THE POWER OF CAREGIVING

Mental Health and Early Childhood Development in Sub-Saharan Africa: A Review of Parenting Programmes

BRIEF REPORT

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HENRIETTE RISVOLL

University of Bergen
SOS Children's Villages Norway
Grieg Foundation

GRIEG FOUNDATION

SOS BARNEBYER

PREFACE BY THE MANAGING DIRECTOR OF SOS CHILDREN'S VILLAGES NORWAY

Mental illness is one of the largest and fastest growing diseases worldwide. Mental disorders can have devastating effects on individuals, families, and communities; by 2030, it is predicted that mental health problems will be the leading cause of illness and mortality globally. Still mental health has been an overlooked thematic area within global policy. By launching this report, SOS Children's Villages Norway aims to change this.

We must increase our focus on the connection between mental health and care for children. The current Covid-19 pandemic has only accelerated the need and urgency for such a focus.

SOS Children's Villages is committed to ensuring that all children realize their right to quality care. In 1949, Hermann Gmeiner established the first SOS Children's Village in the face of strong opposition. Our organization was founded on the belief and recognition – revolutionary at the time – that the most vulnerable children need emotional and physical stability in a family and community environment to develop into their fullest potential. It is now well-known that the good mental health of both children and their caregivers is also a critical element for children's overall health, well-being, and achievement.

In today's world, just as in the post-war European context of our founding, the most vulnerable children are those without parents or at risk of losing parental care. Our conservative estimate shows that one in ten children are living in such unacceptable situations. With more than seven decades of experience informing our work, SOS Children's Villages addresses the root causes that place children at risk. For us, the role of care is the most fundamental aspect of not just a child's personal development, but for the future of society.

SOS Children's Villages Norway produced this report with a goal to better understand the connection between caregivers' mental health and early childhood development (ECD). Many programs are focused on other ECD interventions, such as sanitation, pre-school programs, and prenatal care. However, this study specifically focuses on caregivers' role and how programs targeting parents and other caregivers affect ECD. This is an understudied focus that deserves more attention.

There are several people who I would like to give special gratitude for making this report possible. First and foremost, thank you to the report author, psychologist Henriette Risvoll, who wrote this excellent report that increases our knowledge on mental health. Thank you also to her mentor, Associate Professor Ragnhild Dybdahl and her other colleagues at the Centre of Crisis Psychology, University of Bergen. In addition, thank you to the Grieg Foundation for their committed support over several years and for funding this report.

We hope that all readers of this report will increase their knowledge of the important role mental health plays in global development, in general, and the need for a better understanding of the connection between care and mental health, more specifically.

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Sissel Aarak
Managing Director
SOS Children's Villages Norway

EXECUTIVE SUMMARY

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

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

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

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

Despite the selected studies providing some evidence of positive effects, the wide range of programme content and implementation make comparisons difficult. The results indicate that relatively low-cost community-based interventions targeting different domains of child development (mainly health, learning, nutrition, safety, and responsive caregiving), can promote child development. Yet, few studies demonstrated improvement in parents' mental health and children's physical health. In general, we have limited understanding of why interventions worked, which highlights the need for more thorough investigation into the efficacious components in interventions for future development and implementation of effective programmes. Further shortcomings include that there

is little information of unintended harm caused by interventions; a lack of longitudinal studies, and of large scale-interventions; a lack of knowledge of why some efforts do not work in SSA contexts, and of the process of bringing interventions to scale.

As we were able to identify relatively little research in SSA, the findings in the 15 studies were interpreted in view of the wider literature on parenting from other regions. Interventions seem to work best and give more synergy when they are integrated and multi-sectorial, where parenting content is part of other interventions (e.g., nutrition and social protection). Mental health of parents is important for ECD, but mental health problems may need to be targeted explicitly. Further, not all interventions work. Quality, sufficient frequency of group sessions or home visits, and a structured curriculum appear necessary.

Existing paraprofessional community workers seem to be able to deliver interventions, also in large village groups, and ECD interventions seem to lend themselves well to up-scaling of programmes. Participation of local communities is important for success and sustainability, as well as for evaluation and research. Context and culture are crucial, and may be barriers, so adaptation of programmes and delivery is necessary, but building on evidence-based programmes may be better than creating new ones.

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

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

INTRODUCTION

The overall objective of this study was to provide knowledge on parenting programmes which can be used to promote mental health and early childhood development in low- and middle-income countries (LMIC). We aimed to identify effective approaches and delivery mechanisms of parenting[1] programmes to strengthen the quality care of children, particularly in vulnerable settings, with a focus on Eswatini, Malawi and Zambia.

The two topics - mental health and early childhood development (ECD) - are linked in that early childhood development is important for mental health, and mental health is important for children's development. The reasons for focussing on mental health and ECD are to some extent the same: The challenges in both areas are enormous, the problems affect many people, the consequences are often severe, long-term and in important domains of life, and both areas have been neglected. Importantly, the opportunities for action and for high return of investments are considerable.

WHY MENTAL HEALTH?

Mental health can be understood as a state of wellbeing where people realise their potential, can cope with the normal stresses of life, can work productively, and can contribute to their community. Mental health is therefore an integral part of health and societies' development and resilience, and crucial to reach the sustainable development goals (SDG).

Mental health problems pose an enormous burden to people and societies. This is particularly true in low- and middle-income countries, and in crises, disasters and conflicts. Mental health problems are often linked to stigma and human rights violations. Mental illness is one of the largest and fastest growing categories of burden of disease worldwide (Patel et al., 2018). By 2030, it is predicted that mental health problems will be the leading cause of illness and mortality globally (James et al., 2018). The economic burden of mental conditions is vast, but treatment of common mental disorders leads to improvements in health outcomes and economic production.

WHY EARLY CHILDHOOD DEVELOPMENT?

The development of the youngest children is critical for the development of individuals and societies. The importance of promoting ECD has been recognised in the SDGs. The period of early childhood is usually defined from the beginning of conception until 8 years of age. However, there is often an emphasis on the first 1000 days, meaning from conception to the second birthday, as this period is of critical importance for the rest of the life-span (Black et al., 2017), not least because the child's brain develops rapidly and is extremely sensitive to its environment in this period, whether enriching or adverse (McCoy et al., 2018). Thus, early childhood is a foundation for lifelong physical and mental health, learning, and behaviour.

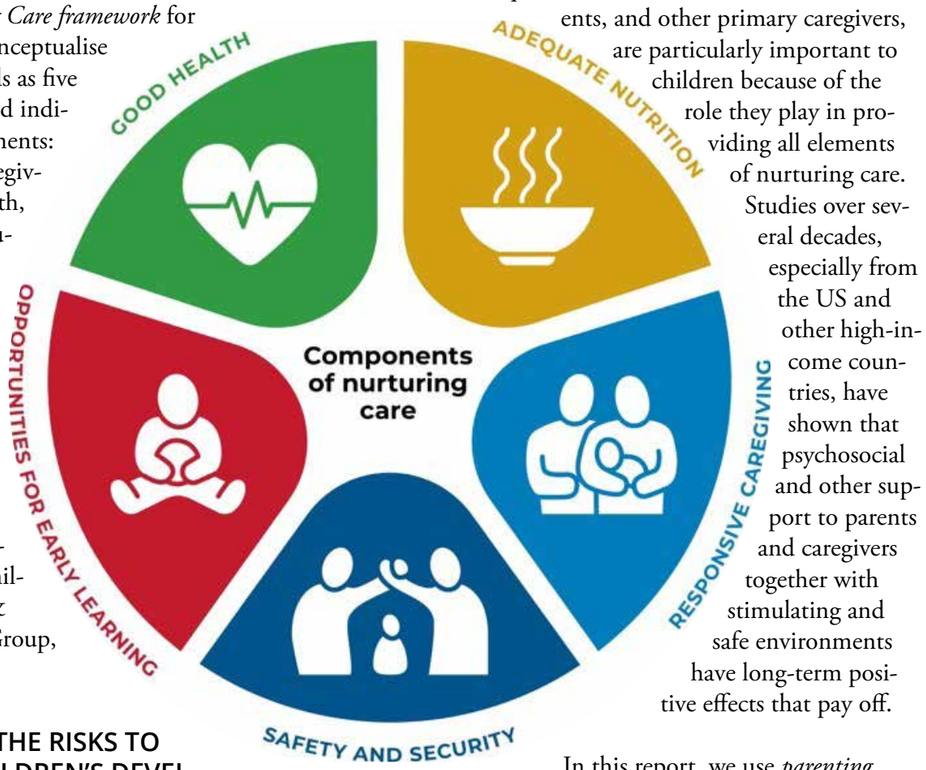
WHY THESE COUNTRIES?

SOS Children's Villages Norway support programmes in Eswatini, Malawi and Zambia, which are among the poorest countries in the world. In all these countries there are great unmet needs in terms of both mental health and ECD. Although much is known about mental health, ECD and parenting programmes in general, less is known in contexts where there is widespread poverty, especially in times of crises, such as the countries that are the focus of the current study.

[1] Or other primary caregivers or guardians

NURTURING CARE AS A CONCEPTUAL FRAMEWORK FOR NEEDS, THREATS AND OPPORTUNITIES

In order to better see the needs, risks and opportunities for interventions in early childhood, a recent framework has been adopted by the World Health Organisation, UNICEF and the World Bank. The *Nurturing Care framework* for ECD helps conceptualise children's needs as five interrelated and indivisible components: responsive caregiving, good health, safety and security, adequate nutrition, and the opportunity for early learning as shown in the figure below (World Health Organization, United Nations Children's Fund, & World Bank Group, 2018).



WHAT ARE THE RISKS TO YOUNG CHILDREN'S DEVELOPMENT?

Major threats to ECD are: Poverty, violence, malnutrition, poor mental health, environmental toxins, lack of stimulation and learning, insecurities, and gender inequities. Adversities create stressors in families and put nurturing care at risk. Adversities and inequalities are likely to rise during and after the Covid-19 pandemic, making more children vulnerable (Yousafzai, 2020). These factors might affect caregivers and reduce their capacity to support, protect and promote the development of young children.

Poor mental health among parents is a serious risk to children's development and wellbeing. Prevalence of maternal depression is widespread, affecting 1 in 5 mothers in LMICs, and is associated with disability and suicide in women, and negative outcomes for children's health, cognition and socioemotional development (Fisher et al., 2012).

WHAT CAN BE DONE? THE ROLE OF PARENTING PROGRAMMES

The aim is to create an enabling environment for countries, families and communities to make sure that children are safe and secure, receive responsive care, health care, opportunities for learning, and adequate nutrition (Black et al., 2017). Parents, and other primary caregivers, are particularly important to children because of the role they play in providing all elements of nurturing care. Studies over several decades, especially from the US and other high-income countries, have shown that psychosocial and other support to parents and caregivers together with stimulating and safe environments have long-term positive effects that pay off.

In this report, we use *parenting programmes* to describe interventions or activities (often programmes consisting of various interventions) that involve a parent/caregiver and aims to improve outcomes (e.g., mental health, cognitive, social and emotional wellbeing, physical health beyond survival) for children 0-8 years of age and their parents. Such programmes typically involve education or support to parents to strengthen their ability to promote positive interactions, cope with stressors, and enhance healthy child development.

WHAT DID WE DO?

This was a desk study that reviewed a large body of research and reports on mental health, early childhood development, and parenting programmes in low- and middle-income countries. We reviewed individual studies, reviews of studies, meta-analyses, books, policy and action documents. Several scholars and resource persons shared information and insights.

For the focused review of parenting programmes in Eswatini, Malawi, Zambia and other countries in sub-Saharan Africa (SSA), we carried out systematic searches of bibliographic databases for relevant research from 2010 until 2020, as well as supplementary search methods.

From more than 4700 studies identified initially, 144 potentially eligible studies were scanned, of which 129 were excluded. The focussed narrative review of high-quality studies on parental programmes that satisfied the criteria of the SSA study (e.g., were conducted in the selected countries or other SSA countries) is based on 15 papers from 12 unique studies published between 2014 and 2020. In addition, we took into account findings and recommendations from numerous other studies from around the world, mainly LMIC.

WHAT DID WE FIND?

EVIDENCE ON PARENTAL PROGRAMMES IN SUB-SAHARAN AFRICA

Quality studies from sub-Saharan countries were few, and from the countries we had selected for the current review, we were only able to identify two studies (from Zambia). However, we identified evidence from other contexts in SSA that we deemed relevant, and these are included in the selected 15 studies.

The 15 papers include a variety of interventions and assessed outcomes, many different methods and study designs, and they focus on various aspects of early childhood development and nurturing care. Sample sizes of the studies ranged from 30 (Giusto et al., 2017) to 1152 (Luoto et al., 2020). Children ranged in age from 4 months to 9 years, but most studies were concerned either with children before age two, or 3-7 years of age.

Most studies were conducted in community settings. The interventions were delivered by trained community workers/facilitators/volunteers, or local "head mothers". More than half of the 15 studies used a randomised controlled design that allowed for conclusions about effect of the intervention, while other designs were process evaluations, use of comparison groups. or qualitative investigation of mechanisms.

Typically, the programmes consisted of 10-12 group sessions and home visits with some elements of education for parents and practice of skills. Typical interventions were: individual counselling or group discussion; cognitive-behavioural strategies; role play; structured or guided parent-child play, including games and songs; educational communications materials which model or guide positive behaviours (e.g., illustrations depicting positive childrearing); and use of (homemade) toys.

Most studies assessed both parental behaviour and child outcome, including nutrition, cognition, harsh discipline, and parent-child interactions. A variety of assessment measures and tools were used. Some parenting programmes were relatively wide-ranging and multi-faceted, while others had a more targeted focus. The wide range of programme content and ways of delivery, as well as measurements and methodological variation, make comparisons difficult.

The results of these interventions are somewhat mixed. Positive effects in some areas are reported

in all studies, but most studies also report a lack of improvement in other areas. Thus, we find moderate evidence of positive impact on parents' knowledge, parenting behaviours and parent-child interaction (e.g., engaging more often with their child in activities like singing, reading to the child, and playing) and cognitive and language development in the given contexts. There is also some evidence for improvement in child nutrition, stunting, diet, socioemotional development, harsh discipline and family violence. The studies provide less evidence on improvement in child physical health and parental mental health.

Knowledge on working factors or effective ingredients in these studies is limited. There is little information on possible negative effects. Many of the studies have small samples, rely on self-report, and lack follow-up measures. However, several studies are of high quality and succeed at providing multi-faceted integrated programmes with a high level of participation and context sensitivity. Some studies have provided follow up data, and reported increased improvement over time, for example in terms of reduced stunting.

EVIDENCE ON PARENTAL PROGRAMMES IN OTHER LMIC CONTEXTS

We identified more than a thousand studies on interventions that involved parents, families or caregivers to improve young children's wellbeing in low- and middle-income countries, mainly in Asia and Latin America. Many focussed on health and nutrition, while less attention was paid to evidence on social protection and child abuse (Saran, White, Albright, & Adona, 2020). Several studies evaluated effects of maternal mental health interventions, and outcomes were primarily mothers' health.

We also identified several relevant systematic reviews of parenting programmes. The interventions included parent skills training, psychoeducation, psychosocial, behavioural, and psychological treatment. The reviews found medium to strong evidence that parental support, early stimulation and education, nutrition and health, and income supplementation, have positive effects on children's cognitive and language development, on mother-child interactions, on improving the home caregiving environment, and parental knowledge of early childhood development. Positive outcomes also included family functioning and parenting behaviours, as well as child mental health and wellbeing to some degree. Many studies showed positive effect across service delivery and social contexts.

Overall, the evidence supports that parent- and family-focused interventions may be valuable to people in low- and middle-income settings. However, in general, there seems to be relatively little emphasis on mental health in early childhood programmes, and relatively little emphasis on early childhood development in mental health interventions. However, scalable programmes targeting maternal depression are promising, and some interventions to support parent-child interaction demonstrated improved parental mental health. There was a lack of longitudinal studies, identification of working ingredients, and interventions that have been implemented to scale.

DISCUSSION: WHAT DO THESE FINDINGS MEAN

This study has provided knowledge on how to support young children's development through parenting programmes. This knowledge can be used to promote mental health and early childhood development in low- and middle-income countries. In order to do this, we have identified needs of young children, as well as what threatens their development. We have also identified approaches and delivery mechanisms of parenting programmes and family strengthening interventions, with a focus on Eswatini, Malawi and Zambia. As we were able to identify few quality studies in the given countries, we have reviewed studies from other countries in SSA, and also included lessons learnt from around the world.

DO WE KNOW WHAT CHILDREN NEED, WHAT THREATENS THEIR DEVELOPMENT, AND HOW TO FULFIL THEIR RIGHTS?

Yes, there is substantial knowledge on children's needs, and on risks to children's development. The *nurturing care* concept provides a promising model for integrating a variety of needs, risks, protective factors and intervention options. This framework

serves as a model for care and services, showing how multiple sectors are needed for families and communities to support children (Banerjee, Britto, Daelmans, Goh, & Peterson, 2019).

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

However, good parenting can moderate risk and protect children from chaos, fear, uncertainty, and deprivation (Miller et al., 2020).

There is less knowledge on what to do, and especially how, in specific contexts, such as the three selected countries of this study. The situation in the three countries vary, both in terms of needs and resources. However, this study indicates that there is enough evidence available to implement parenting programmes, although the needs, resources, partners, and implementation strategies should be adjusted to each context. The 15 studies provide encouraging results in terms of content, delivery and outcome. Although the evidence is not strong, the general evidence-base from other regions is useful for interpretation, and provides support for conclusions. Interventions to support ECD and mental health are needed in all three countries, and parenting programmes are likely to be good investments in all three countries.

WHAT WORKS, AND WHAT SHOULD AND COULD BE DONE?

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

Programmes seem to have multiple positive outcomes, such as changed parenting behaviours, and improvements on different domains of development, including nutrition, cognition, and wellbeing. This may be explained by the interconnected nature of both developmental outcome and parenting. We have limited knowledge of why the interventions worked, or why not, and there is a need for a clearer understanding of the active ingredients in interventions for future implementation and development of efficient programmes.

We found fewer studies that demonstrated improvement in parents' mental health and children's health, and it is possible that we missed these studies as they may focus on health specifically, rather than early childhood development. Mental health of parents is important for ECD, but may need particular attention in programmes. There seems to be a potential for a better link between the two in programmes to support ECD and mental health. It is possible that interventions need to target parental, and especially maternal mental health, more directly. Scalable programmes exist, and could be part of an integrated approach. It is also possible that there should be a clearer division between universal promotion and preventative interventions, and between those that target specific populations in need of treatment, such as those who suffer from physical or mental problems or malnutrition.

In the future, more studies from SSA are needed. More attention should be given to the role of fathers and other family members. Moreover, studies of interventions to support children or parents who live with disabilities are needed. One should also include more information on unintended harm caused by interventions, as well as costing studies. Our findings also support previous reviews' conclusions that good quality longitudinal studies are necessary, and that we need good research on interventions that have been implemented to scale (Britto, Ponguta, Reyes, & Karnati, 2015; Pedersen et al., 2019).

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

The overall evidence suggests that interventions that provide holistic support in several domains have better effect, although these may be more expensive and demand more cooperation. Where possible, one should build on existing preventive and promotive structures and systems, such as integrating nurturing care components into strategies for e.g., maternal health, education, humanitarian, and non-communicable disease policies – ensuring multi-sectorial efforts and a holistic approach. Integrated and multi-sectorial interventions where parenting content is part of other interventions (e.g., nutrition and social protection), seem to work better and give synergy. This means that interventions to support early childhood development and mental health can be good investments also across sectors. Investment in mental health may pay off also in other sectors than health. Similarly, investments in ECD may pay off in terms of education, physical health, less adult crime, and better employment productivity.

IMPLEMENTATION MATTERS

This review shows that programmes can be delivered in many ways, be cost-effective, and be adapted to local contexts. Existing paraprofessional community workers seem to be able to deliver interventions, also in large village groups. ECD interventions seem to lend themselves well to up-scaling of programmes. Participation of local communities is important for success and sustainability, and for evaluation and research. Context and culture are crucial, and adaption of programmes and delivery is necessary, but building on evidence-based programmes may be better than creating new ones (Aboud, Yousafzai, & Nores, 2018). In terms of challenges to implementation, it is likely that contextual and cultural factors may be barriers to larger scale implementation and sustainability. These could be (i) cultural differences in explanations of and attitudes toward young children and mental health; (ii) social context and infrastructure of the country or community (e.g., social protection and health systems); (iii) recruiting and retaining group leaders or providing supervision over time; and (iv) the larger political context.

A recent holistic framework of *nurturing care* seems to be useful for understanding needs, resources, as well as what and how to support. Overall, the evidence is strong that parent- and family-focused interventions can be valuable to people in low- and middle-income settings, and that mental health and ECD are linked. The focussed review of studies in SSA supports that such interventions are feasible and can be effective also in these contexts, although more evidence is needed.

CONCLUSION

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

Mental health and early childhood development are linked in that early childhood development is important to mental health, and mental health is important for children's development. However, there seems to be potential for further exploiting this link when it comes to prevention and treatment. The evidence-base for how to act, and what to do, is growing in both areas, and investments enhance human and economic development for all.

RECOMMENDATIONS

GENERAL RECOMMENDATIONS ON ECD AND MENTAL HEALTH

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

RECOMMENDATIONS TO CIVIL SOCIETY ORGANISATIONS ON ECD AND MENTAL HEALTH

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

RECOMMENDATIONS TO THE NORWEGIAN GOVERNMENT ON ECD AND MENTAL HEALTH

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

RECOMMENDATIONS FOR RESEARCH

- Quality of research should be prioritised in low resource settings, paying attention to context, long-term effects, scaling up, implementation, cost, ethics, lived experience and participatory research
- More diverse and innovative research approaches and methods are needed, together with the development and use of culturally appropriate and validated measures
- The underlying theoretical model of an intervention should be clear in order to investigate working ingredients
- Studies with larger number of participants are needed, as is the inclusion of invisible populations such as children and parents with disabilities

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