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

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

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At present there are no parenting programmes that are both evidence-based and affordable for low- and middle-income countries, where the need is the greatest. Parenting for Lifelong Health⁹ aims to fill this gap. This article sets the context of violence and parenting in low- and middle-income countries, and describes the programmes currently being evaluated in South Africa.

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

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

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

- more likely to be depressed, which tends to result in harsher, more inconsistent parenting (Elder et al., 1995)
- less likely to be affectionate towards and to monitor their children, and more likely to use corporal punishment (Bradley et al., 2001)
- less likely to have the social support that assists better-off parents with their parenting (Duncan et al., 1994).

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

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

Designing and testing programmes

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

There are two prime reasons why programmes may not transfer, especially from high- to low- and middle-income settings. First, cultural differences: a host of factors – including, for instance, language, culture, literacy, poverty, and health and social care delivery systems – may weaken or even cancel out the effects of the programme in the new setting (Mikton, 2012). Second, cost: many evidence-based programmes are proprietary, and are too expensive to roll out at scale in countries where resources are severely limited.

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

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

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

We acknowledge that the reason why many programmes have become proprietary is at least in part to cover the costs of training and supervising those who implement them, and thus to ensure that the programme is implemented with fidelity. If programmes are not implemented so that they are true to the accompanying manual and intentions of the programme, they are likely to be ineffective. This of course presents a problem when materials are freely available, and so our fourth commitment is to develop and seek funding for a group of trainers who can support effective implementation around the world.

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

0–2 years

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

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

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

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

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

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

2–9 years

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

The initial test found improvements in positive parenting behaviour in the group that received the programme, as compared with a group of parents who did not receive the programme. It also achieved high attendance rates (75%), high participant satisfaction, and was found to be culturally acceptable and faithfully implemented by the paraprofessional community facilitators. The programme is now being implemented by our partner, Clowns Without Borders South Africa.

10–17 years

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

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

Future steps

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

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9 More information on Parenting for Lifelong Health is available on the World Health Organization website at: http://www.who.int/violence_injury_prevention/violence/child/plh/en/

10 ‘Thula Sana’ means ‘hush little baby’ in isiXhosa, the primary indigenous African language in the Eastern and Western Cape Provinces.

11 ‘Sinovuyo’ is an isiXhosa word meaning ‘We have happiness’ or ‘We have joy’.