Understanding of Children's Mental Health in Early Childhood Education: A Study of Daycare Centers in Bangladesh

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ABSTRACT

Children's mental health is still an important but often disregarded component of early childhood care and development (ECCD), particularly in environments with limited resources like Bangladesh. This study explored caregivers' knowledge, attitudes, and actions regarding children's mental health in daycare centers, with a focus on how they identify and meet their charges' emotional and behavioral needs. A mixed-approaches convergent parallel design was employed. While standardized surveys were utilized to gather quantitative data from 25 caregivers and five ECCD teachers, ten key informant interviews and observations from five childcare centers yielded qualitative insights. The two data strands were analyzed separately before being joined in order to produce contextually grounded insights. To generate contextually grounded interpretations, the two data strands were first examined independently before being combined. The findings showed a significant lack of awareness: 72% of caregivers were unable to identify mental health and commonly confused it with discipline or physical health. Teachers were aware of warning indicators like arrogance or withdrawal, but they lacked the institutional tools and expertise to react appropriately. Practice was further hindered by ongoing stigma, a lack of organized socio-emotional learning, and a lack of training opportunities. Positive informal methods, such as play-based learning, storytelling, and compassionate interactions between caregivers and children, were noted. The results highlight the critical need to incorporate socio-emotional learning frameworks, caregiver training, and mental health awareness into ECCD programs in order to ensure a more comprehensive approach to early childhood care in Bangladesh.

Keywords: Early Childhood Education, Daycare Centers, Caregiver Awareness, Children's Mental Health

INTRODUCTION

In Bangladesh, early childhood development (ECD) frequently emphasizes social, emotional, cognitive, and physical development. Mental health, emotional well-being, and social development are critical but overlooked components of early childhood care and development (ECCD). The importance of children's mental health as a pillar of early childhood development is becoming more widely acknowledged. Early life is a time of rapid social, emotional, and cognitive development. During this time, relationships and experiences have a significant impact on a child's psychological health and future outcomes. Early emotional stability and mental health are crucial for learning, social skills, and resilience, according to numerous studies (WHO, 2021; UNICEF, 2020).

The mental health component of early childhood care and development (ECCD) is still poorly understood and insufficiently addressed in many low- and middle-income nations, including Bangladesh.

Early childhood education and care programs in Bangladesh, such as daycare centers and pre-primary classrooms, frequently ignore the emotional and psychological domains in favor of focusing primarily on cognitive development and school readiness. Caregivers and educators often misunderstand the concept of "mental health," equating it with behavioral discipline or physical well-being rather than holistic emotional development. Caregivers' ability to recognize, understand, or address children's mental health issues, such as anxiety, withdrawal, aggression, or sadness, is hampered by this knowledge gap. Furthermore, there are still few

opportunities for ECCD teachers and daycare workers to receive formal training in child psychology, socioemotional learning, or mental health awareness.

Perceptions about psychological problems and cultural stigma compound the lack of national attention to child mental health. Instead of being seen as an essential component of early development, mental health is frequently thought of as an issue of adult illness or instability. As a result, children who struggle emotionally or behaviorally might be called "naughty" or "disobedient" instead of people who need emotional support. Both in educational institutions and in the community, this stigma deters candid dialogue and expert intervention.

Few empirical studies have looked at how caregivers in these settings conceptualize and support children's mental health, despite Bangladesh's progress in increasing access to early learning through government and NGO-led initiatives. Since caregivers are the main mediators of children's everyday emotional experiences in daycare and early learning environments, it is crucial to comprehend their awareness and perceptions. Children's sense of safety, belonging, and self-worth all crucial components of mental health are directly impacted by their attitudes and behaviors.

Therefore, the purpose of this study is to investigate how caregivers and ECCD teachers perceive children's mental health in Bangladeshi daycare facilities. It looks into how caregivers define mental health, identify emotional distress, and address children's psychosocial needs in real-world situations. The study uses a mixedmethods convergent parallel design to integrate qualitative insights into perceptions, practices, and institutional challenges with quantitative awareness measures.

This study intends to add to the growing conversation on including mental health into early childhood education in Bangladesh by producing context-specific evidence. Training materials, curricular frameworks, and policy initiatives that incorporate socio-emotional learning and caregiver capacity building into ECCD programs are anticipated to be influenced by the findings. In the end, the study emphasizes the significance of reorienting early education toward a more holistic paradigm that fosters emotional resilience and psychological well-being in addition to cognitive and physical development during the early years of life.

Objectives of the Study

1. To assess caregivers' understanding, perceptions, and attitudes toward the importance of children's mental health in early childhood development within the context of early childhood education in Bangladesh.
2. To identify gaps in caregivers' knowledge and practices regarding children's mental health and well-being.
3. To examine the factors influencing caregivers' awareness, including training, education, experience, and institutional support.
4. To provide recommendations for integrating mental health awareness into early childhood care and education policies and caregiver training programs in Bangladesh.

LITERATURE REVIEW

A significant but frequently overlooked aspect of early childhood care and development (ECCD) is children's mental health. Early emotional well-being establishes the groundwork for lifelong learning, behavior, and health, according to the World Health Organization (WHO, 2020). Although almost one in five children worldwide suffer from a mental health issue prior to reaching adolescence, early detection and intervention are still scarce in low and middle-income countries (LMICs), like Bangladesh (UNICEF, 2021).

Teachers and caregivers play a crucial role in helping young children develop resilience and emotional health (Britto et al., 2017). However, studies conducted in South Asian settings show that ECCD programs often prioritize academic preparedness such as literacy and numeracy while ignoring kids' socioemotional growth (Jena et al, 2020). This disparity is exacerbated in Bangladesh by a lack of institutional support, social stigma surrounding mental health, and inadequate professional training (Ahsan & Khan, 2022).

According to the Nurturing Care Framework (WHO, UNICEF & World Bank, 2018), early learning and nutrition are just as important for a child's overall development as responsive caregiving, safety, and emotional support.

Play-based activities, storytelling, and caregiver-child emotional engagement greatly enhance empathy, emotional regulation, and social skills, according to studies conducted in comparable LMIC settings (Rahman et al., 2018). Even though these needs are becoming more widely acknowledged, there is still a dearth of empirical research on how ECCD and daycare facilities in Bangladesh understand and support children's mental health. For the purpose of informing future ECCD policies and interventions that support holistic child development, this study fills a crucial gap by investigating caregivers' knowledge, attitudes, and behaviors regarding children's mental health.

METHODOLOGY

This study used a convergent parallel design and a mixed-methods approach. In order to provide both depth and breadth in understanding caregivers' awareness of children's mental health, this design was selected. To produce thorough insights, quantitative and qualitative data were gathered concurrently, examined independently, and then combined. Validation, triangulation, and a more comprehensive interpretation of the results were made possible by the integration of findings.

The complexity and multifaceted nature of children's mental health awareness provide justification for using a mixed-methods convergent parallel design. While qualitative interviews and observations offered deeper insights into perceptions, practices, and contextual realities that numbers alone could not capture, quantitative surveys offered quantifiable data on the general level of awareness among caregivers.

The study reduced the time frame between data sources and made sure that both numerical and experiential evidence were given equal weight by operating these strands concurrently. Through this integration, important patterns, discrepancies, and complementarities were found, leading to a more comprehensive understanding of the skills and knowledge of caregivers.

Both closed-ended and open-ended questions were included in the survey to assess caregivers' fundamental understanding, awareness, and behaviors regarding children's mental health. In order to look for potential trends and correlations, factors like years of experience, educational background, and previous training were also taken into account.

In order to supplement the data gathered through the quantitative research, qualitative data was also collected through Key Informant Interviews and non-participant observations. In this regard, five Key Informant Interviews were conducted with ECCD teachers, and five Key Informant Interviews were conducted with caregivers. In this study, the interviews with caregivers aimed to explore the caregivers' perceptions, experiences, challenges, and understanding of the context of the children's mental health. Furthermore, observations of five daycare centers were carried out to explore the daily practices of the caregivers, interactions, and overall caregiving environment.

The data gathered through the quantitative research and the qualitative interviews and observations was analyzed separately and then combined to draw reliable conclusions. The quantitative research and qualitative interviews and observations were conducted to draw reliable descriptive and exploratory quantitative data, rich qualitative data, and then combine the two to draw strong conclusions.

Quantitative Evaluation

A statistical software program SPSS, Stata and R was used to enter survey data. To record variable names, labels, response categories, and coding guidelines, a data dictionary was made. The dataset was examined for out-of-range values (such as invalid ages) and entry errors. Sample characteristics (age, education, years of experience, training, and role; caregiver vs. ECCD teacher) were compiled in descriptive tables. The composite Awareness Score was reported with mean or median, if skewed and standard deviation or IQR, and awareness items were displayed as frequencies and percentages.

Boxplots or histograms for awareness scores and bar charts for categorical items were examples of visual representations. Inferential tests were considered exploratory due to the small sample size (n = 30). When the assumptions of equal variance or normality were in questions, nonparametric tests were employed.

Qualitative Evaluation

With the participants' permission, all Key Informant Interviews (KIIs) were audio recorded and verbatim transcribed into Bangla. While the original transcripts were kept for reference, translations into English were created for analysis and reporting. To guarantee accuracy, back-translation was done for important quotes. The methodical process of familiarization, coding, theme generation, review, theme definition and naming, interpretation, and writing was followed by thematic analysis. Structured checklist scores and narrative field notes were mapped onto the developing thematic framework after observation and interview data were analyzed.

Limitations of the Study

- Limitations on Sample Size.

Five ECCD teachers, five caregivers, and observations from five childcare facilities made up the study's comparatively small sample. The small sample size limits the statistical power of the quantitative results and restricts wider generalizability, even though the qualitative depth was sufficient for exploratory insight.

- Limited institutional and geographic reach.

Information was gathered from particular childcare facilities in a particular region. There may be regional variations in institutional culture, socioeconomic circumstances, and local attitudes about children's mental health. Therefore, when thinking about wider national or international applicability, the results should be interpreted with caution.

- Short Observational Period

The observations were made during a specific time period; they might not accurately reflect regular procedures used at the daycare facilities on various days, during various activities, or during different seasons.

Findings of the study

30 caregivers in all, with an average age of thirty-two, took part in the study; the majority had completed secondary or higher secondary school. Only a small percentage had attended sessions specifically focused on child psychology or mental health, whereas about two-thirds had received some kind of early childhood care and development (ECCD) training.

Most of them were in charge of children between the ages of two and six and had three to five years of experience providing care. These traits are similar to the typical workforce composition in Bangladeshi urban daycare centers, where on-the-job training predominates and formal qualifications are scarce (Rahman et al., 2020).

On a scale of 0 to 80, the composite Awareness Score ranged from 32 to 70 (mean = 49.6, SD = 8.4), indicating generally moderate awareness. Fewer caregivers recognized emotional symptoms like sadness or anxiety, but the majority could recognize physical signs of distress like crying, withdrawal, or appetite loss. Just 40% were aware that behavioral problems could be a sign of more serious psychological problems.

Nearly half of respondents thought that mental health issues in early childhood were "rare," despite the majority agreeing that "children's emotional well-being affects learning outcomes." A behaviorist rather than holistic viewpoint was evident in the roughly 60% of respondents who thought that "discipline and obedience" were signs of good mental health. These sentiments align with previous research in South Asia, where behavioral compliance is frequently linked to mental health (Bhatia et al., 2021; Karki & Adhikari, 2018).

Just 35% of caregivers said they used explicit emotional support techniques, like naming emotions, promoting sharing, or employing techniques for calming down. When confronted with disruptive behavior, the majority resorted to reactive strategies like time-outs or reprimands. Observation data verified that there were few opportunities for structured play and expression, and daily routines gave priority to academic work, feeding, and hygiene over social-emotional engagement.

The first and most noticeable theme demonstrated a narrow and frequently incorrect interpretation of the term "mental health." Instead of focusing on emotional well-being, the majority of caregivers linked mental health to behavior, obedience, or discipline. In Bangla, the term "mental health" was rarely used in casual conversation and was frequently associated with "madness" or serious psychological issues.

"Mental health refers to the state in which a person loses self-control or becomes insane. I interpret it as a sign that kids are mischievous or unresponsive. (Caregiver 03)

"A child's good behavior indicates that their mind is healthy." We believe that their mental state is incorrect when they disobey. (Teacher 02)

These interpretations reveal a lack of conceptual distinction between mental illness and emotional development, as well as a societal stigma associated with mental health. A few caregivers who had participated in ECCD training programs provided more expansive perspectives, characterizing mental health as associated with "happiness," "confidence," or "feeling safe," indicating that professional exposure may improve conceptual clarity.

"A child's mental health refers to their emotional state, including their level of happiness, self-assurance, and security. Emotion is just as important as behavior. (Teacher 05)

These more complex interpretations, however, continued to be the exception rather than the rule. According to the research, caregivers typically view mental health through a behavioral lens and are unaware of the emotional and developmental factors that support early childhood mental health.

Across interviews, caregivers demonstrated sensitivity to overt behavioral signs of distress such as crying, aggression, or withdrawal but had difficulty recognizing less visible emotional indicators like anxiety, sadness, or fear.

"If a child hits others or cries too much, we notice. But if the child is quiet all the time, we think they are just shy." (Caregiver 07)

"Sometimes a child doesn't talk or play, but we assume she is tired or sleepy, not unhappy." (Teacher 03)

This suggests that caregivers are more responsive to externalized behaviors than to internalized emotional cues. Observations confirmed this: caregivers tended to intervene quickly when a child was disruptive but often overlooked quieter forms of distress.

Moreover, when asked what causes such behaviors, most caregivers attributed them to physical tiredness, family problems, or poor discipline rather than emotional factors. This attributional pattern reinforces the idea that caregivers operate from a largely physical or behavioral framework, with minimal psychological interpretation.

"If a child is aggressive, it's because their parents don't control them properly. We tell them to be stricter." (Caregiver 02)

This narrow focus on discipline reflects broader social norms in Bangladesh, where emotional expression is often constrained, and adult authority is prioritized over child autonomy. The lack of understanding of emotional needs prevents caregivers from identifying early signs of mental distress.

Despite conceptual gaps, many caregivers displayed genuine empathy and affection toward children. During observations, several were seen comforting distressed children through physical reassurance, gentle words, or play, even though these actions were spontaneous rather than planned.

"When a child cries, I hold them and say, 'Don't cry, I'm here.' They calm down. We don't discuss why they are sad, but we try to make them happy." (Caregiver 05)

This illustrates a form of intuitive caregiving rooted in emotion but not guided by psychological principles. Play and storytelling were occasionally used as tools for emotional comfort, though not systematically integrated into daily routines.

Observation records also indicated that the daily schedule prioritized feeding, hygiene, and academic readiness activities, leaving limited time for social or emotional engagement. Structured emotional learning activities such as naming emotions, collaborative play, or reflection circles were virtually absent.

"We try to keep children busy with drawing or songs, but we don't know how to teach about feelings." (Teacher 04)

Thus, while caregivers show warmth and responsiveness, the lack of structured training and institutional support limits their ability to promote emotional literacy among children.

Caregivers consistently reported structural and institutional challenges that hindered their capacity to support children's mental health. These included heavy workloads, large class sizes, and lack of supervision or guidance. Most centers operated with minimal staff and limited materials, compelling caregivers to focus on basic care and discipline rather than emotional development.

"We have 20 or more children and only two caregivers. It's hard to give attention to each child's feelings." (Caregiver 01)

No center had written policies or structured guidelines addressing emotional well-being. None had mental health resources, referral systems, or established partnerships with child psychologists. In addition, caregivers reported that management and parents often undervalued the emotional aspects of early education, viewing them as "soft" or secondary compared to academic readiness.

"If a child is quiet or sad, parents say we are not teaching properly. They don't think it's a mental issue."

(Teacher 03)

Cultural stigma further compounded these institutional barriers. Some caregivers feared that discussing mental health might lead to social misunderstanding or parental disapproval. This mirrors broader findings in Bangladeshi society, where mental health is often neglected due to shame and misinformation (Hossain & Ferdous, 2021).

Despite these challenges, a strong theme of curiosity and motivation emerged among caregivers. Many expressed a desire to understand children's emotions better and requested training in areas such as stress management, behavior handling, and communication techniques.

"We want to learn how to talk to children when they are angry or scared. We try from our heart, but we don't have the knowledge." (Caregiver 08)

"If we get training about children's minds, we can handle them better. It will help both us and the children." (Teacher 05)

This emerging openness signals a positive opportunity for intervention. Caregivers' willingness to learn demonstrates that, while awareness is limited, attitudes are receptive. Building on this motivation through structured professional development could significantly enhance mental health literacy and practice.

Overall, the qualitative findings highlight a paradox of care: caregivers are emotionally invested and affectionate but operate within systems that restrict their capacity for intentional emotional support. Their understanding of children's mental health is shaped more by cultural norms and institutional constraints than by developmental knowledge. Nonetheless, their empathy, lived experience, and openness to learning provide a strong foundation for introducing training, supervision, and policies that embed emotional well-being into daily caregiving practice.

DISCUSSION

The results of this study show that caregivers in Bangladeshi daycare centers have a complicated and multilayered understanding of how to deal with children's mental health.

The caregivers' limited conception of children's mental health was one of the study's main conclusions. The majority of respondents acknowledged that children's emotions have an impact on behavior and learning, but their comprehension was frequently limited to ideas of discipline, obedience, or "good behavior." This is consistent with research by Jorm et al. (2012) and Barry et al. (2019), who found that even qualified teachers in low and middle income nations frequently associate mental health with behavioral conformity rather than holistic well-being.

The phrase "mental health" itself has a great deal of societal stigma in Bangladesh and is frequently linked to severe adult mental illness rather than early developmental well-being (Hossain & Ferdous, 2021). As a result, educators and caregivers frequently steer clear of talking about emotional problems in favor of characterizing them as moral or behavioral problems. Despite being exposed to children's emotional displays on a daily basis, 72% of the caregivers assessed in this study were unable to appropriately describe "mental health," which may be explained by this cultural lens.

Quantitative results showed a modest level of awareness, while qualitative research showed discrepancies between conduct and knowledge. Many caregivers could notice indicators of distress such as melancholy, withdrawal, or hostility but lacked the ability to analyze or respond productively. For example, a child who was reclusive was frequently characterized as "lazy" or "spoiled," rather than as a child who might be experiencing worry or unfulfilled emotional needs.

The knowledge-practice divide that has been extensively studied in early childhood research is reflected in this divergence between awareness and practice (Denham et al., 2014; Hyson & Taylor, 2011). Awareness alone is insufficient without constant reflection, supervision, and skill improvement. The deep-rooted behavioral paradigm within the caring culture is demonstrated by the fact that even those who identified emotional indications in the current study preferred to resort to corrective or disciplinary measures.

A significant pattern was that caregivers with formal ECCD training displayed greater awareness ratings and broader conceptualizations of mental health. Qualitative interviews also found that trained caregivers were more likely to describe mental health in terms of “happiness,” “confidence,” and “feeling safe.” This is consistent with research by Rahman et al. (2020), which shows that ECCD training, especially child psychology modules, improves caregivers' attentiveness and empathy.

Nonetheless, there are still insufficient and unequal training chances in Bangladesh. Many daycare centers, especially those sponsored by local NGOs or commercial businesses, rely on unskilled or little trained staff. Moreover, existing training curriculum frequently focus on classroom management, hygiene, and fundamental pedagogy, with little attention on emotional development or mental health literacy. The loop of low awareness and reactive caregiving techniques is strengthened by this structural gap. Though to a lesser degree, experience also had an impact. Longer-serving caregivers showed increased observational sensitivity to children's emotions and behaviors, but this experiential knowledge remained intuitive and unspoken in the absence of formal frameworks or mentorship. In order to transform implicit experience into professional ability, both organized training and chances for reflective practice are crucial.

Addressing children's mental health has been found to be significantly hampered by institutional boundaries and cultural views. According to caregivers, parents or administrators occasionally prevented open discussion of feelings because they saw emotional display as a sign of weakness or misconduct. This is consistent with South Asian social norms, which place a high importance on emotional control and deference to authority (Bhatia et al., 2021). Daycare facilities lacked institutional resources or clear strategies for fostering socioemotional growth. There were no formal play therapy areas, mental health guidelines, or referral systems for kids exhibiting ongoing discomfort in any of the centers that were studied. This institutional hole parallels the broader absence of child mental health considerations in Bangladesh’s National ECCD Policy (2013), which stresses cognitive and physical development but only briefly discusses emotional well-being.

Large class sizes, a lack of resources, and a lack of support personnel were among issues that irritated caregivers and hindered their ability to offer tailored emotional care. "We want to help children when they are sad or angry, but there are too many of them and we have targets to finish," said a teacher. Due to budget and accountability constraints, emotional development frequently receives less attention in early education systems across the globe. These structural constraints are similar to these issues (OECD, 2018).

POLICY RECOMMENDATIONS

Integrate Mental Health in ECCD Policy

Include children's emotional and psychological well-being as a core component of national early childhood care and development (ECCD) frameworks.

Training and Capacity Building

Provide mandatory training for caregivers and teachers on child psychology, socio-emotional learning (SEL), and early detection of mental distress.

Structured Emotional Learning Activities

Incorporate daily routines such as storytelling, play, emotion-naming, and peer interaction to strengthen emotional development in daycare settings.

Parental Awareness Programs

Develop community-based campaigns and parent workshops to reduce stigma and promote positive attitudes toward children's mental health.

Institutional Support and Supervision

Establish guidelines, supervision systems, and referral networks with mental health professionals to ensure continuous support for children and caregivers.

Monitoring and Evaluation

Include mental health indicators in ECCD program assessments to track progress and identify areas for improvement.

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