

Effectiveness of a universal film intervention in reducing violence against children and increasing positive parenting among migrant and displaced caregivers from Myanmar: a community-based cluster randomised trial



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Summary

Background Parenting interventions have been shown to reduce violence against children and promote positive parenting, but evidence on interventions to achieve population-level reach and impact is limited in low-resource settings. We assessed the impact of a universal film intervention for migrant and displaced caregivers from Myanmar living in Thailand.

Methods We implemented a two-arm, cluster randomised trial in Tak province, Thailand, on the border with Myanmar. 44 communities were stratified by district and randomly allocated to intervention or control (1:1) using a computer-generated list of random numbers. Intervention group participants received a screening of a 66-min narrative drama film about parenting, followed by a 30–40-min discussion and a 5-min video and poster summarising key messages. Control group participants received information about local health and social services. Eligible participants were primary caregivers aged 18 years or older with a child aged 4–17 years at enrolment. Participants were surveyed at baseline, endline approximately 4 weeks post-intervention, and follow-up approximately 4 months post-intervention. Primary outcomes were caregiver self-reported use of physical and psychological violence and positive parenting, analysed using both imputed and non-imputed multilevel models estimating differences between study arms at endline and follow-up. Due to the nature of the intervention, participants and assessors were not masked. The trial was prospectively registered with Thai Clinical Trials Registry TCTR20230222005.

Findings Between February and June 2023, 2249 participants in 44 communities completed baseline assessments and were randomly assigned to intervention ($n = 1116$) and control ($n = 1133$). 2023 caregivers ($n = 998$ in intervention and $n = 1025$ in control) completed the four-week endline survey and 1909 caregivers ($n = 961$ in intervention and $n = 948$ in control) completed the four-month follow-up. Intention to treat analyses showed the intervention reduced physical violence (IRR 0.91, 95% CI 0.85–0.97) and increased positive parenting (β 0.46, 95% CI –0.03 to 0.95). No meaningful differences were observed for psychological violence between intervention and control groups, with imprecisely estimated effects close to zero (β 0.47, 95% CI –0.62 to 1.57). Small effects were observed for the secondary and exploratory outcomes of parenting knowledge, belief in the need for harsh punishment, engagement in early learning, family functioning, and social support. Subgroup analyses suggest that the

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intervention may be more effective at reducing physical violence among female caregivers and caregivers of female children and younger children. There were no reported adverse effects.

Interpretation Universal parenting interventions using a film-based entertainment-education approach can effectively reduce physical violence against children and increase positive parenting, with potential for scalability in low-resource settings.

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Keywords: Parenting; Violence against children; Child maltreatment; Refugees; Migrants; Displacement; Conflict; Thailand; Myanmar; Film; Entertainment-education; Mass media interventions; Cluster randomised controlled trial

Research in context

Evidence before this study

We reviewed a global review of 28 systematic and comprehensive reviews published in 2017 and two systematic reviews from 2022 to 2023 assessing the effectiveness of parenting interventions to reduce violence against children in a range of settings, including in humanitarian settings in low- and middle-income countries (LMICs). There was only one systematic review published in 2014 assessing the impact of universal campaigns with a media component on preventing child physical abuse. None of the 17 studies included in this review was conducted in a LMIC, two out of the three studies that assessed child physical abuse incidence found reductions, and four out of four studies that assessed parenting behaviour found improvements. There were no studies in LMICs that used mass media to deliver a parenting intervention. We searched the Global Health (Ovid) and PubMed databases from the first record to May 7, 2024 focusing on studies in LMICs and using MeSH terms and keyword searches with the search terms “violence against children,” “violence,” “child maltreatment,” “physical abuse,”

“psychological abuse,” “physical punishment,” “corporal punishment,” “physical discipline,” “parenting,” “parenting behaviour,” “parenting intervention,” “intervention,” “media,” “entertainment,” and “edutainment.” No studies using experimental or quasi-experimental designs were found.

Added value of this study

To our knowledge, this is the first trial of a universal parenting intervention using mass media or entertainment-education to reduce violence against children and promote positive parenting in a low-resource setting.

Implications of all the available evidence

Our results suggest that a light-touch, universal mass media campaign using narrative film can be used to reduce physical violence against children and increase positive parenting at a population-level. Further research is needed to examine strategies for implementation at scale in low-resource, high-adversity contexts.

Introduction

Violence against children is a global public health crisis affecting one out of two children or an estimated one billion children every year.¹ The most common perpetrators of physical and psychological violence, across child gender and age, are parents and caregivers.² Violence in childhood has well-documented negative impacts on a range of health and social outcomes including mental health disorders, alcohol and drug abuse, suicidal behaviour, risky sexual behaviour, obesity, and increased risk of future violence perpetration and victimisation.³ While violence against children is pervasive around the world, children affected by poverty, armed conflict, and forced displacement are often at increased risk of violence due to stressors on

family and community structures.⁴ Research in multiple conflict and displacement settings has shown that parents and caregivers are more likely to use harsh parenting, including physical and psychological violence, due to heightened exposure to trauma and adversity, breakdown of social support structures, and resulting impacts on caregiver mental health.⁵

Conversely, positive parenting—defined as nurturing and responsive parenting behaviours and interactions—is a well-established protective and promotive factor for children’s development, mental health, and well-being.⁶ Interventions aimed at improving parenting behaviours, knowledge, beliefs, attitudes, and skills have shown impacts on reducing physical and psychological violence against children and promoting positive parenting in

low- and middle-income countries (LMICs), including in conflict-affected settings.^{7–10} A meta-analytic review of 23 randomised controlled trials (RCT) of parenting interventions with conflict-affected populations, primarily in Africa and the Eastern Mediterranean region, found an overall small effect ($d = -0.36$) on reducing physical and psychological violence against children.¹¹ Parenting interventions constitute one of the seven INSPIRE strategies for ending violence against children implemented in 67 countries to date¹² and are a key pillar of the Nurturing Care Framework to promote early childhood development.⁶

Wide-scale implementation of parenting interventions in low-resource, conflict and displacement-affected settings remains limited due to weak service delivery systems and infrastructure and human resource constraints.¹¹ Typical implementation strategies - i.e., in-person or virtual delivery of a structured series of manualised sessions by trained specialist or non-specialist providers - can be challenging to sustain in fragile contexts with limitations on population-level reach and impact. The evidence on brief parenting interventions in conflict and displacement settings is scarce, with only two of the studies from the aforementioned meta-analytic review reporting on light-touch single-session interventions.^{13,14} While their results indicated reductions in harsh and coercive parenting, conclusions are limited by the pilot nature of the studies.

Mass media campaigns using television, film, radio, billboards, and/or digital media can be delivered at the population level to reach large numbers of people at relatively low cost, overcoming challenges of literacy and workforce capacity.¹⁵ Entertainment-education (also known as edutainment) is a type of mass media intervention that purposefully embeds educational messages in narrative entertainment programs (e.g., dramas, situational comedies) to produce social or behaviour change.¹⁶ Studies have shown impacts of entertainment-education interventions on several health-related outcomes such as smoking and attitudes towards gender-based violence and sexually transmitted infection testing.^{17,18} Universal parenting interventions using mass media have been tested in high-income countries only, with a systematic review of 17 studies in five countries (USA, Australia, United Kingdom, Canada, Japan) finding reductions in child physical abuse and impacts on related outcomes of dysfunctional parenting, parental self-efficacy, and parenting knowledge.¹⁹ However, the quality of studies was generally low and there was significant variation in the duration, intensity, and content of interventions (two studies evaluated the Triple p system, which included multiple components such as individual parenting support in addition to media-delivered content). The evidence on brief, light-touch mass media interventions to reduce violence against children and promote positive parenting remains

limited, particularly in LMICs where the majority of the world's children reside.

Entertainment-education interventions have not, to our knowledge, been tested as a strategy to reduce violence against children or promote positive parenting in LMICs. In this study, we conducted a cluster randomised trial of “Being Family,” a universal, light-touch narrative film intervention for migrant and displaced families from Myanmar, as it would be delivered in a real-world community setting. Primary outcomes were positive parenting and physical and psychological violence. Pre-specified secondary outcomes were belief in the need for harsh punishment, psychological distress, family functioning, and parenting knowledge. Exploratory outcomes were engagement in early learning, educational involvement, acceptance of harsh punishment, coping and stress management, social support, and child mental health.

Methods

Study design and participants

We conducted a two-arm, single-blind cluster randomised trial with parallel assignment in 44 communities in Tak province, Thailand, from February 2023 to January 2024.²⁰ The western edge of the province shares a long border with Myanmar, which has had decades of armed conflict and political and economic instability. Estimates of migrants and displaced people from Myanmar residing in Thailand vary from 2 to 3 million, with movement across the border increasing since the military coup in Myanmar in February 2021.²¹ The study was a collaboration with four community-based organisations (Mae Tao Clinic, Help Without Frontiers Thailand Foundation, the Inclusive Education Foundation, and Sermpanya Foundation) implementing education and child protection programs for migrant and displaced communities in Tak province.

Communities where migrant and displaced families from Myanmar reside comprised clusters and were the unit of randomisation to minimise risk of contamination. We first listed communities in four districts in Tak province (Mae Sot, Mae Ramat, Phop Phra, Mae Sot-Phop Phra border) using a database of community-based informal schools for migrant and displaced children available from the Migrant Educational Coordination Centre. We supplemented this list with other communities with a significant presence of families from Myanmar. We purposively selected 44 communities for inclusion in the study based on the presence of approximately 50–70 families from Myanmar, permission from local community leaders to conduct the study, and a geographical buffer (e.g., road) separating selected communities to reduce risk of contamination.

Eligible participants within communities were parents or primary caregivers aged 18 years or older, with a child aged 4–17 years living in the same household,

born in Myanmar and now living in Thailand. Individuals who had significant cognitive, neurological, or developmental impairments that rendered them unable to provide informed consent, as assessed by the local research team, were excluded from the study. All participants provided written informed consent at the time of baseline data collection before randomisation. The study was approved by the Institutional Review Board of the Institute for Population and Social Research (IPSR) at Mahidol University in Thailand (COA. No. 2022/11–217), the Community Ethics Advisory Board on the Thailand–Myanmar border (CEAB-2022-015), and the ethics committees at McMaster University (#15759), Oxford University (SPI_DREC_22_002), and Duke University (2023-0031). The protocol is published²² and registered at Thai Clinical Trials Registry (TCTR20230222005).

Randomisation and masking

Communities were recruited and randomised in blocks of four in a 1:1 ratio using a computer-generated random number in Stata. Blocks were within strata (urban Mae Sot district versus all other more rural districts) to minimise potential imbalance between study arms. Randomisation was done by an independent statistician masked to community identity. Communities and caregivers were recruited and baseline assessments completed within each block before randomisation. It was not possible to mask participants given the nature of the intervention. Data collectors assessed intervention exposure at the end of the endline survey, at which point they became unmasked. Statistical analyses were done by trial statisticians who were masked to group assignment. All decisions regarding analyses were made without seeing the estimated effects of the intervention.

Procedures

Staff from local implementing partners introduced the project to community leaders, secured local approvals, and managed local implementation. Community-based staff were responsible for recruiting eligible caregivers in their community (one per household) and were paid a stipend for their work. Trained data collectors obtained informed consent and enrolled recruited caregivers into the study before the baseline survey. Informed consent and assessments took place in small groups of 4–5 caregivers using Open Data Kit on Android tablets. Each participant was provided with a tablet which displayed the study information sheet, consent statement, and survey items. Data collectors read out the study information sheet to participants and provided opportunities for questions. Participants checked the appropriate box on the informed consent statement displayed on their electronic tablet to indicate consent. A paper copy of the study information sheet with contact information for the local ethics board and research team was also provided.

Following the informed consent procedure, data collectors read out each survey item and corresponding response options, and participants entered their responses on the tablet. Pictorial Likert scales and other visual aids developed during pilot testing were displayed on the tablet to facilitate understanding of response options. Participants with low literacy levels were able to take part in one-on-one interviews in which the data collector read out the survey items and entered participants' verbal responses in the tablet.

The focal child on which participants reported was randomly selected based on having a birthday closest to the assessment date. Assessments were conducted in Burmese in an accessible community location (e.g., school) and took approximately 60–90 min. Participants received a small gift worth approximately US\$4 (~138 Thai Baht; ~8375 Myanmar Kyat [as of Nov 22, 2024]) after each assessment. In addition, a lottery was conducted in each community after each assessment for a chance to win one of 5 prizes worth approximately US\$5. All participants received a list with contact information of community-based organisations providing health and social services.

The film intervention was delivered in each intervention community on a rolling basis from May to September 2023 following randomisation. We selected film as the intervention modality to address implementation challenges identified by local partners (i.e., low literacy among the target population, human resource constraints), building on the work of Sempunya Foundation, a community-based organisation that has produced and screened health promotion, protection, and education films on the Thailand–Myanmar border since 2011. The intervention (English title “Being Family”) comprises a 66-min live action narrative drama film depicting the parenting challenges faced by two families living on the Thailand–Myanmar border and the positive and negative strategies they use to address these challenges. In each intervention community, screening of the film was followed by a 30–40-min facilitated audience discussion, a 5-min video summarising the film's key messages shown immediately after the discussion, and distribution of a poster depicting four main parenting and stress management skills. Key messages depicted in the film were adapted from Parenting for Lifelong Health (PLH), a suite of open-access parenting programs that has been tested in 15 RCTs in LMICs.²³ The film focuses on four key parenting skills: the importance of play and positive parent–child interaction; praise and positive family communication; non-violent behaviour management; and parental coping and stress management. The characters and scenarios depicted in the film reflect different ages and developmental stages to ensure relevance to families with children across a wide age range. Script development and film production took place over 12 months and were informed by formative qualitative

research with migrant and displaced families and an advisory committee composed of local community-based organisations and caregivers from Myanmar. A refugee filmmaker from Myanmar led script writing and film production, all cast and crew members were migrants and displaced people from Myanmar, and the film was shot on location in Mae Sot district.

Film screenings accommodated participants' availability and were held in community spaces (e.g., village halls, schools) using Sermpanya Foundation's mobile cinema. Water and a small snack (US\$0.40) were distributed to audience members. Community volunteers invited study participants and their families to attend the film screening using printed flyers featuring the "Being Family" film poster and attendance was recorded by project staff. Individuals residing in study communities but not enrolled in the study were allowed to attend the film screening following verification by project staff that they lived in the same community. Attendance of non-study participants was monitored but names or other identifying information were not recorded. There was no evidence that individuals from outside the intervention communities attended the film screenings. Four "make-up" screenings were held for caregivers in the intervention communities who were unable to attend the first screening ($n = 21$).

Immediately following the film screening, audience members took part in a 30–40-min discussion about their reflections on the film. A staff member of a local partner organisation with over 20 years of experience in community outreach and education was trained by the first author to facilitate the audience discussion at all the film screenings using a structured discussion guide. The facilitator asked a series of open-ended questions prompting audience members to reflect on the characters and their behaviours in the film, and how they may relate to participants' own lives (e.g., *In the movie, how did the girl feel when the mother hit and shouted at her?*). Audience members who volunteered to share their responses in front of the group were given a small gift (e.g., wash basin [US\$0.55]). Following the discussion, the audience watched a 5-min video of two well-known community members summarising the key messages from the film and received a poster depicting four main parenting and stress management skills ([Supplementary Information](#)).

As parenting interventions are not widely available in this setting, caregivers in the control communities did not receive an intervention apart from the list of community-based education, child protection, and health organisations and services distributed at the end of the baseline survey.

Two project staff members who were not involved in intervention delivery monitored the film screening and audience discussion in all 22 intervention communities. Intervention delivery was assessed using a structured monitoring form documenting whether intervention

components (i.e., screening of film and short summary video, poster distribution) were completed and the extent to which the facilitator of the audience discussion followed the structured guide. Data collectors conducted the endline assessment approximately four weeks post-intervention and approximately four months post-intervention in all study communities following the same procedures described above. Eleven local data collectors (6 female and all with a high school diploma or higher) were recruited and given five days of training on research ethics, study procedures, and assessments before the baseline survey in February 2023, followed by a three-day refresher training before the endline and follow-up surveys. Data collection was supervised by the local research manager and data were checked daily to identify and correct any errors in real-time.

Outcomes

Outcomes were assessed at the individual caregiver level at baseline, endline (four weeks post-intervention), and follow-up (four months post-intervention). The primary outcomes were: physical and psychological violence assessed with items from the International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool,²⁴ a validated self-report measure commonly used in LMICs including Thailand²⁵; and positive parenting assessed with items from the Parent Behaviour Inventory, developed and used by authors AS and EP in a previous trial with migrant and displaced families on the Thailand–Myanmar border.²⁶ Secondary outcomes were belief in the need for harsh punishment assessed by one item from the 2015 Myanmar Demographic Health Survey (DHS)²⁷; caregiver psychological distress (Hopkins Symptom Checklist-10)²⁸; family functioning (Burmese Family Functioning Scale)²⁶; and parenting knowledge assessed with five items developed for this study at endline and follow-up only. Pre-specified exploratory outcomes were engagement in early learning,²⁷ coping and stress management,²⁶ educational involvement,²⁹ acceptance of harsh punishment, perceived emotional and instrumental social support,³⁰ and child internalising³¹ and externalising³² symptoms. Measures were translated and back translated using WHO guidelines³³ and pre-tested before the baseline survey. Internal consistency reliability was good across measures (Cronbach's α median 0.84, IQR 0.75–0.87). All outcomes were self-reported by caregivers and are listed in full in [Supplementary Information](#).

Statistical analysis

The sample size calculation was performed by the trial statistician (GJMT) and based on a two-group comparison of one of the primary outcomes (physical violence, psychological violence, or positive parenting) assessed at endline. Assuming a two-sided significance level of 5% with an intra-cluster correlation coefficient (ICC) of 0.02

(based on a previous RCT conducted by authors AS and EP on the Thailand–Myanmar border²⁶) and a two-tailed test with 0.90 power, 40 clusters with 50 caregivers per cluster would be required to detect a mean difference in primary outcome score (effect size) of 0.20. We estimated a smaller effect size than the total weighted effect size of 0.296 from a review of parenting interventions for child maltreatment prevention,³⁴ given the light-touch nature of the intervention. The total required sample size, after accounting for up to 10% attrition, was estimated at 2223 but was planned with a slight underestimate at 2200 caregivers given the anticipated number of families per cluster (40 clusters with 55 families per cluster). We anticipated that the number of recruited caregivers would vary in each community. We continuously monitored realised power as we enrolled caregivers into the study and stopped recruitment when the harmonic mean of cluster size and number of clusters was close to 90% power, and we reached maximum capacity.

We plotted and assessed the standardised residuals for the primary and secondary outcomes, including plotting residuals against numeric predictors, which supported the normality assumption. Primary outcomes were analysed using multilevel models (linear model for continuous outcomes, Poisson model for count outcomes, and ordered logit with outcome probabilities determined by the logistic cumulative distribution function for ordinal outcomes) specifying three levels for outcomes with baseline measurements: measurement waves are nested within participants who in turn are nested within clusters. Level 1 included a term for categorical time (baseline, endline and follow-up) and the interactions between intervention and categorical time; level 2 included terms for caregiver and child age and gender (which was dichotomised into “male” and “female/other”), centred at the sample mean; and level 3 included terms for intervention and stratification. Thus, the estimate of intervention effectiveness is the interaction between intervention and categorical time. Models without interactions were compared against models with interactions using a multiparameter Wald test (for multiply imputed data) or a likelihood ratio test (for non-imputed data).

Primary analyses were conducted using the intention-to-treat principle. To account for dropouts in the intention-to-treat analysis, the baseline measurement (where available) was treated as a repeated measure and estimation of the intervention effects used maximum likelihood. Missing data were imputed by fully conditional specifications accounting for the clustered nature of the data, with 20 imputations created. Missing data in the predictor variables was negligible and only observed for caregiver age ($n = 4$) and child age ($n = 2$). The primary analysis is from an imputed and adjusted model, which generated differences in the primary outcomes between the two study arms at endline and follow-up using 95% CIs. As

imputation did not meaningfully affect parameter estimates, we present adjusted models with non-imputed data as well. Crude imputed and unimputed models (i.e., models including intervention, time, intervention by time interactions, and stratification) are presented for sensitivity analysis. Two-tailed tests are reported with a statistical significance level of $p < 0.05$.

To test for effect modification, potential moderators were separated into between-cluster and within-cluster components. Models with interactions between moderators and time terms were compared against models that additionally included interactions between moderators, time terms and intervention allocation using likelihood ratio tests. We did six subgroup analyses, by: (i) caregiver gender; (ii) legal status (has legal document versus no legal document); (iii) caregiver education (high, defined as secondary school and above versus low, defined as less than secondary school); (iv) biological parent (versus non-biological caregiver); (v) child age; and (vi) child gender.

Role of the funding source

The funding source had no role in the writing of this manuscript or the decision to submit it for publication. The authors were not precluded from accessing the data in the study and they accept responsibility to submit for publication.

Results

In total, 2249 caregivers in 44 communities were enrolled into the study and completed the baseline survey from February to June 2023. 22 communities with 1116 enrolled caregivers were randomly assigned to the intervention arm and 22 communities with 1133 enrolled caregivers to the control arm. The intervention was implemented in the intervention communities on a rolling basis from May to September 2023. All communities were followed up at endline approximately 4 weeks post-intervention (June to October 2023) and at follow-up approximately 4 months post-intervention (October 2023 to January 2024). 2023 (90.0%) of sampled caregivers did the endline assessment, and 1909 (84.9%) did the follow-up assessment (Fig. 1). There were no differences in attrition across study arms (155 [13.9%] in the intervention group and 185 [16.3%] in the control group). Caregivers not responding at endline and/or follow-up were similar to all other caregivers in baseline levels of primary and secondary outcomes. However, caregivers not responding at endline and/or follow-up, compared to caregivers responding at all three timepoints, were more likely to be younger, male, undocumented, experience food insecurity, live fewer years in Thailand, have a non-biological relationship to the focal child, and have an older focal child (Supplementary Table S1). At the endline, 53 out of 998

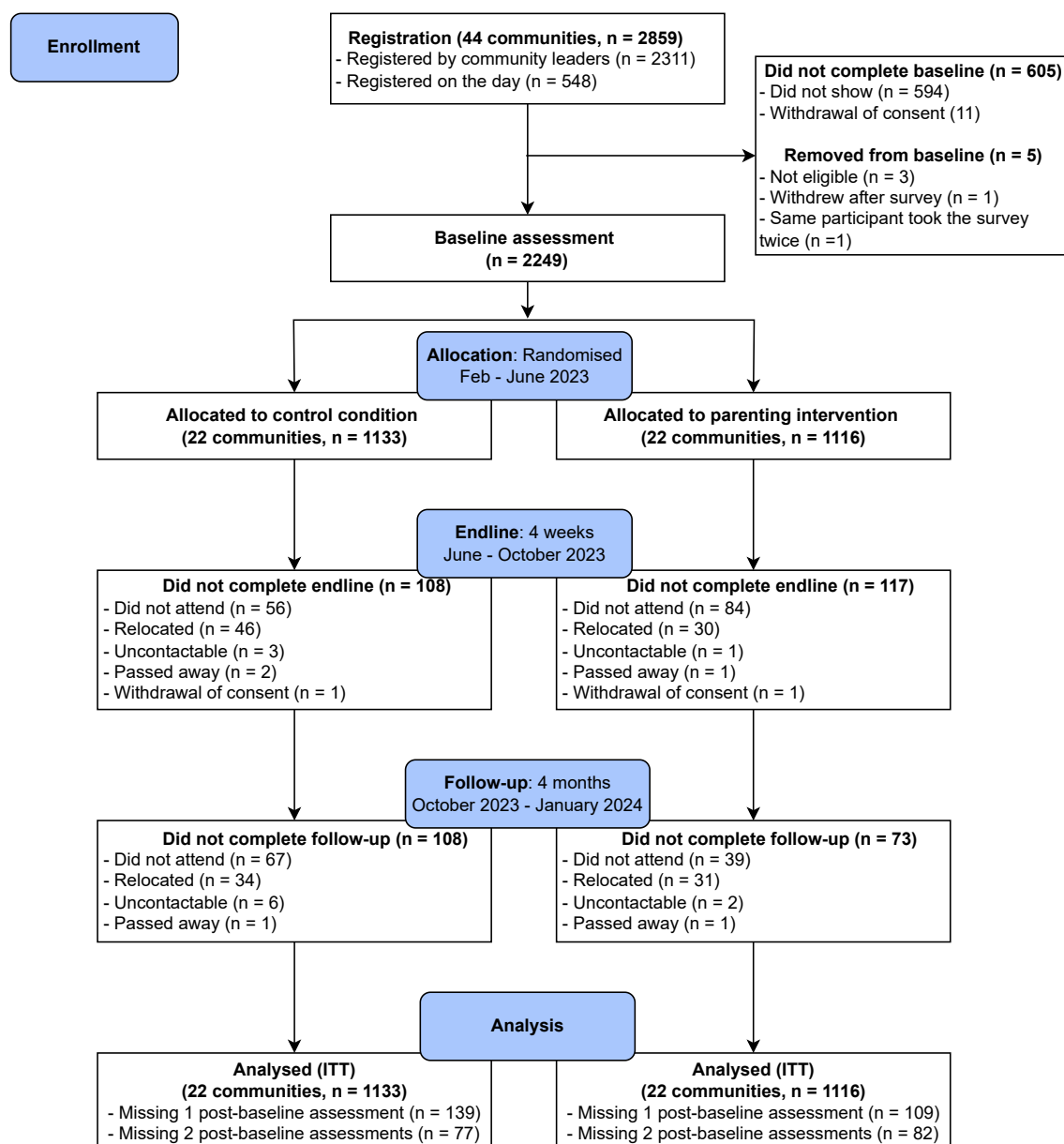


Fig. 1: Effectiveness of a film-based intervention to reduce child maltreatment among migrant and displaced families from Myanmar.

(5.3%) caregivers in the intervention communities and 40 out of 1025 (3.9%) of caregivers in the control communities indicated that they had not been with the focal child during the recall period of the past 30 days. This was the case for 57 out of 961 (5.9%) caregivers in the intervention communities and 40 out of 948 (4.2%) of caregivers in the control communities at follow-up. These caregivers did not complete the parenting measures (International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool²⁴ for physical and psychological violence and Parent

Behaviour Inventory²⁶ for positive parenting) but answered all other survey questions.

No adverse effects of the intervention or trial were reported. Three potential cases of risk of harm were identified during data collection, two involving past suicidality and one involving intimate partner violence. All were addressed following a safety protocol developed for the study.

The mean age of caregivers was 40.2 (SD 11.3), 90.4% were female, 22.2% never attended school, and 73.2% reported not having enough food in the last 30

days. 35.4% of caregivers had lived in Thailand for 5 years or less and 46.2% had lived in Thailand for over 10 years, with 77.7% of all caregivers in the sample lacking legal documentation. The median number of children under 18 years living in the same household was 2 (IQR 1–3) and 81.7% of caregivers were a biological parent of the focal child. The focal child on which the caregiver reported had a mean age of 9.9 (SD 3.9), 48.5% were female, 39.8% were out of school, and 19.8% had a functional impairment defined by difficulties with hearing, seeing, communicating, or moving (Table 1).

At baseline, 68.0% and 96.4% of caregivers reported using some form of physical violence and psychological violence respectively in the past 30 days. Hitting with the hand was the most common form of physical violence and shouting or yelling was the most common form of psychological violence. The mean score for positive parenting was 19.73 (SD 5.80) on a scale of 0–30.

Monitoring data from film screenings in the 22 intervention communities showed that the intervention was delivered as intended with high fidelity. The film was successfully shown in all 22 intervention communities followed by an audience discussion lasting a mean of 38.27 min (SD 7.57). The film was shown in full without interruption in all communities, 99.1% of the structured audience discussions were rated as completed in full, and audience participation was rated as moderately (50%) or very active (50%) in all communities. A total of 930 out of 1116 (83%) study participants (75% female) in the intervention communities were recorded as attending the film screenings, with an average attendance of 83.48% (SD 9.63). In addition, a total of 215 adults (66% female) residing in the intervention communities but not enrolled in the study and 676 children (54% female) were recorded as attending the screenings. On average, a film screening was attended by 42 (SD 7.85, range 24–54) study participants and 34 non-study participants including children.

Caregivers in intervention communities reported lower levels of physical violence at endline (Mean Ratio [MR] 0.91, 95% CI 0.85–0.97, Standardised Mean Difference [SMD] = –0.24) and follow-up (MR 0.95, 95% CI 0.88–1.01, SMD = –0.22). Caregivers in intervention communities also reported a small increase in positive parenting scores compared to caregivers in the control group (endline: β 0.46, 95% CI –0.03 to 0.95, SMD = 0.09; follow-up: β 0.74, 95% CI 0.23–1.24, SMD = 0.12). No meaningful differences were observed in levels of psychological violence between intervention and control groups at either time point, with imprecisely estimated effects close to zero (endline: β 0.47, 95% CI –0.62 to 1.57; follow-up: β –0.21, 95% CI –1.32 to 0.91) (Table 2).

Small positive effects were also observed for the secondary outcomes of parenting knowledge (endline: β

0.59, 95% CI 0.32–0.85, SMD = 0.23; follow-up: β 0.68, 95% CI 0.36–0.99, SMD = 0.26); caregiver engagement in early learning (endline: β 1.64, 95% CI 0.35–2.92, SMD = 0.16; follow-up: β 1.16, 95% CI –0.16 to 2.48, SMD = 0.11), family functioning (endline: β 0.33, 95% CI 0.04–0.62, SMD = 0.11; follow-up: β 0.15, 95% CI –0.04 to 0.55, SMD = 0.07), and social support (endline: β 0.54, 95% CI 0.21–0.87, SMD = 0.15). Caregivers in intervention communities also reported less belief in the need for physical punishment compared to the control group (endline: OR 0.72, 95% CI 0.58–1.11; follow-up: OR 0.84, 95% CI 0.67–1.05). A similar trend was observed for caregiver acceptance of harsh punishment (baseline: β –0.65, 95% CI –1.49 to 0.18, SMD = –0.14); however, estimates are less precise and do not exclude the possibility of a null effect. Narrow interval estimates near zero for caregiver psychological distress, coping and stress management, educational involvement, and child internalising and externalising symptoms suggest the intervention did not meaningfully impact these outcomes. Adjusting for covariates (caregiver and child age and gender) did not change the magnitude or confidence intervals of estimated effects (Supplementary Table S2).

Subgroup analyses suggest that for physical violence prevention, the intervention appeared to be more effective for female caregivers (Likelihood Ratio [LR] 7.07, p = 0.029) and for caregivers of female children (LR 6.55, p = 0.038) and younger children (LR 29.88, p < 0.0001), particularly at endline. There was no indication of differences in effects on positive parenting and psychological violence by any of the tested moderators (Supplementary Table S4).

Discussion

In this community-based cluster randomised trial, we tested the effectiveness of a universal film intervention at reducing violence against children and increasing positive parenting among migrant and displaced caregivers from Myanmar living in Thailand. To our knowledge, this is the first study to evaluate a universal mass media intervention to reduce violence against children and improve parenting behaviour in a LMIC. We found that caregivers who received the film intervention reported greater reductions in physical violence and increases in positive parenting behaviours compared to caregivers in the control group. We found no effects on psychological violence. The film intervention had positive impacts on pre-specified secondary and exploratory outcomes of parenting knowledge, engagement in early learning, family functioning, and social support. Caregivers in intervention communities also reported less belief in the need for physical punishment compared to the control group. Subgroup analyses showed few differential effects based on caregiver and child socio-demographic characteristics, suggesting that

| | Control group | | Intervention group | | Overall sample | |
|--|---------------|------------------------------|--------------------|------------------------------|----------------|------------------------------|
| | N = 1133 | %/Mean (SD)/ Median (IQR) | N = 1116 | %/Mean (SD)/ Median (IQR) | N = 2249 | %/Mean (SD)/ Median (IQR) |
| Sociodemographic characteristics | | | | | | |
| Caregiver gender | | | | | | |
| Male | 90 | 7.9 | 119 | 10.7 | 209 | 9.3 |
| Female | 1041 | 91.9 | 993 | 89.0 | 2034 | 90.4 |
| Other | 2 | 0.2 | 4 | 0.4 | 6 | 0.3 |
| Mean caregiver age (years) | 1131 | 40.2 (11.6) | 1114 | 40.2 (11.1) | 2245 | 40.2 (11.3) |
| Marital status | | | | | | |
| Married | 952 | 84.0 | 953 | 85.4 | 1905 | 84.7 |
| Widowed/widower | 105 | 9.3 | 87 | 7.8 | 192 | 8.5 |
| Divorced/separated | 57 | 5.0 | 60 | 5.4 | 117 | 5.2 |
| Single | 19 | 1.7 | 16 | 1.4 | 35 | 1.6 |
| Living with partner | | | | | | |
| No | 99 | 10.4 | 117 | 12.3 | 216 | 11.3 |
| Yes | 852 | 89.6 | 836 | 87.7 | 1688 | 88.7 |
| Educational attainment | | | | | | |
| Never went to school | 260 | 23.1 | 238 | 21.4 | 498 | 22.2 |
| Primary school (Grade 1–5) | 545 | 48.3 | 595 | 53.5 | 1140 | 50.9 |
| Middle school (Grade 6–9) | 198 | 17.6 | 177 | 15.9 | 375 | 16.7 |
| Secondary school (Grade 10–11) | 86 | 7.6 | 63 | 5.7 | 149 | 6.7 |
| University or higher | 39 | 3.5 | 40 | 3.6 | 79 | 3.5 |
| Employment | | | | | | |
| I work full time throughout the year | 297 | 26.3 | 311 | 27.9 | 608 | 27.1 |
| I work part time or seasonally | 536 | 47.4 | 601 | 54.0 | 1137 | 50.7 |
| I do not work at all | 297 | 26.3 | 201 | 18.1 | 498 | 22.2 |
| Food insecurity | | | | | | |
| None of the time | 299 | 26.5 | 268 | 24.1 | 567 | 25.3 |
| A little of the time | 504 | 44.6 | 570 | 51.3 | 1074 | 47.9 |
| Most of the time | 226 | 20.0 | 177 | 15.9 | 403 | 18.0 |
| Almost all the time | 100 | 8.9 | 97 | 8.7 | 197 | 8.8 |
| Residence | | | | | | |
| Less than 1 year | 91 | 8.1 | 81 | 7.3 | 172 | 7.7 |
| 1–2 years | 124 | 11.0 | 133 | 12.0 | 257 | 11.5 |
| 3–5 years | 176 | 15.7 | 185 | 16.7 | 361 | 16.2 |
| 6–10 years | 200 | 17.8 | 210 | 19.0 | 410 | 18.4 |
| More than 10 years | 532 | 47.4 | 498 | 45.0 | 1030 | 46.2 |
| Have a valid visa | | | | | | |
| No | 863 | 76.6 | 877 | 78.8 | 1740 | 77.7 |
| Yes | 263 | 23.4 | 236 | 21.2 | 499 | 22.3 |
| Have a work permit | | | | | | |
| No | 909 | 80.7 | 935 | 83.9 | 1844 | 82.3 |
| Yes | 218 | 19.3 | 179 | 16.1 | 397 | 17.7 |
| Total number of children < 18 | | | | | | |
| Median number of children under 18 (IQR) | 1132 | 2 (1–3) | 1115 | 2 (1–3) | 2247 | 2 (1–3) |
| Relationship to child | | | | | | |
| Biological parent | 913 | 80.6 | 924 | 82.2 | 1837 | 81.7 |
| Step parent | 11 | 1.0 | 15 | 1.3 | 26 | 1.2 |
| Grand parent | 126 | 11.1 | 110 | 9.9 | 236 | 10.5 |
| Other relative | 77 | 6.8 | 60 | 5.4 | 137 | 6.1 |
| Guardian (non-relative) | 6 | 0.5 | 7 | 0.6 | 13 | 0.6 |

(Table 1 continues on next page)

| | Control group | | Intervention group | | Overall sample | |
|---|---------------|------------------------------|--------------------|------------------------------|----------------|------------------------------|
| | N = 1133 | %/Mean (SD)/ Median (IQR) | N = 1116 | %/Mean (SD)/ Median (IQR) | N = 2249 | %/Mean (SD)/ Median (IQR) |
| (Continued from previous page) | | | | | | |
| Child gender | | | | | | |
| Boy | 589 | 52.0 | 567 | 50.8 | 1156 | 51.4 |
| Girl | 544 | 48.0 | 546 | 48.9 | 1090 | 48.5 |
| Other | 0 | 0.0 | 3 | 0.3 | 3 | 0.1 |
| Mean child age (years) | 1132 | 9.8 (3.9) | 1115 | 10.0 (3.9) | 2247 | 9.9 (3.9) |
| Child currently schooling | | | | | | |
| No | 440 | 38.9 | 454 | 40.7 | 894 | 39.8 |
| Yes | 692 | 61.1 | 661 | 59.3 | 1353 | 60.2 |
| Child earns money | | | | | | |
| No | 907 | 80.1 | 848 | 76.1 | 1755 | 78.1 |
| Yes | 225 | 19.9 | 267 | 24.0 | 492 | 21.9 |
| Child has physical difficulties | | | | | | |
| No | 914 | 80.7 | 890 | 79.8 | 1804 | 80.2 |
| Yes | 219 | 19.3 | 226 | 20.3 | 445 | 19.8 |
| Primary outcomes | | | | | | |
| Positive parenting | 1129 | 19.8 (5.9) | 1116 | 19.6 (5.7) | 2245 | 19.7 (5.8) |
| Median psychological violence (IQR) | 1133 | 11 (6–19) | 1113 | 12 (6–19) | 2246 | 10 (5–18) |
| Median physical violence (IQR) | 1133 | 2 (0–5) | 1114 | 2 (0–5) | 2247 | 2 (0–5) |
| Secondary outcomes | | | | | | |
| Psychological distress | 1126 | 20.4 (5.8) | 1113 | 20.2 (5.7) | 2239 | 20.3 (5.7) |
| Family functioning | 1130 | 12.2 (3.2) | 1114 | 12.1 (3.1) | 2244 | 12.1 (3.1) |
| Belief in the need for physical punishment | | | | | | |
| Strongly disagree | 279 | 24.7 | 267 | 24.0 | 546 | 24.3 |
| Disagree | 190 | 16.8 | 178 | 16.0 | 368 | 16.4 |
| Neutral | 276 | 24.4 | 278 | 25.0 | 554 | 24.7 |
| Agree | 219 | 19.4 | 227 | 20.4 | 446 | 19.9 |
| Strongly agree | 167 | 14.8 | 162 | 14.6 | 329 | 14.7 |
| Exploratory outcomes | | | | | | |
| Coping and stress management | 1132 | 7.3 (1.9) | 1112 | 7.4 (1.9) | 2244 | 7.3 (1.9) |
| Median social support (IQR) | 1131 | 6 (4–9) | 1114 | 6 (4–8) | 2245 | 6 (4–8) |
| Median engagement in early learning (IQR) | 483 | 17 (10–25) | 443 | 17 (10–24) | 926 | 17 (10–24) |
| No baseline measurements for the following secondary and exploratory outcomes: acceptance of harsh punishment [4 items], knowledge about positive parenting, caregiver support for education, child externalising behaviour, child internalising behaviour. | | | | | | |

Table 1: Baseline characteristics (sociodemographic and outcomes).

the film intervention was for the most part similarly effective for all caregivers.

There was no effect on the secondary outcome of caregiver psychological distress or the exploratory outcomes of coping and stress management, child internalising and externalising symptoms, caregiver educational involvement, and acceptance of harsh punishment. While effects on positive parenting and parenting knowledge were sustained at four-month follow-up, reductions in physical violence faded by follow-up and there were no effects on psychological violence at either time point. The study took place at a time of escalating violence in Myanmar and increased security presence in the study sites, which likely contributed to high levels of stress among caregivers and children. In settings with active conflict and

displacement, “booster” screenings as well as more intensive caregiver and family support to complement the film intervention may be needed to prevent physical and psychological violence against children over the longer-term and impact caregiver and child mental health.

Our study addresses several research gaps identified in the WHO guidelines on parenting interventions, including interventions for families living in extreme poverty and in humanitarian settings, and assessment of child maltreatment as a primary outcome.¹⁰ The study is novel in its evaluation of a universal mass media campaign to reduce violence against children and promote positive parenting, which to our knowledge has not been tested in a LMIC or displacement setting. The intervention was co-created with migrant and displaced

| | Post-intervention | | | | | | | | Follow-up | | | | | | | |
|--|-------------------|----------|---------|---------|--------------------|----------|---------|---------|------------------|----------|---------|---------|--------------------|----------|---------|--------|
| | Adjusted Imputed | | | | Adjusted Unimputed | | | | Adjusted Imputed | | | | Adjusted Unimputed | | | |
| | Coeff | (95% CI) | p-value | | Coeff | (95% CI) | p-value | | Coeff | (95% CI) | p-value | | Coeff | (95% CI) | p-value | |
| Primary outcomes | | | | | | | | | | | | | | | | |
| Positive parenting | 0.46 | -0.03 | 0.95 | 0.068 | 0.54 | 0.05 | 1.02 | 0.030 | 0.74 | 0.23 | 1.24 | 0.0040 | 0.69 | 0.20 | 1.19 | 0.0060 |
| Psychological violence | 0.47 | -0.62 | 1.57 | 0.40 | 0.47 | -0.62 | 1.57 | 0.40 | -0.21 | -1.32 | 0.91 | 0.72 | -0.05 | -1.17 | 1.07 | 0.93 |
| Physical violence (MR) | 0.91 | 0.85 | 0.97 | 0.0050 | 0.91 | 0.86 | 0.98 | 0.0060 | 0.95 | 0.88 | 1.01 | 0.11 | 0.97 | 0.91 | 1.04 | 0.37 |
| Secondary outcomes | | | | | | | | | | | | | | | | |
| Caregiver psychological distress | -0.19 | -0.72 | 0.34 | 0.48 | -0.22 | -0.72 | 0.28 | 0.39 | 0.30 | -0.26 | 0.87 | 0.29 | 0.26 | -0.25 | 0.78 | 0.31 |
| Family functioning | 0.33 | 0.04 | 0.62 | 0.024 | 0.36 | 0.08 | 0.64 | 0.013 | 0.26 | -0.04 | 0.55 | 0.088 | 0.23 | -0.06 | 0.52 | 0.12 |
| Belief in need for harsh punishment (OR) | 0.72 | 0.58 | 1.11 | 0.0040 | 0.72 | 0.58 | 0.90 | 0.0040 | 0.84 | 0.67 | 1.05 | 0.13 | 0.83 | 0.66 | 1.03 | 0.095 |
| Exploratory outcomes | | | | | | | | | | | | | | | | |
| Coping and stress management | 0.08 | -0.11 | 0.27 | 0.41 | 0.10 | -0.09 | 0.28 | 0.30 | 0.02 | -0.17 | 0.21 | 0.84 | 0.03 | -0.16 | 0.22 | 0.77 |
| Social support | 0.54 | 0.21 | 0.87 | 0.0010 | 0.53 | 0.20 | 0.86 | 0.0020 | .. | .. | .. | .. | .. | .. | .. | .. |
| Engagement in early learning | .. | .. | .. | .. | 1.64 | 0.35 | 2.92 | 0.013 | .. | .. | .. | .. | 1.16 | -0.16 | 2.48 | 0.085 |
| Acceptance of harsh punishment | -0.65 | -1.49 | 0.18 | 0.13 | -0.61 | -1.43 | 0.21 | 0.14 | -0.44 | -1.35 | 0.46 | 0.34 | -0.47 | -1.36 | 0.42 | 0.30 |
| Parenting knowledge | 0.59 | 0.32 | 0.85 | <0.0001 | 0.57 | 0.31 | 0.83 | <0.0001 | 0.68 | 0.36 | 0.99 | <0.0001 | 0.64 | 0.32 | 0.95 | 0.0001 |
| Educational involvement | .. | .. | .. | .. | 0.13 | -0.48 | 0.73 | 0.69 | .. | .. | .. | .. | -0.12 | -0.64 | 0.41 | 0.66 |
| Child externalising symptoms | .. | .. | .. | .. | .. | .. | .. | .. | -0.30 | -0.95 | 0.34 | 0.35 | -0.32 | -0.94 | 0.31 | 0.32 |
| Child internalising symptoms | .. | .. | .. | .. | .. | .. | .. | .. | -0.26 | -0.91 | 0.40 | 0.45 | -0.27 | -0.91 | 0.37 | 0.41 |

Reported coefficients are: Odds Ratios for belief in need for harsh punishment (multilevel ordered logistic regression - time stratified Brant test with clustered standard errors supported the proportional odds assumption); Mean Ratios (MR) for physical violence (multilevel Poisson regression); all other regression coefficients are Beta estimates for continuous outcomes (linear mixed models). All regression coefficient estimates are of intervention and time interactions except attitudes towards harsh punishment, parenting knowledge, educational involvement, child externalising symptoms, and child internalising symptoms which are estimates of treatment allocation at post-intervention and follow-up time points using mixed models. All models controlled for district stratifier (Mae Sot versus all other districts). Adjusted models additionally controlled for both caregiver and child gender and age measured at baseline.

Table 2: Intervention effects (presented as beta, odds ratios, and mean ratios) adjusted for caregiver and child gender and age measured at baseline.

communities and implemented by a local organisation with over a decade of experience producing and screening educational films with and for migrants and displaced people from Myanmar. There was high uptake (83%) in the intervention communities indicating feasibility, acceptability, and potential scalability of the intervention. The study was conducted with a general population of migrant and displaced caregivers and was well-powered to detect an effect with high response rates and low levels of attrition (10.0% at endline and 15.1% at follow-up) and missing data (99.3% average completion of the full survey at baseline, 98.1% and 97.2% at endline and follow-up respectively). Effect sizes for the primary outcomes of physical violence reduction (SMD -0.24) and positive parenting (SMD 0.09–0.12) are similar to those found in a meta-analytic review of 10 studies (5 in Sub-Saharan Africa) using entertainment-education to promote safer sexual behaviours among youth (SMD 0.08–0.29).¹⁸ In comparison, our previous RCT of a 12-session parenting intervention on the Thailand–Myanmar border found an effect size of 0.39 for reduction in harsh discipline,¹¹ similar to the overall effect size of 0.36 reported in a meta-analytic review of parenting interventions in humanitarian settings.²⁶

Narrative entertainment-education approaches have been hypothesised to operate through a range of mechanisms including social or observational learning,

transportation (i.e., engagement in the narrative), and identification (i.e., involvement with the characters). Evaluations of mass media interventions to change HIV-related attitudes and behaviours in Nigeria and reduce violence against women in Senegal, for instance, found stronger effects among participants reporting higher levels of transportation.^{35,36} We plan to analyse participants' experiences of the film intervention, including qualitative and quantitative data on transportation, identification, realism, relevance, and diffusion, to assess potential mechanisms underlying the effects of this novel intervention. Future analyses will also examine if and how changes in parenting knowledge and attitudes mediate effects on parenting behaviour outcomes. Finally, we plan to conduct a retrospective cost effectiveness study that will inform efforts to replicate, sustain, and scale up the intervention.

Limitations of the study include the reliance of caregiver self-reports on all outcomes. Self-reported measures of parenting are commonly used in low-resource and displacement settings due to the lack of child welfare administrative data. It was not feasible in this context to obtain child reports due to the significant proportion of focal children that would be too young to participate (40.5% of focal children were aged < 9 years) as well as local ethical and safety concerns about asking children to report on violence from their caregivers.

Although we used standardised, international measures of physical and psychological violence against children, self-reported measures may be subject to bias. Community and participant selection were not random given the lack of a pre-existing sampling frame for migrant and displaced families living in the area. Like other complex social interventions, participants and data collectors were not masked to allocation after baseline, which could have introduced bias towards a positive effect. The short follow-up of one month and four months due to significant population movement in this setting limited assessment of longer-term effects. Finally, only 10% of the caregiver sample were male. Although we made every effort to accommodate participants' schedules, men were typically unavailable due to their long work hours. Engaging men in parenting interventions is a common challenge in both high- and low-income settings.³⁷ Future implementation of the film intervention could involve strategies to specifically target male caregivers, for example, conducting screenings at workplaces.

Our results show that a light-touch, universal mass media intervention using narrative film is effective at improving multiple parenting and family outcomes identified in the literature as critical to child and adolescent health. There is currently limited evidence on light-touch parenting interventions that are effective and potentially scalable in low-resource displacement settings. Results from this study, showing a 9% risk reduction for physical violence against children, highlight the potential for entertainment-education interventions to have meaningful impacts on violence prevention when scaled up at a population-level. The unique advantages of an entertainment-education approach, including the ability to reach large numbers with standardised content at low ongoing delivery costs, can be leveraged to improve parenting and family outcomes in other populations and implementation contexts where structural and contextual barriers limit large-scale delivery of parenting support. Future research could examine how mass media parenting interventions could be replicated and scaled up in other settings within a tiered public health model to reach those who might not otherwise be served.

Contributors

AS and EP: conceptualisation, funding acquisition, investigation, methodology, supervision; KZL and SEP: investigation, data curation, project administration; GJMT and SV: formal analysis, methodology, validation; FC: data curation, formal analysis; TJ: conceptualisation, methodology; JL: conceptualisation, funding acquisition; SP: conceptualisation; AG: methodology; MS, NNO, and ICM: project administration; AS wrote the first draft of the manuscript and all authors reviewed and provided input on the final draft. AS had final responsibility for the decision to submit for publication.

Data sharing statement

The de-identified datasets generated from the study along with the statistical plan and analytic code will be available from the corresponding author on reasonable request five years after the end of the project when

all planned manuscripts have been accepted for publication. We will make the data without identifiers available to users only under a data-sharing agreement that stipulates: (i) commitment to using the data only for research purposes; (ii) commitment to securing the data using appropriate data security and storage protocols; (iii) commitment to destroying the data after analyses are complete; and (iv) commitment to publishing any information only at the aggregate level so that no specific characteristics can be linked to individuals or communities.

Declaration of interests

We declare no competing interests.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.lansea.2024.100526>.

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