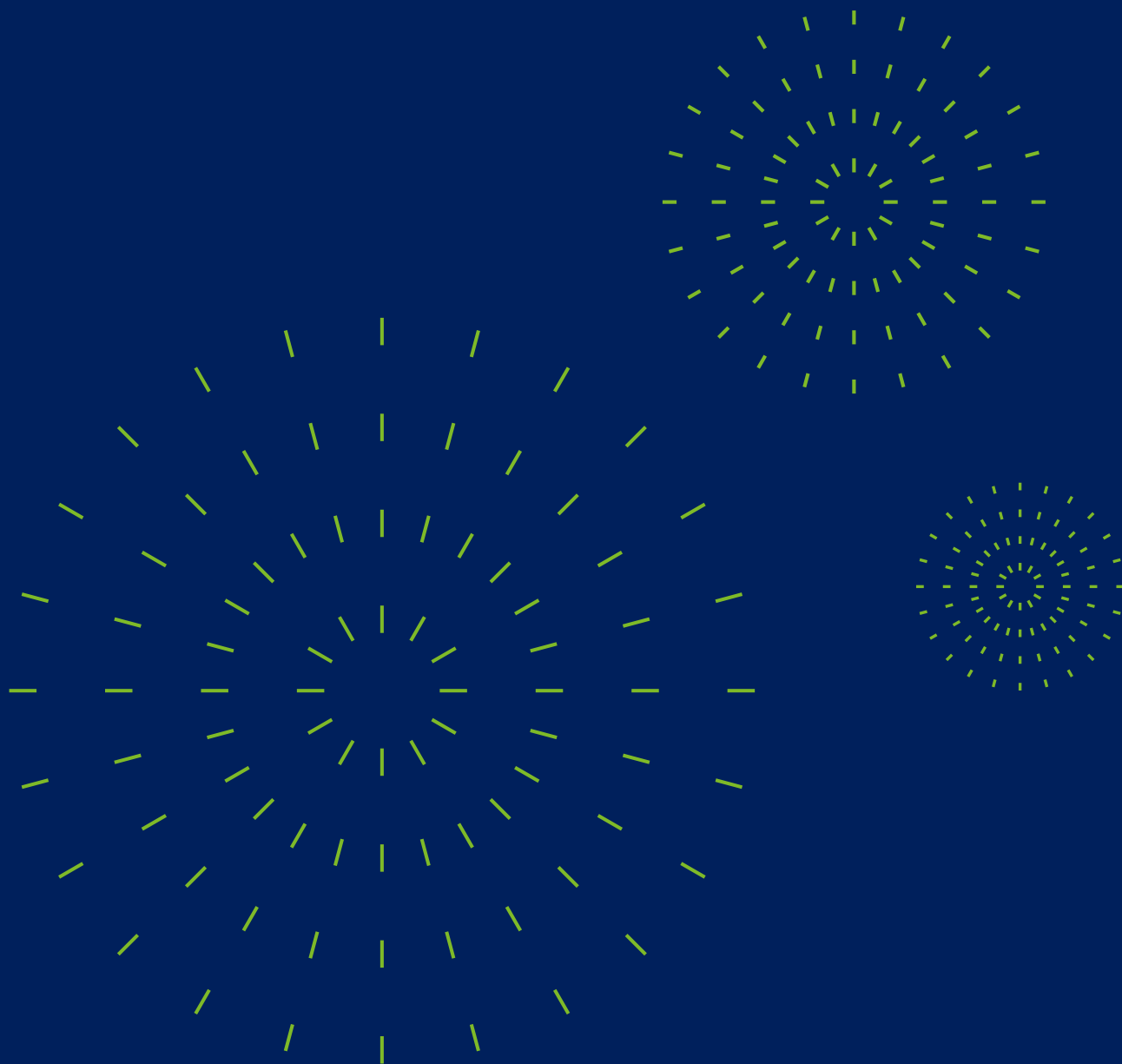# WHO guidelines on parenting interventions to prevent maltreatment and enhance parent–child relationships with children aged 0–17 years

World Health Organization

WHO guidelines on parenting interventions to prevent maltreatment and enhance parent–child relationships with children aged 0–17 years

World Health Organization

Contents

Web annex. GRADE Evidence profiles and evidence to decision tables

(https://apps.who.int/iris/bitstream/handle/10665/365815/9789240065529-eng.pdf)

Acknowledgements

Abbreviations

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CI	confidence interval
ECD	early childhood development
EtD	Evidence-to-Decision
GDG	Guideline Development Group
GRADE	Grading of Recommendations, Assessment, Development, and Evaluation approach
GRC	Guideline Review Committee
NGO	nongovernmental organization
PICO	population intervention comparator outcome question format
SDG	Sustainable Development Goal
SMD	standardized mean difference
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund
VAC	violence against children
WHO	World Health Organization

Glossary

Caregiver: An adult who is responsible for the daily care and support of a child. Primary caregivers include parents, families and other people who are directly responsible for the child at home.

Child maltreatment: The abuse and neglect of children under 18 years of age. It includes all forms of physical and/or emotional ill treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power. The evidence reviews for this guideline include corporal punishment within the category of child maltreatment.

Early child development: Cognitive, physical, language, motor, social and emotional development from 0–8 years of age.

Externalizing behaviour problems: Symptoms of conduct problems such as oppositional or defiant behaviour, or of attention deficit hyperactivity disorder, such as aggressive, noncompliant or challenging behaviours in children.

Harsh parenting: Overreactive, hostile, authoritarian, and abusive parenting.

Internalizing behaviour problems: Child behaviours reflecting a child's emotional or psychological state that typically include anxious, depressive, or withdrawal symptoms, somatic complaints, and, in teenagers, self-directed violence.

Level of prevention: Parenting interventions were classified according to three different prevention levels: indicated, selective, and universal. Indicated interventions are aimed at parents who are referred based on their levels of maltreatment or clinically significant levels of child behaviour problems; selective interventions are aimed at parents based on risk factors for maltreatment or behaviour problems (e.g., poverty); and universal interventions are provided to parents regardless of any maltreatment- or child conduct-related criteria.

Longer-term effects: Defined in the evidence syntheses as intervention effects that remain present beyond 26 weeks post-intervention.

Negative parenting: Parenting behaviours that are either harmful (including maltreatment and harsh parenting), ineffective for behaviour management, or reflect a poor parent–child relationship. Examples of such behaviours are overprotective parenting, poor monitoring, laxness, hostile parenting, and emotional violence.

Parenting: Interactions, behaviours, emotions, knowledge, beliefs, attitudes, and practices associated with the provision of nurturing care.

Parenting interventions: A set of activities or services aimed at improving how parents and caregivers approach and execute their role as parents or caregivers, specifically their parenting knowledge, attitudes, skills, behaviours, and practices.

Parent mental health: Symptoms of depression, anxiety, worry, poor perceived life quality, post-traumatic stress disorder, or stress.

Parenting stress: Perceived stress by parents related to their parenting role.

Positive parenting skills and behaviour: Parenting behaviours that promote a positive parent–child relationship. Examples of such behaviours are appropriate disciplining, praise, warmth, and nurturing behaviours.

Quality of evidence: The Grading of Recommendations, Assessment, Development and Evaluations (GRADE) approach was used to assess the overall quality of evidence. Quality of evidence was based on five criteria: risk of bias, inconsistency, imprecision, indirectness, and publication bias; and was rated as high, moderate, low, or very low.

Randomized controlled trial: A "gold standard" study design for assessing the effectiveness of interventions. Participants are randomly allocated to one or other of the different interventions being studied, and/or a no-intervention control group. Random assignment is done after subjects have consented, and been assessed for eligibility, but before the intervention to be studied begins.

Responsive caregiving: Incorporates anticipatory guidance for safety, education, and development, and the establishment of a caring and understanding relationship with one's child.

Responsiveness: The capacity of the caregiver to respond contingently and appropriately to the child's signals.

Short-term effects: Defined in the evidence syntheses as intervention effects that remain present 4–26 weeks post-intervention.

Violence: The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. Child maltreatment (including violent punishment) is a form of interpersonal violence against children.

Executive summary

Child maltreatment is a global public health problem. It can have detrimental and long-lasting effects on the development and health of children. Preventing child maltreatment has the potential to ensure that hundreds of millions of children can grow up free from exposure to violence and its negative consequences at individual, family, and societal levels. Child maltreatment occurs most frequently in the home at the hands of parents and other caregivers, although it is also prevalent in other settings such as schools and orphanages where children are subject to adult authority. Parenting interventions strengthen the quality of parent–child relationships and help parents and caregivers develop alternatives to violent disciplining.

Purpose of the guideline

This guideline provides evidence-based recommendations on parenting interventions for parents and caregivers of children aged 0–17 years that are designed to reduce child maltreatment and harsh parenting, enhance the parent–child relationship, and prevent poor mental health among parents and emotional and behavioural problems among children.

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Target audience

The guideline is directed at:

- **Relevant government personnel** involved in either establishing parenting programmes or approving the implementation of these by non-state actors. This can include personnel responsible for providing normative guidance and training for programme delivery at the national level, and personnel working at subnational levels (e.g. provincial or municipal).
- **Donors, project developers, programme managers and outcome evaluators from nongovernmental organizations (NGOs), faith-based organizations, and bilateral and multilateral development assistance agencies.**

Guideline development methodology

The recommendations in this guideline were developed using procedures outlined in the *WHO handbook for guideline development (1)*. The steps in this process include (i) identifying key questions and outcomes; (ii) retrieving evidence; (iii) assessing and synthesizing evidence; (iv) formulating recommendations, including research priorities; and planning for (v) dissemination; (vi) implementation, equity and ethical considerations; and (vii) impact evaluation and updating of the guideline. The GRADE methodology *(2)* was followed to prepare evidence profiles related to preselected topics, based on up-to-date systematic reviews and mixed-methods reviews assessing INTEGRATE criteria *(3)*.

The scoping of the guideline and the prioritization of outcomes were carried out by the Guideline Development Group (GDG) in a virtual meeting on 14–17 July 2020. The development and finalization of the evidence-informed recommendations were conducted by the GDG in a virtual meeting on 28–30 March 2022.

Evidence and review process

Evidence to inform the development of the guideline was obtained from four systematic reviews and one narrative review *(4)* that were conducted following the procedures outlined in the *WHO handbook for guideline development (1)*.

The INTEGRATE framework was used by the GDG to inform discussions and decision-making. This included the following considerations: (i) the quality of the evidence across outcomes deemed critical to decision-making; (ii) the balance of benefits and harms; (iii) human rights and sociocultural acceptability; (iv) health equity, equality, and non-discrimination; (v) societal implications; (vi) financial and economic considerations; and (vii) feasibility and health system considerations. Multiple mixed methods reviews on the INTEGRATE criteria were conducted to inform GDG decisions *(5)*.

Recommendations

For the prevention of child maltreatment and to enhance parent–child relationships, and reflecting consensus among GDG members, WHO makes five recommendations for evidence-based parenting interventions.

Recommendation 1. Parenting interventions for parents and caregivers of children aged 2–17 years in low- and middle-income countries

In low- and middle-income countries, evidence-based parenting interventions should be made readily accessible to all parents or caregivers of children aged 2–17 years, in group-based or individualized formats, delivered through a variety of stakeholders, including government organizations such as health, education or social services, and NGOs.

Strength of recommendation: Strong

Quality of evidence: Moderate (for child maltreatment, child externalizing behaviours, child internalizing behaviours, parenting stress); Low (for harsh parenting, positive parenting skills and behaviours, parental mental health).

Recommendation 2. Parenting interventions for parents and caregivers of children aged 2–10 years globally

Globally, evidence-based parenting interventions informed by social learning theory should be made readily accessible to all parents or caregivers of children aged 2–10 years, in group-based or individualized formats, delivered through a variety of stakeholders, including government organizations such as health, education or social services, and NGOs.

Strength of recommendation: Strong

Quality of evidence: Moderate (for child maltreatment and harsh parenting, positive parenting skills and behaviours, child externalizing behaviours, parental mental health); Low (for child internalizing behaviours, parenting stress).

Recommendation 3. Parenting interventions for parents and caregivers of adolescents aged 10–17 years in low- and middle-income countries

In low- and middle-income countries, evidence-based parenting interventions should be made readily accessible to all parents and caregivers of adolescents aged 10–17 years, in group-based or individualized formats that consider the specific needs of adolescents and parents of adolescents, delivered through a variety of stakeholders, including government organizations such as health, education or social services, and NGOs.

Strength of recommendation: Strong

Quality of evidence: Low (for positive parenting skills and behaviours); Very low (for child maltreatment, harsh parenting, child externalizing behaviours, child internalizing behaviours, parental mental health, parenting stress).
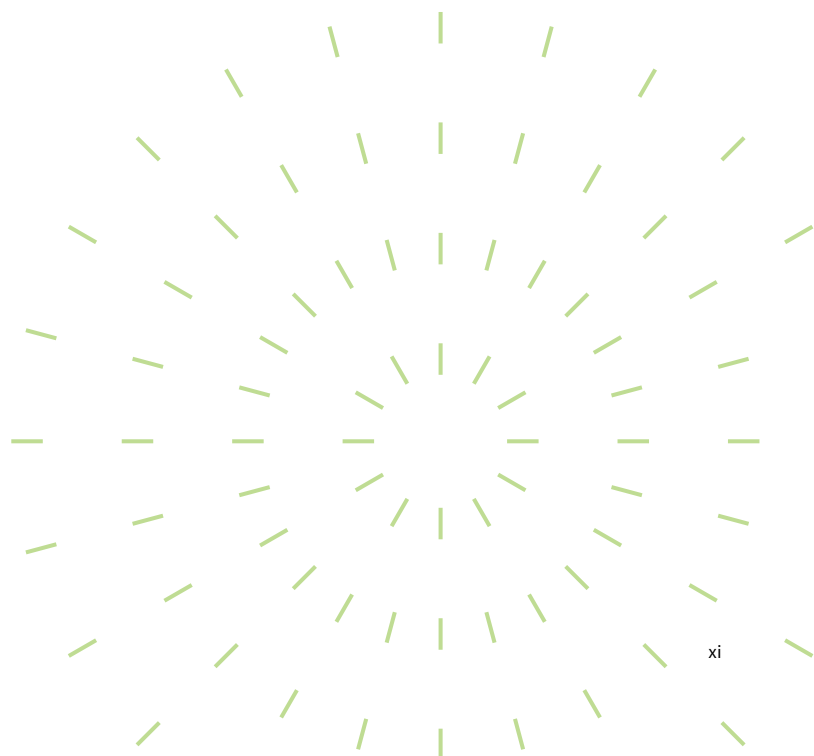
Recommendation 4. Parenting interventions for parents and caregivers of children aged 0–17 years living in humanitarian settings in low- and middle-income countries

In humanitarian settings within low- and middle-income countries, evidence-based parenting interventions or broader evidence-based interventions with a parenting component should be made readily accessible to all parents and caregivers of children aged 0–17 years, in group-based or individualized formats that consider the impact on recipients' mental health.

Strength of recommendation: Strong

Quality of evidence: Moderate (for positive parenting skills and behaviours); Low (for harsh parenting, child internalizing behaviours, parental mental health); Very low (for child maltreatment, child externalizing behaviours, parenting stress).

Recommendation 5. Parenting interventions for parents and caregivers of children aged 0–3 years globally

Following the 2020 publication of *Improving early childhood development: WHO guideline*, to improve early childhood development:

- all infants and children should receive responsive care during the first 3 years of life and parents and other caregivers should be supported to provide responsive care;
- all infants and children should have early learning activities with their parents and other caregivers during the first 3 years of life, and parents and other caregivers should be supported to engage in early learning with their infants and children;
- support for responsive care and early learning should be included as part of interventions for optimal nutrition of infants and young children; and
- psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services.

Strength of recommendation: Strong

Note: This recommendation was previously published in *Improving early childhood development: WHO guideline (6)*.

Research gaps

The GDG identified specific knowledge areas for further research and these are listed on page 40.

Plans for updating the guideline

The WHO Steering Group will continue to follow research developments around parenting interventions to reduce child maltreatment and enhance parent–child relationships. After 5 years, or if significant new evidence emerges sooner or there are concerns that one or more recommendations in the guideline may no longer be valid, relevant WHO departments will coordinate a guideline update.

1. Introduction

Background

Child maltreatment is a global public health problem that can have detrimental and long-lasting effects on the development and health of children. Preventing child maltreatment has the potential to ensure that hundreds of millions of children can grow up free from exposure to violence. This has been recognized by a range of global commitments, notably the United Nations Convention on the Rights of the Child, and the 2030 Agenda for Sustainable Development and its accompanying Sustainable Development Goals (SDGs), which contain targets to end all forms of violence against children and to increase the proportion of children under 5 years of age who are developmentally on track *(7, 8)*.

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Child maltreatment is defined as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" *(9)*, with the clear understanding that all four categories of maltreatment may simultaneously affect the same child. Maltreatment occurs most frequently at home, perpetrated by parents and caregivers, although it is also prevalent in other settings such as schools and orphanages where children are subject to adult authority. Exposure to child maltreatment can have pervasive and long-lasting consequences. These include an increased risk for injuries and disabilities; high-risk behaviours such as smoking, alcohol and drug abuse, and unsafe sex; increased likelihood of involvement in interpersonal and self-directed violence; infectious and noncommunicable diseases; lower reproductive health, and a higher burden of mental health problems *(10)*.

Responsibility for preventing and responding to child maltreatment is shared between government sectors able to influence the underlying causes and risk factors, including education, health, and social protection. For instance, prevention strategies such as providing parent and caregiver support and poverty reduction require organizational inputs and the sharing of resources from several ministries, such as those responsible for health, social development and finance, and frontline health care professionals are often the first point of contact for children who have been exposed to maltreatment.

Parent support in the form of parenting interventions is an important and effective strategy to reduce child maltreatment. However, it should complement rather than substitute for interventions addressing poverty, unemployment, and public health. Parenting interventions are particularly amenable to being implemented across various settings and taken to scale and can be aligned to strategies supporting the SDG agenda *(8, 11)* (see Box 1).

Box 1. Parenting interventions and their contribution to the SDGs

Parenting interventions have the potential to help countries and communities achieve the SDGs and are directly relevant to several SDG targets, most notably: Target 16.2 "End abuse, exploitation, trafficking and all forms of violence against children and torture of children"; Target 4.2 "Provide access to quality early childhood development and care"; Target 5.2 "Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation", and Target 16.1 "Significantly reduce all forms of violence and related death rates everywhere". In addition, the sustained delivery of parenting interventions can advance the achievement of universal social protection systems (Target 1.3), and preventing violence against children through parenting interventions may contribute indirectly towards several other SDG goals, including: the reduction of preventable deaths for children under 5 years (Target 3.2); improved mental health (Target 3.4); and reduced inequalities by providing parenting interventions to families most in need (Target 10.3).

SDG target		How parenting interventions contribute towards SDG target[a]
16.2	End abuse, exploitation, trafficking and all forms of violence against and torture of children.	Parenting interventions reduce harsh parenting and child maltreatment.
16.1	Significantly reduce all forms of violence and related death rates everywhere.	Parenting interventions reduce harsh parenting and child maltreatment.
5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.	Parenting interventions reduce harsh parenting and child maltreatment.
4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.	Parenting interventions have positive effects on child development and parent–child relationships.
1.3	Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.	Parenting interventions can be delivered by social protection systems and reach the most vulnerable families.
3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.	Milder forms of maltreatment can be precursors to severe forms of abuse that may result in death. Parenting interventions can reduce harsh parenting and maltreatment.
3.4	By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.	Parenting interventions reduce the risk for child maltreatment, a known risk factor for noncommunicable diseases. Parenting interventions can improve child and parent mental health.
10.3	Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies, and action in this regard.	Parenting interventions are unlikely to widen social inequalities and instead – by targeting families and children most in need – have the potential to contribute to reduced inequalities of outcome.

[a] Based on underlying evidence reports that informed this guideline *(4, 5)*.

Several WHO guidelines and strategies that refer to the importance of child maltreatment prevention already exist, but this is the first WHO guideline specifically on parent and caregiver support interventions to reduce child maltreatment and enhance parent–child relationships.

Scope

This guideline provides recommendations on parenting interventions to reduce child maltreatment and enhance parent–child relationships. It addresses interventions for parents and caregivers of children aged 0–17 years that are designed to reduce child maltreatment and harsh parenting, enhance parent–child relationships, and prevent poor mental health among parents and emotional and behavioural problems among children. It recommends evidence-based parenting interventions for children and caregivers globally and puts a special emphasis on families living in low- and middle-income countries and other low-resource settings. The guideline acknowledges the complex nature of the interventions themselves, the contexts in which parenting interventions are implemented, and the need for a gender perspective in the development, implementation, and evaluation of such interventions. To this end, data were disaggregated by parent and child gender in the quantitative evidence syntheses. However, since the underlying trials did not disaggregate by gender, only crude indices reflecting the proportion of males and females in the trials were available.

Key questions

Five key questions were developed by the GDG to identify areas for inquiry to inform policy and programme needs of Member States and implementing partners in civil society organizations and development agencies. Each question concerns intervention effectiveness in reducing child maltreatment and enhancing parent–child relationships, and each addresses the specific needs of subpopulations or contexts.

1. What is the effectiveness of parenting interventions for families of children aged 2–17 years living in low- and middle-income countries?

2. What is the effectiveness globally of parenting interventions for families of children aged 2–10 years?

3. What is the effectiveness of parenting interventions for families of adolescents aged 10–17 years living in low- and middle-income countries?

4. What is the effectiveness of parenting interventions for families of children aged 0–17 years living in humanitarian settings in low- and middle-income countries?

5. What is the effectiveness of parenting interventions for families of children aged 0–3 years globally?

Questions were formulated using the population, intervention, comparison, outcome (PICO) format (see Section 3, Recommendations 1–5 for PICO questions).

Population of interest

This guideline focuses on parents and other caregivers of children aged 0–17 years of age.

Interventions of interest

Parenting interventions are structured interventions directed at parents or other caregivers of the child that are designed to improve parent–child interaction and the overall quality of parenting that a child receives. There is usually a focus on parents learning new skills and behaviours to improve the way they relate to their child, although interventions may also address parental knowledge, attitudes, beliefs, and feelings.

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Interventions may target populations that are in need or at risk, or may address the general population. They can be implemented across different contexts and do not assume that formal child protection services are in place. Interventions may be designated by the authors as focusing on reducing child maltreatment or harsh/punitive parenting, improving positive parenting and parent–child relationships, or reducing child behaviour problems. They normally consist of a structured series of sessions, using a range of learning activities, where parents learn to apply parenting principles to their own child and family context, and are set out in manuals that specify the intervention content and procedures. They can be delivered by professional or paraprofessional staff. Interventions may be group-based or individual parent/family-based, may include the children or not, and may be delivered in the home, in community settings, at a centre, or online. They may be combined with other components (e.g., teacher- or child-focused interventions, household economic strengthening).

Defining evidence-based interventions

Evidence-based parenting interventions are interventions that have been shown to be effective and not harmful through rigorous scientific outcome evaluations, including but not limited to randomized controlled trials. While a multitude of parenting interventions exist across the globe, this guideline promotes the implementation of parenting interventions that are based on empirical effectiveness findings.

Essential components of effective parenting interventions

Numerous parenting interventions exist and vary according to their underlying theory (e.g., attachment, self-determination) or their focus (behaviour versus emotion). However, most evidence-based parenting programmes are grounded in relationship perspectives and social learning theory *(12, 13)*. Components of interventions are discrete aspects sometimes delivered in separate sessions that each make a specific contribution to the intervention aims. Parenting interventions usually combine multiple components on parent–child play, praise and reward, and nonviolent alternatives to harsh punishment and maltreating parenting. While the evidence on the effective and essential components of parenting programmes is largely based on research with child problem behaviours as a key outcome, the same programmes with identical components are shown to effectively reduce harsh parenting and child maltreatment and improve parent mental health.

The evidence emphasizes the importance of including skill-building components that help parents to practice the new skills acquired, rather than components that focus on acquisition of information or attitude change alone. It is important to note that adding more parenting components to an intervention does not necessarily translate into higher intervention effectiveness *(14, 15)*.

Effective components with a moderate-to-strong evidence base for reducing child maltreatment, harsh parenting, and child behaviour problems include the following *(14–22)*.

- Nonviolent discipline techniques, including:
  - ignoring negative child behaviours to elicit attention;
  - pointing out natural consequences (i.e., consequences that naturally occur to a child, irrespective of a parent's intervention, such as an object breaking if not handled carefully);
  - applying logical consequences (i.e., consequences imposed by a parent after a child's disruptive or noncompliant behaviour, such as losing privileges);
  - using time-out (i.e., briefly separating a child from the environment where the unacceptable behaviour occurred).
- Positive reinforcement through:
  - praising and rewarding appropriate child behaviours (i.e., reinforcing child behaviour by giving positive attention or privileges to the child).
- Proactive parenting techniques:
  - setting clear family and household rules;
  - monitoring child behaviour (i.e., understanding the lived experiences and environment of children);
  - giving positive and direct commands to children.
- Parental self-management skills such as emotion-regulation, problem-solving, communication and partner/spouse support when delivered in combination with nonviolent discipline techniques.
- Improving the parent–child relationship (particularly for treatment and indicated prevention of child disruptive behaviour problems):
  - child-led play;
  - empathy building.

There is a strong evidence base for time-out as an effective component in reducing children's conduct problems *(16, 18)*. However, time-out is sometimes criticized for potentially disturbing the attachment between parents and children by a parent's withdrawal from the child in times of a child's need for support and soothing. While there is no evidence for iatrogenic or harmful effects of time-out *(23, 24)*, caution is warranted regarding its appropriate implementation *(24)*.
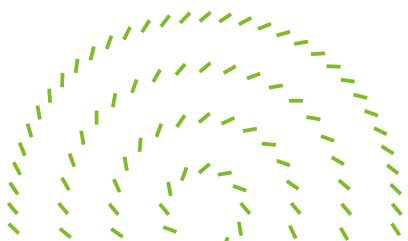
Outcomes of interest

The GDG rated 13 potentially key outcomes by priority. The GRADE evidence profiles and systematic reviews provide detail on the level of available evidence for each outcome and respective questions, and are available in the Web Annex and underlying review reports at https://www.who.int/teams/social-determinants-of-health/violence-prevention/parenting-guidelines (accessed 30 January 2023).

Prioritized outcomes

The following six outcomes were prioritized:

- child maltreatment;
- harsh and negative parenting;
- positive parenting skills and behaviour (subsumes positive parenting skills and behaviour, parental monitoring and supervision, and parent–child relationship and communication);
- child externalizing/behavioural problems (e.g., oppositional, aggressive delinquency, drug use);
- child internalizing problems (e.g., anxiety, depression, post-traumatic symptoms);
- parental mental health and stress.

For the global review of social learning theory-based interventions with parents and caregivers of children aged 2–10 years (Recommendation 2), maltreatment and harsh and negative parenting were combined into a single outcome, whereas for the three low- and middle-income country recommendations (Recommendations 1, 3 and 4), they were presented as two separate outcomes. In practice, the difference is not substantial, since instruments for measuring the two outcomes greatly overlapped *(25)*, and in all reviews harsh and negative parenting were more commonly measured than maltreatment. Moreover, the categories of harsh and negative parenting also included maltreatment.

Additional non-prioritized outcomes

The GDG decided on four additional outcomes that were important but not prioritized in this guideline:

- intimate partner violence;
- parental self-efficacy;
- positive parenting knowledge, attitudes and beliefs;
- parental attitudes towards corporal punishment.

The non-prioritized outcomes did not directly inform the recommendations, and the certainty of evidence was not assessed for these outcomes. Other outcomes that were not addressed in the guideline due to limited available data or because they duplicate *Improving early childhood development: WHO guideline* include:

- the rate of care-seeking;
- child physical health;
- child development.

Target audience

The guideline is directed at:

- **Relevant government personnel**[b] involved in either establishing parenting programmes or approving the implementation of these by non-state actors. This can include personnel responsible for providing normative guidance and training for programme delivery at the national level, and personnel working at subnational levels (e.g. provincial or municipal levels).
- **Donors, project developers, programme managers and outcome evaluators from civil society organizations, faith-based organizations, and bilateral and multilateral development assistance agencies.**

Other relevant WHO guidelines and publications

This global guideline relates to various other WHO recommendations and publications that target parenting, violence prevention, and child development. These include the following resources.

Guideline

Improving early childhood development: WHO guideline (2020)

This guideline stresses the importance of nurturing care. One of the key strong recommendations stresses the importance of responsive caregiving. It recommends that "all infants and children should receive responsive care during the first 3 years of life; parents and other caregivers should be supported to provide responsive care".

Improving early childhood development: WHO guideline. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331306, accessed 24 November 2022).

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[b] The term "government personnel" is used broadly since the ministerial jurisdiction for parenting interventions varies from country to country. In some countries, this may include sectors such as health, social development, and social welfare, but there may be other sectors with jurisdiction such as ministries of community development or of children and women.

Relevant packages and resources

INSPIRE: seven strategies for ending violence against children

INSPIRE is an evidence-based resource for preventing and responding to violence against children and adolescents. It represents a select group of strategies based on the best available evidence to help countries and communities intensify their focus on the prevention programmes and services with the greatest potential to reduce violence against children. The seven strategies are: implementation and enforcement of laws; norms and values; safe environments; parent and caregiver support; income and economic strengthening; response and support services; and education and life skills.

INSPIRE: seven strategies for ending violence against children. Geneva, World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/207717, accessed 24 November 2022).

Nurturing care framework

The Nurturing Care Framework draws on state-of-the-art evidence on how early childhood development unfolds. It sets out the most effective policies and services that will help parents and caregivers provide nurturing care for infants and young children, to enable their healthy growth and development.

Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/272603, accessed 20 January 2023).

mhGAP Evidence resource centre

Parental mental health is known to directly impact childcare practices and can be a risk factor for maltreatment. Parenting programmes can improve the mental health of participating parents. Several WHO recommendations that are relevant for parenting are located in the mhGAP evidence resource centre, available at: https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre.

The mhGAP intervention guide for mental, neurological and substance use disorders in non-specialist health settings

This guide outlines psychosocial interventions for parental mental health that provide for the integrated management of priority mental health conditions using algorithms for clinical decision-making and are for use by doctors, nurses, and other health workers as well as health planners and managers.

mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP). Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/250239, accessed 26 November 2022).

Caregiver skills training for families of children with developmental delays or disabilities

This five-part package provides guidance on caregiver skills training for families of children aged 2–9 years with developmental delays or disabilities. These skills can be used at home to improve their child's engagement in activities and communication, and to promote positive behaviour and skills for daily living.

Caregiver skills training for families of children with developmental delays or disabilities. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240048836, accessed 26 November 2022).

Care for child development: improving the care of young children

These materials guide health workers and other counsellors as they help parents and caregivers build stronger relationships with their children and solve problems in caring for their children at home. The materials recommend play and communication activities for parents and caregivers to stimulate the learning of their children and to help adults learn how to be sensitive to the needs of children and respond appropriately to meet them.

Care for child development: improving the care of young children. Geneva: World Health Organization; 2012 (https://apps.who.int/iris/handle/10665/75149, accessed 26 November 2022).

Caring for the child's healthy growth and development

These materials guide health workers and other providers as they counsel caregivers on infant and young child feeding, responsive caregiving, and opportunities for early learning through play and communication, prevention of childhood illness and timely care-seeking. They are part of a 3-part set entitled *Caring for newborns and children in the community* and are appropriate for use by community health workers.

Caring for the child's healthy growth and development. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/handle/10665/204356, accessed 26 November 2022).

Caring for newborns and children in the community: a training course for community health workers

This training course is part of a WHO-UNICEF package to increase the coverage of household and community interventions to reduce newborn and child mortality, and promote the healthy growth and development of young children. The package consists of three course manuals (*Caring for the newborn at home, Caring for the sick child and Caring for the child's healthy growth and development*) which can be offered separately or in combination.

Caring for newborns and children in the community: a training course for community health workers. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/handle/10665/204273, accessed 26 November 2022).

Responding to child maltreatment: a clinical handbook for health professionals

Only a fraction of child victims of maltreatment ever tell anyone about what happened to them and very few of these children receive the support they need. Health professionals are in a unique position to help the child victims of maltreatment whom they encounter in their day-to-day practice, and can play an important role in mitigating the negative consequences of abuse and neglect and preventing further harm. This resource helps doctors, nurses and other health professionals to identify child maltreatment in their day-to-day practice, communicate safely with children and caregivers about abuse, and learn the necessary skills to respond appropriately to child maltreatment in all its forms.

Responding to child maltreatment: a clinical handbook for health professionals. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/361272, accessed 26 November 2022).

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2. Guideline development process

This guideline was developed in accordance with the evidence-based guideline development methods described in the *WHO handbook for guideline development (1)*. The process included identification of priority questions and outcomes; retrieval, assessment, and synthesis of evidence; formulation of recommendations; and planning for the implementation, dissemination, impact evaluation and updating of the guideline.

WHO Steering Group

The WHO Steering Group included WHO headquarters technical staff from the Violence Prevention Unit in the Social Determinants of Health Department and the Departments of Maternal, Newborn, Child and Adolescent Health, and Ageing; Sexual and Reproductive Health and Research; and Mental Health and Substance Use. The Steering Group also included technical advisers on violence prevention from several WHO regional offices (see Annex 1 for the list of members).

The Steering Group advised on the scope of the guideline; identified individuals to participate as the guideline methodologist and as members of the GDG and the External Review Group; supervised evidence retrieval and synthesis including the GRADE profiles and Evidence-to-Decision tables (EtD tables); organized the GDG meetings; drafted recommendations; and supervised the development of the guideline document. The Steering Group will oversee the dissemination of the guideline.

Guideline Development Group

The GDG was comprised of experts, scientists, members of government ministries, programme implementers, and civil representatives from five WHO regions (see Annex 2 for the list of members). The members prioritized key outcomes; identified the needs for evidence synthesis; reviewed the evidence provided by the evidence synthesis team including the GRADE assessments; reviewed the EtD tables; and finalized the recommendations.

Evidence Synthesis Team

The Centre for Evidence-based Intervention, Department of Social Policy and Intervention, University of Oxford was commissioned to conduct multiple systematic reviews on the effectiveness of parenting interventions relevant to the key questions, and various INTEGRATE reviews about the societal implications of parenting interventions.

The systematic reviews and INTEGRATE reviews were presented at the second GDG meeting (online), 28–30 March 2022. The list of review authors is presented in Annex 3. Three review authors served as GDG members. While the contribution to the evidence reviews by one review author (Catherine Ward) was very minor, the roles of the other two review authors (Sophia Backhaus and Frances Gardner) in guideline development meetings were limited to describing the evidence and assisting other GDG members to understand the EtD Tables.

Guideline methodologists

Two scientists were commissioned to act as methodologists in the guideline development process (see Annex 4). They assisted with the scoping process and formulation of key questions; guided the application of the WHO INTEGRATE framework throughout the guideline development process; provided oversight of systematic reviews and other evidence collection and synthesis methods; supported the application of GRADE in the systematic reviews of effectiveness; assisted in the development of EtD tables; and facilitated the formulation of recommendations through consensus. As active members of the GDG, the guideline methodologists limited their roles to advising on the guideline development process including GRADE ratings and judgement of the strength of recommendations.

Evidence Mapping Team

In preparation for the first WHO GDG meeting, three scientists mapped the available evidence using an "evidence gap map" to provide an overview of the existing evidence base and gaps in evidence on the effects of parenting interventions to reduce child maltreatment (see Annex 5). The map used a PICO framework to identify available and missing evidence from recently published systematic reviews.

Guideline writer

One scientist was commissioned to write the guideline document after the GDG meetings and finalization of the recommendations. The writer was a member of the Evidence Synthesis Team and Evidence Mapping Team and their role in the GDG was limited to describing the evidence and assisting other GDG members in understanding the EtD tables. The writer recused herself from discussions where the recommendations were being debated and from the voting processes.
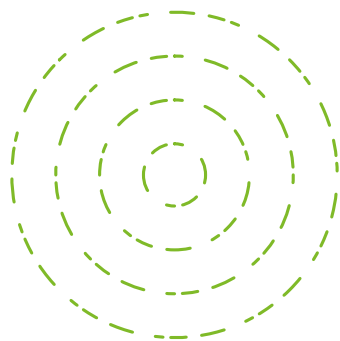
Management of conflicts of interest

The Steering Group, in compliance with the *WHO guidelines for declarations of interests for WHO experts*, managed any potential conflicts of interest (see Annex 8). All potential GDG members were asked to complete and sign the standard WHO declaration of interests and confidentiality undertaking forms. At the meetings, each individual participant verbally stated the interests reported in the written declarations submitted in advance. The group determined that no participant had a conflict of interest that needed management. Potential conflicts of interest for members with multiple roles (i.e., GDG member, Evidence Synthesis Team member, Evidence Mapping Team member, guideline methodologist, guideline writer) were managed by reducing their roles in the GDG to describing the evidence and assisting GDG members to understand the EtD tables and GRADE tables.

Identification of key questions and outcomes

The WHO Secretariat convened a virtual meeting of the GDG in July 2020 to define the scope and content of the proposed guideline, formulate key questions, and determine critical outcomes. The Evidence Gap Maps on parenting intervention effectiveness were reviewed at the meeting.

The GDG agreed on PICO questions about the effectiveness of interventions at universal, selective, and indicated levels of prevention. However, it was not possible to differentiate between these levels in the evidence syntheses as many studies did not clearly define the level of prevention. Consequently, the PICO questions were revised to instead focus on the effectiveness of interventions in five sub-populations:

1. Parents and caregivers of children aged 2–17 years living in low- and middle-income countries;
2. parents and caregivers of children aged 2–10 years globally;
3. parents and caregivers of adolescents aged 10–17 years living in low- and middle-income countries;
4. parents and caregivers of children aged 0–17 years living in humanitarian settings in low- and middle-income countries;
5. parents and caregivers of children aged 0–3 years globally.

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The GDG considered the evidence for each PICO question regarding intervention effectiveness across the different levels of prevention using subgroup analyses with the limited number of studies for which this information was available. The group also acknowledged the importance of parenting support for other populations not specifically listed here, such as parents and caregivers of children with specific vulnerabilities including physical disabilities and cognitive impairment.

Four systematic reviews were conducted to address PICO Questions 1–4 *(4)*. PICO question 5 was initially formulated as: "In families of children aged 0–2 years in low- and middle-income countries, how effective are parenting interventions compared to an inactive or active control condition in improving sensitive parenting, and preventing insensitive, harsh and abusive parenting?" However, on review of the existing *Improving early childhood development: WHO guideline (6)*, it was agreed with the GDG that conducting a new systematic review to answer this question was redundant considering the earlier ECD review and the resulting recommendation on responsive caregiving. It was further agreed that the present guideline would adopt the ECD responsive caregiving recommendation unchanged, and that a narrative review of the literature published after the ECD review (and informed by the initial PICO question) would be conducted to ensure that any new findings on this population would be reflected in the evidence. Accordingly, the evidence reviews for PICO question 5 were driven by the PICO question formulated for the WHO ECD guideline which was: "What is the effectiveness of responsive caregiving interventions in the first 3 years of life on ECD?", supplemented by a narrative review focused on families of children aged 0–2 years in low- and middle-income countries.

The INTEGRATE reviews addressed questions beyond effectiveness by assessing criteria relevant for health decisions and rooted in WHO norms and values *(3)*. The WHO-INTEGRATE Evidence-to-Decision framework guided the development of these reviews that used mixed methods to assess parenting interventions against the following criteria *(5)*:

1. balance of health benefits and harms
2. feasibility and system considerations
3. financial and economic considerations
4. societal implications
5. health equity, equality, and nondiscrimination
6. human rights and sociocultural acceptability
7. societal impact.

Quality assessment and grading of evidence

The results of the systematic reviews of effectiveness were presented to the GDG, along with an assessment of the confidence in the estimates of effect for the prioritized outcomes.

Evidence profiles were prepared according to the GRADE approach in order to assess the overall quality of evidence *(2)*. The evidence for each prioritized outcome was rated as "high", "moderate", "low", or "very low", based on criteria including risk of bias, inconsistency, imprecision, indirectness, and publication bias.

The evidence-retrieval process for the priority questions followed the standard approach outlined in the *WHO handbook for guideline development (1)*, as follows:

1. Commission systematic reviews. The WHO Steering Group reviewed the questions identified and commissioned various systematic reviews. A protocol for each systematic review was developed by expert review teams that included search terms and a strategy according to the inclusion and exclusion criteria for the PICOs defined.

2. Quality assessment of the evidence was performed according to GRADE considering study design, including risk of bias, inconsistency, imprecision, indirectness, and publication bias.

3. Review teams were asked to provide their assessment of the quality of evidence. At the time of the second GDG meeting, GDG members were also asked to indicate their confidence in the evidence based on the criteria in Table 1.

Table 1. Confidence in evidence ratings in guideline process

Quality	Definition	Implications
High	The GDG is very confident that the true effect lies close to that of the estimate of the effect	Further research is very unlikely to change confidence in the estimate of effect
Moderate	The GDG is moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate
Low	Confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the true effect	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate
Very low	The group has very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of the effect	Any estimate of effect is very uncertain

The INTEGRATE reviews and systematic reviews with meta-analyses are available at https://www.who.int/teams/social-determinants-of-health/violence-prevention/parenting-guidelines (accessed 30 January 2023).

Quality of evidence

The overall degree of confidence in the estimates of effect as presented in the GRADE profiles was considered when drafting the recommendations. The higher the quality of evidence across prioritized outcomes that are relevant to decision-making, the higher the likelihood was of a clear positive recommendation – although as outlined below, other factors were considered. The GDG opted for not presenting one overall rating of certainty of evidence across all outcomes for each recommendation but instead argued that it was of greater scientific value to provide the ratings of certainty for each critical outcome separately in each recommendation.

Various factors beyond the quality of evidence served as important criteria for the strength of a recommendation. In accordance with the *WHO handbook for guideline development*, strong recommendations were made when the GDG was confident that the desirable effects of adherence to a recommendation outweighed the undesirable effects. In addition, factors beyond effectiveness as outlined in the INTEGRATE framework impacted the GDG's confidence in the desirable effects of each recommendation.

Managing group processes and decision-making

Two chairpersons were nominated at the opening of the first GDG meeting in July 2020 (online), and the nominations were approved by the GDG. The procedures for decision-making were established at the beginning of the consultation, including a minimal set of rules for agreement and documentation of decision-making. The second GDG meeting on 28–30 March 2022 (online) focused on formulating the recommendations. Deliberations among GDG members took place until consensus was reached. A decision was made that if consensus could not be reached, a positive vote of about two-thirds of the GDG would be required for approval of the proposed recommendation. Decision via vote was needed to decide upon the strength of one recommendation.

The GRADE evidence ratings and EtD tables that informed the recommendations are available in the Web Annex at https://apps.who.int/iris/bitstream/handle/10665/365815/9789240065529-eng.pdf.

The GDG reviewed the EtDs and discussed the draft recommendations taking into consideration: (i) the balance of benefits and harms; (ii) the accordance of parenting interventions with universal human rights standards and principles; (iii) the sociocultural acceptability of parenting interventions to families, delivery staff, key stakeholders, and the general public; (iv) the impact of parenting interventions on health equity, equality, and nondiscrimination; (v) the societal implications of the delivery of parenting interventions; (vi) financial and economic considerations; (vii) feasibility and health system considerations; (viii) quality of evidence informing these criteria. The GDG raised other points for consideration based on their expertise.

Presentation of the recommendations

The five recommendations are presented along with information on:

- the strength of the recommendation
- certainty of evidence for individual outcomes
- justification of the recommendation
- subgroup considerations
- context and system considerations
- implementation considerations
- research priorities specific for the recommendation
- evidence summary table.

After the presentation of each recommendation and accompanying text, the sections present the associated PICO question and a detailed summary of the underlying effectiveness evidence.

Four options for the type of recommendation were agreed upon by the GDG, namely:

1. strong recommendation – the recommendation is based on the confidence that the desirable effects of adherence to the recommendation outweigh the undesirable consequences;

2. context-specific recommendation;

3. research recommendation (evidence is limited and more research is needed);

4. not recommended.

The GDG also reserved the option of making no recommendation.

There is intentional overlap and repetition between the recommendations. This approach was chosen to highlight specific populations, and because feedback from the GDG suggested that many users of this guideline will use each of the recommendations as stand-alone statements. Therefore, repetition of overarching essential information was needed.

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3. Evidence and recommendations

This chapter presents the newly developed WHO recommendations published for the first time in this guideline, alongside one existing recommendation previously published in *Improving early childhood development: WHO guideline (6)*.

The recommendations are based on four systematic reviews addressing key questions on the effectiveness of parenting interventions. One narrative review adds evidence to the existing review for very young children *(26)*. Details of the search strategies, methods, and detailed analyses are given in the reviews *(4, 5)*. The EtD tables (available in Web Annex) provide more detail on the evidence for each recommendation (see Table 2).

Table 2. Evidence that informed each recommendation

Recommendation	Target group	Effectiveness evidence	INTEGRATE evidence
1	Parents and caregivers of children aged 2–17 years living in low- and middle-income countries	Effectiveness review for low- and middle-income countries (131 randomized controlled trials)	• Qualitative perception review (217 studies)
2	Parents and caregivers of children aged 2–10 years, globally	Global effectiveness review (278 randomized controlled trials)	• Human rights review (17 studies) • Review of within-trial moderators (8 studies)
3	Parents and caregivers of adolescents aged 10–17 years living in low- and middle-income countries	Effectiveness reviews for adolescents in low- and middle-income countries (30 randomized controlled trials)	• Review of economic studies (8 reviews/ 7 studies) • Evidence gap map review (76 reviews) • Implementation review
4	Parents and caregivers of children aged 0–17 years living in humanitarian settings in low- and middle-income countries	Humanitarian effectiveness review for low- and middle-income countries (18 randomized controlled trials)	Integrate evidence was largely indirect (drawing on high-income countries or general evidence from low- and middle-income countries) for recommendations 1, 3, 4, 5
5	Parents and caregivers of children aged 0–3 years, globally	• Reviews published for ECD guideline • Updated ECD review	

Recommendation 1

In low- and middle-income countries, evidence-based parenting interventions should be made readily accessible to all parents or caregivers of children aged 2–17 years, in group-based or individualized formats, delivered through a variety of stakeholders, including government organizations such as health, education or social services, and NGOs.

Strength of recommendation

Strong

Certainty of evidence for individual outcomes (all rated as critical):

- Main outcomes of interest
  - Child maltreatment (moderate)
  - Harsh parenting (low)
- Parenting behaviours
  - Positive parenting skills and behaviour (low)
- Downstream effects
  - Child externalizing/behavioural problems (moderate)
  - Child internalizing problems (e.g. anxiety, depression, PTSD, others) (moderate)
  - Parental mental health (low)
  - Parenting stress (moderate)

Note: Information on the certainty of evidence and the process of deciding the strength of the recommendation can be found in the section on Quality of evidence.

Justification

Children aged 2–17 years living in low- and middle-income countries are at elevated risk of maltreatment and associated risk factors and consequences, and have particularly limited access to routinely available parenting interventions that can reduce child maltreatment and enhance parent–child relationships.

Evidence from low- and middle-income countries suggests that parenting interventions are likely effective in reducing child maltreatment and harsh parenting, in improving positive parenting and in reducing child externalizing and internalizing behaviour problems, poor parental mental health and parenting stress, at least in the short term *(4)*, Chapter 2. In addition to a probably positive benefit-harm balance, parenting interventions are probably likely to have overall positive impacts and consequences in respect of human rights and sociocultural acceptability; health equity, equality and nondiscrimination; social, financial, and economic implications; and feasibility and health systems considerations *(5)*, Chapters: 1–7.

These effects of parenting interventions are consistent across a wide range of programme types using group-based and individualized formats and a wide range of service systems, including health, educational and social welfare systems as well as NGOs *(4)*, Chapter 2.

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Subgroup considerations

Low-income or vulnerable families in low- and middle-income countries can be reached by parenting interventions and are likely to obtain good outcomes in terms of reduction in harsh parenting and child behaviour problems. By targeting families, communities, and countries most in need, parenting interventions have good potential for narrowing disparities between groups in child maltreatment and related risks *(4)*, Chapter 2.

Parents and caregivers in low- and middle-income countries may be experiencing additional strains related to household poverty, unemployment, and challenges in ensuring that they and their children have access to adequate health care and education. Special attention must therefore be given to ensuring that, where needed, parenting interventions include provisions that will facilitate parents' participation (e.g. meals, food coupons, payment of transport costs; accessible location and timing) to alleviate household strains and assist with ensuring access to essential services *(5)*, Chapter 2.

The GDG cautioned that in families where serious maltreatment and parent–child conflict is occurring, specialized parenting interventions coupled with child protection service interventions should always be considered to prevent further harms from occurring and mitigate the consequences of previous abuse and neglect.

Context and system considerations

As with other interventions, challenges to scale-up include political will, funding, training, supervision and support of workforce, workforce capacity, maintaining fidelity over time, and finding appropriate systems for governance and sustaining interventions. Although these challenges may apply in every country, they are particularly marked in low- and middle-income countries. Evidence from qualitative studies with staff and managers suggests that staff must be given adequate time and support to prepare and deliver interventions as part of their core duties, and technical support to ensure that intervention fidelity is maintained *(5)*, Chapter 2.

Implementation considerations

Parent and caregiver interventions are likely effective when universally available to all parents and caregivers and when selectively delivered to parents and caregivers at high risk of maltreating their children *(4)*, Chapter 2. There were too few child maltreatment interventions delivered on an indicated basis in low- and middle-income countries to analyse their effects. Effects on positive parenting and child behaviour problem outcomes, however, are likely greater when interventions are delivered on an indicated basis to children showing high levels of problem behaviour. Indicated interventions are similar in content to those delivered on a universal and selective basis, but often have additional components. For example, interventions in response to child maltreatment may include parent mental health and anger management elements over and above routine parenting components, and these interventions are likely to require a higher level of professional skill and training compared to delivery on a universal or selective basis.

Group delivery appears beneficial for sharing problems and solutions with other parents; parents who experienced individualized interventions (such as home visits and phone calls) appreciated the chance for a closer relationship with and tailored help from providers *(5)*, Chapter 2. There are some examples of interventions going to scale in high-income countries, and a smaller number of examples in low- and middle-income countries. Digital and hybrid interventions may help to enhance feasibility at scale *(5)*, Chapter 2.

The GDG noted that parenting interventions should be made available on a long-term, sustainable basis.
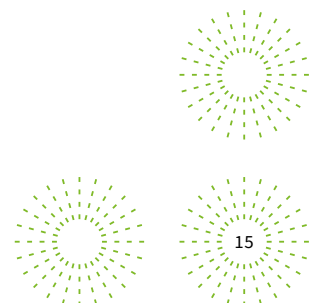
Research priorities

More studies are needed of the long-term outcomes (beyond 6–12 months after the intervention) in low- and middle-income countries; on the involvement of fathers and male caregivers; and on the costs and cost-effectiveness of parenting interventions for parenting and child outcomes. These should include child-reported outcomes about experiences of maltreatment when safe and developmentally appropriate to do so. Implementation research into the feasibility and effectiveness of different approaches to taking parenting interventions to scale in low-resource settings is urgently required, including digital and hybrid interventions for very low-income families. A key consideration is how best to integrate interventions into health, education, and social welfare systems. When conducting and reporting such research, the populations, delivery mechanisms and settings must be clearly specified, and important risks of bias addressed, including intervention developer involvement in effectiveness research, and inadequate allocation concealment.

Table 3. Evidence summary table for Recommendation 1

Outcome	No. of trials	No. of effect sizes	Effect size (Cohen's d)	Confidence interval of effect size	Hetero-geneity (I²)	Certainty of evidence (GRADE)
Prioritized outcomes						
Maltreatment	20	47	-0.39	-0.61, -0.17**	84%	⊕⊕⊕◯ moderate
Physical abuse	13	21	-0.59	-0.92, -0.26**	89%	not rated
Psychological abuse	10	20	-0.26	-0.48, -0.04 *	85%	not rated
Neglect	3	3	-0.15	N/A	27%	not rated
Harsh parenting	44	95	-0.37	-0.54, -0.19**	89%	⊕⊕◯◯ low
Negative parenting	58	207	-0.47	-0.61, -0.32**	90%	not rated
Positive parenting	64	219	0.46	0.29, 0.64**	88%	⊕⊕◯◯ low
Parenting stress	16	23	-0.24	-0.44, -0.03*	72%	⊕⊕⊕◯ moderate
Parent mental health problems	29	55	-0.57	-0.88, -0.27**	90%	⊕⊕◯◯ low
Child emotional-behavioural problems	70	293	-0.62	-0.81, -0.43**	90%	not rated
Child externalizing	54	158	-0.59	-0.80, -0.37**	89%	⊕⊕⊕◯ moderate
Child internalizing	35	90	-0.46	-0.65, -0.27**	84%	⊕⊕⊕◯ moderate

Note: Colour-coding as green = significant effect; blank = non-significant effect; grey = df<4 and untrustworthy results; p-value ranges: 0.05 – 0.01= *, 0.01 – 0.000= **

PICO Question 1

In families of children aged 2–17 years in low- and middle-income countries, how effective are parenting interventions compared to an inactive control:

1. for reducing child maltreatment and harsh parenting?
2. for improving positive parenting behaviours and parental mental health?
3. for reducing negative parenting behaviours and child behavioural and emotional problems?

Summary of evidence for Recommendation 1

Studies in the systematic review on parenting interventions for parents of children and adolescents aged 2–17 years living in low- and middle-income countries (LMIC effectiveness review) took place in 32 different low- and middle-income countries, in all regions of the world. Of the relatively few trials that clearly indicated the level of prevention, 60% were based on selective prevention that targeted parents based on risk for child maltreatment, followed by universal prevention (33%), with very few indicated trials where families were included based on known levels of maltreatment.

Most studies involved group-based parenting interventions (61%), followed by individual-based interventions delivered in a centre or in the home (11%); mixed individual and group (8%); and in-person mixed digital or phone-based interventions (7%). A wide range of interventions was tested largely based on common social learning theory principles. The service system organizing delivery was poorly reported in around half of studies, with the remainder spread between three main delivery systems: health services, schools, or community and other public services. Almost all outcomes were "patient"-reported (normally by parents, plus a few by children) and were mostly assessed soon after the end of the intervention. In the few studies that included longer-term data, most showed sustained effects on maltreatment, but some did not.

Evidence from the LMIC effectiveness review and Qualitative review of perceptions was consistently in the direction of beneficial, rather than harmful, effects. Participants reported valuing similar outcomes to those assessed in the trials; no evidence of harmful effects was found in the few studies addressing non-prioritized outcomes, such as intimate partner violence or child development.

Efficacy/effectiveness

Moderate certainty evidence suggests that, across levels of prevention and in the short term, parenting programmes are likely to reduce child maltreatment (20 trials, 5244 participants, SMD: 0.39 lower, 95% CI 0.61 lower to 0.17 lower); child externalizing outcomes (54 trials, 7987 participants, SMD: 0.59 lower, 95% CI 0.80 lower to 0.37 lower); child internalizing outcomes (35 trials, 5610 participants, SMD: 0.46 lower, 95% CI 0.65 lower to 0.27 lower); and parenting stress (16 trials, 3207 participants, SMD 0.24 lower, 95% CI 0.44 lower to 0.03 lower).

Low-certainty evidence suggests that parenting programmes are likely to reduce harsh parenting (44 trials, 8979 participants, SMD: 0.37 lower, 95% CI 0.54 lower to 0.19 lower); parent mental health problems (29 trials, 5056 participants, SMD: 0.57 lower, 95% CI 0.88 lower to 0.27 lower); as well as probably improve positive parenting (64 trials, 10 976 participants, SMD: 0.46 higher, 95% CI 0.29 higher to 0.64 higher).

In moderator analyses within the LMIC effectiveness review, these findings held across universal, selective, and indicated prevention levels targeting varying levels of risk for maltreatment. Very few programmes in low- and middle-income countries were defined as indicated interventions delivered in response to families identified as perpetrating maltreatment. However, many programmes served communities and parents who reported generally high levels of physical abuse of children. Others targeted families based on levels of child problem behaviour. In moderator analyses, effects on child problem behaviour outcomes were greater in indicated prevention trials, where children showed high levels of problem behaviour, compared to universal or selective programmes. Overall, moderator analyses found no evidence that factors such as poverty, low educational level, child gender, and child or parent age are linked to poorer intervention outcomes.

There were beneficial effects on the non-prioritized outcome of parent self-efficacy (16 trials, SMD: 0.41 higher, 95% CI 0.01 higher to 0.83 higher). A few trials (N= 5) reported a decrease in attitudes supporting corporal punishment (findings were not meta-analysed). Evidence suggests that parenting interventions did not increase or decrease intimate partner violence, although there was borderline evidence of benefit (8 trials; SMD: 0.24 lower, 95% CI 0.50 lower to 0.02 higher).
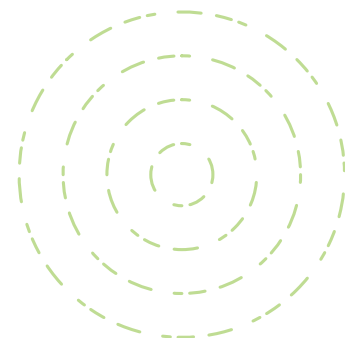
Few studies assessed outcomes beyond the initial post-test assessments, typically 0–3 months after the end of the intervention. Narrative synthesis of studies in the LMIC effectiveness review (n=9) that assessed longer-term outcomes, ranging from 3–14 months post-intervention found that most trials showed sustained effects on maltreatment and harsh parenting; others found that effects had faded.

Population-level outcomes were not assessed; however, it seems unlikely that there would be population-level effects, except where trials aim to change the culture of parenting at community level or reach large proportions of a community. Such effects would be expected to be in the direction of benefit.

Beneficiaries' values

In the studies included in the LMIC effectiveness review, parents report on all outcomes, suggesting their values and opinions feed into trial findings. Moreover, many programmes are designed so that from the outset parents discuss and then set their desired goals for parenting and child behaviour in their family context. In the Qualitative review of perceptions, parents also report valuing the same outcomes as those assessed in the trials. They placed high value on outcomes central to the programmes, including improvements in difficult child behaviours and parent–child relationships. Many also valued the strengthening of spousal and wider family relations; some immigrant parents reported valuing programmes that helped reduce parent–child cultural gaps. Many parents also valued the sense of support they gained from facilitators and other parents.

Adverse effects

No clear evidence of harms was found in the Qualitative review of perceptions, based on participant reactions to taking part in parenting programmes, mainly from high-income countries. Extremely small numbers of parents, in a minority of studies, reported harms from engaging in parenting programmes, such as increasing disagreements between parents about how to raise their child. A few facilitators reported difficulties implementing time-out, although generally reports by parents or staff of difficulties engaging in programmes were very rare, compared to overwhelming reports of benefits from parents and programme delivery staff. From the main effects meta-analyses, and from inspecting the forest plots, there is consistent evidence of beneficial effects.

Broader impact
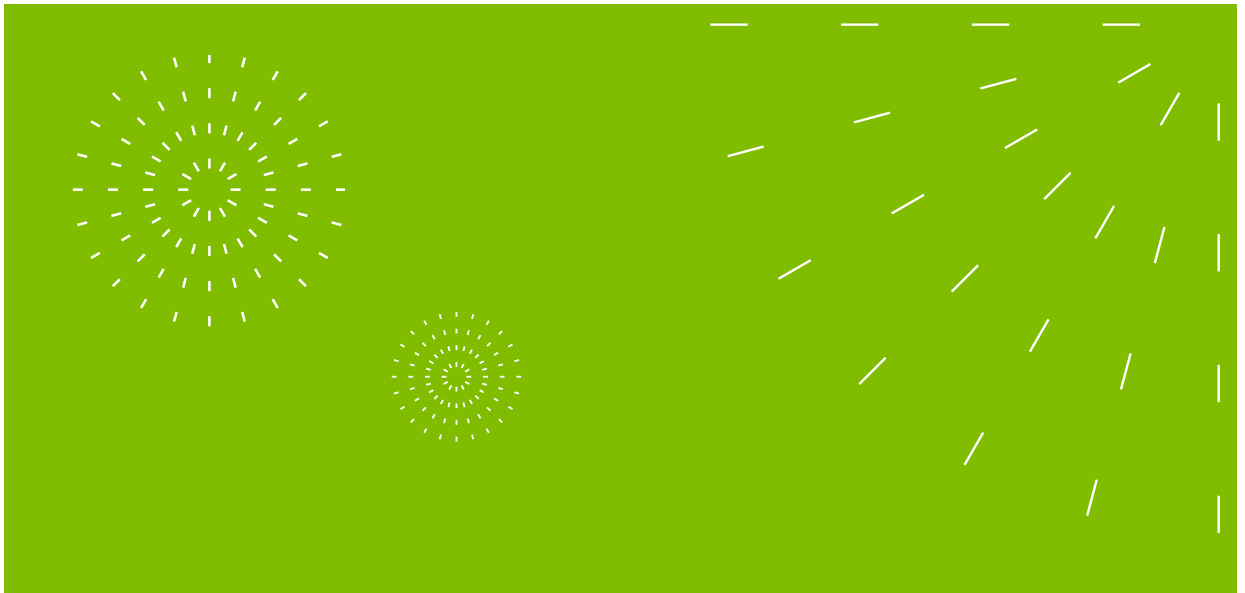
Most trials in the LMIC effectiveness review assessed a range of outcomes, in addition to primary outcomes of parenting and child behaviour. For instance, some programmes showed beneficial effects on parent and child mental health, and, in a much smaller subset of trials, trends towards reductions in intimate partner violence. Some reviews identified by the Evidence gap map review reported benefits for child language and cognitive development in younger children. Studies from the Qualitative review of perceptions mentioned benefits to family harmony and couple relations, and rarely mentioned negative effects on the couple relationship.

Additional information on the underlying evidence can be found in the EtD tables (see Web Annex) and in the evidence reports *(4, 5)*.

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Recommendation 2

Globally, evidence-based parenting interventions informed by social learning theory should be made readily accessible to all parents or caregivers of children aged 2–10 years, in group-based or individualized formats, delivered through a variety of stakeholders, including government organizations such as health, education or social services, and NGOs.

Strength of recommendation

Strong

Certainty of evidence for individual outcomes (all rated as critical):

- Main outcomes of interest
  - Child maltreatment and harsh parenting (moderate)
- Parenting behaviours
  - Positive parenting skills and behaviour (moderate, including longer-term effects)
- Downstream effects
  - Child externalizing/behavioural problems (moderate)
  - Child internalizing problems (e.g., anxiety, depression, PTSD, others) (low)
  - Parental mental health (including longer-term effects) (moderate)
  - Parenting stress (low)

Note: Information on the certainty of evidence and the process of deciding the strength of the recommendation can be found in the section on Quality of evidence.

Justification

There is a key window of opportunity for the prevention of adolescent risk behaviours among children aged 2–10 years – a group vulnerable to certain types of maltreatment, notably physical and emotional abuse, and their associated consequences and risk factors.

This recommendation reflects the evidence from low- and middle-income countries and high-income countries in all world regions that parenting interventions informed by social learning theory for parents and caregivers of children aged 2–10 years are likely effective in reducing child maltreatment and harsh parenting; improving positive parenting; and in reducing poor parental mental health, parenting stress and child externalizing and internalizing behaviour problems, at least in the short term *(4)*, Chapter 3. Beneficial changes in positive and negative parenting were likely sustained in the longer term (6 months to 4 years). In addition to a probably positive benefit-harm balance, parenting interventions are likely to have overall positive impacts and consequences in respect of human rights and sociocultural acceptability; health equity, equality and nondiscrimination; social, financial, and economic implications; and feasibility and health systems considerations *(5)*, Chapters 1–7.

Social learning theory, which combines positive parenting approaches and alternatives to harsh punishment, is the most common and most suitable approach for this age group, when parents are challenged by more disciplinary and conflict-based interactions with their children, compared to in infancy. Depending on the country and intervention specifics, interventions have been successfully delivered in group-based and individualized formats, through government health, educational and social welfare systems, and NGOs *(4)*, Chapter 3.

Subgroup considerations

Very poor and vulnerable families in low- and middle-income countries and high-income countries can be reached by parenting interventions and are likely to experience good outcomes in terms of improvement in parenting practices, as well as reduction in child behaviour problems. By targeting families, communities, and countries most in need, parenting interventions have good potential for narrowing disparities between groups in child maltreatment and related risks *(4)*, Chapter 3.

The GDG cautioned that within families where serious maltreatment and parent–child conflict is occurring, indicated parenting interventions coupled with child protection service interventions should always be considered to prevent further harms from occurring and mitigate the consequences of previous abuse and neglect.

Context and system considerations

Parenting interventions informed by social learning theory are feasible to implement across the globe and can be deployed across contexts with modest cultural and contextual adaptations. As with other interventions, challenges in scale-up include political will, funding, training, supervision and support of workforce, workforce capacity, maintaining fidelity over time, and finding appropriate systems for governance

and for ensuring sustainability. Workforce issues and costs are considerable if interventions are taken to scale in any system. Evidence from qualitative studies with staff and managers suggests that staff must be given adequate time and support to prepare and deliver interventions as part of their core duties, and technical support to ensure that intervention fidelity is maintained *(5)*, Chapter 2.

Implementation considerations

Parent and caregiver interventions are likely to be effective when universally available to all parents and caregivers; when selectively delivered to parents and caregivers at high risk of maltreating their children; and when delivered on an indicated basis to parents and caregivers where maltreatment is already occurring *(4)*, Chapter 3. Moreover, effects on positive parenting and child behaviour outcomes are greater when interventions are delivered on an indicated basis to children showing high levels of behaviour problems. Indicated interventions are similar in parenting content to those delivered on a universal and selective basis, but often have additional components. For example, in maltreatment response interventions there may be trauma-care elements over and above routine parenting components, and they are likely to require a higher level of professional skill and training, compared to delivery on a universal or selective basis.

Group delivery appears beneficial for sharing problems and solutions with other parents, and parents who experienced individualized interventions (such as home visits and phone calls) appreciated the chance for a closer relationship with and tailored help from providers *(5)*, Chapter 2. There are some examples of interventions going to scale in high-income countries, and a smaller number of examples in low- and middle-income countries. Digital and hybrid interventions may help to enhance feasibility at scale *(5)*, Chapter 2.

The GDG noted that parenting interventions should be made available on a long-term, sustainable basis.

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Research priorities

More studies are needed of long-term outcomes beyond 6–12 months after the intervention; on the effectiveness of interventions when delivered by trained lay workers; on the involvement of fathers and male caregivers; on the costs and cost-effectiveness of parenting interventions, particularly for maltreatment prevention outcomes; of the wider social effects of interventions on educational outcomes, social cohesion, and social norms; and of their impact on the economy. Due to mixed findings from various reviews, more research is needed to understand whether programme effectiveness varies according to ethnicity.

Implementation research into the effectiveness of different approaches to taking parenting interventions to scale, including through digital or hybrid delivery, and integrating interventions into health, education, and social welfare systems, including effectiveness research in these real-world settings, is also urgently required. When conducting such research, delivery mechanisms and settings must be clearly specified and important risks of bias addressed, including intervention developer involvement in effectiveness research, and inadequate allocation concealment.

Table 4. Evidence summary table for Recommendation 2

Outcome	No. of trials	No. of effect sizes	Effect size (Cohen's d)	Confidence interval of effect size	Hetero-geneity (I²)	Certainty of evidence (GRADE)
Maltreatment	49	99	-0.34**	-0.47, -0.22	77%	⊕⊕⊕◯ moderate
Physical abuse	26	38	-0.27**	-0.43, -0.12	70%	not rated
Psychological abuse	12	15	-0.40*	-0.72, -0.09	77%	not rated
Neglect	6	13	-0.08†	-0.38, 0.22	67%	not rated
Negative parenting	159	544	-0.46**	-0.54, -0.38	80%	not rated
Positive parenting	131	460	0.49**	0.38, 0.60	85%	⊕⊕⊕◯ moderate
Parenting stress	77	252	-0.34**	-0.43, -0.26	69%	⊕⊕◯◯ low
Parent mental health problems	89	285	-0.24**	-0.30, -0.18	60%	⊕⊕⊕◯ moderate
Child behaviour problems	220	1289	-0.38**	-0.44, -0.31	81%	not rated
Externalizing	211	933	-0.38**	-0.44, -0.31	81%	⊕⊕⊕◯ moderate
Internalizing	72	178	-0.18**	-0.27, -0.09	74%	⊕⊕◯◯ low

Note: Colour-coding as green = significant effect; blank = non-significant effect; grey = df<4 and untrustworthy results; p-value ranges: 0.05 – 0.01= *, 0.01 – 0.000= **, 0.05 – 0.999= †

PICO Question 2

In families of children aged 2–10 years, how effective are parenting interventions based on social learning theory compared to an inactive control condition:

1. for reducing child maltreatment and harsh parenting?
2. for improving positive parenting behaviours and parental mental health?
3. for reducing negative parenting behaviours and child behavioural and emotional problems?

Summary of evidence for Recommendation 2

Studies in the Global effectiveness review (systematic review on parenting interventions for parents of children aged 2–10 years globally) took place in 33 countries, in all regions of the world. Of the relatively few trials that clearly specified the level of prevention, the largest number of studies included parents based on their risk for child maltreatment (selective prevention, 68%), followed by universal prevention (24%), and only 8% included families based on known levels of maltreatment (indicated prevention). Most interventions were delivered in group format (50%), followed by individual sessions (25%), a combination of formats (15%), and self-directed interventions (10%). All interventions were based on principles of social learning theory. Almost all outcomes were "patient"-reported (normally by parents and some by children), mostly assessed at post-test, soon after the end of the intervention. Fifty-four studies reported long-term outcomes, with only a few assessing outcomes beyond 6 months (maximum up to 2 years). Short- and long-term beneficial effects were detected for negative parenting, positive parenting, and parental mental health.

Evidence from the Global effectiveness review, and Qualitative perceptions review was consistently in the direction of beneficial, rather than harmful, effects. Participants reported valuing similar outcomes to those assessed in the trials; no evidence of harmful effects was found in the few studies addressing broader outcomes, such as intimate partner violence or child development.

Efficacy/effectiveness

Moderate certainty evidence suggests that parenting interventions probably reduce child maltreatment, including harsh parenting (49 trials, 5700 participants, SMD: 0.34 lower, 95% CI 0.47 lower to 0.22 lower); parent mental health problems (89 trials, 9459 participants, SMD: 0.24 lower, 95% CI 0.30 lower to 0.18 lower); child externalizing behaviour problems (211 trials, 21 622 participants, SMD: 0.38 lower, 95% CI 0.44 lower to 0.31 lower); and probably improve positive parenting (131 trials, 12 853 participants, SMD: 0.49 upper, 95% CI 0.38 upper to 0.60 upper). Low-certainty evidence suggests that parenting interventions may reduce internalizing behaviour problems (72 trials, 6868 participants, SMD: 0.18 lower, 95% CI 0.27 lower to 0.09 lower); and parenting stress (77 trials, 7023 participants, SMD: 0.34 lower, 95% CI 0.43 lower to 0.26 lower).

In moderator analyses within the Global effectiveness review, these findings were consistent across universal, selective, and indicated prevention programmes, targeting varying level of risk for maltreatment. We note that very few programmes were implemented as indicated prevention with families identified as perpetrating maltreatment. However, many programmes served communities and parents who reported generally high levels of physical abuse of children. Other programmes targeted families based on levels of child problem behaviour. In moderator analyses, effects on positive parenting and child behaviour outcomes were greater in indicated trials, where children showed high levels of problem behaviour, compared to selective programmes. Overall, moderator analyses showed no evidence that factors such as poverty, low educational level, child gender, and parent or child age are linked to poorer intervention outcomes.

Short-term effectiveness

Evidence from a subset of trials with a further 1-6 month follow-up period suggested limited beneficial effects on maltreatment, including harsh parenting (17 trials, SMD: 0.14 lower, 95% CI 0.32 lower to 0.03 upper) and internalizing behaviour problems (29 trials, SMD: 0.05 lower, 95% CI 0.13 lower to 0.03 upper). Clear beneficial effects were found at 1–6 months for positive parenting (41 trials, SMD: 0.27 upper, 95% CI 0.16 upper to 0.37 upper); parenting stress (17 trials, SMD: 0.20 lower, 95% CI 0.36 lower to 0.04 lower); parent mental health (37 trials, SMD 0.16 lower, 95% CI 0.24 lower to 0.09 lower); and externalizing behaviour problems (67 trials, SMD 0.28 lower, 95% CI 0.38 lower to 0.19 lower).

Longer-term effectiveness

Evidence from the subset of trials with a further 6–24 month follow-up period suggested limited beneficial effects on maltreatment and harsh parenting (8 trials, SMD: 0.22 lower, 95% CI 0.47 lower to 0.04 upper); child externalizing and internalizing behaviour problems (33 trials, SMD: 0.06 lower, 95% CI 0.20 lower to 0.08 upper; 10 trials, SMD: 0.04, 95% CI 0.19 lower to 0.10 upper); and parenting stress (10 trials, SMD: 0.08 lower, 95% CI 0.29 lower to 0.14 upper). Clear beneficial effects were found at 6–24 months for positive parenting (27 trials, SMD: 0.26, 95% CI 0.10 upper to 0.42 upper); and parent mental health (12 trials, SMD: 0.11 lower, 95% CI 0.19 lower to 0.02 lower).

There were beneficial effects on the non-prioritized outcome of parent self-efficacy (81 trials, SMD: 0.40 upper, 95% CI: 0.26 upper to 0.53 upper). Two trials reported a decrease in attitudes supporting corporal punishment (findings not meta-analysed), and one trial found decreased violent problem-solving between partners.

Population-level outcomes were not assessed, and just one trial aimed to prevent child maltreatment at the population-level. However, it seems unlikely that there would be population-level effects, except where trials aim to change the culture of parenting at community level or reach large proportions of a community. Such effects would be expected to be in the direction of benefit.

Beneficiaries' values

In the studies included in the Global effectiveness review, parents report on all outcomes, suggesting their values and opinions feed into trial findings. Moreover, many programmes are designed so that from the outset parents discuss and then set their desired goals for parenting and child behaviour in their family context. In the Qualitative perceptions review, parents also report valuing the same outcomes as those assessed in the trials. They emphasized the high value they placed on outcomes central to the programmes, including improvements in difficult child behaviours and parent–child relationships. Many also valued strengthening of spousal and wider family relations; some immigrant parents reported valuing programmes that helped reduce parent–child cultural gaps. Many parents also valued the sense of support they gained from practitioners and other parents.

Adverse effects

No clear or consistent evidence of harms was found in the Qualitative perceptions review on participant reactions to taking part in parenting programmes. Very small numbers of parents in a minority of studies reported harms, such as increasing disagreements about how to raise their child between parents or difficulties engaging in parenting programmes, compared to overwhelming reports of benefits from parents and programme delivery staff. From the main effect meta-analyses of the Global effectiveness review and from inspecting the resulting forest plots, there is consistent evidence of beneficial effects. Eight individual trials of the 278 included in the Global effectiveness review reported potential harms from participating in a parenting intervention, most of which related to less positive and more disruptive child behaviours.

Broader impacts

Most trials in the Global effectiveness review assessed a range of outcomes, in addition to primary outcomes of parenting and child behaviour. Programmes showed beneficial effects on child mental health, and trends towards improving prosocial child behaviours. Some studies identified by the Evidence gap map review reported benefits for child language and cognitive development in younger children. Studies from the Qualitative perceptions review mentioned benefits to family harmony and couple relations, and rarely mentioned negative effects on the couple relationship.

Additional information on the underlying evidence can be found in the EtD tables (Web Annex) and in the evidence reports *(4, 5)*.

Recommendation 3

In low- and middle-income countries, evidence-based parenting interventions should be made readily accessible to all parents and caregivers of adolescents aged 10–17 years, in group-based or individualized formats that consider the specific needs of adolescents and parents of adolescents, delivered through a variety of stakeholders, including government organizations such as health, education or social services, and NGOs.

Strength of recommendation

Strong

Certainty of evidence for individual outcomes (all rated as critical):

- Main outcomes of interest
  - Child maltreatment (very low)
  - Harsh parenting (very low)
- Parenting behaviours
  - Positive parenting skills and behaviour (low)
- Downstream effects
  - Child externalizing/behavioural problems (very low)
  - Child internalizing problems (e.g., anxiety, depression, PTSD, others) (very low)
  - Parental mental health (very low)
  - Parenting stress (very low)

Note: Information on the certainty of evidence and the process of deciding the strength of the recommendation can be found in the section on Quality of evidence.

Justification

Adolescence is an age characterized by increased parent-adolescent conflict, sometimes linked to more autonomous decision-making and risk-taking behaviour. Adolescents are thus considered a particularly vulnerable group to certain types of maltreatment (such as physical, sexual, and emotional abuse) and associated consequences. Adolescents are also particularly prone to a broad range of risk factors (such as unsafe sex, alcohol and drug use), increasing their vulnerability to sexual and physical violence. Caregivers of adolescents therefore often face unique parenting challenges. Nine out of 10 adolescents reside in low- and middle-income countries.

The strong recommendation for interventions specific to parents and caregivers of adolescents is based on the following evidence. First, it reflects the evidence from the LMIC effectiveness review of studies targeting parents and caregivers of adolescents showing that parenting interventions are likely effective in improving positive parenting and reducing overall negative parenting and child externalizing

and internalizing behaviour problems, at least in the short-term *(4)*, Chapter 4. Second, it is reinforced by the strong recommendation derived from the LMIC effectiveness review for interventions to be made readily accessible to all parents and caregivers of children aged 2–17 years, which is inclusive of interventions for adolescents *(4)*, Chapter 2. That review shows parenting interventions are likely to be equally effective for adolescents in reducing child maltreatment and negative parenting, emotional and behavioural problems, and promoting positive parenting, and parent mental health. Third, in addition to a probably positive benefit-harm balance, parenting interventions are likely to have overall positive impacts and consequences in respect of human rights and sociocultural acceptability; health equity, equality and nondiscrimination; social as well as financial and economic implications; and feasibility and health systems considerations *(5)*, Chapters 1–7.

Interventions have been delivered using group-based and individualized formats, through a range of systems, including government organizations such as health, educational and social services, and NGOs *(4)*, Chapters 2, 4.

Subgroup considerations

Very poor and vulnerable families in low- and middle-income countries can be reached by parenting interventions and are likely to experience good outcomes in terms of improvement in parenting practices, as well as reduction in adolescent behaviour problems. By targeting families with adolescents most in need, parenting interventions have the potential to narrow disparities between groups, in maltreatment and related risks *(4)*, Chapters 2, 4.

The GDG cautioned that within families where serious maltreatment and parent-adolescent conflict is occurring, specialized parenting interventions coupled with child/adolescent protection service interventions should always be considered to prevent further harms from occurring and mitigate the consequences of previous abuse and neglect.

Context and system considerations

When designing and delivering interventions for parents of adolescents it is critical to consider neighbourhood- and community-level risk factors which in some low- and middle-income countries may include easy access to drugs, alcohol and weapons, the presence of gangs and organized criminal groups, sexual exploitation (offline and online), and HIV-infection risks. Adolescents are particularly susceptible to such risks, and parents and caregivers participating in adolescent-focused interventions may find it helpful to be offered resources to help them talk with adolescent family members

about alcohol and drug use, violence, the influence of peers, sexual exploitation, and HIV-infection. Facilitating parents' ability to support their adolescents' changing needs, while still helping them provide optimal caregiving, is pivotal in ensuring adolescents' well-being. Including adolescents and increasing the participation of fathers in the intervention activities can, if managed by skilled staff, lead to improved communication and mutual respect.

Systems for delivering parent and caregiver interventions must be accessible and acceptable to parents and adolescents, and have an adequate workforce and organizational capacity to support delivery. Prior to beginning implementation there is a need for careful assessment of organizational readiness, and for advocates or intervention champions at one or more levels in the system (e.g. at policy-maker and donor level, and at delivery level) to help ensure successful implementation and sustainability.

Implementation considerations

Parent and caregiver interventions are likely to be effective when universally accessible by all parents and caregivers and when selectively delivered to parents and caregivers at high risk of maltreating their adolescents *(4)*, Chapters 2, 4. There were too few maltreatment interventions delivered on an indicated basis in low- and middle-income countries to analyse their effects. However, evidence from high-income countries suggests that effects on positive parenting and adolescent behaviour outcomes are greater when interventions are delivered on an indicated basis to adolescents showing high levels of behaviour problems. Indicated interventions are similar in content to those delivered on a universal and selective basis, but often have additional components. For example, in maltreatment response interventions there may be trauma-care elements over and above routine parenting components, and they are likely to require a higher level of professional skill and training compared to delivery on a universal or selective basis.

Evidence from qualitative studies with staff and managers suggests that staff must be given adequate time and support to prepare and deliver interventions as part of their core duties, and technical support to ensure that intervention fidelity is maintained *(5)*, Chapter 2. Strong leadership and support systems can help ensure that these conditions are met. Implementation costs may be reduced if lay health or community workers are employed. Many group-based programmes for this stage of development involve parents and adolescents together in the same groups, meaning that staff may need additional training and support for managing these more challenging group dynamics *(5)*, Chapter 2.

Group delivery appears beneficial for sharing problems and solutions with other parents, and parents who experienced individualized interventions (such as home visits and phone calls) appreciated the chance for a closer relationship with and tailored help from providers *(5)*, Chapter 2. There are some examples of interventions going to scale in high-income countries, and a smaller number of examples in low- and middle-income countries. Digital or hybrid interventions may help to enhance feasibility at scale *(5)*, Chapter 2.

The GDG noted that parenting interventions should be made available on a long-term, sustainable basis.

Research priorities

Given the paucity of studies assessing maltreatment and harsh parenting outcomes, more studies are needed specifically on the effectiveness of parenting interventions in preventing maltreatment and harsh parenting of adolescents in low- and middle-income countries and globally, and on improving the mental health of parents of adolescents. Research on the added value of adapting generic parenting interventions to the specific challenges of parenting adolescents, with attention to the differences between younger adolescents aged 10–14 years, and older adolescents aged 15–17 years, is needed. More studies are also needed that include adolescent self-report outcomes about experiences of maltreatment, when safe and developmentally appropriate to do so. Studies should also assess parenting intervention effects on sexual violence and exploitation of adolescents, adolescent intimate partner violence, alcohol and drug use, and delinquent behaviour and criminal activity; on the involvement of fathers and male caregivers; and on the effectiveness of parenting interventions when delivered by lay workers. There is also a need for research on adolescents' views of the sociocultural acceptability of parenting interventions and the value they ascribe to different outcomes.

Implementation research should focus on strategies to enhance staff training and support, and the sustaining and scaling up of interventions that involve working with parents and adolescents together in the same groups. When conducting evaluation research, the population, delivery mechanisms and settings must be clearly specified, and important risks of bias addressed, including intervention developer involvement in effectiveness research, and inadequate allocation concealment.

Note: The GDG highlighted the need to include adolescents in the evaluation of parenting interventions and to listen to their voices.

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Table 5. Evidence summary table for Recommendation 3

Outcome	No. of trials	No. of effect sizes	Effect size (Cohen's d)	Confidence interval of effect size	Hetero-geneity (I²)	Certainty of evidence (GRADE)
Maltreatment	4	8	-0.33	-0.66, 0.00	81%	⊕○○○ very low
Physical abuse	2	2	-0.91	-2.12, 0.30	78%	not rated
Neglect	1	–	–	–	–	–
Psychological abuse	2	3	-0.05	-2.62, 2.52	73%	not rated
Harsh parenting	7	14	-0.18	-0.72, 0.37	87%	⊕○○○ very low
Negative parenting	11	38	-0.41	-0.77, -0.05*	92%	not rated
Parenting stress	2	3	-0.59	-5.32, 4.15	51%	⊕○○○ very low
Positive parenting	13	68	0.50	0.10, 0.90**	90%	⊕⊕○○ low
Overall adolescent behaviour problems	12	59	-0.72	-1.37, -0.06*	91%	not rated
Externalizing behaviours	9	34	-0.80	-1.76, 0.17	92%	⊕○○○ very low
Internalizing behaviours	5	18	-0.25	-0.73, 0.23	70%	⊕○○○ very low
Parent mental health problems	2	3	-0.51	-1.36, 0.34	72%	⊕○○○ very low

Note: Colour-coding as green = significant effect; blank = non-significant effect; grey = df<4 and untrustworthy results; p-value ranges: 0.05 – 0.01= *, 0.01 – 0.000= **, 0.05 – 0.999= †

PICO Question 3

In families of adolescents aged 10–17 years in low- and middle-income countries, how effective are parenting interventions compared to an inactive or active control condition:

1. for reducing child maltreatment and harsh parenting?
2. for improving positive parenting behaviours and parental mental health?
3. for reducing negative parenting behaviours and child behavioural and emotional problems?

Summary of evidence for Recommendation 3

Studies in the Adolescent effectiveness review on parenting interventions for parents of adolescents aged 10–17 years living in low- and middle-income countries took place in 16 different low- and middle-income countries, in all regions of the world. Most involved group-based parenting interventions (63%), followed by individual-based interventions (17%), and a combination of formats (13%). Many interventions included additional content on effective communication skills, communication about safe sex practices and risky sexual behaviours, and promoting mental health. The service system organizing delivery was poorly reported in half of studies; where reported, the parenting interventions took place in health services, schools, or community or other public settings. Almost all outcomes were "patient"-reported (normally by parents, sometimes by adolescents).

Efficacy/effectiveness

Low-certainty evidence suggests that parenting programmes may improve positive parenting (13 trials, 5052 participants, SMD: 0.50 upper, 95% CI 0.10 upper to 0.90 upper). Because of very low-certainty evidence, it is uncertain whether parenting programmes reduce harsh parenting (7 trials, 1559 participants, SMD: 0.18 lower, 95% CI 0.72 lower to 0.37 upper); negative parenting (11 trials, SMD: 0.41 lower, 95% CI 0.05 lower to 0.77 lower); externalizing adolescent behaviours (9 trials, 1968 participants, SMD: 0.80 lower, 95% CI 1.76 lower to 0.17 higher); internalizing adolescent behaviours (5 trials, 1063 participants, SMD: 0.25 lower, 95% CI 0.72 lower to 0.23 higher); and improve child emotional and behavioural problems (12 trials, SMD: 0.72 lower, 95% CI 0.06 lower to 1.37 lower).

In moderator analyses within the Adolescent effectiveness review, these findings held across universal, selective, and indicated prevention programmes, targeting varying level of risk for maltreatment. We note that very few programmes were implemented as indicated prevention with families identified as perpetrating maltreatment. However, many programmes served communities and parents who reported generally high levels of physical abuse of children. Other programmes targeted families based on levels of child problem behaviour. Overall, moderator analyses showed no evidence that factors such as child gender, and child or parent age are linked to poorer intervention outcomes.

Meta-analyses produced no reliable estimate for maltreatment, parenting stress, and parental mental health due to too few studies reporting on these outcomes. Non-meta-analysed non-prioritized outcomes included intimate partner violence (IPV), parental self-efficacy and parental attitudes to corporal punishment. No trial examined IPV; one trial found an increase in parental self-efficacy; and one found a reduction in attitudes that support corporal punishment following the intervention.

Population-level outcomes were not assessed. However, it seems unlikely that there would be population-level effects, except where trials aim to change the culture of parenting at community level or reach large proportions of a community. Such effects would be expected to be in the direction of benefit.

Beneficiaries' values

In the studies included in the low- and middle-income country Adolescent effectiveness review, parents and/or adolescents report on all outcomes, suggesting their values and opinions feed into trial findings. Moreover, many programmes are designed so that from the outset parents discuss and then set their desired goals for parenting and child behaviour in their family context. In the Qualitative review of perceptions, parents also report valuing the same outcomes as those assessed in the trials. They emphasized the high value they placed on outcomes central to the programmes, including improvements in adolescent difficult behaviours and parent-adolescent relationships. Many also valued strengthening of spousal and wider family relations; some immigrant parents reported valuing programmes that helped reduce parent–child cultural gaps. Many parents also valued the sense of support they gained from practitioners and other parents.

Adverse effects

No clear or consistent evidence of harms was found in the Qualitative review of perceptions, with evidence mainly from high-income countries. Very small numbers of parents in a minority of studies reported harms, such as increasing disagreements about how to raise their child between parents, or difficulties engaging in parenting programmes, compared to overwhelming reports of benefits from parents and programme delivery staff. No harms (and many benefits) were mentioned in the two qualitative studies of the views of parents of adolescents on engaging in programmes in low- and middle-income countries, in Panama and South Africa. From the main effects meta-analyses, and from inspecting the forest plots, there is consistent evidence of effects in the direction of benefit.

Broader impact

Most trials in the effectiveness review assessed a range of outcomes, in addition to primary outcomes of parenting and child behaviour. However, there was insufficient evidence to assess impacts on other outcomes such as adolescent mental health and substance abuse. Studies from the Qualitative review of perceptions mentioned benefits to family harmony and couple relations, and more rarely mentioned negative effects on the couple relationship.
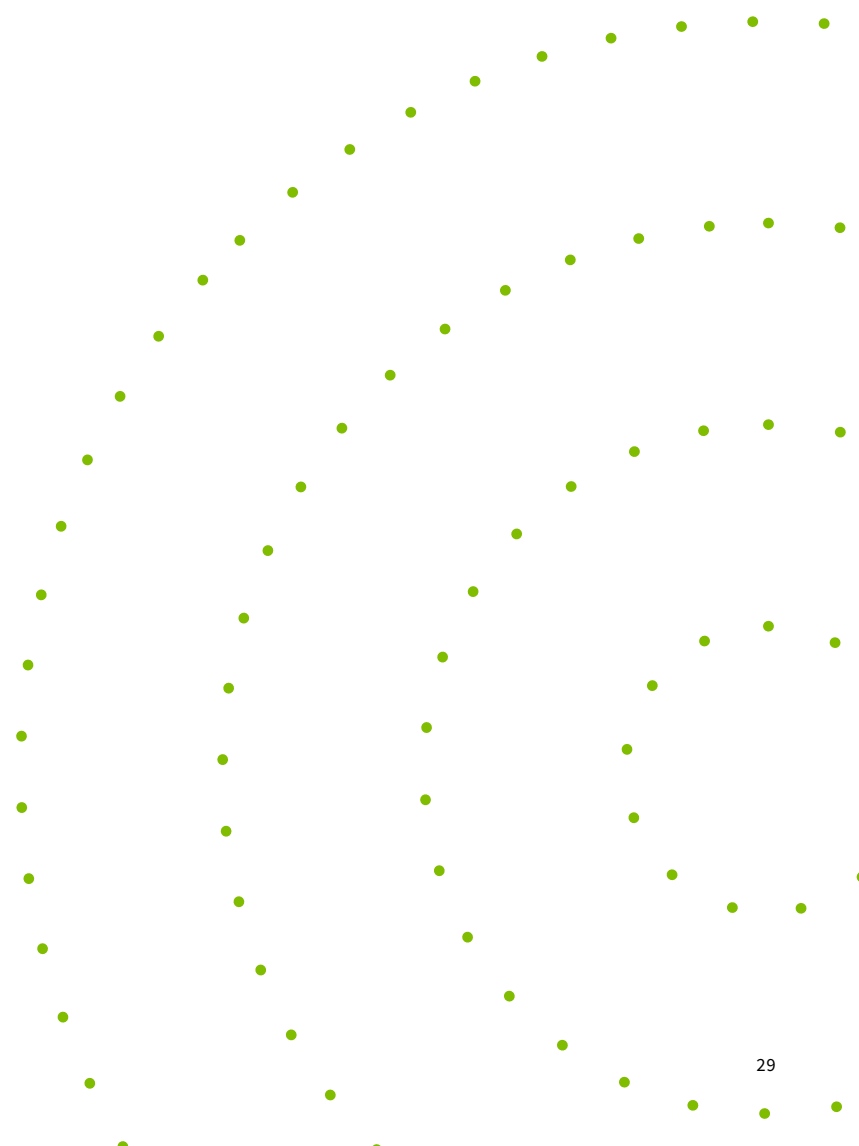
Recommendation 4

In humanitarian settings within low- and middle-income countries, evidence-based parenting interventions or broader evidence-based interventions with a parenting component should be made readily accessible to all parents and caregivers of children aged 0–17 years, in group-based or individualized formats that consider the impact on recipients' mental health.

Strength of recommendation

Strong

Certainty of evidence for individual outcomes (all rated as critical):

- Main outcomes of interest
  – Child maltreatment (very low)
  – Harsh parenting (low)
- Parenting behaviours
  – Positive parenting skills and behaviour (moderate)
- Downstream effects
  – Child externalizing/behavioural problems (very low)
  – Child internalizing problems (e.g., anxiety, depression, PTSD, others) (low)
  – Parental mental health (low)
  – Parenting stress (very low)

Note: Information on the certainty of evidence and the process of deciding the strength of the recommendation can be found in the section on Quality of evidence.

Justification

The objectives of humanitarian action are to save lives, alleviate suffering and maintain human dignity during and in the aftermath of conflict, displacement, and natural disasters, and to strengthen preparedness for the occurrence of such situations. In humanitarian settings formal services are frequently disrupted, and although the family may often be the only remaining system able to nurture and provide care, parenting may be compromised by emotional suffering and exhaustion in the aftermath of emergencies, and a range of additional crisis and re-settlement-related stressors affecting both parents and children.

The strong recommendation for humanitarian settings is based on the following evidence. First, it reflects the evidence from the Low- and middle-income country (LMIC) humanitarian effectiveness review that parenting interventions for parents and caregivers of children aged 0–17 years may be effective for some outcomes in these settings, including reducing harsh parenting and improving positive parenting, at least in the short term *(4)*, Chapter 5. Second, the strong recommendation

from the LMIC effectiveness review for ages 2–17 years is inclusive of interventions for humanitarian settings, and thus reflects relevant evidence for this recommendation *(4)*, Chapter 2. The GDG also noted that several low- and middle-income country trials from non-humanitarian settings that showed parenting interventions are likely to be effective in preventing child maltreatment were conducted in communities with levels of deprivation, social disorganization, or infrastructural breakdown, which bear some resemblance to those in humanitarian settings. This suggests that parenting interventions are likely to be effective across a range of settings, including very low-resource settings, in improving primary outcomes such as reducing child maltreatment and child behavioural problems, and increasing positive parenting. Third, in addition to a probable positive benefit-harm balance, indirect evidence from low- and middle-income countries generally suggests parenting interventions are also likely to have overall positive impacts and consequences in respect of human rights and sociocultural acceptability; health equity, equality and non-discrimination; social, financial, and economic implications; and feasibility and health systems considerations *(5)*, Chapters 1–7.

Subgroup considerations

Very poor and vulnerable families living in humanitarian settings in low- and middle-income countries can be reached by parenting interventions and are likely to experience good outcomes in terms of improvement in parenting practices *(4)*, Chapter 5. Indirect evidence, mainly from other low- and middle-income settings, suggests that by targeting families in humanitarian settings most in need, parenting interventions have the potential to narrow disparities between groups, in maltreatment and related risks *(4)*, Chapter 2.

During prolonged conflicts, displacement, or disasters, even the most caring parents face adversities that are highly likely to impact parent–child interactions. For instance, war-exposed parents have been found to show less warmth and more harshness towards their children. Moreover, parents who are unable to provide the necessary care and seek parenting support often have no or limited access to those services in humanitarian settings. There is also a high likelihood that children, parents and caregivers living in humanitarian contexts may be experiencing traumatic stress reactions, and parenting interventions should therefore be complemented with the provision of trauma-informed psychosocial care and mental health care services where indicated.

While many immigrant and refugee parents and caregivers in low- and middle-income countries and high-income countries have observed that the content of parenting interventions does not conflict with their own cultural values and can aid them in learning about cultural parenting practices in their host countries, careful consideration must nonetheless be given to the sociocultural fit between parenting interventions and those they are intended to benefit.

Context and system considerations

Accessibility of parenting interventions may be hampered by the humanitarian context. While parenting interventions may be easily accessible for families living in camp settings where parenting services are provided by humanitarian staff, it may be a challenge to reach families that are dispersed or living in an armed conflict zone. Additionally, formal health, social welfare and other service delivery systems are likely to be degraded or destroyed, necessitating the delivery of interventions through alternative mechanisms. To ensure that parenting interventions undertaken in these circumstances are integrated into the wider humanitarian effort, their selection, delivery, and monitoring should occur within the framework of established humanitarian coordination platforms. These include local coordination structures linked to the Child Protection Area of Responsibility of the Global Protection Cluster and Mental Health and Psychosocial Support (MHPSS) Technical Working Groups; Minimum Standards for Child Protection in Humanitarian Action, notably standards 10 and 16; and technical guidance provided in the Interagency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings, and the MHPSS Minimum Services Package.

Implementation considerations

The evidence for effectiveness of parenting interventions in humanitarian settings is largely for interventions at a selective level of prevention delivered to parents and caregivers identified as being at elevated risk of maltreatment *(4)*, Chapter 5. Indicated interventions are similar in content to those delivered on a universal and selective basis, but often have additional components. For example, indicated interventions may have trauma-care elements over and above routine parenting components, and they are likely to require a higher level of professional skill and training compared to delivery on a universal or selective basis. Group delivery appears beneficial for sharing problems and solutions, and parents who experienced individualized interventions appreciated the chance for a closer relationship with, and tailored help from, providers. Planning interventions for scale may not be feasible when parenting interventions are delivered rapidly to parents who have recently been affected by an emergency *(5)*, Chapter 2.

Research priorities

More studies are needed on the effectiveness of parenting interventions in humanitarian settings in low- and middle-income countries in preventing child maltreatment. Given the effects of armed conflict and disaster on mental health, other outcomes that should be prioritized for research include child internalizing and externalizing behaviour problems, and parental mental health and parenting stress. More studies are needed with inclusion of self-reported child outcomes about experiences of maltreatment when safe and

developmentally appropriate to do so. Most studies were from conflict zones, rather than natural disasters, and none focused on climate-related disasters due to crop failure, drought, floods, or typhoons. In the context of increasing humanitarian crises due to climate change, future studies in these settings are recommended. Research on the cost-effectiveness of parenting interventions is also needed.

Further research is needed on implementation issues, especially regarding the type and extent of adaptations

needed for humanitarian settings, including critical factors such as length and cost of programmes, integration with other kinds of social and economic support, and training of lay members of refugee communities. When conducting such research, the populations, delivery mechanisms and settings must be clearly specified, and important risks of bias addressed, including intervention developer involvement in effectiveness research, and inadequate allocation concealment.

Table 6. Evidence summary table for Recommendation 4

Outcome	No. of trials	No. of effect sizes	Effect size (Cohen's d)	Confidence interval of effect size	Hetero-geneity (I^2)	Certainty of evidence (GRADE)
Maltreatment	7	28	-0.61†	-1.35, 0.13	95%	⊕◯◯◯ very low
Physical abuse	6	7	-0.72	-1.62, 0.18	95%	not rated
Psychological abuse	3	3	0.02	-0.46, 0.50	56%	not rated
Sexual abuse	2	10	-0.00	-0.33, 0.33	-	not rated
Neglect*	1	1	-	-	-	
Harsh parenting	11	21	-0.50*	-0.96, -0.05	94%	⊕⊕◯◯ low
Negative parenting	12	42	-0.48*	-0.84, -0.12	94%	not rated
Positive parenting	11	35	0.42**	0.17, 0.66	85%	⊕⊕⊕◯ moderate
Parent mental health problems	6	9	-0.41†	-0.96, 0.14	88%	⊕⊕◯◯ low
Parenting stress	2	3	-0.59	-5.32, 4.15	51%	⊕◯◯◯ very low
Child behaviour problems	10	32	-0.39†	-0.83, 0.05	88%	not rated
Externalizing behaviours	8	13	-0.14†	-0.62, 0.35	85%	⊕◯◯◯ very low
Internalizing behaviours	9	16	-0.39†	-0.83, 0.06	86%	⊕⊕◯◯ low

Note: Colour-coding as green = significant effect; blank = non-significant effect; grey = df<4 and untrustworthy results; p-value ranges: 0.05 – 0.01= *, 0.01 – 0.000= **, 0.05 – 0.999= †

PICO Question 4

In families of children aged 0–17 years in humanitarian settings in low- and middle-income countries, how effective are parenting interventions compared to an inactive or active control condition:

1. for reducing child maltreatment and harsh parenting?

2. for improving positive parenting behaviours and parental mental health?

3. for reducing negative parenting behaviours and child behavioural and emotional problems?

Summary of evidence for Recommendation 4

Studies in the Humanitarian effectiveness review on parenting interventions for parents of children and adolescents aged 0–17 years living in humanitarian settings in low- and middle-income countries took place in 14 different low- and middle-income countries, in all regions of the world. Most interventions were tested in post-conflict settings (42%), followed by interventions targeting refugee families (31%), and families living in ongoing conflict or war zones (22%); one study took place in a natural disaster setting (5%). On average, 74% of content of the included interventions addressed parenting, ranging from 20% of parenting components to 100% of content focusing on parenting. Most studies involved group-based parenting interventions (77%), followed by individual-based interventions (17%), and a combination of formats (6%). The service system organizing intervention delivery was poorly reported in around half of studies, with the remainder spread between two delivery systems: health services, or community and other public services.

Most trials (89%) screened parents based on their risk of abuse and maltreatment (selective prevention), and two trials screened parents based on their levels of physical punishment (indicated; 11%). Almost all outcomes were "patient"-reported (normally by parents, sometimes by children), mostly assessed at post-test, soon after the end of the intervention.

Evidence from the Humanitarian effectiveness review, and the Qualitative review of perceptions was consistently in the direction of beneficial, rather than harmful, effects. Participants reported valuing similar outcomes to those assessed in the trials; no evidence of harmful effects was found in the few studies addressing broader outcomes, such as IPV or child development.

Efficacy/effectiveness

Moderate certainty evidence suggests that parenting programmes probably improve positive parenting (12 trials, 3059 participants, SMD: 0.42 upper, 95% CI 0.20 upper to 0.64 upper).

Low-certainty evidence suggests that parenting programmes may reduce harsh parenting (11 trials, 3171 participants, SMD: 0.50 lower, 95% CI 0.96 lower to 0.05 lower) but may make little or no difference to internalizing behaviour problems (9 trials, 1462 participants, SMD: 0.39 lower, 95% CI 0.83 lower to 0.06 upper) and parent mental health problems (9 trials, 1977 participants, SMD: 0.41 lower, 95% CI 0.96 lower to 0.14 upper).

Because of very low-certainty evidence, it is unclear whether parenting programmes reduce child maltreatment (7 trials, 2781 participants, SMD: 0.61 lower, 95% CI 1.35 lower to 0.13 upper) and externalizing behaviour problems (13 trials, 1253 participants, SMD: 0.14 lower, 95% CI 0.62 lower to 0.35 upper). Meta-analyses could not produce a reliable estimate for parenting stress due to too few studies reporting on this outcome.

Non-meta-analysed non-prioritized outcomes included IPV, parental efficacy, and parental attitudes to corporal punishment, suggesting beneficial effects for those outcomes.

Longer-term effects were not assessed.

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Moderation analyses were not run because of the relatively small number of trials. Indirect evidence from the LMIC effectiveness review suggests that effectiveness findings hold across universal, selective, and indicated prevention programmes. In addition, no evidence in other low- or middle-income country settings was found that factors such as poverty, low educational level, child gender, and child or parent age are linked to poorer intervention outcomes.

Beneficiaries' values

In the studies included in the Humanitarian effectiveness review, parents report on all primary outcomes, suggesting their values and opinions feed into trial findings. Moreover, many programmes are designed so that from the outset, parents discuss and then set their desired goals for parenting and child behaviour in their family context. In the Qualitative review of perceptions, parents also report valuing the same outcomes as those assessed in the trials. They emphasized the high value they placed on outcomes central to the programmes, including improvements in difficult child behaviours and parent–child relationships. Many also valued strengthening of spousal and wider family relations; some immigrant parents reported valuing programmes that helped reduce parent–child cultural gaps. Many parents also valued the sense of support they gained from practitioners and other parents.

Adverse effects

No clear or consistent evidence of harms was found in the Qualitative review of perceptions. Very small numbers of parents, in a minority of studies, reported harms, such as increasing disagreements between parents about how to raise their child, or difficulties engaging in parenting programmes, compared to overwhelming reports of benefits from parents and programme delivery staff, including in the very few qualitative studies in humanitarian contexts. It is however noted that this is very indirect evidence as most of the relevant studies were from high-income countries. From the main effect meta-analyses, and from inspecting the forest plots, there is consistent evidence of beneficial effects.

Broader impact

Most trials in the Humanitarian effectiveness review assessed a range of outcomes, in addition to primary outcomes related to parenting and child behaviour. In the Humanitarian effectiveness review, sexual abuse was addressed by two interventions that found mixed effects. However, meta-analyses could not be run due to too few studies assessing sexual abuse, as well as IPV and child mental health. Some reviews identified by the Evidence gap map review of effectiveness reviews reported benefits for child language and cognitive development in younger children. Studies from the Qualitative review of perceptions mentioned benefits to family harmony and couple relations, and more rarely reported negative effects on couple relationships.

Recommendation 5

Following the 2020 *Improving early childhood development: WHO guideline***, to improve early childhood development:**

- **all infants and children should receive responsive care during the first 3 years of life and parents and other caregivers should be supported to provide responsive care;**

- **all infants and children should have early learning activities with their parents and other caregivers during the first 3 years of life and parents and other caregivers should be supported to engage in early learning with their infants and children;**

- **support for responsive care and early learning should be included as part of interventions for optimal nutrition of infants and young children; and**

- **psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services.**

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Strength of recommendation

Strong

Justification

Young children aged 0–3 years are particularly vulnerable to maltreatment and harsh parenting. Parenting interventions for young children teach parents nurturing, nonviolent parenting skills. These skills, newly learned during this critical period, are likely to influence positive parenting behaviours for children of older ages.

Interventions with parents and caregivers of children aged 0–3 years aimed at enhancing ECD are effective globally in improving child cognitive, language, socioemotional and motor development. Strengthening responsive caregiving and opportunities for early learning, through play and communication activities, enhances caregiver sensitivity and responsiveness to the child's needs and cues for care, and promotes positive caregiver-child interactions. Notably, these interventions are effective in enhancing positive parenting practices such as praise, warmth, and appropriate discipline, and improving parent mental health.

While the WHO ECD guideline did not specifically focus on child maltreatment, the recommended interventions and their outcomes are likely to reduce risk factors for child maltreatment and harsh parenting. A large proportion of the evidence reviewed for the WHO ECD guideline directly concerns low- and middle-income countries, with 41 trials studied as part of an update of the review for the guideline conducted in low- and middle-income countries (61 in high-income countries).

Moreover, moderator analyses showed stronger effects in low- and middle-income countries compared to high-income countries for many outcomes *(26)*. Updated searches for the present guideline found a further 11 randomized controlled trials in low- and middle-income countries in the 0–2 years age group. Four of these included harsh parenting or maltreatment outcomes, with two reporting beneficial intervention effects on harsh parenting *(4)*, Chapter 6. Therefore, the ECD recommendations are highly relevant to preventing risk of child maltreatment and are reiterated here.

Considerations and research priorities

Subgroup, context and system, and implementation considerations as stated in the 2020 WHO ECD guideline, are applicable. In addition to the research priorities identified in the 2020 guideline, it is noted that emerging, yet still limited research, focuses on the effectiveness of parenting interventions for parents of very young children to reduce child maltreatment and harsh parenting, and further research on these outcomes is recommended.

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PICO Question 5

PICO question 5 was initially formulated as: "In families of children aged 0–2 years in low- and middle-income countries, how effective are parenting interventions compared to an inactive or active control condition in improving sensitive parenting, and preventing insensitive, harsh and abusive parenting?" However, on review of the existing *Improving early childhood development: WHO guideline (6)*, it was agreed with the GDG that conducting a new systematic review to answer this question was redundant given the earlier ECD review and the resulting recommendation on responsive caregiving. It was further agreed that the present guideline would adopt the ECD responsive caregiving recommendation unchanged, and that a narrative review of the literature published after the ECD review and informed by the initial PICO question would be conducted to ensure that any new findings on this population would be reflected in the evidence. Accordingly, the updated evidence reviews for PICO question 5 were driven by the PICO question formulated for the WHO ECD guideline which was: "What is the effectiveness of responsive caregiving interventions in the first 3 years of life on ECD?", supplemented by a narrative review focused on families of children aged 0–2 years in low- and middle-income countries.

Summary of evidence for Recommendation 5

The global systematic review of parenting interventions aimed at children aged 0–3 years which informed *Improving early childhood development: WHO guideline (6)*, was subsequently expanded with an updated search strategy and additional studies from high-income countries and published in 2021. The largest number of studies were from the South-East Asian Region (n=11), while there were nine studies from the Region of the Americas, eight from the African Region, three from the Western Pacific Region, two from the Eastern Mediterranean Region and one from the European Region. Sample sizes ranged from 44 to 1957, and the mean age of children at baseline ranged from 0 to 27 months. The interventions were delivered to individual parents or parent–child dyads (n=16), to both individuals and groups (n=12) or only to groups (n=6), and most were delivered in homes (n=14) or in a combination of homes, community settings and health settings (n=10). The parenting programmes took place, on average, for 12 months, with the shortest lasting 2 months (n=1), and the longest 24 months (n=4).

Evidence from this effectiveness review *(26)* was unclear for child maltreatment. None of the 40 studies identified by the review assessed effects on child abuse and neglect or other negative parenting outcomes. However, the review identified beneficial effects on outcomes likely to be protective against maltreatment, including parenting knowledge, positive parenting practices and parent–child interaction, and parent depression. Broader, beneficial spill-over effects were found for child socioemotional development. Findings were inconclusive for child behaviour problems. The study ran various moderation analyses and for some outcomes found stronger effects in low- and middle-income countries. Interventions were equally effective for children under and above 1 year of age; for parents participating in short (<12 months) or long (>12 months) interventions; and when delivered individually, in group format, or in a combination of formats, and when delivered in various settings.

For the updated ECD review, additional searches were conducted using search terms described in the LMIC effectiveness review, and 11 further studies were identified. Studies were conducted across three WHO regions: five trials in the African Region from Rwanda (n=3), Ethiopia (n=1) and Zimbabwe (n=1); four trials in the Region of the Americas from Brazil (n=2), Chile (n=1), and Colombia (n=1); and two trials in the Eastern Mediterranean Region from Pakistan (n=2).

Sample sizes ranged from 25 to 1613 participants, and mean age of children at baseline ranged from 1–25 months. The interventions were delivered individually to parents (n=9) or in parent groups (n=2); at home (n=8) or in community or health settings (n=2); (not reported, n=1). The parenting programmes met the parents on average 13.7 times, with the number of intended sessions ranging from 1 to 28 sessions. Interventions were delivered either by lay personnel (n=3), semi-professionals (n=3) or professionals (n=3); unclear (n=2).

Evidence from the updated ECD review showed beneficial effects on violent disciplining for two studies (one of which had no effect at follow-up). One additional study found an effect of an intervention on negative disciplining which also included harsh parenting. One further study measured child maltreatment assessed by social workers. However, no case of abuse or neglect was detected in either group. Most studies observed beneficial effects on positive parenting practices and parent mental health.

Evidence from moderator analyses in the larger LMIC effectiveness review shows that for all outcomes, including maltreatment, effects are similar in the preschool age group (mean age 2–5 years, which has some overlap with the 0–2 years population) as in studies of older children. Across all ages 2–17 years, the data also suggest that effects remained consistent across universal, selective, and indicated prevention programmes, targeting varying levels of risk for maltreatment.

INTEGRATE considerations for Recommendations 1-5

Human rights

Some studies on parenting interventions in low- and middle-income countries and high-income countries made explicit reference to child or human rights concepts. However, many more explicitly teach strategies that follow some of the principles of child rights. For example, most programmes teach alternatives to harsh discipline, and many focus on listening to the child, and following their lead in play. Many take an explicitly respectful and collaborative approach to working with parents, which forms part of their training of delivery staff.

Sociocultural acceptability

Parenting interventions appear to be socially acceptable to parents across a range of communities and to delivery staff across the globe. There are limited data on the sociocultural acceptability of parenting interventions among adolescents or other stakeholder groups, including the general public.

Health equity, equality, and non-discrimination

Overall, there is little or no evidence to show that factors such as poverty, low parent educational level and child age and gender are linked to poorer intervention outcomes. Thus, it is unlikely that parenting programmes would contribute to widening existing inequities. By targeting families, communities, and countries most in need, parenting programmes have good potential for narrowing disparities between groups in maltreatment and related risks, although because poverty predicts lower programme attendance, access is often inequitable, and efforts to further improve accessibility must be intensified.

Societal implications

Very limited direct evidence was found on wider societal effects, such as social cohesion, stigma and norm change at community level. At the family level, it was rare for parents who experienced parenting programmes to view them as potentially stigmatizing. Instead, parents commented on how they valued that those delivering the intervention were non-judgemental, and empathic. Some studies showed evidence that attending a parenting programme could change parents' norms about physical punishment and increase social cohesion for parents meeting in a group format.

Financial and economic considerations

Studies from the LMIC effectiveness review reporting plausible programme costs (n=7) found per-family delivery costs ranging from US$ 30 for a two-session programme in the Islamic Republic of Iran, to US$ 500 for a 14-session programme in South Africa (median US$ 55, at approx. 2015 prices), albeit that estimates were based on a wide range of costing models, contexts, and programme types. Generally, these are lower than programme costs calculated in high-income countries. Studies focused on provider costs, rather than family costs, which include real costs (e.g. for transport), and opportunity costs (e.g. lost earnings or time losses). The cost-effectiveness ratio of parenting programmes in humanitarian settings in low- and middle-income countries may be similar or lower to those in high-income countries. No evidence was found on the impact of parenting interventions on the economy at large.

Feasibility and health system considerations

Parenting interventions have been shown to be feasible to implement in numerous countries, and to be effective in many randomized trials in real-world service settings. There are some examples of interventions going to scale in high-income countries, and a smaller number of examples in low- and middle-income countries. As with other interventions, the literature retrieved documented many challenges in going to scale in several domains, including political will; funding; selection, training, supervision, workforce capacity, support, and retention; maintaining fidelity over time; and selecting and enabling appropriate systems for governance and sustainment of programmes. While these challenges vary hugely by country and setting, opinions expressed in the literature consistently point to the importance of planning for scale from the outset ("beginning with the end in mind").

Detailed INTEGRATE considerations for each recommendation are available in the EtD tables of the Web Annex and the full INTEGRATE review reports at https://www.who.int/teams/social-determinants-of-health/violence-prevention/parenting-guidelines (accessed 30 January 2023).

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4. Research gaps

The GDG identified several areas of insufficient evidence, and the need for further research; these include further evaluation studies across various populations, outcomes, and contexts. Moreover, additional research is needed on several INTEGRATE criteria and delivery characteristics.

Populations

1. Adolescents in low- and middle-income countries: effectiveness of parenting interventions on adolescents in low- and middle-income countries. While the GDG decided on a strong recommendation for this population and setting, it also acknowledged the need for further evidence.

2. Maltreating parents: effectiveness of parenting interventions delivered to parents or caregivers who have already maltreated their children.

3. Families in humanitarian settings: effectiveness of parenting interventions across various humanitarian settings, including health emergencies and natural disasters.

4. Extremely poor families: effectiveness of parenting interventions for families living in extreme poverty.

5. Male caregivers: inclusion of male caregivers in parenting interventions.

Outcomes

1. Prioritization of child maltreatment, including its sub-types, as a key outcome of parenting intervention effectiveness studies.

2. Independent assessments, such as direct observational measures of parenting and child behaviours.

3. Data on the long-term effectiveness of parenting interventions across populations, interventions, and contexts.

4. Inclusion of other caregivers aside from the mother in the collection of response data, including child and adolescent self-reported data (where age appropriate).

5. Improved reporting of baseline characteristics of participants.

6. Increased assessment of IPV as an outcome of intervention effectiveness.

Context

1. Effectiveness evidence from around the world. The GDG identified a lack of randomized trials from various countries and regions (see Fig. 1).

Figure 1. Country status of evaluation studies on parenting intervention effectiveness

Countries with trial evidence

Not applicable

0   1000 2000   4000 km

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: Unpublished sytemtic reviews conducted for WHO guideline on pareting interventions
Map Creation Date: **08 December 2022**
Map Production: WHO GIS Centre for Health, DNA/DDI
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(for a full list of these countries, see *(4)*)

INTEGRATE criteria

1. Improved assessment and reporting of harms and adverse events.

2. A better understanding of whether parenting interventions are in full accordance with human rights standards and principles.

3. Sociocultural acceptability of parenting interventions in low- and middle-income countries, for delivery staff, stakeholders, and the general public.

4. Equity effects for minority ethnic families, especially in low- and middle-income countries.

5. Wider societal effects of parenting interventions, including social cohesion, stigma, and norm change at community level.

6. Enhanced financial and economic considerations of parenting programmes in low- and middle-income countries that include child maltreatment outcomes.

7. Evaluation of parenting interventions in settings feasible for scale-up.

8. Information on all INTEGRATE criteria for families living in humanitarian settings.

Programme delivery

1. A clear understanding of whether the lay workforce is an equally effective delivery agent as professional and semi-professional staff.

5. Adaptation and implementation of the guideline

As this is a global guideline, Member States and other implementing partners are expected to adapt the recommendations according to their settings and to what is feasible within them.

Adaptation considerations

Evidence shows that parenting programmes can be readily adapted across contexts and settings *(27)*. Cultural adaptation may be necessary to ensure high cultural relevance and high levels of engagement and participation satisfaction. However, preserving those essential features that make the interventions effective is crucial and ensures fidelity *(28)*.

Adaptation may include the following steps, as outlined in the INSPIRE framework *(29)*:

- Obtain the original programme materials (usually from the programme developer).
- Develop a programme logic model showing how the programme goals and components are causally linked to the desired changes in the population of interest.
- Identify the programme's core components or, where they are not yet known, its best-practice characteristics, which usually involves carefully reviewing relevant scientific literature.
- Identify and categorize any mismatches between the original programme model and the new context.
- If needed, the original programme should be adapted to meet the needs of the new context while preserving its fidelity.
- The original programme materials should be modified with the goal of reducing mismatches.

Acceptable adaptations include:

- translating materials into local languages and altering vocabulary;
- modifying images so that children and adults resemble the target audience;
- replacing cultural references;
- changing aspects of activities such as physical contact to be in line with local norms;
- adding local evidence-based content to increase the relevance and appeal to participants.

Risky and generally unacceptable adaptations include:

- reducing how long participants are involved in the programme, for instance by cutting down the number or length of sessions;
- cutting out key messages or skills that must be learned;
- removing topics;
- altering the theoretical approach;
- trying to implement the programme with inadequately trained staff or volunteers;
- using fewer than the recommended number of staff.

Implementation considerations

The INSPIRE package *(29)* illustrates various implementation considerations. While the steps are not sequential, they provide clear guidance for operationalizing this guideline (see Fig. 2).

Figure 2. Steps for adapting and implementing this guideline
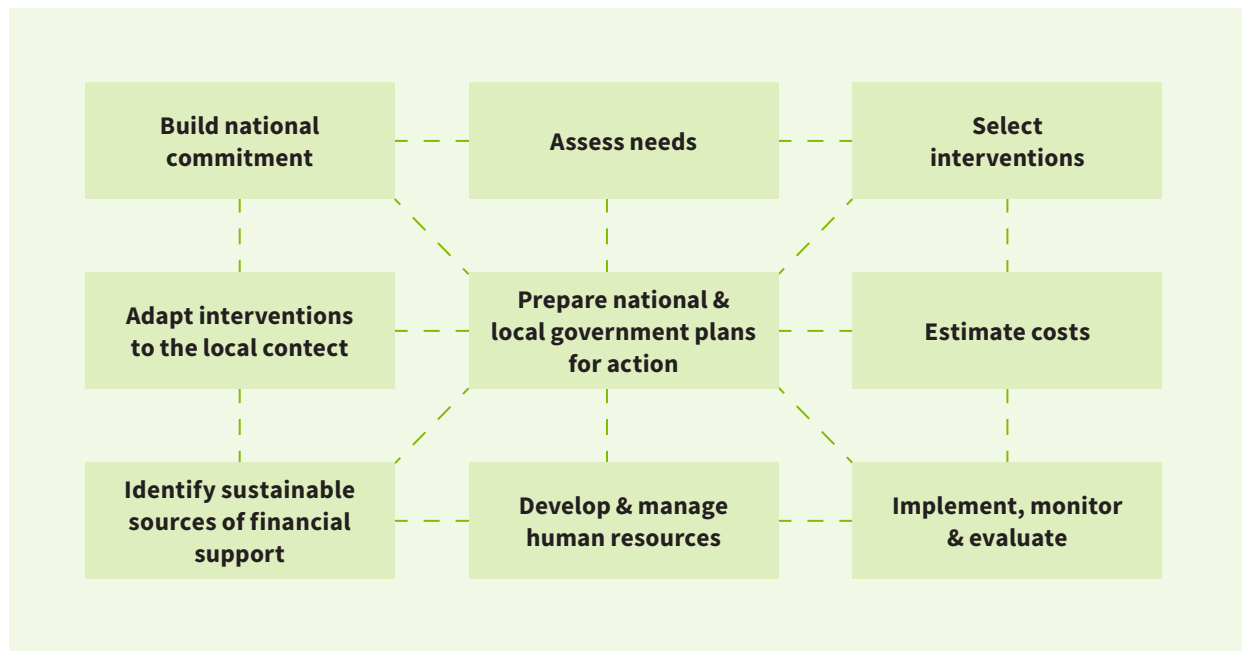
Build national commitment

- Raise awareness among all stakeholders of the magnitude and consequences of child maltreatment and the evidence base of parenting interventions to address it.
- Ensure collaboration and commitment within each main sector involved in the implementation. For parenting interventions, these will likely be the health, social protection, and educational sectors.
- Establish task forces dedicated to initiating the scale-up of parenting interventions.
- Align parenting intervention scalability efforts with pre-existing national action plans, strategies, and existing interventions.

Assess needs

- Assess the status of existing policies, laws, prevention programmes, services, and infrastructure relevant to parenting support and the prevention of violence against children.
- Assess system readiness for scale-up by collecting data from community and government organizations that work with children.

Select interventions

- Ensure that interventions are evidence-based.
- Assess the system and context fit of specific interventions.
- Consider delivering parenting interventions embedded within systems that deliver interventions targeting other health risks such as poverty or poor nutrition.

Adapt interventions to the local context

See section 5.1, Adaptation considerations.

Prepare national and local government plans of action

- Strengthen the infrastructure required to deliver parenting programmes and provide response services, supplies and equipment.
- Develop and manage human resources.
- Use information-sharing, education and communication, and social mobilization.
- Evaluate and monitor progress towards goals defined in the national programme of action (see section 5.3, Monitoring and evaluation of quality and implementation of guideline).

Estimate costs

- Estimate capital and recurrent costs to help programme planners and managers to develop sustainable and feasible delivery plans.

Identify sustainable sources of financial support

- Various factors impact the sustainability of parenting programmes. One key factor is sustained financial support through the inclusion of budget lines to support parenting interventions in national and/or subnational government financing plans.
- In humanitarian settings without clear budget lines, a combination of development funding for research and humanitarian funding for implementation may be required to support the delivery of parenting interventions.

Develop and manage human resources

- Workforce resources should be carefully considered during the implementation process to reduce the potential burden for delivery staff, including adequate time to prepare and run parenting interventions as part of their duties, and adequate support to maintain fidelity.
- Staff responsible for parenting programme delivery should be appropriately trained, deployed and supported.
- Curricula, teaching and learning materials should be as up-to-date as possible.

Implement, monitor, and evaluate

See section 5.3, Monitoring and evaluation of quality and implementation of the guideline.

Implementation of programmes should be planned with scalability in mind. Scaling-up programmes usually requires the endorsement of both local administrators and government policymakers, effective leadership to transform processes, and training of relevant workers and supervisors. Engaging with multiple stakeholders and partners will be critical in strengthening implementation and sustaining progress. Working in collaboration with the many sectors involved can help ensure a comprehensive, cross-sectoral and more sustainable approach. In addition, sustainable sources of financial support should be identified.

During the implementation of a programme, context should be considered. Context may influence the way the programme is implemented, and, consequently, programme fit should be examined for different populations living in varying contexts.

Monitoring and evaluation of quality and implementation of the guideline

Implementation should include mechanisms to facilitate monitoring and evaluation of the interventions through ongoing data collection and analysis. Monitoring should involve regular assessment of whether programmes are being carried out as planned so that problems can be discussed and addressed. Monitoring should follow the progress of planned activities, identify problems, provide feedback to managers and staff, and solve problems before they cause delays. Data should be processed and analysed promptly. Results of the analysis should be passed to those in a position to take corrective action. Evaluation of an intervention should examine effectiveness and cost-effectiveness for different populations and levels of prevention.

WHO will use routine surveys to assess how the parenting recommendations are included in national policies and training courses. WHO will aim to collaborate with national authorities to include questions about the new recommendations, and how the workforce has experienced integrating these into relevant routine national training assessments and supervisory structures.

Supporting local adaptation

Local adaptation of the guideline will be supported through WHO country offices and ministries of health. National guidelines, such as for child health, development, and care, as well as for parenting support or violence prevention that are likely to be affected by the recommendations will be specifically reviewed to integrate approaches where relevant.

Dissemination

The current guideline will be posted on the WHO website. In addition, it will be disseminated through a broad network of international partners, including WHO country and regional offices, ministries of health, WHO collaborating centres, universities, other United Nations agencies and nongovernmental organizations. It is expected that the reviews will be published in peer-reviewed journals.

Plans for updating the guideline

The WHO Steering Group will continue to follow research developments in parenting and child maltreatment prevention, particularly for questions where the quality of evidence was found to be low or very low. If the guideline merits an update (likely five years after the publication of this guideline), or if there are concerns that one or more recommendations in the guideline may no longer be valid, WHO will coordinate a guideline update, following the formal procedures of the WHO handbook for guideline development (1).

As the guideline nears a 5-year review period, WHO, along with partners, will be responsible for conducting a search for new evidence. WHO will welcome suggestions regarding additional questions for evaluation in the guideline when it is due for review.
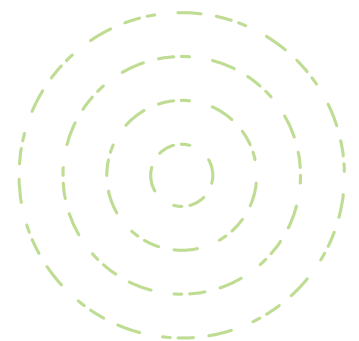
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Ms Binta Sako, Regional Adviser for Violence and Injury Prevention, WHO African Regional Office

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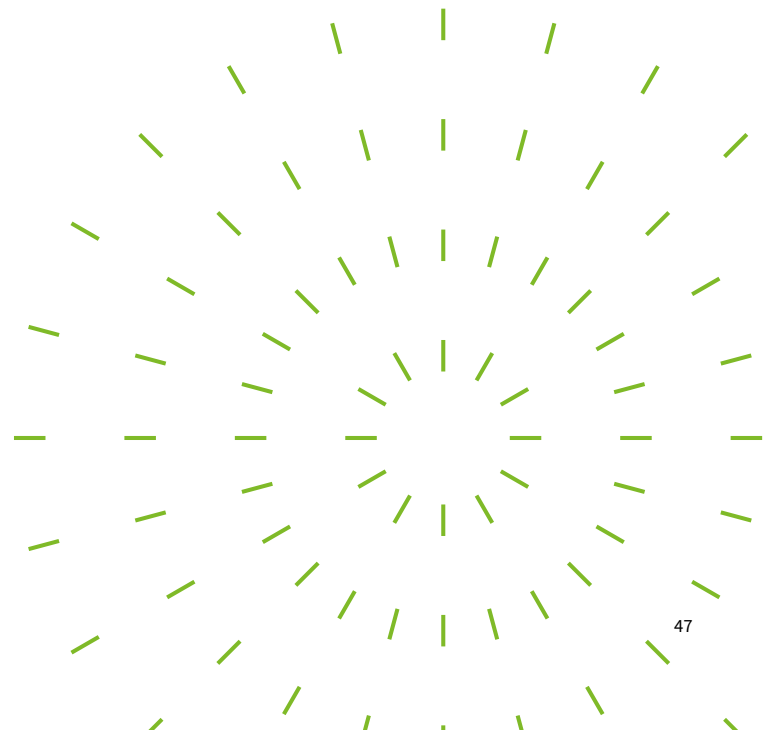
Annex 2: Guideline Development Group

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Professor Eva Rehfuess, Methodologist, Pettenkofer School of Public Health, LMU Munich, Germany

Annex 3: Evidence Synthesis Team

Systematic reviews on parenting intervention effectiveness

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Reviews on INTEGRATE Criteria for Parenting Interventions

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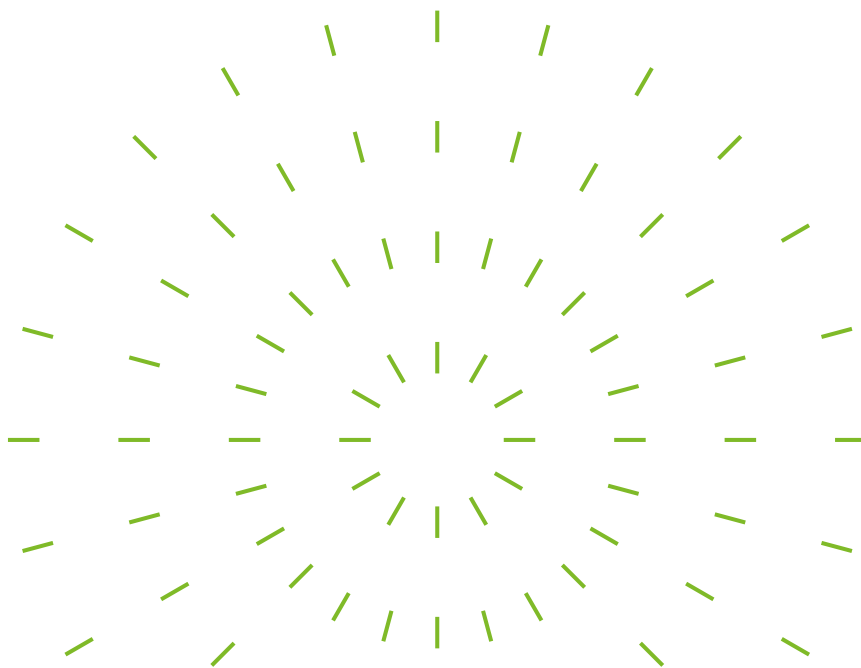
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Annex 7: Guideline writer

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Annex 8: Declarations of conflict of interest

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The names and brief biographies of all proposed GDG members were published on the WHO Violence Prevention webpage for public consultation for a period of 14 days. No comments were received. GDG members were required to update their Declaration of Interest, if necessary, before each meeting and a verbal declaration of interest was solicited at the beginning of each GDG meeting. Declared interests of the GDG are summarized in the table below.

Surname	First name	Affiliation	Declaration
Backhaus	Sophia	Oxford University, United Kingdom	Consultancy payments from WHO Regional Office for Europe and WHO Headquarters totalling less than US$ 30 000 for work on early child development
Cluver	Lucie	Oxford University, United Kingdom and University of Cape Town, South Africa	Co-developer of Parenting for Lifelong Health, a WHO/UNICEF non-commercial, open access parenting programme
Gardner	Frances	Oxford University, United Kingdom	Co-developer of Parenting for Lifelong Health, a WHO/UNICEF non-commercial, open access parenting programme
Kerr	Kaysia	Ministry of Education, Youth and Information, Jamaica	Holds a paid office position where she represents the Jamaican National Parenting Support Commission
Tomlinson	Mark	Stellenbosch University, South Africa	Co-developer of Parenting for Lifelong Health, a WHO/UNICEF non-commercial, open access parenting programme
Ward	Catherine	University of Cape Town, South Africa	Co-developer of Parenting for Lifelong Health, a WHO/UNICEF non-commercial, open access parenting programme