Caring for children: Relationships matter

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Early scientific experiments on the behaviour of rats showed that baby rats that were groomed more frequently by their mothers displayed more advanced brain development and were better able to cope with stressful events than those who did not receive equal attention from their mothers. The outcomes are similar in humans.[1] These early studies underscore the significance of the social environment and human interaction in shaping human functioning and development.

Parents or caregivers[i] are often referred to as a child's "first teachers". This is because of the centrality of the caregiving role, and the considerable influence that caregivers have on a child's development and well-being – from conception onwards. In many cultures and societies, child-rearing and caregiving are perceived as not only the responsibility of the immediate family, but also the extended family, the broader community and the state – which all have an obligation to act as a safety net. "*It takes a village to raise a child*" is a well-known African proverb and principle to which many South African communities subscribe.

Nurturing care is an essential ingredient for optimal child and adolescent development together with other inputs such as maternal and child health care services, household food security, and educational opportunities. Nurturing care includes practical caregiving, stimulation, responsiveness and safety.[2] While each of these dimensions of care are interdependent and interrelated, this essay focuses on responsive care as the extent to which children and adolescents experience responsive care, belonging and acceptance has a significant impact on their physical, cognitive and long-term emotional development.

The essay responds to the following questions:

- Why are caring relationships important for children's development?
- What do we know about systems of care for children in South Africa?
- What are the factors that can compromise care?
- What are the interventions that can improve the quality of caring relationships?

Why are caring relationships important for child development?

Children's experiences of their environments and their relationships, especially early in life, profoundly shape their development and lifelong trajectory. Children and adolescents need – and have the right – to feel secure in their everyday environments. And responsive care is arguably the most essential element required to ensure children and adolescents' emotional security and mental well-being.

Establishing emotional attachment between parents and infant during the first 1,000 days of life is critical for survival in the short-term, and determines the pathway for lifelong healthy, sustained development. Neuroscience indicates that responsive care is fundamental for healthy brain development, while poor maternal care can cause emotional stress and anxiety in infants and young children, in turn impacting on brain structure and function, and reducing children's ability to thrive.[3]

Toxic stress in early childhood is recognised as a major contributor to poor developmental outcomes, and is often related to the quality of the primary caregiving relationship. Toxic stress refers to frequent or prolonged activation of the body's stress management system. Stressful events that are chronic, uncontrollable, and/or experienced without children having access to support from caring adults – such as verbal and physical abuse, witnessing domestic violence, severe maternal depression or prolonged absence of the primary caregiver – are likely to have a sustained and adverse impact on brain development.[4]
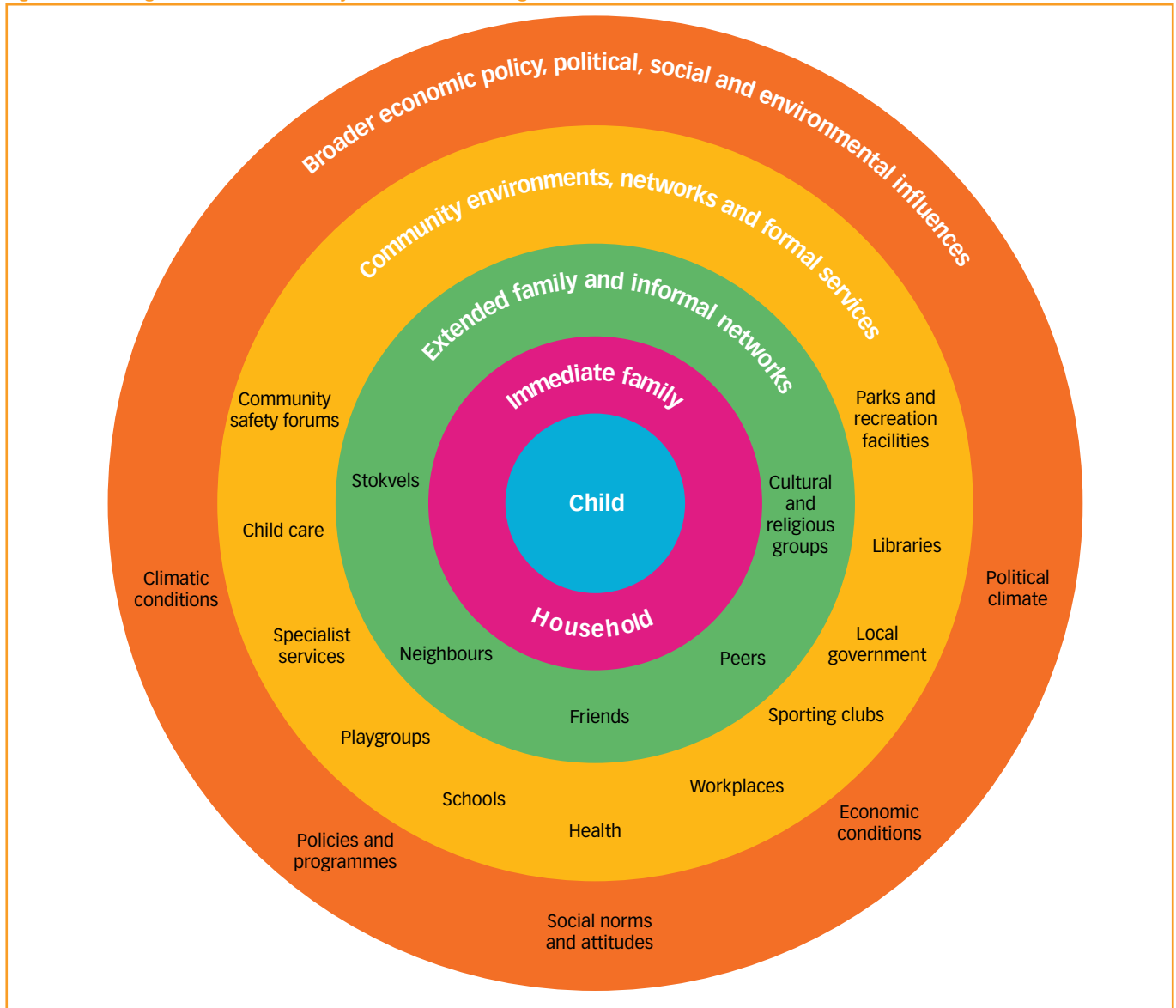
The environment in which children are raised is critical for early development, and primary caregivers have the important task of mediating between the child and his or her environment, and buffering the effects of environmental stressors.

A critical domain of early development is the formation of self and identity, and this is shaped by infants' state of mind and their ability to recognise and regulate feelings. Psychologists note that the recognition and regulation of feelings are also central to survival.[5] Studies of abandoned infants who were institutionalised and deprived of affection and interaction with a responsive caregiver indicate that such deprivation has long-term negative effects on children's cognitive, behavioural and relational functioning.[6] The presence of a responsive, involved caregiver, especially during the early years, is fundamental for children's physical development, emotional security, resilience and awareness of self and others.[7]

Responsive caregiving throughout the life course provides emotional security and promotes trust and a sense of belonging, building the foundation for social-emotional competencies (e.g. self-control, self-motivation, and the ability to engage in purposeful action). Healthy parenting has been found to improve children's

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i   The terms "parents" and "caregivers" are used interchangeably to describe the individuals who perform the primary caregiving and parenting role, including both biological and social "parents".

Figure 12: Enabling care across different layers of the socio-ecological model

Broader economic policy, political, social and environmental influences

Community environments, networks and formal services

Extended family and informal networks

Immediate family

Household

Child

Community safety forums
Stokvels
Child care
Climatic conditions
Specialist services
Neighbours
Playgroups
Schools
Policies and programmes
Health
Social norms and attitudes
Friends
Peers
Cultural and religious groups
Parks and recreation facilities
Libraries
Political climate
Local government
Sporting clubs
Workplaces
Economic conditions

self-esteem, behaviour and food security; reduce educational risks;[8] and enhance cognitive and language development.[9]

As children mature, their needs change and caregiving should respond to these developmental shifts accordingly. For example, older adolescents are generally independent and able to make certain decisions, engage with challenges and problem-solve within their life space. While different risks and stressors come into play at each developmental stage, responsive, nurturing care remains essential in promoting development throughout childhood and adolescence. Early attachment lays the foundation for healthy relationships across the life course, and emotional and behavioural regulation learnt in infancy set the stage for children and adolescents' ability to function as competent social and relational individuals.

Childhood adversity (particularly exposure to multiple risks such as child maltreatment and parental substance abuse) has serious consequences for adolescent health and may lead to violence, substance use and mental health conditions that can compromise the health and well-being of the next generation.[10] Adolescents are the caregivers of tomorrow, and their relationships with own caregivers and families will impact on their parenting styles and ability to provide nurturing care.[11]

Box 4: What is nurturing care?

Nurturing care is defined as a stable environment that is sensitive to children's health and nutritional needs, and that provides protection from harm, opportunities for early learning, and interactions that are responsive, emotionally supportive, and developmentally stimulating.[12] These environments offer acceptance and a sense of belonging and connection demonstrated through an active and constant relationship with the child or adolescent.

Figure 13: Opportunities for care and connection across the life course

Opportunities to strengthen care and support	0 – 4 years	5 – 12 years	13 – 18 years
Social, youth, cultural and faith-based organisations		– – – –	– – – –
Sports clubs and recreation facilities		– – – –	– – – –
Public libraries		– – – –	– – – –
Schools and early learning programmes	· · · · ·	– – – –	– – – –
Community health services	────────	· · · · ·	────────
Homes and families	───────────────────────────────────		

What do we know about systems of care for children in South Africa?

Children and adolescents generally grow up in families, located within communities and social groups that enable community life and facilitate access to resources, as illustrated in figure 12. South African society is diverse and heterogenous. Multiple family forms exist and the notion of who constitutes "family" is defined by individuals themselves. The White Paper on Families defines family relationships of "blood (kinship), adoption, foster care or the ties of marriage (civil, customary or religious), civil union or cohabitation, and go beyond a particular physical residence."[13]

While the primary caregiver bears the main responsibility for providing nurturing care, there are frequently other members of the household who contribute to caregiving tasks. In South Africa, practical caregiving is mostly assumed by women who, by and large, spend more time on practical care than men. In general, fathers' participation in caregiving duties is low, although many offer other forms of parental support.[14]

The HIV/AIDS epidemic has had a momentous impact on South African society, and on children as relatives such as grandmothers and aunts have often assumed caregiving responsibilities for orphaned children. Shared caregiving with the other parent, relatives or neighbours is relatively common. Both children and caregivers may move between households as families attempt to navigate suitable care arrangements for their children,[15] and in 2015, 21% of children in South Africa were not living with either parent.[16] While it is desirable for children to live with family when biological parents are deceased or living elsewhere, findings from a predictive modelling exercise identified parental absence as an important factor that increases children's risk of violence and abuse.[17]

Child-care services, such as day mothers or childminders, are sometimes used for young children not yet in school, though these are not necessarily available or affordable. Current trends indicate that 46% of children under five years old are in the care of a parent or guardian, while 14% are cared for by a day mother during the day, and a further 33% attend early learning programmes.[18]

As children grow older, their reliance on the immediate family for caregiving shifts as they start to engage with different environments, including schools and other community fora such as youth groups, sport clubs and aftercare facilities, as outlined in figure 13. While these external environments cannot replace the intimate nature of family care, they nevertheless have a responsibility to create a nurturing environment and engage with children in a caring manner.

Schools and other community sites present opportunities for meaningful contact and support. The concept of schools as "nodes of care and support" was introduced in South Africa about a decade ago and recognises the potential of schools to identify vulnerable children and link them with support services.[19] The Department of Basic Education intends to implement the Care and Support for Teaching and Learning policy framework which has a similar objective. Clinics are similarly in an ideal position to identify and support pregnant women, caregivers of infants and young children, and adolescents in need of care and support.

As children mature, their relationships with peers, teachers, health professionals and community workers play an increasingly important role in developing their sense of belonging and social connectedness, and have an enduring developmental impact. These external relationships become particularly influential in adolescence and have the potential to provide structural support and appropriate bridging relationships.[20] Youth development programmes and mentorship schemes provide a gateway for healthy social engagement and skills development, and opportunities to build enduring, caring relationships that can last into adulthood. Ideally, strong connections between these different environments should be made and maintained to enable the development of healthy, supportive contexts for children and adolescents in every community.

When families are particularly vulnerable and children are at risk of compromised care, community-based support services provided by non-governmental, faith-based and community-based organisations (CBOs) can play a critical role. For example, the Isibindi

Table 3: Scale of selected environmental stressors impacting on families and children

Measure	Status
Poverty	In 2015, 25% of the population were extremely poor, and 56% lived below the upper bound poverty line.[1]
Unemployment	In 2016, the official unemployment rate stood at 27%. This rate excludes discouraged work-seekers.[1]
HIV/AIDS	In 2017, an estimated 13% of the population was HIV positive; and 21% of women aged 15 – 49 years.[2]
Maternal depression	Area-specific studies indicate that antenatal depression prevalence ranges from 18% to 47%, and postnatal depression from 32% to 35%.[3]
Intimate partner violence	21% of women aged 18 and older report experiencing physical violence by a partner, and 6% report experiencing sexual violence.[4]
Child maltreatment	42% of adolescents report experiencing some form of maltreatment in their lifetime and 35% report experiencing some form of sexual abuse.[5]
Foetal Alcohol Spectrum Disorder	Foetal Alcohol Spectrum Disorder rates ranged from 29 to 290 per 1,000 live births between 2001 and 2011.[6]

Sources: 1. Statistics South Africa (2017) *Poverty Trends in South Africa: An Examination of Absolute Poverty between 2006 and 2015.* Pretoria: Stats SA; 2. Statistics South Africa (2017) *Mid-year Population Estimates. Statistical Release P0302.* Pretoria: Stats SA; 3. Schneider M, Docrat S, Onah M, Tomlinson M, Baron E, Honikman S, Skeen S, van der Westhuizen C, Breuer E, Kagee A, Sorsdahl K & Lund C (2016) Integrating mental health into South Africa's health system: Current status and way forward. *South African Health Review 2015/16.* Durban: Health Systems Trust; 4. Department of Health, Statistics South Africa, Medical Research Council & ICF (2017) *South African Demographic & Health Survey 2016: Key Indicators.* Pretoria and Rockville, Maryland: DOH, Stats SA, MRC & ICF; 5. Burton P, Ward CL, Artz L & Leoschut L (2016) *The Optimus Study on Child Abuse, Violence and Neglect in South Africa (Research Report).* Cape Town: Centre for Justice and Crime Prevention & UCT; 6. Olivier l, Curfs L & Viljoen D (2016) Fetal alcohol spectrum disorders: Prevalence rates in South Africa. *South African Medical Journal,* 106(6 Suppl 1): S103-S106.

"Circles of Care" programme has a large footprint in South Africa. Their services are concentrated in poor communities and provide practical, regular support to vulnerable families in communities with high HIV prevalence, poverty and unemployment, and with limited access to basic and social services. However, community-based and non-profit organisations have limited reach – especially in rural areas. Where they do have a presence, their interventions and impact are often curtailed due to limited resources. Despite these constraints, CBOs have a positive effect on vulnerable HIV-affected children reducing their exposure to violence and abuse, and improving mental health and behaviour.[21]

What are the factors that can compromise care?

Several factors can compromise the development of healthy, caring relationships. While a caregiver may be present in a child's life, it is critical that a caregiver is emotionally available and connected, demonstrating interest and attention through regular, meaningful interaction. Allowing the child to lead these interactions and responding sensitively to the child's needs places the child at the centre of these engagements. In addition, the use of positive rather than harsh discipline has better long-term developmental outcomes, such as reduced aggressive and risky behaviour.[22] Caregiver responses are influenced by the child's temperament and personality, their own personality and parenting style, and childhood experiences. Other factors that influence the caregiver's capacity to provide warm, responsive caregiving include the caregiver's physical and mental health, exposure to stress, coping measures, and access to support and resources.

High levels of unemployment, poverty, and inequality contribute to the adversity experienced by many families in South Africa outlined in table 3. For example, the intersections between poverty and inequality, chronic illnesses including HIV/AIDS, and poor mental health have been well established.[23] Several studies also document the serious challenges associated with providing care in these circumstances.[24] Poverty and inequality also increase the risk of depression[25] and community-based studies in South Africa indicate rates as high as 47% during pregnancy.[26] Maternal depression, in turn, is associated with preterm birth, low birth weight, poor infant growth and reduced cognitive development.[27]

Violence is pervasive in South Africa and is likely to impact directly on caregivers' health and mental well-being, affecting their caregiving ability, and threatening the emotional security of children who witness conflict in their homes. Intimate partner violence is common and is associated with depression,[28] which may cause caregivers to become detached and emotionally unavailable.

Even in families where a biological parent is present, other factors (such as employment or seeking employment, education or training, physical or mental health conditions, including disability or chronic illness) may affect the parent's ability to provide constant, nurturing care. Other common environmental stressors include alcohol and drug abuse, social isolation and stigma.[29]

A recent study shows that good parenting is positively associated with biological parents, parental mental health, and living in the same household as other adults, while poverty and stigma were negatively associated.[30] Support systems for caregivers are therefore essential to provide practical assistance and emotional support, particularly during stressful periods. When social support networks are available, whether through the immediate and extended family or through community-based programmes, they play a valuable promotive and protective role.[31]

Addressing caregiver stress and providing interventions that buffer the effects of stress, especially during periods of high

stress such as the postnatal period, are critical to minimise risks and enhance the development of the caregiver–child relationship. Family support, community-based services and access to a range of support services, such as maternity leave, child care and social assistance, are therefore essential to address caregivers' multidimensional needs.[32]

At a macro level, the Sustainable Development Goals (SDGs) are expected to address the widespread economic insecurity faced by South Africa's caregivers and families. While the current basket of social assistance programmes is supportive, it is limited as a poverty alleviation mechanism, and the Child Support Grant, in particular, is insufficient within the current economic environment.[33] Similarly, other SDG targets, such as addressing gender inequalities and gender-based violence; promoting peaceful, safe and secure environments; and recognising the value of unpaid care work are central to improving conditions for caregivers and families. The SDG focus on maternal health and well-being is also welcomed and will hopefully reinforce strategies to improve quality and access to maternal health services – as target 3.4 specifically includes the promotion of mental health.[34]

What interventions can improve the quality of caring relationships?

Creating enabling and nurturing environments for children to develop and thrive is not only the responsibility of families. Government has an obligation to ensure that the necessary policy, funding and systemic measures are in place. Implementation of key programmatic responses are necessary to shift the *status quo* and enable improved outcomes for children and their caregivers.

Programmes that promote responsive and supportive caregiving

Programmes that promote responsive parenting are recognised as a valuable contribution to improving family life. Good parenting programmes focus on the caregiver–child relationship to strengthen the role of caregivers by promoting their understanding of child development, encouraging secure early relationships, providing a stimulating environment, and promoting positive behaviour management strategies.[35] Programmes should also include relationship and life-skills such as self-care strategies and emotional regulation techniques.[36]

Parenting programmes are showing promise in improving parenting skills and reducing risky behaviours in children and caregivers in contexts similar to South Africa,[37] drawing on a range of delivery vehicles – from home-visiting programmes to health facilities. But there is also a need to identify family strengthening and parenting interventions that are best suited to the complex and fluid care arrangements and family forms in South Africa. For example, the skills gained through parenting interventions should ideally be transferred to other adults within the family; it is therefore important to target the primary caregiver, and to gain family support for the programme.[38]

A number of parenting programmes have been implemented and tested in South Africa. This includes the Parenting for Lifelong Health (PLH) initiative[39] which adopts an age-differentiated approach and targets programmes at caregivers of babies, toddlers, young children and adolescents. Initial results indicate some positive effects, and testing on larger samples are underway. The Parent Centre's Parent–Infant Home Visiting project was among the first evaluations to be conducted in South Africa, and demonstrates robust positive outcomes for low-income pregnant mothers and their infants.[40]

While there is a strong emphasis on targeting vulnerable new mothers and caregivers with young children, the PLH adolescent programme, Sinovuyo Teens, targets caregivers of adolescents. The 14-week programme provides an environment for caregivers and teenagers to jointly discuss parenting and family issues during regular group sessions. Initial evaluation findings[41] found reductions in child abuse and improvements in caregiver and adolescent outcomes, and a larger trial is underway to verify these findings.[42] Important lessons can be garnered from these studies, including considerations for replication and scale-up to ensure broader reach (as outlined in case 6).

Despite the near-universal uptake of antenatal services and well-baby health-care visits there is currently no universal parenting promotion and support programme available to new parents in South Africa. Health-care packages such as Basic Antenatal Care and the Integrated Management of Childhood Illnesses are currently survival-oriented and present an opportunity to incorporate parental care components. The World Health Organisation (WHO) Care for Development package for community health workers (CHWs) is a readily available, affordable and scale-able package that could address this deficit.[43] Other potential strategies include providing supportive parenting materials (such as videos) in antenatal and clinic waiting areas. Innovative programmes exist that show promise, such as the Ububele Baby Mat project which provides psycho-emotional support to mother-and-baby pairs in primary health-care clinic settings.[44]

Home-visiting programmes

Caregiver contact and support are critical to enhance the quality of child–caregiver relationships. There are several types of programme delivery channels that target vulnerable caregivers and their children in South Africa. While facility-based services perform a useful function, they rely on caregivers travelling to the facility to access services and support. Distance to facilities, poor transport services, and lack of finance are some of the reasons for limited access. Home-visiting programmes are therefore effective for reaching the most marginalised populations and ensuring more equitable access to services.[45] Studies from high-income countries show that home-visiting programmes are effective in producing good child and caregiver outcomes, particularly for families of young children, although the cost-benefit is not clear.[46] A number of South African programmes are showing promise in reaching vulnerable caregivers and children and promoting positive outcomes.[47] For example, Philani uses the concept of peer support to train mentor mothers to support at-risk families with young children (see case 9 on p. 74).

The Western Cape province has recognised the significance of the first 1,000 days in promoting the health and wellness of pregnant mothers and infants and enabling children to thrive and reach their full potential.

The province's First 1,000 Days Initiative acknowledges that care in pregnancy encompasses both the pregnant mother and the unborn baby, and goes further to embrace the mother's supportive relationships (father of the baby, family and/or friends), appreciating these critical and interrelated layers of support, as shown in the ecological model on p. 52. The initiative aims to raise awareness of the critical and exquisitely sensitive window of opportunity of the first 1,000 days (starting at conception and continuing for the first two years of life).

Care in pregnancy starts as soon as pregnancy is confirmed, and support is provided through home visits by trained CHWs at selected pilot sites who complete household and individual psychosocial risk assessments and initiate referral to health facilities for antenatal care. Other antenatal clinics screen for psychosocial risk factors (including common mental health conditions, substance abuse and domestic violence) and referrals are made to CHWs who provide supportive home visits. As tools emerge and local resources are mapped, a process is underway to share, evaluate and further refine these tools and referral mechanisms.

CHWs provide psychosocial support for women with mild or moderate risk and link women to social support services (such as the Child Support Grant), whilst those with more serious psychological needs are directed to medical and mental health services. Pregnant women are encouraged to involve the fathers of their babies or a close supportive partner during antenatal clinic visits, and to secure a birthing companion to provide support during labour. Trained peer counsellors provide infant feeding information at each antenatal clinic visit. Some clinics have started antenatal support groups for mothers, and counseling packages are currently being developed to help parents prepare for their newborn baby.

Health promotion materials for the first 1,000 days – including videos on infant–parent socialisation and maps to help parents and caregivers access local social services (such as social grants, playgroups and ECD centres) – are being developed, and delivery models at primary health-care (PHC) level are being evaluated.

The package of services for the first 1,000 days is also being revised to enhance universal services and develop targeted interventions. For example, midwives are getting trained in perinatal mental health and empathetic skills, and a standardised training package for CHWs is underway, drawing on a set of evidence-based practices for the first 1,000 days period. Task sharing within community-oriented primary care teams (which include PHC staff and CHWs) is being explored, informed by best practice models and local needs as determined by CHW household surveillance. This requires the development of new tools for clinical practitioners, lay counselors and home-visitors. For example, a parenting preparedness package with parent information materials is being developed, and an antenatal motivational interview tool, which will provide a checklist of risk and protective factors for the health worker and mother to reflect on before the baby is born, is planned. This builds on longer-term measures of child wellness as outlined by the eight SHANARRI Wellness Indicators (see figure 14) which are used in Scotland to promote a transversal and integrated approach to service delivery across sectors. The tool will also draw on the mother's strengths and motivation to improve her home environment for her baby (for example, deciding to stop smoking).

The role of the CHW home-visitor in establishing a supportive relationship with the pregnant woman and her family is invaluable and lies at the core of the care package for the first 1,000 days. This relationship will provide the safety and support that many women need to cope with adversity and to provide infants with the nurturing care that they need to thrive.
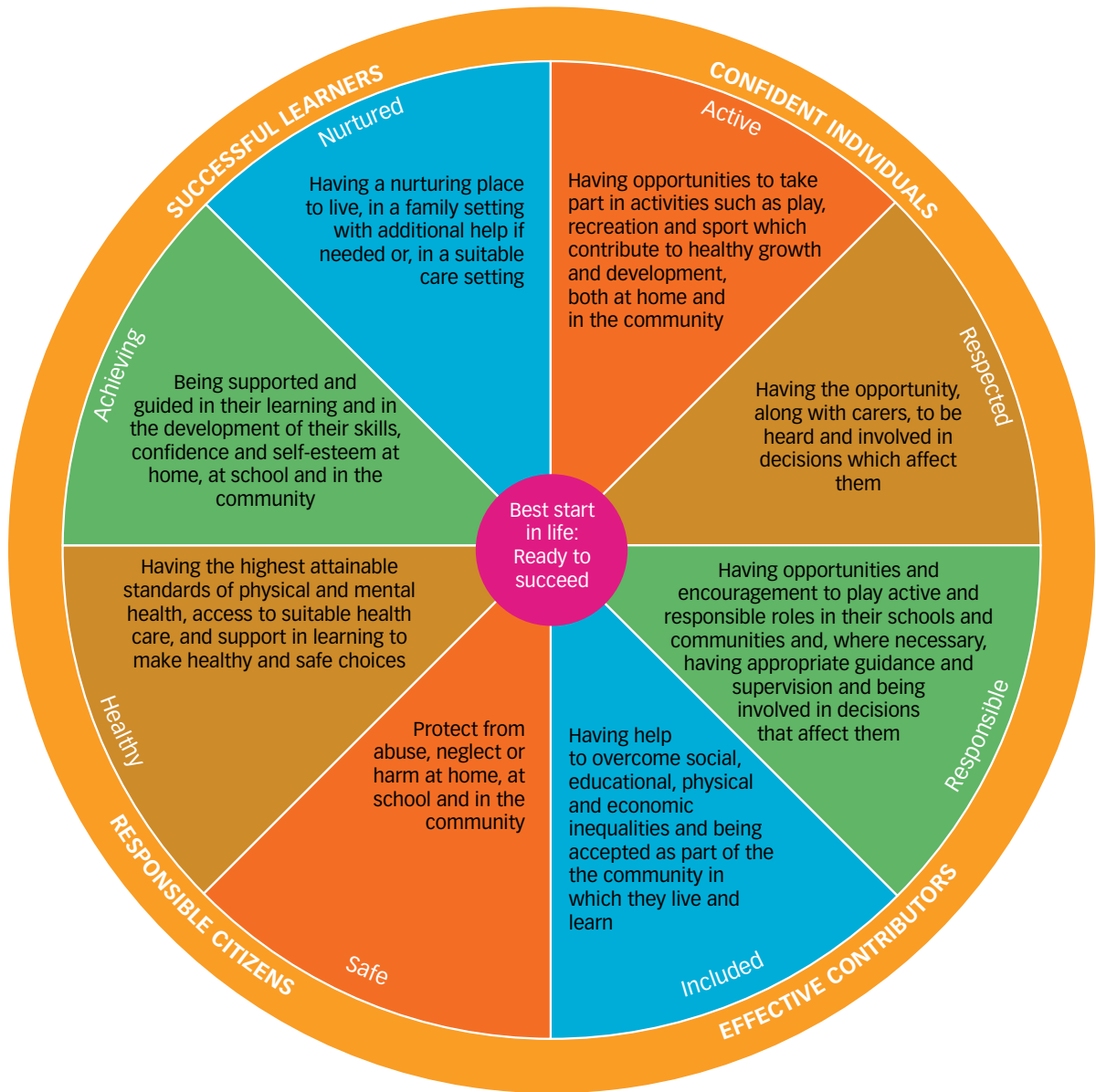

The government's CHW programme similarly intends to improve access to health-care services, and the revised Framework calls for an improved focus on delivery of maternal, neonatal, child and women's health and nutrition services through regular home visits.[48] Such home-visiting services have the potential to identify vulnerable caregivers and families and refer them for follow-up or specialist support. Ongoing support through regular home visits enables regular monitoring and continuity of services and support. Ideally, the home-visitor develops a caring and responsive relationship with the child and caregiver, and is able to model nurturing and responsive care. Taking this to scale would require a shift in focus in the training, mentorship and support of state-employed CHWs to ensure they are able to spend sufficient time to build relationships with families and support responsive caregiving practices.

Community-based child care and youth development programmes

Programmes that support children and families within their communities also play a critical role, creating community awareness of child and youth well-being; liaising with community leaders; and negotiating for improvements in community structures, child protection, safety and health services when needed. Isibindi's "Circles of Care" programme is one such example. The programme offers support to vulnerable children, youth and families through regular home visits, and promotes child care, stimulation and

Figure 14: The SHANARI wheel

SUCCESSFUL LEARNERS

CONFIDENT INDIVIDUALS

Nurtured

Having a nurturing place to live, in a family setting with additional help if needed or, in a suitable care setting

Active

Having opportunities to take part in activities such as play, recreation and sport which contribute to healthy growth and development, both at home and in the community

Achieving

Being supported and guided in their learning and in the development of their skills, confidence and self-esteem at home, at school and in the community

Respected

Having the opportunity, along with carers, to be heard and involved in decisions which affect them

Best start in life: Ready to succeed

Having the highest attainable standards of physical and mental health, access to suitable health care, and support in learning to make healthy and safe choices

Having opportunities and encouragement to play active and responsible roles in their schools and communities and, where necessary, having appropriate guidance and supervision and being involved in decisions that affect them

Healthy

Responsible

Protect from abuse, neglect or harm at home, at school and in the community

Having help to overcome social, educational, physical and economic inequalities and being accepted as part of the the community in which they live and learn

RESPONSIBLE CITIZENS

Safe

Included

EFFECTIVE CONTRIBUTORS

Source: Scottish Government (2017) *Wellbeing*. Viewed 15 September 2017: www.gov.scot/Topics/People/Young-People/gettingitright/wellbeing.

protection through Safe Park programmes. The programme also offers parenting skills training, family strengthening and practical support for caregivers and families. The programme is noted for its responsiveness to the needs of vulnerable children and families, the consistent presence and availability of child and youth care workers, and their invaluable referral role – however, documented evidence of the medium- to long-term impact of Isibindi is needed.[49] The programme's emphasis on caring relationships is commendable and it is filling a significant void at family and community level.[50]

It is also critical to explore the impact of community-based adolescent peer-support and mentoring programmes that may translate into positive adolescent development (such as Isibindi's Adolescent Development Programme, outlined on p. 38).

Identification, referral and support of vulnerable children and families

Clinics, home-visiting programmes, early childhood development centres, child care services, schools and social grant pay-points are all services that caregivers use regularly and are therefore ideal vehicles for promoting additional services and support for caregivers and children.

Antenatal, postnatal and child health services are a key gateway to support services as they provide regular contact with pregnant women. About 90% of pregnant women attend antenatal care.[51] This provides an opportunity for the identification of mental health problems, interpersonal violence, substance abuse, and other environmental risks which, if identified early, can be assessed and referred for appropriate support. The Perinatal Mental Health

The call for "evidence-based" programming has led to increasing investment in studies designed to test the efficacy and effectiveness of parenting interventions. However, lessons from implementation science[52] and public health[53] suggest that the successful translation and up-take of this evidence require a particular set of conditions and expertise. The following questions are offered as a guide for practitioners who are considering implementing programmes that have had positive trial results.

Is the programme generalisable?

In answering this question, it is helpful to look at how representative the trial programme beneficiaries are of the broader group that the programme is designed for. For example, if the programme is designed for primary caregivers in lower-income settings, but the beneficiaries in the trial come from a small urban community in one country, can the results be generalised to communities in rural areas or to people with different cultures?

The participation rate of the target group in the study is also important. To what extent was the participation rate assisted by organisational support, such as transport and meals for participants, and can this level of support be sustained beyond trial interventions? What was the actual impact of the programme on participants; did the results have sustained impact; and what was required in terms of training and logistical support to ensure effectiveness? To what extent were the results influenced by cultural norms, the media, the geographical setting, or incentives such as food and transport?

Is the programme replicable in my setting?

It is important to establish whether the programme is relevant and possible to implement in your context. For example: To what extent does the purpose of the programme align with your organisation's mission and values as well as the needs of your beneficiaries?

Is the programme sufficient to attain the intended outcomes, or does it require additional strategies, programmes and/or media campaigns to sustain the intended outcomes? For example, replacing corporal punishment with positive parenting requires multiple strategies to address pervasive social norms with consistent messages. What partnerships are needed to implement and monitor such a multi-pronged, integrated strategy?

What was the cost of the trial and what would it cost in your setting? This includes logistical support (such as co-ordination and provision of materials) and incentives (such as food, child care and transport provided in the trial) and the extent to which these incentives are essential to ensure the fidelity of the programme.

It is also critical to consider who will deliver the programme. What competencies and qualities are required, and can your staff accommodate the programme given their existing workload and professional interests? What about training, mentoring and support? Do you have capacity in-house, or would you need to cover the costs of an external trainer? And to what extent does the pedagogy of the training fit with your value system. For example, does it recognise prior learning and follow principles of participative adult learning or does it simply tell people what to do? How will this learning be sustained in the long run?

Finally, what are the implications for your organisation's administrative functions – including data collection for monitoring, evaluation and reporting?

What are the implications for policy?

Finally, it is essential to consider the policy environment. Firstly, which policy priority does parenting support align with and how can you position your programme to meet this objective? What government programmes offer the best fit – for example, early childhood development, youth, children and/or families, or prevention of child abuse and neglect? What are the mechanisms for registering and assuring compliance of your programme within the sector's quality assurance systems, and ensuring that you qualify for resource allocation? Secondly, how can you ensure that lessons learnt in implementing programmes inform policy and programme development? And how can you align your efforts with other parenting programmes to enhance the reach and impact of parenting programmes?

It is therefore helpful to participate in broader networks and policy processes through national and sub-national structures. For example, the Tanzanian Parenting Task Force (chaired by that country's Ministry of Health, Community Development, Gender, Education and Children, and supported by UNICEF) co-ordinates and maps parenting initiatives throughout their country. They are also the "parent body" of a home-grown parenting community dialogue programme. A similar model within South Africa's National Child Protection Forum could help organisations delivering parenting programmes to build partnerships, access resources, share lessons learnt, and inform policy and programme design.

Project has been exploring how best to integrate mental health screening into routine antenatal care, and has developed a concise screening tool that can be administered as part of a mental health-care service package.[54] The National Integrated Early Childhood Development Policy aims to build on this foundation and mandates the Department of Health to play an expanded role during the first 1,000 days (as outlined in case 5 on p. 56). This, however, requires reorientation and training of health practitioners to ensure a broader focus on child development and parenting.

Networks of care and support

Community networks can act as a safety net for vulnerable children and families. This can be strengthened by enhancing communication and referral systems between schools, clinics, faith-based organisations and CBOs. For example, the Adolescent Youth Health Services Forum in Khayelitsha, Western Cape, enables NGOs and government services working in the areas of youth health and development to collaborate and share resources.

Informal and formal networks and gatherings – such as peer-support initiatives, stokvels, community policing forums and support groups for teen mothers or parents of children with disabilities – provide regular contact and opportunities to build relationships among neighbours and community members, and should be encouraged. Such activities build social cohesion, restore community trust and facilitate responsive and individualised care.

Conclusion

The promotion and support of nurturing caregiving relationships must be recognised and prioritised at the highest levels if we are to fulfil our vision of a society where children and adolescents are thriving and reach their full potential. The interventions described in this essay can only be implemented effectively if systems and structures are adequately resourced and well-functioning.

Home-, school- and- community-based programmes are critical to reach children and families in their everyday environments, and to enable service providers to identify vulnerabilities and intervene early. These programmes are also more likely to reach those vulnerable families who are most in need of support. Investing in evidence-based preventive programmes that promote nurturing care will significantly contribute to addressing the equity gaps and minimise tertiary costs of mental health conditions, behavioural and relational problems and cognitive deficits.[55]

While earmarked funding is required for certain programmes, there are a few possible quick wins that do not require much additional funding, such as including mental health screening at antenatal and well-baby visits, and using the WHO Care for Development package to provide basic support and information on positive parenting and practical caregiving. Professionals and paraprofessionals working in the health, education and social development sectors have a critical role to play, as every contact with a caregiver or child is a gateway to identify risks and offer appropriate support and referral.

Local implementation of the SDG framework provides a key opportunity to address the multiple risk factors that undermine families' capacity to provide nurturing care, and calls for the strengthening of government and civil society systems to foster the development of enabling environments. But, unless the adoption of the SDGs facilitates improvements in the quality of caregiving relationships and support for caregivers, they are likely to have a limited impact on children's care and development.

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