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# Promoting Early Childhood Development through Combining Cash Transfers and Parenting Programs

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## Abstract

This paper examines the potential for bringing together cash transfer and parenting programs focused on child stimulation to boost child development, particularly for children ages 0–3 years. The paper reviews the rationale for linking both types of programs and the evidence to date on the impact of cash transfer programs, parenting programs, and their combination. The paper reviews the main operational features of 10 examples of combining cash transfer and parenting interventions and identifies four models for structuring the combination: integrated, convergence, alignment, and piggy-backing. The paper finds promising evidence for combining the interventions, where adding the parenting program to the cash transfer program has improved some parental practices and child development outcomes, with results in cognition and language. However, the evidence is still scarce, and more research is needed to understand the key elements of the optimal combinations, fidelity of implementation, cost-effectiveness of different design features, replicability, and sustainability of results.


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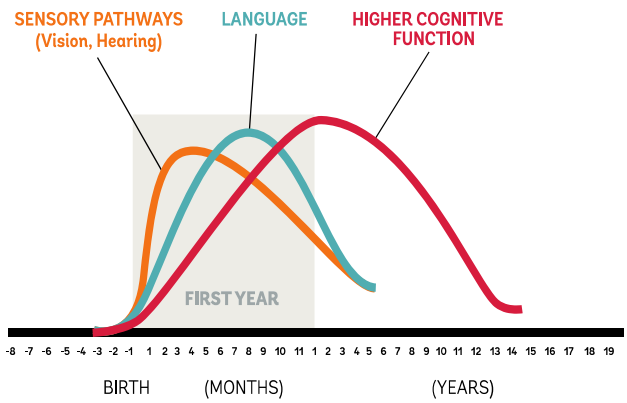
# Chapter 1. Introduction

Investments in the early years of life are the foundation of human capital. Human capital consists of the knowledge, skills, and health that people accumulate throughout their lives, enabling them to realize their potential as productive members of society. Countries need to invest in human capital to sustain economic growth, have a well-prepared workforce and compete effectively in the global economy. Increasingly, governments and international organizations are shifting the attention to invest in human capital. For instance, the World Bank Group has recently launched the Human Capital Project to accelerate investments in people and multiple countries are joining this initiative. To be effective, countries need to start investing early in a child's life, ensuring a strong foundation for human capital accumulation.

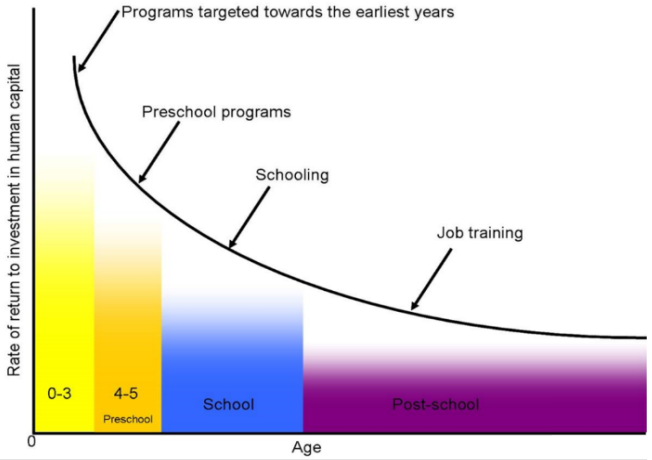
The first 1,000 days of a child's life are a window of opportunity to lay a strong foundation for later achievements. This timeframe is a period of enormous change characterized by a high degree of plasticity in the child's neurological development (figure 1.1). How children develop from conception through age five affects their health, education, and well-being as adults (Grantham-McGregor et al, 2007 and Black et al, 2011, Currie and Almond 2011). Beginning in utero, early investments become cumulative, increasing the value of investments in the later stages of life and serving as a foundation for skills and overall human capital development. As stated by James Heckman, economist and Nobel Laureate: "Skill begets skill" (Cunha and Heckman 2007. Cunha, Heckman, Lochner, and Masterov 2006).

**Figure 1.1: Human brain development**




Source: Nelson (2000). Center on the Developing Child, Harvard University

**Figure 1.2: Rate of Return to Human Capital Investments:** Returns to an extra dollar at various ages




Source: Heckman, J. (2008). "School, Skills, and Synapses"

Investing in the early years is one of the smartest investments a country can make to address extreme poverty, reduce inequality, boost shared prosperity, and develop the human capital needed to grow and diversify its economy. Today, over 250 million children under 5 years old in the developing world risk not reaching their full potential because of deficient investments in nutrition, early

stimulation, early learning, and nurturing care, as well as due to exposure to stress (Britto et al. 2017). An early disadvantage can permanently and profoundly impact a child's development, making remediation more costly and difficult later in life, whereas early investments have been shown to have very high rates of return (figure 1.2). Investing in young children can be a cost-effective strategy not only to promote a healthier and more productive population, but also as a powerful promoter of opportunity for disadvantaged children.

Cash transfer programs are in a privileged position among public sector programs in that they are targeted to the poorest and most vulnerable families where deprivations such as chronic malnutrition and other indicators of poor child development are concentrated. They also benefit from a rich legacy of focusing on behavioral practices, particularly concerning parents' investments in children. There is already established evidence on the contributions made by cash transfers in protecting and boosting children's health, nutrition, education and access to core services (Fernald et al. 2012, De Walque et al. 2017, Bastagli et al. 2016).

Cash transfer programs are often specifically designed to address not only present poverty, but also the intergenerational transmission of poverty by fostering human capital investments, specifically in children. This is done by attaching several "accompanying measures" to the transfer that often take the form of "conditions" or "co-responsibilities" expected from the recipient households as recipients of the cash transfer. The most common of these "co-responsibilities" are related to building the human capital of the children of the household by encouraging or requiring parents to take their babies to health clinics for pre- and post-natal care, attend growth promotion sessions, and to ensure that their children go to school. Increasingly, cash transfer programs are also encouraging parents and caregivers to participate in parenting programs to improve their knowledge and practice as the main architects of their children's development.

How can cash transfers be most effective to boost children's development? This paper is the first effort to bring together evidence and experience from combining cash transfers and parenting interventions to improve child development outcomes. This work builds on an established body of literature that examines the nexus between cash transfer programs and nutrition and health outcomes (Black et al. 2015, Galasso et al. 2016, Leroy et al. 2009, Bastagli et al. 2016), that provides operational guidance on how to combine cash transfers with nutrition interventions (World Bank, 2013), and on policy options for promoting children's growth and development in the early years (see Denboba et al. 2014 for a description of 25 key interventions from pregnancy to 72 months).

This paper focuses on the potential, the practice and the evidence from combining cash transfer programs with parenting interventions. It acknowledges the importance of investments in the first 1,000 days of life, the role of parents as the main agents of children's development, the position of cash transfer programs as direct interlocutors with poor and vulnerable households, and the evidence to date on child development outcomes from cash transfers, parenting programs and their combination.

This paper is organized as follows. Chapter 2 looks at the rationale for combining cash transfers with accompanying measures to boost child development outcomes, such as the development

of language, cognitive skills, motor skills, and social-emotional skills. In chapter 3, we briefly review the evidence of cash transfer programs on child development. In Chapter 4, we review parenting programs summarizing their main elements and evidence from small-scale interventions. Chapter 5 looks at rigorous evidence from four large-scale interventions that combine cash transfer and parenting programs to shed light on the potential effects of combining these interventions. In Chapter 6, we draw lessons from the operational practices used in 10 case studies of combined cash transfer and parenting interventions in lower- and middle-income countries around the world. The paper ends with a discussion on areas for further research and experimentation.

## Chapter 2. Cash Transfers and Accompanying Measures to Boost Child Development: Theory of Change

Poverty has a wide-ranging detrimental effect on child development and human capital formation. Children living in poverty are exposed to a variety of risks, including disease, malnutrition, violence, and neglect. The developmental gaps between children living in more versus less affluent families have been amply documented (see Fernald et al., 2011a and 2013; Carneiro and Heckman, 2003; Currie, 2009; Rubio-Codina et al., 2015; Hart and Risley, 1995). These gaps start early in life and tend to grow over time. In Bangladesh significant cognitive development gaps between children of different socioeconomic backgrounds emerge as early as seven months after birth and increase as the children age (Hamadani et al. 2014). Moreover, there is an increasing consensus that events and experiences in the early years have long-lasting consequences for an individual's development and productivity (Currie and Almond 2011, Campbell et al. 2014, Chetty et al. 2011).

Cash transfer programs can protect households against chronic poverty and financial risks, while also providing a way to leverage critical human capital investments, notably in young children from poor households. Cash transfer programs provide households with the income support to fight poverty and invest in the human capital of their members. Cash transfers enable poor families to spend more on goods (nutritious food, clean water, medicine, toys, books and so on) and services (health care and education). Cash transfers can allow a better time-use for family members, for instance, allowing parents to provide more nurturing care. Cash transfers can improve families' psychological well-being by reducing the pressure of financial strain and deprivation. [1] By doing so, cash transfers may also create a household environment that is more conducive to children's healthy growth and development. Moreover, cash transfers allow families to prevent and mitigate the negative and long-lasting impact that shocks have on human capital formation and individual well-being, supporting the reduction of intergenerational transmission of poverty. In Mexico, PROGRESA Conditional Cash Transfer Program helped to

[1] Cash transfer programs have been found to have improved the psychological well-being of family members in beneficiary households. For instance, Haushofer and Shapiro (2016) found that the Kenyan unconditional cash transfer program GiveDirectly led to an increase of 0.16 SD in happiness (measured by the World Value Survey question on happiness), a 0.17 SD increase in life satisfaction (measured by the World Value Survey), a 0.26 SD reduction in stress (using Cohen's Stress Scale), and a significant reduction in depression (all measured by psychological questionnaires).

mitigate the impact adverse shocks early in life on educational and labor market outcomes the child achieved as an adult (Adhvaryu et al. 2018).

Parents and caregivers are the architects of their children's development. They are crucial to the healthy development of infants, acting as agents responsible for investments in their nutrition, health and safety. They shape the environment in which the child develops and help ensure a safe, supportive home as well as access to key services. Beyond this, parents also actively shape children's skills and socio-emotional development by talking to them, playing with them, reading or telling stories to them and interactively responding to their cues.

Cash transfers address budget constraints which limit households' ability to meet basic needs (e.g. nutritious food or medical treatment) but also look to address information asymmetries and provide incentives for investments in human capital. Private investment might be below the optimal level for the child if parents lack information regarding returns to those investments (e.g. differences between expected and realized rates of return) or if there are intrahousehold principal-agent problems (parents make education decisions for their children, but discount the future at a higher rate of return and, therefore, demand less schooling than is optimal for the child) or conflicts of interest (between parents themselves or between parents and children).

The combination of the cash transfer and the accompanying measures designed to improve parents' own practices and support to children can be a powerful tool to improve child development during the early years. The theoretical framework for combining cash transfers with early years interventions is presented in Figure 3.1, where the top half displays the income effect of cash transfers on children's outcomes. The bottom half displays the information, goods and services that parents access through cash transfer programs' accompanying measures, with results on access to services and changes in young children's physical health, nutrition, cognitive and non-cognitive skills. This model illustrates the following:

- Cash transfer programs operate at the household level, enabling poor parents to relax their household's budget constraints and thus improve their home environment (for instance, providing access to clean water, better sanitation, access to toys and books, etc.), spend more time engaging with their children (for instance, playing, talking and reading to children) and invest in their children's health, nutrition, and education. Cash transfer programs also provide "protection" from chronic poverty and/or income shocks, preventing or mitigating the detrimental impacts that negative shocks could have on human capital accumulation.

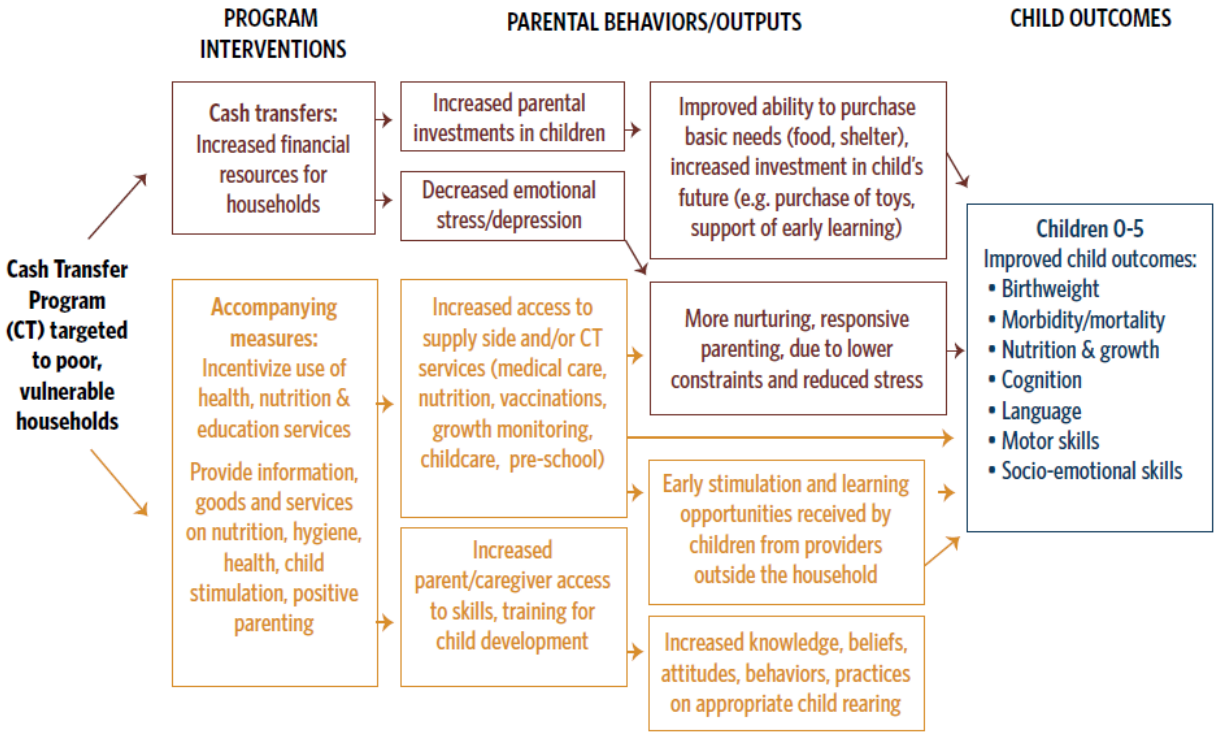
- Cash transfers can improve the psychological well-being of household members by reducing the effects of financial strain and deprivation. In turn, this allows parents to engage more positively with their children to promote child development. Symptoms of depression such as depressed mood, irritability, disrupted sleep, low energy, and hopelessness can clearly impair parents' capacity to nurture and interact with their children. A growing literature demonstrates that maternal depression is associated with

poorer cognitive and physical development of their children (Engle et al. 2009; Minkovitz et al. 2005; and Leiferman et al. 2002).

- Accompanying measures can operate on several levels to promote investments in children's human capital:

    - *They can be used as incentives to encourage pregnant mothers and parents to use available supply-side services* such as the case of requirements for school attendance and growth monitoring commonly found in conditional cash transfers.
    - *Cash transfer programs can directly provide child focused goods and services* as part of the cash transfer program. This approach is often used when supply-side services in health, nutrition and/or education are in limited supply or of poor quality.
    - *Accompanying measures can also be introduced as behavioral elements*, through 'nudges' or information and training for parents to support acquiring knowledge and skills that promote their young children's physical health, cognitive and non-cognitive skills, and care to provide them with a safe and stimulating environment for early learning and development.

**Figure 2.1: Cash Transfers and Accompanying Measures for Child Development**




*Source*: Author's adaptation from Fernald et al. (2012) and Alderman (2015)

To be successful, cash transfer programs need to include the poorest effectively and have regular, predictable, and large enough transfers to enable poor households to invest in the human capital of their members. Moreover, the impact on final outcomes will depend on the quality of the services provided by different sectors as well as the practices inside the household and environment outside the home.

The premise explored in this paper and through practice in many safety net programs is that cash transfers can have larger effects on children's outcomes if they increase their focus on child care and cognitive stimulation through parental training and access to high-quality daycare and preschool opportunities. Strong biological, psychosocial, and economic arguments exist for intervening as early as possible to promote, protect, and support children's development during pregnancy and the first years of life. Evidence from early childhood interventions suggests that impacts are larger on more disadvantaged populations (Engle et al. 2011) and that including a stimulation component can improve the impact on child development. Nores et al. 2010 reviewed 30 ECD interventions in 23 developed and developing countries and found that those that included an educational or stimulation component had larger cognitive effects than cash transfers or solely nutritional interventions. Similarly, Aboud et al. 2015 reviewed 21 stimulation interventions and 18 nutrition interventions for children under 24 months, finding effects from stimulation interventions on cognitive outcomes were, on average, more than four times larger than the effect of nutrition interventions. Cash transfers have the potential to be a promising

way to scale up ECD since they target poverty, which is a root cause of poor child development, have large-scale and efficient delivery platforms, and have significant political support.

## Chapter 3. Cash Transfers and Child Development: A Summary of the Evidence

Robust evidence from impact evaluations of cash transfer programs reveals impacts on reducing poverty, increasing children's food consumption and dietary diversity, increasing pregnant women and young children's use of preventive health services, and, in some cases, improving the physical and psychological well-being of mothers and health and nutrition outcomes among young children. In a recent review of 165 studies of conditional cash transfer (CCT) and unconditional cash transfer (UCT) programs in 30 countries, Bastagli et al. (2016) found strong evidence that cash transfers are associated with reductions in monetary poverty, reporting an increase in total expenditure (25-26 studies) and food expenditure (23/25 studies) and a reduction in poverty measures (6/7 studies). The authors also found that cash transfer programs increase the uptake of health services (9/15 studies) and dietary diversity (7/12 studies). Another review, focused on child outcomes (de Walque et al. 2017), reported improvement in prenatal care (8/12 studies), presence of skilled birth attendance (8/11 studies), growth monitoring (11/14 studies) and child food consumption (3/5 studies). Symptoms of depression can impair mothers' capacity to nurture and interact with their children. A growing literature demonstrates that maternal depression is associated with poorer cognitive and physical development of their children (Engle et al. 2009; Minkovitz et al. 2005; and Leiferman et al. 2002). Ozer et al. 2011 found that the conditional cash transfer program in Mexico (Oportunidades) reduced depressive symptoms in mothers receiving the cash transfer.

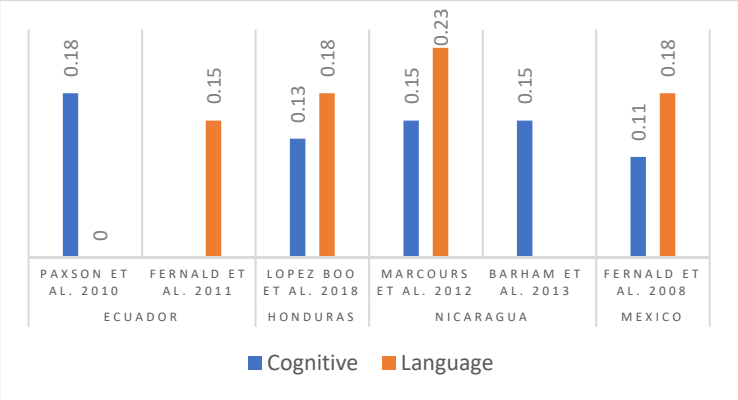
Increments in the use of health services and improvements in dietary diversity sometimes have translated into better health and nutritional outcomes for the children.[2] De Walque et al. 2017 reported improvements from cash transfer programs on birthweight (3/3 studies), perinatal, neonatal or infant mortality (4/6 studies), illness or sick days (9/13 studies), height-for-age or stunting (14/23 studies), weight-for-age or underweight (4/12 studies) and weight-for-height or wasting (4/9 studies). Ultimate impacts on health and nutrition will also depend on the quality of the health and nutrition services available.

Cash transfer programs have had significant impacts on children's cognitive and language skills. In impact evaluations from Ecuador, Honduras, Nicaragua and Mexico, significant impacts of cash transfers on children's cognitive and language skill were documented, at least in a subgroup of

[2] Increased household food consumption has not consistently translated into improved nutrition as impacts on anthropometric outcomes for the children of these beneficiary households have been inconclusive (de Walque et al. 2017). There are several possible explanations for this: (i) food within the household is allocated in such a way that children do not receive more or better nutrition; (ii) the household has little knowledge of adequate feeding practices for infants and young children; and (iii) environmental risks such as a lack of safe water and poor sanitation. Another reason might be limitations in the design of the studies of the impact of cash transfers on child nutrition, including small sample sizes, the sample of children being older and thus less sensitive to nutrition inputs, and delays or errors in program implementation.

children, and ranged between 0.09 and 0.23 standard deviation. In Ecuador, the unconditional cash transfer program *Bono de Desarrollo Humano* had a significant positive impact on long-term memory (+0.18 SD) for children between 3 and 6 years old in rural areas (Paxson and Schady 2010) and language skills (+0.15 SD) only for younger children, aged between 12 to 35 months old (Fernald and Hidrobo 2011). A short-term evaluation of the Nicaragua's conditional cash transfer program *Red de Protección Social* also reported significant positive impact in cognitive skills (short-term memory), language and receptive language after one year of exposure to the program. Those first two impacts were sustained, but smaller in size, after two years (Macours et al. 2012). A long-term impact evaluation of the same program compared boys who benefitted from the program early in life (between in utero period and 2 years old) with those who benefitted from it later (Barham et al. 2013), finding that early exposure in life increased cognitive skills at age 10. In Honduras, the randomized impact evaluation of *Bono 10,000* improved language skills and the overall measure of cognitive development[3] that combined multiple domains (communication, gross motor, fine motor, problem solving, and personal-social) (Lopez Boo and Creamer 2018). The main results on cognitive and language skills are presented in Figure 3.1 and detailed information in table 3.1.

**Figure 3.1: Impact of Cash Transfers on Cognitive and Language Development**




*Sources*: Paxson et al. (2010), Fernald et al. (2011b), Lopez Boo et al. (2018), Marcours et al. (2012), Barham et al. (2013), and Fernald et al. (2008).
*Notes*: Based on Table 3.1. Selected effects are reported in standard deviations when statistical significant at 10 percent. No significant effects are reported as zero and unmeasured effects as missing.

[3] Results for problem solving (cognition) were not reported separately.

## Table 3.1: Effect of Cash Transfers Programs on Cognition, Language, and Behavior

| Evaluation | Country | Sample Size | Evaluation design | Type of cash transfer | Timeframe | Age | Impact (SD) | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Cognitive | Language | Fine Motor | Socio-Emotional |
| Paxson & Schady (2010) | Ecuador | 77 rural parishes<br>T51; C26<br>N=2,069 | RCT | UCT | 2 years | 36-83 months | WJ test: Long-term memory (+) 0.18 SD but not other subscales | TVIP: no significant difference | no significant difference | BPI<br>All: no significant difference<br>Lowest quartile: (+) 0.27 SD |
| Fernald & Hidrobo (2011) | Ecuador | 118 parishes<br>Rural: T51; C26<br>Urban: T28; C13<br>N=1,196 | RCT | UCT | 2 years | 12–35 months | n/a | MA test<br>Rural: (+) 0.15 SD<br>Urban: no significant difference | n/a | n/a |
| Lopez Boo and Creamer (2018) | Honduras | 1,505 children | RCT | CCT - Schooling and Health Check-ups | 1 year | 0-5 years old | Overall ASQ-3: 0.13 SD | Communication:<br>All: (+)0.18 SD | n/a | n/a |
| Macours, Schady, and Vakis (2012) | Nicaragua | 106 Communities<br>T56; C50 | RCT | CCT - Schooling and Health Check-ups | 1 year | 0–83 months | Short-memory: 1st FU: (+) 0.15 SD<br>2nd FU:(+) 0.09 SD | TVIP R: (+) 0.23 SD (1st FU only)<br>Language: 1st FU: (+)0.14 SD. 2nd FU: (+) 0.09 SD | 1st FU: no sign. diff.<br>2nd FU:<br>(+) 0.16 SD | 1st FU:<br>(+)0.13 SD<br>2nd FU:<br>(+) 0.01 SD |
| Barham, Macours, and Maluccio (2013) | Nicaragua | 368 boys<br>C197 late treatment<br>T171 early treatment | Randomized phase-in | CCT - Schooling and Health Check-ups | 3 years | 0-2 years old (early exposure to program) | (+) 0.15 SD for boys exposed to program between 0-24 months | n/a | | no significant difference |
| Fernald, Gertler, and Neufeld (2008) | Mexico | 506 localities<br>T320; C186 | Randomized phase-in | CCT - Schooling and Health Check-ups | 5 years | 24–72 months | Memory: (+)0.11 long-term, (+) 0.10 short term, (+) 0.09 visual integration when doubling CCT | TVIP: (+) 0.18 when doubling CCT | no significant difference | n/a |
| Fernald, Gertler, and Neufeld (2009) | Mexico | 506 localities<br>T320; C186 | Randomized phase-in | CCT - Schooling and Health Check-ups | 10 years | 8-10 years old | no significant difference | no significant difference | n/a | Behavioral problems: reduced by 0.14 SD |

*Sources:* Based on Fernald et al. (2012) and Lopez Boo et al. (2018)

*Notes:* UCT = unconditional cash transfer; CCT = conditional cash transfer. FU stands for Follow up, n/a stands for outcome not measured. TVIP = Peabody Vocabulary Test, WJ = Woodcock-Johnson-Munoz battery, BPI = Behavioral problem index, MA = MacArthur Language Test, and MC = McCarthy test. All significant effects have a p-value<0.05. Effects are reported as standard deviations (SD).

Some impacts on children's behavior and fine motor skills were also reported but were less measured. Three of four evaluations found positive impact on child behavior ranging between 0.01 to 0.23 SD and one of two evaluations on fine motor skills. In Ecuador, improvements in the behavior were found only of beneficiary children in the lowest quartile of per capita expenditure (Paxson and Schady 2010). In Mexico, children who were randomly assigned to the CT program earlier in their lives had fewer behavioral problems at age 10 than those who were randomly assigned to receive the program 18 months later (Fernald et al. 2009). Of the three evaluations that measured fine motor skills, only one study in Nicaragua found that the CT program had a positive impact (0. 16 SD) during the second follow-up.

# Chapter 4. Accompanying Measures to Boost Child Development: Parenting Programs

Accompanying measures can be introduced in different formats to promote child development. They can be used as incentives to increase the use of available services such as to encourage the use of health services for pregnant women and young children or increase the participation in preschool. They can also be introduced as *behavioral elements*, through 'nudges' or information and training for parents to support acquiring knowledge and skills that promote early childhood development. The selection of accompanying measures should be guided by the diagnostic of the challenges identified in the early years. In this chapter, we explore parenting interventions with emphasis in children 0-3 years old given the important role that parents play in the production of children's human capital. The focus of this chapter is on parenting interventions alone and the next chapter will explore the combination of parenting intervention and the cash component.

## 4.1 What is a Parenting Program?

**Figure 4.1: Parenting Programs**

**WHAT IS A PARENTING PROGRAM?**

Interventions or services aimed at enhancing parent-child interactions, parenting knowledge, beliefs, attitudes, behaviors and parenting practices through training, support, and coaching

**WHAT TOPICS DOES IT COVER?**

- Nutrition
- Health
- Hygiene
- Child stimulation
- Positive parenting

**HOW IS IT DELIVERED?**

- Home visits
- Community-based group meetings
- Primary health care facility or health care center
- Combination

Parenting programs are interventions or services aimed at enhancing parent-child interactions and the knowledge, beliefs, attitudes, behaviors, and parenting practices of parents by providing them with training, support, and coaching (Britto et al. 2017). Parenting interventions rely on

indirectly affecting the child by changing parental behavior. They provide skills training using active learning approaches[4] and/or coaching for parents and/or caregivers involving live modeling of skills, practice of skills with their children, direct observation of and feedback on the parent-child interactions, between-sessions homework, and contingency management principles such as logical consequences, time out, and quiet time (Mejia et al. 2012). Specific elements critical for child development include teaching parents better feeding practices for infants and young children; increasing the attachment between parents or caregivers and children; and encouraging the use by parents of learning, book reading, play activities, positive discipline, and problem solving regarding their children's development, care, and feeding (Engle et al. 2011).

## 4.2 What are the elements of a parenting program?

- ***Content***

In developing countries, parenting interventions for infant and toddlers usually focus on nutrition and health, stimulation (play and talk), responsive feeding (quantity and quality), or hygiene (hand washing and toileting) or on a combination of activities in these areas. Stimulation interventions are based on the finding that children need fine motor play activities and materials, along with adult conversation, in order to develop cognitive and language skills in the first few years (Tamis-Lemonda et al. 2001). Nutrition information interventions are based on best practices to support healthy rate of growth including exclusive breastfeeding from birth to six months and provision of sufficient energy, protein, and fats thereafter. Hygiene messages look to reduce child exposure to intestinal diseases.

The three curricula that are most often used to inform the design of parenting programs in developing countries are: (i) the Reach Up model based on the Jamaica home visiting program, which teaches parents how to engage their children in activities to promote cognitive stimulation; (ii) the Care for Child Development model designed by WHO and UNICEF to guide health workers and other community-level workers to provide parents with information and knowledge about cognitive stimulation and about how to provide socio-emotional support to their children; and (iii) the Learning Through Play model developed in Canada to train parents with low levels of education on children's physical and mental development. (For details see box 4.1. 4.2 and 4.3).

Parenting programs use a set of social and behavior change communication (SBCC) strategies to improve parental behavior. A larger number of SBCC techniques seems to be associated with better impacts on child cognitive development. SBCC strategies can include the provision of 1) structured information and instruction (e.g., curriculum organized by developmental stages on what the caregivers should do with their children and why); 2) performance activities (opportunities for parents to practice play activities with their young children and receive

[4] Active learning approaches involve instruction to parents that goes beyond to passively providing information. Parents are actively engaged in discussions, doing activities, and thinking about things they are doing. Frequently involve practicing with children and getting feedback from coaches.

feedback on how the interaction might be strengthened and positive reinforcement); 3) problem solving (identifying facilitators and barriers to behavior change and solutions to reducing barriers, for instance, addressing maternal depression, the need for family support, a lack of time, a lack of resources, and not knowing how to talk to infants.); 4) social support (peer, community, and authority support); 5) material (home-made toys); and 6) small media (songs, role plays, pictures, flash cards, and posters to illustrate ways of stimulating small children). In a systematic review of 21 studies, Aboud et al. 2015 reported that the greater the number of SBCC applied the more effective the intervention was at improving young children's cognitive development. Individually, the 3 techniques with the strongest correlation to children's cognitive outcomes were the use of small media, performance-based techniques, and problem solving.

**Box 4.1: Reach Up Parenting Curriculum (From 6 to 42 months)**

The Reach Up Early Childhood Parenting Program provides a structured training course for home visitors to help parents improve their child's development. The program consists of home visits by trained practitioners to teach parents how to use the materials to teach their children, build parents' self-confidence and develop their knowledge and skills to provide a happy, stimulating environment and encourage the mother to continue activities between visits and integrate them into daily routine. The visits include demonstration of play activities involving the mother, or primary caregiver, in a play session with her child. Visits comprise various combinations of language activities, games, songs, simple jigsaw puzzles, and crayon and paper activities. Homemade toys of recyclable materials and simple picture books are used in the play sessions and left in the home and exchanged at the next visit. Emphasis is placed on enriching verbal interaction between the mother and child; mothers are encouraged to chat with their children and to name things and actions in the house and yard. Mothers are also encouraged to use positive feedback and praise and to avoid physical punishment (Walker et al. 2011).

The Reach Up toolkit includes a weekly curriculum for children 6 months to 42 months old; training manual with demonstration videos that were filmed in Jamaica, Peru and Bangladesh; a supervisor manual; a toy manual and an adaptation and planning manual that helps countries tailor the program to fit their specific needs. In addition to Jamaica, the Reach Up program has been adapted for Bangladesh, Brazil,[5] China, Colombia, Guatemala, India, Madagascar, Peru and Zimbabwe. The material is free, but access needs to be requested through the Reach Up website.[6]

The Reach Up curriculum is based on the successful Jamaica Home Visit Program that is the most influential study of a home visiting program in developing countries. Between 1986 and 1989, 129 malnourished children aged 9–24 months in the poorest neighborhoods in Kingston were randomly assigned to one of two conditions for two years: one group of children served as the control group, while the other group received a home stimulation intervention in which families were visited one hour a week by a community health worker (Grantham-McGregor et al. 1991). Twenty-four months after the intervention started, the study found positive effects on several child development outcomes for those who received the home visits. In terms of cognitive development, children in the treatment group had scores about 0.8 standard deviation higher than those in the control group. Twenty years after the intervention, those who had received the stimulation intervention continued to have higher IQ and educational attainment, improved mental health (reduced depression and social inhibition), less violent behavior, and earnings around 25 percent higher than those in the control group (Gertler and others 2014; Walker and others 2011).

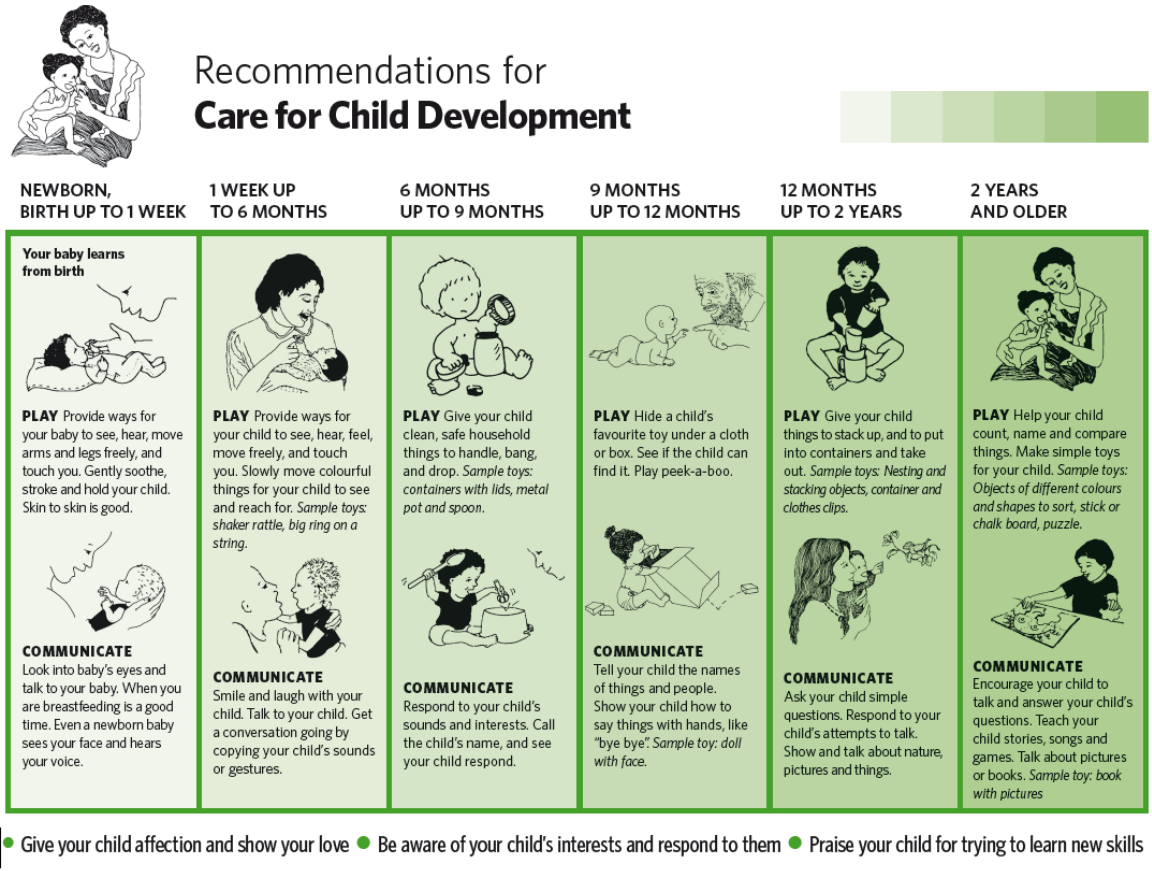
[5] Implementation of Reach Up in Brazil and Zimbabwe has been documented in Smith et al. 2018.

[6] Visit http://www.reachupandlearn.com/ for more information.

**Box 4.2: Care for Child Development Parenting Curriculum (From 0-6)**

The Care for Child Development training package was developed by UNICEF and WHO (UNICEF 2012). It provides information and recommendations for cognitive stimulation and social support to young children, through sensitive and responsive caregiver-child interactions. The package guides health workers and other counselors as they help families build stronger relationships with their children and solve problems in caring for their children at home. It includes modules on how to stimulate children through play and communication as well as advice on feeding, and how to integrate the feeding and caring activities. It provides these materials in the form of a training course with manuals for participants and facilitators and activity cards. The material is available in English and French.[7] The program has been evolving since its inception when it formed part of the WHO's Integrated Management of Childhood Illness strategy. An example of the recommendation is provided in figure 4.2.1.

**Figure 4.2.1: Counseling card**




The efficacy of the curriculum was initially tested using a randomized control trial in Turkey (Ertem, et al., 2006). Pediatricians provided the intensive counseling to 120 families with children under 24 months during two clinic visits one week apart. Interviews were used to assess how the caregiver plays and communicates with her child followed by a discussion of appropriate strategies to promote positive mother-child interaction and play activities. Mothers were also encouraged to read picture books to their child. After a month, there was an increment on home-made toys and reading activities with children. A second efficacy study was conducted in rural China (Jin et al. 2007) on 100 families with children under 24 months where approximately half of them received two sessions of 30-60 minutes by a trained specialist in a period of six months. Positive impact was found on cognitive and language development (approx. 0.50 SD). The WHO/UNICEF Care for Child Development was then tested at a bit

[7] More information on the package is available at https://www.unicef.org/earlychildhood/index_68195.html.

larger scale in Pakistan where 359 of 705 were randomly assigned to the stimulation intervention. This trial, known as the Pakistan Early Child Development Study (PEDS), provided more insight into the effectiveness of the package delivered through front-line health workers through monthly home visits and group meetings since birth until age 24 months. The study found higher development scores on the cognitive, language, and motor scales at 12 and 24 months of age, and on the social-emotional scale at 12 months of age (Yousafzai, et al. 2014). The mothers were less depressed, and the family environment was more positive and stimulating (Petrovic & Yousafzai, 2013).

## Box 4.3: Learning through Play Parenting Curriculum (From pregnancy to six years)

Learning Through Play (LTP) is a low literacy program designed to provide parents and caregivers with information, tools and training on the physical health, growth and mental health of their children (from birth to 6 years of age). The program was originally developed in Toronto, Canada for use by home visitors working with at-risk multi-ethnic parents and children and adapted for use in many developing countries for children 0-6 (Bevc 2004). The objectives of the LTP program are: (a) to provide parents with information on the healthy growth and development of young children (birth to 6 years), focusing on the physical, intellectual, linguistic, and socio-emotional aspects of development; (b) to teach parents play activities that enhance child development; and (c) to promote attachment through active parental involvement in their child's development. The activities aim to enhance child development while simultaneously promoting attachment security by building parents' ability to read and teaching them how to be sensitive to their child's needs. The program uses a hands-on approach that emphasizes learning through demonstration and practice.

The LTP involves a pictorial-based developmental calendars in numerous languages,[8] to assist parents and caregivers in developing play activities and to learn how to stimulate children's development at all stages from 0-6. They are called "calendars" because parents literally hang the materials on the walls in their homes to allow for easy reference. The LTP Calendars encourage parental involvement, creativity, learning, and parent-child attachment. The calendar is accompanied by a comprehensive training manual for workers, which provides additional information on child development and techniques on how to conduct groups or individual sessions for parents, using the calendar as a focus. A training manual has been developed specifically for integrating infant stimulation into emergency feeding situations by International Medical Corps and UNICEF (Hinchs-Dellcrest Centre 2002, Jones & Crow 2017).

The program can be carried out by a variety of workers (e.g. health workers, daycare workers, lay home visitors) after appropriate training. The program is flexible and can be delivered in a variety of formats with individual parents or groups of parents (e.g. a 1-week workshop, integrated with routine antenatal and post-natal visits, or spread over the first 3 years of a child's life, with parent groups conducted at regular intervals). The 'Learning Through Play' calendar is a relatively inexpensive and simple tool that relies minimally on the literacy of the parents.

In Pakistan, the 'Learning Through Play' was adapted to be integrated into the existing health system in rural areas. Results from an experimental design evaluation (Rahman et al. 2008) showed significant increase in the mother's knowledge and positive attitudes towards their infant's development, as well as significant reduction in symptoms of mental distress in the mothers. However, the evaluation did not assess child development outcomes.

[8] Calendar birth to three is available in English, French, Spanish, Chinese, Vietnamese, Punjabi, Tamil, Urdu, Portuguese, Somali, Arabic, Farsi, Hindi, Bengali. Calendar three to six is available in English, French, Spanish, Somali, Chinese, Vietnamese, Tamil, Portuguese, Punjabi, Arabic, Urdu, Hindi, Farsi.

- ***Dosage***

The dosage of a program is a combination of the frequency of the contacts (weekly, fortnightly, monthly), the duration of each contact (minutes), and the duration of the program (number of months). The total intensity of the program ranges from less than 10 hours to 120 hours. There is no conclusive evidence on what is the ideal dosage. In general, more contacts do not necessary translate in better/larger effects child outcomes (Engle et al. 2011). There was only one study conducted in Jamaica to explore the role of different frequencies on child development in a similar context (see box 4.4) where increasing the frequency of the contacts had larger impact on child development.

**Box 4.4: Frequency of contacts and child development**

Two studies were conducted in Jamaica to understand the effectiveness of different frequencies of home visits. In the first study groups received monthly, fortnightly and no home visits. After a year, children whose parents were visited fortnightly showed small but significant increases in development compared with the monthly visits and the control group A. In the second study, groups received either weekly home visits or no visit. Children whose parents were visited once per week showed better development than those in the control group B.

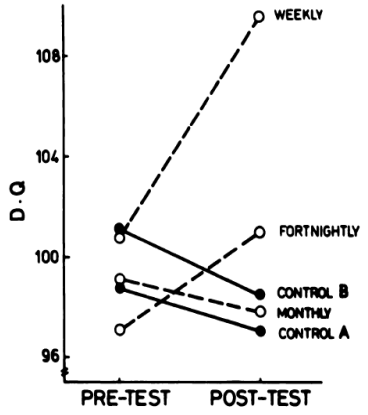



**Figure.** Mean developmental quotients on Griffiths Scales of children older than 18 months of age from study 1 and all those from study 2 at initial testing and after 1 year of intervention.

As the frequency of visiting increased from none to monthly, fortnightly and weekly, the benefits increased as well.

*Source: Powell et al. 1989.*

- ***Delivery modality***

Parenting programs are delivered through home visits, community-based group meetings, visits to primary health care facilities or health centers, or some combination of these. Selection of the appropriate delivery modality will depend on a range of factors, including the context in which the parenting program is being applied, the target population, the qualifications and availability of frontline workers and costs. Table 4.1 provides an overview of some of the pros and cons faced when deciding between home visits to individual families, community-based group meetings or sessions in clinics.

**Table 4.1:**
**Pros and cons of delivery modalities for parenting programs**

| Home visits to individual families | Community-based group meetings | Health center visits |
|---|---|---|
| Pros | | |
| • Allows for tailoring the intervention to the developmental stage of each child and to the household context<br>• Engages the whole family in their own environment<br>• Allows practice with the child<br>• Builds a positive relationship between the home visitor and parents, which can provide them with emotional support and help to reduce maternal depression<br>• Reaches marginal households<br>• Increases take up/participation as families do not need travel | • Brings in motivated parents (self-selection), which bodes well for their compliance with the program's expectations and activities<br>• Encourages peer support among parents and may modify group norms about child rearing.<br>• Lower cost per child; more sustainable and scalable<br>• Less labor intensive than home visits | • Parenting and growth promotion can be combined as part of well baby check-ups<br>• Can adhere to established schedule for well baby check-up, vaccination protocols<br>• Incentives/conditions for receiving cash transfers, can be combined for parenting and health center visits<br>• Relies on more qualified staff to deliver the intervention and might require less training |
| **Cons** | | |
| • Challenging to manage home visitors' caseloads<br>• Requires capacity for managing a range of issues such as domestic violence and drug abuse rather than focusing exclusively on child development<br>• Might require rescheduling and conducting multiple visits when the child is sick, mother is not available despite the | • More difficult to ensure that interventions are tailored to the needs of the children/household<br>• Relies on parents to enroll and attend program and apply lessons<br>• More difficult to schedule age-specific group meeting to deliver a specific curriculum<br>• Often relies on frontline workers to develop new skills to work with groups | • Depends on access to health centers<br>• Depends on cooperation with health sector<br>• Health worker staff may have limited availability, interest in taking on more responsibilities<br>• Coordination issues if NGOs are contracted to deliver programs in health facilities<br>• May not reach most marginalized groups |

| | | |
|---|---|---|
| appointment was made, etc.<br>• Generally more expensive | | who do not regularly visit health facilities |

In terms of effectiveness, there is little experimental evidence to guide choices across these delivery modalities. Two ongoing evaluations funded by the World Bank, one in India and other in Guatemala, can be expected to yield information on the effectiveness of parenting intervention delivered by home visits versus group meetings for improving child development. Additionally, a review that compares 10 studies using the home visit modality with 7 studies that combined home visits and group meeting (Aboud et al. 2015) suggests that the combination of delivery modality had better impact on child development (average 0.60 vs 0.32 standard deviations). But the evidence is still limited to reach general conclusions.

- ***Frontline workers***

Depending the delivery modality, the implementation of the program can rely on health staff, and community workers or both. In developing countries, the programs in general relies on paraprofessionals, especially when they are delivered through home visits or group meetings instead of clinics. Professional can be health staff (e.g. nurses) or specialists (e.g. physiotherapist). Paraprofessionals are community-based agents, such as community health workers, community workers and community educators. Paraprofessional can be paid or voluntary workers and the level of education could vary a lot from illiterate workers to educators. In terms of effectiveness, reviews have found that the quality of the relationship between the parent and the facilitator influence the results of the intervention (Moran et al. 2004; Nowak and Heinrichs 2008; and Sweet and Appelbaum 2004).

- ***Training and supervision***

Another aspect that is important is to have a well-trained workforce and a strong supervision system. In low- and middle-income countries, the staff of parenting programs tend to be mainly community workers and volunteers with limited literacy or a few years of education rather than professionals. This might require longer training before the program starts and during the implementation of the program complemented by coaching and strong supervision. Systematic monitoring and supervision are needed to assess the degree to which a program is being implemented as intended and whether it is conforming to established quality standards.

## 4.3 What is the evidence from parenting interventions on child development outcomes?

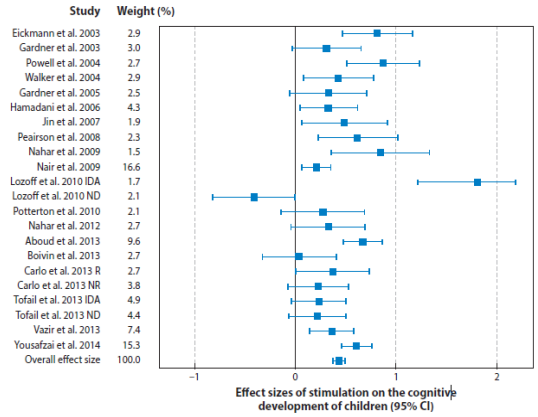
Parenting interventions seem to be more effective to improve parental practices and child development outcomes than to improve anthropometric outcomes. At the same time, in terms of improving child cognitive outcomes, parenting interventions on child stimulation seems to be more effective than nutritional interventions. A recent review of 21 parenting interventions in

developing countries aimed at enhancing early child development found medium-sized effects (0.42 SD) from parenting interventions on cognitive development while the 18 nutrition interventions were less effective in this domain (0.09 SD), see Figure 4.3.

**Figure 4.3: Impact of parenting and nutrition interventions on child cognitive development**

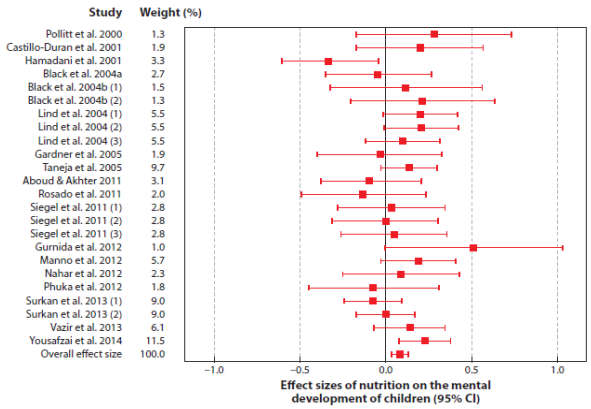
*Panel A: Parenting interventions for child stimulation*

*Average effect on cognitive development: 0.42 standard deviations*




*Panel B: Nutrition Interventions*

*Average effect on cognitive development: 0.09 standard deviations*




Note: Effect sizes (standard mean difference) are represented in a square and 95% confidence interval (CI) represented as lines. Panel A reports effects sizes for promoting play and parent-child interaction versus only standard care. Panel B reports effect sizes for providing extra micronutrients versus a partial set of nutrients or a placebo. In some cases, nutrition interventions include parental education on nutrition, with or without nutrient fortification. All studies are for children 0-24 months at the time of the intervention.

*Source: Aboud and Yousafzai 2015.*

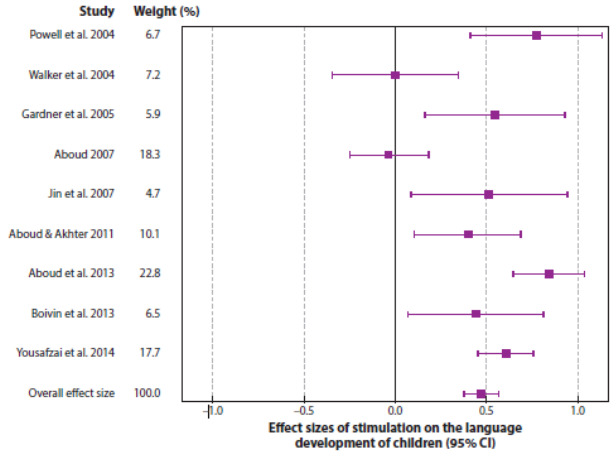
To assess the evidence on parenting interventions, we considered 11 reviews that spanned developing countries (Britto et al. 2017; Aboud et al. 2015; Rao et al. 2014; Grantham-McGregor et al. 2014; Baker-Henningham et al. 2010; Engle et al. 2011; and Walker et al. 2011), developed countries (Filene et al. 2013; Pontoppidan et al. 2016; and Avellar et al. 2017) and both (Nores and Barnett, 2010). See Annex 1 for a short summary of each review. While we focused this review on the impact of the parenting interventions on child cognitive, language and socio-emotional outcomes, we note that most of the reviews of parenting programs found no impact on children's height and weight.

While the evidence on parenting interventions designed to enhance early childhood development is mixed, many studies find that parenting interventions can improve child development, especially cognition and language, but were unclear as to impacts on motor and socio-emotional skills. Studies are mostly based on small efficacy studies with samples of fewer than 100 individuals. While evidence using other delivery modalities is also included, home visits models are the most frequently evaluated. Aboud and Yousafzai (2015) conducted a systematic review and meta-analysis of 21 parenting interventions in developing countries aimed at enhancing early child development and found medium-sized effects of 0.42 and 0.47 standard

deviations on cognitive and language development, respectively (see Figure 4.3 panel A and Figure 4.4). Britto et al. (2017) expanded that review and found that parenting programs had a small to moderate impact on the cognitive development (standardized mean difference of SMD =0·36, in 19 studies) and some positive impacts for motor skills (SMD 0.35, 13 studies) and socio-emotional skills (SMD 0.13, 9 studies) for children under 2 years old. Rao et al. (2014) reviewed 27 parent-focused programs and found that they had an average positive effect on children's cognitive development of 0.35 SD. Mixed results on child development have been reported in some other reviews. For instance, Pontoppidan et al. (2016) reviewed universal parenting interventions for children aged 0 to 12 months old in Australia, Finland, and USA and could not come to any clear conclusions on their impact on child development.

**Figure 4.4: Sizes of Effects of Parenting Interventions for child stimulation on language**

*Average effect on language: 0.47 standard deviations*




*Source*: Aboud and Yousafzai (2015)

Effect sizes on cognitive outcomes seem to be larger in developing countries than developed countries, for poorer and younger children. For developed countries, Filene et al. (2013) reviewed 51 studies that measured the effects of parenting programs in the US on the cognitive and language development of children under 3 years old [9] and found a mean effect on cognitive and language development of 0.25 standard deviation, while impacts in developing countries are around 0.4 standard deviation (Britto et al. 2017, Rao et al. 2014, Aboud et al. 2015). A review of 15 parenting interventions in low and middle-income countries (Engle et al. 2011) found that interventions that combined parenting with a child component had a larger positive effect on child development (median 0·46, range 0.04–0.97) than parent-only programs (0.12, 0.03–0.34). In some cases, effects were greater for younger children than for older children and for poorer children than for richer children.

Parenting interventions improve parental practices and skills. While very few studies have included direct measures of the quality of the home environment or of parental behavior on child stimulation,[10] there is evidence of a strong correlation between child development, positive home environment and engaged parental practices, particularly those related to play activities between the parent and the child (Aboud et al. 2013; Hamadani et al. 2010). Studies from Bangladesh (Aboud and Akhter, 2011; Nahar et al. 2012, and Aboud et al. 2013), Jamaica (Walker et al. 2004), and Colombia (Attanasio et al. 2014) have found effects on the home environment

[9] These studies also measured other outcomes, including maternal life course, birth outcomes, parental behavior and skills, children's physical health, and child maltreatment.

[10] Home stimulation environment can be measured using instruments like HOME Inventory or the Family Care Indicator. See Fernald et al. 2017a for a description of the tools.

and parental behavior of around 0.40-0.55 standard deviation. Filene et al. 2013 reviewed 32 studies of the impact of US parenting programs on parental behavior and skills[11] and found a mean size effect of 0.23 standard deviation (95 percent confidence interval: 0.13 to 0.33).

The existing evidence on large-scale parenting interventions is very limited, and there is no guarantee that interventions that are effective in small efficacy trials will continue to be so when scaled up. In terms of large-scale programs, in the USA, evidence-based large-scale evaluations of parenting interventions such as the Nurse Family Partnership Program[12] have found that these programs had a positive impact on children's development (Avellar et al. 2017). In developing countries, Peru's "Cuna Mas" parenting program improved child development (cognition and language skills) and Niger's parenting program improved socio-emotional development but not cognition or language skills (Araujo et al. 2016 and Premand et al. 2016).

Evidence on the sustainability of parenting programs is mixed. Long-term results from the original small-scale Jamaica Reach Up study found that by the time they were 22 years old, individuals who had received the weekly home visiting intervention when they were 9 – 24 months old had higher IQs, higher educational attainment, less violent behavior, less depression, and higher earnings than their peers who did not benefit from the intervention (Walker et al. 2011 and Gertler et al. 2014). A recent evaluation of a larger-scale evaluation of a parenting intervention on child psychosocial stimulation in Colombia (Andrew et al. 2018) found positive impacts in the short-term but two years after the end of the intervention, there was no impact on any of the outcomes assessed (cognition, language, school readiness, executive function, or behavior). The literature has documented, particularly for early childhood education interventions, that early positive effects can fade out in early or middle childhood but may re-emerge much later in life (see Bailey et al. 2017 for more discussion). One of the most famous example is the Perry Preschool in USA, where the program's large end-of-treatment impact on IQ (0.75 SD) at age 5 had dropped to a statistically insignificant 0.08 SD by age 8 (Schweinhart et al. 2005). While in the long-run, initial fadeout is followed by the detection of impacts in adulthood, although not always on the same kinds of developmental outcomes.

[11] Measured along with indicators of parenting behavior and practices such as promoting a safe and stimulating home environment, positive parenting behavior, growth monitoring**,** and immunizations.

[12] The Nurse Family Partnership programs is one of the most evaluated and well-known parenting interventions in the US. It operates in 32 states and has been identified as a successful model by the Home Visiting Evidence of Effectiveness review launched by the Department of Health and Human Services in the United States (Avellar et al. 2017). This is a free, voluntary program that partners low-income, first-time mothers with a registered nurse home visitor. A specially trained nurse visits the mother throughout her pregnancy and until the child is 2 years of age. A follow-up randomized study of beneficiary children at the age of 6 reported children who received home visits had higher intellectual functioning and a more receptive vocabulary, fewer behavior problems in the borderline or clinical range, and were less likely to be classified as having emotional or behavioral problems than other children (Olds et al. 2004).

# Chapter 5. Combining Cash Transfers and Parenting Programs: Evidence from Four Cases

The existing evidence on the impacts of combining cash transfer and parenting interventions is scarce, but promising. We reviewed evidence from parenting interventions delivered through social protection platforms[13] that were designed to measure the contribution of parenting interventions on child development outcomes in a scalable setting. We reviewed the evaluations included in de Walque et al. (2017) and ran searches for peer-reviewed articles published between May 2015 and June 2017 in PubMed, Google Scholar and JSTOR. In addition, we searched the websites of the World Bank, the International Food Policy Research Institute (IFPRI), and the Inter-American Development Bank for further studies. We also included recent evaluations produced by the World Bank's Strategic Impact Evaluation Fund. We identified four impact evaluations using rigorous methodologies carried out in Colombia, Mexico, Niger, and Peru.

The four evaluations reviewed show that adding parenting interventions to a cash transfer program can improve parenting behaviors as well as child development in the short-term. The number of cases available make it difficult to draw any general conclusions, a situation compounded by the heterogeneity of the programs' designs. Each program is briefly described in this section and table 5.1 summarizes the effects (Annex 2 provides a fuller summary of each case). The three programs that reported results on parenting practices found positive effects on this outcome (Colombia, Niger and Peru). For child development, three studies found positive impact on cognitive and language skills (Colombia, Mexico and Peru) and one on socio-emotional development (Niger). None of the three studies that reported anthropometric outcomes found a positive impact on nutrition.

**Table 5.1: Impact of adding parenting interventions to cash transfer programs**

| | COLOMBIA | MEXICO | NIGER | PERU |
|---|---|---|---|---|
| **Safety net platform*** | CCT | CCT | UCT | CCT |
| **Delivery modality** | home visits | group meetings | home visits and group meetings | home visits and group meetings |

[13] We consider conditional and unconditional cash transfers programs, other complementary interventions run by the Social Protection Ministry, interventions conducted on current or past cash transfer beneficiaries, and intervention that uses the social protection systems to implement the cash transfer program.

| | | | | |
|---|---|---|---|---|
| **Frequency** | One-hour weekly home visits | Two-hour weekly group meetings | One-monthly home visits, one-monthly group meeting and one monthly village assembly | One-hour weekly home visits and fortnightly group meetings |
| **Parenting curriculum** | Adapted from "Reach Up" | *Educación Inicial* | Adapted from UNICEF "Essential Family Practices Package" | Adapted from "Reach Up" |
| **Impact on parental practices and behavior** | Improved parental practices (play activities and play material) in the short term | Not measured | Improved nutrition and stimulation practices and reduced harsh discipline | Improved parental practices: increased play activities and play material, and reduced harsh discipline |
| **Impact on child wasting and stunting** | None | Not reported | None | Not reported |
| **Impacts on cognitive and non-cognitive outcomes** | Improved cognition and language skills but impacts were not sustained in the medium term. No impact on socio-emotional skills | Positive impact on cognition and language only when the program included enhanced pro-motion of the parenting intervention | Improved socio-emotional skills but no impact on other child development domains | Positive impact on child development, especially cognition and language |

Source: Based on impact evaluations reports from Colombia (Attanasio et al. 2014 and Andrew et al. 2018), Mexico (Fernald et al. 2017b), Niger (Barry et al. 2017 and Premand et al. 2016), and Peru (Araujo et al. 2016). Effects sizes and more detailed information of the intervention and evaluation design are presented in Annex 2, Tables 1 to 4.
Note: Reported impacts are based on the comparison of cash transfer plus parenting intervention versus cash transfer alone.
* CCT = Conditional Cash Transfer, UCT= Unconditional Cash Transfer

### *Colombia*

Colombia adapted the successful Jamaican "Reach Up" home visiting program introducing it as part of the "Familias en Acción" cash transfer program, which gives a monetary transfer to mothers provided that their children are up to date with their growth monitoring visits and attend school regularly. Mother leaders elected within their communities by fellow cash transfer recipients were trained to conduct weekly home visits to cash transfer beneficiaries to promote

mother-child interactions by engaging families in play activities centered on children's daily routines and to increase the mother's knowledge of child development and self-esteem. The intervention focused on the mother as the central agent of change and included demonstrations of play activities, encouraging the mother to practice the activities, interactions between the child and the mother, and positive reinforcement for both mother and child. The curriculum on psychosocial stimulation was culturally adapted from Jamaica's Reach Up home visiting program for child stimulation (see Box 4.1 for a description of the Reach Up curriculum), which had been proven to have positive short- and long-term effects on child development (Grantham-McGregor et al. 1991 and Walker et al. 2006 and 2011). Home visitors conducted weekly home visits to approximately five families each during an 18-month period. During the one-hour visits, the home visitors demonstrated developmentally appropriate activities to promote cognitive, language and socio-emotional development in the children, making use of low-cost home-made toys, and identifying learning opportunities for children during the family's daily routines. They were supervised and trained by mentors with an undergraduate degree in psychology or social work who were hired for the project. Each mentor was responsible for 24 home visitors. The intervention was spread over 96 towns in three regions using the community capacity established by the cash transfer program.

Adding the parenting intervention on child stimulation to the cash transfer program had positive short-term impacts on parenting practices and child cognitive development. For the evaluation, 1,420 children between the ages of 12 and 24 months were randomly assigned either to receive psychosocial stimulation through weekly home visits or to a control group that did not benefit from the parenting intervention (Attanasio et al. 2013 and 2014).[14] The evaluation found that the intervention was successful in achieving behavioral changes in the families, which enriched the home environment for children. The intervention increased by around 14 percent the number of different types of toys (effect size 0.53 SD) and the varieties of children's play activities done with an adult (effect size 0.54 SD). The intervention led to a significant improvement in the cognitive scores (0.26 SD) and the receptive language (0.22 SD) of the beneficiary children. See Annex 2, table 1 for more detail.

Mid-term effects were not sustained. A second follow-up evaluation was conducted two years after the end of the intervention, which showed that this positive impact was not sustained in terms of either the children's development at the age of 5 years old or of the practices used by parents (Andrew et al. 2018).

### *Mexico*

Mexico developed the parenting program "Educación Inicial"[15] designed to provide knowledge, skills, training, and opportunities to practice to parents living in rural communities where access

[14] Half of the children in both the treatment and control groups in Colombia received micronutrient supplements, but this had no effect on the children's nutritional status or on other measures of child development.

[15] *Educación Inicial* was developed by a team of Mexican professionals, including psychologists, education experts, and child development specialists, and is deeply grounded in theories of behavior change, child development, and cognitive stimulation.

to early learning programs was very limited, which was integrated to the conditional cash transfer program *Prospera*[16] *(*previously *Oportunidades* and originally *Progresa*). The parenting program was designed and implemented by the National Council for Education Development (CONAFE, which designs implements and evaluates new educational programs targeted to marginalized communities such as indigenous populations). The sessions were intended to enrich parenting practices and strengthen the development of infants and young children, while always supporting, strengthening, and reinforcing the child-caregiver relationship. The program materials included specific ideas of activities for parents to do with their children for each week,[17] discussions of the theoretical underpinnings of each suggested activity, and recommendations for how the community worker (*promotora*) can engage the parents in the group each week. The program provided the community workers with printed and other materials (for example, the theoretical framework of behavior change, instructional guides, health guides, and booklets to distribute to parents) to use during their sessions. Parents were encouraged to make toys at home and to use their existing resources to educate and interact with their children. All program materials are available in Spanish online (Conafe, 2015).

The program was delivered in weekly group sessions[18] that averaged two hours in length during nine months of the year to match the school calendar. Key target groups were pregnant women, infants aged 0 to 1 year old, children aged 1 to 3 years old, mothers, and fathers. The sessions generally focused on one target group at a time. Community workers (*promotoras*) selected within the community ran the group meetings. *Promotoras* were required to be literate as well as bilingual if they were serving indigenous communities. They received two weeks of training[19] every year and delivered the program in a community center or other centrally located structure. There was a structured supervision and feedback system in place in which local supervisors oversee the *promotoras* (with a ratio of 1:10), and program coordinators oversaw the local supervisors, also with a ratio of 1:10.

The evaluation found that adding the parenting intervention was effective in improving child development outcomes only when combined with enhanced promotion. For the purposes of the evaluation, half of the program was randomized to be implemented in combination with an extensive awareness campaign designed to encourage parents to participate in the sessions, while the other half was to be implemented without that awareness campaign (Fernald et al. 2017b). The evaluation was designed to be able to disaggregate the impact of the program on both indigenous and non-indigenous communities. A total of 2,470 children were randomly

[16] *Prospera* provides a targeted transfer to female heads of households and is conditional on their children attending school and on family members obtaining preventive medical care and attending educational workshops on health-related topics (*talleres*).

[17] Weekly themes include general issues such as hygiene and nutrition, the promotion of fine and gross motor development, ways to support children's psycho-social development, and early childhood stimulation to promote cognitive and language development, as well as age- and stage-specific issues such as care during pregnancy, responsive feeding, and specific activities and issues relating to early child development.

[18] The groups consist of about 20 women. In all communities over the course of a year, there are supposed to be 26 sessions for mothers, fathers, and caregivers, 5 sessions for fathers, 18 sessions focusing on children, 8 sessions for pregnant women, and 5 concluding sessions at the end of the annual cycle.

[19] The *promotoras* receive yearly training at the beginning of the operating cycle so that they are using common elements in all communities. During these training sessions, they also receive methodological and instrumental support for conducting the sessions.

allocated to three groups: a control group of households that only received benefits from *Prospera*; (ii) a group of households that received *Prospera* benefits and the *Educación Inicial* program without the intensive awareness campaign; and (iii) a group of households that received *Prospera* benefits and the *Educación Inicial* program with the intensive awareness campaign.[20] The parenting program was effective to improve children's cognitive (0.26 SD) and language skills (0.29 SD) but only when combined with enhanced promotion[21]. The program was only effective in indigenous communities. See Annex 2, table 2 for more detail.

### *Niger*

Niger developed a large-scale home visits parenting program based on the UNICEF "essential family practices" package and integrated into the unconditional cash transfer program[22], targeting chronic poor households in the 5 regions with the highest concentration of poverty. The curriculum went beyond the UNICEF package[23] by taking a holistic approach to children's development by promoting improvements in parenting practice on child nutrition, health, psycho-social stimulation, and protection.[24] A detailed implementation manual was developed to ensure that the intervention was structured, standardized, and scalable. The manual details the content of the curriculum, implementation modalities, and the supervision and quality control arrangements, as well as protocols for recording participants' attendance in the project's monitoring and information system (MIS).

The parenting intervention was delivered by local NGOs as a combination of monthly home visits and group meetings and had a duration of 18 months. Each beneficiary household is invited to participate in three activities per month: (i) a village assembly delivered by an NGO; (ii) a small group meeting (causerie) delivered by a community educator; and (iii) a home visit from the same community educator. The village assembly is organized for approximately 50 beneficiary households on average and is open to non-beneficiary households in those villages as well. The

[20] Community-based staff of *Prospera* worked to disseminate information about the *Educación Inicial* program, to draw attention to the weekly meetings, and to highlight the potential benefits of participating in the program for their children's development. The *promotoras* also made specific efforts to schedule group meetings at different times during the week so that family members could participate fully in both programs. In these communities, the CCT staff members received a description of the *Educación Inicial* program in their quarterly training sessions, received pamphlets about the program for themselves and other pamphlets to distribute to mothers, and were asked to encourage mothers to participate.

[21] The authors reported that the *promotoras* working with the third group of households were under the impression that participation in the parenting program was a mandatory condition for households to receive the cash transfer and may have transmitted this perception to program participants. However, it was not possible to compare the participation rates of each group as no information was recorded on this.

[22] The unconditional cash transfer program also included accompanying measures to support more productive livelihoods and resilience.

[23] UNICEF's "essential family practices" package includes 12 practices: exclusive breastfeeding, complementary feeding, micronutrients, hygiene, immunization, use of bed nets for preventing malaria, psychosocial development, home care for illness, home treatment for infections, **c**are-seeking, compliance with advice**,** and antenatal care. A full list of updated and additional practices can be found at https://www.unicef.org/nutrition/23964_familypractices.html.

[24] The modules include the following topics: exclusive breastfeeding for the first six months; complementary feeding after six months; sleeping under treated mosquito nets; treating diarrhea with oral rehydration solution; handwashing and hygiene; using preventive health care services; taking children to health facilities at the first sign of illness; family planning; language stimulation; play; school readiness, enrollment, and attendance; brain development; discipline, punishment, and conflict management; and attachment and socio-emotional development.

community educator holds one small group meeting for a group of 25 beneficiaries each month and then visits each beneficiary household once every month.

Adding the parenting intervention improved parental practices and socio-emotional development but had no impact on cognitive outcomes. A randomized control trial designed to measure the impact of adding the parenting intervention (Premand et al. 2016) found positive impact on parental behaviors on exclusive breastfeeding and complementary feeding, which increased their children's food security. The intervention also led to parental change on disciplining behavior, particularly relying less on harsh discipline, which could have explained the improvement in children's socio-emotional development. The intervention had no impact on cognitive development or anthropometric outcomes. See Annex 2, table 3 for more detail.

### *Peru*

Peru adapted the Jamaican "Reach Up" home visiting program and implemented it in communities where the conditional cash transfer program "Juntos" was operating, covering both beneficiary and non-beneficiary families. "Cuna Más" is a large-scale early childhood development program aimed at supporting the holistic development of children under the age of 3 living in poverty, while increasing families' knowledge of childrearing practices and strengthening the attachment between children and their caregivers. Cuna Más provides a home visiting service (*Servicio de Acompañamiento a Familias*)[25] in rural communities which are carried out weekly and teams hold monthly group sessions for children under the age of 3 and their primary caregivers, as well as pregnant women. "Cuna Más" operates under a voluntary, co-management model between the government and communities, which are empowered to participate in decision-making, monitoring, and general program operations. The home visiting service is implemented in rural districts with a high incidence of poverty and stunting. Communities nominate individuals to serve as volunteer community workers (*facilitadoras*) who make the weekly, hour-long visits to participating families.

The parenting program improved parental practices and children's cognitive and linguistic skills. An experimental evaluation was designed to measure the impact of the program (Araujo et al. 2016). Half of the 5,300 children under 36 months were randomly assigned to the treatment group while the other half were assigned to a control group who did not benefit from the parenting program**.** The parenting program improved overall child development (0.064 SD) and cognition and language skills (0.06 SD and 0.08 SD respectively). The effects were larger for a subsample where an instrument for direct assessment (Bayley) was used (cognition 0.26 SD and receptive language 0.16 SD). Impacts on children's fine motor skills and socio-emotional skills were small and only significant at 10 percent. The authors also found that parenting practices had improved, with parents spending more time in play activities with their children, making more play materials available to them, and slightly reducing the extent to which they used harsh discipline. See Annex 2, table 4 for more detail.

[25] In urban areas, "Cuna Más" provides childcare services. The results reported in this section are specific to the home visiting component from rural areas.

# Chapter 6. Combining Cash Transfer and Parenting Programs: Program Design and Implementation

In this chapter we discuss four models of how cash transfers can be designed and implemented to include parenting interventions. We also include a brief review of 10 country cases and develop recommendations based on lessons learned from these cases and a literature review of parenting programs.

## 6.1 Case studies on combining cash transfers and parenting programs

Ten cash transfer programs were selected[26] as case studies: Bangladesh (*Jawtno*), Colombia (*Familias en Acción*), Indonesia (PKH, Program *Keluarga Harapan*), Madagascar (Human Development Cash Transfer program), Mexico (*Prospera*), Niger (Niger Safety Nets), Peru (Juntos), Rwanda (*Vision 2020 Umurenge Program*), Senegal (Rapid response child-focused social cash transfer), and Burkina Faso (*Burkin-Naong-Sa ya*).

Information about the selected cash transfer programs and their accompanying measures was gathered in two steps. First, we conducted a desk review of published papers and program documents. Second, we interviewed World Bank and Inter-American Development Bank task team leaders or team members to fill in the gaps in the information collected from the desk review. The questionnaire prepared to structure the interviews was based on work led by the World Bank's Early Year fellows in the Africa Regional Office. The questionnaire included basic characteristics of the cash transfer program, accompanying measures (design and delivery features), finance (cost of cash transfer and accompanying measures), human resources, monitoring and evaluation. The online appendix presents the full questionnaire and description of each case study.

We considered the following design and implementation features: parenting incentives included in the safety net program, delivery modalities for the parenting program, dosage (frequency and duration) for the parenting program, parenting program topics and curriculum, social and behavior change communication strategies, the choice of implementation agency for delivering the parenting program, employment contracts with front-line workers, the profile of front-line workers, and the training and supervision of front-line workers. Table 6.1 summarizes the most common implementation arrangements in the ten selected cases, Annex 3 presents a table summarizing the characteristics for each case study, and the online appendix provides more detailed information on each case study.

[26] The criteria for selection were: (1) The program includes a cash transfer (conditional or unconditional) with a parenting accompanying measure that has been implemented for at least six months; (2) The accompanying measure aligns with the definition of a parenting program considered in this report -teaching parents better feeding practices for infants and young children; increasing the attachment between parents or caregivers and children; and encouraging the use by parents of learning, book reading, play activities, positive discipline, and problem solving regarding their children's development, care, and feeding (Engle et al. et al.2011); (3) The program is implemented in a middle-income or low-income country; and (4) The accompanying measure is backed by a clear theory of change and it is recognized by experts or publications as a program with the potential to have a positive impact on children's development in their early years.

**Table 6.1: Common implementation arrangements for combining cash transfer (CT) and parenting programs**

| Characteristics | Description of most common implementation arrangements |
|---|---|
| 1. Cash transfer program incentives | Incentives are built into the cash transfer programs to encourage beneficiaries to participate in the parenting intervention. Participation in the parenting intervention is usually voluntary and it could be encouraged or more directly promoted through the "soft conditionality" of social pressure and messaging. Among the 10 case studies, only the CCT program in Bangladesh requires the participation in the parenting intervention to receive the cash transfer. |
| 2. Parenting delivery modality | Parenting interventions can be implemented as group or one-on one session and delivered through home visits, community-based group meetings, visits to primary health care facilities or health centers. The most common arrangement combines multiple modalities such as group meetings and home visits (4 cases), and group meetings and health center (3 cases), while only 3 cases used a unique modality. |
| 3. Parenting dosage (frequency and duration) | The intensity and duration of the parenting interventions varies widely. The intensity (the frequency and duration of individual visits) ranges from one-hour visits twice weekly to two-hour sessions every month in the 10 cases reviewed. The group-based community parenting sessions in Niger, Senegal and Colombia were delivered once a month, while the home visits in Colombia, Niger, Peru and Rwanda involved weekly visits. The duration defined as the number of months exposed to the interventions, ranged from six months to 1.5 years. |
| 4. Parenting curriculum | In most of the cases reviewed, the parenting interventions were based on existing models, especially on the material provided by UNICEF's Essential family practices and Care for Development, followed by the Reach Up. Only in two cases they developed their own material. |
| 5. Parenting topics (Content) | While parenting interventions covered multiple topics, the most common topics were: (i) nutrition, health, and hygiene; and (ii) child stimulation, while some interventions covered positive parenting. |
| 6. Social and behavior change communication strategies | Interventions made use of multiple SBCC strategies. In general, they used active learning approaches involving direct feedback to parents and an interactive activity with their child such as play, demonstrations, or peer-to-peer learning. Fathers were included in only few cases for learning activities. |
| 7. Parenting implementing agency | The implementing arrangements vary between UCTs and CCTs. For UCT programs, parenting interventions are implemented by combination of agencies (government, NGOs, cooperation agencies, or think tanks) in 4 of 5 cases. In CCT programs, the national government is usually the unique implementer (4 of 5 cases). |
| 8. Employer of Front-line workers | The national agency is usually the employer for field staff implementing the parenting program. Frequently, the parenting program is delivered by CT program staff. In these cases, the employer of the field staff was usually a national agency or an NGO coordinating with a national agency. |
| 9. Profile of Front-line workers | The front-line staff delivering the parenting interventions are usually trained volunteers. In all the cases studied, there were no minimal educational qualifications for the front-line agents except for literacy, and the position was |

| | |
|---|---|
| | not considered a full-time job. In a handful of cases, the field agents receive either a stipend or a modest wage for their time. In only one of the cases, Senegal, the front-line staff were a mixture of trained outreach workers in collaboration with a volunteer force of local mother leaders. |
| 10. Training and supervision of Front-line workers | The front-line field agents were given varying amounts of training. In all the cases reviewed, the front-line workers received some initial training, and the intensity of the training could go up to six weeks like in Colombia. More frequent supervision (monthly or bimonthly) of the field agents' work generally corresponds to less intensity in the initial training to front-line staff. In most of the cases studied, the field agents receive training and materials to carry out their work. |

Four typologies were identified for combining cash transfer (CT) and parenting programs based on the way in which the cash transfer and the parenting intervention were organized and delivered: integrated, convergence, alignment, and piggy-backing. This institutional architecture is summarized in table 6.2 and described below:

**Table 6.2: Models for Combining Cash Transfers and Parenting**

| Institutional architecture | Description |
|---|---|
| **Integrated** | *The parenting intervention is managed by the cash transfer program.*<br>Examples: Jawtno (Bangladesh), Familias en Accion (Colombia), Burkin-Naong-Sa ya (Burkina Faso), and Niger Safety Nets (Niger). |
| **Convergence** | *Different agencies explicitly combine efforts to bring the separate cash transfer and parenting programs to the same populations.*<br>Examples: Program Keluarga Harapan (PKH) (Indonesia), Prospera and Educación Inicial (Mexico), Human Development Cash Transfer program (Madagascar), and Family Strengthening Intervention (Rwanda). |
| **Alignment** | *The cash transfer and the parenting programs do not explicitly coordinate with one another but deliver interventions to similar if not the same populations.*<br>Example: Juntos and Cuna Más (Peru). |
| **Piggybacking** | *The cash transfer is delivered through a separate established platform such as the primary health care network that is already delivering a parenting program.*<br>Example: Rapid response child-focused social cash transfer (Senegal). |

a) In the *integrated service model*, the CT program incorporates and manages the parenting intervention either directly through their own staff or by contracting out the delivery of the parenting intervention to an external provider (a NGO or consulting company) working as a

sub-contractor to the cash transfer program. This model is often used when participation in a parenting program is a requirement for receiving the cash transfer. This approach gives the CT full control over the delivery of the parenting intervention and helps ensure households' participation. However, expanding the scope of the CT program to include the supply and delivery of an additional line of services can be demanding and often falls outside of the scope the cash transfer program's core objectives. The Colombia *Familias en Acción* CCT program introduced a cluster randomized controlled trial for non-mandatory home visits carried out by trained female community leaders to provide advice on psychosocial stimulation and/or micronutrients over an 18-months period (Attanasio et al. 2014). The *Jawtno* program in Bangladesh also follows this model, with NGO-led parenting sessions introduced as mandatory conditions for receiving the CCT program. In Africa, the UCTs in Burkina Faso (*Burkin-Naong-Sa-Ya)* and Niger (Niger Safety Nets) which combine the monetary transfers with home visits and community-based group sessions also follow this model with the parenting intervention being provided by a NGO involved in the implementation of the cash program. See Annex 3 for more information on the design and implementation arrangements for Bangladesh, Colombia, Niger, and Burkina Faso.

b) In the *managed service convergence model,* different agencies or actors coordinate explicitly to bring the services of the cash transfer program and the parenting intervention to the same population. For example, CT beneficiaries with young children also participate in a parenting intervention managed and delivered by another agency such as a local government, an NGO, or primary health services. The advantages of this approach are that it does not require much inter-institutional coordination in that each agency manages its own program while still promoting the implementation of the complementary interventions to the same target households. This approach has been proven to have positive effects on child outcomes in Mexico between *Prospera/Oportunidades* and the *Educación Inicial* parenting program ran by the National Council for the Promotion of Education (*Consejo Nacional de Fomento Educativo* or CONAFE). In the case of Madagascar, the National Nutrition Office and the Ministry of Education work in coordination with UNICEF and other NGOs to deliver services in nutrition, health, and parenting to the beneficiary households. Rwanda's Vision 2020 *Umurenge* Program (VUP) cash transfer brings together a range of service providers in health, economic development and financial institutions, and educational services to provide services to beneficiary families. Finally, the beneficiaries of Indonesia PKH (managed by the Ministry of Social Affairs) receive parenting guidance on nutrition, health and hygiene through community and individual session organized by the Ministry of Health. See Annex 3 for more information on the design and implementation arrangements in Indonesia, Madagascar, Mexico, and Rwanda.

c) The *alignment of services model* is where the CT and the parenting program operate completely independently from each other but align with each other in some manner, for example, by operating in the same geographic areas and/or communities or using the same criteria to select beneficiary households. This approach is simpler to implement as it demands little to no inter-institutional coordination between the CT program and the providers of the parenting program. However, a key disadvantage of this approach is that there is little to no

way to be sure that the same households are receiving both the CT and the parenting intervention, as the CT does not require all beneficiary parents and caregivers to participate in the parenting intervention. This is the case in Peru where the *Cuna Más* parenting program and the CCT *Juntos* are both managed by the Ministry of Development and Social Inclusion (MIDIS) and operate in the same geographic areas but do not necessarily target the same beneficiary households. See Annex 3 for more information on the design and implementation arrangements in Peru.

d) *In the piggybacking model*, the CT program uses an established platform such as primary health care facilities, to deliver a parenting intervention. This approach has been successfully used in Senegal, where the community organization structure of the Nutrition Enhancement Program (NEP), which operated in poor urban and rural areas of the country, was used to identify eligible beneficiaries and deliver a UCT to mothers of young children in vulnerable families (IEG, 2016). This approach would be easier to implement in a CCT where the CT program already has a working relationship with the health services. See Annex 3 for more information on the design and implementation arrangements in Senegal.

## 6.2 Lessons learned from implementing cash transfers and parenting programs

In addition to lessons from country cases presented above, a number of lessons from experience can be learned from a systematic review of the implementation of parenting programs both in the developing and developed world (National Academies of Sciences, Engineering, and Medicine, 2016). These findings are consistent with those of the impact evaluation studies and highlight a range of good practices and factors that should be considered in the design and implementation of new parenting programs and parenting components in CT programs, as well as in the review of existing ones:

**Combining cash transfer and parenting programs**

- *The choice of models to combine cash transfer and parenting programs needs to be informed by the program and country contexts.* Among the four models identified, the "integrated" model where the parenting intervention is managed within the cash transfer program, was the most commonly used in the 10 cases reviewed. When considering the incorporation of a parenting intervention into a cash transfer program, policymakers should review the institutional capacity of possible providers to manage, coordinate, or align with the cash transfer program.

- *The curriculum, topics and overall demands of the parenting program should inform the choice of implementer for the parenting program.* Parenting programs vary widely in terms of scope, targeting, and services and can drive behavior change in one of many areas of parenting. The duration and frequency of the parenting program need to be aligned with the availability and qualifications of its front-line workers and the needs of the target population.

**Content of Parenting Programs**

- *Tailor content to child's developmental stage.* Parents are more likely to accept and adopt the content of a parenting programs if it resonates with the parenting functions that they are performing and issues that they are facing at the time when they are participating in the program, given a child's particular age and developmental stage.
- *Take into account cultural relevance.* Parenting programs need to take account of the local culture and build on its existing positive parenting practices, while also being prepared to appropriately address cultural practices that are not conducive to child development (such as corporal punishment, a lack of verbal communication with infants, or neglect of play). Adapting to cultures requires an understanding of local customs, child rearing practices, and beliefs and ensuring that they are reflected in the program's curriculum, songs, games, play materials, and books.
- *Take into account conflict and disasters.* Programs implemented in conflict and post-conflict situations need to be designed with the expectation that children are likely to have a heightened sense of vulnerability and sensitivity to environmental threats and high rates of anxiety and depressive symptoms.
- *Target both parents (mother and father) and other caregivers.* Viewing parents as experts in what they and their children need enhances the quality of interactions between parents and program staff. It also increases the parents' trust in these workers, fosters a sense of ownership in the program, and makes them more receptive to the workers' suggestions and training. All the child's caregivers should be involved as partners given that young children are increasingly being cared for grandparents or other members of the family, which means that changing the child care practices of only one of the parents or caregivers may not be sufficient to change the practices of the whole household. To date, fathers have not been incorporated systematically into parenting programs, even though research shows that fathers play an important role in their children's development. Cohort studies have shown the protective and positive effect of fathers on their children's social, educational, behavioral, and psychological outcomes (Panter-Brick et al. 2014). The Alive and Thrive program in Vietnam is an interesting example of how to effectively involve fathers in supporting mothers who are exclusively breastfeeding (www.aliveandthrive.org).
- *Include demonstrations with children and opportunities to practice and receive feedback during the session training*. Incorporating practice into training sessions provides a strong basis for replication at home.

**Delivery of Parenting Programs**

- *Invest in strong program protocol and materials.* For a parenting program to be effective, it must be implemented with strict regard to its requirements and protocols. Given the low levels of education and training of program staff, it is critical that these programs be designed to have a clear operational protocol and strong materials and include a permanent and

systematic supervision and coaching system staffed by professionals supporting sound implementation of the program by its workers.

- *Strengthen social support among participating parents.* Strengthening social support among parents can have multiple benefits including an increased sense of connection and reduced isolation. Programs that use a group format that provides parents with the opportunity to exchange ideas and receive support from their peers may be a key reason why parents join, participate, and continue in parenting programs.
- *Build on existing delivery platforms that the target population is already using*. Using existing delivery platforms such as CTs and health service networks that are already reaching parents and caregivers can be an effective and efficient way to scale up parenting programs and to save time and money. However, care must be taken not to overload staff who are already fully occupied with their regular job responsibilities (such as primary health care workers). Care must be also taken not to burden CT staff with additional functions that are outside their core competencies. It is also important to take into account all of the possible ramifications for the CT program of expecting the existing implementation unit to implement the parenting program themselves versus overseeing its delivery by a contractor.

**Workforce Engagement in Parenting Programs**

- *Ensure adequate workforce training with access to necessary material with frequent and supportive supervision scheme including on-the-job training and coaching for field staff*. In low- and middle-income countries, parenting programs staff tend to be mainly community workers and volunteers with limited literacy or a few years of education rather than paraprofessional educators. While this is a pragmatic low-cost staffing solution, it also means that it is critical to provide these workers with good pre-service training about ECD and about the program's goals complemented by on-the-job training and coaching and strong supervision provided by professionals.
- *Take into account the pros and cons of: paid vs voluntary, financial and non-financial incentives and using professional vs. paraprofessional workers.* There is great variability among parenting programs in terms of the recruitment and responsibilities of workers. Some programs use unpaid volunteer staff or provide small stipends to community workers and/or volunteers, while others pay modest wages to community workers or para-professionals. Each parenting program should carefully define its approach to recruiting and rewarding workers as this will have a direct impact on staff recruitment, performance, and attrition as well as have significant cost implications for the program. Recruiting paid staff can attract more qualified candidates, whereas recruiting community volunteers can bring in people with fewer skills but who are highly motivated to improve the lives of young children. Many programs have high staff attrition rates not only because of the low pay but also because the job is time-consuming, requires significant travel, and can be stressful.
- *Consider financial and non-financial incentives.* A systematic review of more than 100 quantitative and qualitative studies of how intervention design affects the performance of community health workers (CHWs) indicated that good performance was associated with a mix of financial and non-financial incentives, frequent supervision to ensure continuous technical support and training, community involvement, and strong coordination and communication

between the CHWs and health system professionals, which increased the credibility of the CHWs (Kok et al. 2015). An assessment of the lessons from Peru's parenting program (Cuna más) supported the CHW findings with regard to the programs' staff (Josephson et al. 2017). It found that: (i) providing supporting program materials and uniforms can be powerful tools and incentives for a volunteer workforce; (ii) it is important to compensate the travel expenses of workers that have to go to communities other than their own to keep them motivated and to reduce attrition; (iii) although attractive stipends or starting salaries alone are not enough to motivate and retain workers when faced with challenging working conditions such as short-term contracts, unreasonable hours, and significant travel, career ladders and pay scales can attract, reward and retain both professional and volunteer staff; and (iv) requiring community workers and field supervisors to carry heavy workloads and continuously work extra hours can prevent them from carrying out their responsibilities fully and effectively and can be problematic for the program's long-term sustainability and replicability.

**Basic Building Blocks of Parenting Programs**

- *Design the intervention with a solid "logical framework"*. Programs that have an underpinning theory of change that is consistent with the target population's needs and that have components and activities consistent with the theory of change and the target population are considerably more likely to succeed (Segal et al, 2012). This entails analyzing the specific context within which the program will be implemented, defining the desired program outcomes to be achieved, and working backwards to map out what is needed to produce the desired results in the specific context. This is where decisions about the frequency, intensity, duration, timing, and delivery modalities of the program should be determined and adjusted according to the specific needs and constraints of the target population.
- *Invest in a Monitoring and Evaluation (M&E) system for quality assurance and to identify most effective modalities*. Systematic monitoring is needed to assess the degree to which a program is being implemented as intended and whether it is conforming to established quality standards. Most importantly, it makes it possible to assess the performance of program workers and supervisors. The inputs from this monitoring should be used, where necessary, to improve the pre-service and on-the-job training, staff coaching, the program protocols and materials, and the organization and management of the supervisory functions.
- *Manage performance against clear standards of quality.* Systematic evaluations assess the impact of a parenting program on children's development outcomes and on their parents' behaviors and practices. To date, most evaluations of parenting programs rely on self-reported information from parents and caregivers rather than on an objective assessment of child outcomes, which from a methodological standpoint is not only insufficient to measure impact but also introduces bias in the results. To try to address this shortcoming, the World Bank has recently published "A Toolkit for Measuring Early Childhood Development in Low- and Middle-Income Countries" (Fernald et al. 2017a).

The main lessons on content, delivery mechanisms, workforce and basic building blocks are summarized in Table 6.3 below.

**Table 6.3: Lessons learned from Implementation of combining parenting and cash transfer programs**

| Content | Delivery | Workforce | Basic building blocks |
|---|---|---|---|
| •Tailor content to child's developmental stage<br>•Take into account cultural relevance and situations of conflict/disaster<br>•Content of parenting intervention should target both parents (mother and father) and other caregivers<br>•Include demonstrations with children and opportunities to practice and receive feedback during the training sessions | •Invest in strong program protocols and materials to ensure fidelity<br>•Strengthen social support among participating parents<br>•Build on existing delivery platforms that the target population is already using | •Ensure adequate workforce training with access to necessary material<br>•Take into account pros and cons of using professional vs. paraprofessional workers<br>•Establish a frequent and supportive supervision scheme including on-the job training and coaching for field staff<br>•Take into account the pros and cons of paid vs. voluntary work<br>•Consider financial and non-financial incentives | •Design the intervention with a solid "logical framework"<br>•Invest in a monitoring and evaluation system for quality assurance and to identify most effective modalities<br>•Manage performance against clear standards of quality. |

## Chapter 7. Setting an Agenda Moving Forward

This paper has outlined the rationale, evidence, and lessons learned from linking cash transfers and parenting interventions to promote early childhood development, particularly cognitive outcomes.

A clear conclusion is that cash transfer programs can be a useful tool to promote child development during the early years. They provide the financial resources to invest in the human capital of young children and the opportunity for parents to engage more positively with their children by reducing the stress and depression from the feeling of financial strain and deprivation. Evidence shows that cash transfer programs have been successful to reduce poverty, increase food consumption and the use of health services for pregnant women and young children, and, in some cases, improving family well-being and children's nutrition, health, and development.

By attaching "accompanying measures" to the transfer, the program can be designed to support investments in children's human capital. This can be done through providing incentives for parents to use available supply-side services in health, nutrition and education and/or parental training to build skills and adopt behaviors that promote their young children's physical health as

well as enhance their child development. Evidence on parenting interventions shows positive impacts on improving parenting practices, home environments, and child development outcomes in developed and developing countries. However, most of the evidence is from small-scale interventions delivered through home visits.

Both the theory of change and the limited, but positive evidence suggest that supporting poor parents to invest in young children by providing both cash and parenting support not only promotes a healthier and more productive population but also prevents the loss of children's potential, acting as a powerful tool to advance both equity and opportunity. Given the promising and robust evidence from cash transfer and parenting programs individually, this paper argues for and explores the sparse evidence on combining these interventions, notably to boost cognitive outcomes among poorer children where these deficits are concentrated. The sparse evidence from the small number of programs combining cash transfers and parenting – coupled with the heterogeneity in program design -- makes it difficult to make comparisons across programs and to reach any definitive conclusions. However, evidence from four robust impact evaluations of combined programs carried out in Colombia, Mexico, Niger and Peru points to significant impacts, at least in the short term, on parenting practices and children's cognitive and language skills. Among the three studies that reported anthropometric outcomes, none found a positive impact on children's nutritional status.

Operationally, the review of parenting literature and of 10 cases of combined cash transfer and parenting programs underscores many lessons in attempting to coordinate these two types of programs. We identified four models to combine cash transfers and parenting interventions: integrated, managed convergence, alignment, and piggybacking models, but there is no one-size-fits-all model. Many lessons are developed in the paper, with the overarching lesson being that parenting interventions require significant effort to monitor and supervise. When adding such an accompanying measure to a cash transfer program, it is crucial to design and track not only process quality but also structural quality -- notably front-line staff, often community workers interacting with parents. The operational question of the optimal "dose and response" is also critical and requires more research. Although more frequent interactions can increase the size of the impacts, evidence shows that more contact does not necessarily translate into better child outcomes.

Looking forward, policy and program design would benefit from structured research across programs, examining a common set of practical questions on how to best design parenting programs and how to best combine cash transfer and parenting programs. The heterogeneity in the impacts of parenting interventions likely reflects heterogeneity in program design, implementation, what is measured and how it is measured. Unbundling and systematically evaluating the cost-effectiveness of different design features of parenting programs would be useful. There is sparse evidence on the impact of taking parenting interventions to scale, the cost-effectiveness of using alternative delivery modalities, and the sustainability of results.

Moreover, process evaluations are required to understand the fidelity of implementation and the quality of the cash transfer and parenting programs, particularly the quality of the interaction between community workers and caregivers, the role of contexts, and changes in implementation over time and across partners engaged in service delivery.

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## ANNEX 1: Selected reviews for parenting interventions

### 1. Developed countries

#### Pontoppidan, Maiken, Sihu K. Klest, Joshua Patras, and Signe Boe Rayce. 2016. "Effects of Universally Offered Parenting Interventions for Parents with Infants: A Systematic Review." BMJ Open 6 (9): e011706.

The review looked at the effects of universal parenting interventions offered to parents with infants ages 0–12 months in western OECD countries on measures of child development and parent–child relationship. The review considered only randomized control trials of psychosocial parenting interventions that include a minimum of 3 sessions with at least half of the sessions delivered postnatally and program outcomes reported for child development or parent–child relationship. The review included 14 papers representing 7 randomized control trials in 3 countries (Australia, Finland, and USA).

*The findings of the review were mixed, and no clear conclusions could be drawn regarding the effects of universally offered parenting interventions on child development and parent–child relationship for this age group.* For more than half of the outcomes, there were no differences between the intervention and control families. Three studies found one or more significant positive effects of participating in the intervention for child development or improving parent–child relationship; however, one of these studies also found a significant negative effect on parent–child relationship for the intervention group, and four studies did not find any significant effects. This review indicates that there are mixed results of universal parenting interventions for families with infants 0–12 months, and no clear conclusions can currently be drawn regarding effects of this type of intervention on child development and parent–child relationship.

#### Filene, Jill H., Jennifer W. Kaminski, Linda Anne Valle, and Patrice Cachat. 2013. "Components Associated With Home Visiting Program Outcomes: A Meta-Analysis." Pediatrics 132 (Supplement 2): S100–109.

The authors reviewed evaluations of home visiting programs implemented in the US published between 1979 and 2010 that used home visiting as a primary delivery strategy for pregnant women and families with children from birth through age 3 years. A final set of 51 articles included the 6 outcome measures of interest: maternal life course, birth outcomes, parent behaviors and skills, child cognitive outcomes, child physical health, and child maltreatment.

Aggregated to a single effect size per study (k = 51), the mean effect size was 0.20 (95% confidence interval: 0.14 to 0.27), with a range of –0.68 to 3.95. But the *mean effect sizes were significant and positive for only 3 of the 6 outcome domains: maternal life course outcomes, child cognitive outcomes, and parent behaviors and skills*. *Effect sizes for the 24 evaluations that measured child cognitive outcomes were 0.25 (95% confidence interval: 0.11 to 0.38) and for the 32 evaluations measuring parent behavior and skills 0.23 (95% confidence interval:0.13 to 0.33)*. Research design characteristics generally did not predict effect sizes.

*Effect sizes for the parent behaviors and skills outcome were significantly larger for programs that taught parents developmental norms and appropriate expectations, discipline and behavior management techniques, responsive and sensitive parenting practices, and programs that addressed parental substance use. Children's cognitive outcomes were better in programs that taught parents responsive and sensitive*

*parenting practices and programs reporting that they required parents to role-play or practice skills during home visits.*

No consistent pattern of effective components emerged across all outcome domains. Using professional home visitors was a significant predictor of better child physical health outcomes (but no other outcomes), as was teaching discipline and behavior management techniques. However, providing parents with a support group was associated with smaller effect sizes on child physical health. Better child maltreatment outcomes were associated with teaching parents how to select alternative caregivers for children and problem solving.

Avellar S, Paulsell D, Sama-Miller E, Del Grosso P, 2017, Home visiting evidence of effectiveness review. Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services. Washington, DC.

The Home Visiting Evidence of Effectiveness (HomVEE) has reviewed 45 home visiting program models that serve families with pregnant women and children from birth to age 5, finding 20 models that met the department's criteria for effectiveness. Most home visiting models included were designed to promote positive parenting practices. Parenting education is often provided, either through didactic or experiential approaches. Some models use a structured curriculum to provide these services; others take a more flexible approach by addressing specific parenting needs identified during home visits. To a lesser extent, home visiting models integrate parenting interventions that have been found to improve specific parenting behaviors (for example, responsive interactions and positive behavioral support). In addition, home visitors may provide information to parents about child development or safety practices in the home.

*Most models had favorable impacts on primary measures of child development and school readiness and positive parenting practices.* For parenting practice outcomes, of the 21 models with high- or moderate-quality studies that measured this outcome, 14 had favorable effects on primary outcome measures, and 9 had favorable effects on secondary outcome measures. For child development and school readiness, of the 19 models with high- or moderate-quality studies that measured outcomes in this domain, 14 had favorable effects on primary outcome measures, and 8 had favorable effects on secondary outcome measures.

## 2. Developing countries

Rao, N., A. Yousafzai, P. Ip, 2016, Web appendix 2: Systematic review and meta-analyses of parenting and early childhood educational interventions. Supplement appendix of *Britto P R, Lye S J, Proulx K, et al. for the Lancet Early Childhood Development Series Steering Committee. Nurturing care: promoting early childhood development. Lancet 2016.*

The review considers educational interventions, implemented before the target child was 8 years, on multiple child outcomes (cognition, motor development, psychosocial functioning, growth). Studies from three systematic reviews in low-and middle-income countries were used: Aboud and Yousafzai (2015) considered the impact of stimulation (n= 21 studies) and nutrition (n= 18 studies) interventions, delivered to children under 2 years of age on cognitive development. Brown et al., (2014) assessed the effects of center-based daycare for children under 5 years on child and family outcomes and Rao et al. (2014)

evaluated the effectiveness of interventions implemented before the child was 8 years on cognitive development.

Of the 48 studies included, 16 were classified as early parenting. *Small to medium-size effects were found for cognitive (including language and problem-solving skills), motor and socio-emotional development.* The effect size on child cognitive outcomes for children 0-2[27] was 0.36 (95% CI 0.22, 0.49 *p* =.000, n=19), child motor performance was 0.35 (95% CI 0.14, 0.56 *p*= .000, n=13), and child socio-emotional development was 0.13 (95% CI 0.07, 0.19 p = .000, n=9). *There was no significant impact on child height and weight.*

Aboud, Frances E.Aisha K. Yousafzai. 2015. "Global Health and Development in Early Childhood" *Annual Review of Psychology* 66:1, 433-457.

The review examines the extent to which early health, nutrition, and psychosocial stimulation affect cognitive and language development. Only 9 of the 21 stimulation studies and 11 of the 18 nutrition studies analyzed group sample sizes greater than 85. *Nutrition interventions yielded very small effects of d = 0.086 (95% CI 0.036, 0.137), whereas stimulation interventions were moderately effective, with a weighted mean effect size for cognitive outcomes of d = 0.42 (95% CI 0.36, 0.48) and for language outcomes of d = 0.47 (95% CI 0.37, 0.56).* Although all studies included poor, malnourished samples, nearly 30% of stimulation interventions were conducted in medium-high HDI countries (HDI > 0.77), where government resources and education levels are higher. Seventy-one percent of the 21 stimulation studies were conducted in medium-low HDI countries (HDI < 0.711), and 15 or 83% of the 18 nutrition studies were conducted in medium-low HDI countries. Stimulation interventions were labor intensive, with only six providing less than 10 hours contact time; most provided less than 50 hours, but four interventions with high-risk children provided between 60 and 120 hours. Finally, postintervention assessment of stimulation (in 9 of 21 studies) produced significantly higher HOME Inventory scores (indicator of the quality of the household environment for child development) for the intervention compared to control families.

Rao, N., Sun, J., Wong, J.M.S., Weekes, B.S., Ip, P., Shaeffer, S., Young, M.E., Bray, M., Chen, E., & Lee, D. 2014. *Early Childhood Development and Cognitive Development in Developing Countries: A Rigorous Literature Review* DFID, UK Government.

This review evaluated the effectiveness of interventions implemented before the child was 8 years on cognitive development. Here we restricted the results to interventions that are focused on parents.

Twenty-five studies of 38 parenting interventions were reported in the review. These interventions were relatively small-scale interventions (with 10 to 184 parent participants in intervention groups), with an average of 62 parent participants in an intervention. Most of them were designed to promote sensitive and responsive caregiver-child interactions through psychosocial stimulation, in order to improve cognitive and language abilities of infants and young children, but other topics, such as hygiene, feeding, positive discipline, solutions to child refusals and gender equality were also covered in intervention sessions. These interventions targeted children in deprived environments and attempted to reverse the

[27] Only 2 parenting interventions were reported for children 3-5. Mean effect on child cognition was 0.28 but not statistically significant.

negative effects associated with risk factors such as poverty, low birth weight, iron-deficiency, undernutrition and growth retardation. All interventions had key messages or defined curricula and were typically implemented at home by parents (usually mothers) who may vary greatly in their parenting skills and educational backgrounds. Few interventions worked primarily with parents or caregivers. Most programs worked with parents or caregivers and children together and focused on promoting development in infants and toddlers (children under three years). Only eight interventions targeted parents of children three years or above. Many of these interventions were designed as an integrated part of, or as an add-on to, the existing health care system, thereby utilizing professional or paraprofessional community health workers as instructors. Other interventions relied on various trained persons, in particular trained village women (peer educators), who either received a small honorarium or worked on a voluntary basis.

*Parent-focused interventions generally produced small-to-medium-sized positive effects on young children's cognitive development in developing-country contexts.* Effect sizes on child cognitive development were calculated based on 27 interventions in 20 of these studies, *finding average effect size of 0.35 SD,* with a range from -.26 to 2.30. *Interventions that involved both parent and child often had greater effect sizes (d = .42, n = 26) than did parent-only programs (d = .11, n = 6), especially those information-based interventions.*

Interventions that involved guided interactions and practice involving both parent and child often had larger effect sizes than did parent-only programs or information-based interventions. Short-term interventions were effective for children under 18 months, but interventions that lasted at least two years were shown to have sustainable positive effects on older children.

Interventions conducted at least partly in group settings (entirely group-based or home-based and group-based together) were found to have a slightly greater (d = .39, n = 19) effect than home-based interventions (d = .33, n = 13) alone. Significant positive effects on cognitive development were demonstrated in all short-term (from one week to 10 months) interventions for parents and/or at-risk infants/toddlers younger than two years, with at least two contact occasions and provision of a card with child development messages. One study showed that an intervention up to 12 months in duration could only produce sizable and significant effects (0.5 SD) in enhancing cognitive development of children aged below 18 months, but not of older children. Significant effects were shown in both younger and older children if the interventions lasted at least two years and usually consisted of at least fortnightly contact of 30 minutes to one hour. The most effective programs were those with culturally appropriate materials, opportunities for sharing, discussion, and guided parental practice with children. Although most of the studies were not longitudinal and only confirmed short-term effects on young children's cognition, three interventions showed significant positive long-term effects.

### Grantham-McGregor, Sally M., Lia C. H. Fernald, Rose M. C. Kagawa, and Susan Walker. 2014. "Effects of Integrated Child Development and Nutrition Interventions on Child Development and Nutritional Status." *Annals of the New York Academy of Sciences* 1308 (1): 11–32.

This systematic review examined the effect of interventions combining a child stimulation (including center-based preschool and daycare, parent groups, individual parent counseling, or home visiting) and nutrition (micronutrient and/or macronutrient supplementation, nutrition education, breast feeding promotion, or responsive feeding); in some cases, the nutrition interventions also included health-promotion components.

Six studies allowed an evaluation of the effect of at least one of the interventions (child development and/or nutrition) as well as the combination of the interventions. Four studies targeted undernourished children and the others targeted children from poor communities. Sample sizes ranged from 126 to 600 children and children were all under 30 months of age initially with one study beginning in pregnancy.

In each of the four studies where it was possible to assess the independent effects of the two individual interventions (nutrition and child development) and their combination, *stimulation benefited the children's development; effect sizes ranged from 0.37 SD to 0.88 SD.* Stimulation benefited weight gain only in the study with the most severely malnourished children.

The trials showed nutritional interventions usually benefited nutritional status and sometimes benefited child development. *Stimulation consistently benefited child development.* There was no significant loss of any effect when interventions were combined, but there was *little evidence of synergistic interaction between nutrition and stimulation on child development*. Only three trials followed up the children after intervention. All at-scale program evaluations were combined interventions. Five benefited child development, but one did not, and two showed deficits. There was generally little benefit of at-scale programs to nutritional status.

## ANNEX 2: Design and impact evaluation results from cash transfers and parenting interventions

***Table 1***

***Colombia: Using Infrastructure of a Conditional Cash Transfer (Familias en Acción) to Deliver an Early Childhood Education Intervention***

| | | | | |
|---|---|---|---|---|
| **Intervention Type** | CCT + Home Visits + Micronutrient Supplements | | | |
| **Dates of Parenting Intervention** | Feb 2010-Dec 2011 | | | |
| **Geographic Coverage** | 8 departments proximate to Bogotá: Cundinamarca, Boyacá, Santander, Antioquia, Risaralda, Caldas, Huila and Tolima | | | |
| **Target Population** | Municipalities within Familias en Acción coverage since 2002 and which population is between 5,000-50,000 inhabitants | | | |
| **Age group served** | Families with children between 12-24 months at enrolment | | | |
| **Delivery Mechanism** | Home Visits | | | |
| **Who delivers** | Home visitors selected from Madres Líderes | **Families per Visitor:** 50 | | |
| **Training to Visitors** | 2 weeks training + additional week one or two months after program began | | | |
| **Other Staff** | 6 mentors who trained 24 home visitors each and did regular check-ins. Mentors had undergraduate degree in psychology or social work. They had 6 weeks pre-service training and visited community every 7-10 weeks. | | | |
| **Frequency and Length of Treatments** | Home Visits/psychosocial stimulation: 1 hour per week<br>Micronutrient supplements: every 2 weeks | | | |
| **Number of Sessions** | 63 home visits | **Includes Demonstrations?** Yes | | |
| **Content of Sessions** | Psychological stimulation was based on the Jamaican home visiting model, adapted to Colombia's culture and context. Madres Líderes demonstrated play activities using homemade toys, picture books, and form boards. | | | |
| **IMPACT EVALUATION DESIGN** | | | | |
| **Experimental method** | Cluster RCT - 96 Municipalities | | | |
| **Sample Size** | **Baseline:** 1420 | **Follow up:** 1,263 children | **2nd Follow up:** 1,242 children | |
| **Age group evaluated** | **Baseline:** 12-24 months. | | **2nd Follow up:** 4.5 – 5.5 years | |
| **Control group** | **C:** Beneficiaries of cash transfer program | | | |
| **Arms** | **T1:** psychosocial stimulation alone | **T2:** micronutrient supplementation (for anemia) alone | **T3:** T1 + T2 | |
| **Date of Surveys** | **Baseline:** Feb-May 2010. **1st Follow-up:** Dec 2011. **2nd Follow up:** Dec 2013 | | | |
| **EVALUATION RESULTS** | | | | |
| **Parental Practices** | (+) 0.27 SD # of types of play materials and (+) 0.27 SD varieties of play activities done with an adult as measured by FCI. | | | |
| **Cognitive Outcomes:** | **Instrument** | **T1 vs. C** | **T2 vs. C** | **T3 vs. C** |

| | | | | |
|---|---|---|---|---|
| **Cognitive Score** | Bayley-III | (+) 0.26 SD<br>2nd FU: (-) 0.03 SD - No sign. diff | (+) 0.045 SD - No sign. diff.<br>2nd FU: (-) 0.04 SD - No sign. diff | (-) 0.08 SD - No sign. diff.<br>2nd FU: (-) 0.11 SD - No sign. diff |
| **Language** | 1st FU: Bayley-III<br>2nd FU: WM, TVIP | 1st FU: Receptive (+) 0.22 SD. Expressive: (+) 0.08 SD - No sign. diff.<br>2nd FU: (-) No sign | 1st FU: Receptive: (+) 0.04 SD - No sign. diff. Expressive: (+) 0.07 SD - No sign. diff.<br>2nd FU: (-) No sign | 1st FU: Receptive: (-) 0.09 SD - No sign. diff. Expressive: (-) 0.06 SD - No sign. diff.<br>2nd FU: (-) No sign |
| **Fine Motor** | Bayley-III | (+) 0.12 SD - No sign. diff. | (+) 0.10 - No sign. diff. | (-) 0.11 SD - No sign. diff. |
| **Gross Motor** | Bayley-III | (-) 0.02 - No sign. diff. | (-) 0.03 - No sign. diff. | (-) 0.02 - No sign. diff. |
| **Personal-Social** | Executive Function PTT | 2nd FU: (-) 0.01. No sign. diff. | 2nd FU: (+) 0.02. No sign. diff. | 2nd FU: (-)-0.08. No sign. diff. |
| **Height (cm)** | | (+) 0.22 SD- No sign. diff. | (-) 0.04 SD- No sign. diff. | (+) 0.02 SD - No sign. diff. |
| **Weight (kg)** | | (-) 0.12 SD- No sign. diff. | (-) 0.01 SD- No sign. diff. | (+) 0.01 SD- No sign. diff. |
| **Maternal Depression** | CESD (-0.025) No sign. Diff. | | | |

**Sources**: Attanasio et al. 2014 and Andrew et al. 2018. Note: Effect size reported (coef diff /SD)

***Table 2:***

***Mexico: Using the Conditional Cash Transfer Structure (Prospera) to deliver a Parenting Intervention***

| | |
|---|---|
| **Intervention Type** | CCT + Parenting Group Sessions |
| **Dates of Parenting Intervention** | 2008-present |
| **Geographic Coverage** | Parents living in isolated and resource poor rural communities where access to preschool programs is limited. |
| **Target Population** | Prospera population who are either pregnant women or mothers/caregivers/fathers of children (0-3 years) |
| **Age group served** | Children 0-3 years |
| **Delivery Mechanism** | Group Sessions |
| **Who delivers** | Promotoras. Older than 18 years old, willing to travel, literate, and bilingual if serving indigenous community. On average Promotoras were 29 years old with 12.4 years of education. |
| **Families per Visitor** | 20 |
| **Training to Visitors** | 2 weeks of intensive training a year |

| | |
|---|---|
| **Other Staff** | 1 Supervisor every 10 Promotoras; 1 Program Coordinator every 10 Supervisors |
| **Frequency and Length of Treatments** | CCT Prospera: Quarterly Training Sessions<br>Parenting Group Sessions: 2 hours per week |
| **Number of Sessions** | Over 1 year: 26 sessions for mothers, fathers and caregivers; 5 sessions for fathers; 18 sessions focusing on children; 8 sessions for pregnant women; and, 5 concluding sessions at the end of the annual cycle. |
| **Includes Demonstrations?** | Not reported |
| **Content of Sessions** | Program materials include: activities for each week, theoretical underpinnings of activity, and recommendations. Themes include hygiene and nutrition, fine and gross motor development, psycho-social development, and early childhood stimulation, within others. |
| **IMPACT EVALUATION DESIGN** | |
| **Experimental method** | Cluster RCT - 204 communities (102 indigenous and 102 nonindigenous) |
| **Sample Size** | **Baseline:** 2,472 **Follow up:** 1,113 children |
| **Age group evaluated** | **Baseline:** 0-18 months. **Follow-up:** 3-5 years old |
| **Control group** | **C:** CCT only (no parenting sessions are available in the community) |
| **Arms** | **T1:** CCT + availability of Parenting Group Sessions in the community (the CCT program does not promote the Parenting Group Sessions)<br>**T2:** CCT + encouragement from CCT program to attend the Parenting Group Sessions |
| **Date of Surveys** | **Baseline:** 2008. **Follow-up:** 2012 |
| **EVALUATION RESULTS** | |
| **Cognitive Outcomes Tools** | McCarthy Scales of Children's Development (at follow-up) and Extended Ages and Stages Questionnaire (EASQ) (for children > 4 months) |

| | **Comparison Groups** | **T1 vs. C** | **T2 vs. C** | **T2 vs. C Stratified by Indigenous Community** |
|---|---|---|---|---|
| **Cognitive Development** (McCarthy) | General Cognitive Index | (-) 0.01 SD - No sign. diff. | (+) 0.26 SD | (+) 0.25 SD on indigenous children |
| | Memory Score | (+) 0.01 SD - No sign. diff. | (+) 0.28 SD | (+) 0.16 SD on indigenous children - No sign. diff. |
| **Language** (McCarthy) | Verbal Score | (+) 0.02 SD - No sign. diff. | (+) 0.29 SD | (+) 0.15 SD on indigenous children - No sign. diff. |

**Sources:** Fernald et al. 2017b. Note: Effect size reported (coef diff /SD)

***Table 3:***

***Niger Safety Nets Project***

| | |
|---|---|
| **Intervention Type** | CCT + Parenting Home Visits and Group Sessions |
| **Dates of Parenting Intervention** | 2013-present |

| | |
|---|---|
| **Geographic Coverage** | 5 regions with highest concentration of poverty: Dosso, Maradi, Tahoua, Tillabery, and Zinder |
| **Target Population** | Very poor women in chronic poor households (targeted through PMT) + a participatory process determining regions according to poverty levels, chronic vulnerability and local infrastructure. |
| **Age group served** | Households with children <5 years |
| **Delivery Mechanism** | Home Visits + Group Sessions |
| **Who delivers** | Community Educator **Families per Visitor:** 25 |
| **Training to Visitors** | 2 weeks training at beginning + 2 weeks refresher at 6 and 12 months of implementation |
| **Other Staff** | 1 NGO Field Worker operator every 10-15 villages; 1 Quality Controller every 5 NGO field staff; and, 1 Specialized Staff per project office |
| **Treatment Freq. and Length** | Village assemblies: 1 per month + Small-group meetings: 1 per month + Home visits: 1 per month |
| **Number of Sessions** | 54 activities including the village assemblies, the small group-meetings, and the home visits |
| **Includes Demonstrations?** | Yes |
| **Content of Sessions** | Parenting training on nutrition, psycho-social stimulation, health and sanitation. Exclusive breastfeeding for 6 months and complementary afterwards, sleeping under mosquito nets, oral rehydration solution for diarrhea, handwashing, use of preventive health care, health visits, and family planning. |
| **IMPACT EVALUATION DESIGN** | |
| **Experimental method** | Cluster RCT - Geographical Clusters containing at least 150 households |
| **Sample Size** | 6,856 children |
| **Age group evaluated** | **Baseline:** 0-59 months |
| **Control group** | **C:** Unconditional Cash Transfer of 10,000FCFA (about US$20) |
| **Arms** | **T1:** Conditional Cash Transfer + Behavioral Accompanying Measures (BCC) |
| **Date of Surveys** | **Baseline:** Apr-Jun 2012. **Follow-up:** Jan-Jun 2016 |
| **EVALUATION RESULTS** | |
| **Parental Practices** | **Nutrition:** (+) 22.1pp exclusive breastfeeding. (+) complementary feeding: water (+) 21.5pp, mash (+) 12.4pp, eggs (+) 17.3pp, crackers (+) 8.3pp, and fish (+) 13.3 pp. No sig. diff. in milk (+3.6pp), poultry (-0.2pp), and meat (-0.11pp). Food security score (+) 5.6pp/child food insecure (-)4pp. |
| | **Health:** (+) 6pp children's health service utilization. No sign. diff. in fertility or family planning. |
| | **Stimulation:** (+) 42.9pp stimulation index: (+11.4pp) storytelling and (+) 2.6pp reading, (+6.8pp) naming, (+6.7pp) counting, (+6.1pp) drawing, and (+) 6pp types of toys. No sig. diff. in playing (+4.2pp), using stroller (+5.2pp). |
| | **Discipline:** (-) 44.5pp negative disciplining: shouting (-5.8pp), spanking (-6.9pp), hitting (-5pp), insulting (-11.4pp), slapping (- |

| | |
|---|---|
| | 5.4pp) or hitting hands (-4.4pp). No sig. diff. in the use of positive disciplining (-0.2pp). |
| **Cognitive Outcomes:** | **Tools:** Demographic and Health Survey (DHS/MICS) questionnaire and an adopted version of BAYLEY cognitive scale |
| **Cognitive Development** | (+)10.8pp - No sign. diff. |
| **Socio-emotional** | (-) 52.6pp socio-emotional problem Index. (+) 23.9pp sociality score |
| **Nutritional Outcomes** | Difference in composition of households' consumption and expenditures (non-food consumption is 26,060 CFA lower). Translated to a 2.1pp increase in food consumption. HAZ, WAZ and WHZ no sign. |
| **Health Outcomes** | **Children 12-23months:** (+) 11pp received all vaccinations, (+) 9.6pp iron supplementation. No sign. diff. in deworming (+5.3pp) and Vitamin A (-0.7pp). **Children 6-59 months:** (-) 5.3 pp self-reported illness, (+) 8.7pp handwashing with soap. No sign. diff. in diarrhea (-0.8pp), hospitalizations (+0.3pp), and sleeping with treated nets (+3.4pp). No sign. diff. in # of sick individuals in household (-4pp). |

Sources: Barry et al. 2017. Premand et al. 2016

**Table 4:**

***Peru: Cuna Más***

| | |
|---|---|
| **Intervention Type** | Parenting Home Visits and Group Sessions |
| **Dates of Parenting Intervention** | 2013-2015 |
| **Geographic Coverage** | Targeted districts |
| **Target Population** | Rural districts with: poverty incidence rate > 50%, chronic malnutrition in children rate >30%, and where "JUNTOS" operated in 2012 |
| **Age group served** | Children 0-36 months |
| **Delivery Mechanism** | Home Visits + Group Sessions |
| **Who delivers** | Home Visitors: 85% women, 87% parents, Ave. 31 years old, 72% completed High School |
| **Families per Visitor** | 10 |
| **Training to Visitors** | 4 days pre-service + in-service |
| **Other Staff** | 1 Supervisor every 10 visitors. Supervisors were required to have some tertiary education and got 9 days pre-service training + in-service training. 20 Regional Specialist (trained) throughout the country supervising Supervisors. |
| **Frequency and Length of Treatments** | Home visits: 1 hour per week<br>Group Sessions: every other week |
| **Number of Sessions** | 66 Home visits **Includes Demonstrations?** Yes |

| | | | |
|---|---|---|---|
| **Content of Sessions** | Parent and child meetings to improve knowledge on early childhood practices, learning and skill development. | | |
| **IMPACT EVALUATION DESIGN** | | | |
| **Experimental method** | Cluster RCT | | |
| **Sample Size** | 5,339 Children divided into 180 Districts = 120 Treatment + 60 Control | | |
| **Age group evaluated** | **Baseline:** 1-28 months. **Follow-up:** 25-55 months | | |
| **Control group** | **C:** Pure | | |
| **Arms** | **T1:** Home visits + Social and Learning Sessions w/ community + Option of Daycare | | |
| **Date of Surveys** | **Baseline:** Apr-Aug 2013. **Follow-up:** May-Dec 2015 | | |
| **EVALUATION RESULTS** | | | |
| **Parental Practices (HORV)** | (+) 0.20 SD frequency on play activities, (+) 8pp home-made toys, (-) 4pp violent practices for discipline, (+) enrolment in early education | | |
| **Cognitive Outcomes:** | **Test** | **Intention to Treat** | **Treated on the Treated** |
| **Overall Score** | ASQ-3 | (+) 0.06 SD | (+) 0.10 SD |
| | BAYLEYS –III | (+) 0.14 SD | (+) 0.17 SD |
| **Cognitive Score** | ASQ-3 | (+) 0.06 SD | (+) 0.10 SD |
| | BAYLEYS –III | (+) 0.25 SD | (+) 0.30 SD |
| **Language** | ASQ-3 | (+) 0.08 SD | (+) 0.12 SD |
| | BAYLEYS –III | Receptive: (+) 0.16 SD Expressive: (-) 0.11 SD - No sign. diff | Receptive: (+) 0.19 SD Expressive: (-) 0.13 SD - No sign. diff. |
| **Personal-Social** | ASQ-3 | (+) 0.07 SD | (+) 0.10 SD |
| | BAYLEYS –III | Not measured | Not measured |
| **Motor** | ASQ-3 | Fine: (+) 0.06 SD. Gross: (-) 0.01 SD - No sign. diff. | Fine: (+) 0.09 SD. Gross: (-) 0.01 SD - No sign. diff. |
| | BAYLEYS –III | Fine: (+) 0.03 SD - No sign. diff. | Fine: (+) 0.04 SD - No sign. diff. |

Source: Araujo et al. 2016

## ANNEX 3: Summary of Case Studies

| | | 1. Cash transfer program incentives | 2. Parenting delivery modality | 3. Social and Behavior Change Strategies | 4. Parenting topics | 5. Parenting implementing agency | 6. Employer of front-line worker | 7. Profile of front-line workers | 8. Training and supervision of front-line workers | 9. Parenting dosage (frequency and duration) | 10. Parenting curriculum | TYPOLOGY: Institutional Architecture* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Jawtno | **Bangladesh** | CCT, Accompany Measure (AM) is a conditionality | Community based group sessions and health centers visits | Feedback to parents | Nutrition, health, hygiene, child stimulation, positive parenting | National govt - Ministry of Local Government and Rural Development & Cooperatives | National govt | No minimum level of education (need to be literate), paid modestly - BDT 5,000/month (approx. USD 50) | Initial training, receive materials, monthly supervised | Bimonthly for the duration of the program (until child is 5) | Reach UP (Jamaica) | **Integrated** |
| 2. Familias en Accion | **Colombia** | CCT, AM is not a conditionality | Home visit and group meetings | Play | Nutrition, health, hygiene, child stimulation | National Govt – Familias en Accion and research team | National govt | Min. level of reading comprehension is required), stipend of $25.000COP (~$8USD/mo) stipend paid on per child basis | 6 week pre-service training, receive materials, supervised every 7-10 weeks, there is M&E system for the program | Every week for the duration of the intervention (18 months); in total up to approx..72 sessions | Reach UP (Jamaica) | **Integrated** |
| 3. Program Keluarga Harapan (PKH) | **Indonesia** | CCT, AM is not a conditionality | Community based group sessions and health center visits | feedback to parents, media | Nutrition, health, hygiene | National Govt - Ministry of Social Affairs | National govt | No minimum level of education, paid about $250USD/month | Supervised monthly, there is M&E system but not for AM | Once a month (for 2 hours) for duration of the program (until child turns 6) | Own, unstructured (depend on community facilitators) | **Convergence** |
| 4. Human Development Cash Transfer program | **Madagascar** | UCT, (for families with children under 5) | Community based group sessions | Demonstrations, play, feedback to parents | Nutrition, health, hygiene, child stimulation | National Govt - Ministry of Population, Social Protection, and Promotion of Women and Social Development Fund (FID) | National govt | Initial (extensive) training, receive materials, bimonthly supervision, there is M&E system | Initial training, receive materials, bimonthly supervision, there is M&E system | Group sessions are monthly, can last around 3 hours (dancing, singing, sensitization) for duration of program (3 years); in total up to | UNICEF | **Convergence** |

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| | | | | | | | | | | approx. 36 sessions | | |
| 5. Prospera<br><br>a) *Educacion Inicial*<br><br>*b) Modelo de Promoción y Atención del Desarrollo Infantil (PRADI)* | **Mexico** | CCT, AMs are not a conditionality | a) Community based group sessions<br><br>b) Health Center Visit, Home visit, Community based group sessions | a) Demonstrations, feedback to parents, peer-to-peer, inclusion of fathers<br><br>b) Demonstrations, play, feedback to parents, interaction with kids, peer-to-peer | a) Nutrition, health, hygiene, child stimulation<br><br>b) Nutrition, health, hygiene, child stimulation, positive parenting | National Government-Prospera & CONAFE/ Prospera's Units in Health Secretary | a) National Council for the Promotion of Education (CONAFE)<br><br>b)Prospera's Units in Health Secretary | a) No minimum level of education, voluntary<br><br>b) Must have education in field of practice and meet established profile for each role + 2 year min of work on child health related issues. | a)'some' training at the start of each year cycle, receive materials, 'intensive' supervision<br><br>b) Initial training on Child Development Strategy | a) Weekly (2 hrs), for 9 months.<br><br>b) For sessions in clinics, duration and frequency depend on results of screening and diagnosis. | Own | **a) Convergence**<br><br>**b) Integrated** |
| 6. Niger Safety Nets | **Niger** | UCT | Home visit, Community based group sessions | Feedback to parents, media, peer-to-peer | Nutrition, health, hygiene, child stimulation, positive parenting | National Govt & NGO - Niger Safety Nets Unit in Prime Minister's office and Local NGOs, depending on location | NGO | Field worker: No minimum level of education, paid; Community Educator: No minimum level of education, stipend of about $20/mo | Initial training, there is M&E system | Monthly for 18 months. In total: 1 village assembly per month, 1 small group meeting per month, 1 household visit per beneficiary per month | UNICEF | **Integrated** |
| 7. Cuna Mas/ Juntos | **Peru** | Not all AM recipients are CT beneficiaries | Home visit and Community based group sessions | Play, feedback to parents | Nutrition, health, hygiene, child stimulation, positive parenting | National Govt - Ministry for Development and Social Inclusion (MIDIS) | National govt | Stipend of $116/mo | 9 days pre-service training, in service training. There is M&E system | Weekly (1 hr), in total up to approx. 144 sessions. | Reach UP (Jamaica) and previous country experience | **Alignment** |
| 8. Family strengthening Intervention | **Rwanda** | UCT | Home visit | Demonstration, play, feedback to parents, interactions with kids, | Nutrition, health, hygiene, child stimulation, | National Govt & NGO - FXB International and Ministry of Local Govt | National Govt | Voluntary | Initial training, receive materials, there is M&E system | Bimonthly for one year; in total up to approx. 24 sessions | UNICEF/WHO: "Care for Child Development" | **Convergence** |

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| | | | | inclusion of fathers | positive parenting | | | | | | | |
| 9. Rapid response child-focused social cash transfer | **Senegal** | UCT | Community based group sessions, health center visits and mass media | Demonstrations, play, feedback to parents, peer-to-peer. (Other: grandmother groups to stimulate culture/behavior change) | Nutrition, health, hygiene, positive parenting | National Govt & NGO: Cellule de Lutte contre la Malnutrition (CLM), 12 NGOs across country | NGO | No minimum level of education (need to be literate), stipend | Some initial training, receive materials, monthly supervision | Monthly group sessions in total up to approx. 6 sessions. | UNICEF | **Piggybacking (to health sector)** |
| 10. Burkin-Naong-Saya CT | **Burkina Faso** | UCT | Home visit and Community based group sessions (small group and large village assemblies) | Demonstrations, play, feedback to parents, peer-to-peer. | Nutrition, health, hygiene, child stimulation, positive parenting | NGO | NGO | No minimum level of education, voluntary | Initial training, intervention has a M&E system | Monthly village assemblies (2 hrs); Monthly small group meetings w/ pregnant women & mothers (1 hr); Weekly home visits (1 hr). in total up to approx. 36 sessions | UNICEF's "Essential Family Practices" ; "Scaling Up Nutrition" (SUN). The ECD protocol built on modules such as CCFCs protocol "Learning through Play (birth through 6 years old)". | **Integrated** |
| **Categories** | | (1) UCT, (2) CCT, AM is a conditionality (3) CCT, AM is not a conditionality | (1) home visits, (2) community based group sessions, (3) health center visits, (4) a combination of the above | (1) demonstrations, (2) play, (3) media, (4) peer-to-peer, (5) interaction with kids, (6) inclusion of fathers, (7) feedback to parents, (8) a combination of the above | (1) nutrition, health, hygiene, (2) child stimulation, (3) positive parenting, (4) a combination of the above | (1) National govt, (2) NGO, (3) Intl Org, (4) other | (1) National govt, (2) NGO, (3) other | (1) level of education, (2) voluntary, stipend, paid. | (1) front line personal receive training, (2) front line personal receive materials, (3) front line personal receive are supervised (frequency), (4) the intervention has a M&E system, (5) a combination of the above, specify | (1) frequency of sessions; (2) total number of sessions (frequency multiplied by # of years/month of the program) | (1) Reach Up (Jamaica), (2) UNICEF, (3) Own, (4) Other | (1) integrated, (2) convergence, (3) alignment, (4) piggybacking. |

* Definition of terms used in the table:

**(1) Acronyms:**

1. CT: Cash transfer
2. UCT: Unconditional cash transfer
3. CCT: Conditional cash transfer
4. AM: Accompanying measure
5. PHC: Primary Health Care
6. NGO: Non-governmental organization
7. M&E: Monitoring and Evaluation

**(2) Institutional Architecture**: The relationship by which the CT and a parenting intervention is designed and delivered.

1. Integrated: The parenting intervention is managed by the CT.
2. Managed Convergence: Different agencies/actors converge to bring the inputs required to the same households. CT beneficiary households with young children also participate in a parenting intervention managed and delivered by another program/agency.
3. Alignment: CT and a parenting program align with each other in some manner, but continue to operate completely independently.
4. Piggybacking: CT framework is mounted onto an established program, such as the PHC network to deliver cash and parenting intervention.

For more details see the online appendix