ARNEC CASE STUDY

Promoting parents/caregivers' psychosocial support to ensure the well-being of children during COVID-19

CHILDFUND INTERNATIONAL, INDONESIA

ChildFund EARLY START UNIVERSITY OF WOLLONGONG AUSTRALIA ARNEC Asia-Pacific Regional Network for Early Childhood

ABOUT CHILDFUND INTERNATIONAL

ChildFund International (formally known as China's Children's Fund and Christian Children's Fund) was established in 1938 and is an independent, non-profit, international development organisation that works to reduce poverty and improve child safety, health and wellbeing, and education for children in developing countries. ChildFund works in 24 countries across Africa, Asia, and North and South America through 240 local partners reaching 13 million children and families. ChildFund works with local partners, particularly grassroots organisations made up of local community members, to embed sustainable, community-driven approaches to supporting children. They also work in partnership with governments, corporations, and individuals. ChildFund's work is targeted towards three age groups including, birth to 5 years, 6 to 14 years, and 15 to 24 years. The organisation is funded through grants and individual and corporate donors, as well as child sponsorship programs.

EXECUTIVE SUMMARY OF THE IBU ANAK TANGGUH KOTA BOGOR PSYCHOSOCIAL SUPPORT PROGRAM DURING COVID-19

ChildFund's ***Ibu Anak Tangguh Kota Bogor*** program was a pilot program developed to prevent the prevalence of early childhood stunting within Indonesia. The delivery of the program was adapted to include an online model in response to restrictions on face-to-face sessions during the COVID-19 pandemic. However, face-to-face delivery was still prioritised as access to technology and internet connectivity varied across locations. The program consisted of three main components: (1) A balanced nutrition parental intervention in which children received 30 days of four-star diet food provision, and parents attended 12 nutrition classes and participated in cooking practice and a cooking competition; (2) A responsive parenting intervention targeted towards increasing parental knowledge around the benefits of parental mental health, behaviour guidance, and playful, stimulating parenting (within this component, parents participated in 12 classes on responsive parenting around the 12 themes of responsive parenting and 12 themes of playful stimulation); (3) The behaviour change communication (BCC) intervention – a community-based intervention in which members of the community formed BCC working groups and created a stunting awareness campaign to promote community-level behaviour change. Key outcomes from the program included 96.49% of children experiencing weight gain, and 73.4% of parents reporting application of play and psychosocial stimulation practices within the home environment after the program.

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KEY PROGRAM FEATURES

The *Ibu Anak Tangguh Kota Bogor* program was a pilot program developed to contribute to the National Strategy for the Acceleration of Stunting Prevention 2018-2024 by achieving increased coverage and quality of nutrition services and decreasing stunting prevalence. The delivery of the program was adapted in response to the COVID-19 pandemic to include online delivery for *red zones* which were affected by COVID-19. However, face-to-face delivery was still prioritised over online delivery due to technological and geographical constraints such as access to internet and technological devices.

The pilot program drew heavily on ChildFund parenting programs that were initiated in 2016 and focused on responsive parenting (pre-primary) and positive parenting (school-aged). These two flagship programs utilised a community capacity building model whereby whole communities were empowered to enact change and provide positive environments for children to learn and develop. The current program was developed from the experiences, learnings, and situational analyses from the implementation of these two programs in 177 urban/rural villages across 32 regions/cities in collaboration with 15 community empowerment partner organisations in the provinces of South Sumatra, Lampung, Banten, West Java, Central Java, DIY Yogyakarta, DKI Jakarta, and East Nusa Tenggara.

The program consisted of three main components:

1. **Balanced Nutrition** – parent capacity building component and provision of food to families
2. **Responsive Parenting** – parent capacity building component
3. **Behaviour Change Communication (BCC)** – community capacity building component

The *Ibu Anak Tangguh Kota Bogor* program was implemented from January to June 2021 in Pasir Kuda and Pair Jaya villages. COVID-19 related physical restrictions resulted in shifts from face-to-face delivery to accessible remote communication media (e.g., Facebook, WhatsApp, Zoom).

PROGRAM RATIONALE

The program was a continuation of an existing initiative responding to the growing rates of child stunting and wasting: failure to grow and delayed development resulting from extended lack of nutritional intake, recurrent infectious diseases, and inadequate psychosocial stimulation. ChildFund recognised that the most effective approach to reducing incidence of stunting and wasting amongst children under five years incorporated cross-sectoral interventions targeted towards reducing risk factors (i.e., macronutrient deficiencies, infections, and inadequate psychosocial stimulation).

During the COVID-19 pandemic, this program was prioritised in response to UNICEF predictions that the pandemic would likely increase risk factors associated with stunting, including children spending considerable time away from early childhood education settings and receiving reduced psychosocial and developmental stimulation. ChildFund identified that, due to these closures, the program needed to include a greater focus on supporting parents to provide similar levels of stimulation through responsive parenting practices in the home environment, as well as providing modules which focused on supporting parental mental health. Additionally, messaging around COVID-19 prevention and hygiene practices were included within the program content.

GOALS OF THE PROGRAM

The program was driven by ChildFund with the aim of "improving the behaviour of parents and society in supporting the quality of children's growth and development". A detailed framework was established for the program with clear goals, targets, and indicators, which is available in PDF format on request.

PROGRAM DEVELOPMENT AND STRUCTURE

ChildFund followed a comprehensive and clearly developed methodology to implement all program components in a timely manner and leverage local resources (e.g., Community Health Centres). The program design positioned parents as the first and foremost caregivers for their children and supported them to develop skills and knowledge to support children's growth and development and realise their optimal potential. Parents were supported by *facilitators* (see below), and facilitators were trained by ChildFund Child Development Specialists (see Training & Support, below). Key community members (*village cadres*) were identified to oversee program implementation at the local level and provide a pool of potential facilitators.

The intervention phase of the program was implemented within a clearly defined window, from March to May 2021, and involved a range of activities to build parents skills and knowledge while also embedding the program in the community (see Content, below).

Key personnel. *Village cadres* were volunteer community members who were, prior to the program, recruited by the *Puskesmas* (Community Health Centres) to manage the *Posyandus* (Integrated Service Posts). The main responsibilities of the cadres were to help provide the services of the 5-table system at the Posyandus (on a monthly basis). This included: (1) registration, (2) measurement of height and weight, (3) recording, (4), balanced diet counselling, and (5) health services. Village cadres also conducted regular home visits to monitor children's growth and weight and provide

guidance for parents. ChildFund partners and village governments selected village cadres to become program *facilitators*. Additional facilitators were selected from parent groups that demonstrated sound knowledge and active engagement during parenting classes. In total, 12 *Nutrition Program Facilitators* and nine *Responsive Parenting Program Facilitators* were selected. Program facilitators also conducted home visits once per month (separate to the home visits conducted by village cadres) to determine changes in parents' mental health and plan to support any arising needs within the program.

CONTENT

Balanced Nutrition

This component focused on balanced-diet management by providing nutritional resources and cooking practice.

- 30-day food provision of four-star diet for morning snack, lunch, afternoon snack, and dinner
- Twelve weekly meetings of Nutrition Class (combined with four-star menu cooking practice)
- Twelve themes taught during this class: explanations of stunting and prevention, balanced nutrition, four-star menu, frequency of eating and portion sizes for children under five, food ingredients, texture and how to cook the food, feed the children, causes of weight loss, physical activity and exercise, and the importance of rest and sleep for children
- Four-star Menu Cooking Competition (the culmination of the nutrition cooking class intervention)

Responsive parenting

This component focused on increasing knowledge of the benefits of good parental mental health, reducing parental violence towards children through positive behaviour guidance, and encouraging positive outcomes for children by promoting a playful parenting approach within stimulation sessions. There were 12 x weekly, 90-minute meetings of the Responsive Parenting Class (consisting of 60 minutes for responsive parenting knowledge and skills, and 30 minutes for developmental stimulation activities). These covered,

- Twelve themes of responsive parenting included: (1) the meaning and reflection of parenting roles, (2) short- and long-term goals of parenting, (3) understanding child rights, (4) birth delivery preparations, (5) brain development, (6) balanced nutrition for early childhood, (7) positive discipline and independence, (8) positive rules and statement for positive relation parent and child, (9) sexual education for early childhood, (10) understanding school readiness, (11) health and hygiene, and (12) accessing health services
- Twelve themes of playful stimulation included differentiated activities for 3- to 4-year-olds, 4- to 5-year-olds, and 5- to 6-year-olds (i.e., cognitive play for 2- to 3-year-olds, storytelling for 3- to 4-year-olds, and guess the picture for 4- to 5-year-olds)
- Building parents' skills in supporting their own mental health and wellbeing

Behaviour Change Communication (BCC)

This component was targeted towards community members through the formation of behaviour change communication working groups. These groups empowered members to create their own stunting awareness campaign to promote community-level positive behaviour change.

- Assistance in designing behaviour change communication material in the form of murals, posters, banners, fans, and e-media
- Production and distribution of behaviour change communication materials by involving the community in the pilot area.

TRAINING & SUPPORT

Program implementation was supported by the Program Facilitators. In February 2021, training of facilitators included:

1. **Three days of nutritional training for nutrition program facilitators**
   Training materials focused on understanding stunting, balanced nutrition, handling malnutrition, infant and child feeding, and the practice of cooking a four-star diet menu (a complementary food menu consisting of four major food groups as nutritional elements, namely carbohydrates, animal protein, vegetable protein, fruit and vegetables. The four elements are the standard of balanced nutrition needed by children under five for their growth and development).
2. **Three days of responsive parenting training for responsive parenting program facilitators**
   Trained in 12 themes of responsive parenting and 12 themes of developmental stimulation skills for children aged two to five years in cognitive, language, motor, and social-emotional aspects.
3. **Two-day workshop of Behaviour Change Communication (BCC)**
   BCC training for representatives from the nutrition facilitator group, responsive parenting facilitator group, village government personnel, and interested young people from both villages. These personnel formed the Behaviour Change Communication (BCC) working groups. A situational analysis was carried out by these groups to identify conditions

within the villages that hinder stunting prevention. Based on this information, each village prepared an Action Plan for BCC material development, conducted both on- and off-line.

The training was provided by a Child Development Specialist. Capacity building for facilitators was carried out during five full day Module Review meetings, consisting of in-depth discussions led by ChildFund Child Development Specialists, with support from local partner facilitators on cultural contextualization. Training and capacity building of program facilitators was conducted over the Zoom online meeting platform and included components on wellbeing and parent mental health.

DURATION & INTENSITY

The pilot program commenced in February 2021 and was completed in June 2021. The direct implementation of the family support components was conducted over a three-month period from March to May 2021 with weekly nutrition and responsive parenting classes over twelve weeks.

A total of 57 children (2 x 0 to 1 year olds; 14 x 1 to 2 year olds; 20 x 2 to 3 year olds; 17 x 3 to 4 year olds; 4 x 4 to 5 year olds) completed the program and were selected as they identified as either malnourished or at risk of stunting or wasting. This was determined from examination of public health data from the district health office. The children were divided into six intervention point groups based on their residential location. Two points operated in the Pasir Kuda Village and four points in the Pasir Jaya Village.

Due to the COVID-19 pandemic, there was some variation in the delivery of the program components. In red zone locations, where face-to-face classes were not possible due to active cases of COVID-19, the modality was changed to weekly 30-minute Facebook and/or WhatsApp group video calls. However, it is important to note that challenges with access to technology and/or the internet limited the efficacy of this modality for some parents. For some of the remote villages where lockdown restrictions were not in place, sessions were held face-to-face with strict COVID-19 protocols and policies in place, including social distancing and mask-wearing.

FUNDING

Funding for the program was part of a pre-existing funding model, with the intent and flexibility to reach more parents through the pilot program.

PARTNERSHIPS

ChildFund worked closely with local governments (e.g., Pancasan Public Health Services) to strengthen their policies about ECD and parents. These partnerships were vital in the development and implementation of the program. ChildFund worked closely with Bogor City Government, including public health services, child protection services, and women empowerment services. This included the Public Health Expert Association (for the nutrition component of the program), Cipta Foundation for Behaviour Change Communication, and Warga Upadaya Foundation (for advocacy work).

IMPACTS & OUTCOMES

The impacts and outcomes of the *Ibu Anak Tangguh Kota Bogor* pilot program were examined among 57 children and their parents from two villages in Bogor City, West Java, Indonesia.

- 96.49% of children experienced weight gain with monthly growth-rate monitoring identifying that 37% of children did not experience a decline during the program period
- Of the 57 children who were initially identified as underweight/at risk of stunting and wasting, 39 children demonstrated good nutritional status after the program
- Most of the weight gained occurred within the first month of the program when children received a complete, balanced nutritional intake
- 73.4% of parents (compared to 10% at baseline) replicated play and psychosocial stimulation of children within the home environment
- Positive perceptions of parenting increased from 31.7% to 100%, with 89.1% of parents reporting an awareness that parenting requires more than natural instincts and imitation of how they themselves were raised
- Parents increased their understanding on four main categories of children's rights (survival, developmental, protective, participative rights). 1.6% of children understood children's rights at baseline vs. 65.5% following participation

At a community level, the program reached approximately 25% of the population of each village. This was planned to stimulate community action and a capacity building model in which knowledge was passed on to other community members and families regarding the prevention of stunting. The Behaviour Change Communication component of the program resulted in the empowerment of communities as they learnt new paradigms and skills sets and gained hands-on experience in driving community-level change.

ChildFund published three strong advocacy messages following the responsive parenting aspect of the program on the national website of stunting prevention. These included: (1) the importance of responsive parenting on stunting prevention, (2) the role of gender

(e.g., father/mother) and responsive parenting on stunting prevention, and (3) the significance of early child education to end stunting.

EVALUATION

Prior to commencing the program, a representative from ChildFund consulted with each community to ensure that the aims and content of the program were aligned with the needs of each community.

The 24-hour Food Dietary Recall Survey was completed by parents at baseline and end line data collection points. Structured interviews were also conducted at both data collection points to capture detailed information about the food, beverages, and dietary supplements, as well as feeding times, portion sizes, and food sources consumed by the children in the previous 24 hours. Data was also collected on the perspectives and behaviours of parents in meeting their children's growth and developmental needs through baseline surveys and compared to data collected through end line surveys.

A sub-sample of 57 children were assessed throughout the entire comprehensive program process, with monthly data collected and evaluated on children's growth rates from baseline in January 2021 through to end line in June 2021.

FACILITATORS & BARRIERS

Key Facilitators:

- COVID-19 was seen as an opportunity to shift focus to familial mental health as this was often an under-represented area of focus within ECCD in Indonesia
- Flexibility of program modality (between face-to-face and online) depending on community exposure to active cases of COVID-19
- Working directly with local communities and governments strengthened community capacity and provided insight into local contexts
- Visiting communities and explaining the program led to general openness to the program amongst community members and understanding of the need
- Significant language barriers experienced upon visiting some communities were alleviated through the inclusion of local partners
- Parenting groups created a bond between parents, enabling opportunities to discuss challenges and support one another

Key Barriers:

- Parents working out of area, where another family member was looking after the child, had less engagement with the program
- Online/remote program delivery was challenging due to instability of internet networks and limited access to appropriate technology for some families
- Most of the target parents (mothers) work in the informal sector (e.g., domestic assistants, laundry workers, shopkeepers, part-time workers) and prioritised work that generates income rather than participating in intervention activities when timing overlapped
- Seven children could not fully participate in the program as their residence was too far from the location of the face-to-face meetings
- Responsive Parenting itself is a complex interdisciplinary issue. The transfer of all aspects of Responsive Parenting knowledge and skills in the short duration of the intervention to the facilitators was a challenging process
- The limited ability and sensitivity to capture issues that deserve to be packaged as behaviour change messages and the lack of supporting equipment (i.e., laptops) became challenges for BCC working groups
- Delays in permission to implement the program from the Bogor City
- COVID-19 Task Force meant that the intervention was postponed until mid-February 2021
- The postponement of the intervention schedule from the initial target shortened the stages and duration of interventions for nutrition management, responsive parenting, and BCC media development
- There was a slowdown in all activities involving the nutrition and responsive parenting facilitators, young people, and village officials due to their eventful lives during the fasting period of Ramadan and the celebration of Eid al-Fitr
- The duration of the intervention phase of the program only lasted for three months. This reportedly resulted in a lack of consistent behavioural changes in parents and children as well as supporting communities. The key to sustainable mentoring after the program is in the hands of the facilitators who still have regular interactions with parents and children
- COVID-19 tests had to be carried out prior to the facilitator training with approximately 25% of selected facilitators having to cancel their participation in the training because their test results were positive for COVID-19. As a result, they had to quickly find replacement participants who after the training process were identified as not having sufficient capacity to become the facilitators
- The implementation of COVID-19 regulations with strict social distancing complicated the initiation of

activities during the program (i.e., facilitators could only demonstrate processes from a distance)

FUTURE DIRECTIONS

- Interventions within the program may be sustainable within the participating communities through the continued utilisation of trained cadres and facilitators, positive endorsements from families, children, community members and other stakeholders, as well as lessons learned from the program by local public health services and governments
- By understanding the learnings and documentation of the pilot program, the intervention may be implemented within other communities that wish to develop local initiatives and resilience in addressing and preventing stunting
- The full documentation of the program, both in the form of written reports and workshops, can function as a means to share all the learning processes and changes that occurred. This can garner greater support and action from various other development actors from government agencies, the private sector, universities, and the media

LINKS TO THE WHO NURTURING CARE FRAMEWORK OUTCOMES	
	The program alleviated incidence of stunting through holistic parental and community program
	Children were provided with a balanced nutritional intake during the program, with targeted programs building parental capacity to provide adequate nutrition to their children
	A responsive parenting program increased parental capacity to provide adequate nutrition and psychosocial stimulation
	The parenting program increased parental capacity to facilitate and engage in play with children within the home environment

Mapping to Nurturing Care Framework (NCF)

NURTURING CARE – OUTPUTS (STRATEGIC ACTIONS)

The NCF suggests five strategic actions for a program to align with best practice:

1. LEAD AND INVEST

- The program adopted a multi-level structure with clear role descriptions for ChildFund, local NGOs and local government, facilitators, and parents to collectively support parental wellbeing and ECD.
- There was a well-developed and documented program plan, with clearly articulated vision, goals and targets, and protocols for implementation.
- Clear roles, responsibilities and training for implementation were assigned on an organisational level by ChildFund, accountabilities were given to facilitators to execute all program components.
- Due to the nature of ChildFund and its funding models, funding for the program was relatively easily obtained (i.e., transferred from other previously existing programs). While a great per participant cost analyses was presented, preparing long-term financial strategies to support the program was still required.

2. FOCUS ON FAMILIES

- The primary focus of the COVID-19 program was to support families through the nutritional and parenting facilitators, including the provision of resources and activities to enhance home learning experiences and well-balanced diet management.
- Program facilitators and parents shared regular, informal feedback on the experiences and program implementation, which afforded opportunities for responsive amendments on a needs basis.
- Families were supported by nutritional and parenting facilitators to become the drivers of change for children's development. Facilitators were specifically trained for the purpose of this program and participated in regular group meetings with trainers to assist correct program implementation and deal with barriers.
- Working groups were created for families to strengthen and support community platforms for early childhood development. Those groups empowered parents to create their own stunting awareness campaign on a community-level.

3. STRENGTHEN SERVICES

- The ChildFund COVID-19 response program was based on previously implemented parenting and ECD programs and, in the future, could strengthen those existing programs with the structures of remote and home learning components.
- This program supported existing services (e.g., community health centres). The facitilators were trained and provide additional support to families
- Protocols were in place to train and supervise all program implementers (e.g., facilitators and youth), to ensure good quality of practices and experiences for all participants
- Strong local government partnerships were formed to strengthen community practice, ownership and policy.

4. MONITOR PROGRESS

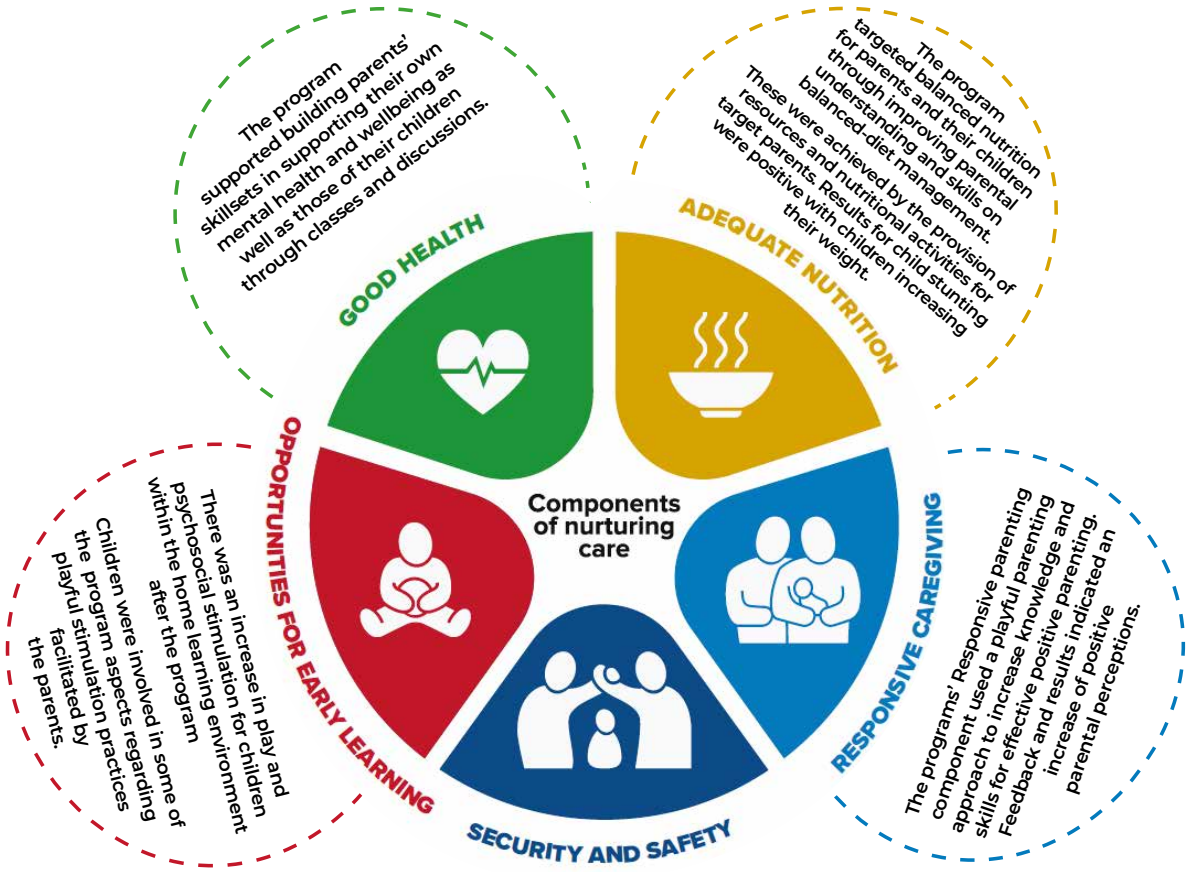
- Progress was monitored based upon facilitator, parental and community feedback through regular sessions with the focus on information sharing and program implementation evaluation.
- Child outcomes were collected though monthly evaluation of children's growth rates.

5. USE DATA AND INNOVATE

- The program was piloted within two local villages. Since then, the positive impacts and outcomes on parents and children have been evaluated and shared through webinars and formal documentation (e.g., manuscripts) with partner organisations.
- Data and resources have been shared with and through partnerships, such as ARNEC, to support an international platform for early learning and research regarding effective practices in response to the pandemic.
- Children's growth data was obtained and interventions were provided on the basis of this data, as well as data collected by the services.

NURTURING CARE – OUTCOMES

To reach children's full potential of adequate early development, the NCF identifies five components of nurturing care, including good health, adequate nutrition, responsive caregiving, opportunities for early learning, and security and safety.



Stakeholder experiences and considerations for future implementation

Stakeholders from Education, Health and Nutrition sectors recognised that this program:

- Ensured women and young children have access to good-quality health and nutrition services and/or information
- Made health and nutrition services more supportive of nurturing care
- Increased outreach for families and children at risk of stunting
- Collaborated with other sectors to ensure a continuum of nurturing care
- Ensured good health practices, hygiene and nutrition information were imparted to families
- Put family engagement at the core of their program

This program primarily focused on parents. However, data from a sub-sample of 57 children demonstrated that the focus on responsive parenting, including balanced nutrition, play and psychosocial stimulation by parents within the home environment, had a significant, positive impact on many children.

Future implementation of the program would likely be beneficial in other vulnerable communities, and may continue to make use of both remote and in-person components where possible. Some families reported difficulties engaging with the program due to being slightly out of area, or parents working away from the home, making in-person components difficult to attend. This should be balanced in future iterations of the program, ensuring the program is as inclusive as possible.

Links to research base and previous evidence

- The social support networks created within the Ibu Anak Tangguh Kota Bogor program through the establishment of parent groups, link to evidence supporting positive associations between participation in social support networks and parental wellbeing, particularly when dealing with stressful life events (Balaji et al., 2007; Ginja et al., 2018). These groups can support and motivate mothers to provide more positive and stimulating interactions with their children (Belcher et al., 2007; Phua et al., 2020; Yesmin et al., 2016)
- Parental engagement through play and positive interactions in the early years of a child's life is associated with positive developmental outcomes for children (Boonk et al., 2017; Lehrl et al., 2020; Melhuish et al., 2008; Zhang et al, 2021). It is important that programs seeking to support positive outcomes for children through parental interventions focus on messaging around supporting child development to ensure that parents do not feel that ideas are being pushed upon them (L'Hote et al., 2018).
- Similar stimulation and feeding interventions, with a focus on building parental capacity and knowledge have been evaluated in developing countries within the Asia-Pacific. Findings from these studies indicate benefits for children's growth, development, and nutritional status and positive changes to parental practices and knowledge (Aboud & Akhter, 2011; Aboud et al., 2013; Nahar et al., 2012).

Policy considerations

Child stunting is a growing concern in Indonesia, and this has been significantly exacerbated by the COVID-19 pandemic. The pandemic placed parents at the forefront of supporting their children in the home environment. ChildFund responded quickly and effectively, identifying the need for supportive programs (e.g., responsive parenting, nutrition and psychosocial stimulation) to support parental mental health and positively influence children's growth and development to prevent child stunting.

The successful design, development, implementation and evaluation of the program depended on a number of background conditions that should be highlighted. These include, but are not limited to,

1. **Use of technology**
   ChildFund delivered their usual family support modules, however due to the COVID-19 pandemic, the modality was changed to weekly 30-minute Facebook and/or WhatsApp group video calls. For some of the remote villages where lockdown restrictions were less prominent, sessions were still held face-to-face, adhering to COVID-safe protocols. It is recognised that geographic location and transport are significant barriers for vulnerable families accessing services. To ensure an inclusive and equitable approach, use of technology – necessitating funding and necessary digital infrastructure – is critical in supporting families during times of crisis and beyond.

2. **Remote community engagement**
   ChildFund works with local partners, particularly grassroots organisations made up of local community members, to support children and families. Existing community presence, as well as regular sourcing of feedback from community members, was central to the success of this program. The program relied on a subsection of community members (approximately 25%) to pass messaging onto other community members. Expanding access to high-quality parental support would be a significant benefit to communities, and would improve parent and child outcomes on a broader scale. Engaging community members in program design should also be a key consideration. Further, the role and support provided by facilitators/village cadres was critical. Additional incentives for these workers ought to be considered, given their pivotal role in providing support to family with malnourished children.

3. **Emphasis on importance of home-learning environment**
   The most critical step policymakers can take is to better understand the home learning environment through rigorous formative research. Due to the COVID-19 pandemic and additional roles undertaken by parents outside of traditional education settings, the time is ripe to better understand (1) how to support parents in the home environment, and (2) how supporting parents influences children in the home environment.

4. **Pre-existing programs and workforce**
   ChildFund's program implementation was supported by existing personnel, however they did receive training specific to the COVID-19 context and resulting changes to pre-existing programs. The training was provided by a Child Development Specialist, and regular group meetings were conducted to share feedback and suggestions on program implementation. Stable, ongoing funding for staff and specialists is essential to the ongoing success of programs that support parents and children. Moreover, staff professional development and training ought to be prioritised to meet the regularly-changing needs of families and the communities in which they are based.

5. **Flexibility and program responsiveness**
   Funding for ChildFund's program was part of a pre-existing funding model, allowing them the flexibility and responsiveness to reach more parents through the pilot program. This speaks to the importance of funding for future implementation. In the context of stunting, it is also imperative for policymakers to consider measures that will ensure adequate nutrition for children and families. For instance, subsidising healthy food options and placing tax on unhealthy options.

Reference list

Aboud, F.E., & Akhter, S. (2011). A cluster-randomized evaluation of a responsive stimulation and feeding intervention in Bangladesh. Pediatrics, 127(5), 1191-1197. https://doi.org/10.1542/peds.2010-2160

Aboud, F.E., Singla, D.R., Nahil, M.I., & Borisova, I. (2013). Effectiveness of a parenting program in Bangladesh to address early childhood health, growth and development. Social Science & Medicine, 97, 250-258. http://dx.doi.org/10.1016/j.socscimed.2013.06.020

Balaji, A.B., Claussen, A.H., Smith, C., Visser, S.N., Morales, M.J., & Perou, R. (2007). Social support networks and maternal health and wellbeing. Journal of Women's Health, 16(10). https://doi.org/10.1089/jwh.2007.CDC10

Belcher, H.M., Watkins, K., Johnson, E., & Ialongo, N. (2007). Early Head Start: factors associated with caregiver knowledge of child development, parenting behavior, and parenting stress. NHSA Dialog: A Research-to-Practice. Journal for the Early Intervention Field, 10(1), 6-19.

Boonk, L., Gijselaers, H.J.M., Ritzen, H., & Brand-Gruwel, S. (2017). A review of the relationship between parental involvement indicators and academic achievement. Educational Research Review, 24, 10-30. https://doi.org/10.1016/j.edurev.2018.02.001

Ginja, S., Coad, J., Bailey, E., Kendall, S., Goodenough, T., Nightingale, S., Smiddy, J., Day, C., & Lingam, R. (2018). Associations between social support, mental wellbeing, self-efficacy and technology use in first time antenatal women: data from the BaBBLes cohort study. BMC Pregnancy and Childbirth, 18(441), 1-11. https://doi.org/10.1186/s12884-018-2049-x

Lehrl, S., Evangelou, M., & Sammons, P. (2020). The home learning environment and its role in shaping children's educational development. School Effectiveness and School Improvement, 31(1), 1-6. https://doi.org/10.1080/09243453.2020.1693487

L'Hote, E.L., Kendall-Taylor, N., O'Neil, M., Busso, D., Volmert, D., & Nichols, J. (2018). Talking about the science of parenting. Frameworks Institute. https://www.parentingrc.org.au/wp-content/uploads/Talking-about-the-Science-of-Parenting.pdf

Melhuish, E.C., Phan, M.B., Sammons, P., Siraj-Blatchford, I., & Taggart, B. (2008). Effects of the home learning environment and preschool centre experience upon literacy and numeracy development in early primary school. Journal of Social Issues, 64(1), 95-114. https://doi.org/10.1111/j.1540-4560.2008.00550.x

Nahar, B., Hossain, M.I., Hamadani, J.D., Ahmed, T., Huda, S.N., Grantham-McGregor, S.M., & Persson, L.A. (2012). Effects of a community-based approach of food and psychosocial stimulation on growth and development of severely malnourished children in Bangladesh: a randomised trial. European Journal of Clinical Nutrition, 66(6), 701-709. https://doi.org/10.1038/ejcn.2012.13

Phua, D.Y., Kee, M.Z.L., & Meaney, M.J. (2020). Positive maternal mental health, parenting, and child development. Biological Psychiatry, 87(4), 328-337. https://doi.org/10.1016/j.biopsych.2019.09.028

Yesmin, S., Rahman, N.F., & Khatun, R. (2016). Community based psychosocial intervention in reducing maternal depression and improving infant's development in Bangladesh: A randomized control trial. IOSR Journal of Nursing and Health Science, 5(3), 11-20. http://dx.doi.org/10.9790/1959-0503021120

Zhang, C., Qiu, W., Li, H., Zhang, L., Li, X., & Li, J. (2021). Parental stress and home activities for young children during the stay-at-home quarantine time in China. Early Education and Development, 32(6), 843-862. https://doi.org/10.1080/10409289.2021.1949561

This is one of the ten case studies from ARNEC's documentation of good ECD practices and innovations in the context of COVID-19.

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