et al. (2014), the evidence base on their effectiveness in HICs is inconclusive, with the exception of five studies on the Triple P programme (both Level 1 and multi-level Triple P).

A key challenge evident in both systematic reviews, as well as the primary studies included in our review, is the lack of definition or theoretical mapping of different constructs, including attitudes, beliefs, behaviours, and social norms. As noted by Lokot et al. (2020), norms are almost never the main focus in intervention research, which tends to assume linkages between these different constructs. However, these linkages may not be straightforward. For example, although harsh parenting and corporal punishment are often deemed normative in Asian LMICs (Lansford & Deater-Deckard, 2012), surveys reveal that only a minority of adults in many LMICs believe such practices are necessary for childrearing (UNICEF, 2014). In addition, it would be important to promote an intersectional understanding of the how gender, age, race, ethnicity, social class, and other power hierarchies affect social norms that condone violent and harsh parenting (Lokot et al., 2020). The conceptual framework on social norms and violence in childhood proposed by Lilleston et al. (2017), which describes the forces that maintain and drive change regarding this violence, may provide an example of a broad, ecological perspective that can help to better define and map constructs for future studies.

Finally, Marcus et al. (2020) provide several recommendations in relation to changing social norms through parenting programmes. Drawing from the full range of studies included in their review, the authors suggest that programmes aiming to reduce violence against adolescents should consider adopting structural and systematic approaches to changing harmful norms, such as including discussion of gendered social norms on violence and engaged parenting (e.g., COMPASS, Parceria Project in Brazil). The reviewers further contend that a better understanding of the local normative context may inform strategies to promote participant receptiveness to programme content (e.g., Happy Families), and that activities that encourage diffusion of parenting skills, such as through church groups and neighbour participation in home visits (Cluver et al., 2018), should be scaled-up horizontally. Finally, they also suggest embedding interventions within public services; engaging 'norms' influencers (e.g., priests, community health workers) (Jejeebhoy et al., 2014; Puffer et al., 2017); investing in participant social networks (Cluver et al., 2018), offering programmes at workplaces, with time off to attend (Bogart et al., 2013); and the holding of refresher sessions, text message reminders, and ad hoc follow-up support.

Limitations

Our review bears several limitations. First, both systematic reviews did not focus on parenting programme impacts on attitudes, beliefs, or social norms as measured through RCTs, leading to the inclusion of only two relevant intervention studies in Lokot et al. (2020), and four studies with findings from three RCTs in Marcus et al. (2020). Second, both reviews were restrictive in scope. The review by Lokot et al. (2020), utilized a very specific search strategy that only comprised records that contained the word 'norm,' and only included English language studies. The review by Marcus et al. (2020) was limited to programmes for parents of adolescents, likely excluding the majority of otherwise relevant studies, given that most programmes focus on parenting during early and middle childhood. Third, we relied on the Oxford LMIC database of parenting programme RCTs to identify outcome measures related to parental attitudes, beliefs, and social norms; many measures were only briefly described in the database and it is possible that some were overlooked for lack of explicit reference to such outcomes. Fourth, we limited our inclusion criteria to LMIC countries, although the body of literature in this field is much more extensive in HICs (e.g., Poole et al., 2014). Finally, we did not include non-RCTs in our review, as we wanted to focus on study methods designed to demonstrate effectiveness. However, the inclusion of qualitative, quasi-experimental, and pre-post evaluations would have resulted in a larger study pool, including the incorporation of participant perceptions as to how and whether attitudes, beliefs, and social norms were affected by programmes at the individual, family, and community levels.

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Table 4. Findings on stigma experiences according to relevant features of parenting programmes

Study	Study country	Programme target population; Sample (N); Studies (k)	Experienced stigma	Self-stigma	Perceived or anticipated stigma
Aspoas & Zaytoon, 2014	South Africa	Low-income mothers (N = 11)		Recruitment & delivery[a]: • Should be able to solve their own problems • Embarrassed to share 'small' problems relating to infant care • Seeking help from an outsider	Recruitment & delivery[a]: • Fear of judgment by peers who would wonder about their problems
Beasley et al., 2018	US	Low-income pregnant mothers; (n = 42 mothers, n = 25 nurses)	Role of service providers[a]: • Judgmental or rude behaviour is a barrier to engagement		
Bradley et al., 2020	UK	Homeless families (N = 13 in qualitative study)			Recruitment & delivery[a]: • Unease that peers and service providers might think they were 'bad' parents
Butler et al., 2021	UK	Parents with mental health difficulties (N = 12)			Recruitment & delivery[c]: • Self-directed interventions avoid the stigma parents with mental health difficulties could feel in group-based delivery
Butler et al., 2020*	UK, USA, Ireland, Canada, Panama, Chile, Australia	Various vulnerable groups (N = 822 across k = 26)			Recruitment & delivery[ab]: • Fear of judgment as a 'bad parent' and feeling obligated to participate, especially among those mandated to attend under the child welfare system • Fear of judgment from professionals and other parents about 'being told how to parent'
Fogarty et al., 2020	Australia	Women who have recently experienced IPV (N = 16)		Recruitment & delivery[a]: • A barrier to sustained engagement included experiences of guilt and blame	Recruitment & delivery[a]: • A barrier to initial engagement was fear of being judged for experiences of IPV and their

Table 4. Findings on stigma experiences according to relevant features of parenting programmes

Study	Study country	Programme target population; Sample (N); Studies (k)	Experienced stigma	Self-stigma	Perceived or anticipated stigma
				for their children's exposure to IPV	children's exposure to IPV, as well as previous negative help-seeking experiences
Furlong et al., 2012	Ireland	Parents of children with conduct problems (N = 33)	Recruitment & delivery[a]: • A barrier to continued engagement was a feeling of isolation from other parents in the group, whom they perceived to have fewer problems with their children		
Garcia-Huidobro et al., 2016	USA	Latino families, mainly low-income and those with substance abusing youth (n = 12 parents, n = 10 facilitators)		Recruitment & delivery[ac]: • Participation negatively affected as fathers disliked receiving advice about how to parent or solve problems in their families	Recruitment & delivery[ac]: • Participation negatively affected as fathers viewed child rearing to be a mother's responsibility
Ghate & Ramella, 2002	UK	Parents of young people at risk of or engaged in offending, or failing to attend school (n = 800, parents, n = 500 adolescents, n = 800 providers)	Recruitment & delivery[d]: • Several commented on the anger & stigmatization felt by parents who were required to attend the programme on a mandatory basis		Recruitment & delivery[c]: • Expression of initial scepticism that locating the programme within youth justice system buildings would deter and stigmatize parents
Houlding et al., 2012	Canada	Low-income Aboriginal families (n = 11 parents, n = 8 practitioners)			Recruitment & delivery[a]: • Experienced reduction in anticipated stigma when parents realized that many others also faced similar difficulties

Table 4. Findings on stigma experiences according to relevant features of parenting programmes

Study	Study country	Programme target population; Sample (N); Studies (k)	Experienced stigma	Self-stigma	Perceived or anticipated stigma
Javier, 2018	USA	Filipino American parents of adolescents (3 studies: n = 20, n = 15, n = 15)			Recruitment & delivery[ab]: • Most prevalent barriers to enrolment were shame and fear of stigma, with parents worried that they would be judged as incompetent or failures as parents
Kane et al., 2007*	UK	Parents of children with emotional & behaviour problems (N = 140 across k = 4)		Recruitment & delivery[ab]: • Parents reported feelings of guilt and complete responsibility for management of their children's behaviour problems	Recruitment & delivery[ab]: • Many parents feared social isolation and stigma, and did not seek help for fear of rejection
Leckey et al., 2021	Ireland	Parents of children at risk of maltreatment (N = 12)			Recruitment & delivery[a]: • Some parents initially apprehensive about sharing problems with others in the group, due to fear of perceptions of being a 'bad' or incapable parent, or judging their parenting skills
Mamauag et al., 2020	Philippines	Low-income parents who are cash transfer recipients (N = 47)			Recruitment & delivery[d]: • Programme was renamed *Masayang Pamilya Para sa Batang Pilipino* (or Happy Family for the Filipino Child) to focus on positive emotions and the whole family, to potentially reduce stigma to parent participants
McCoy et al., 2020 (formative)	Thailand	Low-income families in rural areas (N = 20 service providers)			Recruitment & delivery[c]: • Location of service venue in a community-based hospital

Table 4. Findings on stigma experiences according to relevant features of parenting programmes

Study	Study country	Programme target population; Sample (N); Studies (k)	Experienced stigma	Self-stigma	Perceived or anticipated stigma
					viewed as non-stigmatizing by some (as services concern health and wellness) but as stigmatizing by one participant (e.g., indicates that the parent is in a 'problem group') • Home visits perceived as potentially stigmatizing to participating families given aim of the service (i.e., child maltreatment prevention) – may be seen in the community as abusive families
Mytton et al., 2014*	UK, US, Australia, New Zealand, Canada	Various vulnerable groups (k = 26)			Recruitment & delivery[ac]: • Barriers to participation included the fear of being labelled a 'bad' parent, and fathers feeling uncomfortable in predominantly female groups
Onyskiw et al., 1999	Canada	Families at risk of child abuse and neglect (n = 17 parents, n = 10 providers)			Recruitment & delivery[ac]: • Location of service venue in a public space (i.e., in a shopping mall) viewed as non-stigmatizing • Name of the service (Together for Kids) viewed favourably for not calling attention to child abuse

* Systematic review

Perceptions expressed by: [a] Parent participants, [b] Potential parent participants, [c] Service providers, [d] Evaluators

Table 5: Findings from included systematic reviews on parenting programme impacts on social norms

Study	Review focus	Countries included (N)	Studies included (k), relevant programmes evaluated by RCTs (n)	Sample size (N)	Included relevant programmes and countries	Relevant findings
Lokot et al., 2020	1) Social norms contribution to CPD acceptability; 2) contextual factors influencing social norms & CPD; 3) Impact of interventions on social norms sustaining CPB	N = 59 overall; N = 2 RCT countries	k = 37 in total; k = 2 relevant RCTs[a]; n = 2 programmes	N = 321,008[c] across all studies; N = 2,133 in included RCTs	REAL Fathers Initiative, Uganda (Ashburn et al., 2017)	Programme had no effect on gender norms, but authors found changes in attitudes on physical punishment
					COMPASS caregiver plus girls' curriculum, Democratic Republic of Congo (Stark et al., 2018)*	No changes in attitudes towards gender inequitable norms or physical discipline of children in comparison to control at 1 year follow-up; norms sustaining CPD may take longer or require higher intervention dosage (only one discussion group was delivered per month)
Marcus et al., 2020	Impact and social norms change of parenting programmes aiming to reduce violence against adolescents and child marriage	N = 23 overall; N = 3 RCT countries	k = 58 in total; k = 4 papers[b] from 3 RCTs; n = 3	N = 15,075 across all studies; N = 3,177 in included RCTs	Happy Families, Thailand (Annan et al. 2017; Puffer et al., 2017)	Review focused on behaviour change (Study focus was on behaviours and not beliefs, attitudes, or social norms)
					PLH Sinovuyo Teen, South Africa (Cluver et al., 2018)**	Review focused on behaviour change (Study changes in attitudes condoning harsh punishment noted in Table X)
					COMPASS caregiver + girls' curriculum, Democratic Republic of Congo (Stark et al, 2018)*	(Findings described above)

CPD = corporal punishment and/or discipline

*Study included in both reviews

**Study included in listing of primary studies

[c] Sample sizes for some included studies not stated

Table 6: Findings from included primary studies on parenting programme impacts on social norms

Study	Study country	Intervention	Sample size (N)	Outcome measure (P, S, N/A), Instrument	Method of report	Time point	Effect size[a] [95% CI]
Cluver et al., 2018	South Africa	PLH Sinovuyo Teen	N = 552 (270 INT, 282 CTL)	Attitudes condoning harsh punishment (S), ICAST-Trial Attitudes subscale	Interview (parent report)	5-9 months post-intervention	**-0.46 [-0.69 to -0.24], p < .001**
Gülirmak & Orak, 2020	Turkey	Web-based distance education programme	N = 60 (30 INT, 30 CTL)	Overprotective mothering (N/A), PARI subscale	Questionnaire (parent report)	7 weeks post-baseline	**-0.72[b] [-1.24, -0.20], p = 0.007**
				Democratic attitude and equality (N/A), PARI subscale	Questionnaire (parent report)	7 weeks post-baseline	-0.06[b] [-0.57, 0.45], p = 0.820
				Strict discipline (N/A), PARI subscale	Questionnaire (parent report)	7 weeks post-baseline	**-1.57[b] [-2.15, -0.99], p = <0.001**
				Positive attitudes (N/A), Recognition of Emotional Maltreatment Scale (REMS) subscale	Questionnaire (parent report)	7 weeks post-baseline	**1.48[b] [0.91, 2.06], p = 0.059**
Ismayilova & Karimli, 2020	Burkina Faso	Trickle Up (TU+) (economic intervention plus family coaching)	N = 240 (120 INT, 120 CTL)	Child protective attitudes (concerning education, child marriage, child labour, physical punishment) (N/A), N/A	Interview (parent report)	12 months post-baseline	**0.39, adjusted mean difference = 0.55 [0.08, 1.01], p = 0.022**
						24 months post-baseline	0.15, adjusted mean difference = 0.19 [-0.61, 0.99], p = 0.647
Lachman et al., 2020	Tanzania	Skilful Parenting and an agribusiness programme	N = 118 (58 INT, 60 CTL)	Endorsement of corporal punishment, UNICEF MICS (1 item)	Interview (parent report)	12 months post-baseline	Hedges D_w = -0.43, [-0.79 to 0.07]
Lachman et al., 2021	Philippines	Masayang Pamilya Para Sa Batang Pilipino	N = 120 (60 INT, 60 CTL)	Endorsement of corporal punishment (S), UNICEF MICS (1 item)	Interview (parent report)	6 months post-baseline (1-month post-intervention)	-0.33 [-0.69, 0.03]

Study	Study country	Intervention	Sample size (N)	Outcome measure (P, S, N/A), Instrument	Method of report	Time point	Effect size[a] [95% CI]
		Parenting Programme (PLH-YC)				18 months post-baseline (12 months post-intervention)	0.14 [-0.22, 0.50]
				Attitudes supporting corporal punishment (S), ICAST-Trial Attitudes subscale	Interview (parent report)	6 months post-baseline (1-month post-intervention)	-0.04 [-0.40, 0.32]
						18 months post-baseline (12 months post-intervention)	-0.12 [-0.48, 0.24]
Ofoha et al., 2019	Nigeria	Parenting Education Programme for Corporal Punishment Prevention (PEP)	N = 300 (150 INT, 150 CTL)	Parental attitudes toward corporal punishment (N/A), N/A	Interview or questionnaire (parent report)	8 weeks post-baseline	**-0.85[b] [-1.08, -0.61]**
						12 weeks post-baseline	**-0.82[b] [-1.06, -0.58]**
				Parental beliefs about the perceived value of corporal punishment (N/A), N/A	Interview or questionnaire (parent report)	8 weeks post-baseline	**-0.93[b] [-1.17, -0.69]**
						12 weeks post-baseline	**-0.94[b] [-1.18, -0.70]**
Sawasdipanich et al., 2010	Thailand	Parental cognitive adjustment programme	N = 116 (53 INT, 63 CTL)	Parental attitudes toward child rearing (N/A), Adult-Adolescent Parenting Inventory	Unclear if by questionnaire or interview (parent report)	16 weeks post-baseline	**0.60[b] [0.23, 0.97]**
Sener & Cimete, 2016	Turkey	Programme based on Social Cognitive Theory & Smith's Model of Health and Illness (SMHI)	N = 77 (39 INT, 38 CTL)	Democratic attitude (N/A), Parent Attitude Scale (PAS) sub-scale	N/A	Immediate post-intervention	**0.84[b] [0.37, 1.31]**
						3-months post-intervention	**1.20[b] [0.71, 1.68]**
				Authoritarian attitude (N/A), Parent Attitude Scale (PAS) sub-scale	N/A	Immediate post-intervention	**-0.81[b] [-1.27, -0.34]**
						3-months post-intervention	**-0.99[b] [-1.46, -0.51]**
					N/A	Immediate post-intervention	**-0.77[b] [-1.23, -0.30]**

Study	Study country	Intervention	Sample size (N)	Outcome measure (P, S, N/A), Instrument	Method of report	Time point	Effect size[a] [95% CI]
				Overprotective attitude (N/A), Parent Attitude Scale (PAS) sub-scale		3-months post-intervention	**-1.37** [b] **[-1.87, -0.88]**
				Permissive attitude (N/A), Parent Attitude Scale (PAS) sub-scale	N/A	Immediate post-intervention	**-0.54** [b] **[-0.99, -0.08]**
						3-months post-intervention	**-0.78** [b] **[-1.24, -0.32]**
Yusuf et al., 2019	Turkey	Triple P Level 4	N = 60 (30 INT, 30 CTL)	Overprotective parenting attitude (S), PARI subscale	Interview (parent report)	8 weeks post-baseline	-0.43**[b]** [-0.94, 0.09], p = 0.094
				Democratic attitude (S), PARI subscale	Interview (parent report)	8 weeks post-baseline	**0.92[b] [0.39, 1.46], p = 0.008**
				Rejection of homemaking attitude (S), PARI subscale	Interview (parent report)	8 weeks post-baseline	**-0.64[b] [-1.16, -0.12], p = 0.069**
				Marital conflict in child rearing (S), PARI subscale	Interview (parent report)	8 weeks post-baseline	-0.36[b] [-0.87, 0.15], p = 0.209
				Strict discipline (S), PARI subscale	Interview (parent report)	8 weeks post-baseline	**-0.61**[b] **[-1.13, -0.09], p = 0.08**

[a]Effect sizes in Cohen's *d* unless otherwise indicated

[b]Calculated by the reviewers using means and standard deviations

Significant effects are in bold (95% CI not crossing 0)

P = Primary outcome; S = Secondary outcome

INT = Intervention group; CTL = Control group

N/A = Not available

PARI = Parenting Attitude Research Instrument; MICS = Multiple Indicator Cluster Survey

APPENDICES

Appendix A1.
Searches for qualitative studies of parenting interventions, potentially relevant to multiple INTEGRATE questions

A database search strategy was developed in EMBASE, using terms associated with parenting programmes and qualitative research methods (see Table 1). The search strategy was adapted for other databases as necessary. A literature search was conducted on seven electronic databases in March 2021 (EMBASE, PsycINFO, CINAHL, ERIC, Global Health, Applied Social Sciences Index & Abstracts (ASSIA), the International Bibliography of the Social Sciences (IBSS) and the Social Science Premium Collection), from inception to the present date.
Papers were included if they: (1) were written in English; (2) employed qualitative methods (with any number of participants greater than one); (3) involved parents/caregivers who had participated or been invited to take part in a parenting programme or involved staff participating in a parenting programme; and (4) involved parent/caregiver, child or staff (at any level, including decision makers) perceptions of parenting programmes.
Exclusion criteria in this review were: papers on children with disabilities and illnesses (e.g. autism, cerebral palsy or cancer); programmes aimed at children with anxiety, OCD, PTSD, depression or self-harm; papers not concerning a parenting intervention but perceptions of parents' needs, child-rearing views or parenting factors; and interventions for parent involvement in education, reading or schools; and papers focused on family therapy, antenatal parenting interventions, mindfulness-based programmes or transition to parenthood programmes.
The database search strategy yielded 12,945 citations and resulted in a total of 10,088 after deduplication. Title and abstract screening were undertaken, which left a total of 217 studies for the full-text screening stage. A data extraction form was created, and we extracted data on participants, country, population target group, intervention type, delivery format and study content related to any of the INTEGRATE questions.

EMBASE search strategy		
1	PI – phenomenon of interest	(parent child* or "parent education" or "parent* training" or (parent* adj3 (program* or intervent* or train* or education)) or (mother* adj3 (program* or intervent* or train* or education)) or (father* adj3 (program* or intervent* or train* or education)) or

		(caregiv* adj3 (program* or intervent* or train* or education)) or (family adj3 (program* or intervent* or train* or education)) or "parent* skills" or "family skills" or "family based" or "family focused").tw
2	D – design	(perce* OR perspective* OR opinion* OR experience* OR belie* OR view* OR opinion*).tw
3.	R – research type	(qualitative OR mixed method OR phenomenol* OR grounded theor* OR focus group or "thematic analysis" or "thematic analyses").tw
4.	Final search	(1 AND 2 AND 3)

Appendix A2.
Search strategies for Feasibility chapter

Search 1. Systematic search for literature on scale-up of social care and parenting interventions (approximately 2,000 documents screened)

Key concepts	**Scale-up**	**Intervention**	**Psychosocial**	**LMICs**
Searched in	Titles/abstracts/ keywords	Titles/abstracts/keywords	Titles/abstracts/keywords	Titles/abstracts/keywords
Search terms	(scal* ADJ1 up)	intervention* OR	parent* OR “care giv*” OR care-	“develop* countr*” OR

OR “scale-up” OR “roll-out” OR (roll* ADJ1 out) OR (nation* ADJ5 roll* ADJ1 out) OR (nation* ADJ5 roll-out) OR bottom-up OR “bottom up” OR (full ADJ1 scale)	programme* OR treatment* OR strateg* OR implement* OR prevention* OR therap* OR evidence-based OR “evidence based” OR EBI* OR EBPP* OR (nation* ADJ1 service*) OR session* OR training Course workshop	givi* OR “social” OR “social care” OR social-care OR parent* OR “parenting-programme*” OR child-care OR “child care” OR “child protection” OR (child ADJ5 protection) OR “public health” OR “childhood development” psychosocial OR psycholog* OR emotion* OR cogniti* OR behaviour* OR mental-health OR “mental health” OR well-being OR “well being” OR psychiatr*	underdevelop* OR “under developed” OR "low income economies" OR "lower income economy" OR "lower income economies" OR Africa OR “Sub-Saharan Africa” OR “middle income countries”

Search 2. Measures of facilitator competent adherence systematic search

(parent* OR caregiver* OR guardian* OR carer*.ab) AND (training OR program* OR intervention* OR treatment OR trial* or prevention.ab) AND (competen* OR quality OR adheren* OR fidelity* OR integrity OR compliance.ab) AND (child* OR kid* OR adolesc* OR teen* OR youth* OR baby OR babies OR toddler* OR neonate* OR infant* OR newborn OR juvenile* OR minor* OR early child* OR ECD.ab) AND (facilitator* OR practitioner* OR therapist* OR clinician* OR teacher* OR worker* OR provider* OR leader* OR specialist* OR professional* OR coordinator* OR administrator* OR counsellor* OR counselor* OR implementer* OR coach* OR instructor* OR trainer* OR mentor* OR educator*.ab) AND (scale* OR subscale* OR tool* OR measure* OR instrument* OR report* OR index* OR checklist* OR test*.ab).

Searched in:

- Applied Social Sciences Index and Abstracts, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials (CENTRAL), EconLIT, PsycINFO, EBSCO combined search (CINAHL, ERIC, MEDLINE), Global Health, The International Bibliography of the Social Sciences (IBSS), Social Science Premium Collection, and ProQuest Dissertations and Theses
- Gardner et al. forthcoming review
- Contacted authors
- Forward and backward citation tracking.

Search 3. Non-systematic search for studies on facilitator characteristics

13	(facilitator* or practitioner* or clinician*).ab.
14	limit 13 to (English language and yr=”1980 -Current”
15	(program* or trial* or interven* or eval*).ti.
16	limit 15 to (English language and yr=”1980 -Current”
17	parent*.ti.
18	limit 17 to (English language and yr=”1980 -Current”
19	(outcome* or factor* or demographic* or characteristic*).ab.
20	limit 19 to (English language and yr=”1980 -Current”
21	13 and 14 and 15 and 16 and 17 and 18 and 19 and 20

- Search conducted in EMBASE and PsycINFO. Used the studies from this search to find other studies, particularly conducting forward and backward citation tracking
- Also looked for terms not included in the search (e.g. therapist) and searched for these.

Search 4. Searches on family recruitment

Search terms in Google Scholar: parent training + parenting program + parenting intervention + recruitment + enrolment + attendance + engagement + adherence + compliance + involvement + participation + dropout + drop out + retention + attrition + systematic + review

Strategy: reviewed first 10 pages.

Search 5. Search on family engagement

Search terms in Google Scholar: parent training + parenting program + parenting intervention + attendance + engagement + adherence + compliance + involvement + participation + dropout + drop out + retention + attrition + systematic + review

Strategy: reviewed first 15 pages

Search 6. Google Scholar Searches on engagement in digital parenting interventions

Search terms: digital + mhealth + online + internet + self lead + web based + remote + parent training + parenting program + parenting intervention + engagement + adherence + compliance + involvement + participation + dropout + retention + attrition + review

Strategy: reviewed first 10 pages.

Appendix 3, Tables 6-9 for Human Rights chapter.

Table 6. Characteristics of included interventions

Intervention	Original programme (if an adaptation)	Programme developers	Country	Reports and papers identified	Target population & child age	Aims	Description
International Child Development Programme (ICDP)	ICDP (developed in Norway) (ICDP, 2021)	ICDP International	Colombia	• Cook et al. (2017) • Hundeide & Armstrong (2011) • Hundeide (2013)	Parents & caregivers of young children living in a community with high levels of civil conflict	To assist the psychosocial needs of children at risk by improving child-caregiver communication, interactions, and relationships; influencing the caregiver's conception and experience of the child; and enhancing the positive aspects of caregivers' existing cultural caring resources (Hundeide, 2013)	8-week group sessions
Ladnaan programme	Connect programme (developed in Canada) (Connect Parent Group, 2018)	• Ladnaan: Osman et al (2017) (Ladnann programme) • Connect: Maples Adolescent Treatment Centre & Simon Fraser University	Sweden	• RCT: Osman, Flacking et al. (2017) • RCT: Osman, Salari, et al. (2017) • Doctoral thesis: Osman (2017) • Qualitative study: Osman et al. (2019) • Process evaluation (pre-print): Osman et al. (2020) • Rooth et al. (2017) • Moretti et al. (2009)	Somali immigrant parents of children aged 11-16 years with self-perceived parenting stress	First 2 sessions aim to provide an introduction on parenting styles, child rights, and the family legal system, while remaining 10 sessions (Connect) aim to strengthen parent-child relationships and attachment	12 weekly group sessions (1-2 hours per week)
Better Parenting Nigeria (BPN)	Yekokeb Berhan Program (YBP) for Highly	• BPN: 4Children Nigeria	Nigeria	• Community Discussion Guide:	Parents & caregivers of	To strengthen caregiver-child relationships, increase caregiver capacity	20 core sessions with 8 additional

	Vulnerable Children (developed in Ethiopia)	• YBP: Pact, FHI360, & REPSSI		USAID & 4Children Nigeria (2018a) • Facilitator Manual: USAID & 4Children Nigeria (2018b)	children aged 0-18 years	to understand family needs and access resources and services, and to improve caregiver capacity to protect children from harm and exploitation.	optional sessions
Families First Programme (FFP)	Positive Discipline in Everyday Parenting (PDEP)	Save the Children	Indonesia	• PDEP parent handbook: Durrant (2016) • FFP: RCT protocol in Indonesia: Ruiz-Casares et al. (2019) • FFP: Ruiz-Casares et al. (2021)	Parents & caregivers of children aged 0-18 years	Components include: 1) identifying parents' long-term childrearing goals; 2) providing warmth and structure; 3) understanding how children think and feel; and 4) problem-solving (Ruiz-Casares et al., 2019)	10 weekly group sessions and 4 home visits
Parenting on the Move	N/A	Centre for Interactive Pedagogy & Save the Children North West Balkans	Serbia	• Trainers & mentors handbook: Save the Children (2021a) • Moderator's handbook: Save the Children (2021b)	Migrant and refugee families of children aged 0-12 years	To support migrant/refugee parents in providing for child well-being, resilience, and education, by reinforcing personal/family strengths and stress management, developing competencies to respond to child needs, reinforcing parent-child connections, finding constructive ways to spend free time, and encouraging family cohesion and intercultural exchange.	4 months of 17 weekly group sessions (45-60 minutes per session)
Program P	N/A	Promundo, CulturaSalud, & REDMAS	Unspecified	• Programme manual: Promundo et al. (2013)	Fathers & male caregivers of children aged 0-4 years	To promote gender equality within the couple relationship, improve men's self-confidence and efficacy in caregiving for the child to develop and	11 weekly group sessions (recommended but flexible)

						thrive, promote positive parenting and healthy relationships with children through rejection of VAC, and to prevent violence against women and promote healthy and happy relationships.	

Note: N/A = not applicable

Table 7. Characteristics of included studies

Intervention	First author (year)	Country	Design	Participants/ Child age	Sample size	Control	Outcome measures/key study findings	Cohen's *d* effect size (p value)[a] or odds ratio (OR)
International Child Development Programme (ICDP)	Cook et al. (2017)	Colombia	Case study	Parents and caregivers of young children (under 8 years)	Overall project involved over 2,000 participants	N/A	N/A	N/A
Ladnaan programme	Osman, Salari et al. (2017)	Sweden	RCT (same study as below)	Parents of children aged 11-16 years	120 INT = 60 CTL = 60	Waitlist	Secondary: • improved parental mental health • parental competence (efficacy) • parental competence (satisfaction)	0.85 (<0.001) [a] 1.81 (<0.001) [a] 0.98 (<0.001) [a]
	Osman, Flacking et al. (2017)	Sweden	RCT (same study as above)	Parents of children aged 11-16 years	120 INT = 60 CTL = 60	Waitlist	Primary: child emotional & behavioural problems (16 measures in total) • aggressive behaviour • social problems • externalizing problems	0.76 (<.001) [a] 0.83 (<.001) [a] 0.60 (<.001) [a]

	Osman et al. (2019)	Sweden	Qualitative study	Mothers & fathers of children aged 11-16 years who participated in Ladnaan	50	N/A	• "A light has been shed": knowledge was valued on legal rights of parents and children in Sweden, child services, parent-child relationship • Improved parenting confidence • Improvements in being emotionally aware and available to their children	N/A
	Osman et al. (2020)	Sweden	Mixed methods process evaluation (in parallel with above RCT)	Parenting group leaders, a lecturer, Connect instructors, internal facilitators, & parents	Not reported	N/A	• Contextual facilitators: Involved well-known Somalis • Contextual barriers: lack of manager support, insufficient childcare, potential lack of sustainability due to social services implementation • Reach: 95% of contacted parents participated; 69% attended >8 sessions; 70% took part in 2 initial sessions (including child rights) • Fidelity: training & supervision vital for group leader competence & self-confidence; perceived high level of fidelity • Adaptations: provided free transport, word-of-mouth recruitment by parents • Group leader satisfaction: societal information sessions contributed to retention (including child rights)	N/A
Families First Programme (FFP)	Ruiz-Casares et al. (2021)	Indonesia	Cluster RCT protocol	Parents & caregivers of children aged up to 7 years	736 INT = 374 CTL = 362	Waitlist	Primary: presence or absence of caregiver reported physical & emotional punishment	NSE at immediate or 6 months post

							Explanatory: • positive & involved parenting • positive discipline • setting limits • opinion on discipline Exploratory: • child social & emotional well-being • attitudes towards institutionalization of children • monitoring/supervision Other: • parenting stress • caregiver mental health • perceived social support • stimulation in home environment • interparental conflict regarding childrearing	NSE OR = 1.51 (1.19, 1.93) NSE NSE NSE NSE NSE Not reported Not reported Not reported Not reported Not reported

Note: N/A = not applicable; NSE = no significant effect

Table 8. Reflection of the CRC general principles and child-centred parenting support

Intervention	**CRC Principles**				**Child-centred parenting support: Promotes parental & family awareness of child rights**
	Best interests of the child (art. 3.1)	**Right to be heard (art. 12)**	**Right to survival & development (art. 6)**	**Right to non-discrimination (art. 2)**	
International Child	No information*	Implicitly - through home tasks, caregivers practice	Implicitly – promotes loving care and guidance	Implicitly – aims to counteract negative	Not explicitly; aims to create positive community

Intervention	CRC Principles				Child-centred parenting support: Promotes parental & family awareness of child rights
	Best interests of the child (art. 3.1)	Right to be heard (art. 12)	Right to survival & development (art. 6)	Right to non-discrimination (art. 2)	
Development Programme (ICDP)		reciprocal exchanges with their children; emphasis on the child being listened to, heard, and answered in a positive way (Hundeide & Armstrong, 2011)	so that to ensure healthy child development (Hundeide & Armstrong, 2011)	conceptions of the child & prevent stigmatization (Hundeide & Armstrong, 2011)	conditions for the fulfillment of child rights (Hundeide & Armstrong, 2011)
Ladnaan programme	No information*	Implicitly - Connect programme supports parents to acknowledge children's own life experiences, values, and needs, as well as to communicate their views (Rooth et al., 2017). May also be explicitly addressed in Session 2 on the CRC, but insufficient information is available.	Implicitly – Connect is based on attachment theory and introduces parents to knowledge & skills related to child development and attachment needs (Osman et al., 2019)	Although discrimination is mentioned as a problem commonly faced by Somali immigrants in Sweden, there is no information on whether the programme explicitly or implicitly addresses this (Osman, 2017; Osman, Salari, et al., 2017)	Explicitly promotes awareness of child rights - Session 2 out of 12 focuses on the CRC and how it is reflected in parenting (Osman et al., 2019)
Better Parenting Nigeria	Explicitly – mentioned in Session 14 on child rights, protection, & responsibility (USAID & 4Children Nigeria, 2018b)	Explicitly – mentioned in Session 14 on child rights, protection, & responsibility (USAID & 4Children Nigeria, 2018b)	Explicitly – mentioned in Session 14 on child rights, protection, & responsibility (USAID & 4Children Nigeria, 2018b)	Explicitly – mentioned in Session 14 on child rights, protection, & responsibility; discrimination also frequently mentioned as a problem faced by those living with HIV in Session 15 (USAID & 4Children Nigeria, 2018b)	Explicitly promotes awareness of child rights – Session 14 focuses on child rights, protection, & responsibility (USAID & 4Children Nigeria, 2018b)
Families First Programme (FFP)	PDEP: Explicitly – Article 3.1 is quoted in the parent handbook (Durrant, 2016)	PDEP: Explicitly – Article 12 is quoted in the parent handbook; mentions hearing child point of view when discussing	PDEP: Explicitly includes information on child rights and right to survival & development in the preface of the parent	No information*	PDEP: Explicitly includes information on child rights and best interests in the preface of the parent handbook; CRC articles are interspersed;

Intervention	CRC Principles				Child-centred parenting support: Promotes parental & family awareness of child rights
	Best interests of the child (art. 3.1)	Right to be heard (art. 12)	Right to survival & development (art. 6)	Right to non-discrimination (art. 2)	
		household rules and considering child point of view during adolescence; also mentions that positive discipline involves several aspects, including considering how your child thinks and feels (Durrant, 2016)	handbook; emphasis on promoting an understanding child development and respecting child developmental needs frequently mentioned; positive discipline described as non-violent, solution-focused, respectful, & based on child development principles (Durrant, 2016)		frames positive discipline as reliant on 1) research on healthy child development, 2) research on effective parenting, 3) child rights principles (Durrant, 2016)
Parenting on the Move	Explicitly includes information for moderators, trainers, & mentors on the CRC and best interests of the child; states that the programme is founded on several principles, including acting in the best interest of children and adults (Save the Children, 2021a, 2021b)	Explicitly includes information for moderators, trainers, & mentors on the CRC and right to participation; states that the programme is founded on several principles, including participation of children & parents (Save the Children, 2021a, 2021b)	Explicitly includes information for moderators, trainers, & mentors on the CRC and right to survival & development; positive discipline is described as based on the right of the child to healthy development; Workshop Session 10 can involve showing a film on how toxic stress derails healthy child development; parental warmth involves respecting the development stage of the child (Save the Children, 2021a, 2021b)	Explicitly includes information for moderators, trainers, & mentors on the CRC and right to non-discrimination; states that the programme is founded on several principles, including an inclusive & non-discriminatory approach; states that working with families from different cultural backgrounds requires valuing non-discriminatory behaviour; there is a detailed section for moderators that describes prejudice & discrimination (Save the Children, 2021a, 2021b)	Explicitly promotes awareness of child rights; states that the programme encourages parenting to develop skills and exchange their behaviour to better understand child rights; one section with information for the moderator discusses right to education for migrant & refugee children (Save the Children, 2021b)

Intervention	CRC Principles				Child-centred parenting support: Promotes parental & family awareness of child rights
	Best interests of the child (art. 3.1)	Right to be heard (art. 12)	Right to survival & development (art. 6)	Right to non-discrimination (art. 2)	
Program P	No information*	No information*	Explicitly – Manual mentions that violent punishment can threaten child rights to education, development, health & survival; emphasis on understanding what child is capable of during his/her stage of development – there is a handout on child development stages for participants (Promundo et al. 2013)	Implicitly – mentions gender discrimination & traditional gender norms as affecting children's ability to develop to their full potential; mentions that a programme objective is encouraging couples to teach values of gender equality to children and to model such equality in their relationships; some discussion on gendered toys in Session 7 (Promundo et al. 2013)	Explicitly includes some information on child rights for facilitators but not for parents; mentions the CRC and that fathers must also be involved in protecting child rights; including support for gender equality and valuing the rights of women and children as a programme principle; states that positive discipline is founded on child rights principles, as part of text for facilitators; Session 9 is titled 'The Needs and Rights of Children,' but it discusses stages of child development & positive parenting rather than explicit rights (Promundo et al. 2013)

*Sufficient information on this area has not been provided in the studies, reports, or manuals included in this review.

Table 9. Reflection of obligations to respect, protect, and fulfil/promote

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
International Child Development Programme (ICDP)	• Respects values & norms of local communities by envisioning the programme as	• Supports early childhood rights with one of the programme objectives being to	• Supports good child health with an objective of promoting psychosocial care	• Prevents VAC with qualitative research with caregivers in Huila, Colombia,	No information*	• Supports parents to take into account child views by setting home tasks that help the parent realize

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
	community-based psychosocial care, with resources in the local community that should be mobilized and with training adapted to local needs & traditions (Hundeide & Armstrong, 2013) • Fosters mutual respect between children & caregivers: qualitative research with 30 parent participants in Huila, Colombia, found that the programme helped them to be more respectful of children (Hudeide & Armstrong, 2013)	promote sensitive emotional expressive communication & interactions, leading to a positive emotional & playful parent-child relationship (Hudeide, 2013)	competence, with human empathy and compassion as a basis of care for vulnerable children; aims to explore methods of discipline without the use of violence in group discussions (Hundeide & Armstrong, 2011)	finding that they were able to move away from physical punishment of children (Hundeide & Armstrong, 2011)		importance of reciprocal exchange, in which the child is listened to and answered in a positive way (Hundeide & Armstrong, 2013) • Supports parents to offer direction & guidance in child centred way with 8 guidelines for interaction: 1) Show positive feelings, 2) Follow the child's initiative, 3) Establish intimate dialogue, including non-verbal expressions, 4) Confirm & praise, 5) Focus the child, establish shared attention, 6) Provide meaning with enthusiasm, 7) Use enriching explanations, 8) Regulate child behaviour by planning together, scaffolding, setting limits, providing challenges (Hundeide & Armstrong, 2013)

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
Ladnaan programme	• Fosters mutual respect between children & caregivers, as qualitative study with programme participants reported that showing empathy & compassion to their children led to strengthened mutual understanding & respect; also reported that they noted the importance of respecting children's perspective & independence (Osman at al., 2019) • Provides ways of dealing with family conflict that are rights respecting, with Session 6 on 'Conflict is Part of Attachment,' which aims to acknowledge that conflict is a natural part of the parent-child relationship, and can help	• Supports adolescent rights as the Connect Programme focuses on parent-teen attachment as foremost in its theoretical rationale, structure, & content; it encourages collaborative rather than coercive parenting strategies in monitoring, limit setting, and addressing teen problem behaviour; differs from many other parenting programmes as it focuses on issues related to a adolescence, such as sensitivity to attachment needs in adolescence, the role of conflict in growth and change, and the importance of teen autonomy (Moretti et al., 2009)	• Supports good child health with the Connect programme aiming to promote children's mental health (Osman, 2017); also addresses VAC risk factors, such as through the effective reduction in parental mental health problems (B=3.62, 95% CI 2.01 to 5.18, p<0.001) and improvement in sense of efficacy (B=-6.72, 95% CI -8.15 to -5.28, p<0.001), as well as improvements in child aggression (B=2.07, 95% CI 1.06 to 3.07, p<0.001) and externalizing behaviour (B=2.24, 95% CI 0.96 to 3.53, p<0.001) (Osman, Flacking et al., 2017)	• Supports prevention of VAC indirectly by addressing risk factors (see column at left)	• Supports parenting in ethnic minority communities through adaptation for and targeting of Somali immigrant parents in Sweden, with qualitative research findings on parenting challenges and opportunities for improved parenting informing the adaptation (Osman 2017)	• Supports parents to take into account child views with Session 7 on 'Autonomy Includes Connection,' which helps parents develop skills to recognize that teens need autonomy while maintaining connections with parents (Osman et al., 2019); parents reported abandoning authoritarian parenting and supporting child autonomy & self-determination (Osman, 2017) • Enables evolving capacities with Session 5 on 'Attachment Is For Life' focusing on developing skills to recognize the attachment needs of infants, small children and teens, with parenting confirming that they gained an increased awareness of their child's attachment needs across different age

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
	relationships grow when expressed & responded to in a constructive way (Osman at al., 2019); conflict management is concerned with promoting awareness of mutuality and arriving at solutions on equal terms (Rooth et al., 2017)					groups (Osman et al., 2019) • Supports parents to offer direction & guidance in child centred way through dialogue, with the 'processing relations' domain of the Connect Programme focused on parent & child reciprocal communication and mutual respect (Rooth et al., 2017)
Better Parenting Nigeria	• Recognizes both mothers & fathers, with Session 16 on 'Gender Norms' addressing the importance of fathers in children's lives (USAID & 4Children Nigeria, 2018b) • Respects values & norms of local communities with Session 2 focused on 'Culture and Social Norms' – encourages parents to reflect on both positive and	• Supports adolescent rights with 4 supplemental sessions on adolescents: 1) Basics of adolescents development, 2) Building relationships with adolescents, 3) Establishing rules & routines, problem solving & conflict resolution, 4) Keeping adolescents safe & healthy (including information on	• Supports child rights to play, with 3 of the supplementary ECD sessions discussing the importance of play and encouraging interactive play, with specific suggestions on how to play with ages 0-3+ (USAID & 4Children Nigeria, 2018a) • Supports good health with Session 17 focusing on 'Nutrition and Adequate Diet';	• Prevents VAC by including mention of risks of sexual violence, alcohol as a risk factor for violence, forms of VAC, signs/symptoms of a child who is experiencing harm, HIV and stigma-related violence, and an emphasis on positive discipline (USAID & 4Children Nigeria, 2018a)	• Supports children with disabilities with Session 7 focused on 'Children with Special Needs,' which mentions different types of disabilities as well as encourages the mapping of local support services and the provision of referrals for families who need them (USAID & 4Children Nigeria, 2018b)	• Supports parents to take into account child views in Session 8 on Parent-Child Communication by encouraging active listening of children's concerns & opinions; Session 9 on 'Family Rules, Boundaries & Roles' by emphasizing child participation in setting family rules (USAID & 4Children Nigeria, 2018b) • Enables evolving capacities through Session 5 on 'Child Developmental

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
	negative local customs and social rules (USAID & 4Children Nigeria, 2018a) • Fosters mutual respect between children & caregivers, with Session 2 on 'Building Relationships with Adolescents' briefly mentioning that parents can show trust and respect to adolescents by giving them more responsibilities (USAID & 4Children Nigeria, 2018b) • Provides ways of dealing with family conflict that are rights respecting, with Session 3 on 'Establishing Rules & Routines, Problem Solving & Conflict Resolution' focused on positive discipline that should never involve hitting children (USAID &	substance use and sexual health); mentions that during ages 13-18, children need supervision & guidance to help with risky behaviours, with some information on HIV in Session 15 (USAID & 4Children Nigeria, 2018b) • Supports early childhood rights with 4 supplemental sessions on ECD: 1) Bonding, attachment, & caregiver well-being, 2) Basics of ECD, 3) Early learning & behaviour management, 4) Keeping children safe & healthy (USAID & 4Children Nigeria, 2018b)	there is content on HIV in multiple session, with an exclusive focus in Session 15; supplementary session 4 on ECD focuses on keeping children safe and healthy; Session 10 focuses on 'Discipline' and includes discussion of benefits of positive reinforcement & rewarding good behaviour, as well as negative effects of physical punishment (USAID & 4Children Nigeria, 2018a, 2018b) • Encourages social, creative & learning activities in a digital environment, with Session 19 on '21st Century Parenting Realities & Challenges' including discussions on the internet, social media, & online safety (USAID &	• Prevents family separation with Session 18 focused on 'Family Centred Care for Children Apart from Parents, which emphasizes the importance of children growing up in families, and skills for parents receiving children back from formal care (USAID & 4Children Nigeria, 2018b)		Stages' and a case story on parental expectations and stages of development, as well as Session 6 on 'Changing Needs as Children Grow', which emphasizes primary needs, common behaviours, and appropriate parental responses during early childhood, middle childhood, and late childhood; 4 supplemental session on ECD and 4 on adolescents • Supports parents to offer direction & guidance through dialogue and example with Session 13 on 'Role Modelling' (what behaviours parents would like to pass on to their children) and Session 8 on 'Parent-Child Communication' (e.g., listening, observing, speaking, questioning) (USAID &

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
	4Children Nigeria, 2018a)		4Children Nigeria, 2018a, 2018b)			4Children Nigeria, 2018b)
Families First Programme (FFP)	• PDEP: Fosters mutual respect between children and caregivers through repeated emphasis on developing a mutually respectful relationship at each developmental stage, including at 6-12 months, indicating that parents should show that they will respect child attempts to communicate; also mentions the need to respect child rights to control their own body and to respect your child's feelings • PDEP: Provides ways of dealing with family conflict that are rights respecting by mentioning non-violent conflict resolution as a building block established during	• FFP: Supports early childhood rights by way of positive and sensitive relationship building, with an emphasis on providing warmth & structure (Session 3), understanding how children think & feel during infancy (Session 4), and understanding middle childhood and temperament (Session 7); 5 sessions are organized around child developmental stages (Ruiz-Casares et al., 2019) • PDEP: Handbook organized around child developmental stages, with an emphasis on warmth (including emotional security, affection, sensitivity, & empathy) during each of 8 identified	• PDEP: Supports child rights to play by indicating that showing warmth to children involves play; cites CRC art. 31 on right to play; includes scenarios that describe a lot of play activities, problem solving around stopping playtime and being safe during play • PDEP: Supports good health by citing CRC art. 24 on right to health and nutrition; positive discipline is frame as based on child rights to healthy development; includes information on preventing shaking babies and scenarios such as playing near cards and toddlers getting potentially injured; also asks parents to consider why	• FFP: Programme aims to prevent VAC (physical & emotional abuse); implied that it helps prevent family separation, as eligible families will need to have at least one risk factor associated with child placement into residential care (Ruiz-Casares et al., 2019) • PDEP: Emphasizes non-violence repeatedly; cites CRC art. 19; preface indicates that the handbook is a response to the UN World Report on VAC; mentions that positive discipline is based on child rights to healthy development, protection from violence, & participation in	No information*	• PDEP: Supports parents to take into account child views by providing examples of giving warmth to children including looking at the situation from their point of view; providing structure by discussing rules with them and hearing their point of view; nurturing child independence during adolescence by considering their point of view when they feel unfairly treated; positive discipline includes considering how your child thinks and feels (Durrant, 2016) • FFP: Provides direction & guidance relevant to child developmental stages with Session 4 on infancy, 5 on early and late toddlerhood, 6 on preschool & middle childhood, 7

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
	early childhood; discusses opportunities to teach conflict resolution through communication & problem solving, and in context of different developmental stages (Durrant (2016)	developmental stages (Durrant, 2016) • PDEP: Supports adolescent rights by including a scenario in which the parent should discuss the child's risky behaviour; discussion topic around why adolescents do risky things and break rules (Durrant, 2016)	adolescents engage in risky behaviour (Durrant, 2016)	their learning; positive discipline is described as non-violent, solution focused, respectful, and based on child development principles (Durrant, 2016)		on middle childhood, 8 on late childhood & adolescence • PDEP: Supports parents to provide direction & guidance in child-centred way, with content on 'structure' emphasizing dialogue and acting as a positive role model and guide; obtaining long-term parenting goals described as requiring modeling social skills and having the child practice; emphasizes that the way children learn to cope with stress is from watching how parents do it
Parenting on the Move	• Recognizes both mothers and fathers, with guidance that moderators should consult with participants on mixing or separating women and men • Fosters mutual respect by including relaxation activities	• Supports positive & sensitive relationship building with an emphasis on the provision of warmth that respects the child's developmental stages and needs, as well as the provision of structure that reminds the child of	• Supports child rights to play by incorporating a set of cards (POM Games to Go) for parents to use with children • Encourages social activities & learning in a digital environment by mentioning in	• Prevention of VAC is emphasized in Workshop 13 on a Punishment-free Upbringing, which aims for parents to accept that it is possible to raise a child without punishment and to learn to do so; mentions that CRC	• Supports rights during migration with lots of explanation for moderators on challenges facing migrant families; programme was developed in working with 700 Roma families in Serbia, and is	• Supports parents to take into account child views & involvement in decision-making by encouraging them to provide children with enough information needed to make good decisions, and to be fair and flexible (Save the Children, 2021b)

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
	that respect the child's feelings; positive discipline is based on relationship of trust & respect between children & parents • Ways of dealing with family conflict include a positive discipline objective of improving parental understanding of the rights of the child as well as encouraging non-violent and constructive resolutions (Save the Children, 2021b)	the rules of behaviour and gives the child enough information to make good decisions (Save the Children, 2021b)	Workshop 3 on 'Health Care & safety of Children' that it is important for parents to keep up with new technologies, such as safe use of Internet, as well as Workshop 15 on 'Competencies for Lifelong Learning' which mentions encouraging children to learn different technologies • Supports good health by encouraging moderators to maintain the position that corporal punishment is not acceptable from the viewpoint of child rights; Workshops 3 & 4 focus on healthcare, child safety, first aid (Save the Children, 2021b)	emphasizes the need for protection from any kind of violence, exploitation, & neglect • Supports prevention of family separation indirectly by acknowledging that there are increased risks of migrant/refugee child separation from their families and of experiencing harm; provides information for moderators that group sessions can include other adult caretakers, especially where parents & children are separated (Save the Children, 2021b)	intended for families accommodated in collective centres; advocates for the programme to be an integral part of a system of comprehensive support to refugee & migrant families (Save the Children, 2021b)	• Enables involving capacities by emphasizing warmth and structure for child development; objective for Workshop 14 on Everyone Learns in Their Own Way is for parents to understand that children learn in different ways and to see how they can support their learning • Supports provision of dialogue & example by encouraging parents to talk to child often and listen carefully, as well as to be a good role model with their behaviour (Workshop 8 on Psychosocial Wellbeing & Resilience of the Child, Workshop 10 on Helping a Child Cope with Stress)
Program P	• Targets fathers • Promotes respect for diversity with facilitators by	Supports positive & sensitive relationship-building: Session 6 on Caregiving focuses on	• Support for child rights to play in Session 7 through discussion on	• Prevention of violence content in Session 8, which focuses on	No information*	• Enables evolving capacities with handout information in Session 9 on stages

Intervention	Rights-respecting parenting support: Respecting the role of parents & family	Rights-protecting parenting support: Parenting support in the protection of rights				Rights-enabling parenting support: Fulfilling/ promoting child agency
		Supporting needs at different developmental stages	Promoting positive outcomes	Preventing harm & child conflict with the law	Supporting especially vulnerable groups	
	indicating that the programme recognizes many types of families, including same sex parents, single parents, foster parents, extended family, etc. (Promundo et al., 2013) • Fosters mutual respect between children & caregivers, as well as provides ways of dealing with family conflict that are rights respecting, with Session 8 focused on resolving conflict with partners & children, with homework focused on making a promise within the family that there should be respect for everyone's right to disagree (Promundo et al., 2013)	responding to babies with affection and developing an emotional connection; Session 9 on the Needs and Rights of Children – key messages focus on unconditional love, verbal & physical affection, empathy & sensitivity to children's needs; handout for parents on stages of child development (Promundo et al. 2013)	gendered toys and the importance of games and playtime as an important part of life and key to communication with children • Supports good health during infancy by emphasizing the importance of breastfeeding, also includes non-violence messaging with Session 8 focuses on Non-violence including experiences of violence and resolving conflict with partners & children; Session 8 key messages include emphasis that a life free from violence is a human right (Promundo et al. 2013)	Non-violence with an emphasis on IPV but also key messages on the harms of corporal punishment, having 'no excuse for violence', using communication and socio-emotional regulation, modeling non-violent behaviour (Promundo et al. 2013)		of child development and emphasis on understanding what child is capable of during his/her stage of development; information on how to bond with your baby in Session 6 (Promundo et al. 2013)

*Sufficient information on this area has not been provided in the studies, reports, or manuals included in this review.

*ECD = early childhood development

Appendix A4: Guiding Framework - A child rights-based framework for parenting programmes

Child-Centred Parenting Support	Rights-Respecting Parenting Support	Rights-Protecting Parenting Support	Rights-Enabling Parenting Support
Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
Human rights-based Approach (a) A 'holistic' approach in implementing rights under the Convention (b) The principle of universality, indivisibility and interdependence applying to all human rights (GC No 3, para 6; GC No 7, para 3, 10; GC No 14, para 5; GC No 1, para 5, 7)	***Respect for parents and family (arts 5 and 18)*** (a) Role of parents should be fully recognised; and (b) Recognition of the importance of family environment, including members of extended family… (GC No 4, para 7, 15; GC No 7, para 10, 15, 18; GC No 13, para 3(h); GC No 9, para 45) (CO Mozambique 2002, para 40(a), 41[i]; CO El Salvador 2010, para 46[ii]; CO Tuvalu 2013, para 42[iii]; CO Marshall Islands 2007, para 37, 38[iv]; CO Sierra Leone 2000, **para 49[v];** CO Zambia 2003, para 36, 37[vi]) States should recognise their responsibility to support parents (and extended family) in accordance with articles 18 and 5 (DGD 2004, para 17) (CO Guyana 2004, para 33, 34; CO Malaysia 2007, para 50, 51[vii]; CO El Salvador 2010, para 47(c); CO Mongolia 2010, para 41[viii]; CO Nigeria 2005, para 40, 41[ix]; CO Nigeria 2010, para 49[x]; CO Niue 2013, para 32[xi]; CO Nicaragua	***Parenting to protect and support adolescent rights (State obligations)*** (a) Develop and implement, in a manner consistent with adolescents' evolving capacities, policies and programmes to promote the health and development of adolescents - Provide parents with appropriate assistance to support the well-being of adolescents, which includes, parental education and information to facilitate mutual trust in parent-child relationships and more opening in discussions surrounding sexuality, sexual behaviour and risky lifestyles - Education/information on the role of mothers and fathers	***The Principle of Evolving Capacities*** The evolving capacities of the child is an enabling principle that addresses the process of gradual acquisition of competencies, understanding and agency (GC No 25, para 19) Evolving capacities should be seen as a positive and enabling process, not an excuse for authoritarian practices that restrict children's autonomy and self-expression and which have traditionally been justified by pointing to children's relative immaturity and their need for socialization' (GC No. 7, para 17) [Art 5] The child has a right to direction and guidance, which compensates for their lack of knowledge, experience and understanding – the more the child knows, has experienced and understands, the more the parent must transform parental

Child-Centred Parenting Support	Rights-Respecting Parenting Support	Rights-Protecting Parenting Support	Rights-Enabling Parenting Support
Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
	2005, para 36, 37(a), 37(b)[xii]; CO Thailand 2012, para 50; CO Malawi 2002, para 36(a); CO Honduras 2007, para 46(a), 46(b); CO Bhutan 2008, para 40, 41[xiii]; CO Ghana 2015, para 42[xiv]; CO Honduras 2015, para 51, 52; CO Cook Islands 2020, para 32(c)[xv]; CO Tuvalu 2020, para 33[xvi] Parents (and other caregivers) are children's first educators (GC No 7, para 29) - States must provide support to enhance parent's understanding of children's rights – encourage respect for children's dignity - Develop programmes that complement parents' role and focus on parental empowerment and education (GC No 7, para 29) - Consult parents, experts and community members to ensure programmes are age-appropriate and culturally relevant (GC No 7, para 29) (CO Paraguay 2001, para 34(a)[xvii]; CO Guatemala 2010, para 56, 57[xviii]; CO Japan 2010, para 50, 51[xix])	- Respect for local context and cultural norms (GC No 4, para 16) - Involve adolescents in the development of prevention and protection strategies for adolescent violence (GC No 20, para 51)	direction and guidance into reminders and advice and later to an exchange on equal footing (GC No 12, para 84; GC No 20, 18)

Child-Centred Parenting Support	Rights-Respecting Parenting Support	Rights-Protecting Parenting Support	Rights-Enabling Parenting Support
Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
The child as rights-holder (a) Respect the child as a rights-bearing person (GC No 13, para 59; GC No 7, para 5, 14(a)) (b) Respects the dignity, life, survival, well-being, health, development, participation and non-discrimination of the child (GC No 13, para 59; GC No 21, para 10, 11)	***Responsibility of both parents*** (a) CRC emphasizes that 'both parents have common responsibility for the upbringing and development of the child (18.1) - Parental support must be targeted to both mothers *and* fathers; - Men should play a key role in the socialization of children, acting not only as role models but also as **full participants in family life and responsibilities**. (DGD, 2004, para 7) (GC No 4, para 16; GC No. 7, para 19) (CO Solomon Islands 2003, para33(b)[xx]; CO Guyana 2004, para 33[xxi]; CO El Salvador 2010, para 47(a); CO Niue 2013, para 44; CO Sao Tome and Principe 2013, para 39(c)[xxii]; CO Ecuador 2005, para 39, 40[xxiii]; CO Sierra Leone 2000, para 49; CO Malawi 2002, para 35, 36(b)[xxiv]; CO Niger 2002, para 36, 37[xxv]; CO Bhutan 2008, para 41; CO Malawi 2009, para 42(c); CO Niue 2013, para 43, 44[xxvi]; CO Cook Islands 2020, para 32(c); CO Tuvalu 2020, para 33)	***Parenting to support rights in early childhood (State obligations)*** States must provide parental support to create conditions that promote well-being – all aspects of child's early development (GC No 6, para 10) - Improve perinatal care for mothers and babies; - Parental education that affirms the child's status as a rights-holder and fosters respect for the views of the child (GC No 7, para 14(a)(b)(c)) - Assistance will include parenting education, counselling and other carers that supports and encourages **positive and sensitive relationships with young children and enhances understanding of children's rights and best interests** (GC No 7, para 20, 20(c))	***Parenting support to enable evolving capacities* (State obligations)** [Art 5] Parents (and others) should be encouraged to offer 'direction and guidance' in a child-centred way, through dialogue and example, in ways that enhance young children's capacities to exercise their rights…' (GC No 7, para 17) (CO Serbia 2008, para 39(a); CO Sierra Leonne 2000, para 49) [Art 5]States should support parents/caregivers, promoting awareness on the need to 'respect children's evolving autonomy capacities and privacy' (GC No 25, para 21) [Art 5] States should support parents/caregivers balance their responsibilities (to protect) with their role to enable the child's agency, using 'the best interests of the child, and the child's evolving capacities as guiding principles' (GC No 25, para 85) States should take measures to build the capacity of parents and extended family to provide

Child-Centred Parenting Support	Rights-Respecting Parenting Support	Rights-Protecting Parenting Support	Rights-Enabling Parenting Support
Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
			direction and guidance that takes into account the child's view, in accordance with evolving capacities, recognising the child as an active rights whole **who is increasingly able to exercise their rights as they develop, age and mature.** (GC No 21, para 35) (CO Cyprus 2003, para 38[xxvii]; CO Sierra Leone 2000, para 49; CO Oman 2006, para 37(e)[xxviii]
General Principles The general principles provide a lens through which the process of implementation should be viewed. They also act as a guide for determining what measures are needed to guarantee the realization of children's rights under the CRC (GC No 20, para 14) (a) **BEST INTERESTS -** [Art. 3(1)] A rights-based coordinated, multisectoral strategy to ensure children's best interests are always starting point for service planning and provision (b) **RIGHT TO BE HEARD** [Art. 12, 13] Understanding that the child has a right to express her	***Flexible and culturally sensitive approach to family*** (a) **DEF'N of FAMILY -** 'Family' should be understood as a 'variety of arrangements' that include nuclear family, the extended family and other traditional and modern community-based arrangements… (b) **DEF'N of PARENTS/FAMILY** Must be understood within the local context; can be variable and changing in many regions; often include grandparents, siblings and other relatives, guardians, care providers and neighbours'	***Parenting to support rights as a result of migration (State obligations)*** States should provide appropriate assistance to parents and legal guardians in the performance of their child rearing responsibilities (art. 18) - Social benefits, child allowances and other social support services regardless of the migration status of the parents or the child (CO El Salvador 2010, para 47(f), 47(e); CO Sri Lanka 2003, para 30, 31[xl]; CO Ecuador 2005, para 42; CO Philippines 2005, para 44; CO Moldova 2009, para 42, 43; CO	Parenting support should be based on an understanding of the unique parent-child relationship: – Emphasis on mutual empathy and respect over prohibition and control

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Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
views and be consulted in matters affecting her within the family, community and local/national context (c) **NON-DISCRIMINATION** [Art. 2] Monitor and combat discrimination in whatever form it takes and wherever it occurs – within families, communities or society (d) **RIGHT TO DEV** [Art. 6(2)] [Art 18 and 27] Promote the full and harmonious development of the child's personality, talents, mental and physical abilities…	(DGD 1994, CRC/C/34, para 190; DGD 2006, CRC/C/153, para 644, 648; DGD 2001, CRC/C/111, para 701; GC No 7, para 15; GC No 14, para 59; GC No 15, para 78; GC No 21, para 35; GC No 23, para 27; GC No 7, para 19) (CO Nigeria 2005, para 42(b); CO Uganda 2005, para 41, 42(b), 42(c)[xxix]; CO Swaziland 2006, para 38, 39[xxx]; CO Malawi 2009, para 42(c)[xxxi]; CO Guinea-Bissau 2013, para 48, 49(a), 49(b)[xxxii]; CO Dominican Republic 2015, para 39, 40(c)[xxxiii]) [Art 18.2 and 18.3] Assistance to 'parents' will mean appropriate assistance to parents, legal guardians and extended families' in the performance of their child-rearing responsibilities' (GC No 7, para 19, 20) MUST be consistent with other rights under the CRC - 'appropriate leaves no room for the justification of violence of other degrading forms of discipline' (GC No.8, para 28) (CO Moldova 2009, para 42, 43(a), 43(b); CO Niger 2002, para 36, 37; CO Mauritania 2009, para 44, 45[xxxiv]; CO Ghana 2015, para 38(b), 39(b); CO Cote D'Ivoire 2019, para 37(b), 38(b)[xxxv])	Philippines 2009, para 45, 46; CO Thailand 2012, para 49, 50, 55[xli])	

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Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
	[Art 18.1, 18.2] Respecting the values and norms of ethnic and other minorities will require special attention and guidance to those traditions and norms which may differ from broader society (GC No 4, para 16) (CO Uzbekistan 2013, para 32, 33[xxxvi]; CO China 2005, para 44, **45**[xxxvii]; CO China 2013, para 42[xxxviii]; CO Pakistan 2009, para 43, 44[xxxix]		
Implementing Obligations (articles 4 and 42) (a) **AWARENESS/EDUCATION** [Art 42] 'Individuals need to know what children rights are' (GC No 5, para 66) **'If parents and other family members…do not understand the implications of the Convention, and above all its confirmation of the equal status of children as subjects of rights, it is unlikely the rights set out in the convention will be realized** (GC No 5, para 66) - States should ensure that communities, parents and children are aware of the CRC and children's rights principles, and pay greater	***Implementing parenting support in a rights-based, culturally sensitive manner*** Promote parenting education programmes that: - Builds on existing positive behaviours and attitudes – *'complementing the parents' role and developed as far as possible in partnership with parents…*(GC 7, para 29(b)' - Focuses on disseminating information on the rights of the child and the rights of parents under the UNCRC - Encourages parent-child relationships that foster mutual respect between children and their adult carers - Promotes the involvement of children in decision-making (at all ages)	***Parenting to prevent family separation and strengthen family (State obligations)*** States must take active measures to 'restore or enhance the family's capacity to take care of the child' (GC No. 14, para 61) - Comprehensive national policy on families' (material assistance, service plans, social and health services, child-sensitive family counselling, education and housing) (DGD, 2006, para 645) - Provide support, financial and otherwise to assist extended family and communities caring for orphans or children without parental care	

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Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
attention to promoting child rights, and adopting a rights-based approach to childhood programmes (GC No 7, para 31; DGD 2004, CRC/C/SR.979, para 21)	- Educates parents and carers on the importance of respecting, promoting and enabling the evolving capacities of the child for the progressive exercise of rights within the family; - Provides ways of dealing with conflict within the family that are rights-respecting and reflect the CRC; - Ensures parents and primary caregivers understand that their responsibilities must make the child's best interests a basic concern; - Assists parents and other carers to create living conditions and an environment for optimal development (GC No 12, para 88, 93, 94; GC No 7, para 14(a)(b)(c); GC No 7, para 17) (CO Sao Tome and Principe 2013, para 39(d))	(CO Solomon Islands 2003, para 32(a), 33(a); CO Uruguay 2007, para 38, 39[xlii]; CO Serbia 2008, para 38, 39[xliii]; CO Malawi 2009 para 41, 42(b)(c)[xliv]; CO El Salvador 2010, para 46, 47(c), 47(d), 47(e), 47(f);CO Finland 2011, para 31, 32(a), 32(b) 33(c)[2]; CO St Vincent and Grenadines 2002, para 31(a), 31(b)[xlv]; CO Equatorial Guinea 2004, para 36, 37[xlvi]; CO Ecuador 2005, para 41, 42; CO Ecuador, 2010, para 48, 49(a); Philippines 2005, para 45[xlvii]; CO Marshall Islands 2007, para 35, 36; CO Sudan 2002, para 38(a)[xlviii]; CO Nepal 2005, para 49, 50(a)[xlix]; CO Mexico 2006, para 38[l]; CO Suriname 2007, para 38, 39[li]; CO Tanzania 2015, para 49(d)[lii])	
		Parenting to prevent violence within the family (State obligations) Families (including extended families) have the greatest potential	

[2] CRC Committee, Concluding Observations: Finland, 3 August 2011, para 31, 32.

Child-Centred Parenting Support	Rights-Respecting Parenting Support	Rights-Protecting Parenting Support	Rights-Enabling Parenting Support
Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
		to protect children and to prevent violence. Strengthening family life, supporting families and working with families must be a priority child protection activity at every stage of intervention, particularly prevention and early interventions (GC No 13, para 72(d)) States must provide: - Comprehensive awareness raising, guidance and training to parents and other close family members (GC No. 8, para 38) - Guidance and education on positive, non-violent relationships to parents reflecting child rights-based approach (GC No 8, para 46) - Promoting non-violence parenting and education should be built into health, welfare and education services (GC No 8, para 48, 49) - Focus on parental engagement, education and information, rather than punishment (DGD, 2001)	

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Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
		(CO Mongolia 2010, para 41; CO Sudan 2002, para 40(c), 40(d); CO Honduras 2015, para 42[liii]; CO Côte D'Ivoire 2019, para 28(b), 28(c); CO Tuvalu 2020, para 28(b))	
		Parenting to support rights of children with disabilities (State obligations) Parental support to ensure children are cared for by their family - Parental education on disability and its causes - Parental education that recognises the child's unique physical and mental requirements - Parental support that is sensitive to the stress and difficulties for caregivers raising children with disabilities - Parental education that provides material and other forms of support – i.e. sign language - Parental support that educations parents on signs and risks of abuse (GC No 9, para 41) (CO Moldova 2009, para 40, 41[liv]; CO Uzbekistan 2013, para 45, 46[lv])	

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Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
		Parenting to support indigenous child rights (State obligations) Parental support should be 'culturally appropriate' and implemented in a manner that 'safeguards the integrity of indigenous families and communities' by assisting them in their child-rearing responsibilities under articles 3, 5, 18, 25 and 27(3) (GC No 11, para 46) 'States should work with indigenous families to collect data on the family situation…and such information should be used to design policies relating to family environment…in a culturally sensitive way' (GC No 11, para 47) (CO New Zealand 2003, para 42[lvi])	
		Parenting to prevent child offending (State obligations) Parental support should focus on social potential of parents and family in preventing child-offending (GC No 10, para 19) - Training to enhance parent-child interaction - Community and family support through home visitation programmes	

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Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
		- Early childhood education (GC No 10, para 19)	
		Parenting to support child health (State obligations) States should adopt evidence-based interventions to support good parenting, including parenting skills education, support groups and family counselling, in particularly for families experiencing children's health and other social challenges (GC No 15, para 67)	
		Parenting to support children's right to play (State obligations) States should promote awareness and understanding among parents on the centrality of play for children's development (GC Comment No 17, para 18 States should provide guidance on: - How to listen to children while playing - Create environments that facilitate play; - Allow children to play freely with other children; - Encourage creativity, dexterity; - Balance safety with discovery; - Value of play and guided exposure to cultural, artistic and recreational	

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Adopting a child rights-based approach (arts 2, 3(1), 6, 12)	Respecting the role of parents and family in the upbringing of the child (arts 5 and 18)	Protecting the rights of the child through parental support (arts 9, 19, 20, 23, 24, 27, 30, 31)	Promoting/fulfilling child evolving capacities in the exercise of rights (art 5)
		activities (GC No 17, para 56(a))	
- ‘		***Parenting to prevent children ending up in street situations (State obligations)*** - Universal education on child rights and positive parenting that prioritizes (in a non-stigmatizing way) families with children at risk of ending up in street situation. - Prioritize listening to children - Involving children in decision-making - Positive child rearing and discipline - Non-violent conflict resolution and attachment parenting - Parenting to promote early childhood development (GC NO 21, para 48)	
		Parenting in digital environment (State obligations) - Guidance to parents and caregivers should encourage children’s social, creative and learning activities in the digital environment and	

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		emphasise the use of digital technologies should not replace direct, responsive interactions among children themselves or between children and parent/caregivers (GC No 25, para 85)	

[i] CRC Committee, Concluding Observations: Mozambique, 3 April 2002, CRC/C/15/Add. 172, para 40, 41
[ii] CRC Committee, Concluding Observations: El Salvador, 17 February 2010, CRC/C/SLV/CO/3-4, para 46, 47
[iii] CRC Committee, Concluding Observations: Tuvalu, 30 October 2013, CRC/C/TUV/CO/1, para 42
[iv] CRC Committee, Concluding Observations: Marshall Islands, 19 November 2007, CRC/C/MHL/CO/2, para 36, 37, 38, 39
[v] CRC Committee, Concluding Observations: Sierra Leone, 24 February 2000, CRC/C/15/Add.116, para 49
[vi] CRC Committee, Concluding Observations: Zambia, 2 July 2003, CRC/C/15/Add.206, para 36, 38
[vii] CRC Committee, Concluding Observations: Malaysia, 25 June 2007, CRC/C/MYS/CO/1, para 50, 51
[viii] CRC Committee, Concluding Observations: Mongolia, March 2010, CRC/C/MNG/CO/3-4, para 40, 41(a)
[ix] CRC Committee, Concluding Observations: Nigeria, 13 April 2005, CRC/C/15/Add.257, para 40, 41
[x] CRC Committee, Concluding Observations: Nigeria, 21 June 2010, CRC/C/NGA/CO/3-4, para 49
[xi] CRC Committee, Concluding Observations: Niue, CRC/C/NIU/CO/1, 26 June 2013, para 43, 44.
[xii] CRC Committee, Concluding Observations: Nicaragua, 21 September 2005, CRC/C/15/Add.265, para 36, 37(a), 37(b)
[xiii] CRC Committee, Concluding Observations: Bhutan, 8 October 2008, CRC/C/BTN/CO/2, para 40, 41
[xiv] CRC Committee, Concluding Observations: Ghana, 9 June 2015, CRC/C/GHA/CO/3-5, para 37, 38(b), 39, 40(b), 42
[xv] CRC Committee, Concluding Observations: Cook Islands, 2 April 2020, CRC/C/COK/CO/2-5, para 32(c)
[xvi] CRC Committee, Concluding Observations: Tuvalu, 31 March 2020, CRC/C/TUV/CO/2-5, para 28(b), 33
[xvii] CRC Committee, Concluding Observations: Paraguay, 6 November 2001, CRC/C/15/Add.166, para 33
[xviii] CRC Committee, Concluding Observations: Guatemala, 25 October 2010, CRC/C/GTM/CO/3-4, para 56, 57
[xix] CRC Committee, Concluding Observations: Japan, 20 June 2010, CRC/C/JPN/CO/3, para 50, 51
[xx] CRC Committee, Concluding Observations: Solomon Islands, 2 July 2003, CRC/C/15/Add.208, para 32, 33
[xxi] CRC Committee, Concluding Observation: Guyana, 26 February 2004, CRC/C/15/Add.224, para 33, 34
[xxii] CRC Committee, Concluding Observations: Sao Tome and Principe, 29 October 2013, CRC/C/STP/CO/2-4, para 38, 39(b), 39(d)
[xxiii] CRC Committee, Concluding Observations: Ecuador, 13 September 2005, CRC/C/15/Add.262, para 39 – 42; Concluding Observations: Ecuador, 2 March 2010, CRC/C/ECU/CO/4, para 48, 49(a)
[xxiv] CRC Committee, Concluding Observations: Malawi, 2 April 2002, CRC/C/15/Add.174, para 35, 36(a), 36(b)
[xxv] CRC Committee, Concluding Observations: Niger, 13 June 2002, CRC/C/15/Add.179, para 36, 37
[xxvi] CRC Committee, Concluding Observations: Niue, 26 June 2013, CRC/C/NIU/CO/1, para 43, 44
[xxvii] CRC Committee, Concluding Observations: Cyprus, 2 July 2003, CRC/C/15/Add. 205, para 38
[xxviii] CRC Committee, Concluding Observations: Oman, 29 September 2006, CRC/C/OMN/CO/2, para 37(e)
[xxix] CRC Committee, Concluding Observations: Uganda, 23 November 2005, CRC/C/UGA/CO/2, para 42(a), 42(b)
[xxx] CRC Committee, Concluding Observations: Swaziland, 16 October 2006, CRC/C/SWZ/CO/1, para 38, 39, 40(c)
[xxxi] CRC Committee, Concluding Observations: Malawi, 27 March 2009, CRC/C/MWI/CO/2, para 42(b)
[xxxii] CRC Committee, Concluding Observations: Guinea-Bissau, 8 July 2013, CRC/C/GNB/CO/2-4, para 48, 49(a)
[xxxiii] CRC Committee, Concluding Observations: Dominican Republic, 6 March 2015, CRC/C/DOM/CO/3-5, para 39, 40(c)
[xxxiv] CRC Committee, Concluding Observations: Mauritania, 17 June 2009, CRC/C/MRT/CO/2, para 44, 45
[xxxv] CRC Committee, Concluding Observations: Côte d'Ivoire, 12 July 2009, CRC/C/CIV/CO/2, para 37(b), 38(b)
[xxxvi] CRC Committee, Concluding Observations: Uzbekistan, 10 July 2013, CRC/C/UZB/CO/3-4, para 32, 33

[xxxvii] CRC Committee, Concluding Observations: China, 24 November 200
[xxxviii] CRC Committee, Concluding Observations: China, 29 October 2013, CRC/C/CHN/CO/3-4, para 42
[xxxix] CRC Committee, Concluding Observations: Pakistan, 15 October 2009, CRC/C/PAK/CO/3-4, para 43, 44
[xl] CRC Committee, Concluding Observations: Sri Lanka, 2 July 2003, CRC/C/15/Add.207, para 30, 31
[xli] CRC Committee, Concluding Observations: Thailand, 17 February 2012, CRC/C/THA/CO/3-4, para 49, 50, 55
[xlii] CRC Committee, Concluding Observations: Uruguay, 5 July 2007, CRC/C/URY/CO/2, para 38, 39
[xliii] CRC Committee, Concluding Observations: Serbia, 20 June 2008, CRC/C/SRB/CO/1, para 38, 39(a)
[xliv] CRC Committee, Concluding Observations: Malawi, 27 March 2009, CRC/C/MWI/CO/2, para 41, 42(b)(c)
[xlv] CRC Committee, Concluding Observations: St Vincent and Grenadines, 13 June 2002, CRC/C/15/Add.184, para 31(a), 31(b)
[xlvi] CRC Committee, Concluding Observations: Equatorial Guinea, 3 November 2004, CRC/C/15/Add.245, para 36 - 37
[xlvii] CRC Committee Concluding Observations: the Philippines, 21 September 2005, CRC/C/15/Add.259, para 44, 45; Concluding Observations: the Philippines, 22 October 2009, CRC/C/PHL/CO/3-4, para 45, 46
[xlviii] CRC Committee, Concluding Observations: Sudan, 9 October 2002, CRC/C/15/Add.190, para 37, 38
[xlix] CRC Committee, Concluding Observations: Nepal, 21 September 2005, CRC/C/15/Add.261, para 49, 50(a)
[l] CRC Committee, Concluding Observations: Mexico, 8 June 2006, CRC/C/MEX/CO/3, para 38
[li] CRC Committee, Concluding Observations: Suriname, 18 June 2007, CRC/C/SUR/CO/2, para 38, 39
[lii] CRC Committee, Concluding Observations: United Republic of Tanzania, 3 March 2015, CRC/C/TZA/CO/3-5, para 49(d)
[liii] CRC Committee, Concluding Observations: Honduras, 3 July 2015, CRC/C/HND/CO4-5, para 42, 52
[liv] CRC Committee, Concluding Observations: Moldova, 20 February 2009, CRC/C/MDA/CO/3, para 40, 41, 42, 43
[lv] CRC Committee, Concluding Observations: Uzbekistan, 10 July 2013, CRC/C/UZB/CO/3-4, para 45, 46
[lvi] CRC Committee, Concluding Observations: New Zealand, 27 October 2003, CRC/C/15/Add. 216, para 42