
BUILDING A RONDAVEL OF SUPPORT

The development and pilot randomised controlled trial of a parenting programme to reduce the risk of child maltreatment in low-income families with children aged three to eight years in South Africa

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Trinity Term 2016

Thesis submitted in partial fulfilment of the degree of Doctor of Philosophy in Social Intervention by stand-alone papers at the University of Oxford.

Word count: Approximately 72, 905

“I beat my child because I do not know what else to do.”

– Mother of a three-year-old son in Khayelitsha, Cape Town

“Nonviolent discipline was a really difficult concept. We are not used to these things.... I was not convinced as a facilitator. We could see that [the parents] were listening to us, but they were just not getting it.”

– Community-based facilitator of the Sinovuyo Caring Families Programme in Khayelitsha, Cape Town

“Now my children recognise and respect me as their mother because I’m not shouting at them. I talk with them and spend a lot of time with them.”

– Mother of a six-year-old daughter after participating in the Sinovuyo Caring Families Programme in Khayelitsha, Cape Town

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DECLARATION OF AUTHORSHIP

I, Jamie M. Lachman, hereby declare that this thesis is my own work, except where otherwise stated.

Signed:

Date:

Place:

ABSTRACT

Background: In high-income countries, parenting programmes have been shown to be effective in reducing the risk of child maltreatment. However, there is limited evidence of their effectiveness in low- and middle-income countries. This thesis focuses on the development and pilot randomised controlled trial (RCT) of a parenting programme to reduce the risk of child maltreatment in low-income families with young children in Cape Town, South Africa.

Methods: This thesis is comprised of three studies submitted as papers for publication. The first study focused on the development of an evidence-informed, locally relevant parenting programme for families with children aged three to eight years in Cape Town, South Africa. Intervention development took place over three stages: (a) identification of core intervention components common in evidence-based parenting programmes; (b) formative evaluation using qualitative in-depth interviews and semi-structured focus groups with South African practitioners and low-income parents; and (c) integration of evidence-based approaches and local contextual issues to develop the intervention structure, protocols, and manual.

The second study used a pilot RCT ($N = 68$ parent-child dyads) to examine the evaluation feasibility and initial effects of the parenting programme developed during the first study in Cape Town – the Sinovuyo Caring Families Programme. Parents of children aged three to eight years with clinical levels of parent-reported child behaviour problems were randomly allocated to either a 12-session, group-based parenting programme or a wait-list control group. Primary outcomes included parent-report and observational assessments of positive parenting, harsh parenting, and child behaviour problems; secondary outcomes included parent-report of parent depression, parenting stress, and social support. Assessments occurred at baseline and immediate post-test (i.e., 3-months after baseline).

The third study was a mixed-methods process evaluation assessing the feasibility of the parenting programme based on three theoretical dimensions: participation, implementation, and acceptability. Quantitative data included attendance registers, fidelity checklists, satisfaction surveys, and parent-report of engagement in home practice activities. Qualitative data included post-programme focus groups with community facilitators ($n = 8$), individual interviews with a randomly selected group of

parents ($n = 15$), transcripts from parenting sessions, and minutes from supervision sessions with facilitators.

Results: In the first study, the formative evaluation suggested that many evidence-based parenting programme components and approaches were compatible with the local cultural context. These included managing child behaviour problems, learning effective discipline strategies, building positive parent-child relationships, and reducing parenting stress. Findings also suggested that programmes may benefit from including additional content on keeping children safe in violent communities, communicating about HIV/AIDS and poverty, involving fathers and alternative caregivers, and incorporating cultural values of social responsibility and respect.

The pilot RCT in the second study showed high levels of study recruitment and retention, outcome measurement reliability and response rates, and a minimal effect of clustering due to delivering the intervention in groups of parents. Analyses showed moderate intervention effects for parent-report of increased positive parenting and observations of improved child-led play. However, observational assessments also found reduced frequency of positive child behavior in the treatment group in comparison to controls.

In the third study, quantitative results showed high levels of programme acceptability, implementation, and participation. Thematic analysis of qualitative data identified seven themes related to feasibility: (a) receptivity to strengthening existing parenting practices, (b) initial resistance to new parenting skills, (c) contextualising content within a cultural framework, (d) reinforcing implementation fidelity and improving quality of delivery, (e) challenges delivering content on nonviolent discipline, (f) supporting participant involvement, and (g) engagement in a collaborative learning approach.

Conclusion: This thesis is the first in sub-Saharan Africa to use a systematic approach to develop and rigorously pilot a parenting programme to reduce the risk of maltreatment against young children in low-resource settings. Initial results indicate that a parenting programme derived from evidence-based approaches is feasible, culturally acceptable, and has the potential to reduce the risk of child maltreatment by improving positive parenting behaviour. Further intervention development and testing is necessary to strengthen core programme components and determine programme effectiveness.

ACKNOWLEDGMENTS

This thesis was a collaborative effort and would not have been possible without the valuable contributions of many individuals and institutions. I am deeply grateful for the dedication and commitment of the mothers who participated in the research and intervention aspects of this thesis. I appreciate their willingness to share of themselves, their families, and their young children as well as their commitment to “giving it a go”.

I am grateful for the generous financial support from the John Fell Fund, the World Health Organization, Ilifa Labantwana, the European Research Council, and the South African National Lottery Distribution Trust Fund who made this research possible. It is also with gratitude that I acknowledge the Clarendon Fund for providing a full academic scholarship to fund this doctoral research at Oxford. I also wish to thank the Parent Centre, and Ikamva Labantu as community partners during the study.

This thesis would not have been possible without the commitment of the Sinovuyo research team – Daphney Makasi, Joyce Nikelo, Julia Limba, Nozuko Boqwana, Tembela Molwana, and Yvonne Sani – who worked tirelessly on data collection, which included trips to the Eastern Cape to track down participants. You are my CCs. I also wish to thank the Sinovuyo interns, Julia Rosenfeld and Olivia Marie Cosgray, for their assistance in project coordination, and Inge Wessels for being a consistent source of emotional, intellectual, and technical support throughout the entire process.

I am incredibly grateful for the Sinovuyo facilitation team – Andiswa Mgedle, Babalwa Xamsana, Fundiswa Menziwa, Marjorie Feni, Nontobeko Mdudu, Thandie Matikinca, and Viwe Xhotyeni. I am continuously inspired by such beautiful and inspiring women who dedicate their lives to building a Rondavel of Support for families in South Africa.

And my fellow Clowns Without Borders, Sibongile Tsoanyane, who co-created many of the cultural aspects of the Sinovuyo programme and has been a close collaborator for the past 8 years, and Lindokuhle Lulama Ngcobo, with whom I have the joy of sharing the many ups and downs of juggling staffing, projects, partners, and more.

I also wish to thank my fellow Sinovuyo Caring Families Project investigators, Associate Processor Cathy Ward, Professor Frances Gardner, and Professor Judy Hutchings, who have taught me so much about conducting rigorous research of parenting programmes. Judy, for your mentorship regarding programme development,

training, and supervision, Frances, for your inclusivity and the many opportunities you have provided me to learn and grow as a researcher, and Cathy, for being my ex officio secondary supervisor while I have lived in Cape Town.

I wish to thank my friends and colleagues at Oxford, Cape Town, and elsewhere: Dr Mark Boyes, Dr Thees Spreckelsen, Dr G.J. Menendez, and Ms Michelle Hoogenhooft for teaching me everything I know about statistics, Dr Patty Leijten for making me aware of the exciting possibilities of factorial research, Stephen Heyns for your meticulous last-minute proofreading, Elona, Andrew, and Kori for helping me build a bridge that connects Oxford and Cape Town, and especially, Dr Franziska Meinck, whose research on child maltreatment in South Africa provided much of this thesis's theoretical foundation and who has been a most appreciated colleague and friend.

I wish to thank Professor Paul Montgomery, Dr Rachel Bray, Professor Chris Bonell, Dr Jorun Rugkasa, Professor Andy Dawes, Professor Mark Tomlinson, Professor Peter Cooper, Professor Lynne Murray, Associate Professor Jose Ruben Parra Cardona, Dr Anilena Mejia, and Dr Christopher Mikton for their advice regarding this research.

I am most grateful for my supervisor, Professor Lucie Cluver. From the day I stumbled into your office as an itinerant clown with no knowledge of RCTs or effect sizes to the recent days in which you have sacrificed hours of sleep to review my thesis while flying around the world, you have always gone above and beyond my expectations of how a supervisor must mentor her student. Your dedication to rigorous, meaningful, and impactful research for the benefit of children and families in South Africa is a constant inspiration to me. Thank you! Thank you! Thank you!

Lastly, I wish to thank my siblings, David, Kathryn, Jesse, and Adam, for putting up with my absent craziness, as well as my darling nephews and niece, Noah, Eli, and Isla, for teaching me so much about child-led play and special time. I have missed you so much while bouncing between South Africa and the UK. To my Uncle Peter, it is an honour to be continuing in your footsteps in Cape Town. Your question, "So what?" instigated this journey many years ago. And to my Lisa, you have kept me alive and present in my soul through the dark days. You are a joy to my heart and a constant reminder to live each day fully. And finally, this thesis would not be possible without my own parents, Margaret and Anthony. As your child, I bow in deep gratitude for your love, support, and encouragement to grow into my dreams.

NOTE ON THE CANDIDATE'S ROLE

Wider project information

This thesis is part of the Sinovuyo Caring Families Project – a research project implemented in collaboration with the University of Oxford's Department of Social Policy and Intervention, the University of Cape Town's Department of Psychology, and Bangor University's Department of Psychology.¹ The Sinovuyo Caring Families Project is focused on reducing the risk of child maltreatment in families with young children in South Africa. It includes four phases of implementation: (a) formative evaluation, (b) feasibility pilot RCT, (c) large-scale RCT evaluation, and (d) dissemination. In 2012, the project team developed a local parenting programme – the Sinovuyo Caring Families Programme – by integrating evidence-based components with findings from a formative evaluation in Cape Town. In 2013, we conducted the feasibility pilot RCT of this programme in Khayelitsha, a high-density low-income township in Cape Town. Based on the findings from this pilot, we revised the programme manual and implementation plan before further testing. From 2014 to 2016, the programme is being evaluated in a larger RCT in Khayelitsha and Nyanga, another high-density township in Cape Town ($N = 290$ low-income families). The study includes an immediate post-test data collection as well as a one-year follow-up in 2016. Preliminary results from this trial will be available by August 2016.²

This project has strong academic and policy implications in the field of child and family mental health. It responds to a worldwide call for research on parenting

¹ Co-principal investigators: Professor Lucie Cluver and Associate Professor Catherine Ward. Co-investigators: Professor Judy Hutchings, Professor Frances Gardner, and the D.Phil. candidate. The D.Phil. candidate was the lead intellectual investigator during Phases A and B.

² Funding for the Sinovuyo Caring Families Project comes from the World Health Organisation, the Fell Fund, the South African National Lottery Distribution Trust Fund, the Rand Merchant Bank Fund, the ApexHi Charitable Trust, the European Research Council, the Leverhulme Fund, and the Ilifa Labantwana Fund.

programmes to reduce violence against children during early childhood development in LMICs (Mikton, MacMillan, Dua, & Betancourt, 2014). It is also in alignment with the South African Government's *White Paper on Families in South Africa* and the Western Cape Provincial Government's *Integrated Violence Prevention Policy Framework* (Department of Social Development, 2012; Western Cape Government, 2013).

Furthermore, the Sinovuyo Project is linked to a larger research initiative led by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), called *Parenting for Lifelong Health (PLH)*, of which the candidate is a Steering Committee member.³ This initiative is focused on the development and testing of a suite of affordable and effective parenting programmes to prevent violence against children in LMICs. The suite includes programmes for children based on the developmental ages of 0 to 23 months (*PLH for Babies and Infants*), 2 to 9 years (*PLH for Young Children*), and 10 to 17 years (*PLH for Adolescents and Teens*). Using South Africa as an incubator for initial programme development and testing, the *Sinovuyo Caring Families Programme* is the local iteration of *PLH for Young Children*.⁴ There are also plans to adapt and deliver this programme for other LMICs contexts, including the Philippines as part of the candidate's intended post-doctoral research, in Western Kenya as part of the Saving Brains Initiative, and in the Democratic Republic of Congo, Zambia, and South Sudan with Catholic Relief Services and USAID.

³ http://www.who.int/violence_injury_prevention/violence/child/plh/en/

⁴ As part of this thesis, Sinovuyo Caring Families Programme was developed and piloted for families with children aged three to eight years. During the larger RCT, the research team expanded the target age to include children aged two to nine years in order to be in alignment with the objectives of Parenting for Lifelong Health.

The candidate's role

As a co-investigator of the Sinovuyo Caring Families Project, the candidate's role in this study was to provide intellectual leadership on a wide range of activities. First, the candidate was the lead investigator responsible for the design and implementation of the intervention development, pilot RCT, and feasibility study phases of the project. This included co-writing and submitting all grant proposals for the study, submitting applications for ethical approval, registering trial protocols, designing questionnaires and interview guides, and monitoring mobile-assisted data collection. The candidate also managed a team of field researchers ($N = 6$), research interns ($N = 2$), and Masters and Honours students from the University of Cape Town who assisted in the recruitment, data collection, programme implementation, and observational data coding.

Second, the candidate conducted all primary qualitative and quantitative data analyses with the exception of coding the observational data which required fluency in isiXhosa. This assessment tool was coded by Ms Sindiswe Mlotshwa and Ms Inge Wessels from the University of Cape Town's Department of Psychology. Furthermore, Ms Liora Sherr (University College of London) and Ms Jane Kelly (University of Cape Town) conducted secondary thematic analyses of qualitative data during the formative evaluation and feasibility study, respectively.

Third, the candidate was the primary person responsible for the design, development, and delivery of the Sinovuyo Caring Families Programme. He wrote all programme protocols and materials (including a facilitator manual and parent handbook, available upon request). The candidate was also responsible for recruiting and training programme facilitators during the pilot RCT in 2013 and the larger RCT from 2014 to 2016. As part of their training, he also delivered the programme to the facilitators each

week prior to delivery of the parent groups sessions by the facilitators. The candidate also conducted weekly supervision of the facilitators at the end of each week. Furthermore, the candidate established and managed all community partnerships during the course of the study.

Lastly, the candidate has been actively involved in the dissemination of the results of this study at conferences, symposia, and in policy meetings in South Africa and internationally. Conference presentations included the 2nd Colloquium of the University of Cape Town Safety and Violence Initiative (November 2013), the Centre for Evidence Based Early Intervention 2014 Annual Conference (Bangor, April 2014), the Society for Prevention Research Annual Meetings (Washington DC, May 2014 and May 2015), the 21st World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions (Durban, August 2014), the WHO and University of Cambridge Global Violence Prevention Conference (September 2014), and the First Annual Conference on Child and Adolescent Mental Health in Kampala, Uganda (February 2015). The latter conference also included a workshop for professional psychologists and psychiatrists on evidence-based parenting principles and programme approaches. The candidate has also presented findings to the South African Department of Social Development, USAID South Africa, and at multiple parenting symposia organised by one of the project's funders, Ilifa Labantwana. Finally, the candidate has given presentations and lectures for the Centre of Evidence-Based Intervention colloquium at Oxford, the Children and Youth in a Changing World interdepartmental seminar series at Oxford, and the University of Cape Town's Department of Psychiatry lunchtime seminar series.

KEY TERMS

Sinovuyo: “We have happiness together” in isiXhosa

Child: Any person under the age of 18 years.

Adult: Any person over the age of 18 years.

Parent/Caregiver: This thesis uses the terms “parents” and “caregivers” interchangeably to refer to biological parents, grandparents, foster parents, other relatives, and any other adult who is either legally or self-designated as a child’s primary guardian.

Child maltreatment: Child maltreatment is defined according to the World Health Organization’s definition as “all forms of physical and/or emotional ill-treatment, sexual abuse, neglect, negligent treatment, commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival or development or dignity in the context of a relationship or responsibility, trust or power” (World Health Organization, March 1999). For the purpose of this thesis, the terms “child maltreatment” and “child abuse” are used interchangeably.

Corporal punishment: Corporal punishment is defined as any physical discipline used to cause a child pain with the intention of controlling or managing behaviour (Straus, 2001). While some literature distinguishes corporal punishment from physical abuse due to its intention not to cause injury to a child (Gershoff, 2002), this thesis recognises that corporal punishment is part of a continuum of violence against children characterised as maltreatment (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998).

Harsh parenting: Harsh parenting is defined as negative, or authoritarian, parent behaviour that is either physical or emotional, including corporal punishment and child maltreatment. This thesis uses the Parent-Child Conflicts Tactics Scale (CTSPC) as a measurement of harsh parenting. This scale assesses the severity and chronicity of verbal, physical, emotional, and neglectful abusive parent behaviour regardless of perceived injury or harm (Straus et al., 1998). Moreover, harsh parenting and corporal discipline have been identified as a major risk factor for more severe levels of child maltreatment (Stith et al., 2009).

Positive parenting: Positive parenting is characterised as nurturing, supportive, attentive, and consistent parent behaviour (McKee et al., 2007). It encompasses dimensions of authoritative behaviour (i.e., high control, high responsiveness, and high autonomy) in contrast to authoritarian behaviour (i.e., high control, low responsiveness, and low autonomy), permissive behaviour (i.e., low control, high responsiveness, and high autonomy), and neglectful behaviour (i.e., low control, low responsiveness, and high autonomy) (Baumrind, 1991; Maccoby, 1992).

Parenting programme: Parenting programmes are defined as any programme – individual, group-based, or self-administered – designed to improve parenting behaviour and parent-child relationships (Wessels & Ward, 2015). As such, parenting programmes do not include early childhood development programmes focused solely on improving the nutritional intake or health of children.

IsiXhosa: IsiXhosa is an indigenous South African language that is also one of the three official languages of the Western Cape, the province in which Cape Town is located.

LIST OF ACRONYMS

ANCOVA	Analysis of covariance
BDI-II	Beck Depression Inventory
CONSORT	Consolidated Standards of Reporting Trials
CTS2S	Revised Conflict Tactics Scale – Short Form
CTSPC	Parent-Child Conflict Tactics Scale
DPICS	Dyadic Parent-Child Interaction Coding System
ECBI	Eyberg Child Behaviour Inventory
HICs	High-income countries as classified by the World Bank
ICAST-R	International Society for the Prevention of Child Abuse and Neglect's Child Abuse Screening Tools-Retrospective Version
ICCs	Inter-cluster correlation coefficients
IY	Incredible Years
LMICs	Low- and middle-income countries as classified by the World Bank
MRC	United Kingdom Medical Research Council
MSPSS	Multidimensional Scale of Perceived Social Support
NGO	Non-governmental organisation
PARYC	Parenting Young Children Scale
PCIT	Parent-Child Interaction Therapy
PIMD	Provincial Indices of Multiple Deprivation
PMTO	Parent Management Training Oregon
RCT	Randomised controlled trial
SAIMD	South African Index of Multiple Deprivation
SOCS	Sinovuyo Observation Coding System
Triple P	Triple P Positive Parenting Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER ONE. INTRODUCTION

This thesis focuses on the development and pilot evaluation of an evidence-informed parenting programme in South Africa. It has the overall objective of reducing the risk of child maltreatment in low-income families with children aged three to eight years. It also aims to contribute to the existing literature regarding intervention development, cultural adaptation, implementation science, and the effectiveness of parenting programmes in low- and middle-income countries. Furthermore, it also addresses the discourse regarding the effectiveness of home grown programmes versus those imported from other contexts (Leijten, Melendez-Torres, Knerr, & Gardner, 2016). It proposes an alternative approach to developing new interventions or adapting existing programmes that is grounded in both the evidence of what works and the local cultural context in South Africa. Thus, it offers a real-world application of an integrated intervention development model that may be relevant to emerging research on the transferability of complex social interventions across cultural and contextual settings.

This thesis is organised into seven chapters and is comprised of three studies submitted for publication, which are presented as standalone chapters (i.e., Chapters Four to Six). Chapter Two is a literature review focused on child maltreatment and the effectiveness of parenting programmes – defined as interventions in which parents learn to improve parent-child relationships through increased positive parenting behaviour and reduced harsh or inconsistent discipline (Wessels & Ward, 2015) – in reducing child maltreatment. Drawing upon evidence from high-income countries as well as low- and middle income countries, it uses an ecological framework to develop a problem theory model on the risk and protective factors for child maltreatment in South Africa. It also explores potential local cultural and contextual factors that might influence these factors. In addition, Chapter Two proposes an overall conceptual model regarding the

mechanisms by which parenting programmes may reduce the risk of child maltreatment. It utilises research from distillation studies, systematic reviews, meta-analyses, and implementation research to construct a theory of change model that forms the basis for subsequent intervention development and testing.

Chapter Three discusses the methodological frameworks of the thesis. It presents an integrated programme development model that situates participatory community-based approaches and cultural adaptation methodologies within the first two phases of the United Kingdom Medical Research Council's guidelines for developing and evaluating complex interventions: development and feasibility piloting (Craig et al., 2008) (Barrera, Castro, Strycker, & Toobert, 2013; Fraenkel, 2006). This chapter also provides an overview of the research methods used in this thesis. It describes the setting where the study took place and the recruitment of participants in each phase of the study. Next, it discusses the ethical considerations of conducting a study in South Africa. Finally, this chapter summarises the study design and methods used in each subsequent chapter.

Chapter Four (Paper One) describes the process used to develop an evidence-informed, locally relevant parenting programme for low-income families in South Africa – the Sinovuyo Caring Families Programme (“Sinovuyo” means “We have happiness” in isiXhosa). Programme development took place in three stages: (a) the identification of evidence-based parenting programme principles and content; (b) a formative evaluation with practitioners ($N = 29$) and low-income parents of young children living in Cape Town, South Africa ($N = 97$); and (c) the integration of findings from the first two stages to inform the manualisation of intervention content and protocols. The following research questions are addressed in this chapter:

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- a. What are the core intervention components common to parenting programmes that have been shown to be effective in reducing the risk of child maltreatment?
 - b. What are the perceptions of low-income parents and practitioners regarding the content necessary for inclusion in parenting programmes?
 - c. What are the potential local cultural and contextual factors that may affect programme acceptability?
 - d. What are the potential barriers to programme implementation and participation?

Chapter Five (Paper Two) presents quantitative findings from a pilot randomised controlled trial (RCT) of the Sinovuyo programme in Cape Town, South Africa. It investigates the evaluation feasibility and initial effectiveness of the programme in reducing the risk of child maltreatment. Participants were low-income parents of children aged three to eight years with clinical levels of behavioural problems ($N = 68$). Evaluation feasibility outcomes included study recruitment and retention, outcome measure reliability, participant response rates, and the potential effect of clustering due to delivering the intervention to groups of parents. Primary outcomes were parent-report and observational assessments of harsh parenting, positive parenting, and child behavioural problems; secondary outcomes were parent-report of depression, parenting stress, and social support. This chapter aims to address the following research questions:

- a. What is the feasibility of conducting a rigorously designed RCT of a parenting programme in low-resource communities characterised by high crime, poverty, and HIV/AIDS?
- b. What is the preliminary effectiveness of a parenting programme in reducing the risk of child maltreatment in families with children aged three to eight years with clinical levels of behaviour problems?

Chapter Six (Paper Three) is a mixed-methods process evaluation study examining the feasibility of the Sinovuyo programme from three theoretical dimensions: acceptability, implementation, and participation. Quantitative data included attendance registers, fidelity checklists, satisfaction surveys, and parent-report of

engagement in home practice activities. Qualitative data included post-programme focus groups with community facilitators ($N = 8$), individual interviews with randomly selected parents ($N = 15$), transcripts from parenting group sessions, and minutes from supervision sessions with facilitators. By merging quantitative and qualitative data, this chapter addresses the following research questions:

- a. What are the perceptions of facilitators and parents regarding the acceptability of programme content, structure, and delivery?
- b. What is the feasibility of implementing a parenting programme in a low-resource context using community-based facilitators?
- c. What is the level of participation by low-income parents based on rates of enrolment, attendance, and engagement?

Finally, Chapter Seven discusses the key findings regarding the results from each paper. It then explores the overall limitations and strengths of the study. The chapter also discusses possible implications for policy making and practice. Finally, the thesis concludes by outlining potential areas for future research on the effectiveness of parenting programmes to reduce the risk of child maltreatment in LMICs.

CHAPTER TWO. LITERATURE REVIEW

Overview

This literature review chapter is structured around two sections. The first section examines the problem theory regarding child maltreatment in South Africa. It discusses the prevalence of child maltreatment and its impact on child and adult outcomes. It also explores the risk and protective factors associated with maltreatment from an ecological perspective. This includes examining literature from high-income countries (HICs), as well as evidence from low- and middle-income countries (LMICs), and South Africa, in particular. In addition, it discusses the socio-political and cultural context of South Africa and its potential influence on family dynamics, parenting, and risks of child maltreatment. Finally, the section integrates the literature into a proposed problem theory model to understand the determinants of child maltreatment in South Africa.

The second section examines the evidence regarding the effectiveness of parenting programmes on reducing the risk of child maltreatment at home, including reducing harsh parenting and corporal punishment, as well as improving positive parenting behaviour. It also discusses the common theoretical foundations of evidence-based parenting programmes. Furthermore, it explores existing evidence regarding the behavioural change mechanisms and delivery methods that have been shown to be effective in reducing harsh parenting and other risks associated with child maltreatment. Finally, it proposes an overall theory of change model to inform the subsequent the early stage intervention development and feasibility pilot of a parenting program for low-income families with children ages three to eight in South Africa.

Background on Child Maltreatment

Prevalence of child maltreatment

Child maltreatment – defined as physical, emotional, and sexual abuse as well as neglect (World Health Organization, March 1999) – affects millions of children each year on a global level (World Health Organization, 2014). Studies in HICs estimate that between 4% and 16% of children are physically maltreated each year, with 10% of children experiencing emotional abuse and neglect (Gilbert et al., 2009). Furthermore, evidence suggests that parents or primary guardians of children perpetrate 80% of reported abuse cases in HICs. In LMICs, children often experience maltreatment at significantly higher rates than in HICs (Lansford & Deater-Deckard, 2012; Reza et al., 2009; Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn, & Alink, 2013; UNICEF, 2014). A recent review of studies from 42 LMICs found prevalence rates of physical violence against girls ranging from 25% to 74% (UNICEF, 2014). Although data is more limited for boys, surveys from five LMICs (Ghana, Mozambique, Bolivia, Cameroon, and Uganda) showed that 28% to 55% of boys experienced non-fatal physical violence before the age of 15. Moreover, these surveys indicate that parents and other adult caregivers are a major source of child maltreatment. For instance, over 70% of children aged two to 14 years in sub-Saharan Africa and the Middle East experience some form of violent discipline or psychological aggression at home, primarily via harsh parenting from adult caregivers (UNICEF, 2014).

Other research supports this trend. A recent review comparing different forms of child abuse across 28 LMICs found the highest child maltreatment rates in Africa (Akmatov, 2011). Using data collected from the UNICEF Multiple Indicator Cluster Surveys ($N = 124,916$ children aged two to 14 years), results showed that 83% of children experienced psychological aggression, 64% experienced moderate physical

abuse, and 43% experienced severe physical abuse (Akmatov, 2011). In another study examining physical discipline and childrearing in 24 LMICs ($N = 30,470$ families with children aged two to four years), 63% of interviewed parents reported that their children experienced physical violence in the past month; 66% also reported that their children experienced psychological aggression (Lansford & Deater-Deckard, 2012). In addition, countries with low Human Development Index scores were linked to higher rates of maltreatment in comparison to wealthier countries. Likewise, caregivers in poorer countries were more likely to consider physical punishment as a necessary discipline strategy for childrearing (Lansford & Deater-Deckard, 2012).

Children living in South Africa also experience alarmingly high rates of maltreatment (Makoe, 2009). In a national survey of 925 adult parents, 57% reported using corporal punishment with almost one-third resorting to more severe forms of punishment (Dawes, De Sas Kroppiwinski, Kafaar, & Richter, 2005). Likewise, a recent survey of 3,515 youth aged 10 to 17 years showed lifetime prevalence rates of 55% for physical abuse, 36% for emotional abuse, and 9% for contact sexual abuse (Meinck, Cluver, Boyes, & Loening-Voysey, 2016). Conducted in low-income communities in two South African provinces – the Western Cape and Mpumalanga – this longitudinal study also found monthly incidence rates of 11.8% for physical abuse, 10.3% for emotional abuse, and 2.7% for contact sexual abuse at one-year follow-up. Similar to findings from other studies in LMICs, the primary sources of physical and emotional abuse were caregivers or other relatives at home. Recent qualitative research in low-income communities in Cape Town also suggests that physical punishment is a daily experience for children ($N = 24$ Xhosa children aged eight to twelve years) (Breen, Daniels, & Tomlinson, 2015). In addition to experiencing harsh discipline from their primary caregivers, children also reported abuse by other adults and older siblings.

Impact of child maltreatment

Child maltreatment has long been associated with increased risks of developing negative child, adolescent, and adult outcomes (Font & Berger, 2015). Research in HICs has linked child abuse during early childhood to increased risks of child behaviour problems and other psychopathologies, poor educational performance, risky sexual behaviour, obesity, criminal behaviour, and drug and alcohol abuse in adolescence and adulthood (Gilbert et al., 2009). For instance, in the United States, violence against children has been shown to negatively affect child neurodevelopment leading to dissociative adaptation (Perry, 2001) and delayed cognitive development (MacKenzie, Nicklas, Waldfogel, & Brooks-Gunn, 2012). A systematic review of 124 studies in predominantly HICs found that victims of abuse are more likely to develop depressive disorders and have an increased risk of suicidal ideation; they are also almost twice more likely to develop substance abuse problems than non-affected children (Norman et al., 2012). Furthermore, a large-scale retrospective study in the USA ($N = 17,337$ adults) showed that children affected by adverse life events including child maltreatment are associated with poorer health outcomes including an increased risk for cardiovascular disease, hypertension, and asthma (Anda et al., 2006). Moreover, child maltreatment has substantial intergenerational effects in which parents who experienced maltreatment during childhood are more likely to maltreat their own children (Pears & Capaldi, 2001). In a review of the intergenerational transfer of poor parenting, parents who experienced negative parenting as children were more at risk for coercive parenting, low supervision, poor attachment, and child abuse (Serbin & Karp, 2004). Likewise, children in the aforementioned qualitative study in Cape Town reported that parents were more likely to use corporal punishment if the parents had experienced harsh discipline during their own childhood (Breen et al., 2015).

Child maltreatment may also have a negative impact on society beyond the sphere of individual and family systems. This includes increased burden on government and non-governmental service delivery systems as well as lower economic productivity of victims of abuse (Department of Social Development, Department of Women Children and People with Disabilities, & UNICEF, 2012). For instance, a study in the USA ($N = 807$) found that adults with histories of childhood physical abuse or neglect earned approximately US\$5,000 less than non-affected adults in 2003 (Currie & Widom, 2010). There are also considerable economic costs associated with child maltreatment and its impact on child and adult outcomes. In 2008, the estimated lifetime cost per nonfatal victim of child abuse in the USA was US\$210,012. This was calculated based on loss of productivity as well as costs for child and adult healthcare, child welfare, criminal justice, and special education. In total, the national economic burden of child maltreatment was estimated to be US\$585 billion (Fang, Brown, Florence, & Mercy, 2012). Furthermore, in a review examining over 186 cultural groups across the world, higher rates of corporal punishment were associated with higher levels of societal violence, including aggression in children, interpersonal violence, and warfare (Lansford & Dodge, 2008).

In South Africa, the literature suggests similar associations of maltreatment with negative child and adult outcomes (Makoe, 2009). Multiple studies in Cape Town have shown links between violence against children and increased risk of depression, aggression, conduct problems, and posttraumatic stress disorder in adolescents (Du Plessis, Kaminer, Hardy, & Benjamin, 2015; Fincham, Altes, Stein, & Seedat, 2009; Seedat, Nyamai, Njenga, Vythilingum, & Stein, 2004; Ward, Flisher, Zissis, Muller, & Lombard, 2001). Research in rural communities has also demonstrated increased risks for alcohol and substance abuse, depression, suicidality, and HIV infection in adults

who experienced physical abuse and emotional neglect during childhood (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010). Longitudinal research has also shown increased risk of transactional sex amongst AIDS-affected youth aged 10 to 17 years who experience physical and emotional abuse (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011). Finally, evidence suggests that child maltreatment is a major risk factor for later intimate partner violence, both as a victim and as a perpetrator (Dunkle et al., 2004).

Ecological framework for understanding child maltreatment

The determinants of child maltreatment can be best understood within an ecological framework that situates the individual child or parent within intersecting and interrelated environments (Bronfenbrenner, 1979). Belsky (1980) further adapted Bronfenbrenner's theory of human ecology in order to understand the risk and protective factors associated with child maltreatment from four levels of analysis: individual, microsystem, exosystem, and macrosystem. The individual level examines individual characteristics of parents that may affect their parenting behaviour. The microsystem level is concerned with interactions at the child and family level where child maltreatment may or may not occur. The exosystem level includes formal and informal social structures in which the family and individual are embedded, such as neighbourhoods, social networks, employment availability, and social services. Although these may not necessarily involve the individual directly, they still may have an indirect effect on the individual and microsystem levels (e.g., employment of an intimate partner or the presence of youth gangs in the neighbourhood). Lastly, the macrosystem level is concerned with prevailing cultural values and norms, laws and policies, and economic trends that may influence parenting behaviour and the likelihood of abuse (Belsky, 1980).

Risk and protective factors in HICs.

The human ecology model has provided a foundation for extensive reviews and meta-analyses examining the risk and protective factors for child maltreatment in the developed world (Black, Heyman, & Slep, 2001; Black, Slep, & Heyman, 2001; Schumacher, Smith Slep, & Heyman, 2001; Stith et al., 2009). For instance, an extensive meta-analysis examined 39 different risk factors for physical abuse and neglect from 155 studies (Stith et al., 2009). On the individual level (i.e., parental characteristics), results predicting child maltreatment showed large effects for higher parental anger/hyper-reactivity ($r = .34$) and whether a parent perceived a child as problematic ($r = .30$). Medium effect sizes were found for higher anxiety ($r = .29$), psychopathology ($r = .28$), and depression ($r = .27$), as well as poorer parent-child relationships ($r = .22$), unplanned pregnancy ($r = .28$), criminality ($r = .21$), and parental experience of childhood abuse ($r = .21$). Small effects were shown for poor parenting behaviours ($r = .17$), higher stress ($r = .19$), alcohol abuse ($r = .17$), unemployment ($r = .15$), and single parenthood ($r = .12$). Although attitudes supporting corporal punishment were not linked to physical abuse, there was a medium effect for increased parental use of corporal punishment on increased risk of abuse ($r = .26$). This supports other evidence demonstrating strong associations between corporal punishment and more severe forms of abuse (Whipple & Richey, 1997). Finally, factors associated with decreased risk of physical abuse were more positive parent-child relationships ($r = -.27$), higher parental self-esteem ($r = -.24$), higher social support ($r = -.18$), and greater parent coping and problem solving skills ($r = -.14$).

On the microsystem level (i.e., child and family characteristics), there was a large effect for increased family conflict ($r = .39$), as well as a medium effect for more child externalising behaviours ($r = .23$) and intimate partner violence ($r = .22$). Lower

socioeconomic status ($r = .14$), larger family size ($r = .15$), and more child internalising behaviours ($r = .15$) were associated with small effect sizes. Results also demonstrated that decreased risk of physical abuse was associated with stronger family cohesion ($r = -.39$), higher child social competence ($r = -.26$), and higher marital satisfaction ($r = -.16$).

Risk and protective factors in LMICs.

Although research in LMICs is more limited, studies have recently emerged using a similar ecological perspective to understand the risk and protective factors for child maltreatment. For instance, the aforementioned study that combined results from UNICEF Multiple Indicator Cluster Surveys in 28 LMICs found higher risks for physical or psychological abuse in families with boys, those living in more crowded households, and those with lower socioeconomic status (Akmatov, 2011). In contrast to the 2009 Stith et al. study, a parental attitude supporting corporal punishment was the strongest predictor of child abuse.

Another recent review examined the determinants of physical and sexual child abuse from 23 quantitative studies in Africa (Meinck, Cluver, Boyes, & Mhlongo, 2014). Although unable to conduct meta-analyses due to high heterogeneity (sample sizes ranged from 77 to 126,696 respondents), individual parental risk factors associated with increased risk of abuse included higher rates of more inconsistent parenting, chronic illness, HIV-positive status and AIDS illness, mental health problems, disability, and substance abuse. Child risk factors included younger children, boys, children with disability or chronic illness, higher child behaviour problems, school non-attendance, and poor academic performance. Family risk factors included higher rates of intimate partner violence and poorer family functioning. Community and social risk factors included higher levels of household poverty and living in low-income,

urban communities. Protective factors associated with reduced risk of abuse included living with a biological parent, maternal employment, and higher birth order of the child (Meinck et al., 2014).

Risk and protective factors in South Africa.

Research in South Africa has identified similar risk and protective factors. A national survey on corporal punishment identified women as the main source of physical punishment, chiefly due to their role as primary caregivers of children (Dawes et al., 2005). Results also suggested that young children between the ages of four and five were at the highest risk of experiencing harsh discipline. Furthermore, non-empathic parenting behaviour and attitudes supporting harsh discipline predicted greater severity of punishment.

A more recent study examined the risk and protective factors for physical and emotional abuse of highly vulnerable adolescents aged 13 to 19 years in low-income communities in Cape Town ($N = 603$) (Meinck, D., Boyes, & Ndhlovu, 2013). This included a high proportion of children orphaned by AIDS (40%) or other causes (34%). Parental factors were higher rates of caregiver AIDS illness ($OR = 2.25$), caregiver disability ($OR = 1.18$), and inconsistent discipline ($OR = 2.03$). Child-level risk factors for severe physical and emotional abuse included AIDS-orphan status ($OR = 1.95$), experiencing bullying ($OR = 4.13$), school non-attendance ($OR = 2.44$) and school non-achievement ($OR = 1.70$). Family factors included extreme poverty ($OR = 3.41$), intimate partner violence ($OR = 2.35$), number of parental changes experienced during childhood ($OR = 2.41$), and living with a stepparent ($OR = 4.13$). Community-level factors for increased risk of abuse were AIDS-related stigma ($OR = 1.15$) and community violence ($OR = 2.09$). On the other hand, more frequent positive parenting behaviour ($OR = -0.62$) and having an employed person in the household ($OR = -0.68$)

were identified as protective factors. Although the sample was over-represented by AIDS-orphaned children and thus potentially not representative of a wider South African population, results provide a valuable insight into risk factors for children living in high HIV-prevalent communities such as Khayelitsha, Cape Town (Meinck et al., 2013).

Another cross-sectional survey of 2,477 parent-child dyads examined the determinants for positive and negative parenting in high HIV-prevalent communities in rural and peri-urban KwaZulu-Natal (Lachman, 2011). Although limited in its ability to show causality between independent and dependent variables and not focused specifically on child maltreatment, this study found risk factors associated with reduced positive parenting to include families living in rural areas ($\beta = -.165$) and poorer families ($\beta = -.057$). Families living in urban areas ($\beta = .154$), children with more behavioural problems ($\beta = -.233$), boys ($\beta = -.070$), and parents with higher anxiety ($\beta = -.070$) were also associated with an increased risk of poor parental supervision and inconsistent discipline.

Comparison of evidence from HICs, LMICs, and South Africa

Table 1 summarises the risk and protective factors from studies on child maltreatment in HICs, LMICs, and South Africa. On a parent level, the use of corporal punishment, poor parenting, and inconsistent discipline was identified as risk factors across contexts. Parental mental health problems such as anxiety and stress were also associated to increased risks of child maltreatment. Interestingly, while attitudes supporting corporal punishment were associated to increased risks of child maltreatment in LMICs and South Africa, they were not identified as a risk factor in HICs in the review by Stith et al. On the other hand, the intergenerational transfer of abuse was a risk factor in both HICs and LMICs. Additional parental risk factors that

may be specific to sub-Saharan African countries were factors related to parental disability and morbidity, particularly due to HIV/AIDS. On a family level, higher levels of child behaviour problems, intimate partner violence, and lower socioeconomic status predicted increased risks of maltreatment in both HICs and LMICs. The link between child behaviour problems and child maltreatment is particularly salient when considering that many parenting programmes are targeted at reducing conduct problems in young children (e.g., Furlong et al., 2013). While child age was not a risk factor in HICs, younger children were associated with increased risk of abuse in LMICs and South Africa. Poor school attendance and academic performance were also associated with higher risks of child maltreatment in LMICs but not HICs; however, since these studies were cross-sectional and thus cannot demonstrate causality, it may be that increased risks of child maltreatment predict poorer educational outcomes. Finally, positive parent-child relationships and parenting skills were identified as protective factors in both HICs and LMICs – highlighting another potential mechanism for reducing the risk of child maltreatment. However, the list of risk and protective factors mentioned in this thesis is by no means exhaustive or systematic, but rather relied on the evidence from other systematic reviews. There may be additional similarities or differences between high- and low-resource settings, as well as more nuanced contrasts within contexts such as across socioeconomic backgrounds.

Table 1. Summary of risk and protective factors based on quantitative evidence from HICs, LMICs, and South Africa.

Factor	Source of Evidence		
	HIC ¹	LMIC ²	SA ³
Individual risk factors			
Attitude supporting corporal punishment		X	X
Use of corporal punishment	X	X	X
Poor parenting behaviour and inconsistent discipline	X	X	X
Perception of child as problematic	X		
Parental anger/hyper-reactivity	X	X	
Parental mental health problems	X	X	X
Poor relationships with own parents	X		
Unplanned pregnancy	X		
Parental criminality	X		
Parental experience of child abuse	X	X	
Alcohol and/or substance abuse	X	X	X
Parental disability or chronic illness		X	X
HIV-positive status and AIDS illness			X
Family/child risk factors			
Family conflict/poor functioning	X	X	
Child with behavioural problems	X	X	X
Intimate partner violence	X	X	X
Low socioeconomic status	X	X	X
Large family size	X		
Boys		X	
Younger children		X	X
Children with disabilities or chronic illness		X	
School non-attendance and poor academic performance		X	X
Living in low-income communities		X	
Community violence			X
Child experience of bullying			X
Number of parental changes during childhood			X
AIDS-related stigma (child)			X
Protective factors			
Positive parent-child relationships	X	X	X
Positive parenting skills	X	X	X
Positive parental self esteem	X		
Parental social support	X		
Strong family cohesion	X		
Child social competence			
Marital satisfaction			
Living with a biological parent		X	
Parental employment		X	X
Higher birth order of child		X	

¹ Stith et al., 2009. ² Akmatov, 2011; Meinck et al., 2014. ³ Dawes et al., 2005, Lachman, 2011; Meinck et al., 2013.

Cumulative risk of abuse.

Risk factors for child maltreatment frequently coincide, thus increasing the risk of abuse (Lachman et al., 2002). For example, families affected by HIV/AIDS are also more likely to experience intimate partner violence; and women affected by intimate partner violence are also more likely to become infected with HIV (Jewkes, Dunkle, Nduna, & Shai, 2010). Both groups are also at risk for developing mental health problems (Kuo, Operario, & Cluver, 2012), which are associated with neglectful or abusive parenting (Cohen, Hien, & Batchelder, 2008). Families affected by HIV/AIDS are also more likely to experience more socioeconomic challenges (Collins & Leibbrandt, 2007), which are associated with higher rates of inconsistent discipline and reduced parental affection (Bradley & Corwyn, 2002). Finally, children living in families affected by adverse factors, such as poverty, intimate partner violence, and substance abuse, are more likely to develop behavioural difficulties (Moolla, 2012), which are reciprocally linked to increased risk of harsh parenting and potential abuse (Dodge, Bates, & Pettit, 1990; Lansford et al., 2011; Pardini, 2008). On the other hand, evidence suggests that increased positive parenting may reduce the risk of child maltreatment and its impact on negative child outcomes in the context of cumulative risk (Trentacosta et al., 2008).

Context and culture in South Africa relevant to parenting programmes

Legacy of Apartheid and labour migration.

One must also take into consideration the role of history, culture, and context in shaping family dynamics, parenting behaviours, and the risk of child maltreatment. South Africa's unique socio-political history is characterised by centuries of economic and political oppression of the majority of the population. During the Apartheid era from 1948 to 1994, the white-minority government enacted many laws that resulted in

the systematic disenfranchisement, marginalisation, and impoverishment of African, Coloured, and Indian South African families.⁵ Laws such as the Group Areas Act divided the country up into racially segregated areas, effectively restricting the majority of South Africans from living in the developed parts of the country because they were not classified as white. Those who were permitted to live close to the cities and towns to provide labour had to live in high density, low-income suburbs known as townships. Although the Group Areas Act was repealed in 1991, one of the legacies of this law is persistent spatial inequality that reflects the racial categories of Apartheid. During Apartheid, many parents seeking employment in urban areas were forced to leave their children in designated Native areas with alternative caregivers (Bozalek, 1999). This migratory labour system continues to impact family dynamics today as many families experience high levels of mobility and fragmentation (Amoateng, Richter, Makiwane, & Rama, 2004). Due to fluctuations in employment availability and economic status, children are often cared for by extended family members and shift between geographical locations during the course of their childhoods (Bray & Brandt, 2007). This may lead to insecure attachments and anxieties over living situations (Ansell & Van Blerk, 2004), as well as increased risk of abuse and neglect (Meinck et al., 2013).

South Africa is also characterised by high levels of community and social violence (Du Plessis et al., 2015). As recently as 1996, corporal punishment of children was legal in South African schools, and even encouraged in the curriculum as a legitimate form of behaviour management and control (Morrell, 2006). Although this practice has since been abolished, research suggests that it persists in many schools throughout the country (Govender & Sookrajh, 2014). Furthermore, community

⁵ In South Africa, the term “coloured” is used to describe people of mixed-race descent as a distinct ethnic population group.

violence is an endemic problem in South Africa that has its roots in the anti-Apartheid struggle. From the mid-1970s to the mid-1990s, urban townships became the nexus of violent conflict between youth activists and the Apartheid government. Towards the end of Apartheid, community violence between rival political factions was also a daily occurrence further destabilising families (Barbarin, Richter, & De Wet, 2001). In spite of considerable effort on the current government to decrease violence in urban areas, high rates of violent crime persist primarily due to gang violence, theft, drug and alcohol abuse, and inter-personal conflict (Shields, Nadasen, & Pierce, 2008). Thus, many low-income children continue to experience community violence as a part of their daily lives growing up in South Africa (Bray, Gooskens, Kahn, Moses, & Seekings, 2010).

Laws regarding maltreatment and child wellbeing.

Since the dismantling of Apartheid and the adoption of a national constitution based on democratic principles, the South African government has passed a number of laws focused on improving the rights and wellbeing of children. For instance, the Children's Act, 2005 (Act 38 of 2005) is the primary framework for government policy regarding children. Although the Act does not specifically prohibit corporal punishment in the home, Section 7 calls for the protection of children against abuse and provides guidelines for the establishment of a national child protection structure. Section 18 of the Children's Act also makes provisions for early intervention programmes to prevent violence against children and improve child wellbeing. Importantly, the Act emphasises that early childhood programmes should provide education and support to parents, promote positive parent-child relationships, and be appropriate to the developmental stages of children (South African Government, 2005). Furthermore, the Department of Social Development has recently issued a White Paper on Families in South Africa that

specifically highlights the need to implement parenting programmes on a national level to support vulnerable families (Department of Social Development, 2012).

Nevertheless, there remains a substantial gap between government policy and the capacity to implement these policies due to lack of financial commitment and scarcity of human resources (Makoae, 2009).

Poverty and childhood.

It is also important to consider the impact of poverty on parenting behaviour in a South African context. Despite being classified as a middle-income country (World Bank, 2010), the majority of the 18.5 million children in South Africa continue to live in families affected by extreme poverty (Berry, 2013). A total of 58% of children live under the national poverty line (below R604 or £30 per capita income per month), and more than a half live in households receiving child support grants from the government. Unemployment rates in South Africa are roughly 25% of the able workforce, and more than a third of children live in households where there is no adult working. Poverty has also affected family composition with only 18% of children living with both parents in the poorest households; 21% of children are also either single or double orphans. Furthermore, although the provision of basic social services has improved over the past 25 years, approximately a third of children continue to have no access to drinking water and sanitation facilities, and more than 25% of children live in informal housing (Berry, 2013).

Although there is limited research on the direct impact of poverty on child maltreatment in South Africa, research elsewhere has demonstrated increased risks of child maltreatment and poor parenting in families with low socioeconomic status (Gershoff, 2002; Katz, 2007). Socioeconomic factors associated with negative parenting behaviour include lower income, greater material hardship, lower educational

status, higher rates of unemployment, and poorer community environment (Conger et al., 1992; Fox, Platz, & Bentley, 1995; Gershoff, Aber, Raver, & Lennon, 2007; Hill & Tyson, 2008; Klebanov, Brooksgunn, & Duncan, 1994; Lempers, Clarklempers, & Simons, 1989; McLoyd, Jayaratne, Ceballo, & Borquez, 1994; Schneider & Foucault, 2009). Poverty has also been associated with more inconsistent discipline and reduced parental affection (Bradley & Corwyn, 2002). Likewise, in South Africa higher rates of unemployment have been linked to increased family stress, physical punishment, and other forms of abuse (Richter, 1994).

Impact of HIV and AIDS.

In South Africa, the HIV/AIDS epidemic continues to have a negative impact on family functioning and wellbeing (Cluver, Orkin, Gardner, & Boyes, 2011; Lachman, Cluver, Boyes, Kuo, & Casale, 2014). With a national antenatal prevalence of 30.2% and approximately 1.9 million children orphaned by AIDS (UNICEF & UNAIDS, 2011), family disruptions such as AIDS-related parental illness, parental absence, and parental death have substantially impacted parent-child relationships and parenting behaviour (Richter & Naicker, 2013). Recent research has demonstrated that South African children orphaned by AIDS and living with AIDS-ill caregivers are more vulnerable to abuse and maltreatment by their caregivers than non-affected children (Cluver, Orkin, Boyes, et al., 2011). HIV/AIDS-affected families are also associated with a number of risk factors for child maltreatment including increased poverty (Gillies, Tolley, & Wolstenholme, 1996), higher parental depression (Kuo et al., 2012), greater lack of social support (Casale & Wild, 2012), and increased child behaviour problems (Sipsma et al., 2013). A cross-sectional survey on HIV-positive mothers of young children living in township communities also showed associations between higher rates of maternal depression, HIV-illness, negative coping, and parent-child

dysfunction (Allen et al., 2014). Another cross-sectional survey in KwaZulu-Natal ($N = 2,477$ caregiver-child dyads) found that the impact of familial HIV/AIDS on reduced positive parenting was mediated by higher levels of poverty, caregiver depression, and child behaviour problems (Lachman et al., 2014). On the other hand, increased social support has been linked to improved parenting behaviour in high HIV-prevalent communities, thus suggesting the importance of strengthening extended family and neighbourhood networks to reduce the risk of child maltreatment (Casale et al., 2015).

Cultural beliefs and practices regarding parenting and maltreatment.

Cultural beliefs, norms, and practices also have a strong influence on parenting behaviour (Bornstein, 2012). In South Africa, it may be useful to view parenting beliefs and practices of black South Africans through the lens of *Ubuntu*, the African humanist value that emphasises collectivism, social responsibility, interdependence, and respect (Sliep, 2010).⁶ Instead of prioritising an individual parent's responsibility towards a child, many South African families place greater emphasis on the family unit and its role in the socialisation of children (Viljoen, 1994). Moreover, parenting is generally considered a communal activity that extends beyond the nuclear unit (Amoateng et al., 2004). As a result, grandparents, aunts, uncles, older siblings, and even neighbours often consider themselves to be responsible for instilling values in and providing care for young children. Furthermore, instead of one-on-one interactions between children and adults, qualitative research suggests that socialisation often occurs during activities that involve the entire family (Balton, 2009). These may include mealtimes, attending church, and even communal storytelling. Additionally, ethnographic research in South Africa suggests that family dynamics are co-created through reciprocal relations rather

⁶ Ubuntu comes from the saying, "*umuntu ngumuntu ngabantu*" which literally means a person is a person because of/ by means of/ through (other) people (Hanks, 2008).

than a unidirectional imposition of values from parent to child (Bray et al., 2010). The act of caregiving is also relational in which children are often involved in activities such as domestic chores, supervision of younger siblings, and caring for ill adults, especially in the context of HIV/AIDS and poverty (Bray & Brandt, 2007).

There is conflicting literature regarding norms and behaviours around physical discipline and corporal punishment in South Africa. Due to the tension between modern and traditional parenting practices, families often find themselves caught in between the influence of Western notions of authoritative parenting styles and more traditional authoritarian practices (Roman, 2014).⁷ Although corporal punishment is predominantly viewed as an acceptable corrective discipline strategy in South Africa, recent research with low-income families suggests that parents choose to identify with a more authoritative style of parenting characterised by supportive and attentive behaviour (Latouf & Dunn, 2010; Roman, 2011). Furthermore, the national survey of attitudes towards corporal punishment found that an overwhelming majority of parents considered nonviolent discipline as a preferred strategy over corporal punishment (72% of respondents) (Dawes et al., 2005). However, results also showed that 57% of respondents still engaged in corporal punishment. In addition, the survey found that attitudes in support of physical punishment and non-empathic parenting were the strongest predictors of severity of abuse. This coincides with the findings of the aforementioned meta-analysis that demonstrated strong correlations between attitudes supporting corporal punishment and increased risk of physical abuse (Akmatov, 2011). These findings may suggest a disconnection between parenting goals and practices as well as a diverse range of norms and beliefs regarding harsh parenting in South Africa.

⁷ Baumrind (1991) characterises “authoritative” parenting styles as having high levels of demandingness/control, responsiveness, and autonomy, while “authoritarian” parenting is characterised as having high levels of demandingness/control with low levels of responsiveness and autonomy.

Despite shifting attitudes regarding parenting styles, many South African parents may not have the knowledge, skills, or self-efficacy to adopt less harsh discipline strategies (Roman, 2014).

Gender and family dynamics in South Africa.

Although South African families are predominantly structured around a patriarchal system, caregiving is typically viewed as part of a woman's domain (Ramphela, 2002). Parenting responsibilities in low-income South African families are often shared between mothers, grandmothers, aunts, and older sisters (Bray & Brandt, 2007). Thus, children often identify with multiple female caregivers as important sources of support, attachment, and resilience (Bray et al., 2010). At the same time, female caregivers are often cited as the primary source of child maltreatment at home. This is primarily due to the role of women as the principal caregivers in households who have the responsibility of rearing and disciplining their children. In contexts where corporal punishment and harsh discipline are considered acceptable, women are more likely to engage in child maltreatment as part of their normative parenting behaviours than men who have less frequent contact and interaction with their children (Dawes et al., 2005; Meinck et al., 2013).

Much research has also been focused on the absence of fathers and the reduced role of fatherhood in South Africa (Richter, Chikovre, & Makusha, 2010). Since almost half of fathers in South Africa do not live in the same household as their children, many children have limited or no contact with their fathers over the course of their childhoods (Bray et al., 2010). Nevertheless, even when not living in the household, fathers may have a positive influence on child wellbeing, especially in reducing aggression in boys (Richter & Morrell, 2008). Ethnographic research in Cape Town suggests that men often play supportive roles in providing material support, child

care, and other domestic duties (Bray & Brandt, 2007). Furthermore, a cross-sectional survey of 274 adolescents living in Langa, Cape Town, found associations between higher academic achievement in boys and the presence of fathers (Mboya & Nesengani, 1999). On the other hand, the South African national survey on corporal punishment found that male caregivers were as likely to use harsh discipline as female caregivers (Dawes et al., 2005). They were also more likely to use more severe forms of punishment than women. As discussed elsewhere, higher rates of intimate partner violence between men and women are also linked to increased risk of abuse by both men and women (Meinck, 2014). As a result, the presence of fathers or other male caregivers may also increase the risk of child maltreatment if there is marital conflict in the household, or if fathers do not possess alternative discipline strategies to corporal punishment.

Problem theory model

In summary, the following problem theory model is proposed based on the literature reviewed above regarding the risk and protective factors for child maltreatment (Figure 1). This ecological model considers both global factors (i.e., an etic perspective) as well as those that are specific to a South African cultural context (i.e., an emic perspective). Furthermore, it is important to recognise the limitations of two-dimensional models to adequately capture complex interrelationships between different factors. While cultural norms and beliefs operate on the macrosystem level, they also inform individual, family, and community relationships. Nevertheless, the proposed model provides a useful platform for subsequent intervention development and testing. For instance, interventions to reduce child maltreatment in South Africa may be most effective when targeted at families with high risk for abuse such as those affected by poverty and HIV/AIDS, as well as families with children who have clinical

levels of behavioural problems. Likewise, programmes that increase the frequency of protective factors like social support, positive parenting behaviour, and access to child protection services may reduce the likelihood of abuse.

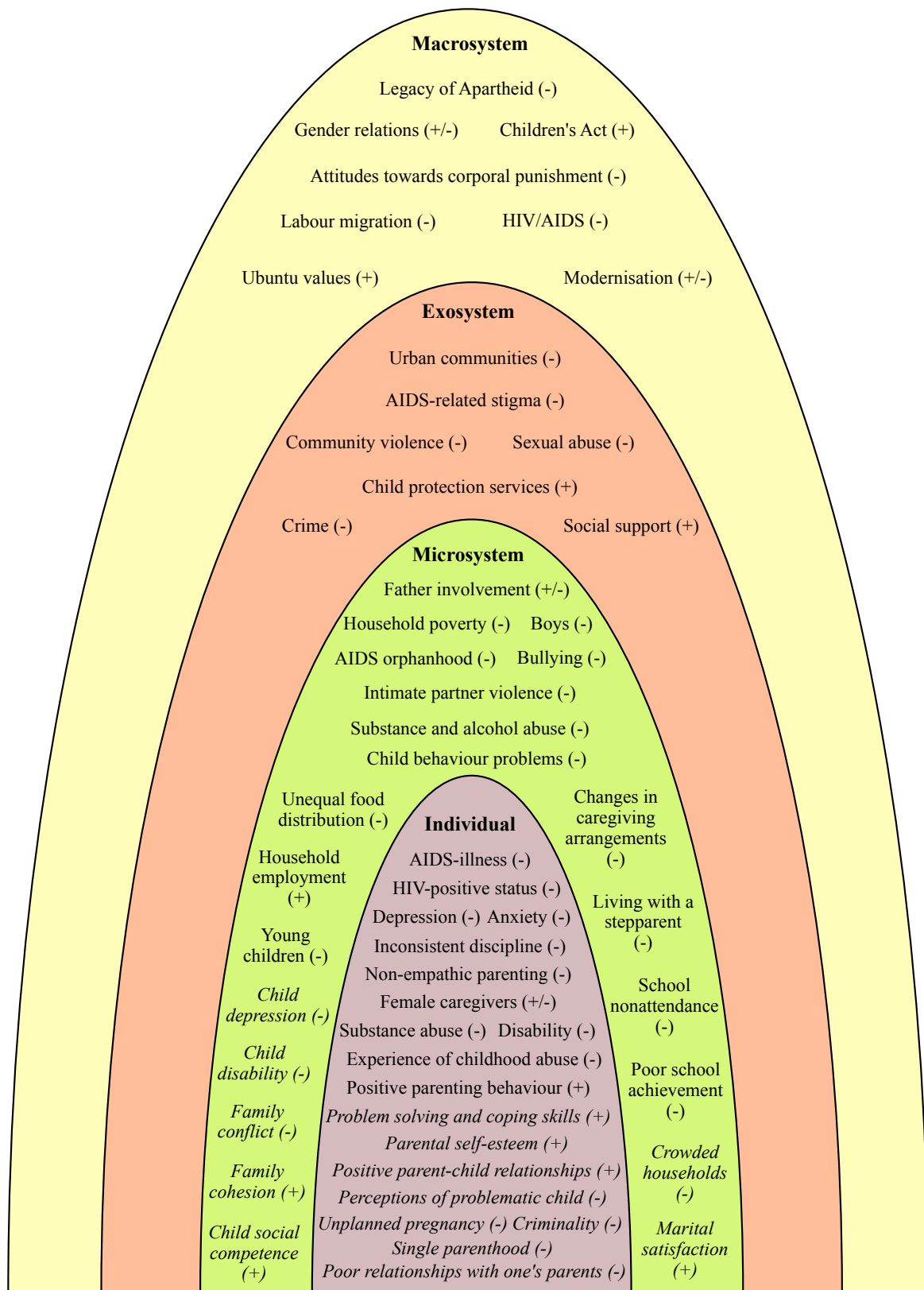


Figure 1. Problem theory for child maltreatment in South Africa based on an ecological framework model.⁸

⁸ Italicised factors are based on literature from outside of South Africa; (+) protective factor; (-) risk factor; (+/-) risk and protective factor.

Evidence for Parenting Programmes to Reduce Child Maltreatment

Evidence in high-income countries

There is encouraging evidence from HICs on the effectiveness of parenting programmes to reduce the risk of child maltreatment (Barlow, Johnston, Kendrick, Polnay, & Stewart-Brown, 2006; Chen & Chan, 2015; Mikton & Butchart, 2009). For instance, Barlow et al. (2006) conducted a systematic review focused specifically on programmes delivered to families with a history of child abuse. Although the review did not conduct a meta-analysis of effects, results found seven studies from the United States that examined the effect of parenting programmes in reducing repeated incidents of child abuse and neglect. One study ($N = 16$) showed found significant reductions in further incidents of child maltreatment using an objective measurement based on agency records of child abuse. The intervention combined a group-based parenting programme derived from a pre-existing intervention, Parents Are Teachers, with intensive home visits for physically abusive parents of children aged two to ten years. Results at one-year follow-up showed no instances of child maltreatment in the intervention group in comparison to standard child protection services (Wolfe, Sandler, & Kaufman, 1981).

Three other studies in the review also showed significant intervention effects in reducing the risk of child maltreatment based on measurements of reduced child abuse potential and improved positive parenting behaviour. An RCT of Parent-Child Interaction Therapy (PCIT, $N = 110$) showed significantly fewer parent-reported incidents of physical abuse for parents allocated to PCIT in comparison to controls in families with physically abusive parents of children aged four to twelve years (Chaffin et al., 2004). Reductions in physical abuse were also mediated by reduced negative parent-child relationships. Another RCT of PCIT ($N = 34$) showed a large effect on

reducing child abuse potential in comparison with standard child protection services ($d = -0.99$) (Terao, 1999). An RCT of the Incredible Years, a 12-session group-based parenting programme for families with children aged three to eight years, showed significant improvements in parental involvement in comparison to controls ($N = 26$; $d = 0.76$) (Hughes & Gottlieb, 2004). However, with the exception of the Chaffin study, all of the included studies had small sample sizes due to logistical challenges in recruiting participants with a history of abuse primarily from referral agencies.

A more recent systematic review of parenting programmes for children aged three to twelve years included 13 studies that used either a randomised ($n = 9$) or quasi-randomised ($n = 4$) controlled trial design (Furlong et al., 2013). The majority of the studies were conducted in either the United States or United Kingdom with the remaining studies in Western Europe. Sample sizes ranged from 28 to 153, with three of the studies having over 100 participants. Nine of the studies examined the effect of the Incredible Years, although the length of delivery ranged from 9 to 24 weekly sessions. Other evaluated programmes included the Barkley's Parent Training programme (10 weekly sessions followed by 5 monthly booster sessions), a parenting programme derived from Parent Management Training Oregon and the Incredible Years (11 bi-weekly sessions), the Comet Parent Management Training, Practitioner-Assisted Programme (11 weekly sessions), and a version of the Triple P Parenting Programme delivered in a workplace setting over four weekly sessions followed by four weekly telephone consultations.

Although the review did not specifically focus on reductions of child maltreatment, it examined intervention effects on harsh parenting and positive parenting in addition to child conduct problems as the main outcome. Meta-analyses found significant reductions in harsh parenting behaviour for parent-report (SMD -0.77) and

observational assessments (SMD -0.42) in comparison to control groups. Analyses also showed improvements in positive parenting skills for both parent-report (SMD 0.53) and observational assessments (SMD 0.47).

Most recently, a meta-analysis examined the effects of 31 RCTs of home-visiting or group-based parenting programmes that focused on preventing child maltreatment (Chen & Chan, 2015). These studies included those on parenting programmes for families selected randomly within a community ($N = 2,293$, 31.1%), specific families at risk of maltreatment ($N = 4,382$, 32.1%), and those where child maltreatment had already occurred ($N = 467$, 6.54%). The majority of studies were from HICs ($n = 29$) and focused on programmes with children under five years of age. Although there was a high level of heterogeneity ($I^2 = 75.39$, $p < .001$), meta-analysis demonstrated a total weighted random effect size of 0.30. Studies that used the Parent-Child Conflict Tactics Scale (Straus et al., 1998) as a measurement of harsh and neglectful parenting showed a lower effect size of 0.21. The meta-analysis also found small to moderate effects for improvements in positive parenting ($ES = 0.23$), parent-child interaction ($ES = 0.52$), and sense of competence ($ES = 0.22$), as well as reductions in attitudes supporting corporal punishment ($ES = -0.34$). Finally, the study examined different types of programme structure and delivery. Although it did not compare the effect of programme variation across studies (see the discussion on the Kaminski meta-analysis below), findings demonstrated moderate effects on reducing child maltreatment for programmes that were delivered to a selected population ($ES = -0.24$), less than 12 sessions ($ES = -0.33$), and by professionals ($ES = -0.26$). Results also showed roughly equal effects for programmes delivered to groups ($ES = -0.24$), individuals ($ES = -0.22$), or a mixture of the two ($ES = -0.27$).

Many individual parenting programmes have consistently shown positive effects on reducing the risk of maltreatment across diverse populations for families with young children. These include the PCIT, the Incredible Years, the Triple P Positive Parenting Programme, and Parent Management Training Oregon (Eyberg et al., 1995; Patterson, Chamberlain, & Reid, 1982; Sanders, 2008; Webster-Stratton, 1998b). The aforementioned an RCT of PCIT in the United States ($N = 110$) showed efficacy in preventing future abuse amongst physically abusive parenting in parent-child dyads with children aged four to twelve years (Chaffin et al., 2004). PCIT includes six group sessions followed by intensive consultations with parent-child dyads (Eyberg, Boggs, & Algina, 1995). Based on child welfare reports, only 19% of parents in the intervention group were re-reported for abuse compared to 49% in the control group. PCIT has also demonstrated positive effects in reducing child maltreatment and harsh parenting in multiple settings including Hong Kong (Leung, Tsang, Heung, & Yiu, 2009) and Puerto Rico (Matos, Bauermeister, & Bernal, 2009).

The Incredible Years (IY) has also demonstrated evidence in improving positive parenting and reducing harsh or ineffective parenting, along with reducing child conduct problems, in multiple settings including the USA, UK, Europe, and New Zealand (Axberg & Broberg, 2008; Fergusson, Stanley, & Horwood, 2009; Gardner, Burton, & Klimes, 2006; Larsson et al., 2009; McGilloway et al., 2012). Research has also found positive intervention effects of IY on improving parenting behaviour in RCTs with low-income families and ethnic minorities (Gardner, Hutchings, Bywater, & Whitaker, 2010; Leijten, Raaijmakers, de Castro, & Matthys, 2013; McGilloway et al., 2012; McGilloway et al., 2014; Reid, Webster-Stratton, & Beauchaine, 2001). The programme uses a collaborative, principle-based approach with video vignettes, role-plays, and home practice activities to engage parents in positive parenting and effective

discipline behaviours. Although originally tested as a 12-session programme, IY has recently been expanded to include versions ranging from 12-20 sessions, as well as programmes specifically for babies (0-12 months), toddlers (1-3 years), pre-schoolers (3-6 years), and school aged children (6-12 years) (Webster-Stratton & Herman, 2010).

The Triple P Parenting Programme (Triple P) has also demonstrated promising results in reducing the risk of maltreatment in multiple contexts including Australia, the USA, New Zealand, Canada, Belgium, and Norway (Sanders, 2011). Triple P uses a multilevel treatment and prevention programme with five levels of increased intensity. Level One (Universal Triple P) involves information campaigns at a population level using media strategies. Level Two (Selected Triple P) is a low intensity intervention delivered over a series of group-based seminars or individual consultations. Level Three (Enhanced Triple P) expands the seminar series into four 2-minute consultations with active skills training for parents in either individual or group-based settings. Level Four (Standard Triple P) is the most frequently tested version of Triple P. It is an eight-session group or individual-based programme targeted at families with children with clinical levels of behaviour problems. Finally, Level Five (Enhanced Triple P) provides more intensive consultation and support for parents with additional risk factors ranging from intimate partner violence and parental depression to parents with obese children or those experiencing divorce (Sanders, 2011). Triple P has been tested in multiple RCTs and other non-randomised studies demonstrating effectiveness in improving positive parenting behaviour and reducing harsh parenting, as well as reducing child conduct problems (De Graaf, Speetjens, Smit, De Wolff, & Tavecchio, 2008; Nowak & Heinrichs, 2008; Thomas & Zimmer-Gembeck, 2007). For instance, a meta-analysis of Triple P Level Four programme identified 19 studies using a randomised ($n = 18$) or non-randomised ($n = 1$) design that evaluated parenting behaviour and parent sense of

competence (De Graaf et al., 2008). Although there was a high heterogeneity of included studies (e.g., sample sizes ranged from 9 to 691 participants), analyses found an overall mean effect of 0.68 for improvements of parenting styles regarding parental perception of dysfunctional parenting. In addition, a large-scale cluster RCT in South Carolina of Triple P's multilevel programme ($N = 18$ counties) showed significant reductions at the population level after a two-year period of dissemination for reported child maltreatment cases ($d = -1.09$), child out-of-home placement ($d = -1.22$), and child maltreatment injuries ($d = -1.14$) (Prinz & Sanders, 2007). However, a recent systematic review on Triple P has called into question the effectiveness of the intervention. This meta-analysis of 33 trials evaluating child outcomes found substantial selective reporting biases as well as potential conflicts of interest due to the involvement of the developers in the study (Wilson et al., 2012).

Finally, Parent Management Training Oregon (PMTO) has demonstrated positive effects in reducing the risk of child maltreatment through improvements in positive parenting and reductions in harsh parenting (Forgatch, Patterson, & Gewirtz, 2013). It is typically delivered to groups of parents of children aged 2 to 18 years over 10-14 sessions using role-plays, group discussions, and weekly home practice assignments (Forgatch, Bullock, Patterson, & Steiner, 2004). It has also been tested and disseminated widely across multiple settings for diverse populations. For instance, the group-based version of PMTO for parents and teens has demonstrated effectiveness when adapted for Latino parents (Martinez & Eddy, 2005; Parra Cardona, 2015). Recent research has also shown PMTO's transferability across cultural settings with sustained treatment effects and strong fidelity when implemented at scale in Norway (Ogden, Forgatch, Askeland, Patterson, & Bullock, 2005).

Evidence in LMICs

Despite the need for similar interventions to address child maltreatment on a global level, there is very little evidence of the effectiveness of parenting programmes in LMICs (World Health Organization, 2010). A recent systematic review identified 12 studies from LMICs that examined the effectiveness of parenting interventions on reducing harsh or abusive parenting and improving positive parenting behaviour (Knerr, Gardner, & Cluver, 2013). One of these studies tested the effect of an intervention designed to improve mother-infant interaction between mothers and infants from late pregnancy to 18-months postpartum in Khayelitsha, Cape Town ($N = 449$) (Cooper et al., 2009). Although the study did not directly measure child maltreatment outcomes, results indicated positive intervention effects for reduced maternal intrusiveness ($d = -0.24$) and improved maternal sensitivity ($d = 0.26$) at 12-months follow-up in comparison to controls. Furthermore, the intervention was delivered by local female community-based health workers with no formal training prior to the study, thus indicating the potential feasibility of implementing parenting programmes in low-resource contexts using paraprofessionals.

Another study included in the systematic review examined the efficacy of a group-based parenting programme for middle-income families with children aged two to nine in Iran ($N = 224$) (Oveisi et al., 2010). This study found a large effect size for reducing dysfunctional parenting practices ($d = -1.20$) and a moderate effect size in the reduction of child abuse ($d = -0.50$) in comparison to controls (Oveisi et al., 2010; Straus et al., 1998). However, this study was limited by its exclusive reliance on parent-report data, which may be susceptible to reporting biases (Hawes & Dadds, 2006). More recently, a pilot RCT in Panama examined the efficacy of Triple P's brief intervention on "Dealing with Disobedience" with parents of children aged three to 12

years ($N = 108$) (Mejia, Calam, & Sanders, 2015). Although this study experienced high rates of parent dropout (30%), results showed moderate effects on reducing dysfunctional parenting at 6-month follow-up ($d = -0.59$).

Common theoretical foundations and components of evidence-based parenting programmes

Many evidence-based parenting programmes share common theoretical foundations and programmatic components derived from over 50 years of research (Pearl, 2009). The majority of these programmes are grounded in either attachment theory (Bowlby, 1974) or social learning theory (Bandura, 1977). Programmes based on attachment theory focus on improving parental sensitivity and reducing intrusive or disruptive behaviours in order to promote strong parent-child attachment and security as an antecedent for positive child mental health and behaviour. These programmes are generally delivered to families with very young children from birth to three years (Bakermans-Kranenburg, Van Ijzendoorn, & Juffer, 2003; Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010). Examples of attachment based interventions include the aforementioned mother-infant programme tested in South Africa, Thula Sana (Cooper et al., 2009), the STEEP Project (Steps Toward Effective Enjoyable Parenting), a programme developed in the Netherlands that is delivered to mothers and children from prenatal to two years of age in a combination of home visits and group sessions (Egeland, 2004), and the Attachment and Biobehavioural Catch-Up (ABC) programme, a 10-session intervention developed specifically for families at risk of child maltreatment (Bernard et al., 2012).

Programmes based on social learning theory are generally most effective during later childhood either prior to or after the onset of child behaviour problems (Furlong et al., 2013). Social learning theory considers the role of parent behaviour and the effect of

harsh or ineffective parenting on the development of child behaviour problems (Patterson, DeBaryshe, & Ramsey, 1989). Examples of social learning based programmes include the aforementioned interventions, PCIT, IY, PMTO, and Triple P. These programmes focus on building positive parent-child relationships prior to learning nonviolent discipline strategies (Kazdin, 1997). By improving the quality of parent-child relationships through positive parenting, children are less likely to misbehave. Correspondingly, this reduces the need to enforce limits on child behaviour or resort to corrective discipline and punishment. Parents also learn to regulate their own emotions while replacing harsh and inconsistent parenting with nonviolent and consistent behaviour management strategies. Common positive parenting skills include child-led play, socio-emotional coaching, specific labelled praise, and simple rewards to support pro-social behaviour. Nonviolent discipline strategies to manage difficult child behaviours include establishing household rules and routines, positive instruction-giving, ignoring negative attention-seeking behaviour, time-out for aggressive behaviour and non-compliance, use of realistic consequences, and involving children in problem solving (Hutchings, Gardner, & Lane, 2004).

Recent research has attempted to identify specific parenting programme components shown to be effective in reducing child behaviour problems and the risk of child maltreatment. A meta-analysis examined 77 evaluations of parenting programmes targeted at preventing or treating child behaviour problems in families with children from birth to seven years (Kaminski, Valle, Filene, & Boyle, 2008). This study also examined parenting behaviour as a proximal outcome. In order to investigate associations of programme components with parenting and child behaviour, researchers coded variables for programme content (e.g., child development, positive interactions with child, or disciplinary communication) and delivery (e.g., manualisation, modelling,

homework, or role-playing). Results indicated that the inclusion of emotional communication ($ES = 1.47$), consistent responding ($ES = 0.59$), and practising parenting skills with children ($ES = 0.91$) were associated with larger effect sizes for improved parenting than programmes without those components. Additionally, positive parent-child interaction ($ES = -0.36$), responsiveness, sensitivity, and nurturing ($ES = -0.58$), problem solving ($ES = -0.49$), time-out ($ES = -0.54$), and practising of skills with children during training sessions ($ES = -0.69$) were associated with larger effect sizes for reductions in child behaviour problems. Although programme manualisation was associated with reduced programme effectiveness, the meta-analysis only measured whether or not a programme included a manual. Other research has argued that programme manualisation is an essential component for implementation fidelity and dissemination (Elliott & Mihalic, 2004).

Issues of implementation fidelity are also important factors regarding the effectiveness of parenting programmes (Bellg et al., 2004). Implementation fidelity refers to whether an intervention is delivered as intended by the developers – both in terms of programme content and quality of delivery. As evidence-based programmes are disseminated widely in multiple settings, the likelihood of programme drift or variation increases. This departure from a programme's original design makes it more challenging to discern whether a programme will have the same outcome effects as the evaluated version. As a result, programme developers have devised rigorous procedures, manuals, and training to assure treatment fidelity. For example, programmes such as Triple P, PMTO, and the Incredible Years often use comprehensive facilitator checklists and report forms to monitor programme delivery (Webster-Stratton & Herman, 2010). These programmes also require extensive training, supervision, monitoring, and engagement by the implementing agency to maintain high

fidelity and quality of delivery (Ogden et al., 2005; Turner, Nicholson, & Sanders, 2011; Webster-Stratton, 2004).

Recent research also demonstrates that the quality of delivery by programme facilitators is equally as important as fidelity to specific components. For instance, a multisite RCT of the Incredible Years in North Wales ($N = 11$ sites, 153 families) examined the role of process skills used by facilitators during programme delivery (Eames et al., 2009). Results found that higher levels of facilitators' listening ($F = 5.67$), empathy ($F = 3.81$), physical encouragement ($F = 4.55$), and positive behaviour skills ($F = 4.49$) significantly predicted improvements in observed positive parenting skills. Indicating the importance of modelling behaviour, analysis of covariance found significant associations between higher rates of praise of parents by facilitators and parents' praise of their own children ($\beta = .35$). Likewise, higher frequency reflective behaviour by facilitators was associated with increased frequency in the reflective behaviours of parents ($\beta = .20$) (Eames et al., 2010).

Theory of change model

This study proposes the following theory of change model to inform further intervention development and testing (Figure 2). Evidence-based parenting programmes contain similar programme components and delivery methods (Kaminski et al., 2008). These components address proximal adult outcomes that include reduced harsh or intrusive parenting, as well as improved positive parenting skills, parental monitoring and supervision, consistent limit-setting behaviours, and nonviolent discipline skills (Furlong et al., 2013). Improvements in parenting behaviour have also been shown to improve parental mental health such as maternal depression and parenting stress (Barlow, Coren, & Stewart-Brown, 2002; Bennett, Barlow, Huband, Smailagic, & Roloff, 2013). They may also increase parental sense of competence, self-efficacy, and

social support (Armstrong, Birnie-Lefcovitch, & Ungar, 2005; Gardner et al., 2006; Leung, Sanders, Leung, Mak, & Lau, 2003). As parents gain more self-efficacy with nonviolent discipline as an effective child behaviour management strategy, existing attitudes regarding the necessity for corporal punishment may also decrease (Galanter et al., 2012). These changes may directly affect more distal child outcomes including reduced child behaviour problems and improved socio-emotional regulation (Barlow et al., 2010; Furlong et al., 2013). Due to the reciprocal relationship between child behaviour and parenting, improvements in child outcomes may further improve parenting behaviours (Burke, Pardini, & Loeber, 2008). They may also reduce the likelihood of abuse due to increased compliance and prosocial behaviour of children (Pardini, Fite, & Burke, 2008). Finally, improvements in parent and child outcomes may contribute to the overall reduction in risk of child maltreatment (Chen & Chan, 2015).

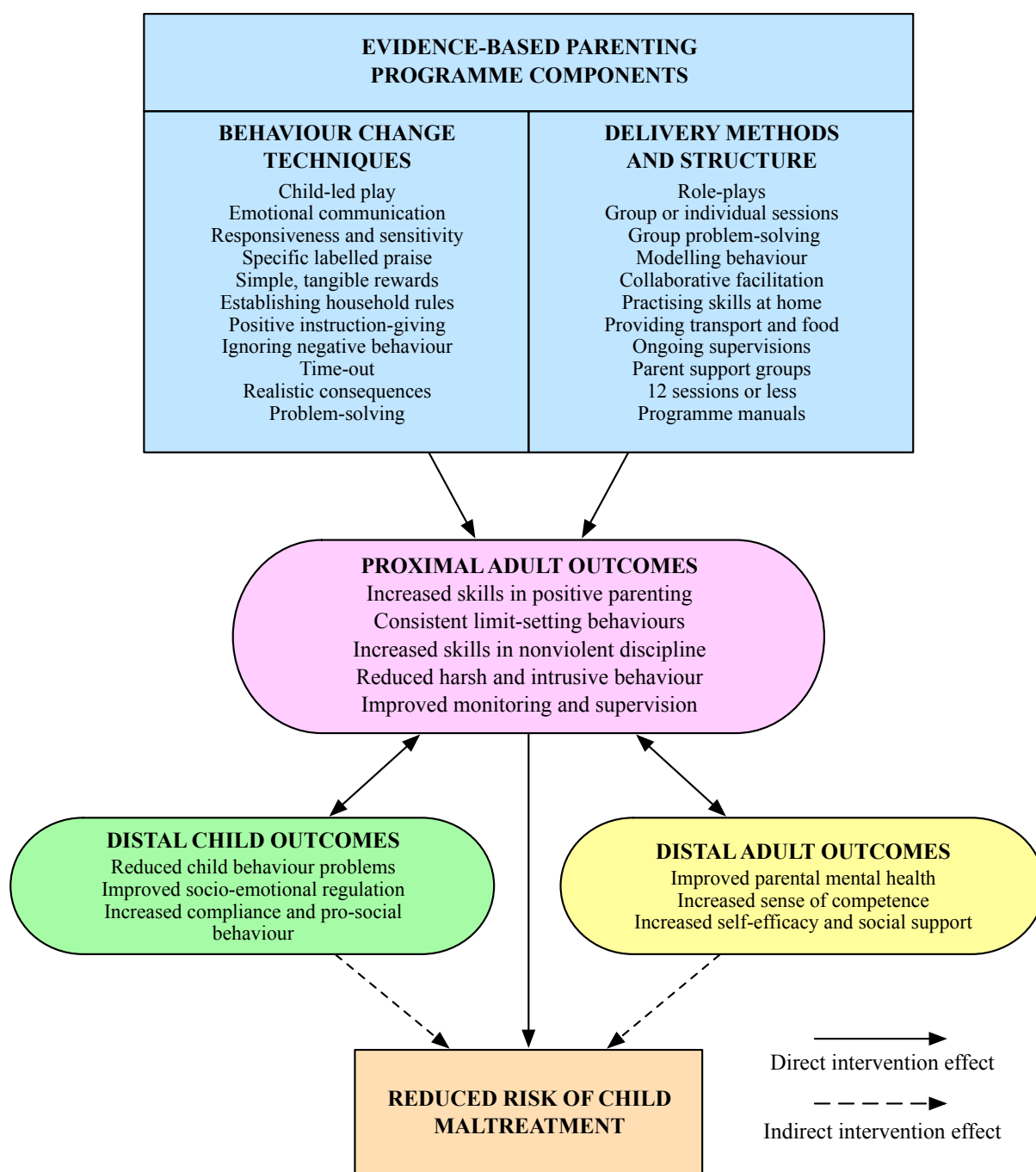


Figure 2. Theory of change model for parenting programmes with reduced risk of child maltreatment as the ultimate outcome.

CHAPTER THREE. METHODOLOGICAL FRAMEWORKS

Overview

This chapter presents the methodological frameworks upon which the subsequent chapters of the thesis are based. The first section discusses the overall theoretical approach regarding developing and evaluating parenting programmes. It begins with a discussion of the United Kingdom Medical Research Council's (MRC) guidelines for complex interventions and their relevance to parenting programmes (Craig et al., 2008). It also examines other theoretical frameworks grounded in collaborative family-based intervention development and cultural adaptation research (Barrera et al., 2013; Fraenkel, 2006). The section concludes by proposing an intervention development and evaluation model that integrates these approaches for further application in this study.

The second section provides an overview of the methods used in the study. It describes the setting where the study took place and the recruitment methods for each part of the thesis. Next, discusses the overall ethical considerations regarding the treatment of participants in the thesis. Finally, this chapter presents an overview of the study design for each paper.

Theoretical Framework

The Medical Research Council guidelines for complex interventions

This study uses the MRC's guidelines for designing and evaluating complex interventions as a methodological foundation (Craig et al., 2008). The MRC framework suggests a nonlinear, interacting model that can be implemented over four phases:

Phase One: Development; Phase Two: Feasibility/Piloting; Phase Three: Evaluation; and Phase Four: Implementation (Figure 1).⁹

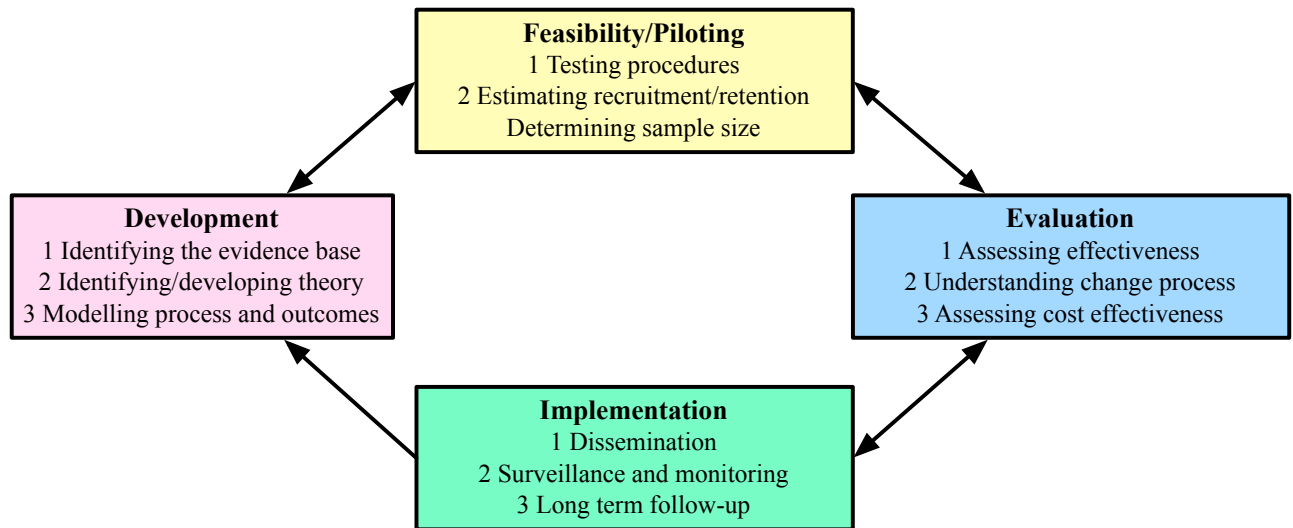


Figure 3. The United Kingdom Medical Research Council's framework on the development and evaluation of complex interventions (Craig et al., 2008).

The Development Phase establishes a theoretical foundation for intervention development and evaluation prior to testing. In order to maximise the potential to achieve positive results, it is important that interventions are grounded in existing literature regarding a particular clinical problem or social phenomenon (i.e., problem theory) and mechanisms or processes of change (i.e., theory of change) (Kazdin, 2001). Problem theory examines a particular phenomenon's incidence and prevalence as well as potential risk and protective factors. Building upon problem theory, theory of change refers to the specific hypotheses regarding the mechanisms by which a particular intervention may have a positive effect on the problem. Theory of change models are essential to understanding where an intervention needs to be applied, how it operates, and what to evaluate (Hinshaw, 2002). This may include defining potential moderators

⁹ The MRC defines complex interventions as those which contain: (a) several interacting components, (b) different levels of service delivery, (c) various groups or organisational targets, (d) multiple and variable outcomes, and (e) high degrees of flexibility (Craig et al., 2008).

and mediators of intervention effects based on the problem theory (Fraser, Richman, Galinsky, & Day, 2009).

The Development Phase is also an opportunity to define the evaluation strategy for testing the intervention in the real world. This includes identifying the target population, research design, outcome measures, data collection procedures, and ethical protocols. It also explores the literature regarding the evidence of effectiveness of existing interventions that address a particular social problem. This may include the examination of distillation studies, systematic reviews, and meta-analyses, as well as the content and approaches of individual studies.

The Feasibility/Piloting Phase involves the preliminary testing of the evaluation strategy, intervention outcomes, and implementation feasibility. Feasibility pilot trials are considered important steps in preparation for larger experimental studies (Lancaster, Dodd, & Williamson, 2004). Potential designs may include pre-test and post-test assessments, comparison controls, or pilot randomised controlled trials (RCTs) (Campbell, Murray, et al., 2007). Even at this early stage of intervention testing, it is recommended to use randomised designs that control for confounding factors while reducing potential biases due to selection, allocation, and evaluation (Shadish, Cook, & Campbell, 2002). This also allows researchers to examine the feasibility of implementing rigorous evaluation methods prior to testing in larger experimental studies.

The Feasibility/Piloting Phase also begins the process of testing theory in action. It normally investigates the suitability of study protocols, outcome measures, randomisation procedures, recruitment, and retention of participants. In addition, feasibility pilot studies assess intervention feasibility by examining programme dosage, implementation fidelity, and participant satisfaction. Although often limited in their

ability to detect significant effects due to small sample sizes, pilot studies are also opportunities to conduct exploratory analyses of intervention effects. This is particularly important when probing for potential harmful effects prior to testing in a larger population (Thabane et al., 2010).

The Evaluation Phase examines intervention effectiveness, usually through individual, multisite, or cluster RCTs. Ideally, this phase will combine outcome and process evaluations to test the internal and external validity of the study (Oakley et al., 2006). The internal validity focuses on determining the causal relationship between intervention components and outcomes by controlling for confounding factors. In addition to examining the intervention's effect on primary outcomes, this may include analysing potential subgroups, moderators, and mediators of effects. On the other hand, the external validity measures the practical importance of outcome effects and demonstrates whether an intervention is suitable for a wider population (Flay et al., 2005). Researchers often employ mixed-method approaches to examine these factors. Methods may include self-report and observational assessments of outcome effects, as well as quantitative and qualitative assessments of implementation.

Finally, if results from the Evaluation Phase are positive, the Implementation Phase usually involves the wider dissemination of the programme. It also includes ongoing monitoring and evaluation of programme implementation at scale (Craig et al., 2008). This may include diffusion studies as well as studies examining the transferability of the intervention to other contexts. The Implementation Phase is also an opportunity to develop sustainable programme delivery mechanisms and to monitor outcomes over a long-term period at the population level.

While the MRC Framework presents four distinct phases of research, these are by no means sequential and linear. It is important to acknowledge that the development

and evaluation of complex interventions is an iterative and evolving process in which the different phases influence one another (Campbell, Murray, et al., 2007). For instance, the Feasibility/Piloting Phase is an opportunity to test, confirm, or reconfigure hypothesised problem theory and theory of change models while assessing initial programme outcomes. Findings may inform further programme development and require additional formative research prior to moving on to the Evaluation Phase. Furthermore, new information emerging during the Evaluation Phase may prompt investigators to rethink existing problem theories or theories of change that in turn influence the design of interventions. Likewise, interventions may require additional piloting and evaluating in order to test mechanisms for taking the programme to scale during the Implementation Phase. As a result, the MRC model is more concerned with the interrelationship between the different phases rather than a unidirectional progression towards an ultimate resolution.

Parenting programmes as complex interventions

Parenting programmes – defined as interventions in which parents learn to improve parent-child relationships through increased positive parenting behaviour and reduced harsh or inconsistent discipline (Wessels & Ward, 2015) – are useful examples of complex interventions. They often contain many interacting components such as teaching parents skills and principles, supporting parental mental health, and increasing access to social services. Some also have multiple levels of delivery that may include group settings, one-on-one consultations in clinics, home-based visits, or a combination of group activities and individual visits. Parenting programmes are also often delivered to different types of beneficiaries, including parents, children, or teachers. In addition, they frequently incorporate a wide variety of methods such as modelling appropriate

behaviour, role-playing skills during sessions, practising skills at home, and using vignettes to identify parenting principles (Kazdin, 1997).

Evaluations of parenting programmes are also often complex. Although most evidence on parenting programmes is focused on children with clinical levels of conduct problems (Furlong et al., 2013), parenting programmes have also been shown to be effective when delivered to a wide range of target beneficiaries including, but not limited to, physically abusive parents (Chaffin et al., 2004), children with developmental delays (Bagner & Eyberg, 2007), children with depressed parents (Beardslee, Gladstone, Wright, & Cooper, 2003), low-income families (Leijten, Raaijmakers, de Castro, van den Ban, & Matthys, 2013; McGilloway et al., 2012), teenage parents (Barlow et al., 2011), mothers in prison (Menting, de Castro, Wijngaards-de Meij, & Matthys, 2014), and families affected by HIV and AIDS (Rotheram-Borus, Lee, Gwadz, & Draimin, 2001). As aforementioned in Chapter Two, various systematic reviews have demonstrated the effectiveness of parenting programmes on a large number of outcomes as well. These include reduced reoccurrence of child abuse and risks of child maltreatment (Barlow et al., 2006; Chen & Chan, 2015), reduced insensitive parenting and infant attachment security (Bakermans-Kranenburg et al., 2003), reduced parental depression, anxiety, and other maternal mental health problems (Barlow et al., 2002), and reduced child conduct problems and harsh parenting, and improved positive parenting skills (Furlong et al., 2013).

Evaluations of parenting programmes frequently utilise multiple levels of assessment to examine intervention effects. While adding to the complexity of data collection, multiple levels of assessment allow for a more robust analysis of intervention effectiveness by avoiding method overlap between predictors and

outcomes (Aspland & Gardner, 2003). These may include independent observational assessments as well as psychometric scales administered to parents, children, teachers, or service providers. Evaluations of parenting programmes often assess outcomes measured on the parent level (e.g., parenting style, parenting stress, parent sense of competence and efficacy, parental depression), child level (e.g., cognitive development, social competence, behaviour, and conduct problems), family level (e.g., parent-child interaction, intimate partner violence), and community level (e.g., reduced reports of child maltreatment). Importantly, some evaluations have demonstrated that changes on a parent level mediate outcomes on the child level. For instance, an RCT of the Incredible Years in North Wales ($N = 153$) showed that improvements in positive parenting skills predicted reductions in child conduct problems (Gardner et al., 2010).

Furthermore, evaluations of group-based parenting programmes require more complex statistical analysis procedures than individually administered interventions (Pals et al., 2008). Participants allocated to the intervention arm often receive the programme in small groups while participants in the control group are either ungrouped or receive alternative interventions. This may result in inter-cluster correlations within the treatment group due to the unique experiences of individuals in a specific parenting group (Baldwin, Murray, & Shadish, 2005). For instance, parents may experience increased social support or inter-group dysfunction within a specific group that might affect outcomes. Likewise, there may be variations in programme implementation across treatment groups due to differences in the quality of facilitation or other service delivery factors. Thus, statistical analyses of RCTs of group-based parenting programmes must account for their partially nested design (Roberts & Roberts, 2005).

It is also important to evaluate process outcomes when assessing the effectiveness of parenting programmes (Oakley et al., 2006). Often parenting

programmes fail to produce positive effects due to implementation factors such as inadequate participation, poor delivery, or cultural inappropriateness (Durlak & DuPre, 2008). Parenting programmes require rigorous training and supervision of facilitators in order to achieve high-quality delivery (Ogden et al., 2005). While programmes often rely on protocols and detailed manuals to enhance implementation fidelity (Elliott & Mihalic, 2004), many also use client-centred and collaborative approaches that allow for flexibility and variation during delivery (Webster-Stratton, 1998a). Barriers to participation, particularly in underserved or at-risk populations, may reduce the effectiveness of programmes (Nix, Bierman, & McMahon, 2009). Finally, cultural or contextual factors may also affect the impact of parenting programmes on target populations (Lau, 2006).

Process evaluations provide the opportunity for in-depth analyses of these implementation factors and may be particularly useful when attempting to disentangle mixed results from experiment trials (Moore et al., 2014). Quantitative assessments of programme participation may identify particular subgroup populations that are at greater risk of low programme engagement. Investigators often use fidelity checklists to determine whether interventions were delivered as designed and the extent to which programme drift occurred (Forgatch, Patterson, & DeGarmo, 2005). When process outcomes are integrated with intervention outcome evaluations, researchers may also examine the effect of implementation on programme effectiveness. For instance, high quality of delivery in parenting programmes has been linked to positive parenting and child behaviour outcomes (Eames et al., 2010; Eames et al., 2009). Qualitative methods such as interviews or focus groups with parents and practitioners may also provide additional insight regarding the mechanisms by which parents engage in programme content (Holtrop, Parra Cardona, & Forgatch, 2014). Thus, process evaluations may

contribute to our understanding of how parenting programme functions and the potential factors that might further strengthen intervention effectiveness.

Collaborative family programme development

This study also uses a collaborative family programme development model as a methodological framework for intervention development and pilot testing (Fraenkel, 2006). Originally developed to inform interventions for homeless families, this iterative process includes the following stages: (a) establishing collaborative relationships with community stakeholders; (b) intensive interviewing of family members, (c) intensive interviewing of service providers; (d) analysis of qualitative data to identify local themes and potential barriers or enablers of programme implementation; (e) development of programme format, content, and manual; (f) feasibility piloting with intended population, (g) programme revision; (h) intensive interviewing of families and service providers to assess feasibility; (i) evaluating programme effectiveness in RCTs; and (j) dissemination and adaptation of programme for other settings (Fraenkel, 2006). The collaborative family programme development model is particularly concerned with engaging vulnerable families who are often marginalised from the process of intervention development and testing. Although social scientists and professionals remain central to the process, the model attempts to address social inequalities by placing community engagement and participation at the forefront of development. At the same time, the process recognises the importance of considering existing evidence regarding problem theory, theory of change, and the effectiveness of similar interventions. As a result, it attempts to integrate existing evidence within a local context while empowering community members as active participants in the research.

Cultural adaptation of parenting programmes

This study also draws upon existing research on the cultural adaptation of parenting programmes and other social interventions (Barrera et al., 2013). Cultural adaptation may be defined as “the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings, and values” (Bernal, Jimenez-Chafey, & Domenech-Rodriguez, 2009; p.362). When developing new or adapting existing interventions for underserved populations, it is important to consider both existing evidence and local sociocultural contexts that may affect programme effectiveness and sustainability (Castro, Barrera, & Martinez, 2004). This is especially relevant in LMICs where families often live in vastly different social and cultural circumstances than those that have participated in evidence-based programmes in HICs (Kumpfer, Alvarado, Smith, & Bellamy, 2002). For instance, poverty is more severe and violence far more widespread in LMICs, and both of these compromise parenting and increase the risk of harsh parenting (Kotchick & Forehand, 2002; Krug, Mercy, Dahlberg, & Zwi, 2002). Furthermore, norms and values about parenting and family structure differ across cultures, making direct implementation of Western-developed interventions potentially problematic (Kumpfer et al., 2002). Changes in family dynamics, such as severe parental illness, absence, and death, may also negatively influence the effectiveness of parenting programmes (Foster & Williamson, 2000). As a result, key components of parenting interventions delivered from a Western perspective may be perceived as culturally irrelevant or inappropriate by parents in other contexts (Martin-Storey, 2009). Finally, due to licensing fees, lengthy accreditation processes, and complex delivery systems that require high-skilled professionals, many evidence-based and licensed parenting programmes are

prohibitively expensive for governments and non-profit organisations with limited resources in LMICs, such as those in South Africa (Mikton, 2012).

There is limited empirical research examining whether culturally adapted parenting programmes are more effective than original programmes (Castro, Barrera, & Holleran Steiker, 2010). Nonetheless, research has shown that adaptation may improve participation and retention – key indicators of programme effectiveness (Lau, 2006). Although not specifically focused on parenting interventions, some meta-analyses have found a consistent positive effect of culturally adapted behavioural programmes in comparison to controls. A meta-analysis of 76 studies reported a medium effect size for studies that evaluated culturally adapted behavioural programmes ($d = 0.45$) (Griner & Smith, 2006). Interventions that were tailored for specific population groups, contained translated programme materials, and were delivered in native languages were also more effective than those designed for a wider, more diverse population. Another meta-analysis of 65 experimental and quasi-experimental studies on cultural adaptations of mental health interventions found similar effect sizes ($d = 0.46$) (Smith, Domenech Rodriguez, & Bernal, 2011). While the review had a high heterogeneity of included studies, moderator analyses showed more rigorously adapted interventions to be more effective than those with cosmetic changes.

There are many models that propose a systematic approach to culturally adapting evidence-based programmes (Castro, Barrera, & Holleran Steiker, 2010). These models are also useful when developing and implementing evidence-informed parenting programmes in new contexts. Although cultural adaptation is often understood as the adaptation of an existing intervention, it is also possible to extract components of existing evidence-based interventions to develop new culturally relevant

parenting programmes (Chorpita, Daleiden, & Weisz, 2005). This process often utilizes the same tools and frameworks used in traditional cultural adaptation models.

In order to adapt components from evidence-based parenting programmes as part of the intervention development process, this thesis uses Barrera et al.'s five-phased approach to cultural adaptation: (a) information gathering, (b) preliminary adaptation design, (c) preliminary adaptation tests, (d) adaptation refinement, and (e) a cultural adaptation experimental trial (2013). The information-gathering phase uses a theory-driven and data-driven approach to determine the extent to which adaptation is required (Lau, 2006). This phase may include literature reviews, quantitative surveys, and formative studies with potential beneficiaries and service providers. The second phase, preliminary adaptation design, integrates findings from the first phase to inform initial adaptation of the original intervention. Unless there is overwhelming evidence from the information-gathering phase for changing essential components, this stage attempts to maintain the core integrity of the original intervention. The intervention is typically translated into the local language using idioms and metaphors that are likely to resonate with the target population. Additional culturally specific content and delivery methods may also be integrated into the programme. The third stage, preliminary adaptation tests, involves the pilot testing of the adapted intervention. Similar to the MRC framework, this stage examines issues of study feasibility, programme feasibility, and initial assessments of intervention effects on primary and secondary outcomes. The fourth phase, adaptation refinement, involves further intervention adaptation based on results from the preliminary tests. Lastly, the final phase tests the effectiveness of the culturally adapted intervention in experimental studies such as RCTs. These may either compare the programme to a control group (i.e., no intervention) or to its original format in two-armed trials. These trials are also important opportunities for testing

potential moderators of treatment effects that may be relevant to the cultural adaptation process, such as ethnicity or level of acculturation (Barrera et al., 2013).

Systematic cultural adaptation and intervention development processes such as those of Barrera et al. (2013) and Fraenkel (2006) have been employed successfully in studies on parenting programmes adapted for Latinos in North America (Borrego, Anhalt, Terao, Vargas, & Urquiza, 2006; Martinez & Eddy, 2005; Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; McCabe & Yeh, 2009). For instance, an adaptation of Parent Management Training Oregon (PMTO) followed Fraenkel's model to assess the appropriateness of programme components for Latino immigrants in the USA ($N = 83$ families) (Parra Cardona et al., 2009). Initial qualitative research found that while Latino parents were receptive to programme components, additional emphasis on respect and cultural traditions was deemed necessary to assure cultural acceptability. Subsequently, researchers conducted a pilot study with Latino families ($N = 12$) to examine the feasibility of the culturally adapted programme (Parra Cardona et al., 2012). Results indicated a high attendance rate in the adapted intervention with 91% of participants attending 9 out of 12 sessions. Participants also reported high levels of satisfaction and positive feedback on the appropriateness of programme components, principles, and activities. A further RCT study investigated how much cultural adaptation is necessary for programme effectiveness. This trial allocated families to either a minimally adapted version of PMTO, a more rigorously culturally adapted version of PMTO that included additional components for Latino families, and a wait-list control group. While there were no differences in changes in parenting behaviour between the adapted versions of PMTO, results showed significant improvements for both intervention groups in comparison to the control arm (Parra Cardona, 2015).

On the other hand, emerging evidence suggests that the costly process of cultural adaptation may not be necessary in every context. A recent meta-analytic review identified 17 randomised and quasi-randomised studies that tested the effectiveness of evidence-based parenting programmes developed in one country and transported to another (Gardner, Montgomery, & Knerr, 2015). Although focused on child problem behaviour instead of parenting outcomes, the meta-analysis found substantial effect sizes for interventions tested by RCTs ($SMD = -0.71$). Importantly, the programmes were transported with minimum adaptation beyond the translation of materials, thus indicating that the basic principles of parenting programmes may be applicable across cultures. However, this review only included one study of an intervention developed in a HIC and used in a LMIC (i.e., Iran). Thus, further research on the transferability of evidence-based parenting programmes and components is necessary.

Integrated model for intervention development and evaluation

This thesis proposes an eight-step approach to intervention development and evaluation that integrates Fraenkel's collaborative family programme development model (2006) and Barrera's cultural adaptation model (2013) within the MRC framework (see Figure 4). The first six steps of the model were directly applied in the work presented in this thesis and took place over the course of three years from 2012 to 2014.

The first three steps can be considered an extension of the Development Phase outlined by the MRC framework (i.e., Chapter Four). Step One focuses on identifying problem theory, theory of change, and existing evidence regarding the effectiveness of parenting programmes on reducing the risk of child maltreatment. Barrera's cultural adaptation model is particularly relevant during this stage when examining the literature

on potential cultural and contextual factors that might affect programme feasibility and effectiveness. Step Two involves a formative evaluation to actively engage service providers and target beneficiaries in the initial stages of programme development. It draws upon the participatory approach outlined by Fraenkel, as well as the information gathering phase of Barrera's cultural adaptation model. Methods include in-depth qualitative research in order to determine the acceptability of evidence-based approaches and content. It is also important to identify specific programme components that may need to be added or adapted to fit the local population. Step Three focuses on developing a preliminary intervention design based on findings from the literature review and formative evaluation. This phase involves balancing fidelity to existing evidence with local cultural and contextual factors in order to create an intervention that is both evidence-informed and locally relevant. During this step, one defines intervention content, structure, delivery methods, and materials in preparation for subsequent pilot testing.

The next three steps of the proposed integrated model for intervention development and evaluation are closely aligned with the Feasibility/Piloting Phase of the MRC framework. Steps Four and Five can occur simultaneously using a small-scale experimental study such as an RCT to assess the feasibility of the intervention and evaluation design. In Step Four (i.e., Chapter Five), one investigates the preliminary effectiveness of the intervention with particular concern for possible harmful effects. When conducting studies in new contexts or for different cultural groups, one may also examine the feasibility of using rigorous evaluation methods including randomisation procedures and data collection methods. Referring to Fraenkel's collaborative model, one might also engage local stakeholders to assess the acceptability of the study design, including potential ethical issues, such as withholding the intervention from participants

allocated to a control group. Step Five (i.e., Chapter Six) assesses the feasibility of the intervention design in a process evaluation. Researchers may use both qualitative and quantitative methods to examine programme acceptability, participation, and implementation. The collaborative approach continues during this step by actively explore the perceptions of service providers and participants on the cultural acceptability of programme content. In particular, it is important to highlight areas in which local cultural values or practices either promote or diminish programme fidelity and engagement, and how that might affect ultimate intervention outcomes.

Although the final three steps of the integrated model were beyond the scope of this thesis, it is important to consider them even during the initial phases of intervention development and piloting. Step Six involves intervention revision based on the results from feasibility pilot studies. One may convene a consultative workshop with programme developers and other stakeholders to determine the extent of revisions needed to strengthen intervention design. If major revisions are deemed necessary due to harmful effects, inadequate programme delivery, or poor participation, one may need to repeat to Steps Two through Five before conducting a larger evaluation. Step Seven involves the evaluation of intervention effectiveness in a large-scale individual or cluster RCT. With sufficient sample size, one may have the statistical power to conduct mediator and moderator analyses. This would allow investigators to test the conceptual model, or theory of change, proposed in Step One, as well as identify interaction effects for specific population groups. One may also examine relationships between process outcomes, such as intervention dosage or implementation fidelity, and intervention outcomes. Finally, Step Eight involves the dissemination of research findings to local stakeholders, as well as preparations for wide scale implementation of the intervention. This may include establishing sustainable organisational structures to support the

training and certification of service providers, as well as the ongoing monitoring of implementation fidelity. Although it may no longer be possible to use rigorous research methods such as RCTs when programmes are implemented at scale, one may continue to evaluate intervention outcomes on a population level through step-wedged or even simple pre-post designs.

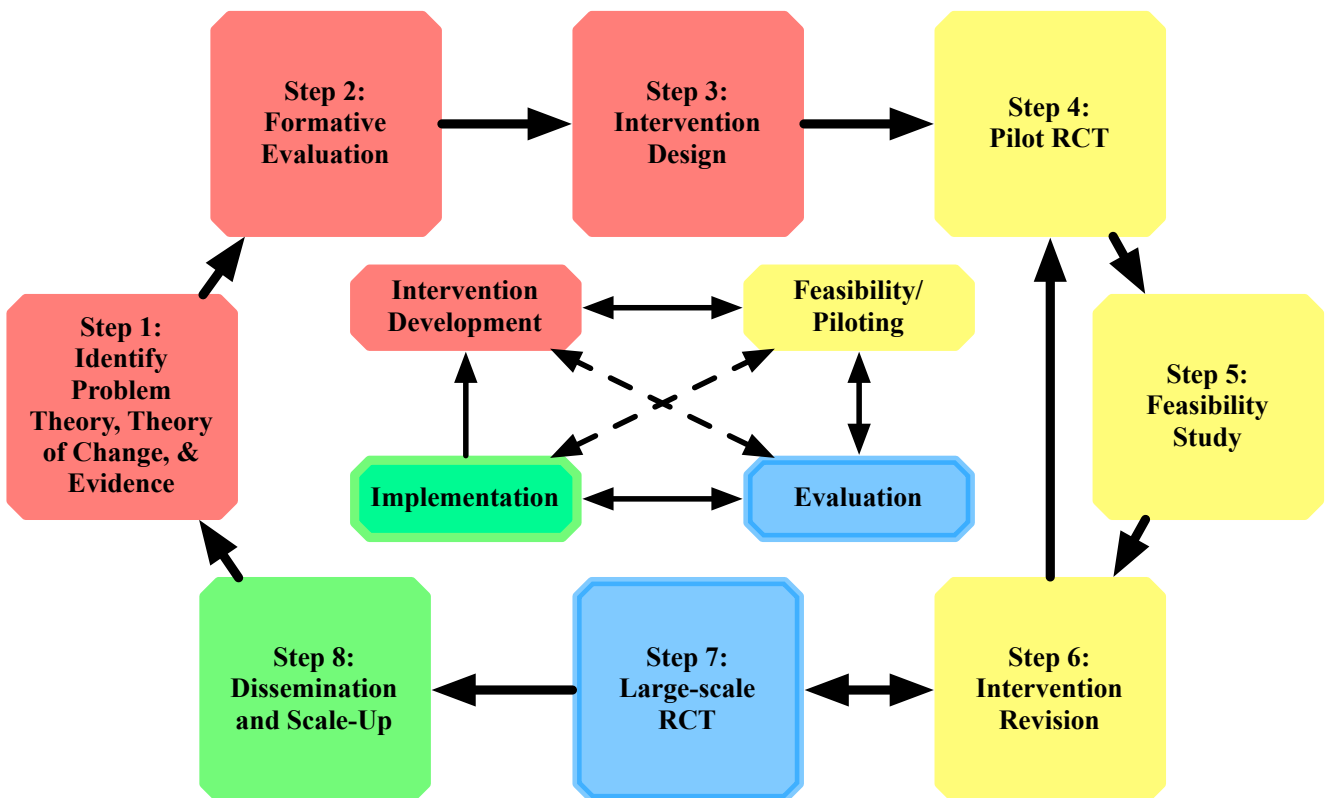


Figure 4. Integrated model for intervention development and evaluation.

Overview of Methods

Setting

This study was conducted in low-income isiXhosa-speaking communities in Cape Town, in the Western Cape province of South Africa. Study sites were areas of multiple deprivation as classified by the South African Index of Multiple Deprivation (SAIMD) 2007 (Noble, 2009). The SAIMD combines five levels of deprivation to create an overall index of multiple deprivation. These include income and materials (e.g., “number of people living in a household with a household income below 40% of the mean equivalent household income”), employment (e.g., “number of people who are unemployed”), education (e.g., “number of 18 to 65 year olds who have no school at the secondary level or above”), health (e.g., “years of potential life lost”), and living environment (e.g., “number of people living in a household that is a shack”) (Wright & Noble, 2009).

The SAIMD assesses multiple deprivation on both the municipal ward level and by data zones (Noble, Barnes, Wright, & Roberts, 2008). Data zones are comprised of approximately 2,000 people, each based on Census Enumeration Areas using geographical nesting, population size and density, and internal homogeneity. Results from the SAIMD study in 2007 indicated that the Western Cape was an area of comparatively lower deprivation than other provinces in South Africa, such as the Eastern Cape or KwaZulu-Natal. Nevertheless, data zone mapping identified areas of acute deprivation within Cape Town in the township communities previously designated as black African-only during Apartheid. Amidst the relative wealth of Cape Town, these communities – Gugulethu, Philippi, Langa, Nyanga, and Khayelitsha – lie along Cape Town’s N2 highway corridor (Noble, 2009). For instance, the Cape Town Municipal Ward 90 in Khayelitsha is characterised by the highest multiple deprivation

in the Western Cape with a Provincial Index of Multiple Deprivation (PIMD) of 420.40 (population, 32,000). Likewise, Ward 39 in Gugulethu (population, 18,000; PIMD = 382.54), Ward 34 in Philippi (population, 28,000; PIMD = 376.50), and Ward 37 in Nyanga (population, 16,000; PIMD = 376.28) are ranked the 6th, 8th, and 9th most deprived wards, respectively, in the Western Cape (see Figure 5) (Noble, 2009).

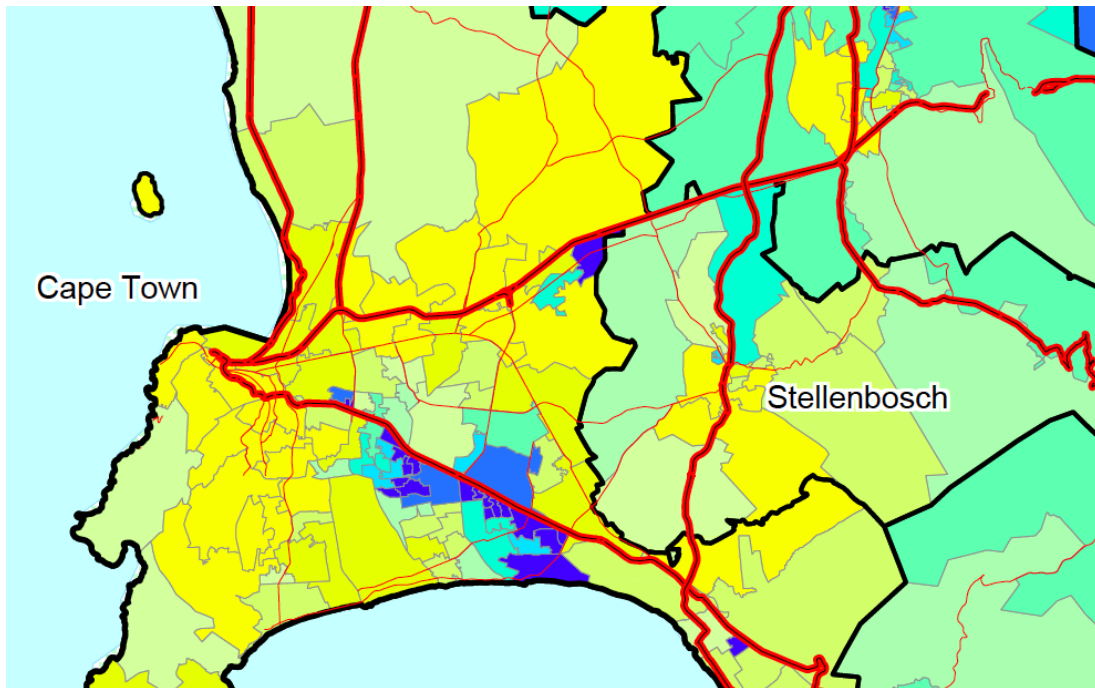


Figure 5. South African Indices of Multiple Deprivation map delineating areas of multiple deprivation in dark blue along the N2 highway corridor.

In addition to high levels of poverty, the predominantly isiXhosa-speaking townships in Cape Town are characterised by other risk factors for child maltreatment. These include intimate partner violence, drug and alcohol abuse, violent crime, and HIV/AIDS (Meinck et al., 2013). For instance, South African government statistics show adult HIV-prevalence rates of 33% from antenatal clinic testing in Khayelitsha (Department of Social Development, 2007). Likewise, a recent survey of low-income mothers in Cape Town demonstrated that 92% reported at least one form of lifetime intimate partner violence, 54% reported severe physical abuse, 92% reported being beaten, and 18% reported being the victims of child sexual abuse (Moolla, 2012).



Figure 6. Informal and formal settlements in Khayelitsha, Cape Town.

The intervention development phase of this study primarily took place in the township communities of Gugulethu, Nyanga, Philippi, Langa, Crossroads, Kuils River, and Khayelitsha. The research team worked closely with three local partner NGOs – Ikamva Labantu, Salesians Lifechoices, and the Parent Centre – to identify potential study sites and eligible participants. Parent focus groups were conducted at various community centres that were accessible to participants; individual interviews occurred in the homes of participants. Interviews with practitioners took place at the offices of partner NGOs in Khayelitsha and Wynberg, a middle-class suburb in Cape Town. Intervention development workshops were conducted at the University of Cape Town Department of Psychology and at Wolfson College in the University of Oxford.

The pilot RCT and feasibility studies were targeted exclusively at families living in Khayelitsha. Khayelitsha consists of both informal and formal settlements and contains approximately 390,000 mainly isiXhosa-speaking people (Statistics South Africa, 2012). In order to facilitate data collection and programme implementation, the

research field office was embedded in Khayelitsha at Ikamva Labantu's Health and Wellness Centre (see Figure 7). Screening of participants was conducted at the centre, as well as at food distribution sites or in participants' homes. Baseline interviews, observational video assessments, and post-test qualitative interviews also took place in the homes of participants. The parenting programme sessions were delivered at the Health and Wellness Centre, as were the post-programme focus groups with programme facilitators.



Figure 7. Ikamva Labantu's Health and Wellness Centre where the parenting programme sessions were delivered and the research field office was located.

Participants

Formative Evaluation.

Parents ($N = 97$) during the formative evaluation – Step Two of the integrated model of intervention development – were recruited using systematic, non-probabilistic sampling based on referrals from partner organisations (Mays & Pope, 1995). In order to reach potential beneficiaries who were not receiving support services, recruitment also included publicity posters and “word-of-mouth” referrals using chain-referral techniques. Community volunteers served as original informants and recruited participants through neighbourhood contacts (Biernacki & Waldorf, 1981). Although the study attempted to recruit both male and female participants in mixed groups, most participants were female ($n = 93$, 95%). This gender imbalance was not unexpected given the high ratio of females to males as primary caregivers of children in South Africa (Hosegood & Madhavan, 2010).

Inclusion criteria required parents to be isiXhosa-speaking, self-designated as primary guardians of at least one child between the ages of three and eight, and above 18 years old. In order to identify highly-vulnerable families, eligible parents were also required to have experienced at least one of the following: (a) affected by recent illness, (b) experienced recent bereavement in the family, (c) experienced family violence, or (d) experiencing behavioural difficulties with their children.

Practitioner respondents ($N = 29$) during the formative evaluation were recruited from community-based organisations in Cape Town. Inclusion criteria required respondents to have previous experience with providing services to vulnerable children and families.

Pilot RCT.

During the Pilot RCT – Step Four of the integrated model for intervention development – participants ($N = 68$) were recruited by referrals from Ikamva Labantu ($n = 47$, 69%) and from parents who participated in the formative evaluation study ($n = 21$, 31%). In order to avoid potential stigmatisation associated with poor parenting, the intervention was presented as a programme to support families experiencing difficulties with their children's behaviour. Referrals from Ikamva Labantu were based on registries of families enrolled in the organisation's orphans and vulnerable children programme (see www.ikamva.com). This programme included weekly home assessments by local community workers to determine the needs of vulnerable families within the community. The programme provided families with ongoing services that included food parcels, paralegal advice, and assistance in enrolling children at early childhood development centres.

Inclusion criteria during the pilot RCT required participants to be isiXhosa-speaking adults above the age of 18 who identified themselves as primary guardians of children aged three to eight years. These included biological parents, relatives or non-kin foster caregivers, with no restrictions on biological relationship. Inclusion criteria also required participants to reside in the same household as the child for at least four nights per week. This criterion was chosen due to evidence suggesting that primary caregivers are more likely to engage in harsh parenting and violent discipline than those who are not directly responsible for child behaviour management (Breen et al., 2015; Meinck et al., 2013). It also increased the likelihood that parents would be able to engage in home practice activities with their children during programme delivery.

Trained research assistants conducted the screening process after obtaining informed consent from the participants. Each parent was asked to select one child

between the ages of three to eight who was living in his/her household and presenting the most difficult behaviour to manage. The research assistant then administered the parent-report of the Eyberg Child Behaviour Inventory (ECBI) as a screening tool for child problem behaviour. Parents were included in the study if they reported a clinical level of 11 or more symptoms on the ECBI problem scale based on recommended cut-offs (Eyberg & Pincus, 1999). Clinical cut-offs have been utilised in prior studies on parenting programmes as a means of increasing the probability that participating families will benefit from parent management training (Gardner et al., 2006; Hutchings et al., 2007; Kjøbli & Ogden, 2012; McGilloway et al., 2012; Sanders, Markie-Dadds, Tully, & Bor, 2000). Moreover, since corporal punishment is a normative strategy for child behaviour management in the South African context, selecting families that reported elevated levels of child problem behaviour increased the likelihood that participants had a high risk of child maltreatment. Finally, participants or their children exhibiting acute mental health problems or evidence of severe abuse were excluded from the study and referred to social services ($n = 1$ parent was excluded from the study due to severe mental health problems). Although multiple caregivers per child could participate in parenting programme, only one parent per household was recruited to participate in the study.

Feasibility study.

The feasibility study – Step Five of the integrated model for intervention development – took place at the same time as the pilot RCT. Parent interviewees were randomly selected from a subset of study participants who had attended at least one session of the parenting programme ($n = 15$). Focus groups were also conducted with the facilitators who delivered the intervention. These facilitators were employees of the service provider, a local non-profit organisation called Clowns Without Borders South

Africa. Employment criteria required facilitators to be isiXhosa-speaking parents, have prior experience facilitating groups, and have received basic training in early childhood development. Although the service provider attempted to recruit male facilitators, none were employed during the job interview process.

Ethical considerations

This section briefly describes the ethical considerations applied in this study. Maintaining the highest ethical principles regarding the treatment of participants is an essential aspect of conducting research. Grounded in the Hippocratic principle of “First Do No Harm”, researchers need to be cognisant of the potential impact that conducting a study may have on participants (Chalmers, 2003). This involves (a) obtaining informed consent to participate in the study; (b) assuring the confidentiality and anonymity of data shared by participants; (c) being aware of power dynamics and unequal relationships that may exist between researchers and participants; (d) making study participants aware of the consequences of participation, including potential risks and harm that may occur either from involvement in the evaluation or the intervention; and (e) mitigating the impact of any adverse events that might happen to either participants or research personnel during the course of the study (British Psychological Society, 2000).

Although the non-involvement of investigators is a guiding principle in experimental research, one occasionally may be ethically obligated to intervene in the lives of study participants, especially in the context of conducting research in resource poor areas such as South Africa. For instance, researchers may encounter conditions of extreme poverty or severe physical and mental illness that may require assistance beyond the objectives or capacity of the evaluated intervention. Furthermore, during data collection or programme implementation, participants may disclose serious life

threatening or damaging events such as rape, exposure to HIV, or severe child abuse and neglect that require an immediate response and referral to appropriate social services. Finally, there may be instances in which confidentiality must be broken due to ethical issues regarding child protection (Nama & Swartz, 2002).

Guidelines.

Guidelines for ethical protocols for this study included sources from the UK (i.e., the British Psychological Association, 2006) and South Africa (i.e., the Department of Health Research Ethics Guidelines 2004, the Department of Health Guidelines for Good Clinical Practice in South Africa 2006, the National Health Act, 2003 (Act 61 of 2003), the Children's Act, 2005 (Act 38 of 2005), the Children's Amendment Act, 2007 (Act 41 of 2007) and the Sexual Offences Act, 2007 (Act 32 of 2007)).

Training of research staff.

Implementing a rigorous evaluation design required research staff to have a strong understanding of ethical protocols. These included obtaining informed consent, explaining randomisation procedures, conducting unbiased outcome and process assessments, and maintaining blinding of allocation. In addition, research assistants were required to follow the study's strict referral procedures, especially concerned with child protection issues and confidentiality around HIV-status.

All field staff participated in a training workshop led by the D.Phil. candidate (60 hours). This workshop covered numerous topics including the ethical conduct of research with adult and child participants, the protection against harm for respondents, and protocols on health and safety, child protection, and HIV/AIDS. The workshop also included training on referral procedures and how to manage disclosures of abuse, neglect, violence, rape, and ill health. The D.Phil. candidate also explained each stage of the research project and every assessment tool so that research assistants understood

the constructs of the measurements as well as their administration and potential impact on participants. The research assistants' level of competency in following informed consent and data collection procedures was ascertained by conducting individual performance assessments with each assistant as well as monitoring research in the field. When competency levels were judged to be insufficient, additional training was provided.

Informed consent.

In the context of conducting research in LMICs, it is important to verify that informed consent procedures are conducted in an understandable and non-threatening manner. Potential participants in underserved communities often have difficulties reading, thus requiring research staff to verbally explain the study and their rights to refuse participation with no penalties. This may create an unequal power dynamic in which participants may feel obliged or even pressured to give consent without adequately understanding the study. Language may also be a barrier to understanding complex scientific concepts and procedures involved in randomisation, data collection, and treatment allocation. Poorly administered informed consent procedures might result in high study dropout if participants are unaware of what is required from their involvement (Osrin et al., 2009).

In this study, the informed consent process was conducted by trained research staff with over five years of experience working with vulnerable families in low-income communities in South Africa. All consent and information forms were read aloud in isiXhosa to participants. Participants were told they had the right to decline to participate, and that they could drop out at any time. In the pilot RCT study, the randomisation procedures and wait-list control design were explained carefully to the participants. Information sheets also outlined the intervention structure and expectations

regarding involvement in the programme. Participants were also informed that any information they provided would remain confidential, except in cases where significant harm to themselves or others were disclosed. Confidentiality procedures included the use of non-personally identifying ID numbers instead of names on research materials and the maintenance of data in locked computer databases and filing cabinets. Contact procedures for follow-up interviews were also explained to participants. Even if participants refused to participate in the study, they were offered information and referrals to health or social services. All participants were given a telephone contact number to call if they had any questions or concerns. Finally, in order to avoid stigma, no project materials or informed consent forms mentioned ‘HIV’, ‘AIDS’, ‘intimate partner violence’, ‘abuse’, or ‘maltreatment’.

Incentives.

Studies in HICs often use financial rewards such as gift cards or cash to incentivise participation in parenting programmes and RCTs (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005). Given the low-resource context and limited budget of this study, such an approach was not feasible. Moreover, providing financial incentives for programme participation would have compromised the external validity of the study by reducing its scalability. Nevertheless, although no financial rewards were made for participation, a variety of methods were used to encourage involvement. A nutritious lunch was provided during data collection and programme sessions. Each study participant also received a certificate and a donated toy for her child at the end of the study. Parents who participated in the intervention also received a certificate of completion at the end of the programme. Finally, parents who participated in the qualitative interviews during feasibility study received a small food parcel consisting of tea, sugar, and maize meal.

Mitigating potential risks of harm.

The focus of this study was to develop and evaluate the impact of a parenting programme to reduce the risk of child maltreatment in low-income families. Therefore it was likely that the overall potential benefits of the research and intervention in improving family wellbeing outweighed risks of harm against participants.

Nevertheless, two levels of potential harm were considered: participation in the research study and participation in the intervention.

In terms of participating in the research study, there was a possibility that the opportunity to discuss family difficulties might have prompted distress (Alderson & Morrow, 2004). Communicating about mental health issues, intimate partner violence, and child maltreatment may also cause psychological distress to either adult or child respondents. Implementing new parenting skills at home had the potential to exacerbate conflict between family members. Furthermore, breaches in confidentiality would have exposed respondents to potential harm, such as stigmatisation and even violence, from partners, peers, and other community members.

This study had the following protocol in order to respond to disclosure of abuse as well as reduce any risk of parents or children becoming distressed.

- All participants were informed at the consent stage that everything they said was confidential unless it became clear that they or their children were at risk of significant harm.
- As in all research, there was a possibility that participants would take the opportunity to disclose difficult living circumstances or abuse. This study recognised that researchers had a responsibility towards parents and children if information disclosed suggested that they were at risk of severe harm.

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- The two co-principal investigators supervised referrals, which were directed through our partner organisation, Ikamva Labantu.
 - Ikamva Labantu had a rigorous referral procedure that included support services from social workers, psychologists, and paralegal staff.
 - The research team discussed the possibilities for referral to the Department of Social Development, Child Welfare, or other mental health organisations with Ikamva Labantu staff.
 - Although no participants reported rape in the prior 72 hours, immediate action would have been taken to ensure post-exposure prophylactic medication.
 - All households in the study received resource sheets of local health and social services as well as contact numbers of Lifeline, Childline, and HIV helplines.
 - In order to protect confidentiality of the participants from the stigma associated with HIV/AIDS and intimate partner violence, interviews were conducted in as much privacy as possible.

Risks of harm from participating in the intervention was also considered and monitored throughout this project (Lorenc & Oliver, 2014). Statistical analyses used two-tailed tests examine potential negative and positive intervention effects. Research participants were also monitored during intervention implementation to assess whether participation placed them or any other individuals at risk of harm. The qualitative focus groups and interviews also explored potential risks due to participation in either the intervention or the pilot RCT study.

During the course of the study, there were no reported cases of severe abuse or rape. However, three participants were referred to social services in order to access government grants and food support because of their high levels of deprivation. One participant in the control group was also referred to the community partner's early

childhood development programme due to her four-year-old child presenting extremely violent and aggressive behaviour at home and in the community. Since this information was disclosed after baseline data collection, the participant remained in the study due to the intention-to-treat design.

In addition, research with vulnerable families can result in increased stress on research staff due to participants disclosing difficult personal information as well as the demands of maintaining rigorous study procedures. All research personnel received instruction in stress reduction and coping techniques as part of their initial training. This training was provided by the D.Phil. candidate, who is a trained facilitator in Mindfulness Based Stress Reduction (Kabat-Zinn, 2013). Weekly debriefing meetings with research personnel were also conducted to discuss any potentially distressing events that may have occurred during data collection. Staff participated in one-on-one reviews at the end of each data collection wave in order to assess performance as well as their psychological and other personal needs. Furthermore, one of the study principal investigators, Associate Professor Catherine Ward, was a clinical psychologist and available for consultation in order to mitigate any potential harm to research staff and implementing partners.

Conducting research in high-crime, low-resource settings.

Conducting research in South African also involves potential risks of harm to research personnel. As mentioned above, Khayelitsha is a high-crime area where armed robbery, vehicle hijacking, sexual assault, and homicide occur at high rates (South African Police Service, 2014). In recent years, Khayelitsha has also been characterised by frequent political action over service delivery issues and police brutality. These community actions are often accompanied by violent protests including burning vehicles and looting.

The safety of fieldwork staff was of paramount concern in this study. All fieldwork staff members were trained in awareness and safety measures for research in resource-poor, high-violence environments. This included training in risk avoidance and driving awareness to reduce the likelihood of hijacking. Furthermore, the research staff did not undertake assessments in any situation in which they felt uncomfortable or unsafe, and were encouraged to travel in pairs in less safe areas. An emergency notification protocol was also followed in the event of community-wide violence. Our community partner, Ikamva Labantu, notified the research management team if the community was unsafe. If data collection was currently underway, all personnel were immediately evacuated and remained in contact with the research manager (i.e., the D.Phil. candidate) until in a safe location outside of Khayelitsha. Fortunately, with the exception of one instance of armed robbery, none of the staff was personally injured or harmed during the course of the study.

Approval.

This study was granted ethical approval by University of Oxford Central University Research Ethics Committee (ref SSD/CUREC2/11-40) and the University of Cape Town Psychology Department Research Ethics Committee (refs 2012_05_01 and 2012_12_01). The CUREC ethics application, amendments, approval letters, and trial registry protocols may be found in Appendix C, pages 340-389.

Study designs

Paper One: Intervention development.

The intervention development phase of this study involved the first three steps of the proposed integrated model: Step 1: identify problem theory, theory of change, and existing evidence; Step 2: conduct a formative evaluation study with target beneficiaries and practitioners; and Step 3: integrate findings from the previous steps to

develop intervention content, structure, and delivery methods. For more information about data collection and analysis procedures during the intervention development study, see Chapter 4, pages 123-127.

The formative evaluation was grounded in community based participatory research methods (CBPR). CBPR has been used widely as a means to engage disadvantaged and vulnerable populations in intervention development (Parra Cardona et al., 2009; Wainberg, Alfredo Gonzalez, et al., 2007). CBPR approaches attempt to redress existing power imbalances between researchers and community members (Jones & Wells, 2007). This may be particularly relevant in South Africa given its political and social history of inequality and institutional discrimination (Lazarus, Bulbulia, Taliep, & Naidoo, 2015). Instead of imposing solutions from academic institutions traditionally regarded as elitist and white-dominated, CBPR provides a platform for previously disempowered community members to be active participants in the development of interventions delivered in their communities. CBPR also regards local community members as equal stakeholders with knowledge and expertise that is essential to create locally relevant interventions with strong community participation (Cornwall & Jewkes, 1995).

This study used community-based participatory research methods to actively involve local stakeholders in the early intervention development process. In order to engage a diversity of perspectives, data was collected from multiple sources in low-income communities in Cape Town. This included conducting semi-structured focus groups ($n = 10$ focus groups; $n = 86$ parents) and individual interviews ($n = 11$) with low-income parents as well as focus groups with local practitioners ($n = 4$ focus groups; $n = 29$ practitioners). Parents were specifically recruited from similar communities as the intended beneficiaries of the eventually developed parenting programme. Likewise,

the research team engaged practitioners with levels of expertise similar to the community workers who were recruited and trained to deliver the programme during the pilot. Interviews were conducted using an open-ended, collaborative approach to solicit views from respondents (Glaser & Strauss, 1999). Facilitators followed an interview guide structured around three grand themes: (a) experiences of parents, (b) parenting programme content, and (c) service delivery issues (Parra Cardona et al., 2009).¹⁰

The first theme focused on the daily challenges that low-income parents experienced in providing care for their children. It also explored existing strategies that parents used to cope with these challenges. Focusing both on perceptions of social norms and individual parenting practices, interviewers also encouraged respondents to describe how parents disciplined their children. Although the focus of this study was to develop a programme to reduce the risk of child maltreatment, the interviews did not directly address this theme in order to avoid influencing the perceptions and attitudes of parents and practitioners regarding harsh parenting. Finally, this theme explored existing cultural values that influenced perceptions regarding the roles and responsibilities of parents.

The second theme examined respondents' views regarding content necessary for inclusion in parenting programmes delivered to low-income families. This step was structured around a priori defined intervention components identified from the literature review. Topics included (a) responding to children's needs, (b) parent-child interaction, (c) discipline and supervision, and (d) education and social behaviour. Parents were asked to indicate which components they perceived would be most useful and to

¹⁰ To review the interview schedules and protocols used during the formative evaluation, see Appendix D, pages 390-397.

provide reasons why they should be included in parenting programmes. During this theme, interviewers actively encouraged respondents to offer additional topics for inclusion. These emergent topics were then included in subsequent interviews and focus groups. Throughout this theme, interviewers also investigated potential cultural values that might affect programme acceptability when designing parenting interventions for South African families.

In the final theme, interviewers facilitated a discussion about service delivery issues that might affect programme participation and implementation. Subthemes included (a) strategies for programme recruitment; (b) whether programmes should be targeted at specific beneficiaries or more universally delivered; (c) potential barriers and enablers of programme participant and engagement; (c) preferences regarding programme activities, length, timing, and setting (e.g., home-based or group sessions); (d) and the training required to provide skills to programme facilitators.



Figure 8. Focus group with parents in Philippi during the formative evaluation.

Paper Two: Pilot RCT.

The second paper of this thesis focused on Step 4 of the proposed integrated model for programme development and intervention: pilot testing of evaluation feasibility and initial intervention effects. This section provides an overview of the study design and assessment measures. For a summary of measures, please see Table 2, page 98. For more detailed information about data collection and analysis procedures, please see Chapter 5, pages 160-172.

Evaluation feasibility.

This study used an RCT design to test the feasibility of conducting a larger experimental trial of the developed parenting programme in the South African context. Lancaster et al (2004) suggests that pilot studies should adhere as closely as possible to the eventual protocols of subsequent experimental trials. This includes using similar recruitment methods, inclusion criteria, randomisation procedures, outcome measures, and statistical analyses that will be used in the larger study (Moore, Carter, Nietert, & Stewart, 2011).

The following evaluation feasibility outcomes were examined in this study: (a) the recruitment and retention rates of participants, (b) the suitability and effectiveness of randomisation procedures, (c) the reliability and response rates of parent-report and observational data collection methods, and (d) the potential effect of clustering due to delivering the intervention in groups of parents. Recruitment rates were calculated based on the number of potential participants who were contactable, met the inclusion criteria, and enrolled in the study after consenting to participate. Randomisation feasibility included examining the blinding of assessors and the extent of group contamination. Retention rates were calculated based on dropout at any stage during the study. The study also examined the reliability of self-report and observational

measurements used to assess intervention outcomes. Response rates were analysed based on the extent of missingness of data on the item and scale level. Finally, potential clustering within the intervention group was examined by assessing the intra-cluster correlation coefficient (ICC) on primary and secondary outcomes.

Preliminary intervention effects.

The pilot RCT study also examined the preliminary effectiveness of a parenting programme designed to reduce the risk of child maltreatment in low-income families with children aged three to eight years. In addition to testing evaluation feasibility outcomes, pilot RCTs may provide initial signs of treatment effects and indications of potential clinical relevance (Thabane et al., 2010). They also may detect instances of significant harm that require adjustments to study protocols and intervention approaches, or even the cancellation of larger experimental studies.

The pilot RCT study selected outcomes based on the problem theory and theory of change models mentioned in the above literature review (see Figures 1 and 2, pages 47 and 60, respectively). Demographic factors included those related to the identified risk and protective factors for child maltreatment in South Africa and other LMICs. As potential mechanisms of change, primary and secondary intervention outcomes were also selected based on their associations with reduced risk of child maltreatment. There were also outcomes that evidence-based parenting programmes have shown to be effective in addressing. Primary outcomes were parent-report and observational assessments of harsh parenting, positive parenting, and child behaviour problems. Secondary outcomes were parenting stress, parental depression, and perceived social support. The following sections describe the outcomes used in the pilot RCT.

Table 2. Summary of outcome measures used during the pilot RCT.

Outcome	Measurement	Items
Evaluation feasibility outcomes		
Recruitment and retention	Enrolment registers and completed questionnaires	
Effectiveness of randomisation	Extent of blinding and contamination	
Reliability of outcome measures	Cronbach's alpha and inter-cluster coefficients	
Response rates	Little's Missing Completely at Random test	
Within-group clustering	Intra-cluster correlation coefficients	
Demographic factors		119
Parent and child demographics	SA General Health Survey	17
Household poverty	Economic Asset Index	9
	Hunger Scale	3
	Self-report on receipt of government grants	5
Intimate partner violence	Revised Conflict Tactics Short Form	11
Parent history of child maltreatment	International Child Abuse Screening Tool-Retrospective Version	10
Parent health	Demographic and Health Survey	14
Parent HIV-status and/or AIDS sickness	Self-report; Verbal Autopsy Questionnaire	18
Child AIDS-related orphanhood	Parent-report; Verbal Autopsy Questionnaire	18
Parent physical disability	Washington Group on Disability Stats	7
Parent substance abuse	WHO Alcohol, Smoking, and Substance Screening Tool	7
Primary outcomes – Parent-report		77
Harsh parenting	Parent-Child Conflict Tactics Scale	27
Positive parenting	Parenting Young Children Scale	14
Child behaviour problems	Eyberg Child Behaviour Checklist	36
Primary outcomes – Observational assessments		n/a
Positive parenting	Sinovuyo Observation Coding Scale	n/a
Effective parenting	Sinovuyo Observation Coding Scale	n/a
Negative parenting	Sinovuyo Observation Coding Scale	n/a
Positive child behaviour	Sinovuyo Observation Coding Scale	n/a
Negative child behaviour	Sinovuyo Observation Coding Scale	n/a
Child-led play	Sinovuyo Observation Coding Scale	n/a
Secondary outcomes – Parent-report		44
Parenting distress	Parenting Stress Index-Short Form	12
Parental depression	Beck Depression Inventory	21
Perceived social support	Multidimensional scale of perceived social support	12

Socio-demographic variables.

Socio-demographic variables were selected from the individual and microsystem levels of the ecological framework. Individual caregiver factors included age, gender, level of education, marital status, employment status, source of income, parental substance abuse, disability, physical illness, HIV-positive status or AIDS-related illness, experience of intimate partner violence, and parental history of abuse in childhood. Use of alcohol and other substances was assessed using the WHO Alcohol, Smoking and Substance Screening Tool (ASSIST; 10 items) (Humeniuk et al., 2008). Parental disability was measured using items recommended by the Washington Group on Disability Statistics from the Centres for Disease Control and Prevention (6 items) (Madans, Loeb, & Altman, 2011). Parental physical illness was assessed using items from the Health Systems Trust South African Health Review 2006 (Ijumba & Padarath, 2006) and the South African Demographic and Health Survey (Department of Health & Medical Research Council, 2007) (16 items). The Verbal Autopsy was used to determine caregiver HIV-positive status and AIDS-related illness based on a conservative approach requiring the presence of 3 or more AIDS-related symptoms defined by the WHO (i.e., oral candidiasis, respiratory tract infection, and persistent diarrhoea; VA; 18 items) (Lopman et al., 2006; World Health Organization, 1994). Parental experience of intimate partner violence within the previous month was measured using the Revised Conflict Tactics Short Form scale (CTS2S; 10 items) (Straus & Douglas, 2004). Lastly, parental history of child maltreatment in their families of origin was assessed using an adapted version of the International Society for the Prevention of Child Abuse and Neglect's Child Abuse Screening Tools-Retrospective Version (ICAST-R, 11 items) (Dunne et al., 2009).

On the microsystem level, child and family factors included child age, gender, school attendance, relationship to parent, AIDS-orphanhood status, household size, household structure, and poverty. Child AIDS-orphanhood status was determined using the same approach as described above for parental HIV-status and AIDS-related illness. As a proxy for household poverty, food insecurity in the previous month was measured using the Hunger Scale Questionnaire (9 items) (Labadarios et al., 2003). Household poverty was also assessed based on the number of government support grants that the family received.

Harsh parenting.

Many studies on child maltreatment assess harsh parenting outcomes using a combination of the following types of measurement: official government rates of reported abuse, parent-report or child-report measures, and observational assessments (Chen & Chan, 2015). Official reports of abuse were not practical were due to unreliable reporting and monitoring systems in South Africa (Makoe, 2009). Child-report assessments were also not used due to the young age of children included in this study (Alderson & Morrow, 2004). On the other hand, both self-report and observational assessments of harsh parenting were included in the pilot RCT.

There are many different parent-report assessment tools that measure child maltreatment and harsh discipline. These include, but are not limited to, the Parent-Child Conflict Tactics Scale, the Child Abuse Potential Inventory, the International Child Abuse Screening Tool-Parent Version, and items from the UNICEF Multiple Indicator Cluster Survey (Milner, 1986; Runyan et al., 2009; Straus et al., 1998; UNICEF, 2014). Although each scale has its own merits, the Parent-Child Conflict Tactics Scale (CTSPC; 27 items) was selected due to its previous application in an RCT of a parenting programme in a LMIC (Oveisi et al., 2010). The CTSPC has also been

used to assess harsh parenting in South Africa with families affected by HIV/AIDS and intimate partner violence (Moolla, 2012; Mueller, Alie, Jonas, Brown, & Sherr, 2011). The CTSPC produces an overall assessment of harsh parenting as well as subscales measuring psychological aggression, physical assault, neglect, and nonviolent discipline. A previous study in Cape Town showed good internal consistency of the overall scale ($\alpha = .76$), thus indicating its potential reliability as a measurement in a similar context (Moolla, 2012).

Positive parenting.

There are also many assessment tools used to measure positive parenting behaviour. A recent review identified 52 instruments that assess parental nurturance based on parent-report, youth-report, or both (Locke & Prinz, 2002). In this study, the Parenting Young Children Scale (PARYC, 14 items) was selected due to its specificity regarding the key parenting skills that the Sinovuyo programme attempts to address (McEachern et al., 2011). For instance, the positive parenting subscale measures the frequency of how often parents praise their children's behaviour. Likewise, the limit-setting subscale measures the frequency of child behaviour management techniques such as establishing enforceable rules. While the PARYC is a relatively new assessment tool with no previous use in LMICs, the validation study of the scale demonstrated consistent negative associations with child behaviour problems.

Child behaviour problems.

There are three main instruments that use parent-reports of child behaviour problems: the Eyberg Child Behaviour Inventory (ECBI), the Strengths and Difficulties Questionnaire (SDQ), and the Child Behaviour Checklist (CBCL) (Achenbach & Ruffle, 2000; Eyberg & Ross, 1978; Goodman, 2001). Although each assessment tool has been previously administered in studies in South Africa, the ECBI (36 items) was selected

due to its extensive use throughout the world as a diagnostic tool to evaluate parenting programmes in RCTs (Gardner, Shaw, Dishion, Burton, & Supplee, 2007; Hutchings et al., 2007; McGilloway et al., 2012; Reid et al., 2001; Sanders, 2008). The ECBI measures the frequency of a child externalising behaviour and whether the parent considers the behaviour to be a problem. In the context of reducing the risk of child maltreatment, the problem scale may be particularly useful. As mentioned in the literature review, a meta-analysis demonstrated large effects for increased risk of physical abuse when parents view their children as problematic (Stith et al., 2009). The ECBI showed strong internal consistency in a previous study in Cape Town ($\alpha = .89$) (Moolla, 2012).

Observational assessments.

This study also used observational assessments to examine potential intervention effects on parenting and child behaviour. Observational assessments are often considered more objective and reliable than self-report instruments since they may be less susceptible to reporting biases (Aspland & Gardner, 2003). Moreover, the combination of observational and parent-report approaches provides a more robust assessment of behaviour change using multiple perspectives to examine intervention effectiveness (Gardner, 2000). Many evaluations of parenting interventions have used observational tools to independently measure treatment effects (e.g., Gardner, Shaw, Dishion, Burton, & Supplee, 2007; Hutchings et al., 2007; McGilloway et al., 2012; Reid et al., 2001; Sanders, 2008). Examples include the Dyadic Parent-Child Interaction Coding System (DPICS) (Eyberg & Robinson, 2000) and the Family Observation Scale (FOS) (Sanders, 1996). For instance, a RCT of the Incredible Years with socioeconomically disadvantaged families in Ireland ($N = 149$) used the DPICS to

independently assess child problem behaviour, child positive behaviour, positive parenting, and critical parenting (McGilloway et al., 2012).

During initial preparations for this trial, it was determined that existing tools were too complex to be used by research assistants with limited clinical expertise. For example, the use of an interval time sampling method to code 36 behaviours in the DPICS ($n = 36$) was viewed as too difficult to apply in practice without considerable training and support. After an extensive review process of observation measures, the DPICS was selected to be adapted into a simpler coding system. Adaptation was conducted by an Honours student from the University of Cape Town Department of Psychology (Mlotshwa, 2013). The adaptation process involved consultations with isiXhosa research assistants to reduce the complexity of the DPICS system by either collapsing or eliminating codes. Codes were eliminated if they did not conform with isiXhosa communication norms or common use of language. For example, research assistants advised that Xhosa parents rarely use “descriptive questions” or “critical statements” when communicating to children. Codes were collapsed in order to increase the frequency of coding certain behaviours while reducing the number of items to code. For example, “critical statements” and “negative commands” by parents were combined into one behavioural subcategory called “parent-negative verbal” in the new system.

The final version of the coding system – the Sinovuyo Observational Coding System (SOCS) – is based on five primary categories: (a) positive parenting, (b) effective parenting, (c) negative parenting, (d) positive child behaviours, and (e) child deviance. Positive parenting behaviours are either positive verbal and nonverbal parent behaviour directed towards the child. Examples of positive verbal behaviour include statements of affection and words of praise or approval. Positive nonverbal behaviour include physical expressions of affection such as hugs, smiles, or clapping of hands as

to encourage or celebrate a child's accomplishment. Effective parenting refers to parenting behaviours that are conducive to positive child behaviours. These include appropriate use of consequences or positive commands. Negative parenting behaviours include negative verbal (e.g., critical statements, negative commands, or threats of punishment), indirect commands (e.g., unclear instructions that do not identify a specific child behaviour), and negative physical (e.g., intrusive or harmful parent-initiated contact such as pinching, slapping, or hitting). Positive child behaviours include compliance to instructions, positive verbal communication to either a parent or oneself (e.g., expressions of warmth, pleasure, or gratitude), and positive nonverbal behaviour (e.g., smiles, laughter, or child-initiated hugs or kisses). Child deviance refers to noncompliance, negative verbal communication, and negative physical behaviour. Negative verbal communication is coded when the child uses disrespectful language towards the parent, whined, or cried. Negative physical behaviour includes harmful or destructive behaviours towards an object, parent, or oneself. Finally, assessors also record the level of engagement in child-led play as a coder impression of positive parenting based on a Likert scale from 1 to 3 (i.e., 1 = parent directed interaction; 2 = shared parent-child interaction; 3 = child-directed interaction) (Mlotsha, 2013).

A SOCS manual was developed by Ms Mlotsha to code the behaviours in the video assessments. This manual explains each behavioural category in detail and provides illustrative examples as a guide for coders. For example, verbal behaviours follow a "one sentence rule" in which a clearly defined sentence is coded as a single instance (e.g., "Good job for finishing the puzzle"). Furthermore, both physical and verbal behaviours are coded as separate instances if they occur at the same time. Likewise, simultaneous positive/negative parent and child behaviours are coded separately. If a behaviour continues without pause for more than five seconds, assessors

use a “five second rule” in which behaviours are recorded as a new instance after every five seconds.

Research assistants received 40 hours of training prior to conducting observational assessments in the homes of participants with both the parent and child present. Researchers used handheld video recording devices to capture parent-child interaction (i.e., cell phones with a video camera function). At the beginning of the assessment, research assistants instructed parents to involve their children in a number of activities that included free play (10 minutes), tidying up (up to 5 minutes), preparation of food (up to 5 minutes), and eating a small snack (5 minutes). At the end of each activity, the research assistant prompted the parent to move onto the next activity with minimal interruptions. Although parents and children were required to be in the same room at the beginning of the assessment, no further restrictions were placed on their movements. If a parent and child became separated during the assessment, the research assistant moved the camera between the two of them in order to record the behaviours of both participants as much as possible (for observational assessment scripts and manual, see Appendix G, pages 423-428).

Two students fluent in isiXhosa from the University of Cape Town Department of Psychology followed the SOCS manual while coding the behaviours from the video recording. Coding of each video assessment took approximately 20-25 minutes. Assessors then coded ten videos twice to establish intra-rater reliability based on intra-class correlation coefficients. Coding of videos were conducted at least seven days apart. The coder with the higher intra-rater reliability was designated as the criterion coder. In order to determine inter-rater reliability, both raters coded the same ten videos each. Coding continued until assessors achieved at least an inter-cluster correlation

coefficient threshold of 0.70 as an acceptable level of inter-rater reliability (Aspland & Gardner, 2003).

Secondary outcomes¹¹

The pilot RCT also assessed parenting stress, parental depression, and perceived social support as secondary outcomes related to risks of child maltreatment. Parenting stress was measured using the Parenting Distress subscale of the Parenting Stress Index-Short Form (PSI-SF, 12 items) (Abidin, 1995). This parent-report scale has been used widely throughout the world (Anderson, 2008; Leung, Leung, Chan, Tso, & Ip, 2005; McGilloway et al., 2012; Oburu & Palmerus, 2003; Schneider & Foucault, 2009), including prior use in South African populations (Moolla, 2012; Potterton, Stewart, & Cooper, 2007). In the recent study on women affected by intimate partner violence in Cape Town, the PSI-SF had strong internal consistency ($\alpha = 0.88$) (Moolla, 2012).

Parental depression was measured using the Beck Depression Inventory (BDI-II) (Beck & Steer, 1988). The BDI-II is a 21-item parent-report scale designed to assess the intensity of depression for both clinical patients and the general population. It has been translated into isiXhosa and validated with rural families living in the Eastern Cape province of South Africa (Steele, 2003). This validation study found excellent internal consistency ($\alpha = 0.93$) in a population of 122 isiXhosa-speaking adults. It has also been used in other studies with South African populations (Ward, Flisher, Zissiz, Muller, & Lombard, 2009), populations affected by HIV/AIDS (Murphy, Marelich, Armistead, Herbeck, & Payne, 2010), and to assess parental mental health in randomised controlled trials of parenting interventions (Gardner et al., 2006; Hutchings et al., 2007; McGilloway et al., 2012; Sanders et al., 2000).

¹¹ Although the theory of change model included parent sense of self-efficacy and sense of competence, these measures were removed from the final questionnaire due to the length of assessments and redundancy with other measures such as the Parenting Stress Index.

Finally, the Multidimensional Scale of Perceived Social Support (MSPSS, 12 items) was used to measure parents' perceptions of social support (Dahlem, Zimet, & Walker, 1991; Zimet, Powell, Farley, Werkman, & Berkoff, 1990). This parent-report scale has been used previously in LMICs, including a recent study of caregivers in high HIV-prevalent areas of South Africa (Kuo et al., 2012) and a cluster RCT of a parenting intervention for mothers in Pakistan (Rahman, Malik, Sikander, Roberts, & Creed, 2008).



Figure 9. Research assistant conducting post-test data collection in Khayelitsha.

Paper Three: Feasibility study¹²

The third paper of this thesis focused on Step 5 of the integrated intervention development and evaluation model, feasibility testing. It was a process evaluation examining programme feasibility based on three dimensions: acceptability, implementation, and participation. The study used a mixed methods approach based on the ontological and epistemological framework of *pragmatism* (Johnson & Onwuegbuzie, 2004). Pragmatism provides a middle ground between relativism and positivism in which knowledge is both constructed based on theory and grounded in physical reality. Instead of abstract philosophical theories, it values practical theories, such as theory of change models, that can be applied to real world situations and solutions to social problems. Pragmatism also offers practical approaches to answering research questions without placing hierarchical value on the superiority of qualitative or quantitative methods. It also acknowledges that different research methods may be more appropriate to answering specific research questions and often combines inductive and deductive processes. For instance, while quantitative methods during feasibility studies are useful to examine descriptive information regarding programme implementation, qualitative methods may provide a more in-depth explanation of underlying processes involved in assessing feasibility (Creswell, 2003).

Mixed-methods research often integrates quantitative and qualitative data using one of three approaches: merging, connecting, or embedding (Creswell, Klassen, Plano Clark, & Smith, 2011). Merging data involves the integration of qualitative and quantitative data, typically in a discussion section of a study. This approach uses triangulation to increase the validity of results while considering areas in which

¹² For more detailed information about the data collection and analysis procedures used during the feasibility study, see Chapter 6, pages 198-211.

qualitative or quantitative data converges or diverges. Connecting data involves using qualitative methods to inform the collection of quantitative data or vice versa. This is usually conducted in a sequential manner whereby results from one phase inform the research questions of the next phase. Lastly, embedding data normally situates one method within the other such as using qualitative data to provide a deeper understanding of quantitative results from an experimental trial (Creswell et al., 2011).

Mixed method studies often integrate merging, connecting, and embedding approaches, especially when using pragmatic approaches to address specific research questions. For instance, the entire thesis is structured using a mixed methods sequential embedded design. The formative evaluation used qualitative data to inform the development of a parenting programme. Next, the preliminary effects of the programme on reducing the risk of child maltreatment were quantitatively tested during the pilot RCT study. Finally, the process evaluation merged quantitative and qualitative data to assess the feasibility of the intervention based on three theoretical dimensions: participation, implementation, and acceptability (see Figure 10).

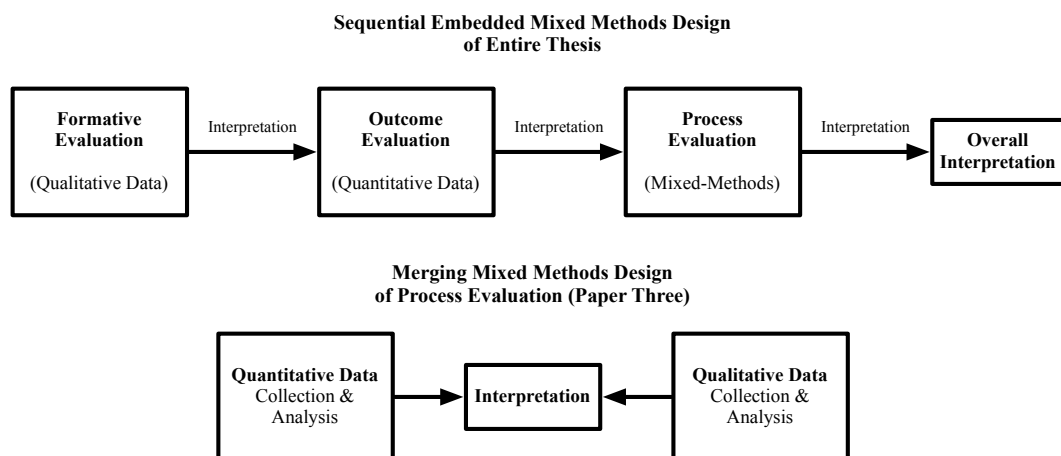


Figure 10. Practical applications of pragmatic mixed methods research designs.

Quantitative data.

Participation

Participation – the extent to which participants enrol, attend, and engage in a programme – has been shown to be an important component in determining intervention feasibility and understanding its effectiveness or null effects (Andrews & Dowden, 2005). Interventions often fail to achieve positive results when applied in real-world settings due to poor participation of intended beneficiaries (Axford, Lehtonen, Kaoukji, Tobin, & Berry, 2012). Moreover, the most vulnerable families who might require parenting training support more urgently often do not participate in programmes (Dumka, Garza, Roosa, & Stoerzinger, 1997). Low enrolment and attendance may be due to various logistical barriers including scheduling conflicts, child care, and transportation. In addition, parent characteristics such as low socioeconomic status, depression, lack of self-efficacy, or alcohol and substance use, may reduce participation (Dumas, Nissley-Tsiopinis, & Moreland, 2007). Furthermore, target beneficiaries may perceive that parenting programmes are not relevant to their lives or do not address their concerns, thus leading to low enrolment and attendance rates as well as high dropout (Baker, Arnold, & Meagher, 2011).

There is considerable research linking parenting programme attendance and completion rates with intervention outcomes (Kazdin & Wassell, 1998; Prinz & Miller, 1994). For instance, a meta-analysis of parenting programmes found a positive effect of consistent attendance on reducing child behaviour problems (Lundahl, Risser, & Lovejoy, 2006). A study of a parenting programme for rural families in the US ($N = 209$) demonstrated that higher rates of attendance were associated with improvements in child management behaviours and parent-child relationships for both mothers and fathers (Spoth & Redmond, 1996). Another study in the US of a parenting programme

delivered to predominantly low-income parents ($N = 455$) found associations between the high quality of participation in programmes and reductions in physical punishment, as well as improvements in parental warmth, positive perceptions of the child, and school involvement (Nix et al., 2009). Interestingly, attendance rate was not associated with parenting outcomes, thus suggesting that the quality of engagement in programmes may be more relevant than participation alone.

In the current process evaluation study, participation was assessed by examining rates of enrolment, attendance, completion, dropout, and engagement. Enrolment was based on the number of participants who attended at least one programme session. Attendance was based on the number of sessions received by enrolled parents. “Number of sessions received” was defined as either participating in a group session or receiving an individual home consultation during the same week as the group session. This study used an attendance rate of at least 66% or 8 sessions to determine an acceptable overall rate of programme attendance (Webster-Stratton & Herman, 2010). Programme completion was defined as having attended at least 50% of programme. Programme dropout was defined as having missed a minimum of three consecutive sessions without returning to the programme.

Programme engagement was assessed by examining transcripts from parent group sessions. During each session, parents reported whether they were able to implement the assigned home practice activities from the previous week. A research assistant recorded written transcripts of these feedback sessions each week. These transcripts were then analysed to determine whether the parents completed their home practice assignments according to the intervention protocol. A weekly rate of engagement was calculated based on the ratio of completed assignments to the number of parents in attendance during the session. Finally, an overall rating of engagement

was determined by summing each weekly rate. Although it is possible that non-attendees also completed the home activities, the study was only able to examine engagement based on those in attendance at any given session.

Programme fidelity.

When assessing the feasibility and effectiveness of an intervention, it is also important to measure implementation fidelity (Bellg et al., 2004). This may be particularly useful when examining null effects of interventions. Non-significant results may either be a result of programme ineffectiveness, because the programme was not implemented as intended, or a combination of both (Borrelli, 2011). Moreover, fidelity measurements in pilot trials enable researchers to assess whether a programme will be feasible during larger trials (Lancaster et al., 2004). While treatment fidelity typically encompasses programme design, training, delivery, receipt, and enactment, this study primarily focused on the delivery aspects of implementation in terms of adherence to programme protocols and quality of delivery (Borrelli et al., 2005).

Implementation fidelity was quantitatively measured by examining facilitator self-report checklists. In order to produce a basic level of fidelity, a ratio of programme implementation to programme design was created (Moncher, 1991). A standard of 80% programme fidelity was considered as “high treatment fidelity” (Borrelli et al., 2005). The accuracy of self-report checklists was also verified by examining a random sample of four programme videos per facilitation team.

Programme acceptability.

Lastly, programme acceptability was quantitatively assessed using a 40-item questionnaire adapted from the *Incredible Years Parent Program Satisfaction Questionnaire* (Webster-Stratton, 1989). This survey investigated the perceptions of parents regarding whether the programme fulfilled their expectations, the acceptability

of delivery methods, the acceptability of parenting skills, and the quality of programme facilitation. Overall satisfaction ratings were based on summing items from parents who attended at least one session.

Qualitative data.

Qualitative data during the feasibility study was collected from four sources: post-programme interviews with parents (n = 15), post-programme focus groups with facilitators (n = 8), transcripts from parenting group sessions, and minutes from facilitator supervision sessions. The feasibility study used a similarly structured interview guide as the formative evaluation.¹³ Interviewers examined the following themes in an open-ended approach: (a) perceived changes in parenting style, child behaviour, and parent-child relationships; (b) existing barriers to participation during sessions and engagement in skills at home; and (c) the acceptability and appropriateness of program content, delivery, and structure. Interviews also investigated the extent to which parents and facilitators understood specific parenting skills taught during the programme, how often were they used, and whether they found the skills useful. In addition, the focus groups with programme facilitators investigated barriers to programme delivery as well as issues regarding training, supervision, and institutional support during implementation.

¹³ The interview guide for the feasibility study is included in Appendix H, pages 429-435.

CHAPTER FOUR. PAPER #1: Integrating Evidence and Context to Develop a Parenting Program for Low-Income Families In South Africa¹⁴

Published: Lachman, J. M., Sherr, L., Cluver, L., Ward, C. L., Hutchings, J., & Gardner, F. (2016). Integrating evidence and context to develop a parenting program for low-income families in South Africa. *Journal of Child and Family Studies*, 25(7), 2337-2352. doi: 10.1007/s10826-016-0389-6

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This research was funded by the John Fell Fund (n°103/757), the World Health Organization (n°SPHQ12-APW-851), and the European Research Council under the European Union's Seventh Framework Programme (FP7/2007-2013; ERC grant agreement n°313421).

¹⁴ This paper has been written using US spelling to be in alignment with the journal's submission guidelines.

Abstract

Children living in low- and middle-income countries, such as South Africa, face elevated risks of child maltreatment. Although evidence-based parenting programs have been shown to reduce rates of abuse in high-income countries, few studies have examined their effectiveness in low- and middle-income countries. Moreover, local cultural contexts may require the adaptation of evidence-based approaches in order to assure program acceptability and effectiveness. This study focused on the systematic development of an evidence-informed, locally relevant parenting program for socioeconomically disadvantaged families with parents of children aged three to eight years, in Cape Town, South Africa. Intervention development took place over three stages: (a) identification of common core intervention components in evidence-based parenting programs, (b) formative evaluation using qualitative in-depth interviews and semi-structured focus groups with local practitioners and low-income parents, and (c) development of intervention structure, format, and protocols. The process resulted in a manualized, group-based, 12-session parenting program that integrated existing evidence of effective components within a local, culturally relevant context. Recommended next steps are rigorous piloting to test feasibility and preliminary intervention effects followed by experimental trials to examine intervention effectiveness in a real-world setting.

Key words: Child maltreatment, intervention development, parenting programs, formative evaluation, South Africa

Introduction

Positive parent-child interaction is an essential requirement for positive early childhood development (Eshel, Daelmans, de Mello, & Martines, 2006). Children who receive positive reinforcement and involvement, warmth and affection, and consistent nonviolent discipline are more likely to achieve their developmental potential, learn pro-social skills, and make a meaningful contribution to society (Kotchick & Forehand, 2002). They are also more likely to transfer these skills to their own children, thus strengthening the intergenerational transfer of positive parent-child relationships and child development (Belsky, Jaffee, Sligo, Woodward, & Silva, 2005).

On the other hand, inconsistent and abusive parenting is linked to maladaptive behaviors in children as well as negative adolescent and adult outcomes (Patterson et al., 1989). This is particularly concerning in low- and middle-income countries (LMICs) where children experience high levels of violent discipline and psychological aggression (UNICEF, 2014). For instance, in South Africa, a recent survey using child-report data in low-income contexts found lifetime prevalence rates of 55% for physical abuse and 36% for emotional abuse with caregivers as the primary source of abuse (Meinck et al., 2016). These findings are supported by other surveys from LMICs that report that 70% of children between the ages of two and 14 years experience harsh parenting in the home (UNICEF, 2010). Furthermore, harsh discipline and corporal punishment are often considered normative parenting practices in LMICs (Lansford & Deater-Deckard, 2012).

Delivering programs that prevent or reduce violence against children during early childhood is increasingly becoming a global public health issue (Mikton et al., 2014). Systematic reviews have demonstrated promising evidence that parenting programs that strengthen positive parent-child relationships reduce the risk of child

maltreatment while improving child wellbeing in families with young children (Barlow et al., 2006; Furlong et al., 2013). However, there is limited evidence for such programs from LMICs (Knerr et al., 2013; Mejia, Calam, & Sanders, 2012). Furthermore, although a recent meta-analysis showed that evidence-based parenting programs may be equally effective when transported to another country, only one identified study was in a LMIC (Iran) (Gardner et al., 2015). In South Africa, the dissemination of evidence-based approaches is very limited; a review of current parenting programs implemented has shown that few are based on the theoretical frameworks that underpin effective programs or incorporate strategies known to be effective (Wessels & Ward, 2015).

It is important that parenting programs delivered in LMICs are culturally relevant to potential beneficiaries and practitioners in order to assure acceptability, feasibility, and effectiveness (Castro et al., 2004). Families in LMICs often live in vastly different social and cultural circumstances than those who have participated in evidence-based programs in high-income countries (HICs) (Kumpfer et al., 2002). As a result, key components of parenting interventions delivered from a Western perspective may be perceived as culturally irrelevant or inappropriate by parents in other contexts (Martin-Storey, 2009). Furthermore, poverty and violence are far more widespread in LMICs, and both compromise parenting and increase the risk of harsh parenting (Kotchick & Forehand, 2002; Krug et al., 2002). Norms and values about parenting and family structure may also differ across cultures, making direct implementation of Western-developed interventions potentially problematic (Kumpfer et al., 2002). For example, economic migration coupled with the HIV/AIDS pandemic in South Africa has resulted in an extended foster care system in which the primary caregivers are often neither biological parents nor blood relatives (Bray & Brandt, 2007). Changes in family circumstances, such as severe parental illness, absence and death, may also negatively

influence the effectiveness of parenting programs (Foster & Williamson, 2000). Finally, due to licensing fees, program costs, training requirements and the need for high-skilled professionals as practitioners, many evidence-based parenting programs are prohibitively expensive in LMIC contexts such as South Africa (Mikton, 2012).

The main objective of our study was to develop a parenting program to reduce the risk of child maltreatment and improve child wellbeing in low-income families with young children in Cape Town, South Africa. We used the United Kingdom Medical Research Council's framework for designing and evaluating complex social interventions as a foundation for program development (Craig et al., 2008). This paper reports on the framework's development phase, which includes three key stages in preparation for pilot feasibility testing. In Stage One, we examined meta-analyses, distillation studies, and specific interventions to identify core evidence-based components regarding content and delivery that are derived from theory-driven behavior change approaches. In Stage Two, we engaged local practitioners and parents in Cape Town in a formative evaluation to inform program development. We used a collaborative model for community-based program development to assess stakeholder perceptions of content necessary for inclusion in programs (Fraenkel, 2006). In Stage Three, we integrated findings from the previous stages in order to establish a balance between fidelity to existing evidence and fit to the local population (Castro et al., 2004). This stage involved the development of the content and structure of the program, including the manualization of intervention protocols (see Figure 4, Page 75).

Stage One: Identifying Core Intervention Components

Stage One focused on identifying the core intervention components associated with evidence-based parenting programs. Although still in its nascent stage, there is an emerging body of literature examining effective components of parenting programs, including systematic reviews, distillation studies, meta-analyses, and reviews on implementation. First, we examined systematic reviews to identify parenting programs with strong evidence for improving parenting behavior and reducing child behavior problems (Barlow et al., 2006; Chen & Chan, 2015; Furlong et al., 2013; Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009). Interventions with robust evidence included the Incredible Years (Webster-Stratton & Reid, 2003), Parent-Child Interaction Therapy (Eyberg et al., 1995), Parent Management Training-Oregon (Forgatch et al., 2013), and Triple P Positive Parenting Program (Sanders, 2008). These programs share a common theoretical foundation based on social learning theory principles which views harsh or ineffective parenting as contributing to the development of child behavior problems (Bandura, 1977). They also use similar approaches that focus on building positive parent-child relationships prior to learning nonviolent discipline strategies (Hanf, 1969). By improving the quality of parent-child relationships through positive parenting, children are less likely to misbehave. This reduces the needs of parents to enforce limits and use potentially violent disciplinary methods. Parents also learn to regulate their own emotions while replacing harsh and inconsistent parenting with nonviolent and consistent discipline strategies (Hutchings et al., 2004).

Next, we examined studies that used a distillation and matching model approach to determine the frequency of certain behavior change techniques or strategies in evidence-based treatments (Chorpita et al., 2005). While limited in their ability to

establish causality or isolate the effect of a specific component, these studies provide an overview of the most common elements associated with positive intervention effects. For instance, in a survey of 322 randomized controlled trials of child mental health treatments (not limited to parenting interventions), the top five most frequently occurring practices in evidence-based programs addressing externalizing behavior problems included praise, time-out, tangible rewards, positive commands, and problem solving (Chorpita & Daleiden, 2009). As a result, these elements were considered to be essential techniques for inclusion in an evidence-informed parenting program.

In addition, we examined a meta-analysis of 77 studies that investigated the effects of parenting program components on parenting behavior and child behavior problems (Kaminski et al., 2008). Results indicated that the inclusion of emotional communication, consistent responsive parenting, and the practicing of parenting skills with children was associated with larger effect sizes for improving parenting behavior than programs without those components. Additionally, programs that included content on positive parent-child interaction, parental responsiveness, problem solving, time-out, and practicing of skills with children during training sessions were also associated with larger effect sizes for reductions in child behavior problems.

Finally, we considered additional implementation factors that might improve participation and engagement. In contrast to more didactic learning approaches, common delivery methods of evidence-based parenting programs include group-based problem solving, collaborative facilitation processes, modeling with videos, and the practicing of parenting skills (Snell-Johns, Mendez, & Smith, 2004). Furthermore, adequate training and supervision of program facilitators were identified as essential program components to assure implementation fidelity and quality of delivery (Sethi, Kerns, Sanders, & Ralph, 2014). Lastly, important factors to promote high participation

of parents in programs includes providing incentives for recruitment, establishing strong community partnerships, and assuring that programs were accessible to low-income parents (Axford et al., 2012).

We then convened a series of meetings with the authors to construct the following theory of change model, drawing upon the aforementioned systematic reviews, meta-analyses, and distillation studies to develop a parenting program in South Africa. Evidence-based components and delivery methods were hypothesized to lead to proximal adult outcomes. These included improved positive parenting, as well as reduced harsh parenting and ineffective discipline (Furlong et al., 2013). In addition, improvements in parent-child relationships during parenting programs have been linked to improvements in parental mental health (Barlow et al., 2002; Bennett et al., 2013). They may also increase parental sense of competence, self-efficacy, and social support (Armstrong et al., 2005; Gardner et al., 2006; Leung et al., 2003). Parenting interventions have also been shown to directly affect distal child outcomes such as reducing child behavior problems via improvements in adult outcomes (Gardner et al., 2010). Improvements in child behavior may also reduce the likelihood of abuse due to increased compliance and prosocial behaviour (Pardini et al., 2008). Finally, both parent and child outcomes contribute to the overall reduction in risk of child maltreatment (see Figure 10).

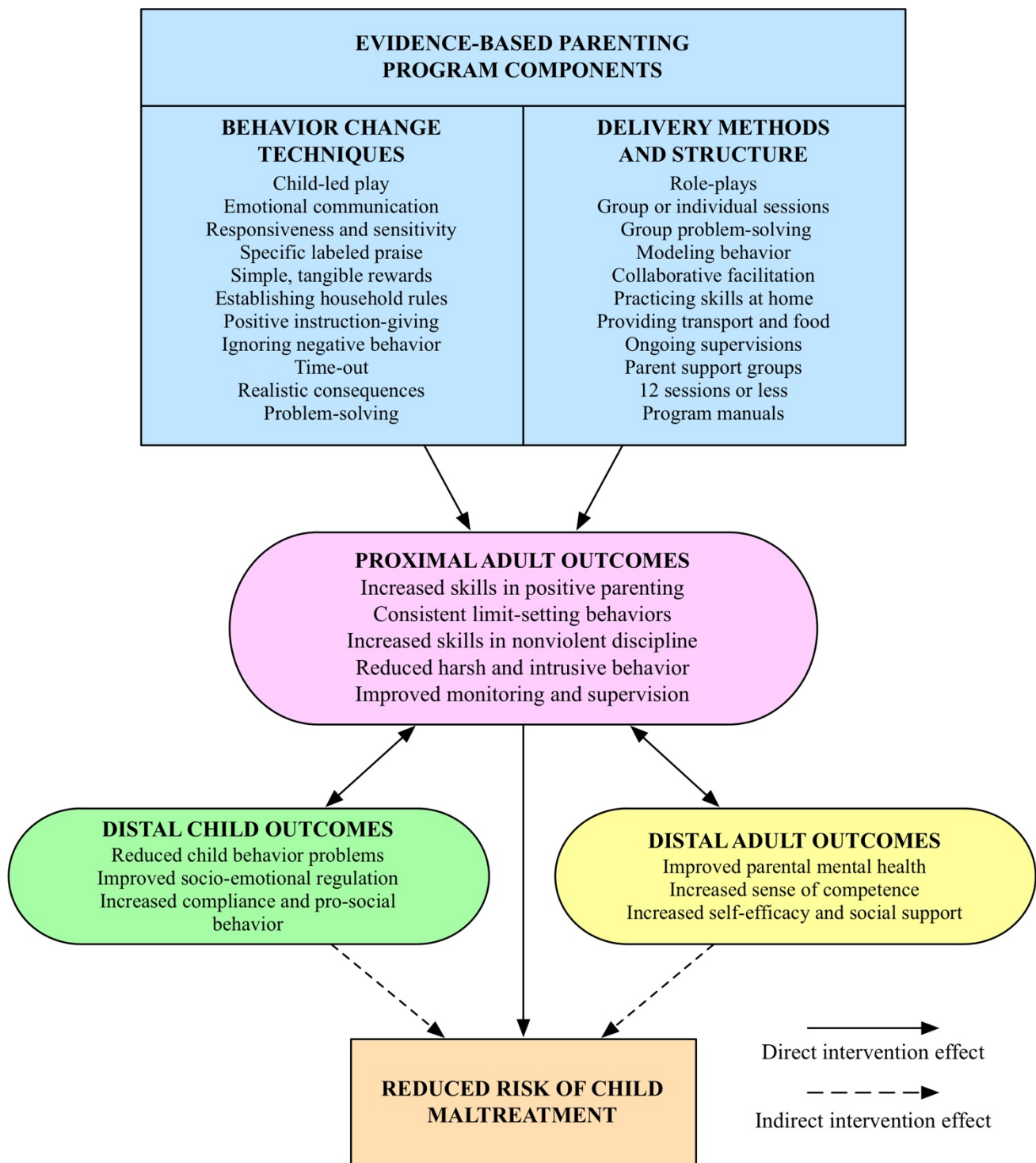


Figure 11. Parenting program theory of change to reduce risk of child maltreatment.

Stage Two: Formative Evaluation

Stage Two used participatory approaches to engage community stakeholders in the development of the program for low-income families in South Africa (Fraenkel, 2006). By engaging local parents and practitioners in the process of program development, this stage aimed to reduce potential barriers to participation by identifying factors likely to increase program acceptability (Kazdin, 2000). We focused on three main research questions: (a) what are the perceptions of low-income parents and practitioners regarding content necessary for inclusion in parenting programs in South Africa; (b) what are the potential cultural and contextual factors that may affect program acceptability; and (c) what are potential barriers and enablers to program implementation and participation?

Stage Two: Methods

Setting and recruitment.

This qualitative formative evaluation was conducted in low-income, predominantly isiXhosa-speaking communities in Cape Town¹⁵. These communities are characterized by high levels of unemployment, crime, and HIV-prevalence, poor educational and health resources, and limited access to basic sanitation (Statistics South Africa, 2012). Data were collected from multiple sources: parent interviews ($n = 11$), parent focus groups ($n = 10$; 86 participants), and practitioner focus groups ($n = 4$; 29 participants). While the focus groups provided an opportunity to examine a diversity of parents' and service providers' perceptions and behaviors, the interviews allowed a more in-depth understanding of the perception of parents regarding content necessary for inclusion in parenting programs. Parents were recruited via referrals from local

¹⁵ IsiXhosa is an indigenous South African language and is also one of the three official languages of the Western Cape, the province in which Cape Town is located.

community organizations, by word-of-mouth, and through chain-referral sampling. Inclusion criteria required parents to be isiXhosa-speaking, aged 18 years or older, and self-identified as the primary person responsible for a child aged three to eight years. Practitioners were community workers recruited from local non-governmental organizations that provide services to disadvantaged children and families. Inclusion criteria for practitioners required respondents to have previous experience delivering family programs in low-income communities.

Data collection.

The study protocol was approved by the ethics committees from the University of Oxford (ref SSD/CUREC2/11-40) and the University of Cape Town (ref 2012_05_01). All data collection instruments were translated into isiXhosa, and the translations checked by back-translation. After giving informed consent, participants completed a brief demographic survey assessing age, gender, housing conditions, employment status, and a three-item household hunger scale as a proxy for socioeconomic status (Labadarios et al., 2003). Trained research assistants conducted all of the interviews and focus groups with parents in isiXhosa. Focus groups with practitioners were conducted in English. Interviews lasted 60 minutes and took place in participants' homes; focus groups lasted approximately 120 minutes and were conducted in local community centers. Interviews and focus groups were audio recorded, transcribed verbatim, and translated into English. Research assistants also recorded simultaneous written notes in English. Participants were provided with lunch and transportation to focus group venues.

Interview guide.¹⁶

Interviewers used an open-ended approach that followed an interview guide divided into three broad questions. The first question explored respondents' perceptions regarding content for inclusion in parenting programs in low-income communities. Interview participants were presented with a range of themes based on existing literature on the content of evidence-based parenting programs (i.e., discipline, communication, safety, responding to children's needs). They were then asked to describe the importance and relevance of each theme for inclusion in parenting programs delivered to low-income families in their community. The second question investigated how local cultural values might inform program acceptability. The third question explored potential barriers and enablers of participation. The guide for focus groups was structured similarly to the interview guide, with the exception that respondents participated in an interactive exercise to identify important themes for inclusion in parenting groups. Respondents wrote different themes on notecards and then placed these themes closer or further away from an image of a family depending on how important they perceived them to be included in a parenting group. Each respondent had the opportunity to move the cards around and explain their reasoning for placement. Written transcripts were examined immediately following each interview and focus group in order to identify additional emergent themes (Corbin & Strauss, 2008). These themes were then included in subsequent data collection. For instance, investigating the role of fathers as caregivers was not originally part of the guides but rather included following the initial interviews and focus groups when this was raised as an important issue by respondents.

¹⁶ Interview guides and protocols for focus groups and interviews can be found in Appendix C.

Data analysis.¹⁷

The research team used a thematic approach within an experiential framework to manually analyze qualitative data (Braun & Clarke, 2006). Two independent raters examined the transcripts using an initial open coding procedure to identify emergent themes or concepts from the data. If there were any queries as a result of translation or context, these were clarified with professional translators. These themes were then grouped into larger themes, or categories, using axial coding based on the perceptions of respondents regarding content for inclusion in parenting programs, as well as potential barriers or enablers of program participation and delivery. After consensus was reached between the coders regarding the emergent themes, we re-examined the transcripts for coherent patterns and divergent viewpoints. Particular attention was given to contrasting views and variations emerging from the data, and how these divergent viewpoints existed on a continuum of attitudes and behaviors. For instance, the category, “Addressing corporal punishment and other discipline strategies,” contained variations in how parents engaged in corporal punishment and their perceptions of its necessity for effective child behavior management. These categories were then integrated using selective coding into a larger theoretical representation of the shared experiences and perspectives of the participants (Corbin & Strauss, 2008). Findings were then discussed within the research team with a particular focus on the validity and representativeness of individual themes. Finally, we selected data extracts to represent key themes identified from the data.

¹⁷ Qualitative data analysis was conducted manually during the formative evaluation and feasibility study of this thesis. Although using Computer Assisted Qualitative Data Analysis (CAQDAS) might have been more efficient and transparent, the D.Phil. candidate and secondary raters elected to use a more tactile approach to spatially analyse and conceptualise data (Jones, 2007). The use of a word processor for qualitative data has been shown to be an equally valid approach in order to code data and retrieve text (Fielding & Lee, 1998). Furthermore, coding with CAQDAS may inhibit researchers’ ability to achieve sufficient analytical distance to accurately identify emergent themes and categories (Gilbert, 2002).

Stage Two: Results

The majority of respondents were female (parents: 95.9%; practitioners: 93.1%), middle-aged (parents: $M = 38.43$ years; practitioners: $M = 44.90$ years). Parents lived in more crowded households, cared for more children, and experienced higher levels of economic hardship than practitioners. More than half of the parents were unemployed, about one-third reported that they had experienced household hunger more than five times in the past month, and over two-thirds lived in informal dwellings (e.g., corrugated tin shacks without running water). Finally, one quarter of the parents reported experiencing violence as a child and almost half reported experiencing intimate partner violence in the previous month (see Table 2).

Table 3. Characteristics of interview and focus group participants.

	Parents ($N = 97$)	Practitioners ($N = 29$)
Parent age, M (SD)	38.43 (14.90)	44.90 (12.36)
Parent gender, n female (%)	93 (95.9)	27 (93.1)
Number of people in household, M (SD)	6.80 (2.91)	4.69 (1.89)
Number of children in household, M (SD)	3.35 (2.09)	1.97 (1.43)
Type of household structure, n informal (%)	58 (67.4)	25 (86.2)
Employment status, n employed (%)	47 (48.5)	29 (100.0)
Level of education completed, grade, M (SD)	9.57 (2.63)	10.55 (2.40)
Experience hunger ≥ 5 times in previous month, n (%) ¹	27 (31.4)	3 (11.1)
Parent experienced violence as child, n (%)	24 (25.3)	-
Parent experienced intimate partner violence in previous month, n (%)	44 (45.8)	-

¹ Based on the Hunger Scale Questionnaire (Labadarios et al., 2003)

Thematic analyses of interviews with parents and practitioners identified seven key topics for inclusion in parenting programs: (a) learning how to manage difficult

child behavior, (b) addressing corporal punishment and other discipline strategies, (c) building positive relationships with children, (d) keeping children safe in dangerous communities, (e) coping with parenting stress, (f) communicating about HIV/AIDS and bereavement, and (g) involving fathers in caregiving responsibilities. Data analyses also highlighted the importance of framing content within a local cultural context of social responsibility and respect. Finally, specific recommendations were made regarding potential barriers and enablers of participation and delivery.¹⁸

Content for parenting programs.

Learning how to difficult child behavior.

“You can never feel yourself as a parent because they do not obey you,” (parent #3, interview).

Learning how to manage child behavior problems was a dominant theme throughout the interviews and focus groups. Parents considered their current parenting approaches to be ineffective in reducing persistent disruptive child behavior (e.g., disrespect, defiance, stealing, violent behavior, and tantrums), which was linked to a low sense of parental self-efficacy and increased stress in their lives. Furthermore, parents generally recognized that their children’s negative behavior was directly linked to their own actions: “You must be the first one to know the right way to behave” (parent #18, focus group). Using the metaphor of a mother crab teaching her children to move sideways (i.e. negatively) instead of forwards, one parent echoed a commonly perceived awareness of reciprocal behavior modeling: “It is said when a crab is moving sideways, its young ones also move sideways” (parent #5, interview).

¹⁸ The number of illustrative quotes were constrained by word limitations of the journal where this paper was submitted. As a result, additional quotes regarding each them are provided in Appendix I.1, pages 436-445.

Addressing corporal punishment and other discipline strategies.

“I beat them because my parents beat me. I don’t know of any other way”
(parent #70, focus group).

Although corporal punishment was perceived as normative, parents reported a wide range of attitudes towards harsh discipline. Some respondents viewed corporal punishment as an integral part of a parent’s responsibility to teach children appropriate behavior. For instance, one mother believed that “a child that is not beaten doesn’t listen to anyone, and doesn’t care about other people,” (parent #48, focus group). Others reported using a combination of verbal commands with violent discipline as a last resort to enforce compliance. Some parents also explained that they used corporal punishment because they lacked alternative skills. Others expressed a desire to break the intergenerational transfer of harsh parenting skills: “The way I grew up, my mother being so rough, I do not wish to raise my children that way” (parent #10, interview). Even those who used corporal punishment were generally receptive to learning nonviolent discipline strategies: “It would be a great help to learn ways to teach your child respect without hitting,” (parent #40, focus group). In fact, many of these practices already existed amongst the respondents. One mother described how she began using nonviolent techniques when she realized that corporal punishment was ineffective: “I once beat my child, but then I saw that it was not working. Now I have a chart with a star and a sad face” (parent #17, focus group). Another parent incentivized positive behavior by using rewards: “I don’t beat my child. I take him out when he behaves well” (parent #48, focus group).

Building positive relationships with children.

“A child feels free when playing with you” (parent #44, focus group).

Respondents articulated the need to learn how to build positive relationships with their children as an important mechanism of improving child behavior and increasing cognitive and social development. Parents described how playing with their children developed a sense of mutual trust and open communication. Others explained how using verbal encouragement increased child compliance. For example, one parent explained: “I praise my child for the good he has done so he can do more good things” (parent #4, interview). However, another parent said that she lacked the skills or time to engage in positive parent-child interaction: “I’d love to get some advice on how to play with a child. I’m just watching her if she plays on her own” (parent #10, interview). Likewise, practitioners noted that parents struggled to praise their children: “Parents find it hard, as they were not praised themselves. How can they give what they never had?” (practitioner #3). Furthermore, respondents explained that isiXhosa parents living in low-income communities often struggled to find the time to engage in positive parent-child interaction due to other domestic responsibilities: “In our culture, playing with kids is unheard of. There are lots of chores, so there is no time for playing” (practitioner #4).

Keeping children safe in dangerous communities.

“A child must not let the sun set on her. She must be in the home” (parent #8, interview).

Respondents expressed concern about child safety in communities characterized by violent crime, sexual violence, substance abuse, and delinquency. Perceived threats to child safety were due to two main factors: potential violence against children (particularly girls) and the negative influence on boys of other adolescents’ deviant behavior. As a result, parents highlighted the importance of learning techniques to encourage children to play near their homes or in other safe places. Some of these skills

already existed in the community. For instance, some parents described how they used social networks to share child-monitoring responsibilities, “If I am not around, I leave them with my cousin. We look after them together” (parent #4, interview). Others articulated strategies that combined positive relationship-building and child safety: “I protect her by knowing what she likes most in the house. I tell her that I love her” (parent #7, interview). Nevertheless, child safety was perceived as a significant source of parenting stress and a high priority in potential programs.

Coping with parenting stress.

“You mess up many things when you are stressed.... It needs to be controlled” (parent #56, focus group).

Respondents expressed the need to learn effective stress management techniques from parenting programs. Many parents described how severe socioeconomic deprivation contributed to elevated levels of anxiety and stress: “At my home nobody is working. When we have no food, stress is really gnawing me” (parent #22, focus group). Parents reported a sense of inadequacy in their ability to provide for their children: “It is very painful to see your child want something that you don’t have” (parent #19, focus group). Respondents also expressed difficulties in coping with increased stress due to family conflict, illness, and bereavement. In addition, respondents articulated the interconnectedness between high levels of stress and harsh parenting behavior, including yelling at their children, threatening abandonment, and violent discipline. Some parents shared that they avoided parental responsibilities and often resorted to alcohol and drug use as a means of coping with stress. Others reported positive coping mechanisms, including listening to music, talking to friends, and attending church. Moreover, respondents generally accepted the utility of sharing these coping strategies as well as learning new techniques of stress reduction.

Communicating about HIV/AIDS and bereavement.

“I don’t speak about heavy matters with my children. I don’t know how” (parent #7, interview).

Respondents generally agreed about the importance of learning how to communicate with their children about sensitive topics such as HIV/AIDS and bereavement. For instance, some parents reported fears concerning disclosure regarding either personal or child HIV-status. One grandmother described how she struggled to maintain privacy while managing her child’s antiretroviral treatment: “I tried to say to her, ‘you must not tell others what the pills are for. You must only say they are for asthma. Although me and you know what they are for” (parent #67, focus group). Furthermore, respondents identified the need for parents to learn developmentally appropriate ways of discussing these issues with children. Parents suggested that these discussions should be situated within a larger context of improving parent-child communication and problem-solving. This was largely due to perceived social stigma associated with HIV/AIDS and orphanhood.

Involving fathers in caregiving responsibilities.

“A father must know the needs of a child. A father must protect and show love. A father must teach respect” (practitioner #18).

When asked whether programs would benefit from involving fathers and other male caregivers, respondents were in overwhelming agreement. However, some parents believed that men would resist participation since childcare was perceived to be part of the female domain: “Fathers do not like to care. Any responsibility for the child is thrown to the mother” (parent #5, interview). Respondents also articulated concerns that it would be particularly challenging to recruit men for programs. Practitioners suggested that men might only be willing to participate in parenting groups exclusively

delivered to men: “In our culture, men don’t talk openly in front of women” (practitioner #14). Nevertheless, the majority of parents believed that male involvement in parenting programs would improve relationships between fathers and children as well as intimate partner relationships at home.

Cultural values.

Strengthening social responsibility.

“Be a parent to all children” (parent #8, interview).

Articulating a shared sense of responsibility regarding parent roles, respondents believed that programs would be more effective if they reflected the complex family dynamics in which low-income South African children are raised. Parents described how multiple caregivers shared the responsibility for the upbringing of children in households. Others explained that children often spent considerable time away from their immediate caregivers, including living with other family members in rural communities during school holidays. Additionally, respondents indicated that many adults shared parental responsibilities with other parents in their immediate community. As a result, respondents suggested that program content should provide examples of effective parenting beyond traditional family systems whilst strengthening social support mechanisms in the community.

Instilling respect or *Intlonipho*.

“A child without respect is not a child” (parent #15, focus group).

Intlonipho (“respect” in isiXhosa) was also perceived as an essential value for inclusion in parenting programs: “Respect is the first thing. Children must respect older adults and each other” (parent #15, focus group). Importantly, respondents viewed *intlonipho* as a value that must be actively demonstrated by parents: “You, as a parent, must respect and then teach your kids to respect” (practitioner #11). Reciprocity was

further emphasized in regards to teaching respectful behavior: “You must respect your children because your children look at your behavior. Things that you want her to do must be things you do yourself” (parent #30, focus group). Finally, respondents believed that parenting programs would be more effective if they addressed parental goals of respectful child behavior.

Program feasibility.

Increasing accessibility for low-income families.

“You can pull them in by food because we are starving” (parent #23, focus group).

Overall, respondents perceived that parenting programs would benefit parents and caregivers in poor, underserved communities. Respondents indicated that programs would be especially relevant to those parents who were struggling to manage poor child behavior and stress. Nevertheless, parents and practitioners identified a number of potential barriers to participation. Finding time to attend group meetings was perceived as a key challenge for parents, especially those who were employed. Other perceived barriers included lack of funds for transportation to group sessions, poor weather conditions, parental or child illness, and childcare responsibilities with small children. However, some parents disagreed that childcare would be a barrier: “Even [though] I have got a child but that does not mean I cannot attend. I just take the child and put him on my back” (parent #5, interview). Some practitioners viewed the presence of children in group sessions as an opportunity for parents to practice skills directly with their children instead of doing role-plays. However, others thought that the inclusion of children might be problematic due to the unpredictability of children’s behavior, and thus advocated for the provision of childcare during group sessions.

When probed for potential solutions to these barriers, respondents suggested that providing food, childcare, and reimbursements for public transportation were essential to enable participation by low-income families. Others recommended a versatile program format that could be delivered either through group sessions or individually at home for sick, old, or disabled parents. In addition, respondents proposed that practitioners conduct home consultations prior to program inception in order to orient parents to program goals and address potential barriers to participation. Parents also recommended that programs use text messages to remind participants about sessions and home activities. Finally, there was some disagreement about whether financial compensation was necessary to promote participation. While some respondents argued that parents would only participate if they were given money or food vouchers for attendance, others insisted that it would be sufficient to offer the programs free of cost, especially if parents were able to see the benefits of such programs in their lives. Nevertheless, it was generally agreed that some form of recognition, such as certificates of completion and prizes for full attendance, would incentivize attendance.

Improving delivery mechanisms of parenting programs.

“A very good story opens the door to something new” (practitioner #10).

When asked about preferred format of delivery, respondents perceived the benefits of group-based programs that allowed participants to collaboratively solve childrearing challenges and share effective parenting strategies: “When parents are meeting and sharing difficulties, perhaps one comes up with a plan, which can end up fixing things inside your home” (parent #2, interview). However, other parents expressed reservations about communicating private matters in a group setting and preferred individualized consultation: “There are things that I can’t talk about in a group” (parent #40, focus group). Practitioners emphasized that parenting programs

would be more effective if they used a less didactic and more experiential approach to introducing new parenting skills: “You can have two ways of cooking a stew. Instead of using the old way, you can take another new way and try it. See how it tastes, how it feels” (practitioner #20). Respondents differed when asked about the acceptability of using role-plays during group sessions. While some believed that parents would resist engaging in role-plays, others believed that parents would benefit from practicing skills during the sessions before trying them at home, especially if the role-play was adequately explained and framed as an enjoyable activity. Finally, respondents recommended that programs contain culturally resonant forms of interaction in order to increase acceptability and engagement. These included allowing participants to define a ritual to start sessions (e.g., prayer or songs) and using traditional stories, songs, and common children’s games to introduce session topics and core parenting principles.

Stage Three: Integrating Evidence and Context

The third stage focused on integrating evidence with local contextual factors. The objective of this stage was to finalize program development by creating an intervention that was both culturally relevant and grounded in evidence of effectiveness (Castro et al., 2004). This stage involved three steps: (a) convening an intervention development workgroup, (b) creating program content, and (c) manualizing program protocols.

Convening an intervention development workgroup

We convened a series of workshops and consultations with experts in the field of parenting interventions to guide program development. Expert consultants included academics with extensive experience implementing and researching parenting programs in HICs and LMICs, local and international family-based intervention development experts, professionals involved in child protection and advocacy, and directors of

community-based partner organizations in South Africa. We also consulted with local practitioners who had experience implementing family-based interventions for vulnerable children. Three workshops were conducted to select, adapt, and augment previously identified evidence-based intervention content and integrate them with findings from the formative evaluation (Wainberg, McKinnon, et al., 2007). We assessed each component identified from Stage One regarding its contextual and cultural relevance, feasibility, and importance as a core function of our theory of change model (see Figure 11, page 122). The expert committee also made recommendations on whether a specific component should be retained, adapted, or excluded, as well as whether additional locally identified components were necessary for inclusion. The intervention development workshops also assessed the extent to which the themes that emerged from the formative evaluation in Stage Two were in alignment with the literature. The expert committee considered whether the inclusion of context specific themes would affect the importance of maintaining fidelity to evidence-based approaches and components. We addressed this issue by minimizing the number of additional components while integrating contextual messaging within existing evidence-based content. For example, content regarding child safety in high-crime communities was included in the component on consistent limit-setting behaviors entitled, “Establishing household rules and routines.”

Creating program content

The workgroups resulted in the development of an evidence-informed parenting program specifically tailored to low-income South African families – the Sinovuyo Caring Families Program. This 12-session, group-based program incorporated contextual elements that were highlighted during the formative evaluation. As a culturally resonant mechanism for communicating evidence-based principles, the

program was structured around the metaphor of constructing a “rondavel,” or traditional hut familiar to South African families. Content focused on building mud walls (i.e., positive parent-child relationships) before adding a thatch roof (i.e., limit-setting and nonviolent discipline strategies) to the “Rondavel of Support” (see Figure 12).

Parenting skills were framed within the context of teaching children respectful behavior (i.e., *intlonipho*) and the reciprocal role of parents in modeling this behavior. Along with emphasizing child-led play, the program also encouraged parent-child involvement in daily chores and routines to take into account increased demands arising from domestic work in low-income households. Furthermore, the program addressed developmentally appropriate ways of communicating with young children about HIV/AIDS and bereavement as well as skills to monitor and keep children safe in high-crime communities. Simple relaxation exercises derived from Mindfulness Based Stress Reduction were included to address elevated stress levels (see Table 3) (Kabat-Zinn, 2013).

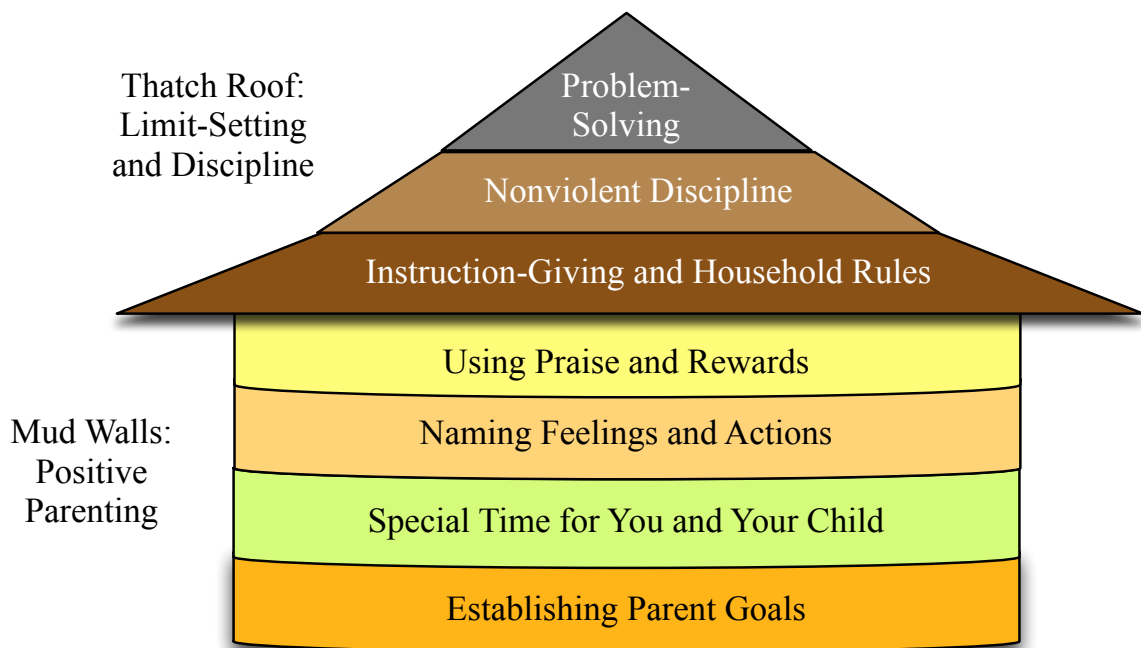


Figure 12. “Building a Rondavel of Support” program model for the Sinovuyo Caring Families Program.

Table 4. Integration of content from evidence-based parenting interventions and locally adapted or additional content for South African families.¹⁹

Core component	Evidence-based content	Specific content adapted for South Africa	Specific content added for South Africa
Building positive parent-child relationships	• Child-led play • Descriptive commenting • Socio-emotional communication • Praise and rewards	• Parent-child involvement in daily chores and routines	• Communicatin g about HIV/AIDS and bereavement
Effective limit-setting and discipline	• Establishing household rules • Positive instruction-giving • Ignoring negative attention-seeking behavior • Time-out • Consequences • Problem-solving	• Modeling respectful behavior (i.e., <i>intlonipho</i>)	• Keeping children safe in violent communities (curfews and monitoring)
Parental stress management	• Parental emotional self-regulation	• Awareness activities adapted from Mindfulness Based Stress Reduction	• Promoting existing coping strategies (e.g., prayer)
Delivery and structure	• Group or individual sessions • Collaborative facilitation • Group discussions and problem-solving • Modeling with videos • Practicing skills • Parent support groups • Transportation and refreshments	• Involvement of fathers • Group sessions with individual home consultations • Illustrated scenarios depicting complex family structures (instead of videos) • Text messaging to support participation and engagement	• Traditional stories, songs, and games to introduce content

¹⁹ This model draws upon Wainberg et al's (2007) work on adapting an HIV prevention program for adults with mentally illness.

Lonwabo and his father are sharing some time together...

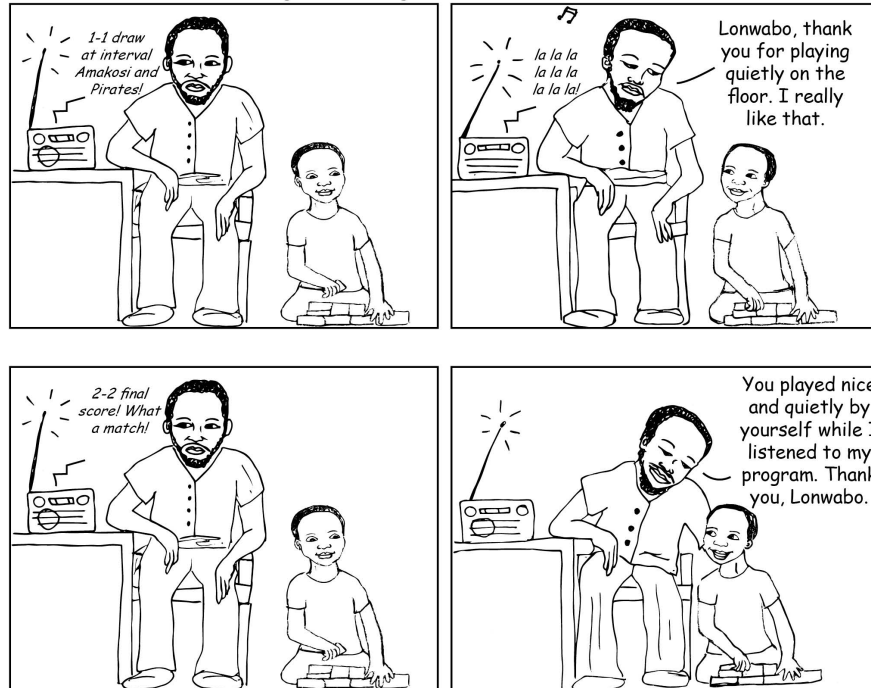


Figure 13. Illustrated story demonstrating a father using specific, labeled praise to reinforce his child's positive behavior.

Nosipho is playing with her dolls on the floor.

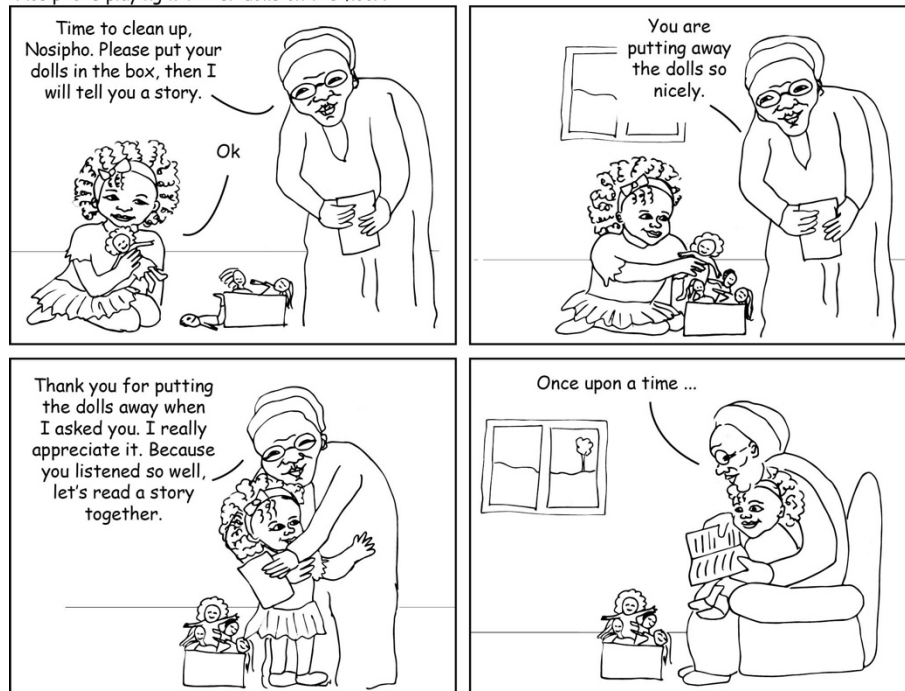


Figure 14. Example of an illustrated storyboard with a grandmother reinforcing her granddaughter's compliance with instructions by using labeled praise and tangible rewards.²⁰

²⁰ Illustrations by Shifrah Getz from InsideOut Inspired Designs™.

Core evidence-based delivery methods were designed to include (a) group discussion on parenting principles, (b) role-plays to practice parenting skills, (d) take-home activities to apply skills with children, and (d) group problem-solving around challenges experienced at home. In addition, the program included low-cost elements specifically designed for low-resource settings. Instead of creating locally relevant video vignettes – which would have been costly to produce and depend on availability of resources to show them – the program incorporated illustrated stories, or comic strips, to present examples of parenting behavior from which participants could identify principles (Figures 13 and 14). These scenarios depicted diverse family dynamics in both rural and urban South Africa as well as promoting the role of men as caregivers. Finally, although program delivery was primarily structured around parent group sessions, individualized home consultations were also included to accommodate participants who are unable to attend weekday sessions due to illness, disability, or employment. These home consultations also provided opportunities for one-on-one coaching involving parents practicing skills with their children.

Manualization of program protocols ²¹

Once the program protocols were defined, the first author created a facilitator manual in a format accessible to South African community-based facilitators. The core instructional content of the manual was derived from Hutchings's *The Little Parent Handbook*, which contains simple explanations for low-educated parents on core evidence-based parenting skills (Hutchings, 2013). The first author also used culturally relevant material such as traditional stories, songs, and games from a local South African program, Injabulo Family Program, that was developed by Clowns Without

²¹ For more detail regarding the content of the facilitator manual, please see Appendix B, pages 319-339. Complete program manuals and other materials are also available from the author upon request.

Borders South Africa (McLaren-Lachman, 2010). The first author also created a parent handbook as a supplemental component to support participant engagement. Simplified content for low-educated parents was derived from the facilitator manual. The handbook also contained a weekly checklist to assist parents in completing home practice assignments. Finally, weekly text message boosters were created to (a) remind participants to attend sessions, (b) encourage parents to practice skills at home with their children, (c) praise parents for their participation in the program. Additional one-on-one consultations with the wider research team were conducted to provide ongoing feedback on material development. These consultations took place primarily through email exchange and Skype meetings due to the wide geographical dispersal of experts. Members of the research team reviewed each chapter of the manual and provided comments or suggested edits to improve the clarity of protocols.

Once the manual development was completed, we used a consensus driven approach to translate the manual into isiXhosa (Sumathipala & Murray, 2000). This involved establishing a translation committee that included program developers and bilingual program facilitators ($n = 8$). The facilitators worked in teams of four, each translating separate sections of the manual into isiXhosa. Next, the teams exchanged translated sections and back-translated them into English. The translation committee then met to assess whether there were any inconsistencies in translation or terminology that required additional explanation by program developers. These discrepancies were resolved by consensus once the committee had discussed the translation and reached agreement on the correct terminology (Jones & Hunter, 1995). For instance, “time-out” was originally translated as “*ixesha lekhefu*” or “time to take a break.” However, upon further consultation and piloting, the translation committee determined that “*ixesha lokuzipholisa*” or “time to cool down” would be more culturally appropriate, given local

families' association of increased body heat with stress and agitation. Finally, the intervention workgroup reviewed the final manual for consistency with evidence-based practices prior to testing in a pilot feasibility trial (Lachman et al., in revision).

Discussion

This paper describes the process of systematically developing a parenting program for disadvantaged families with young children in South Africa. It provides a real-world application of the initial development stage of the United Kingdom Medical Research Council's framework for developing and evaluating complex social interventions (Craig et al., 2008). The integration of evidence-based approaches within a local cultural context was undertaken in three stages: (1) identification of evidence-based parenting program components and approaches; (2) formative evaluation with intended practitioners and beneficiaries in Cape Town; and (3) development of an evidence-informed, locally relevant 12-session parenting program for at-risk, low-income South African families.

Relevance of results from the formative evaluation

Findings from the formative evaluation in Stage Two highlight the importance of considering contextual factors in the development of locally relevant parenting programs. Although respondents' attitudes towards corporal punishment were consistent with other qualitative research in Cape Town (Breen et al., 2015), they also reported using positive parenting and nonviolent discipline strategies as well. These findings are similar to those reported in other studies in LMICs. For instance, surveys in 33 LMICs (not including South Africa) showed that 77% to 96% of parents of young children used nonviolent discipline techniques (UNICEF, 2010). In fact, these surveys suggest that parents generally utilized a combination of discipline strategies that include forms of violent discipline and psychological aggression as well as nonviolent

behaviors. Despite this, the majority of parents also reported that they did not believe violent discipline was necessary to raise children.

Many of the recommendations were compatible with the evidence-based parenting program components and approaches identified in Stage One of the study. Parents and practitioners also highlighted the need for evidence-based content such as playing with children, praising good behavior, establishing household rules, and using effective discipline strategies. Parents also articulated concepts that aligned with social learning theory principles, such as the importance of modeling good behavior (Bandura, 1977). Likewise, their preference for group sessions and sharing of skills may conform with program delivery methods that use a collaborative approach to elicit parenting principles from participants (Hutchings et al., 2004).

Findings underscore the necessity of including content specific for low-income families in South Africa. Programs may be more effective if they take into account potential time constraints that could limit opportunities for positive relationship-building between parents and children at home. In addition to playing with children, programs could suggest that parents involve children in their own daily chores and routines, such as collecting firewood and water, cleaning the house, and attending religious activities. Furthermore, it may be necessary to emphasize strategies that increase the safety of children in violent communities. It may also be helpful to include additional components that support parental mental health, particularly for parents experiencing increased stress due to poverty, illness, and violence. Parents may also benefit from learning developmentally appropriate ways of communicating about issues that carry social stigma, such as HIV/AIDS and death, without harming children or placing family members at risk of discrimination (Bastien, Kajula, & Muhwezi, 2011).

The participation of fathers in programs may relieve some of the burden of parental responsibility on female caregivers. Due to their low hierarchical status in many traditional South African households, women may encounter resistance or even conflict from male adults or elders in the household when trying to implement new parenting skills (Amoateng et al., 2004). Achieving participation of fathers in programs may be challenging due to attitudes that regard parenting to be part of a woman's domain (Ramphela, 2002). Another issue is that many low-income South African children are raised by a multiple caregivers in which grandparents, aunts, and even neighbors sharing the responsibility for raising a child (Bray & Brandt, 2007). Thus, parenting programs that offer involvement to multiple caregivers including men may strengthen the consistency of care and discipline delivered to children.

Findings highlight the importance of ensuring that parenting programs fit within existing South African cultural systems. Parents' emphasis on *intlonipho* (respect) and social responsibility may be understood as expressions of *ubuntu*, the African value of collective humanism (Hanks, 2008). *Ubuntu* is considered an important source of resilience in low-income South African families (Tom, 2010). Parenting programs that build upon existing social networks may strengthen a sense of a collective responsibility towards children, thus improving communal supervision and care of children. Parents may also identify more strongly with programs that emphasize effective ways to promote *intlonipho* as a parental goal for their children. It may also be useful to understand *intlonipho* as a reciprocal value in which respect is established through the modeling of appropriate behavior by parents (Bray et al., 2010).

Contribution to cultural adaptation research

This study provides a useful contribution to existing research on the cultural adaptation of evidence-based treatments across diverse settings (Lau, 2006). The

formative evaluation allowed developers to target distinct contextual factors identified by practitioners and parents that may enhance participant engagement and intervention effectiveness. These factors were both cosmetic additions designed to increase cultural acceptability (e.g., the “Rondavel of Support” model) as well as additional content specific to South African families (e.g., communicating about HIV/AIDS). At the same time, it retained the common core elements of evidence-based parenting programs that have been shown to contribute to the reduction of harsh parenting and child behavior problems (Kaminski et al., 2008).

This study also demonstrates the utility of developing interventions based on theory-driven behavioral change techniques (Michie, Johnston, Francis, Hardeman, & Eccles, 2008). This allowed the research team to culturally tailor the intervention for a local population whilst preserving the underlying function of evidence-based parenting programs. Other interventions developed in similar contexts may also benefit from using this generalized approach that takes into account both intervention functions (i.e., immediate proximal effects of activities) and specific forms (i.e., discrete actions such as labeled praise) (Bonell, Fletcher, Morton, Lorenc, & Moore, 2012). This may allow greater flexibility to selectively adapt content for local contexts while maintaining functions linked to intervention theory of change.

Limitations

This study had a number of limitations. In Stage One, the identification of program components was constrained by the limited empirical evidence of effective components based on systematic reviews, distillation studies, meta-analyses, and expert consultations. We recognize that other methods of identifying essential components may provide further insight into active core ingredients for parenting programs. This includes evidence from randomized microtrials on the efficacy of discrete parenting

techniques (Leijten et al., 2015), factorial experiment trials that test different components in relation to each other (Collins, Murphy, Nair, & Strecher, 2005), mediation analyses on mechanisms of change for specific parenting styles (Gardner et al., 2010), and research that examines the relationship between implementation factors and effectiveness (Forgatch et al., 2005). During the formative evaluation in Stage Two, men were vastly under-represented in the sample. Although we attempted to recruit both male and female participants in mixed groups, this gender imbalance was similar to other South African studies on family systems, in which male respondents were harder to recruit (Hosegood & Madhavan, 2010). Likewise, this study did not engage children as respondents, who may have provided an alternative perspective regarding parenting (Bray et al., 2010). Nevertheless, the large sample size that included both parents and practitioners afforded a diversity of perspectives and data collection methods, thus strengthening the validity of results. Finally, in Stage Three, community stakeholders were not consulted regarding the acceptability of finalized intervention protocols and manuals. While this may have strengthened the participatory aspects of the study, we determined that subsequent piloting with intended beneficiaries would provide more accurate data regarding intervention feasibility and cultural acceptability.

Recommendations for future research

Additional research is currently underway to further test the Sinovuyo program prior to wide-scale implementation and dissemination. A subsequent pilot study conducted in 2013 ($N = 68$) combined qualitative and quantitative methods to assess the preliminary effectiveness and feasibility of the program in Cape Town, South Africa (Lachman et al., in revision; Lachman, 2016). A larger randomized controlled trial is also currently being conducted to examine intervention effectiveness, as well as potential moderators and mediators of program effects ($N = 296$ families in Cape Town).

This will also enable researchers to examine behavioral change mechanisms as well as whether specific subgroups respond to the intervention differently. Lastly, research may benefit by continuing to actively involve policy makers, practitioners, parents, and children as equal partners in the development and evaluation process. This participatory approach may ultimately improve the cultural relevance and feasibility of parenting programs, thus increasing the likelihood of their effectiveness in reducing the risk of violence against children in LMICs.

References

- Amoateng, A. Y., Richter, L. M., Makiwane, M., & Rama, S. (2004). *Describing the structure and needs of families in South Africa: Towards the development of a national policy framework for families*. Pretoria: Human Sciences Research Council.
- Armstrong, M. I., Birnie-Lefcovitch, S., & Ungar, M. T. (2005). Pathways between social support, family well being, quality of parenting, and child resilience: What we know. *Journal of Child and Family Studies*, 14(2), 269-281.
- Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging parents in parenting programs: Lessons from research and practice. *Children and Youth Services Review*, 34(10), 2061-2071. doi: 10.1016/J.Childyouth.2012.06.011
- Bandura, A. (1977). *Social learning theory*. New York: General Learning Press.
- Barlow, J., Coren, E., & Stewart-Brown, S. (2002). Meta-analysis of the effectiveness of parenting programmes in improving maternal psychosocial health. *British Journal of General Practice*, 52(476), 223-233.
- Barlow, J., Johnston, I., Kendrick, D., Polnay, L., & Stewart-Brown, S. (2006). Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. *Cochrane Database of Systematic Reviews*, 3, 1-20.
- Bastien, S., Kajula, L. J., & Muhwezi, W. W. (2011). A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health*, 8(25), 1-17. doi: 10.1186/1742-4755-8-25
- Belsky, J., Jaffee, S. R., Sligo, J., Woodward, L., & Silva, P. A. (2005). Intergenerational transmission of warm-sensitive-stimulating parenting: A prospective study of mothers and fathers of 3-year-olds. *Child Development*, 76(2), 384-396.
- Bennett, C., Barlow, J., Huband, N., Smailagic, N., & Roloff, V. (2013). Group-based parenting programs for improving parenting and psychosocial functioning: A systematic review. *Journal of the Society for Social Work and Research*, 4(4), 300-332.
- Bonell, C., Fletcher, A., Morton, M., Lorenc, T., & Moore, L. (2012). Realist randomised controlled trials: A new approach to evaluating complex public health interventions. *Social Science and Medicine*, 75(12), 2299-2306. doi: 10.1016/j.socscimed.2012.08.032
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi: 10.1191/1478088706qp063oa
- Bray, R., & Brandt, R. (2007). Child care and poverty in South Africa. *Journal of Children and Poverty*, 13(1), 1-19. doi: 10.1080/10796120601171187
- Bray, R., Gooskens, I., Kahn, L., Moses, S., & Seekings, J. (2010). *Growing up in the new South Africa: Childhood and adolescence in post-apartheid South Africa*. Cape Town: Human Sciences Research Council.
- Breen, A., Daniels, K., & Tomlinson, M. (2015). Children's experiences of corporal punishment: A qualitative study in an urban township of South Africa. *Child Abuse & Neglect*, 48, 131-139. doi: 10.1016/j.chiabu.2015.04.022
- Castro, F. G., Barrera, M., & Martinez, C. R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*, 5(1), 41-45.

-
- Chen, M., & Chan, K. L. (2015). Effects of parenting programs on child maltreatment prevention: A meta-analysis. *Trauma, Violence, and Abuse*, 17(1), 88-104. doi: 10.1177/1524838014566718
- Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology*, 77(3), 566-579. doi: 10.1037/a0014565
- Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Service Research*, 7(1), 5-20.
- Collins, L. M., Murphy, S. A., Nair, V. N., & Strecher, V. J. (2005). A strategy for optimizing and evaluating behavioral interventions. *Annals of Behavioral Medicine*, 30(1), 65-73. doi: 10.1207/S15324796abm3001_8
- Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research : techniques and procedures for developing grounded theory* (3rd ed.). Los Angeles, Calif. ; London: Sage.
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: The new Medical Research Council guidance. *British Medical Journal*, 337, a1655.
- Eshel, N., Daelmans, B., de Mello, M., & Martinez, J. (2006). Responsive parenting: Interventions and outcomes. *Bulletin of the World Health Organization*, 84, 991-998.
- Eyberg, S. M., Boggs, S. R., & Algina, J. (1995). Parent-Child Interaction Therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families. *Psychopharmacology Bulletin*, 31(1), 83-91.
- Fielding, N. G., & Lee, R. M. (1998). *Computer analysis and qualitative research*. London: Sage Publications.
- Forgatch, M. S., Patterson, G. R., & DeGarmo, D. S. (2005). Evaluating fidelity: Predictive validity for a measure of competent adherence to the Oregon model of parent management training. *Behavior Therapy*, 36(1), 3-13. doi: 10.1016/S0005-7894(05)80049-8
- Forgatch, M. S., Patterson, G. R., & Gewirtz, A. H. (2013). Looking forward: The promise of widespread implementation of parent training programs. *Perspectives on Psychological Science*, 8(6), 682-694. doi: 10.1177/1745691613503478
- Foster, C., & Williamson, J. (2000). A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS 2000*, 14, S275-S284.
- Fraenkel, P. (2006). Engaging families as experts: Collaborative family program development. *Family Process*, 45(2), 237-257.
- Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2013). Cochrane Review: Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years (Review). *Evidence-Based Child Health: A Cochrane Review Journal*, 8(2), 318-692. doi: 10.1002/ebch.1905
- Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: Outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry*, 47(11), 1123-1132. doi: 10.1111/J.1469-7610.2006.01668.X
- Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. (2010). Who benefits and how does it work? Moderators and mediators of outcome in an effectiveness trial of a
-

-
- parenting intervention. *Journal of Clinical Child and Adolescent Psychology*, 39(4), 568-580. doi: 10.1080/15374416.2010.486315
- Gardner, F., Montgomery, P., & Knerr, W. (2015). Transporting evidence-based parenting programs for child problem behavior (age 3-10) between countries: Systematic review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology*, 1-14. doi: 10.1080/15374416.2015.1015134
- Gilbert, L. S. (2002). Going the distance: 'Closeness' in qualitative data analysis software. *International Journal of Social Research Methodology*, 5(3), 215-228.
- Hanf, C. (1969). *A two-stage program for modifying maternal controlling during mother-child (M-C) interaction*. Paper presented at the Meeting of the Western Psychological Association, Vancouver, BC, Canada.
- Hanks, T. L. (2008). The Ubuntu paradigm: Psychology's next force? *Journal of Humanistic Psychology*, 48(1), 116-135. doi: 10.1177/0022167807303004
- Hosegood, V., & Madhavan, S. (2010). Data availability on men's involvement in families in sub-Saharan Africa to inform family-centred programmes for children affected by HIV and AIDS. *Journal of the International AIDS Society*, 13(Suppl 2), S5. doi: 10.1186/1758-2652-13-S2-S5
- Hutchings, J. (2013). *The Little Parent Handbook*. Bangor, Wales: University of Wales Bangor School of Education.
- Hutchings, J., Gardner, F., & Lane, E. (2004). Making evidence-based intervention work. In D. Farrington, C. Sutton, & D. Utting (Eds.), *Support from the start: Working with young children and their families to reduce the risks of crime and antisocial behaviour* (pp. 69-79). London: Department for Education and Skills.
- Jones, J., & Hunter, D. (1995). Consensus methods for medical and health services research. *British Medical Journal*, 311(7001), 376-380.
- Jones, M. L. (2007). Using software to analyse qualitative data. *Malaysian Journal of Qualitative Research*, 1(1), 64-76.
- Kabat-Zinn, J. (2013). *Full catastrophe living (revised edition): Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Bantam Books.
- Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology*, 36(4), 567-589. doi: 10.1007/s10802-007-9201-9
- Kazdin, A. E. (2000). Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. *Journal of Child and Family Studies*, 9(2), 157-174.
- Knerr, W., Gardner, F., & Cluver, L. (2013). Improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries: A systematic review. *Prevention Science*, 14(4), 352-363. doi: 10.1007/s11121-012-0314-1
- Kotchick, B. A., & Forehand, R. (2002). Putting parenting in perspective: A discussion of the contextual factors that shape parenting practices. *Journal of Child and Family Studies*, 11, 255-269.
- Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The World Report on Violence and Health. *Lancet*, 360(9339), 1083-1088. doi: 10.1016/S0140-6736(02)11133-0
- Kumpfer, K. L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science*, 3(3), 241-246.
-

-
- Labadarios, D., Maunder, E., Steyn, N., MacIntyre, U., Swart, R., Gericke, G., . . . Dannhauser, A. (2003). National food consumption survey in children aged 1-9 years: South Africa 1999. *Forum Nutrition*, 56, 106-109.
- Lachman, J. M., Cluver, L., Ward, C. L., Hutchings, J., Gardner, F., Wessels, I., & Mlotshwa, S. (in review). Pilot randomized controlled trial of a parenting program to reduce the risk of child maltreatment in South Africa.
- Lachman, J. M., Cluver, L., Kelly, J., Ward, C. L., Hutchings, J., Gardner, F. (2016). Process evaluation of a parenting program for low-income families in South Africa. *Research on Social Work Practice*. doi: 10.1177/1049731516645665
- Lansford, J. E., & Deater-Deckard, K. (2012). Childrearing discipline and violence in developing countries. *Child Development*, 83(1), 62-75. doi: 10.1111/j.1467-8624.2011.01676.x
- Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice*, 13(4), 295-310. doi: 10.1111/j.1468-2850.2006.00042.x
- Leijten, P., Dishion, T. J., Thomaes, S., Raaikmakers, M. A. J., Orobio de Castro, B., & Mattys, W. (2015). Bringing parenting interventions back to the future: How randomized controlled microtrials may benefit parenting intervention effectiveness. *Clinical Psychology: Science and Practice*, 22, 47-57. doi: 10.1111/cpsp.12087
- Leung, C., Sanders, M. R., Leung, S., Mak, R., & Lau, J. (2003). An outcome evaluation of the implementation of the Triple P-Positive Parenting Program in Hong Kong. *Family Process*, 42(4), 531-544. doi: 10.1111/j.1545-5300.2003.00531.x
- Martin-Storey, A., Temcheff, C., Martin, E., & Stack, D. (2009). Interventions for childhood aggression in a cross-cultural context. *Psychology Developing Societies*, 21(2), 235-256. doi: 10.1177/097133360902100204
- McLaren-Lachman, J. (2010). "Storytelling, Drama, and Mindfulness in Psychosocial Interventions for Children and Guardians Affected by HIV/AIDS in Southern Africa – Developing Pathways to Locally Sustainable Care". *South African Theatre Journal*, 24, 67-81.
- Meinck, F., Cluver, L. D., Boyes, M. E., & Loening-Voysey, H. (2016). Physical, emotional, and sexual abuse of children in South Africa: Incidence, prevalence, perpetrators, and locations. *Journal of Epidemiology and Community Health*.
- Mejia, A., Calam, R., & Sanders, M. R. (2012). A review of parenting programs in developing countries: Opportunities and challenges for preventing emotional and behavioral difficulties in children. *Clinical Child and Family Psychology Review*, 15(2), 163-175. doi: 10.1007/s10567-012-0116-9
- Michie, S., Johnston, M., Francis, J., Hardeman, W., & Eccles, M. (2008). From theory to intervention: Mapping theoretically derived behavioural determinants to behaviour change techniques. *Applied Psychology - An International Review-Psychologie Appliquee-Revue Internationale*, 57(4), 660-680. doi: 10.1111/J.1464-0597.2008.00341.X
- Mikton, C. (2012). Two challenges to importing evidence-based child maltreatment prevention programs developed in high-income countries to low- and middle-income countries: Generalizability and affordability. In H. Dubowitz (Ed.), *World perspectives on child abuse* (Vol. 10, pp. 97). Aurora, CO: International Society for the Prevention of Child Abuse and Neglect.
-

-
- Mikton, C., MacMillan, H., Dua, T., & Betancourt, T. S. (2014). Integration of prevention of violence against children and early child development. *The Lancet Global Health*, 2(8), e442-443. doi: 10.1016/S2214-109X(14)70233-5
- Pardini, D. A., Fite, P. J., & Burke, J. D. (2008). Bidirectional associations between parenting practices and conduct problems in boys from childhood to adolescence: The moderating effect of age and African-American ethnicity. *Journal of Abnormal Child Psychology*, 36(5), 647-662. doi: 10.1007/s10802-007-9162-z
- Patterson, G. R., DeBaryshe, B. D., & Ramsey, E. (1989). A developmental perspective on antisocial behavior. *The American Psychologist*, 44(2), 329-335. doi: 10.1037/0003-066X.44.2.329
- Piquero, A. R., Farrington, D. P., Welsh, B. C., Tremblay, R., & Jennings, W. G. (2009). Effects of early family/parent training programs on antisocial behavior and delinquency. *Journal of Experimental Criminology*, 5(2), 83-120. doi: 10.1007/S11292-009-9072-X
- Ramphela, M. (2002). *Steering by the stars: Being young in South Africa*. Cape Town: Tafelberg.
- Sanders, M. R. (2008). The efficacy of the Triple P-Positive Parenting Program in improving parenting and child behavior: A comparison with two other treatment conditions. *Behaviour Research and Therapy*, 46(4), 411-427. doi: 10.1016/j.brat.2008.01.001
- Sethi, S., Kerns, S. E. U., Sanders, M. R., & Ralph, A. (2014). The international dissemination of evidence-based parenting interventions: Impact on practitioner content and process self-efficacy. *International Journal of Mental Health Promotion*, 16(2), 126-137. doi: 10.1080/14623730.2014.917896
- Snell-Johns, J., Mendez, J. L., & Smith, B. H. (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *Journal of Family Psychology*, 18(1), 19-35. doi: 10.1037/0893-3200.18.1.19
- Statistics South Africa. (2012). *Census 2011*. Pretoria: Statistics South Africa.
- Sumathipala, A., & Murray, J. (2000). New approach to translating instruments for cross-cultural research: A combined qualitative and quantitative approach for translation and consensus generation. *International Journal of Methods in Psychiatric Research*, 9(2), 87-95. doi: 10.1002/mpr.83
- Tom, C. L. (2010). *Raising a child with attention deficit/hyperactivity disorder: Exploring the experience of black parents*. (Unpublished master's thesis), University of Pretoria, Pretoria.
- UNICEF. (2010). *Child disciplinary practices at home: Evidence from a range of low- and middle-income countries*. New York: UNICEF.
- UNICEF. (2014). *Hidden in plain sight: A statistical analysis of violence against children*. New York: UNICEF.
- Wainberg, M. L., McKinnon, K., Mattos, P. E., Pinto, D., Mann, C. G., dos Santos de Oliveira, C. S., . . . PRISSMA Project. (2007). A model for adapting evidence-based behavioral interventions to a new culture: HIV prevention for psychiatric patients in Rio de Janeiro, Brazil. *AIDS and Behavior*, 11(6), 872-883. doi: 10.1007/s10461-006-9181-8
- Webster-Stratton, C., & Reid, J. (2003). The Incredible Years Parents, Teachers, and Children Training Series: A multifaceted treatment approach for young children with conduct problems. In W. Kazdin A., J. (Ed.), *Evidence-based*
-

-
- psychotherapies for children and adolescents* (pp. 224-240). New York: Guilford Press.
- Wessels, I., & Ward, C. L. (2015). A 'best buy' for violence prevention: Evaluating parenting skills programmes. *South African Crime Quarterly*, 54, 17-28. doi: 10.4314/sacq.v54i1.2

CHAPTER FIVE. PAPER #2: Pilot Randomized Controlled Trial of a Parenting Program to Reduce the Risk of Child Maltreatment in South Africa²²

In revision: Child Abuse & Neglect.

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This research was funded by the Ilifa Labantwana Fund (n°T141/79), the John Fell Fund (n°103/757), the South African National Lottery Distribution Trust Fund (n°43137), and the European Research Council under the European Union's Seventh Framework Programme (FP7/2007-2013; ERC grant agreement n°313421).

ClinicalTrials.gov Identifier: NCT01802294

Pan African Clinical Trial Registry: PACTR201302000455414

²² This paper has been written using US spelling to be in alignment with the journal's submission guidelines.

Abstract

Parenting programs in high-income countries have been shown to reduce the risk of child maltreatment. However, there is limited evidence of their effectiveness in low- and middle-income countries. The objective of this pilot study was to examine the feasibility of conducting a randomized controlled trial of a locally developed parenting program and its initial effects in reducing the risk of child maltreatment in Cape Town, South Africa. Low-income parents ($N = 68$) with children aged three to eight years were randomly allocated to either a group-based parenting program or a wait-list control group. Assessments were taken at baseline and at immediate post-test after the intervention was delivered. Primary outcomes were parent-report and observational assessments of harsh parenting, positive parenting, and child behavior problems. Secondary outcomes were parent-report assessments of parental depression, parenting stress, and social support. Results demonstrated high levels of study recruitment and retention, measurement reliability, and response rates. Analyses found moderate treatment effects for increased frequency of parent-report of positive parenting ($d = 0.63$) and observational assessments of child-led play ($d = 0.57$). There were also potentially clinically relevant though non-significant treatment effects for reduced frequency of reported child behaviour problems, increased frequency of reported perceived social support, and reduced frequency of observed negative parenting. Observational assessments also found moderate treatment effects for less frequent observed positive child behavior ($d = -0.56$) and clinically relevant though non-significant effects of more frequent observed negative child behaviour. Findings suggest the feasibility of conducting a rigorous evaluation of a parenting program with highly vulnerable families in low-resource communities. Results also suggest initial intervention effectiveness in reducing the risk of child maltreatment by improving

positive parenting behavior. Further development is required to strengthen program components regarding nonviolent discipline and child behavior management. Future research would benefit from a larger trial with sufficient power to determine program effectiveness.

Keywords: child maltreatment, positive parenting, intervention research, South Africa

Introduction

Child maltreatment during early childhood has long been associated with increased risk of developing negative outcomes in adolescence and adulthood. Child maltreatment – defined as physical, emotional, and sexual abuse and neglect (World Health Organization, March 1999) – is linked to increased child behavior problems (Kim, Cicchetti, Rogosch, & Manly, 2009), which predict poor educational performance, juvenile delinquency, and criminal activity (Patterson et al., 1989). Victims of child maltreatment are also more likely to develop depressive disorders, and almost twice as likely to develop substance abuse problems than non-affected children (Norman et al., 2012). Child maltreatment is also a major risk factor for later intimate partner violence, both as victim and as perpetrator (Dunkle et al., 2004). Moreover, harsh and abusive parenting has substantial intergenerational effects; parents who experienced maltreatment as children are also more likely to maltreat their own children (Pears & Capaldi, 2001). On the other hand, positive parenting behavior – such as parental warmth and consistent limit-setting – may reduce the likelihood of child maltreatment, especially in the context of cumulative risk (Trentacosta et al., 2008).

While child maltreatment is a global concern, children living in South Africa often experience particularly high levels of maltreatment with lifetime prevalence rates of 55% for physical abuse and 36% for emotional abuse (Meinck et al., 2016). Moreover, elevated societal risks – such as high levels of poverty, HIV/AIDS, drug and alcohol abuse, and community and interpersonal violence – frequently coincide in South Africa, thus increasing the risk of abuse (Lachman et al., 2002). For example, families affected by HIV/AIDS are also more likely to experience intimate partner violence, and women affected by intimate partner violence are also more likely to become infected with HIV (Jewkes, Dunkle, Nduna, & Shai, 2010). Both groups are at

risk for poor mental health (Kuo et al., 2012; Levendosky, Leahy, Bogat, Davidson, & von Eye, 2006), which is associated with neglectful or abusive parenting (Cohen et al., 2008). Families affected by HIV/AIDS are also more likely to experience socioeconomic challenges (Collins & Leibbrandt, 2007), which decrease the capacity of parents to interact positively with their children (Gershoff et al., 2007). Finally, South African children living in families affected by adverse factors are more likely to develop behavioral difficulties (Moolla, 2012), which are reciprocally linked to increased risk of harsh parenting and potential abuse (Pardini, 2008).

There is encouraging evidence from high-income countries (HICs) of the effectiveness of parenting programs in reducing the risk of child maltreatment (Barlow et al., 2006; Chen & Chan, 2015). Parenting programs delivered during early childhood prior to or at the outset of problem behaviors are particularly important for later risk reduction (Kazdin, 1997). Furthermore, evidence from HICs has shown that group-based parenting programs may be effective for socioeconomically disadvantaged families (Leijten, Raaijmakers, de Castro, & Matthys, 2013; McGilloway et al., 2012). Recent reviews have also identified limited but promising evidence of effectiveness in low- and middle-income countries (LMICs) (Knerr et al., 2013), and the transportability of evidence-based parenting interventions from HICs to LMICs (Gardner et al., 2015). However, while parenting programs have shown some effectiveness in LMICs when delivered to families with infants, few have been tested in randomized controlled trials with disadvantaged families with older children in sub-Saharan Africa (Cooper et al., 2009; Cooper et al., 2014).

This present study aims to contribute to the literature on the effectiveness of parenting programs in reducing the risk of child maltreatment and improving positive parenting in LMICs. By utilizing a randomized controlled trial design, we examined the

feasibility of rigorously evaluating a locally developed parenting program delivered to low-income families with children aged three to eight years in Cape Town, South Africa. Pilot feasibility trials are considered essential steps in preparation for larger experimental studies (Lancaster et al., 2004). They allow for close examination of the suitability of study protocols, outcome measures, randomization procedures, and recruitment and retention of participants. Although limited in their ability to detect significant effects, pilot studies also provide the opportunity to conduct exploratory analyses of intervention outcomes and probe for possible harmful effects prior to testing in a larger population. As a result, this study examined the following research questions: (a) what is the feasibility of conducting a randomized controlled trial of a parenting program delivered to families with young children living in low-income communities characterized by high crime, poverty, and HIV/AIDS; and (b) what is the preliminary effectiveness of the program in reducing risks related to child maltreatment for the intervention group in comparison to controls?

Methods

This trial is reported in line with the CONSORT (Consolidated Standards of Reporting Trials) guidelines on randomized controlled trials (Altman et al., 2001).

Setting

The study took place from March to August 2013 in Khayelitsha, a low-income suburb in Cape Town, South Africa. Khayelitsha consists of both informal and formal settlements with a population of approximately 390,000 mainly isiXhosa-speaking people (Statistics South Africa, 2012).²³ It is characterized by high levels of poverty,

²³ IsiXhosa is an indigenous South African language that is also one of the three official languages of the Western Cape, the province in which Cape Town is located.

intimate partner violence, substance abuse, and HIV-prevalence – all risk factors for potential physical and emotional child abuse (Meinck, 2014).

Participants

Parent-child dyads ($N = 68$) were recruited from two sources: referrals from local community organizations ($n = 47$, 69%) and participants recruited by word-of-mouth from a formative evaluation conducted by the authors in 2012 to inform the development of the tested parenting program ($n = 21$, 31%) (Lachman et al., 2016). Inclusion criteria required parents to be (a) isiXhosa-speaking adults over the age of 18; (b) identify themselves as a primary guardian of at least one child aged three to eight years; (c) reside in the same household as their children for at least four nights per week, in order to assure adequate time for engagement in parenting skills at home with their children; (d) and be available and willing to participate in weekday program sessions. Primary guardians were any adult caregiver who self-identified as the primary person responsible for a child's wellbeing, including biological parents, relatives, or non-kin foster caregivers, with no restrictions on biological relationship. Although multiple caregivers of a child were invited to attend program sessions, only one parent was interviewed per household.

In addition, we included an inclusion criteria for elevated child behavior problems based on a cut-off of 11 or more problems on the parent-report form of the Eyberg Child Behavior Inventory problem scale (Eyberg & Pincus, 1999). This was particularly important given that children with behavioral difficulties face an increased risk of abuse by caregivers (Lansford et al., 2011). It also increased the likelihood that parents would be motivated to participate in a parenting program that addressed child management issues. Moreover, if there were multiple children between the ages of three to eight with elevated levels of behavior problems in a household, the parent was asked

to choose the child whose behavior was the most difficult to manage. Finally, the exclusion criteria included participants or children who exhibited acute mental health problems or evidence of severe abuse.

Sample size calculation²⁴

Sample size calculations were exploratory due to the lack of existing studies in South Africa. Preliminary calculations were based on a randomized controlled trial of a parenting program of similar length for families in the United States, the Incredible Years ($N = 54$ parents) (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). We used a G*Power 3 calculator (Erdfelder, Faul, & Buchner, 1996) with an *a priori* power analysis based on the study's screening tool – the Eyberg Child Behavior Inventory (ECBI) problem scale (Cohen's $d = 0.80$ in the Incredible Years study). Assuming a Type I error of $p < 0.05$ and 80% power, the sample size necessary to detect a significant effect was calculated at 52 participants. Estimating an attrition rate of 15%, the total sample was set at a minimum of 60 participants, which meant that the study was powered to detect a large effect size, but not a small one.

Randomization

An external researcher not directly involved in the study conducted the randomization procedures remotely in Oxford, United Kingdom. Participants were

²⁴ Based on recommendations from the D.Phil. candidate's Confirmation of Status examination, post-hoc sample size calculations were conducted using the results from a randomized controlled trial ($N = 224$) of a parenting program for mothers of children aged 2 to 6 years in Iran called SOS Help for Parents (www.sosprograms.com) (Oveisi et al., 2010). It was determined that the Iranian study would be more applicable given that it used the same primary outcome measure to measure harsh parenting – the Parent-Child Conflict Tactics Scale (CTSPC) (Straus et al., 1998). The Iranian study also used analysis of covariance to examine differences between allocation groups at post-test, which was the principle method of analysis for this study. Assuming a Type I error of $p < 0.05$ and 80% power with an F statistic of 10.02 from the Iranian study (intervention group: $n = 110$; control group: $n = 136$) and a 15% attrition rate, the sample size necessary to detect a significant effect would have been 220 participants. Since the Iranian study had a much smaller effect size than the Incredible Years study (Webster-Stratton et al. 1998) ($d = 0.41$ versus $d = 0.80$ respectively), post hoc sample size calculations were much higher than from the original sample size calculations, thus indicating that the pilot trial was underpowered. Nevertheless, these are not reported in the paper submitted for publication in order to be consistent with the trial protocol, which used the original sample size calculations based on the Incredible Years trial.

randomly allocated on a 1:1 ratio to an intervention or wait-list control group after baseline data collection using a concealed computerized program, SealedEnvelopeTM. To assure equal distribution across groups, randomization was stratified by child age and gender. Our implementing partner, Clowns Without Borders South Africa, notified participants of their allocation status via telephone. Although program implementers and participants were aware of their allocation status, researchers conducting self-report interviews and observational assessments were blind to allocation. After post-test data collection, the control group received the intervention from September to November 2013.

Ethical procedures

All study protocols were approved by institutional review boards at the Universities of Oxford and Cape Town, and registered with ClinicalTrials.gov and the Pan African Clinical Trial Registry (NCT01802294; PACTR201302000455414). In order to compensate for low levels of literacy, research staff conducted informed consent procedures verbally in isiXhosa with parents in private. Parents were told they had the right to decline consent, and that they could leave the study at any time. With the exception of a snack provided during observational assessments and a certificate of completion and simple toy at the end of post-test data collection, no financial incentives were provided for participation in the evaluation study. The implementing partner also provided lunch, public transportation, and certificates to parents during parenting sessions as part of program delivery.

Intervention

Parents in the intervention group were invited to participate in the Sinovuyo Caring Families Program, an evidence-informed, group-based parenting program developed in South Africa using community based participatory approaches (Lachman

et al., 2016). This program was derived from common elements of evidence-based parent management training programs (Kaminski et al., 2008). It is based on social learning theory (Bandura, 1977) and focuses on improving positive parent-child relationships prior to learning authoritative limit-setting and nonviolent discipline strategies (Kazdin, 1997). Core components include content on child-led play, emotional communication, praise and rewards, instruction-giving and household rules, and nonviolent discipline strategies such as ignoring negative attention-seeking behaviors, time-out for aggressive behavior or noncompliance, and consequences (Hutchings et al., 2004).

The program also contains specific material tailored for low-income families living in South Africa. Facilitators follow a manualized program protocol designed for low-resource settings, which requires no equipment beyond homemade toys from recycled materials, paper, and pens. Parenting principles are introduced using traditional stories and illustrated scenarios that mirror typical extended family households in the South African context (Bozalek, 1999). Parents set their own goals for their children's behavior at the beginning of the program (often incorporating local cultural values such as respect and social responsibility), and the program assists each parent to achieve their individual goals. The program encourages parents to spend time with their children by collaborating together on household chores, which, in poverty-affected households, can take a great deal of time each day, thereby making it difficult for parents to find the time to play with their children (Bray & Brandt, 2007). The program also includes specific content on keeping children safe in communities characterized by violence (Meth, 2013), as well as methods to communicate with children about HIV/AIDS and poverty. Mindfulness-based techniques are incorporated

to assist parents in managing stress due to high levels of community violence, illness, and poverty (Kabat-Zinn, 2013).

A local non-governmental organization (NGO), Clowns Without Borders South Africa (www.cwbsa.org), delivered the program to the intervention group over 12 weekly sessions from April to June 2013. Community-based workers with a basic level of training in early childhood development facilitated the sessions in pairs to three parent groups consisting of 10 to 14 parents per group. Each session lasted between two and three hours and included the following activities: (a) opening prayer, (b) mindful physical exercise, (c) children's song, (d) introduction of core parenting principle, (e) group discussion on the benefits of the principle, (f) working through illustrated stories, (g) practicing parenting skills through role-plays, (h) assignment of homework to implement the skills at home during the week, and (i) closing prayer. Whenever possible, additional home consultation was provided to parents who missed a session or were having difficulties implementing parenting skills (Table 5).

Table 5. Description of the Sinovuyo Caring Families Program

Focus	Themes
Group dynamics (Sessions 1, 4 & 12)	Establishing ground rules and parent goals; Connecting with other participants during the week; Identifying ways to maintain parenting skills and support after the program
Positive parenting (Sessions 1-5)	Spending special time with your child; Child-led play; Building language skills with descriptive commenting; Emotional labeling to promote social-emotional regulation; Using specific, labeled praise and simple, realistic rewards to encourage good behavior
Limit-setting (Sessions 6-7)	Using positive, clear instructions; Establishing rules to keep your child safe in the community and at home
Nonviolent discipline (Sessions 8-11)	Using ignore with negative attention-seeking behaviors; Time-out for aggressive behavior or noncompliance; Consequences to develop personal responsibility; Involving children in problem-solving; Communicating about challenging issues (HIV/AIDS and poverty)
Stress reduction (Entire program)	Body relaxation and mindful movement exercises; Taking a 3-minute cool-down; Loving-kindness

Measures²⁵

Demographic information.

Demographic information included parent factors: age, gender, marital status, level of education, and employment status; child factors: age, gender, relationship to caregiver; and family factors: household size, type of household structure (i.e., informal or formal), number of children under 18 per household, and number of government grants received per household. In addition, household poverty was assessed using the nine-item Hunger Scale Questionnaire (Labadarios et al., 2003). Parents reported on the occurrence of hunger over the previous 30 days, and whether there had been hunger more than five times during that period (e.g., “the household has run out of money to buy food”). Items were summed to create a total score of household hunger intensity.

This study also measured the following risk factors associated with child maltreatment in South Africa (Meinck et al., 2013): (a) familial HIV/AIDS using the Verbal Autopsy Questionnaire for child AIDS-orphanhood or parental HIV-positive status, (VA, 18 items) (Lopman et al., 2006); (b) incidence of intimate partner violence using the Revised Conflict Tactics Short Form scale (CTS2S, 10 items) (Straus & Douglas, 2004); and (c) whether the parent had experienced abuse as a child using the International Society for the Prevention of Child Abuse and Neglect’s Child Abuse Screening Tools-Retrospective Version (ICAST-R, 11 items) (Dunne et al., 2009). Separate variables were created for each risk factor as well as a variable for overall cumulative risk for abuse that included parental depression and household poverty.

²⁵ For a more detailed description of the measures used in this study, please see Appendix D.

Evaluation feasibility outcomes.

In order to assess the feasibility of conducting a randomized controlled trial of a parenting program in a low-resource South African context, we examined study recruitment and retention rates, randomization procedures, data collection methods, and the effect of using a partially nested design to evaluate treatment effects (Pals et al., 2008). Recruitment rates were calculated based on the number of potential participants who were contactable, met the inclusion criteria, and enrolled in the study after obtaining informed consent. Retention rates were calculated based on dropout of enrolled participants at any stage during the study. We examined randomization feasibility by assessing the efficacy of blinding assessors and the extent of group contamination. Furthermore, since many of the measures were not previously validated in South Africa, we examined the reliability and response rates of self-report outcomes and observational assessments. Finally, potential within-group effects were examined by analyzing intra-cluster correlation coefficients.

Intervention effectiveness outcomes.

Primary outcomes associated with increased risk of child maltreatment were self-report and observational assessments of harsh parenting, positive parenting, and child behavior problems. Secondary outcomes were self-report measurements of parenting stress, parental depression, and perceived social support.

Primary self-report outcomes.

Harsh parenting was measured using the Parent-Child Conflict Tactics Scale (CTSPC, 23 items) (Straus et al., 1998). The CTSPC has been used widely in studies on parenting in South Africa (Mueller et al., 2011). An overall assessment of harsh parenting during the past three months was assessed by summing individual subscales for psychological aggression (e.g., “shouted, yelled, or screamed at”), physical assault

(e.g., “hit on the bottom with a belt”), and neglect (e.g., “was too drunk to take care of your child”). The CTSPC also contains a separate subscale for nonviolent discipline that was analyzed separately from the items on harsh parenting (4 items, e.g., “explained why something was wrong”).

Positive parenting was assessed using the positive parenting and setting limits subscales from the Parenting Young Children Scale (PARYC; 7 items each) (McEachern et al., 2011). The PARYC measures the frequency of parent behavior over the previous month. Items are summed to create total frequency scores for positive parenting (e.g., “how often do you play with your child”) and setting limits (e.g., “how often do you stick to your rules and not change your mind”).

Child behavior problems were measured using the ECBI (36 items) (Eyberg & Pincus, 1999). The ECBI has been previously utilized in South Africa with strong internal consistency ($\alpha = .89$) (Moolla, 2012). Parents are asked how often a specific behavior occurred in the past month and whether the behavior was considered a problem for them (e.g., “acts defiant when told to do something”). The ECBI produces total intensity and problem subscale scores.

Primary observational assessment outcomes.

Observed parenting and child behavior was assessed using the Sinovuyo Observational Coding System (SOCS) (Mlotshwa, 2013). The SOCS was developed based on adaptations of the Dyadic Parent-Child Interaction Coding System (Eyberg & Robinson, 2000) and Family Observation Scale (Sanders, 1996) to fit the South African context. It assesses the frequency of behaviors during a set of prescribed activities involving the parent and child: free play (10 minutes), tidying up (up to 5 minutes), and preparing and eating a snack (10 minutes). Two raters coded videos by assessing the frequency of parenting behavior, including positive parenting (i.e., positive verbal or

positive nonverbal behaviors), effective parenting (i.e., use of consequences and positive commands), and negative parenting (i.e., indirect commands, negative verbal, and negative physical behaviors). Child behavior categories were positive child behavior (i.e., compliance, positive verbal, and positive nonverbal behaviors) and negative child behavior (i.e., noncompliance, negative verbal, or negative physical behaviors). Assessors also recorded coder impressions of the level of engagement in child-led play as an additional indication of positive parenting. Raters coded ten videos to establish intra-rater reliability with a criterion coder prior to coding the complete dataset. In order to determine inter-rater reliability, 30% of videos were coded by both raters.

Secondary Outcomes.

Parenting stress was measured using the Parenting Distress subscale (12 items) of the Parenting Stress Index-Short Form (Abidin, 1995). This scale has previously been used with at-risk South African populations (Potterton et al., 2007). The subscale assesses the frequency of parenting stress experienced within the previous three months (e.g., “I felt trapped by my responsibilities as a parent”). Items are summed with higher scores indicating higher levels of stress.

Parental depression was measured using the Beck Depression Inventory (BDI-II) (Beck & Steer, 1988). The BDI-II is a 21-item scale designed to assess the intensity of depression in both clinical patients and for the general population. It has been translated into isiXhosa and validated in South Africa (Steele, 2003). Parents are asked to choose from a series of statements describing their experience of depressive symptoms over the past two weeks. Responses are summed with higher scores indicating higher levels of depressive symptoms. We used clinical cut-off scores of 14

to 19 for mild depression, 20 to 28 for moderate depression, and 29 and above for severe depression in the study sample (Beck & Steer, 1988).

The Multidimensional Scale of Perceived Social Support (MSPSS, 12 items) was used to measure parental social support (Zimet et al., 1990). The MSPSS has been used previously in South Africa with high reliability (Casale et al., 2015). Parents report on levels of agreement with statements reflecting support from family, friends, and other sources (e.g., “I get the emotional support and help I need from my family”). Items are summed to create a total score with higher scores indicating higher levels of perceived social support (range 12 to 60).

Data collection and management

Questionnaires and assessment protocols were translated into isiXhosa and back-translated into English to ensure accuracy of translation. Trained isiXhosa-speaking research assistants blind to group allocation conducted face-to-face interviews and recorded videos of observational assessments with participants using low-cost mobile phones. Screening at baseline occurred in February 2013 at a local community center and lasted approximately 30 minutes for each participant. Self-report and observational assessments took place in participants’ homes and lasted approximately 60 and 30 minutes respectively. Post-test data collection took place in July 2013, immediately after the intervention group received the program, and about three and a half months after baseline.

After each assessment, the mobile phones instantly transmitted self-report data to a secure central network server. Observation videos were also extracted from the phones every day. Electronic data was accessible via a password known only to senior members of the research team. All data was also backed up on an external hard drive and in paper format. Non-electronic data was stored in a locked filing cabinet at the

University of Cape Town. Outcome data was cleaned and entered into SPSS 21.0 for analysis.

Data analysis

In order to determine the reliability of assessment tools, we examined the internal consistency of self-report measures and the inter-rater reliability of observational assessments. Acceptable thresholds were set at 0.70 based on Cronbach's alpha coefficients and inter-cluster correlation coefficients, respectively (Aspland & Gardner, 2003; Cronbach, 1951). Outcome data analyses were conducted with an intention-to-treat design using multiple imputation at the item level to account for missing data (Streiner & Geddes, 2001). Little's Missing Completely at Random (MCAR) test with expectation maximization assessed response rates and the randomness of missing data (Li, 2013). The Multiple Imputation by Chained Equations method was used with a fully conditional specification and a Markov Chain Monte Carlo algorithm (10 maximum iterations) (Graham, Olchowski, & Gilreath, 2007). Twenty multiple imputed datasets were created in order to minimize the potential impact of individually imputed data. Intra-cluster correlations coefficients were calculated within the intervention group to measure the level of dependency of outcomes for members in the same parenting group (Pals et al., 2008).

Baseline differences between intervention and control groups were examined for demographic data and outcome measures using independent t-tests and Chi-square crosstab analyses. To test the preliminary effectiveness of the intervention at immediate post-test, multivariate mixed-effects models (SPSS mixed) were used with baseline scores as covariates. This procedure is considered a more robust statistical analytic approach than analyses of covariance since it takes into account potential within-group effects in the intervention arm (Baldwin et al., 2005). Fixed effects included treatment

allocation and baseline outcomes. Random effects included allocation and parenting group assignment to account for the partially nested data in the intervention arm. In order to examine whether there was an effect of grouping participants, treatment allocation was included as a repeated measure with individual participants nested within parenting group assignment. Furthermore, the restricted maximum likelihood estimation method (REML) was used to produce less biased estimates of variance due to the small number of parent groups (Bauer, Sterba, & Hallfors, 2008). In order to assess the potential clinical relevance of outcomes in this pilot study, we examined tests for significance of effect (set at the $p < 0.05$ level), as well as the direction and magnitude of bias corrected Cohen's d effect sizes (Gardner & Altman, 1986). While tests for significance based on p -values may determine whether there is a statistically reasonable likelihood of detecting an intervention effect, the estimation of effect sizes is generally recommended as a more appropriate approach for studies with small sample sizes (Kianifard & Islam, 2011). An effect size of 0.2 was considered small, 0.5 was moderate, and 0.8 or higher was large (Cohen, 1988). Finally, this study used a threshold of $d = 0.25$ to determine a clinically relevant effect (Wolf, 1986).²⁶

Results

Characteristics of the sample are summarized in Table 6. Participants were predominantly unemployed, female, unmarried, and biological parents of children targeted in assessments. Non-biological parents were grandmothers ($n = 21$), aunts ($n = 5$), and one foster mother. The average number of children per household was 2.66 with a total household size of 5.71 members. Child gender was evenly split between boys

²⁶ An effect of $d = 0.25$ means that in order to have one more positive outcome in the intervention group than the control group, the intervention would have to be delivered to 13 people. In other words, for every 100 participants approximately 8 families would have a more positive outcome compared to those who do not receive the intervention, assuming that 25% of the control group also have favorable outcomes (Magnusson, 2014; Schünemann et al., 2008).

and girls with a mean age of 5.40 years old.

In terms of risk factors for child maltreatment, 34% of parents reported experiencing violence from an intimate partner in the past month at baseline, 72% reported experiencing physical abuse as a child, and 31% of the parents were either AIDS-symptomatic, HIV-positive, or caring for a child orphaned by AIDS. As indicators of household poverty, 75% lived in informal housing, (e.g., corrugated tin shacks), 79% reported experiencing hunger more than five days in the previous month, and 46% depended on more than one source of government support. Forty-six percent of the participants reported symptoms of mild to severe depression. Forty-three percent of the participants also reported experiencing three or more risk factors for child maltreatment (i.e., extreme poverty, familial HIV/AIDS, intimate partner violence, mild to severe parental depression, and/or history of child maltreatment).

In terms of discipline practices at baseline, 43% of the parents reported shouting, yelling, or screaming at their child, 74% reported using some form of corporal punishment such as hitting their child, and 21% reported using severe physical punishment such as beating up their child repeatedly. In terms of positive parenting behavior, 32% reported playing with their child, and 49% reported praising their child's good behavior often.

Program enrolment was high. Ninety-four percent of the parents allocated to the intervention group attended at least one session with enrolled parents attending an average of nine out of twelve sessions (75% attendance rate). A third of the parents missed only one or no sessions, and 88% attended six or more sessions. Only four participants were characterized as program dropouts after missing at least three consecutive sessions and not returning to the program. Facilitators also reported implementing 91% of the manualized activities based on fidelity checklists.

Table 6. Demographic characteristics of the sample at baseline¹

	Total (<i>n</i> = 68)	Control (<i>n</i> = 34)	Intervention (<i>n</i> = 34)
Parent characteristics			
Parent age, M (SD)	41.57 (13.15)	41.09 (13.32)	42.06 (13.16)
Parent gender, <i>n</i> female, %	67, 98.5%	34, 100.0%	33, 97.1%
Marital status, <i>n</i> single, %	50, 73.5%	26, 76.5%	24, 70.6%
Not completed high school, <i>n</i> (%)	56, 82.4%	25, 73.5%	31, 90.9%
Unemployed, <i>n</i> (%)	66, 97.1%	32, 94.1%	34, 100.0%
Child characteristics			
Child age, M (SD)	5.40 (1.69)	5.18 (1.73)	5.62 (1.65)
Child gender, <i>n</i> female (%)	33, 48.5%	17, 50.0%	16, 47.1%
Relationship to parent, <i>n</i> biological (%)	41, 60.3%	20, 58.8%	21, 61.8%
Family characteristics			
Informal housing, <i>n</i> (%)	51, 75.0%	25, 73.5%	26, 76.5%
Household size, M (SD)	5.71 (2.86)	5.56 (2.19)	5.58 (3.43)
Children per household, M (SD)	2.66 (1.32)	2.68 (1.43)	2.74 (1.33)
Two or more sources of gov't support, <i>n</i> (%)	31, 45.6%	14, 41.2%	17, 50.0%
Social risk factors for child abuse			
Experienced hunger ≥ 5 times in previous 30 days, ^a <i>n</i> (%)	54, 79.4%	25, 73.5%	29, 85.3%
Family affected by HIV/AIDS, ^b <i>n</i> (%)	21, 30.9%	11, 32.4%	10, 29.4%
Parent experienced intimate partner violence in previous month, ^c <i>n</i> (%)	23, 33.8%	12, 35.3%	11, 32.4%
Parent experienced physical abuse as a child, ^d <i>n</i> (%)	49, 72.1%	24, 70.6%	25, 73.5%
Mild parental depression, ^e <i>n</i> (%)	12, 17.6%	10, 29.4%	2, 5.9%
Moderate parental depression, ^e <i>n</i> (%)	10, 14.7%	4, 11.8%	6, 17.6%
Severe parental depression, ^e <i>n</i> (%)	9, 13.2%	5, 14.7%	4, 11.8%
Three or more risk factors for abuse, <i>n</i> (%)	29, 42.6%	12, 35.3%	17, 50.0%

¹ Independent t-tests and Chi-squared tests found no significant differences between groups at baseline; ^a Based on the Hunger Scale Questionnaire; ^b Based on three or more symptoms on the Verbal Autopsy; ^c Conflict Tactics Scale; ^d ISPCAN Child Abuse Screening Tool-Retrospective; ^e Becks Depression Inventory.

Study feasibility

Study retention is summarized in the flow diagram (Figure 13). Out of the 116 participants referred to the study, 94 were contactable and screened (72.4%). Sixty-eight parents were eligible and included in the study (70.8%). Reasons for ineligibility included the parent reporting less than 11 child problem behaviors on the ECBI problem scale, the respondent not being the child's primary caregiver, the child's age not being between three and eight years, and unavailability for baseline assessment.

Study retention for self-report data was considerably higher than anticipated with only two dropouts (97.1%). Observation assessment retention rates were also high (88.2% baseline, 89.7% post-test). Incomplete assessments or dropouts were due to the family relocating to another province, the child no longer living with the parent, either parent or child refusing to be videoed, and withdrawing from the study for personal reasons.

There were only four (5.9%) reported instances of compromised interviewer blindness in which participants disclosed their allocation status to researchers at post-test. Although a few parents discussed the program with control group participants who lived nearby, significant contamination was considered unlikely based on interviews with the control group.

The internal reliability of parent-report outcome measures ranged from .75 to .93 with the exception of the Parent-Child Conflict Tactics Scale's nonviolent discipline subscale ($\alpha = .20$). This was excluded from further analyses. Inter-rater reliability coefficients were acceptable for all of the observational assessments (ICC = 0.74 to 0.97, $p < 0.05$) (Table 6).

Table 7. Reliability of self-report and observational measures

Parent-report assessments	Items	α
Harsh parenting ^a	23	.75
Nonviolent discipline ^a	4	.20
Positive parenting, frequency ^b	7	.81
Positive parenting, problem ^b	7	.84
Setting limits, frequency ^c	7	.81
Setting limits, problem ^c	7	.89
Child behavior, intensity ^d	36	.93
Child behavior, problem ^d	36	.86
Parenting stress ^e	12	.85
Parent depression ^f	23	.89
Social support ^g	12	.70
Observational assessments	Items	<i>ICC</i>
Positive parenting	n/a	.97**
Effective parenting	n/a	.90**
Negative parenting	n/a	.93**
Child positive behavior	n/a	.74*
Child deviance	n/a	.74*
Child-led play	n/a	.82**

* $p < 0.05$; ** $p < 0.01$; ^a Parent-Child Conflict Tactics, ^b Parenting Young Children Positive Parenting, ^c Parenting Young Children Setting Limits, ^d Eyberg Child Behavior Inventory, ^e Parenting Stress Index-Short Form, ^f Beck Depression Inventory, ^g Multidimensional Scale of Perceived Social Support.

Little's MCAR test on outcome variables indicated that the data was missing at random (Chi-Square = 2288.267, DF = 8869, Sig. = 1.000). Missing Value Analysis found 60.3% of the cases had missing data with a total of 2.8% missing values. Outcomes missing over 10% of the data were parent history of child maltreatment (17.6% missing on three variables at baseline, 16.2% missing on eight variables at post-test) and observation assessments of parenting and child behavior (11.8% and 10.3% missing variables at baseline and post-test, respectively).

Sensitivity analyses found no significant differences between the means of incomplete outcomes and pooled imputed outcomes. Moreover, due to the small sample size, the influence of potential outliers (those with z -scores greater than ± 2.5) was

examined by performing analyses twice – with and without outliers – with nearly identical results for all outcomes.

Independent t-tests and Chi-square tests found no differences between the intervention and control groups for all demographics and outcome measures at baseline (Tables 6, 8, and 9). Finally, within-group analyses found no significant intra-cluster correlation coefficients for any of the outcome measures, thus indicating that there was minimal effect of parent group assignment within the intervention allocation.

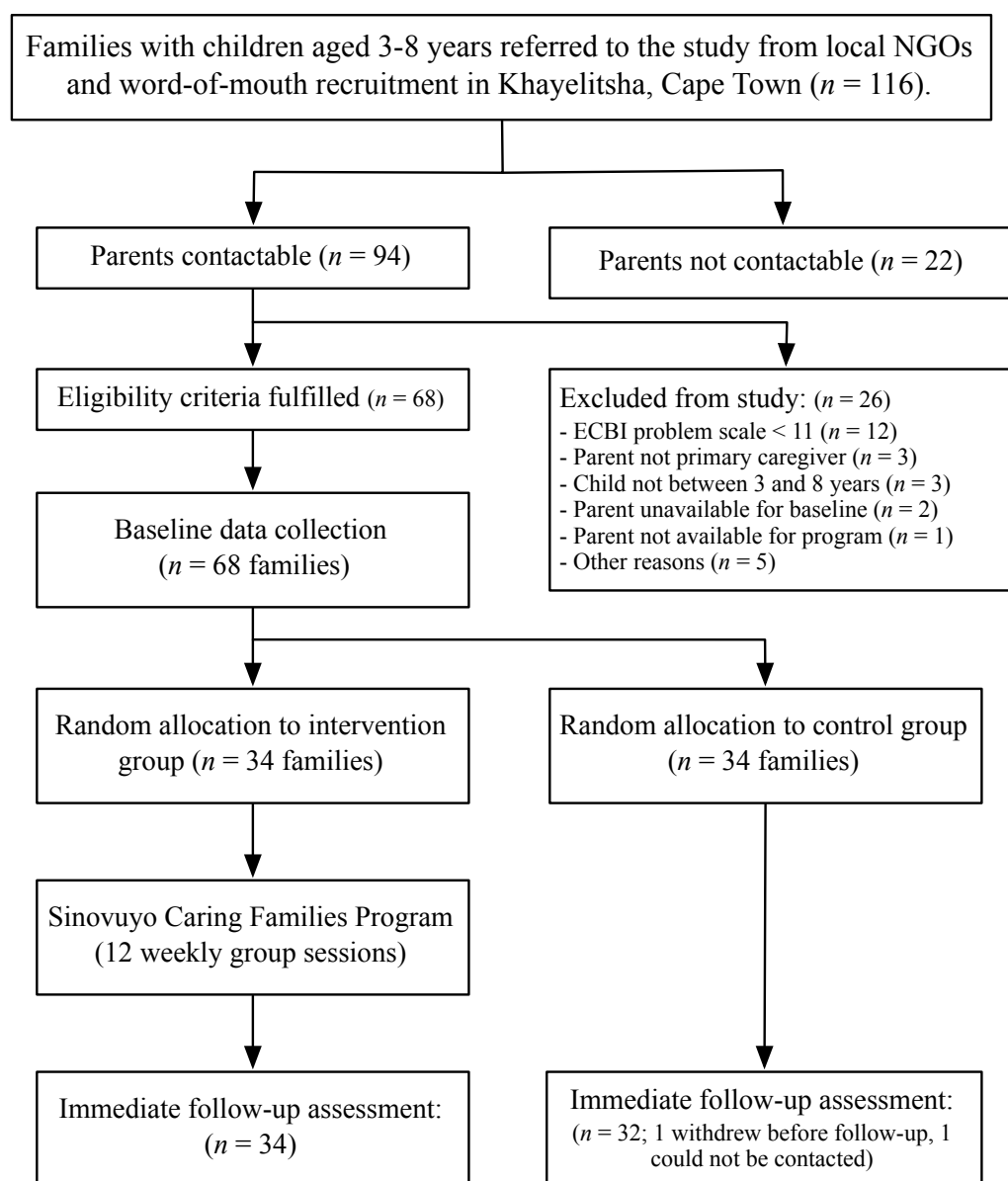


Figure 15. RCT study flow diagram.

Intervention effects

Parent-report.

Multivariate mixed model analyses of parent-report data are summarized in Table 7. Analyses showed significant treatment effects for positive parenting, $F(1,65) = 6.97, p < .05$), with parents in the intervention group reporting more frequent positive parenting at post-test assessment in comparison to controls ($d = 0.63$, 95% CI [0.14, 1.12]). There were also potentially clinically relevant but non-significant intervention effects for reduced intensity of child behavior problems ($d = -0.29$; 95% CI [-0.77, 0.19]) and increased perceived social support in comparison to controls ($d = 0.27$; 95% CI [-0.21, 0.75]).

Observational assessments.

Results from observational assessments are summarized in Table 8. Models suggested significant treatment effects for coder impressions of child-led play, $F(1,65) = 5.70, p < .05$), with improvements in the intervention group in comparison to controls ($d = 0.57$, 95% CI [0.09, 1.06]). There was also a non-significant but clinically relevant treatment effect for decreased frequency of observed negative parenting ($d = -0.33$; 95% CI [-0.81, 0.14]). On the other hand, models also suggested significant negative treatment effects for observed child positive behavior, $F(1,65) = 5.60, p < .05$), with decreased frequency of positive behavior in the intervention group in comparison to controls ($d = -0.56$, 95% CI [-1.05, -0.08]). There was also a non-significant but clinically relevant difference between groups in the frequency of observed negative child behavior with a higher frequency observed in the intervention group in comparison to controls ($d = 0.30$; 95% CI [-0.18, 0.78]).

There were no other significant differences or effect sizes over $d = 0.25$ between groups for the remaining self-report or observed outcomes.

Table 8. Results summarizing parent-report measures at baseline and post-test using multivariate mixed modeling and an intention-to-treat analysis

Measure	Control (<i>n</i> = 34)		Intervention (<i>n</i> = 34)		<i>F</i> Statistic	Estimated mean difference ² [95% CI]	Effect size ³ [95% CI]
	Baseline	Post-test ¹	Baseline	Post-test ¹			
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)			
Primary Outcomes							
Harsh parenting ^a	9.95 (8.06)	3.47 (3.01)	8.24 (5.75)	3.55 (5.18)	0.01	0.08 [-1.98, 2.14]	0.02 [-0.46, 0.49]
Positive parenting, frequency ^b	20.12 (9.30)	20.21 (7.28)	21.50 (9.09)	25.29 (8.56)	6.97*	5.08** [1.23, 8.92]	0.63** [0.14, 1.12]
Setting limits, frequency ^c	23.79 (8.77)	21.12 (7.06)	24.79 (9.30)	20.71 (8.71)	0.06	-0.41 [-4.25, 3.43)	-0.05 [-0.53, 0.42]
Child behavior problems, intensity ^d	122.56 (42.50)	111.39 (37.72)	120.59 (41.66)	99.78 (41.85)	1.44	-11.59 [-30.88, 7.70]	-0.29+ [-0.77, 0.19]
Child behavior problems, problem ^d	21.09 (7.06)	16.45 (7.98)	20.74 (6.87)	15.49 (9.52)	0.21	-0.97 [-5.22, 3.29]	-0.11 [-0.58, 0.37]
Secondary Outcomes							
Parenting stress ^e	24.20 (9.79)	22.40 (7.63)	21.90 (9.17)	20.53 (8.20)	0.96	-1.88 [-5.72, 1.96]	-0.23 [-0.71, 0.24]
Parental depression ^f	14.60 (10.41)	8.77 (8.59)	12.36 (10.78)	9.93 (10.02)	0.26	1.16 [-3.36, 5.68]	0.12 [-0.35, 0.60]
Social support ^g	58.60 (9.70)	57.44 (10.04)	55.65 (9.55)	60.07 (9.38)	1.25	2.63 [-2.07, 7.34]	0.27+ [-0.21, 0.75]

¹ Post-test means adjusted for baseline scores, no differences at baseline; ² Difference in mean follow-up scores between intervention and waiting list control conditions adjusted for baseline scores; ³ Bias corrected Cohen's *d*. ** $p < .01$. + $d > 0.25$ (i.e., clinically relevant). ^a Parent-Child Conflict Tactics, ^b Parenting Young Children Positive Parenting, ^c Parenting Young Children Setting Limits, ^d Eyberg Child Behavior Inventory, ^e Parenting Stress Index-Short Form, ^f Beck Depression Inventory, ^g Multidimensional Scale of Perceived Social Support.

Table 9. Results summarizing observational measures at baseline and post-test using multivariate mixed modeling and an intention-to-treat analysis.

Measure	Control (<i>n</i> = 34)		Intervention (<i>n</i> = 34)		<i>F</i> Statistic	Estimated mean difference ² [95% CI]	Effect size ³ [95% CI]
	Baseline <i>M</i> (<i>SD</i>)	Post-test ¹ <i>M</i> (<i>SD</i>)	Baseline <i>M</i> (<i>SD</i>)	Post-test ¹ <i>M</i> (<i>SD</i>)			
Parent Behavior							
Positive parenting	7.71 (8.93)	6.63 (5.56)	7.78 (6.33)	7.40 (5.56)	0.34	0.77 [-2.09, 3.63]	0.13 [-0.35, 0.61]
Negative parenting	5.59 (5.11)	4.53 (3.34)	7.48 (9.70)	3.32 (3.78)	2.03	-1.21 [-2.94, 0.52]	-0.34 ⁺ [-0.81, 0.14]
Effective parenting	13.06 (9.39)	8.66 (4.55)	10.62 (5.27)	8.21 (3.95)	0.20	-0.45 [-2.51, 1.62]	-0.10 [-0.58, 0.37]
Child-led play	0.54 (0.72)	0.45 (0.73)	0.64 (0.73)	0.87 (0.70)	5.70 *	0.42 [*] [0.07, 0.76]	0.57 [*] [0.09, 1.06]
Child Behavior							
Positive behavior	17.95 (11.72)	13.52 (7.21)	15.48 (9.82)	9.99 (5.05)	5.60*	-3.53 [*] [-6.54, -0.52]	-0.56 [*] [-1.05, -0.08]
Negative behavior	2.24 (7.00)	0.52 (1.66)	1.85 (1.96)	1.08 (2.36)	2.46	0.56 [-0.34, 1.45]	0.30 ⁺ [-0.18, 0.78]

¹ Post-test means adjusted for baseline scores, no differences at baseline; ² Difference in mean follow-up scores between intervention and waiting list control conditions adjusted for baseline scores; ³ Bias corrected Cohen's *d*. * $p < .05$. ⁺ $d > 0.25$ (i.e., clinically relevant).

Discussion

This study is the one of the first to examine the feasibility of conducting a randomized controlled trial evaluation of a parenting program for families with children aged three to eight in sub-Saharan Africa. Findings indicate that it is possible to implement a rigorous evaluation of a parenting intervention despite working with highly vulnerable families living in impoverished communities. Results show high levels of study recruitment and retention, as well as strong reliability of parent-report and observational measures. By maintaining allocation concealment and using rigorous randomization procedures including an intention-to-treat design, we were able to limit selection and reporting biases. Moreover, the combination of self-report and observational assessments illustrates that it is possible to use a robust approach to analyze parenting and child behavior from multiple perspectives in this context with limited resources.

Exploratory outcome analyses of the program's impact on reducing child maltreatment showed mixed results. The moderate effect sizes for increased frequency of positive parenting in the intervention group provide some initial indications that the program may reduce potential risks of abuse. Moreover, these effects were found in both parent-report and observational assessments, thus contributing to the robustness of results. This is particularly important given evidence on the role of positive parenting as a protective factor in reducing harsh parenting and child behavior problems during early childhood (Trentacosta et al., 2008). Results regarding harsh parenting and child behavior were less conclusive. Although observational assessments showed clinically relevant treatment effects for reduced harsh parenting, there were no differences between groups for parent-report on the Parent-Child Conflict Tactics scale. Instead,

analyses showed significant reductions in parent-reports of harsh parenting from baseline to post-test, thus suggesting either a potential Hawthorne effect as a result of participating in the study or a response bias due to social desirability. (Flay, 1986). Furthermore, the less frequent positive child behavior observed in the intervention group suggests that additional emphasis on limit-setting and nonviolent discipline may be necessary to have a positive effect on child behavior. However, it is important to note that results are limited by the timing of post-test assessment immediately after program delivery. Other studies have reported that parents may require more time to practice nonviolent approaches to discipline in order to implement them with consistency and confidence (Whittingham, Sofronoff, Sheffield, & Sanders, 2009). Thus, a longer-term follow-up would have enabled us to examine potential delayed treatment effects (Kumkale & Albarracin, 2004).²⁷

This study has a number of limitations. First, as a pilot study, the internal validity of outcome results must be considered with caution due to the small sample size (Lancaster et al., 2004). High variance due to heterogeneity within groups often occurs in studies with small samples making it difficult to distinguish intervention effects (i.e., variance due to allocation) amidst other sources of variance (Hopkin, Hoyle, & Gottfredson, 2015). In addition, although RCTs of similar parenting programmes have found strong convergences of effects between self-report and observational assessments (e.g., Gardner et al., 2006; Hutchings et al., 2007; McGilloway et al., 2012), concurrent validity based on pairwise correlations was not established between observational and self-report measures of parent and child behaviour (see Table 11 in Appendix J, page 456).

²⁷ For a more detailed discussion regarding the mixed results, please see the Chapter Seven (pages 233-283).

The small selective sample size also limits the generalizability of the results to a wider population. Participants were recruited from a specific population group in which many of the families were already receiving support from a local community-based organization. Additional research would benefit from including families who are not receiving social services since they may respond differently to the program. Furthermore, two key population groups were not engaged: fathers and employed parents. Employed parents were unable to participate in the study because the group sessions were delivered on weekdays. Although evening sessions may have accommodated this group, pre-program consultations with parents found resistance to attending program sessions after nightfall due to very high neighborhood crime levels. Moreover, challenges in recruiting male caregivers are an often-cited occurrence in parent training programs, even in high-income countries (Wong, Roubinov, Gonzales, Dumka, & Millsap, 2013). The lack of male participation in the study may have been a result of recruitment biases due to the research staff consisting primarily of women. There also may have been cultural barriers as a result of childrearing being traditionally viewed as a woman's responsibility (Panter-Brick et al., 2014). Furthermore, fathers who did not reside in the same household as the participating child were excluded due to the study inclusion criteria. Future research may need to reconsider this criterion since South African fathers often do not live in the same household as their children and have limited contact with them over the course of their lifetimes (Bray et al., 2010).

Finally, more research is needed on the psychometric properties of self-report measurements and observational methods. It is possible that there are cultural, linguistic, or contextual issues that need to be taken into account with respect to measuring harsh parenting and child behavior, as well as other outcomes in this study. With the

exception of the Beck Depression Index, the majority of outcome measurements in this study have not been psychometrically tested for isiXhosa-speaking populations in South Africa. Although most have been used in similar contexts, the validity of the scales has yet to be evaluated as to whether they measure the same constructs as originally designed. Likewise, the Sinovuyo Observational Coding System may require additional piloting and testing to determine its reliability in assessing parent and child behaviors.

Results highlight a number of key recommendations for future program development and evaluation. Further program revision is necessary to improve intervention effects, particularly for child behavior problems and harsh parenting. The Sinovuyo program was initially designed with greater emphasis and time allocated to promoting positive parenting behavior before introducing limit-setting skills and nonviolent discipline. Nonviolent discipline strategies such as ignoring negative attention-seeking behavior or time-out may require additional sessions or revised content in order for parents to correctly integrate them within their daily parenting practices. In addition, programs may need to actively involve parents and children in joint sessions or via intensive coaching at home in order to improve child behavior.

Additional research is also necessary in order to determine program effectiveness and feasibility. A process evaluation would provide the opportunity to further examine the cultural acceptability of the program as well as any potential barriers to implementation and participation (Durlak & DuPre, 2008). This would allow further development by integrating outcome and process data prior to further testing (Oakley et al., 2006). Moreover, a planned randomized controlled trial with an adapted program and a larger sample size will provide sufficient statistical power to detect intervention effects. This will also enable moderator and mediator analyses to be

conducted to investigate mechanisms of change and potential differential effects for specific population groups or conditions. By including a longer follow-up assessment, we will also be able to determine whether there are delays or any changes in intervention effects over time.

In conclusion, this pilot randomized controlled trial demonstrates the feasibility of conducting a rigorous evaluation of a locally developed parenting program for highly vulnerable families. This is particularly relevant in the context of South Africa where parenting programs are often implemented with minimal evaluation (Wessels & Ward, 2015). Although results were mixed with regard to its effectiveness, there were encouraging signs that the program may reduce the risk of child maltreatment by improving positive parenting skills. Nevertheless, the program may require additional content or revision to strengthen delivery, specifically with regard to teaching nonviolent discipline skills and managing difficult child behavior. A subsequent large-scale test with longer follow-up assessments is recommended to determine program effectiveness and generalizability.

References

- Abidin, R. R. (1995). *Parenting Stress Index (PSI) manual* (3rd ed.). Charlottesville, VA: Pediatric Psychology Press.
- Altman, D. G., Schulz, K. F., Moher, D., Egger, M., Davidoff, F., Elbourne, D., . . . Lang, T. (2001). The revised CONSORT statement for reporting randomized trials: Explanation and elaboration. *Annals of Internal Medicine*, 134(8), 663-694.
- Aspland, H., & Gardner, F. (2003). Observational measures of parent-child interaction: An introductory review. *Child and Adolescent Mental Health*, 8(3), 136-143.
- Baldwin, S. A., Murray, D. M., & Shadish, W. R. (2005). Empirically supported treatments or type I errors? Problems with the analysis of data from group-administered treatments. *Journal of Consulting and Clinical Psychology*, 73(5), 924-935. doi: 10.1037/0022-006x.73.5.924
- Bandura, A. (1977). *Social learning theory*. New York: General Learning Press.
- Barlow, J., Johnston, I., Kendrick, D., Polnay, L., & Stewart-Brown, S. (2006). Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. *Cochrane Database of Systematic Reviews*, 3, 1-20.
- Bauer, D. J., Sterba, S. K., & Hallfors, D. D. (2008). Evaluating group-based interventions when control participants are ungrouped. *Multivariate Behavioral Research*, 43(2), 210-236.
- Beck, A. T., & Steer, R. A. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluations. *Clinical Psychology Review*, 8, 77-100.
- Bozalek, V. (1999). Contextualizing caring in black South African families. *Social Politics*, 6(1), 85-99.
- Bray, R., & Brandt, R. (2007). Child care and poverty in South Africa. *Journal of Children and Poverty*, 13(1), 1-19. doi: 10.1080/10796120601171187
- Bray, R., Gooskens, I., Kahn, L., Moses, S., & Seekings, J. (2010). *Growing up in the new South Africa: Childhood and adolescence in post-apartheid South Africa*. Cape Town: Human Sciences Research Council.
- Casale, M., Cluver, L., Crankshaw, T., Kuo, C., Lachman, J. M., & Wild, L. G. (2015). Direct and indirect effects of caregiver social support on adolescent psychological outcomes in two South African AIDS-affected communities. *American Journal of Community Psychology*, 1-11.
- Chen, M., & Chan, K. L. (2015). Effects of parenting programs on child maltreatment prevention: A meta-analysis. *Trauma, Violence, and Abuse*, 17(1), 88-104. doi: 10.1177/1524838014566718
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Hillsdale, NJ: Erlbaum.
- Cohen, L. R., Hien, D. A., & Batchelder, S. (2008). The impact of cumulative maternal trauma and diagnosis on parenting behavior. *Child Maltreatment*, 13(1), 27-38.
- Collins, D., & Leibbrandt, M. (2007). The financial impact of HIV/AIDS on poor households in South Africa. *AIDS*, 21(Suppl 7), S75-S81.
- Cooper, P. J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A., . . . Murray, L. (2009). Improving quality of mother-infant relationship and infant attachment in a socioeconomically deprived community in South Africa: Randomised controlled trial. *British Medical Journal*, 338, b974-b974.

-
- Cooper, P. J., Vally, Z., Cooper, H., Radford, T., Sharples, A., Tomlinson, M., & Murray, L. (2014). Promoting mother-infant book sharing and infant attention and language development in an impoverished South African population: A pilot study. *Early Childhood Education Journal*, 42, 143-152. doi: 10.1007/s10643-013-0591-8
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16(3), 297-334.
- Dunkle, K., Jewkes, R., Brown, H., Gray, G., McIntyre, J., & Harlow, S. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*, 363(9419), 1415-1421.
- Dunne, M. P., Zolotorb, A., Runyanb, D., Andrevia-Miller, I., Yuen Chood, W., Dunnea, S., . . . Youssefj, R. (2009). ISPCAN Child Abuse Screening Tools Retrospective version (ICAST-R): Delphi study and field testing in seven countries. *Child Abuse & Neglect*, 33(11), 815-825.
- Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, 41(3-4), 327-350.
- Erdfelder, E., Faul, F., & Buchner, A. (1996). GPOWER: A general power analysis program. *Behavior Research Methods, Instruments, and Computers: A Journal of the Psychonomic Society, Inc*, 28, 1-11.
- Eyberg, S., & Pincus, D. (1999). *Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory - revised: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Eyberg, S., & Robinson, E. A. (2000). *Dyadic Parent-Child Interaction Coding System: A manual*. Seattle, WA: The Parenting Clinic, Department of Family and Child Nursing, School of Nursing, University of Washington.
- Flay, B. R. (1986). Efficacy and effectiveness trials (and other phases of research) in the development of health promotion programs. *Preventive Medicine*, 15(5), 451-474.
- Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: Outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry*, 47(11), 1123-1132. doi: 10.1111/J.1469-7610.2006.01668.X
- Gardner, F., Montgomery, P., & Knerr, W. (2015). Transporting evidence-based parenting programs for child problem behavior (age 3-10) between countries: Systematic review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology*, 1-14. doi: 10.1080/15374416.2015.1015134
- Gardner, M. J., & Altman, D. G. (1986). Confidence-intervals rather than P-values: Estimation rather than hypothesis-testing. *British Medical Journal*, 292(6522), 746-750.
- Gershoff, E. T., Aber, L., Raver, C., & Lennon, M. (2007). Income is not enough: Incorporating material hardship into models of income associations with parenting and child development. *Child Development*, 78(1), 70-95.
- Graham, J. W., Olchowski, A. E., & Gilreath, T. D. (2007). How many imputations are really needed? Some practical clarifications of multiple imputation theory. *Prevention Science*, 8(3), 206-213. doi: 10.1007/S11121-007-0070-9
-

-
- Hopkin, C. R., Hoyle, R. H., & Gottfredson, N. C. (2015). Maximizing the yield of small samples in prevention research: A review of general strategies and best practices. *Prevention Science*. doi: 10.1007/s11121-014-0542-7
- Hutchings, J., Gardner, F., & Lane, E. (2004). Making evidence-based intervention work. In D. Farrington, C. Sutton, & D. Utting (Eds.), *Support from the start: Working with young children and their families to reduce the risks of crime and antisocial behaviour* (pp. 69-79). London: Department for Education and Skills.
- Hutchings, J., Gardner, F., Lane, E., Bywater, T., Daley, D., Whitaker, C., . . . Edwards, R. T. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomised controlled trial. *British Medical Journal*, 334(7595), 678-682. doi: 10.1136/Bmj.39126.620799.55
- Jewkes, R., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *Lancet*, 376, 41-48.
- Kabat-Zinn, J. (2013). *Full catastrophe living (revised edition): Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Bantam Books.
- Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology*, 36(4), 567-589. doi: 10.1007/s10802-007-9201-9
- Kazdin, A. E. (1997). Parent management training: Evidence, outcomes, and issues. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(10), 1349-1356. doi: 10.1097/00004583-199710000-00016
- Kianifard, F., & Islam, M. Z. (2011). A guide to the design and analysis of small clinical studies. *Pharmaceutical Statistics*, 10(4), 363-368.
- Kim, J., Cicchetti, D., Rogosch, F. A., & Manly, J. T. (2009). Child maltreatment and trajectories of personality and behavioral functioning: Implications for the development of personality disorder. *Development and Psychopathology*, 21(3), 889-912. doi: 10.1017/S0954579409000480
- Knerr, W., Gardner, F., & Cluver, L. (2013). Improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries: A systematic review. *Prevention Science*, 14(4), 352-363. doi: 10.1007/s11121-012-0314-1
- Kumkale, G. T., & Albarracin, D. (2004). The sleeper effect in persuasion: A meta-analytic review. *Psychological Bulletin*, 130(1), 143-172.
- Kuo, C., Operario, D., & Cluver, L. (2012). Depression among carers of AIDS-orphaned and other-orphaned children in Umlazi Township, South Africa. *Global Public Health*, 7(3), 253-269. doi: 10.1080/17441692.2011.626436
- Labadarios, D., Maunder, E., Steyn, N., MacIntyre, U., Swart, R., Gericke, G., . . . Dannhauser, A. (2003). National food consumption survey in children aged 1-9 years: South Africa 1999. *Forum Nutrition*, 56, 106-109.
- Lachman, J. M., Sherr, L., Cluver, L., Ward, C. L., Hutchings, J., & Gardner, F. (2016). Integrating evidence and context to develop a parenting program for low-income families in South Africa. *Journal of Child and Family Studies*, 25(7), 2337-2352. doi: 10.1007/s10826-016-0389-6
- Lachman, P., Poblete, X., Ebigbo, P. O., Nyandiya-Bundy, S., Bundy, R. P., Killian, B., & Doek, J. (2002). Challenges facing child protection. *Child Abuse & Neglect*, 26(6-7), 587-617.
-

-
- Lancaster, G. A., Dodd, S., & Williamson, P. R. (2004). Design and analysis of pilot studies: Recommendations for good practice. *Journal of Evaluation in Clinical Practice*, 10(2), 307-312. doi: 10.1111/j.2002.384.doc.x
- Lansford, J. E., Criss, M. M., Laird, R. D., Shaw, D. S., Pettit, G. S., Bates, J. E., & Dodge, K. A. (2011). Reciprocal relations between parents' physical discipline and children's externalizing behavior during middle childhood and adolescence. *Development and Psychopathology*, 23(1), 225-238. doi: 10.1017/S0954579410000751
- Leijten, P., Raaijmakers, M. A. J., de Castro, B. O., & Matthys, W. (2013). Does socioeconomic status matter? A meta-analysis on parent training effectiveness for disruptive child behavior. *Journal of Clinical Child and Adolescent Psychology*, 42(3), 384-392.
- Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology*, 20(4), 544-552.
- Li, C. (2013). Little's test of missing completely at random. *Stata Journal*, 13(4), 795-809.
- Lopman, B. A., Barnabas, R. V., Boerma, J. T., Chawira, G., Gaitskell, K., Harrop, T., . . . Gregson, S. (2006). Creating and validating an algorithm to measure AIDS mortality in the adult population using verbal autopsy. *Plos Medicine*, 3(8), 1273-1281. doi: 10.1371/journal.pmed.0030312
- Magnusson, K. (2014). Interpreting Cohen's d effect size: An interactive visualization. from <http://rpsychologist.com/d3/cohend/>
- McEachern, A., Dishion, T., Weaver, C., Shaw, D., Wilson, M., & Gardner, F. (2011). Parenting Young Children (PARYC): Validation of a self-report parenting measure. *Journal of Child and Family Studies*, 21(3). doi: 10.1007/s10826-011-9503-y
- McGilloway, S., Mhailie, G. N., Bywater, T., Furlong, M., Leckey, Y., Kelly, P., . . . Donnelly, M. (2012). A parenting intervention for childhood behavioral problems: A randomized controlled trial in disadvantaged community-based settings. *Journal of Consulting and Clinical Psychology*, 80(1), 116.
- Meinck, F. (2014). *Physical, emotional and sexual child abuse victimisation in South Africa: Findings from a prospective cohort study*. Oxford: University of Oxford.
- Meinck, F., Cluver, L. D., Boyes, M. E., & Loening-Voysey, H. (2016). Physical, emotional, and sexual abuse of children in South Africa: Incidence, prevalence, perpetrators, and locations. *Journal of Epidemiology and Community Health*.
- Meinck, F., D., C. L., Boyes, M. E., & Ndhlovu, L. D. (2013). Risk and protective factors for physical and emotional abuse victimisation amongst vulnerable children in South Africa. *Child Abuse Review*, 24(3), 182-197.
- Meth, P. (2013). 'I don't like my children to grow up in this bad area': Parental anxieties about living in informal settlements. *International Journal of Urban and Regional Research*, 37(2), 537-555. doi: 10.1111/J.1468-2427.2012.01199.X
- Mlotshwa, S. C. (2013). *Developing an observational assessment for evaluating the Sinovuyo Caring Families Parent Training Programme*. (Unpublished honours thesis), University of Cape Town, Cape Town.
- Moolla, S. (2012). *Parenting: Risk and protective factors for mothers with a history of family violence*. (Unpublished master's thesis), University of Cape Town, Cape Town.
-

-
- Mueller, J., Alie, C., Jonas, B., Brown, E., & Sherr, L. (2011). A quasi-experimental evaluation of a community-based art therapy intervention exploring the psychosocial health of children affected by HIV in South Africa. *Tropical Medicine and International Health*, 16(1), 57-66. doi: 10.1111/J.1365-3156.2010.02682.X
- Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *Plos Medicine*, 9(11). doi: 10.1371/Journal.Pmed.1001349
- Oakley, A., Strange, V., Bonell, C., Allen, E., Stephenson, J., & RIPPLE Study Team. (2006). Process evaluation in randomised controlled trials of complex interventions. *British Medical Journal*, 332(7538), 413-416. doi: 10.1136/bmj.332.7538.413
- Oveisi, S., Ardabili, H. E., Dadds, M. R., Majdzadeh, R., Mohammadkhani, P., Rad, J. A., & Shahrivar, Z. (2010). Primary prevention of parent-child conflict and abuse in Iranian mothers: A randomized controlled trial. *Child Abuse and Neglect*, 34(3), 206-213.
- Pals, S. L., Murray, D. M., Alfano, C. M., Shadish, W. R., Hannan, P. J., & Baker, W. L. (2008). Individually randomized group treatment trials: A critical appraisal of frequently used design and analytic approaches. *American Journal of Public Health*, 98(8), 1418-1424. doi: 10.2105/AJPH.2007.127027
- Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., & Leckman, J. F. (2014). Practitioner review: Engaging fathers: Recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*, 55(11), 1187-1212. doi: 10.1111/jcpp.12280
- Pardini, D. A. (2008). Novel insights into longstanding theories of bidirectional parent-child influences: Introduction to the special section. *Journal of Abnormal Child Psychology*, 36(5), 627-631.
- Patterson, G. R., DeBaryshe, B. D., & Ramsey, E. (1989). A developmental perspective on antisocial behavior. *The American Psychologist*, 44(2), 329-335. doi: 10.1037/0003-066X.44.2.329
- Pears, K. C., & Capaldi, D. M. (2001). Intergenerational transmission of abuse: A two-generational prospective study of an at-risk sample. *Child Abuse & Neglect*, 25(11), 1439-1461.
- Potterton, J., Stewart, A., & Cooper, P. (2007). Parenting stress of caregivers of young children who are HIV positive. *African Journal of Psychiatry*, 10(4), 210-214.
- Sanders, M. R., Waugh, L., Tully, L., & Hynes, K. (1996). *The Revised Family Observation Schedule. FOS-III*. Brisbane: University of Queensland.
- Schünemann, H. J., Oxman, A. D., Vist, G. E., Higgins, J. P., Deeks, J. J., Glasziou, P., & Guyatt, G. H. (2008). Interpreting results and drawing conclusions. *Cochrane handbook for systematic reviews of interventions version*, 5(0).
- Statistics South Africa. (2012). *Census 2011*. Pretoria: Statistics South Africa.
- Steele, G. I. (2003). *The development and validation of the Xhosa translations of the Beck Depression Inventory, the Beck Anxiety Inventory, and the Beck Hopelessness Scale*. (Unpublished master's thesis), Rhodes University, Grahamstown, South Africa.
-

-
- Straus, M. A., & Douglas, E. M. (2004). A short form of the Revised Conflict Tactics Scales, and typologies for severity and mutuality. *Violence and Victims, 19*(5), 507-519.
- Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W., & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect, 22*(4), 249-270. doi: S0145-2134(97)00174-9
- Streiner, D., & Geddes, J. (2001). Intention to treat analysis in clinical trials when there are missing data. *Evidence-Based Mental Health, 4*(3), 70-71.
- Trentacosta, C. J., Hyde, L. W., Shaw, D. S., Dishion, T. J., Gardner, F., & Wilson, M. (2008). The relations among cumulative risk, parenting, and behavior problems during early childhood. *Journal of Child Psychology and Psychiatry, 49*(11), 1211-1219. doi: 10.1111/j.1469-7610.2008.01941.x
- Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology, 56*(4), 558-566.
- Wessels, I., & Ward, C. L. (2015). A 'best buy' for violence prevention: Evaluating parenting skills programmes. *South African Crime Quarterly, 54*, 17-28. doi: 10.4314/sacq.v54i1.2
- Wessels, I. M. (2012). *Parenting programmes in South Africa: Investigating design and evaluation practices*. (Unpublished master's thesis), University of Cape Town, Cape Town.
- Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Stepping Stones Triple P: An RCT of a parenting program with parents of a child diagnosed with an autism spectrum disorder. *Journal of Abnormal Child Psychology, 37*(4), 469-480.
- Wolf, F. M. (1986). *Meta-analysis: Quantitative methods for research synthesis*. Beverly Hills, CA: Sage.
- Wong, J. J., Roubinov, D. S., Gonzales, N. A., Dumka, L. E., & Millsap, R. E. (2013). Father enrollment and participation in a parenting intervention: Personal and contextual predictors. *Family Process, 52*(3), 440-454. doi: 10.1111/Famp.12024
- World Health Organization. (March 1999). *Report on the consultation on child abuse prevention*. Geneva: World Health Organisation.
- Zimet, G. D., Powell, S. S., Farley, G. K., Werkman, S., & Berkoff, K. A. (1990). Psychometric characteristics of the Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment, 55*(3-4), 610-617. doi: 10.1080/00223891.1990.9674095

CHAPTER SIX. PAPER #3: Process evaluation of a parenting program for low-income families in South Africa²⁸

Published citation: Lachman, J. M., Cluver, L., Kelly, J., Ward, C. L., Hutchings, J., Gardner, F. (2016). Process evaluation of a parenting program for low-income families in South Africa. *Research on Social Work Practice*. doi: 10.1177/1049731516645665

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This research was funded by the Ilifa Labantwana Fund (T141/79), the John Fell Fund, University of Oxford (103/757), the South African National Lottery Distribution Trust Fund (43137), and the European Research Council under the European Union's Seventh Framework Programme (FP7/2007-2013; ERC grant agreement 313421).

²⁸ This paper has been written using US spelling to be in alignment with the journal's submission guidelines.

Abstract

There is considerable evidence in high-income countries of the effectiveness of parenting programs in reducing the risk of child maltreatment. However, research on the feasibility of evidence-based approaches in low- and middle-income countries is limited. This mixed-methods study was nested within a randomized controlled trial of a 12-week, group-based parenting program developed for low-income parents of children aged three to eight years in Cape Town, South Africa ($N = 68$). The study examined the feasibility of the program on three dimensions: acceptability, implementation, and participation. Quantitative data included attendance registers, fidelity checklists, satisfaction surveys, and parent-report of engagement in home practice activities. Qualitative data included post-program focus groups with the eight community facilitators, individual interviews with 15 randomly selected parents, transcripts from parent group sessions, and minutes from supervision sessions with facilitators. Quantitative results showed high levels of satisfaction, program fidelity, and participation. Thematic analysis identified seven themes related to feasibility: (a) receptivity to content that strengthened existing parenting practices; (b) initial resistance to new parenting skills; (c) contextualizing content within a cultural framework; (d) reinforcing fidelity and improving quality of delivery; (e) challenges delivering content on nonviolent discipline; (f) supporting participant involvement; and (g) engagement in the collaborative learning approach. Results suggest that a parenting program derived from evidence-based approaches can be implemented with a high degree of feasibility in low-resource settings. Findings also underscore the importance of considering the interconnected relationship between acceptability, implementation, and participation when assessing program feasibility.

Keywords: parenting, child maltreatment, implementation, process evaluation

Introduction

Child maltreatment – defined as physical, emotional, and sexual abuse and neglect (World Health Organization, March 1999) – affects millions of children each year (World Health Organization, 2014). Moreover, prevalence rates in low- and middle-income countries (LMICs) are much higher in comparison with those in high-income countries (HICs) (Stoltenborgh et al., 2013). For instance, in South Africa, a recent survey of 3,515 youth aged 10 to 17 years showed lifetime prevalence rates of 55% for physical abuse, 36% for emotional abuse, and 9% for contact sexual abuse (Meinck et al., 2016). This is a serious public health issue due to associations between child maltreatment during early childhood and increased risks of developing negative child, adolescent, and adult outcomes later in life (Font & Berger, 2015).

Over the past decade, public health and children's rights organizations have issued numerous calls for the global dissemination of evidence-based interventions to prevent child maltreatment (World Health Organization & UNICEF, 2008). In particular, parenting programs in HICs have demonstrated promising evidence in reducing harsh parenting and other factors associated with increased risk of maltreatment (Barlow et al., 2006; Chen & Chan, 2015; Furlong et al., 2013). A recent meta-analysis also showed that evidence-based parenting programs transported to new countries may be as effective as in their country of origin (Gardner et al., 2015). However, this review identified only one study of a program developed in a HIC and transported to a LMIC (Iran). As a result, there remains limited evidence regarding the effectiveness and feasibility of parenting programs in LMICs (Knerr et al., 2013).

The purpose of this mixed-methods process evaluation study was to determine the feasibility of an evidence-informed, locally developed parenting program for low-

income families in Cape Town, South Africa. We used the United Kingdom Medical Research Council guidance as a theoretical framework for conducting process evaluations of complex interventions (Moore et al.). Process evaluations have become increasingly relevant as a complement to outcome evaluations (Oakley et al., 2006). They are particularly important when examining issues of program feasibility during the early stages of intervention development or when adapting parenting interventions for new settings (Lau, 2006). Process evaluations may also provide greater understanding of how a program functions in a given context prior to subsequent testing in larger trials (Moore et al.).

Previous process evaluations of parenting programs in HICs have identified three key dimensions that may influence the feasibility and effectiveness of parenting programs: acceptability, implementation, and participation (Berkel, Mauricio, Schoenfelder, & Sandler, 2011; Kazdin, 2000). Acceptability can be defined as the extent to which a program is perceived as culturally and contextually relevant by the intended service providers and beneficiaries (Kazdin, 2000). Cultural and contextual factors may include local language, population, metaphors, content, concepts, goals, methods, and the political, economic, and social environment in which an intervention is delivered (Bernal, 2006). If a program fails to accommodate these factors, it may compromise implementation and participant engagement, thus further diminishing program feasibility and effectiveness (Castro et al., 2004). Implementation refers to the intervention components delivered to a target population and the quality of delivery by program implementers (Durlak & DuPre, 2008). This is particularly important when examining null effects of interventions, which may either be a result of program ineffectiveness or because the program was not delivered as intended (Borrelli, 2011).

Implementation may also be influenced by other factors including training of program facilitators and organizational management dynamics (Moore et al.). Lastly, participation – the extent to which participants enroll, attend, and engage in a program – has been shown to be an important component in understanding whether an intervention is feasible in a particular context (Andrews & Dowden, 2005). Participation data on enrolment and attendance rates can help determine the minimum number of group sessions necessary to assure positive intervention effects or explain null effects (Flay et al., 2005). In addition, the quality of participant engagement may be equally important in predicting changes in parenting behavior (Nix et al., 2009).

In South Africa, issues regarding program feasibility may be very different from those present in HICs, especially when delivering parenting programs to highly vulnerable families. Many South African families live in isolated communities characterized by extreme poverty and high violence, where access to resources and professional services is limited (Meth, 2013). Service delivery often relies on non-specialist community workers who are either volunteers or low-paid paraprofessionals (Altman, 2008). In addition, since many children are often raised by multiple caregivers over the course of their childhoods, it is important to investigate whether parenting programs designed for nuclear families are relevant in South Africa (Bray & Brandt, 2007). Furthermore, potential differences in cultural norms and practices regarding caregiving may affect program feasibility. Since corporal punishment is commonly accepted as a normative discipline strategy by South African parents and children (Breen et al., 2015; Dawes et al., 2005), research is necessary to examine the acceptability of more authoritative parenting styles developed in HICs that promote positive reinforcement and nonviolent discipline. Finally, South African cultural values

such as respect, social responsibility, and reciprocity may have a significant impact on the feasibility of parenting programs and their relevance to target populations (Bray et al., 2010).

In summary, this study addressed the following research questions regarding the feasibility of a parenting program in Cape Town, South Africa: (1) What was the level of acceptability, implementation, and participation of an evidence-informed, group-based parenting program delivered by community facilitators to low-income parents with children aged three to eight years? (2) What were the barriers and enablers to program implementation and participation in a low-resource context as perceived by community facilitators and low-income parents? (3) How did South African facilitators and parents perceive the acceptability of a locally-developed parenting program derived from evidence-based principles and approaches?

Methods

Study design

This mixed-methods process evaluation study was conducted alongside a small-scale randomized controlled trial (RCT) that examined the preliminary effectiveness of the intervention with low-income families with children aged three to eight years (Lachman et al., in revision). Participants in the RCT were randomly allocated on a 1:1 ratio to a treatment or waitlist control group. Although the control group received no comparative active treatment during the trial, participants were waitlisted to receive the parenting program directly after post-treatment outcome data was collected. As a result, this study examined the program feasibility for the entire sample after all of the participants had participated in the program (see Figure 16 for flow diagram).

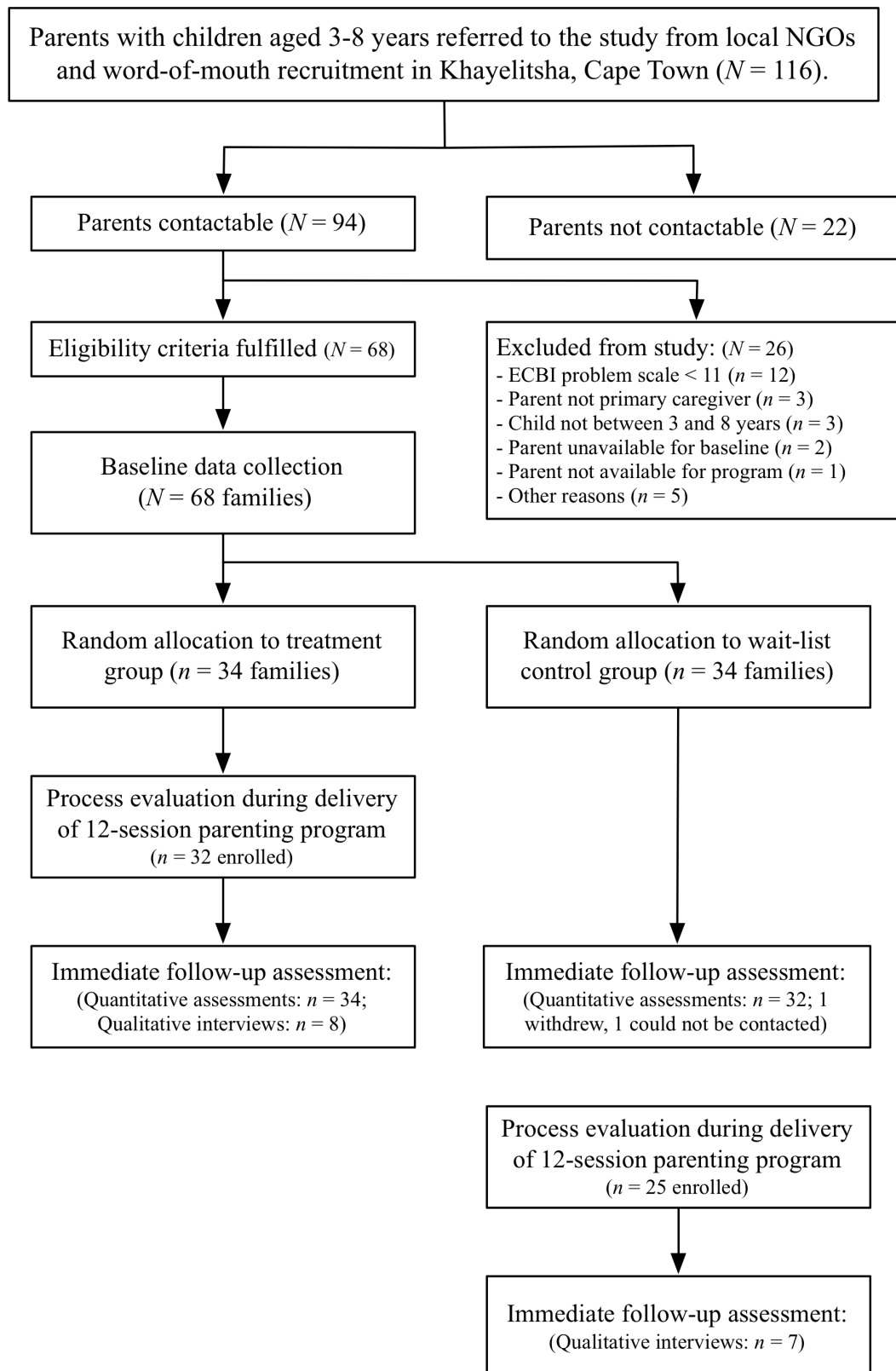


Figure 16. Process evaluation study flow diagram.

Setting

This study was conducted from April to November 2013 in Khayelitsha, a high-density, low-income suburb of Cape Town with a population of approximately 390,000 predominantly isiXhosa-speaking people (Statistics South Africa, 2012).²⁹ The majority of families in Khayelitsha live in either government-subsidized housing, fabricated homes in the backyards of formal homes, or corrugated tin shacks in informal settlements with limited access to running water, sanitation, or electricity. Khayelitsha is also characterized by high levels of poverty, unemployment, community violence, drug and alcohol abuse, and HIV-prevalence (Statistics South Africa, 2012). Similar to many other low-income communities in South Africa, children in Khayelitsha are predominantly raised by female caregivers – mothers, aunts, grandmothers, or older sisters – with minimal presence of fathers in the household (Bray et al., 2010).

Participants

Sixty-eight parents (age: M 41.57, 13.15 SD; 98.5% female) were recruited from referrals by a local nongovernment organization ($n = 47$, 69%) and from a formative evaluation conducted in 2012 ($n = 21$, 31%) (Lachman et al., 2016). Recruitment from the local organization were based on referrals from families enrolled an orphans and vulnerable children program. The program provided families with ongoing services that included food parcels, paralegal advice, and assistance in enrolling children at early childhood development centres. Recruitment from the formative evaluation included chain referral sampling using community volunteers as

²⁹ IsiXhosa is an indigenous South African language that is also one of the three official languages of the Western Cape, the province in which Cape Town is located.

original informants who recruited participants through neighbourhood contacts (Biernacki & Waldorf, 1981).

Inclusion criteria required parents to be (a) living in Khayelitsha; (b) isiXhosa-speaking; (c) aged 18 or above; (d) the primary caregiver of a child between the ages of three and eight (child age: M 5.40, 1.69 SD; 48.5% female); and (e) a resident in the same household as the child for at least four nights per week. Although parents were predominantly single mothers (73.5%), non-biological parents, relatives, or non-kin foster caregivers who met the other trial criteria were also included. In order to recruit parents who were at risk of using harsh discipline practices to manage their children's behavior, we screened families based on parent-report of their child's behavior using the Eyberg Child Behavior Inventory Problem Scale with a clinical cut-off of 11 or more symptoms (Eyberg & Pincus, 1999).

Participating families were from highly vulnerable populations, mostly living in informal houses and overcrowded conditions. Seventy-nine percent reported experiencing household hunger more than five days during the previous month at baseline (e.g., running out of money to buy food). About one-third of the respondents were either caring for a child orphaned by AIDS or were AIDS symptomatic themselves; one-third reported being victims of intimate partner violence in the previous month; and almost three-quarters of the parents had experienced some form of physical abuse as children. For the qualitative study, we randomly selected 15 parents to participate in individual interviews from those who had attended at least one session of the program (Table 10).

Community facilitators were employees of Clowns Without Borders South Africa, a non-profit organization in South Africa (www.cwbsa.org). Employment

qualifications required facilitators to be isiXhosa-speaking parents, have prior experience facilitating groups, basic training in early childhood development, and live in close proximity to the community where the study took place. Facilitators were all mothers with a minimum high school level education (Age: M 36.50, 4.90 SD).

Table 10. Demographic characteristics of the parents at baseline.

	Total (<i>n</i> = 68)	Interviewed (<i>n</i> = 15)
Parent characteristics		
Parent age, M (SD)	41.57 (13.15)	40.47 (11.41)
Parent gender, <i>n</i> female, %	67, 98.5%	15, 100.0%
Marital status, <i>n</i> single, %	50, 73.5%	9, 60.0%
Employment status, <i>n</i> unemployed, %	66, 97.1%	14, 93.3%
Child characteristics		
Child age, M (SD)	5.40 (1.69)	6.13 (1.41)
Child gender, <i>n</i> female, %	33, 48.5%	10, 66.7%
Relationship to parent, <i>n</i> biological parent, %	41, 60.3%	10, 66.7%
Family characteristics		
Type of household structure, <i>n</i> informal, %	51, 75.0%	12, 80.0%
Number of people in household, M (SD)	5.71 (2.86)	7.13 (4.22)
Experience hunger ≥ 5 times in previous month, ^a <i>n</i> , % ^a	54, 79.4%	13, 86.7%
Family affected by HIV/AIDS, ^b <i>n</i> , % ^b	21, 30.9%	5, 33.3%
Parent experienced intimate partner violence in previous month, ^c <i>n</i> , %	23, 33.8%	5, 33.3%
Parent experienced physical abuse as a child, ^d <i>n</i> , % ^d	49, 72.1%	13, 86.7%

^a Based on the Hunger Scale Questionnaire (Labadarios et al., 2003); ^b Based on 3 or more symptoms on the Verbal Autopsy Questionnaire (Lopman et al., 2006); ^c Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996); ^d ISPCAN (International Society for the Prevention of Child Abuse and Neglect) Child Abuse Screening Tool-Retrospective (Dunne et al., 2009).

The Sinovuyo Caring Families Program

Content.

The Sinovuyo Caring Families Program is a group-based parenting program developed using community-based participatory approaches with local parents and service providers in South Africa (Lachman et al., 2016). It is grounded in social learning theory that has demonstrated how parents play an important role in modeling and reinforcing child behavior (Bandura, 1977). The program aimed to integrate evidence-based approaches within a local context for at-risk South African families. Evidence-based approaches are presented using a cultural metaphor of constructing a “Rondavel of Support” – a traditional hut with mud walls and a thatched roof that is found in many rural African communities (see Figure 12, page 138). The initial sessions focus on developing strong positive parent-child relationships (i.e., mud walls) prior to learning nonviolent discipline strategies (i.e., thatch roof). The first six sessions of the program focus on (a) establishing parent goals around child behavioral outcomes; (b) spending special time with children through child-led play; (c) descriptive commenting; (d) communicating about emotions; (e) using specific, labeled praise; and (f) using rewards to encourage positive behavior. The final six sessions address limit-setting and nonviolent discipline skills: (a) giving positive and clear instructions; (b) establishing household rules; (c) ignoring negative attention-seeking behavior; (d) using time-out for aggressive behaviors or noncompliance; (e) using realistic consequences; and (f) involving children in problem-solving. Each session is introduced using a traditional Southern African story related to the specific session’s theme. Local cultural values such as respect, reciprocity, and social responsibility are also emphasized throughout the program. Content also addresses local issues regarding supervision of children in

high-crime communities and developmentally appropriate ways to communicate with children about HIV/AIDS and poverty. Finally, participants learn simple mindfulness exercises to reduce stress associated with parenting and other social factors (Kabat-Zinn, 2013).

Design.

The Sinovuyo program is delivered to groups of 12 to 15 parents over 12 weekly sessions. Each session follows a similar format and was approximately 2.5 hours long. At the beginning of each session, the parents report on their experience implementing parenting skills at home during the previous week. Next, parents are introduced to the session's core parenting skill (e.g., using specific, labeled praise) and discussed its benefits for their children. Then, parents are guided through illustrated stories that depicted scenes of typical South African families demonstrating parenting practices either correctly or incorrectly (see Figures 17 and 18). Next, the parents practice these skills in role-plays with one parent acting as the "child" and the other as the "adult". Finally, sessions close with parents receiving assignments to practice the parenting skills at home.

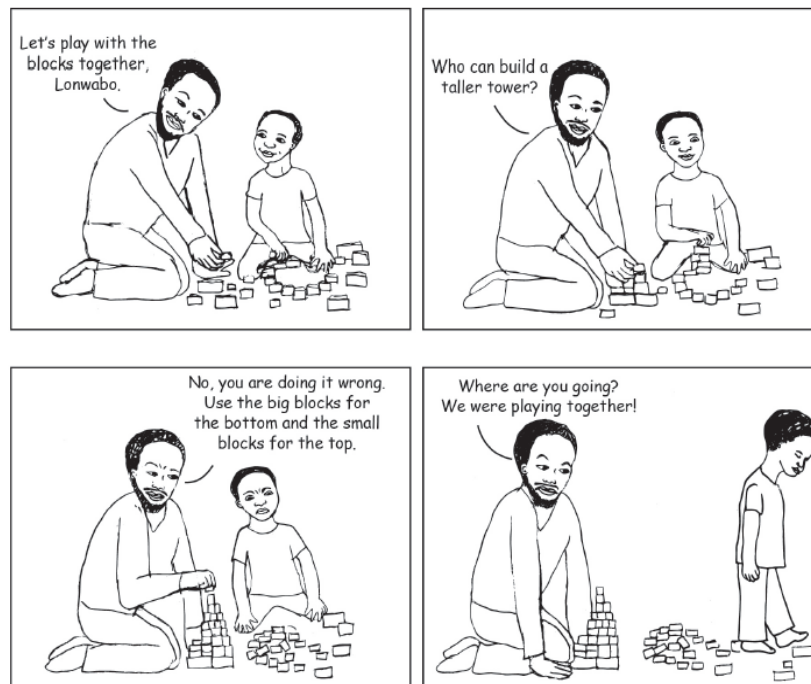


Figure 17. Illustrated storyboard showing an incorrect example of child-led play in which a father engages his son a competitive, parent-led activity.

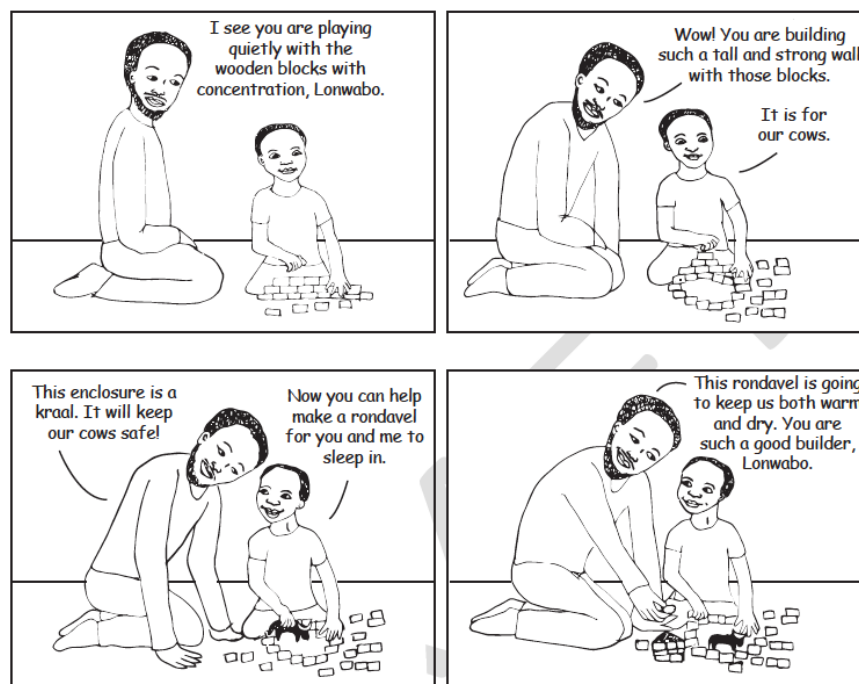


Figure 18. Illustrated story board showing the corrected example of the father allowing his child to take the lead during play while he uses language to describe the actions of his child.³⁰

³⁰ Illustrations by Shifrah Getz from InsideOut Inspired Designs™.

Delivery.

The Sinovuyo program was developed as a low-cost intervention capable of being delivered by community based facilitators with limited professional experience prior to training. Facilitators receive initial training in collaborative facilitation methods and parenting principles (30 hours), weekly training on specific session content during implementation (20 hours), and experiential training by participating in the program prior to facilitation (24 hours). A key aspect of the training is reinforcing the program's collaborative learning approach to promote parental participation. This method requires the following expertise from program facilitators: (a) a strong understanding of social learning principles; (b) the ability to facilitate the active engagement of parents in identifying parenting principles and developing effective child behavior management strategies; (c) the ability to facilitate discussions with open-ended questions in order to generate collective problem-solving; (d) the capacity to model parenting behaviors; (e) and an empathic attitude towards each parent's individual experiences (Hutchings et al., 2004). Facilitators also participate in weekly supervision sessions that involved reviewing video recordings of sessions, problem-solving challenges experienced delivering the program during the previous week, and role-playing solutions to improve the quality of delivery and support facilitator learning.

Scaffolding.

The Sinovuyo program uses programmatic "scaffolding" to support implementation and participation. Traditionally, "scaffolding" refers to a parent's active and structured support of child cognitive and behavioral development using problem-solving and encouragement (Wood, Bruner, & Ross, 1976). This concept can also be applied to the extent to which a program is able to support facilitators with the delivery

skills needed to engage parents in the behavioral change process. Accordingly, the Sinovuyo program includes a facilitator manual and parent handbook to strengthen treatment fidelity and participant adherence to prescribed activities. Facilitators perform home visit consultations to support parents who are having difficulties with program material or attending group sessions. Weekly text messages serve as boosters to remind parents of home practice activities and encourage attendance at sessions. The program also encourages participants to form “Sinovuyo partner” relationships with other parents in the program in order to create a peer support network outside the group sessions. Finally, the program provides financial support for public transportation and lunch at each session.

Quantitative data collection and analyses

Parents’ perceptions of overall program acceptability were assessed using a 36-item questionnaire adapted from the Incredible Years Parent Program Satisfaction Questionnaire (Webster-Stratton, 1989). Using a Likert scale of 0 to 5, participants reported on whether the program fulfilled their expectations (10 items, e.g., “overall feeling about achieving [parent’s] goal in this program”), the acceptability of delivery methods (10 items, e.g., “practice of skills at home”), the acceptability of parenting skills taught (10 items, e.g., “naming feelings”), the quality of program facilitation (4 items; e.g., “quality of interaction”), and the supportiveness of the group (2 items, e.g., “group’s support of parent”). Research assistants who were not associated with program delivery administered the survey at the end of program completion. Items were summed to create an overall satisfaction rating as well as satisfaction ratings for each subscale. Total scores were based on weighted means out of 100 for comparison purposes across subscales.

Program fidelity was assessed using self-report checklists completed by facilitators who viewed video recordings from each session and indicated whether or not they delivered a particular component. Video recordings of a random sample of four sessions per parent group were examined in order to verify the accuracy of self-report data. Program fidelity scores were created by calculating a ratio of number of activities implemented to the number of activities designated in the program manual.

We also examined program participation based on enrollment, dropout, and attendance rates, as well as the rate of parental engagement in home practice activities. Enrollment rate was based on the percentage of participants in the study who attended at least one session. Attendance rate was based on those who enrolled and was calculated by summing session attendance as well as home visit consultations for parents who missed a session. Dropout from the program was based on parents who missed three consecutive sessions and were unavailable for home visits consultations. Parental engagement was measured in each session by calculating completion rates of assigned home activities for those who had attended the previous session.

All quantitative data was entered into SPSS 21.0 and cleaned by the first author prior to analyses.

Qualitative data collection and analyses

Data collection.

We used a contextualist framework to guide qualitative data collection and analysis regarding the feasibility of the Sinovuyo program (Braun & Clarke, 2006). As a pragmatic approach to qualitative research situated between essentialism and constructionism, a contextualist epistemology allows for the integration of theory-driven, deductive approaches with data-driven inductive methods (Fereday & Muir-

Cochrane, 2006). We collected qualitative data from four sources: (a) individual interviews with the sub-sample of parents; (b) focus group interviews with facilitators; (c) transcripts from parenting group sessions; and (d) transcripts of facilitators' supervision session. All interviews took place during the month after post-program data collection, lasted approximately one hour, and took place in the homes of participants. An English-speaking researcher conducted the interviews with the help of a professional isiXhosa-speaking interpreter. The interpreter was instructed to translate the English questions and isiXhosa answers verbatim during each interview. The interpreter was also provided with the interview guide prior to the interviews in order to familiarize herself with the purpose and structure of the interview. Parents were given a small food parcel as compensation for participating in the interviews (approximate value: US\$5). Focus group interviews with community facilitators ($n = 8$ participants) took place at a community center after program delivery, lasted approximately 2.5 hours, and were conducted in English by the first author. Interviews were captured on digital recorders with written notes as backup. All of the data was transcribed verbatim.

In addition to interviews, the research team collected qualitative data during the parent group and facilitator supervision sessions. Community facilitators recorded written notes in English during participants' feedback regarding their engagement in weekly home practice assignments. A research assistant recorded detailed minutes of each supervision session in English.

Interview guide.³¹

We used a semi-structured interview guide with an open-ended approach to examine the following themes: (a) perceived changes in parenting style, child behavior,

³¹ The interview guides and protocols for focus groups and interviews can be found in Appendix G.

and parent-child relationships; (b) perceived appropriateness of program content, design, and method of delivery; and (c) perceived barriers and enablers to participation and engagement in the program. Additional probing explored perceptions of the extent to which respondents understood the specific parenting skills taught during the program, how often they used them, and whether they found the program material acceptable and useful.

Qualitative data analysis.

Two data coders used thematic analysis to manually assess, code, and group data into clusters of themes (Braun & Clarke, 2006). Each coder read through the transcripts identifying initial codes that emerged from the texts. Queries arising from translation or context were discussed and clarified with isiXhosa-speaking research assistants. Initial codes were grouped into categories based on the following a priori classification: program content, delivery, and structure. These categories were further divided into themes regarding perceived program feasibility based on acceptability, implementation, and participation. After a consensus was reached between the coders, the research team re-examined the transcripts to identify coherent patterns and divergent viewpoints. The entire team then discussed findings in relation to the overall dataset and in the light of existing literature, with particular focus on the validity and representativeness of individual themes. Finally, we selected data extracts to illustrate these key themes.

Reliability and validity.

The research team used a number of measures to strengthen the reliability and validity of findings. First, to increase the diversity of perspectives and experiences, we collected data from multiple sources. Second, we attempted to reduce selection bias by

randomly selecting the participants for interviews from all of the parents who had attended at least one session. Third, audiotapes with verbatim transcription ensured that we had accurately captured the data. Fourth, we used two data coders to increase the reliability when reviewing and coding transcripts. Fifth, we maintained an audit trail that included a registered trial protocol, coding matrix, and minutes from research team meetings.

Ethical procedures

This study was granted ethical approval by University of Oxford Central University Research Ethics Committee (ref SSD/CUREC2/11-40) and the University of Cape Town Psychology Department Research Ethics Committee (ref 2012_12_01). Research assistants with prior experience working on research projects in South Africa conducted informed consent procedures with the participants. They were fluent in isiXhosa and extensively trained in ethics, informed consent, and interviewing techniques. All participants were told that they had the right to decline to participate, and that they could drop out of the feasibility study at any time and continue participating in the program and main study.

Results

As a mixed-methods study, we integrated quantitative and qualitative data during final analyses regarding the feasibility of the Sinovuyo program. Analyses identified seven emergent themes in terms of acceptability, implementation, and participation: (a) receptivity to content that strengthened existing parenting practices; (b) initial resistance to new parenting skills; (c) contextualizing content within a cultural framework; (d) reinforcing fidelity and improving quality of delivery; (e) challenges delivering content on nonviolent discipline; (f) supporting participant

involvement; and (g) engagement in the collaborative learning approach. Themes regarding the importance of supporting participation, reinforcing program fidelity, and situating content within a local cultural context were anticipated based on findings from previous process evaluation studies of parenting programs as well as from the formative evaluation phase conducted prior to testing the program (Lachman et al., 2016). On the other hand, the themes regarding parents' receptivity to strengthening existing skills, their resistance to new skills, facilitators' challenges delivering content on nonviolent discipline strategies, and respondents' strong engagement in the collaborative learning process emerged from qualitative data analyses. These are summarized in Figure 19 and reported in detail below.

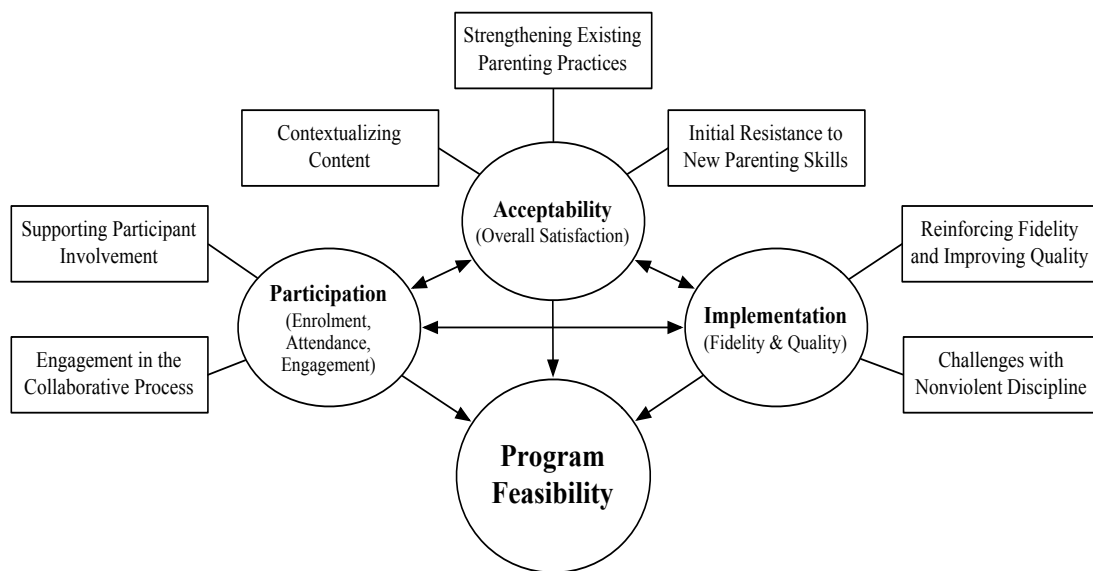


Figure 19. Conceptual model for program feasibility based on results.

Acceptability

Satisfaction.

Out of a total score of 100, participants reported high overall satisfaction with the program (Mean 94.22, 5.12 SD). Parents gave high ratings to the program's ability to meet their goals and expectations (Mean 89.55, SD 8.27), the format of delivery

(Mean 94.41, SD 11.97), the appropriateness of parenting skills taught by the program (Mean 96.00, SD 5.81), the quality of facilitation (Mean 98.62, SD 3.24), and supportiveness of the group (Mean 97.24, SD 3.79).

Receptivity to strengthening existing skills.

Qualitative data showed an overall high degree of receptivity to the program content and delivery. This was particularly evident in terms of content that was perceived to strengthen parenting practices that already existed in some form in the community. These practices included spending quality time with children, using specific praise and rewards for good behavior, enforcing household rules consistently, giving positive and specific instructions, and stress reduction activities. For example, one mother explained how the program helped increase child compliance by rephrasing how she gave instructions: “Before [the program], I use to say in a negative way, ‘do not leave this house before you clean up and make up the room.’ But now [my child] listens because I give clear and positive instructions” (parent #70, interview). Many parents also described how these changes in their own behavior led to improved relationships with their children: “Now my children recognise and respect me as their mother because I’m not shouting at them. It’s the way I talk with them and spend a lot of time with them” (parent #29, interview). This level of reciprocity between the parent and her children supports the underpinning social learning theory on which the program is based by demonstrating that parents understood the importance of modeling appropriate behavior towards their children.

Initial resistance to new parenting skills.

While parents were receptive to program content that strengthened existing parenting practices, many parents initially resisted skills that were perceived as

culturally dissonant or disruptive of normative parenting practices. For instance, facilitators perceived that parents were at first reluctant to engage in child-led play: “Parents were not used to playing with their children. It was a new thing to them” (facilitator #2, focus group). However, this resistance often diminished when parents were able to perceive the impact of joint play on their children’s behavior: “When we spend special time together, I can see that he is very happy, and it helps him to do positive things” (parent #55, interview).

Facilitators reported that some parents resisted using language to communicate about emotions: “In our culture, we don’t talk about our feelings.... We do not have those kinds of words, like, excited or mad.... So, how can you help your child to understand their feelings when you cannot deal with your own situation?” (facilitator #6, focus group). Nevertheless, other parents were more receptive to communicating about emotions, which was also associated with a perceived increased sense of empathy in their children: “I tell him, ‘my child, this is how I feel.’ He also notices how I feel and tells me, ‘Mama, I can see that you are not happy’” (parent #29, interview).

Many respondents initially resisted adopting the nonviolent discipline techniques emphasized by the program: “When we learned that we must not beat the kids, in our culture, it’s not normal” (parent #11, interview). However, in spite of having experienced corporal punishment as children themselves, others expressed an increased understanding about the utility of nonviolent techniques to improve child behavior: “I used to spank him just the way I was also raised, which was not working at all. Now, I found that talking to my child works” (parent #11, interview).

Contextualizing content within a cultural framework.

Respondents reported that the cultural idioms, metaphors, and traditional forms of expression embedded within the program increased the acceptability of core program principles and content. For instance, respondents expressed a strong affinity with the “Building a Rondavel of Support” program model (Figure 10). This provided a cultural reference point familiar to isiXhosa-speaking families with ties to rural communities: “Whenever we go home to the Eastern Cape, the first place we sleep is in a rondavel. It is the center of the family” (facilitator #6, supervision notes). In addition, participants highlighted the importance of contextualizing the program within culturally relevant forms of interaction. For example, respondents described how traditional stories and songs helped communicate parenting principles in a culturally resonant manner and promoted a sense of collectivity. Parents also reported that the traditional stories and children’s songs provided opportunities for positive parent-child interaction while reinforcing core program principles in ways that were culturally resonant.

Implementation

Program fidelity.

Quantitative data analysis based on self-report fidelity checklists showed that facilitators implemented 93.0% of the manualized activities. This was verified with 100% reliability by examining four randomly selected video recordings per parent group.

Reinforcing program fidelity and improving quality of delivery.

Qualitative analyses identified a number of factors that were perceived to have strengthened program fidelity and quality of delivery. Facilitators described how they relied on the program manual to inform their preparations and delivery of sessions.

Likewise, the practical training sessions provided during program delivery were viewed as essential for maintaining fidelity to program protocols. As one facilitator explained, “The [practical] sessions helped remind us of everything we learned. They helped us prepare and understand some ways of delivering” (facilitator #2, focus group). In addition, they described how reviewing video recordings of sessions provided an opportunity to reflect on their delivery and improve competency: “It was very useful because it was where I saw what I can improve on. It’s where we were able to catch mistakes” (facilitator #4, focus group). Finally, the facilitators articulated that the weekly supervision sessions improved their facilitation skills. They particularly highlighted the way supervision modeled core delivery methods and principles of the program through role-plays and collective problem-solving: “The encouragement and praise [during supervision sessions] helped with our confidence... Also, the way questions were asked to help us to think more about how to deliver the program” (facilitator #1, focus group).

Challenges with nonviolent discipline techniques.

Although they expressed confidence in their proficiency in delivering the majority of program content, facilitators articulated a lack of self-efficacy regarding nonviolent discipline techniques. These strategies required facilitators to clearly distinguish which parenting approach would be most appropriate for a specific problem behavior. For instance, whereas the manual suggested ignoring negative attention-seeking behaviors such as temper tantrums, it recommended time-out as a more effective strategy for aggressive or noncompliant behaviors. However, facilitators struggled to make this distinction:

It was a really difficult concept. We are not used to these things. I could feel that the way that I delivered it, there was no separating the behaviors for Ignore,

Time-Out, and Consequences. I was not as convinced as a facilitator. We could see that [the parents] were listening to us, but they were just not getting it (facilitator #1, focus group).

Nevertheless, as facilitators gained experience with implementation, they articulated an increased sense of competence with these more nuanced aspects of the program: “[The parents] can feel when you are not sure about something. But now at least we have that confidence of okay, we’re gonna do it... So, even they feel like this is okay. We were more competent” (facilitator #5, focus group). As a result, increased self-efficacy was perceived to be associated with improved delivery of, and parental receptivity towards, program content.

Participation

Enrollment, attendance, and engagement.

Quantitative data demonstrated a high rate of program enrollment: 85.3% of participants included in the study attended at least one session ($n = 58/68$ participants). Reasons for non-enrollment included obtaining full-time employment ($n = 4$), relocation outside Cape Town ($n = 3$), and refusal to participate for unknown reasons ($n = 3$). Out of the 58 participants who enrolled, attendance and engagement was also high. Mean attendance was 8.5 out of 12 sessions (Mean 71.5%, SD 26.5), 71.9% attended six or more sessions ($n = 42$), and 32.8% missed only one session, or none ($n = 17$). Reasons for missed sessions included part-time employment, days on which government grants had to be collected, parent or child illness, severe weather, funerals, and political unrest. Eight participants (13.8%) were characterized as program dropouts after having missed at least three consecutive sessions and not returning. Analysis of transcripts of home practice feedback showed that attending parents engaged in an average of 91.3% of the assigned activities during the previous week. Reasons for not

completing home practice included missing the previous session, parent or child illness, or a lack of perceived self-efficacy in applying the assigned parenting skills.

Supporting participant involvement.

Respondents identified a number of program components that strengthened participant involvement. Parents explained how the parent handbook supported engagement and adherence to program content: “The handbook helped me a lot because sometimes I would go back and look at maybe where I went wrong” (parent #65, interview). Respondents also described how the weekly text messages reminded parents of their home practice, reinforced core principles, and created a sense of program continuity during the week. This had limitations, however, as those who did not own a cell phone were not able to benefit from the text message reminders. Parents also reported that the pre-program home visit consultations helped overcome potential barriers to enrollment by orienting them to program goals and structure: “It was important because they explained to me about the program. If they didn’t come [to my house], I wasn’t going to go to the program” (parent #2, interview). In addition, they appreciated the home visits in which facilitators conducted sessions individually with parents who had missed a group session. However, facilitators reported that parents who missed many sessions were often unavailable for home visits. Parents also described how the program encouraged the creation of peer support networks by linking participants who lived near to each other: “Sometimes it was helpful. If there was something I didn’t understand, I was phoning her and asking what must I do” (parent #2, interview). However, not all parents interacted with their support network: “I’m not gonna lie. I never contacted her. She never contacted me” (parent #70, interview).

Lastly, respondents emphasized that providing transportation, childcare, and lunch helped maintain high rates of program attendance.

Engagement in the collaborative approach.

Respondents demonstrated a high level of engagement with the collaborative delivery approach used throughout the program. In spite of their relative lack of experience, facilitators displayed a proficiency in adopting reflective listening techniques to elicit parent's views and needs: "Before, I would correct people, but I learned that it blocks them from expressing themselves. Accepting and exploring creates an atmosphere where people can be open" (facilitator #1, focus group). Furthermore, many parents were receptive to the emphasis on collective problem-solving: "It was helpful for us as a group to talk together and try to solve our problems, to come up with a solution" (parent #51, interview).

Respondents considered the experiential activities that combined illustrated stories, role-plays, and home practice activities to be effective in promoting participation. The illustrated stories that depicted parents living in similar contexts were viewed as particularly important tools for engaging parents in the collaborative process. As one facilitator explained, "the illustrated stories were one part where you really see [the parents] come alive. You really see them sharing and thinking and talking" (facilitator #3, focus group). Parents also articulated how the stories helped communicate parenting skills in a clear and understandable manner: "I can see the granny with the child, how she is sitting, and how they are talking... so, it helps to understand that you have to go to that level when you talk to the child" (parent #43, interview). This was especially important for including parents with low levels of literacy: "Oh, the pictures were helping a lot. Even though I don't understand the

language in terms of reading” (parent #34, interview). Finally, respondents reported that the role-plays helped parents understand the utility of parenting skills and experience parenting from the perspective of the child. Many parents also said that the role-plays increased their sense of confidence in applying the parenting skills with their children at home: “It was helpful because we were practicing it there [during the session], and then we came home and did it with our kids” (parent #11, interview).

Discussion

This study is one of the first of its kind to use a mixed-methods approach to examine the feasibility of a locally developed, evidence-informed parenting program in sub-Saharan Africa. The integration of quantitative and qualitative data analyses provides an in-depth understanding of the applicability of the program with the highly vulnerable, low-income families for whom it was developed. The study also offers an opportunity to examine feasibility from multiple theoretical domains that include program acceptability, implementation, and participation.

Overall, results indicate a high degree of feasibility of adapting and implementing evidence-based parenting principles and approaches for low-resource contexts. These findings are promising given the vastly different cultural and contextual circumstances that low-income, isiXhosa-speaking parents experience in South Africa in comparison with families from HICs. Despite the multiple life stressors experienced by participants, program participation was strong. Although low socioeconomic status has often been cited as a barrier to involvement (Heinrichs et al., 2005), a high proportion of parents participated in at least one session of the program. Moreover, the low dropout rate in comparison to parenting programs in HICs suggests that a strong commitment to program completion by participants (Axford et al., 2012). Similarly, the

mean attendance rate of 71.5% was comparable to trials of parenting programs of similar length in the United Kingdom and United States (Hutchings et al., 2007). Furthermore, this is the first study to show that community workers with limited professional qualifications and prior knowledge of evidence-based approaches can deliver a parenting program for families with children aged three to eight years with a high degree of fidelity. Since facilitators were aware that their performance was being monitored, it is possible that recording videos of sessions influenced the rate of fidelity. This suggests that establishing overt monitoring systems and systematic supervision of implementation may be essential for ensuring implementation adherence.

Current findings reinforce the importance of providing programmatic scaffolding to increase the likelihood of strong implementation and participation. For example, pre-program consultations to address practical and psychological concerns of participants have also been shown to improve early engagement in other interventions (Ingoldsby, 2010). Furthermore, many programs have successfully overcome structural barriers to participation by providing transportation, childcare, and food (Axford et al., 2012). Recent research has also demonstrated the utility of text messages in improving program completion with parents at high risk of child maltreatment in the United States (Murray, Woodruff, Moon, & Finney, 2015). Likewise, the provision of manuals has been shown to increase adherence to treatment protocols and engagement in program content (Elliott & Mihalic, 2004). Finally, the reported benefits of experiential training and supervision of program facilitators is consistent with prior research on their role in maintaining treatment fidelity and improving quality of delivery (Sethi et al., 2014).

Results also highlight the potential benefits of integrating social learning theory

principles throughout all levels of program implementation. For instance, the program used the same approaches for skills acquisition and utilization to train both facilitators and parents. These included modeling of parenting principles, collective problem-solving, practicing skills, and positive reinforcement. Furthermore, these approaches were perceived as particularly effective in addressing challenges with more complex content. Although the facilitators initially articulated a lack of self-efficacy towards nonviolent discipline strategies, the supervision sessions and experiential training provided them with the opportunity to build confidence and competency by practicing these skills in a supportive environment. The same methods were also perceived as useful in overcoming parental resistance to adopting these practices with their children at home, thus emphasizing the dynamic relationship between the quality of implementation and participation.

Findings confirm the importance of integrating evidence-based approaches within a local cultural context in order to increase the acceptability of parenting programs (Lau, 2006). This mirrors research on Latino populations in the United States that found higher receptivity to program content when core components were embedded within a culturally relevant context (Parra Cardona et al., 2012). For instance, parents strongly identified with the program's culturally sensitive framework. The "Rondavel of Support", traditional stories, and children's songs provided familiar reference points for understanding the structure and content of the program. Likewise, participants resonated with the depictions of South African families modeling parenting skills in the illustrated stories. Finally, the collaborative learning approach may have resonated with African values of shared responsibility and collectivism as exemplified by the *indaba*,

or communal gathering, traditionally used to solve problems in South Africa (Sulamoyo, 2010).

More in-depth adaptation and development may be necessary to deliver parenting approaches that challenge pre-existing norms of parenting behavior. On the one hand, findings show high engagement in content that reinforced everyday parenting practices in the community (i.e., praise, household rules, instruction-giving, and stress reduction). However, new practices such as nonviolent discipline and emotional labeling were met with initial resistance by parents who perceived them as culturally dissonant. Facilitators reported difficulties delivering the same content, thus suggesting that facilitators may have struggled to transfer skills that they themselves did not have prior experience with using. It is possible that additional facilitator training combined with more time allocated to complex content is required to adequately address concerns regarding cultural appropriateness. For example, an adaptation of the Incredible Years Teacher Training Program in Jamaica required extra sessions in order to deliver new concepts and skills to beneficiaries (Baker-Henningham, Scott, Jones, & Walker, 2012).

It is important to emphasize that these challenges are not unique to the South African context. For instance, a qualitative study of a comparable parenting program with disadvantaged families in Ireland found similar difficulties in implementing time-out (Furlong & McGilloway, 2012). Furthermore, none of the parenting skills were rejected in totality by the parents; rather, they utilized them to varying degrees. This selective engagement of parenting skills corresponds to research in the United States in which parents experimented with different parenting strategies depending on their personal preferences and family contexts (Holtrop et al., 2014). Thus, instead of labeling content as either culturally acceptable or inappropriate, future research may

benefit from examining how South African parents negotiate decisions on whether to make use of parenting strategies within the context of existing cultural norms and values.

This study has several limitations. First, findings may not be generalizable to other contexts and population groups. The small sample size was limited to predominantly unemployed, low-income, isiXhosa-speaking mothers living in an urban South African setting. It is possible that programs implemented in more rural and isolated communities may encounter additional barriers to participation or increased resistance to new parenting approaches. Second, since the study only recruited female caregivers, results do not provide insight regarding the program's feasibility across gender. Given the context of family systems in South Africa in which many children do not have regular contact with their fathers, it is not surprising that only women participated in the program (Bray & Brandt, 2007). Other studies have found it necessary to include content specific to fatherhood, employ male facilitators, and deliver sessions to exclusively male groups in order to increase participation of men (Panter-Brick et al., 2014). Third, it is important to consider potential respondent biases due to social desirability, particularly with client satisfaction surveys (Brestan, Jacobs, Rayfield, & Eyberg, 1999). Nevertheless, the study's mixed-methods approach, which allowed for triangulation of data from multiple sources, respondents, and analytic approaches, increases the trustworthiness of results. Fourth, the random selection of enrolled participants for the qualitative interviews included few participants with low attendance rates. A more purposive sampling approach that included participants with low attendance may have provided additional perspectives regarding barriers to participation and engagement (Watters & Biernacki, 1989). Finally, the study may have

benefited from including children as respondents in order to provide a child-led perspective on program feasibility (Bray et al., 2010).

This study provides a valuable contribution to existing literature on implementation science. By examining acceptability, implementation, and participation, the research team was able to test an overall conceptual model that integrates multiple factors associated with the feasibility of parenting programs. While many studies explore these dimensions separately (Dumas et al., 2007), it is equally important to consider how they influence each other in reciprocal relationships (Koerting et al., 2013). Results suggest that challenges in program delivery were linked to initial resistance to engaging in nonviolent discipline techniques. This resistance further contributed to facilitators' low sense of self-efficacy in their capacity to deliver this component of the program. This may have influenced perceptions that the parenting skill was culturally inappropriate. On the other hand, the strong emphasis on framing evidence-based parenting principles within a culturally relevant context was perceived to have influenced both implementation fidelity and participation.

Findings also contribute to the literature on parenting. The overall acceptability of evidence-informed parenting components supports emerging research indicating the transferability of parenting programs across contexts (Gardner et al., 2015; Leijten, Melendez-Torres, Knerr, & Gardner, 2016). This suggests that parents are generally receptive to learning positive parenting strategies despite vastly different cultural backgrounds and circumstances. At the same time, it is important to recognize the role of context and its influence on parenting behavior. It may be challenging for parents in LMICs to sustain nonviolent child behavior management skills without changing prevailing norms regarding corporal punishment on a population level. Likewise,

strategies that use socioemotional regulation to promote positive parent and child behavior may be less effective in contexts where there are linguistic and cultural barriers to communicating about emotions. Nonetheless, the high participation rates of parents in the program indicate that South African parents may be receptive to interventions that provide support and training on effective child behavior management. In fact, in contrast to examples in HICs in which some parenting programs struggle to maintain acceptable levels of attendance and engagement when delivered to highly deprived populations (Heinrichs et al. 2005), findings support evidence from the formative evaluation phase of this study that suggests a strong willingness of low-income parents in South Africa to learn alternative discipline strategies from corporal punishment.

In conclusion, this study's findings have important implications for further research on parenting programs and other family interventions in LMICs. Additional quantitative research is necessary on the predictors of participation in order to identify specific risk and protective factors for enrollment, attendance, and engagement. This would enable the identification of high-risk families who may require extra support and scaffolding. Future research that includes observational assessments of program implementation may also provide a more objective assessment of program fidelity and quality of delivery (Eames et al., 2009). These studies should be nested within larger experimental trials with sufficient statistical power to test the associations between program feasibility and effectiveness in reducing the risk of child maltreatment. Finally, factorial research designs may provide further understanding on the dimensions of program feasibility and how they relate to intervention effectiveness (Collins et al., 2005). By testing multiple active delivery components in a factorial design, we may be

able to optimize parenting programs according to cost effectiveness and scalability, as well as their effectiveness in reducing the risk of child maltreatment. This may further reduce the cost of delivery while increasing the reach of parenting programs for vulnerable families living in low-resource contexts throughout LMICs.

References

- Altman, M. (2008). Expanding early childhood services: Labour market challenges. *Agenda*, 22(78), 120-131.
- Andrews, D. A., & Dowden, C. (2005). Managing correctional treatment for reduced recidivism: A meta-analytic review of programme integrity. *Legal criminology and psychology*, 20, 173-187.
- Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging parents in parenting programs: Lessons from research and practice. *Children and Youth Services Review*, 34(10), 2061-2071. doi: 10.1016/J.Childyouth.2012.06.011
- Baker-Henningham, H., Scott, S., Jones, K., & Walker, S. (2012). Reducing child conduct problems and promoting social skills in a middle-income country: Cluster randomised controlled trial. *British Journal of Psychiatry*, 201(2), 101-108. doi: 10.1192/Bjp.Bp.111.096834
- Bandura, A. (1977). *Social learning theory*. New York: General Learning Press.
- Barlow, J., Johnston, I., Kendrick, D., Polnay, L., & Stewart-Brown, S. (2006). Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. *Cochrane Database of Systematic Reviews*, 3, 1-20.
- Berkel, C., Mauricio, A. M., Schoenfelder, E., & Sandler, I. N. (2011). Putting the pieces together: An integrated model of program implementation. *Prevention Science*, 12(1), 23-33. doi: 10.1007/S11121-010-0186-1
- Bernal, G. (2006). Intervention development and cultural adaptation research with diverse families. *Family Process*, 45(2), 143-151.
- Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research*, 10(2), 141-163.
- Borrelli, B. (2011). The assessment, monitoring, and enhancement of treatment fidelity in public health clinical trials. *Journal of Public Health Dentistry*, 71 Suppl 1, S52-63.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi: 10.1191/1478088706qp063oa
- Bray, R., & Brandt, R. (2007). Child care and poverty in South Africa. *Journal of Children and Poverty*, 13(1), 1-19. doi: 10.1080/10796120601171187
- Bray, R., Gooskens, I., Kahn, L., Moses, S., & Seekings, J. (2010). *Growing up in the new South Africa: Childhood and adolescence in post-apartheid South Africa*. Cape Town: Human Sciences Research Council.
- Breen, A., Daniels, K., & Tomlinson, M. (2015). Children's experiences of corporal punishment: A qualitative study in an urban township of South Africa. *Child Abuse & Neglect*, 48, 131-139. doi: 10.1016/j.chiabu.2015.04.022
- Brestan, E. V., Jacobs, J. R., Rayfield, A. D., & Eyberg, S. M. (1999). A consumer satisfaction measure for parent-child treatments and its relation to measures of child behavior change. *Behavior Therapy*, 30(1), 17-30. doi: 10.1016/S0005-7894(99)80043-4
- Castro, F. G., Barrera, M., & Martinez, C. R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*, 5(1), 41-45.

-
- Chen, M., & Chan, K. L. (2015). Effects of parenting programs on child maltreatment prevention: A meta-analysis. *Trauma, Violence, and Abuse, 17*(1), 88-104. doi: 10.1177/1524838014566718
- Collins, L. M., Murphy, S. A., Nair, V. N., & Strecher, V. J. (2005). A strategy for optimizing and evaluating behavioral interventions. *Annals of Behavioral Medicine, 30*(1), 65-73. doi: 10.1207/S15324796abm3001_8
- Dawes, A., De Sas Kropiwnicki, Z., Kafaar, Z., & Richter, L. (2005). *Corporal punishment of children: A South African national survey*. Cape Town: Human Sciences Research Council.
- Dumas, J. E., Nissley-Tsiopinis, J., & Moreland, A. D. (2007). From intent to enrollment, attendance, and participation in preventive parenting groups. *Journal of Child and Family Studies, 16*(1), 1-26.
- Dunne, M. P., Zolotorb, A., Runyanb, D., Andrevia-Millerc, I., Yuen Chood, W., Dunnea, S., . . . Youssefj, R. (2009). ISPCAN Child Abuse Screening Tools Retrospective version (ICAST-R): Delphi study and field testing in seven countries. *Child Abuse & Neglect, 33*(11), 815-825.
- Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*(3-4), 327-350.
- Eames, C., Daley, D., Hutchings, J., Whitaker, C. J., Jones, K., Hughes, J. C., & Bywater, T. (2009). Treatment fidelity as a predictor of behaviour change in parents attending group-based parent training. *Child Care Health and Development, 35*(5), 603-612. doi: 10.1111/J.1365-2214.2009.00975.X
- Elliott, D. S., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science, 5*(1), 47-53.
- Eyberg, S., & Pincus, D. (1999). *Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory - revised: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5*(1), 80-93.
- Flay, B. R., Biglan, A., Boruch, R. F., Castro, F. G., Gottfredson, D., Kellam, S., . . . Ji, P. (2005). Standards of evidence: Criteria for efficacy, effectiveness, and dissemination. *Prevention Science, 6*(3), 151-175. doi: 10.1007/S11121-005-5553-Y
- Font, S. A., & Berger, L. M. (2015). Child maltreatment and children's developmental trajectories in early to middle childhood. *Child Development, 86*(2), 536-556.
- Furlong, M., & McGilloway, S. (2012). The Incredible Years Parenting Program in Ireland: A qualitative analysis of the experience of disadvantaged parents. *Clinical Child Psychology and Psychiatry, 17*(4), 616-630. doi: 10.1177/1359104511426406
- Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2013). Cochrane Review: Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years (Review). *Evidence-Based Child Health: A Cochrane Review Journal, 8*(2), 318-692. doi: 10.1002/ebch.1905
-

-
- Gardner, F., Montgomery, P., & Knerr, W. (2015). Transporting evidence-based parenting programs for child problem behavior (age 3-10) between countries: Systematic review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology*, 1-14. doi: 10.1080/15374416.2015.1015134
- Heinrichs, N., Bertram, H., Kuschel, A., & Hahlweg, K. (2005). Parent recruitment and retention in a universal prevention program for child behavior and emotional problems: Barriers to research and program participation. *Prevention Science*, 6(4), 275-286. doi: 10.1007/S11121-005-0006-1
- Holtrop, K., Parra Cardona, J. R., & Forgatch, M. S. (2014). Examining the process of change in an evidence-based parent training intervention: A qualitative study grounded in the experiences of participants. *Prevention Science*, 15(5), 745-756. doi: 10.1007/S11121-013-0401-Y
- Hutchings, J., Gardner, F., & Lane, E. (2004). Making evidence-based intervention work. In D. Farrington, C. Sutton, & D. Utting (Eds.), *Support from the start: Working with young children and their families to reduce the risks of crime and antisocial behaviour* (pp. 69-79). London: Department for Education and Skills.
- Hutchings, J., Gardner, F., Lane, E., Bywater, T., Daley, D., Whitaker, C., . . . Edwards, R. T. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomised controlled trial. *British Medical Journal*, 334(7595), 678-682. doi: 10.1136/Bmj.39126.620799.55
- Ingoldsby, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies*, 19(5), 629-645. doi: 10.1007/S10826-009-9350-2
- Kabat-Zinn, J. (1994). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. San Francisco: Delta Trade Paperbacks.
- Kabat-Zinn, J. (2013). *Full catastrophe living (revised edition): Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Bantam Books.
- Kazdin, A. E. (2000). Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. *Journal of Child and Family Studies*, 9(2), 157-174.
- Knerr, W., Gardner, F., & Cluver, L. (2013). Improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries: A systematic review. *Prevention Science*, 14(4), 352-363. doi: 10.1007/s11121-012-0314-1
- Koerting, J., Smith, E., Knowles, M. M., Latter, S., Elsey, H., McCann, D. C., . . . Sonuga-Barke, E. J. (2013). Barriers to, and facilitators of, parenting programmes for childhood behaviour problems: A qualitative synthesis of studies of parents' and professionals' perceptions. *European Child and Adolescent Psychiatry*, 22(11), 653-670.
- Labadarios, D., Maunder, E., Steyn, N., MacIntyre, U., Swart, R., Gericke, G., . . . Dannhauser, A. (2003). National food consumption survey in children aged 1-9 years: South Africa 1999. *Forum Nutrition*, 56, 106-109.
- Lachman, J. M., Cluver, L., Ward, C. L., Hutchings, J., Gardner, F., Wessels, I., & Mlotshwa, S. (in revision). Pilot randomized controlled trial of a parenting program to reduce the risk of child maltreatment in South Africa.
- Lachman, J. M., Sherr, L., Cluver, L., Ward, C. L., Hutchings, J., & Gardner, F. (2016). Integrating evidence and context to develop a parenting program for low-
-

-
- income families in South Africa. *Journal of Child and Family Studies*, 25(7), 2337-2352. doi: 10.1007/s10826-016-0389-6
- Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice*, 13(4), 295-310. doi: 10.1111/j.1468-2850.2006.00042.x
- Leijten, P., Melendez-Torres, G., Knerr, W., & Gardner, F. (2016). Transported versus homegrown parenting interventions for reducing disruptive child behavior: A multilevel meta-regression study. *Journal of the American Academy of Child & Adolescent Psychiatry*. doi: 10.1016/j.jaac.2016.05.003
- Lopman, B. A., Barnabas, R. V., Boerma, J. T., Chawira, G., Gaitskell, K., Harrop, T., . . . Gregson, S. (2006). Creating and validating an algorithm to measure AIDS mortality in the adult population using verbal autopsy. *Plos Medicine*, 3(8), 1273-1281. doi: 10.1371/journal.pmed.0030312
- Meinck, F. (2014). *Physical, emotional and sexual child abuse victimisation in South Africa: Findings from a prospective cohort study*. Oxford: University of Oxford.
- Meinck, F., Cluver, L. D., Boyes, M. E., & Loening-Voysey, H. (2016). Physical, emotional, and sexual abuse of children in South Africa: Incidence, prevalence, perpetrators, and locations. *Journal of Epidemiology and Community Health*.
- Meth, P. (2013). 'I don't like my children to grow up in this bad area': Parental anxieties about living in informal settlements. *International Journal of Urban and Regional Research*, 37(2), 537-555. doi: 10.1111/J.1468-2427.2012.01199.X
- Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., & Hardeman, W. Process evaluation of complex interventions: UK Medical Research Council (MRC) guidance, 2014. London: MRC.
- Murray, K. W., Woodruff, K., Moon, C., & Finney, C. (2015). Using text messaging to improve attendance and completion in a parent training program. *Journal of Child and Family Studies*, 24, 1-10.
- Nix, R. L., Bierman, K. L., & McMahon, R. J. (2009). How attendance and quality of participation affect treatment response to parent management training. *Journal of Consulting and Clinical Psychology*, 77(3), 429-438. doi: 10.1037/a0015028
- Oakley, A., Strange, V., Bonell, C., Allen, E., Stephenson, J., & RIPPLE Study Team. (2006). Process evaluation in randomised controlled trials of complex interventions. *British Medical Journal*, 332(7538), 413-416. doi: 10.1136/bmj.332.7538.413
- Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., & Leckman, J. F. (2014). Practitioner review: Engaging fathers: Recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*, 55(11), 1187-1212. doi: 10.1111/jcpp.12280
- Parra Cardona, J. R., Domenech-Rodriguez, M., Forgatch, M., Sullivan, C., Bybee, D., Holtrop, K., . . . G., B. (2012). Culturally adapting an evidence-based parenting intervention for Latino immigrants: The need to integrate fidelity and cultural relevance. *Family Process*, 51(1), 56-72.
- Sethi, S., Kerns, S. E. U., Sanders, M. R., & Ralph, A. (2014). The international dissemination of evidence-based parenting interventions: Impact on practitioner content and process self-efficacy. *International Journal of Mental Health Promotion*, 16(2), 126-137. doi: 10.1080/14623730.2014.917896
-

-
- Statistics South Africa. (2012). *Census 2011*. Pretoria: Statistics South Africa.
- Stoltenborgh, M., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Alink, L. R. A. (2013). Cultural-geographical differences in the occurrence of child physical abuse? A meta-analysis of global prevalence. *International Journal of Psychology*, 48(2), 81-94. doi: 10.1080/00207594.2012.697165
- Straus, M., Hamby, S., Boney-McCoy, S., & Sugarman, D. (1996). The revised conflict tactics scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues*, 17, 283-316.
- Sulamoyo, D. (2010). "I am because we are": Ubuntu as a cultural strategy for OD and change in sub-Saharan Africa. *Organization Development Journal*, 28(4), 41-51.
- Watters, J. K., & Biernacki, P. (1989). Targeted sampling: Options for the study of hidden populations. *Social Problems*, 36(4), 416-430.
- Webster-Stratton, C. (1989). *The Incredible Years*. Seattle, WA: Incredible Years.
- Wood, D., Bruner, J., & Ross, G. (1976). The role of tutoring in problem solving. *Journal of Child Psychology and Child Psychiatry*, 17, 89-100.
- World Health Organization. (2014). *Global Status Report on Violence Prevention 2014*. Geneva: WHO, United Nations Development Programme, United Nations Office on Drugs and Crime.
- World Health Organization. (March 1999). *Report on the consultation on child abuse prevention*. Geneva: World Health Organisation.
- World Health Organization & UNICEF. (2008). *World Report on Child Injury Prevention*. Geneva: World Health Organization.

CHAPTER SEVEN. DISCUSSION

Overview

The main objective of this thesis was to contribute to the existing literature on the development and evaluation of parenting programmes in low- and middle-income countries. This thesis had three specific aims: 1) to develop a parenting programme that integrates evidence-based approaches within a local South African context for vulnerable families with children aged three to eight years; 2) to test the feasibility of conducting a pilot randomised controlled trial and the programme's initial effectiveness in reducing the risk of child maltreatment in this context; and 3) to examine the feasibility of the programme in terms of cultural acceptability, implementation, and participation. Findings provide important insights regarding the transferability of evidence-based approaches across cultural and contextual settings from high-income countries to LMICs. They also demonstrate the utility of using an integrated intervention development and evaluation model derived from the UK Medical Research Council's framework for developing and evaluating complex interventions (see Figure 2, page 38) (Craig et al., 2008). Findings also establish an important foundation for further development and testing of the programme as part of an iterative process in building evidence of effectiveness.

The three main papers in this thesis fill a number of gaps in the existing literature on the development and evaluation of parenting interventions in LMICs, and in particular, South Africa. The first paper (Chapter 4) contributes to the literature on cultural adaptation and intervention development of parenting programmes (Bernal, 2006; Castro et al., 2010). It used a community-based collaborative approach to develop an intervention that is based both on the best available evidence and the needs identified

by local service providers and parents (Fraenkel, 2006). The integration of evidence-based parenting programme components within a South African cultural context provides a practical application of how one might balance fidelity to evidence with fit to context.

The second paper (Chapter 5) responds to the need to increase the evidence base regarding the effectiveness of parenting programmes in LMICs (Knerr et al., 2013; Mejia et al., 2012). It builds on existing research in South Africa that has demonstrated the feasibility of conducting high-quality trials of parenting programmes for families with children up to 18 months of age (Cooper et al., 2009; Vally, Murray, Tomlinson, & Cooper, 2014), as well as from recent studies in Panama and Liberia on parenting programmes for children between the ages of three and ten ((Mejia, Calam, et al., 2015; Puffer et al., 2015). The pilot RCT study demonstrated the utility of conducting a rigorous evaluation following the CONSORT (Consolidated Standards of Reporting Trials) guidelines for reporting on clinical trials (Altman et al., 2001; Moher et al., 2010). While interpretation of results regarding intervention effectiveness are limited due to the study's small sample size, preliminary findings indicated improvements in positive parenting skills with no severe harmful effects.

The third paper (Chapter 6) makes a valuable contribution to existing research on programme feasibility, especially in the context of delivering parenting programmes in low-resource settings (Furlong & McGilloway, 2014; Mejia, Ulph, & Calam, 2015). Its mixed methods approach allowed for a thorough examination of multiple dimensions of feasibility based on acceptability, implementation, and participation (Berkel et al., 2011; Durlak & DuPre, 2008; Kazdin, 2000). Findings demonstrated a

high degree of programme feasibility while highlighting a number of important areas for further intervention development.

This discussion chapter provides an overview of findings and key points of each study. It offers a detailed discussion on the relevance of findings to existing research on intervention development, pilot testing, and feasibility studies. It also discusses the limitations and strengths of the thesis in terms of internal and external validity. In addition, it provides recommendations for future research as well as implications for intervention development, policy, and practice. Finally, it situates the thesis within the larger framework of ongoing research focused on developing, evaluating, and disseminating evidence-based parenting interventions to prevent child maltreatment and improve child wellbeing in LMICs.

Paper #1: Integrating Evidence and Context to Develop a Parenting Programme for Low-Income Families in South Africa.

The first paper in this thesis focused on the development of a parenting programme for low-income families with children aged three to eight years in South Africa. In preparation for subsequent pilot feasibility testing, it included three key stages. The first stage identified core evidence-based parenting programme components by examining distillation studies, meta-analyses, and specific intervention manuals and protocols. The second stage involved a formative evaluation using community-based participatory approaches to assess local stakeholders' perceptions regarding content necessary for inclusion in parenting programmes. The third stage integrated findings from the previous two stages in order to inform the design and manualisation of an evidence-informed, locally relevant programme.

This study highlights the importance of considering both existing evidence and local context when developing interventions for a specific population. On the one hand, it is important to maintain fidelity to existing evidence in order to replicate results that have been demonstrated in previous studies (Chaffin et al., 2004). Unless there is strong empirical data regarding essential and non-essential components, unsystematic changes may result in reduced effectiveness or even harmful effects (Elliott & Mihalic, 2004). On the other hand, systematic cultural adaptation grounded in qualitative and quantitative data may improve programme effectiveness and relevance (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). Contextual issues regarding language, values, and customs, the availability of service delivery mechanisms, and specific risk and protective factors may require additional components to address local population needs (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009).

The case against adaptation

Results from the formative evaluation found many similarities between evidence-based approaches and local stakeholder perceptions of content necessary for inclusion in parenting programmes (Kaminski et al., 2008). These findings may be interpreted to support literature arguing that the lengthy process involved in cultural adaptation studies is unnecessary and a potentially inefficient use of limited financial resources (Castro et al., 2010). A recent meta-analysis on the transportability of evidence-based parenting programmes suggests that many parent management training approaches may be effective across diverse cultures with minimal adaptation (Gardner et al., 2015). This study identified 17 trials of four interventions from the United States and Australia – Triple P, PMTO, PCIT, and the Incredible Years – that were tested in ten countries outside of their country of origin. Although only one study of a

programme transported to a LMIC was included (i.e., Iran), results showed medium effects on reducing child behaviour problems (SMD -0.71, 95% CI -0.97, -0.44) and stronger effects for interventions tested in countries with more culturally disparate populations (SMD -1.50, 95% CI -2.25, -0.75). Importantly, inclusion criteria required programmes to be clear replications of the original intervention with minimum cultural adaptation.

A more recent RCT in Panama also illustrates the potential transferability of evidence-based approaches across cultural and contextual settings (Mejia, Calam, et al., 2015). This study examined the efficacy of a minimally adapted version of Triple P's Level 3 discussion group on "dealing with disobedience" ($N = 108$ parents of children aged three to ten years). During a formative evaluation, the original programme showed high acceptability and feasibility with potential practitioners and parents, thus suggesting that extensive adaptation was not necessary (Mejia, Calam, & Sanders, 2014a; Mejia, Calam, & Sanders, 2014b). As a result, adaptation was limited to translating original material into Spanish and using a local facilitator who was culturally adept at incorporating local examples and *dichos* ("proverbs" in English) into sessions. Results at 6-months follow-up found strong effects for reduced behaviour problems ($d = -1.09$, 95% CI [-1.57, -0.60]) and moderate effects for reduced dysfunctional parenting in comparison to controls ($d = -0.59$, 95% CI [-1.04, -0.12]).

The case for adaptation

Findings from this thesis also support the case for in-depth cultural adaptation of evidence-based approaches in order to increase the likelihood of programme acceptability, feasibility, and effectiveness (Kreuter et al., 2003). The formative evaluation identified specific local contextual factors that may need to be considered

when transferring parenting programmes to sub-Saharan Africa. For instance, families living in communities with high HIV-prevalence may require additional support that is not included in existing evidence-based programmes from HICs (Antle, Wells, Goldie, DeMatteo, & King, 2001). Respondents' concerns regarding the parental disclosure of HIV-status, parental illness, and mortality to children are consistent with the findings from other qualitative research in South Africa (Heeren, Jemmott, Sidloyi, & Ngwane, 2012). Furthermore, numerous studies have demonstrated negative associations between poorly managed disclosure and poor parent-child interaction, parental mental health, and child wellbeing (Murphy, Koranyi, Crim, & Whited, 1999; Palin et al., 2009; Shaffer, Jones, Kotchick, & Forehand, 2001). Negative impacts associated with poor disclosure include increased risk of stigma, discrimination, and violence against children and adults (Delaney, Serovich, & Lim, 2008). Moreover, the potential benefits of carefully managed disclosure to children include increased antiretroviral adherence for HIV-positive children as well as improved mental and physical health (World Health Organization, 2011). As a result, UNICEF and the World Health Organization have recommended that programmes delivered in high HIV-prevalence areas assist parents by identifying and practising appropriate methods of disclosure based on their children's cognitive and emotional development (UNICEF & World Health Organization, 2010; World Health Organization, 2011). Although the Sinovuyo programme did not explicitly address HIV disclosure, it incorporated a section on communicating about difficult issues and provided additional training to facilitators on assisting HIV-affected families.

Results also support the importance of incorporating cultural values into programmes delivered to South African families. Values such as respect, social

responsibility, and reciprocity may be understood as expressions of *ubuntu* – a core African value expressed in the proverb “*umuntu ngumuntu ngabantu*” (a person is a person because of other people) (Bonn, 2007). While programmes from Western cultures often emphasise child autonomy and individuation, *ubuntu* encompasses a sense of collectivism and interconnectedness that underlies interpersonal relationships in many African cultures (Bhana, 2010). Thus, programmes that frame parent skills training within a wider context of building respectful behaviour may strengthen participation and engagement (Siu, 2015). These cultural values may be transferrable to parenting programmes delivered in other contexts since Latino and Asian parents also identify strongly with respect as a core parenting value (Leung et al., 2003; Parra Cardona et al., 2012; Parra Cardona et al., 2009). Furthermore, programmes that cultivate a sense of *ubuntu* within group settings may help strengthen social cohesion as an important source of resilience (Tom, 2010). This may be especially important in low-income communities where social support has been shown to mitigate the negative impact of poverty, intimate partner violence, and HIV/AIDS on parenting and child wellbeing (Casale et al., 2015; Coker et al., 2002; Hashima & Amato, 1994; Raikes & Thompson, 2005; Williams, 1996).

Findings also suggest that parenting programmes designed for nuclear families consisting of parent-child dyads may not as appropriate in contexts where children are raised in more complex family systems. Along with the legacy of racial dislocation during the Apartheid era, the impact of HIV/AIDS and poverty has further destabilised family structures in South Africa (Smit, 2007). Children are often cared for by extended family networks or foster parents, and experience frequent social instability as they move between families and geographical locations (Bozalek, 1999). Programmes may

need to find strategies in which families can implement more consistent parenting practices on a family level or with multiple, changing caregivers. Potential approaches may involve including alternative caregivers in group sessions or conducting home visits with the entire family at certain points during programme delivery. Furthermore, programmes may need to assist participants to find solutions to resistance from other family members. As indicated in the feasibility study, female participants, especially young mothers who are considered low status in many traditional households, may encounter resistance or even come into conflict with male adults or elders in the household when trying to implement new parenting skills (Amoateng et al., 2004). Likewise, harsh or inconsistent discipline from an alternative caregiver may undermine the effectiveness of a participant's use of positive parenting skills to encourage positive child behaviour. This may be further compromised in households where children witness regular intimate partner violence (Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009). Finally, it is important to recognise the limitations of parenting programmes that are delivered in isolation from other social support services (Richter, Foster, & Sherr, 2006). Participants living in multiply deprived areas may require additional economic strengthening support to address parenting stress that is related to acute poverty (Chaffin & Bergdorf, 2011). Referrals to child protection and gender-based violence agencies may also be necessary when available. Unfortunately, in many resource-poor contexts, these services are severely limited or dysfunctional. In such situations, additional training may be required for programme facilitators to be able to manage these issues.

Towards cultural sensitivity: Balancing fidelity and fit

In summary, instead of making stark choices between a “one size fits all” or specifically tailored approach, it may be more practical to develop evidence-informed interventions structured around cultural sensitivity (Meija, Leijten, Lachman & Cardona, 2016). Cultural sensitivity allows for a certain degree of flexibility in programme delivery while adhering to core components that have been shown to be essential for effectiveness (Bernal, Bonilla, & Bellido, 1995; Kumpfer et al., 2002). For instance, in order to meet the needs of specific parent groups and diverse populations, the Incredible Years uses a client-led approach that allows facilitators to adjust delivery for specific population groups (Webster-Stratton, 2009). This has enabled it to demonstrate a wide range of applicability and effectiveness across multi-ethnic and socioeconomic backgrounds in the United States and other HICs with minimal adaptation (Axberg & Broberg, 2008; Fergusson et al., 2009; Larsson et al., 2009; Leijten, Raaijmakers, de Castro, van den Ban, et al., 2013; McGilloway et al., 2012; Reid et al., 2001).

Culturally sensitive interventions may also be more applicable in contexts such as South Africa where families are continuously interacting with political, economic, and social transformation (Richter, 1999). Low-income isiXhosa-speaking families in Cape Town are a heterogeneous cultural group representing many different sociocultural backgrounds (Bray et al., 2010). Families may include those from urban, modernised families who have lived in Cape Town for many generations, as well as recent migrants from rural, traditional communities in the Eastern Cape (Bray & Brandt, 2007). Respondents’ perceptions regarding corporal punishment illustrate the complexities of delivering parenting programmes to population groups that may seem

culturally homogenous on the surface. While many parents reported using corporal punishment as a normative discipline strategy, others were receptive to learning other techniques to manage difficult child behaviour. This is consistent with research findings that demonstrate that, although corporal punishment is widespread throughout LMICs, caregivers also engage in nonviolent discipline practices. Moreover, surveys have shown that a majority of adult caregivers in LMICs do not believe that harsh discipline is necessary to raise a child (Breen et al., 2015; Dawes et al., 2005; UNICEF, 2010, 2014).

In order to develop culturally sensitive interventions, additional research is necessary on core parenting programme functions regarding the immediate proximal effects of programme activities (Bonell et al., 2012). This would allow greater flexibility in programme delivery in order to fit the needs of a particular population group without compromising positive intervention effects. For example, although child-directed play is considered an essential component in parenting programmes (Eyberg, Nelson, & Boggs, 2008), respondents from the formative evaluation reported that low-income South African families may encounter difficulties finding time to engage in play due to domestic responsibilities. In addition to child-led play, it may be more feasible and culturally acceptable to promote mutually directed adult-child activities, such as involvement in household chores or subsistence farming (Henry, 1990). The inclusion of both activities in programme protocols may allow for greater cultural relevance while fulfilling the overall function of increasing positive parenting and positive child behaviour. Furthermore, by emphasising function over form, facilitators may be able to tailor specific programme activities to meet each individual parent's needs within a group setting. However, this may require a high degree of facilitation

skills and more complex implementation fidelity monitoring systems, which may not be feasible in LMICs.

Lastly, one of the challenges in developing the Sinovuyo programme manual was the lack of knowledge on whether adapting a certain component would either compromise or enhance programme effectiveness. More empirical evidence is necessary to identify the active components of interventions and the extent to which the adaptation of these components is necessary to fit a local context. The development team often had to rely on expert opinion and client preferences instead of empirical data when balancing fidelity to evidence with fit to context. For example, the replacement of videos with illustrated vignettes was considered an acceptable adaptation since it maintained the core function of the collaborative social learning approach while addressing resource constraints. However, there is no empirical data indicating whether or not this change affected the potential impact of the intervention. Different levels of adaptation could be tested in multi-arm trials such as the recent three-arm RCT that compared a minimally adapted version and a more culturally enhanced version of PMTO for Latin American immigrants in the United States (Parra Cardona, 2015). Alternatively, factorial experiments could provide insight on the differential effects of adaptations of discrete as well as potential interaction effects between adapted components (Collins, Dziak, Kugler, & Trail, 2014).

Paper #2: Pilot Randomised Controlled Trial of a Parenting Programme to Reduce the Risk of Child Maltreatment in South Africa

The second paper of this thesis had two aims related to the MRC guidelines for developing and evaluating complex interventions: assessing evaluation feasibility and testing preliminary intervention effectiveness (Craig et al., 2008). First, this study

examined the feasibility of conducting an RCT evaluation of the parenting programme developed during the first part of this thesis. Evaluation feasibility outcomes included (a) the recruitment and retention rates of participants; (b) the suitability and effectiveness of randomisation procedures; (c) the reliability and response rates of parent-report and observational data collection methods; and (d) the potential effect of clustering due to delivering the intervention in groups of parents. Results suggest a high degree of evaluation feasibility using a rigorous intention-to-treat design. The study achieved high rates of recruitment prior to screening and retention at post-test. Randomisation procedures were rigorously implemented with no significant differences between groups at baseline for demographic and outcome variables, negligible study contamination during programme implementation, and very few instances of compromised blinding. With the exception of the Parent-Child Conflict Tactics nonviolent parenting subscale, reliability and response rates of outcome measures were also within the acceptable range.

Second, the paper conducted preliminary analyses of the intervention's effectiveness in reducing the risk of child maltreatment in comparison to a wait-list control group. With the exception of parental depression, observed effective parenting, and observed positive child behaviour, paired t-tests showed that both allocation groups improved significantly from baseline to post-test on all of the tested outcomes, thus indicating that there were no major instances of harm against participants. ANCOVA analyses using an intention-to-treat design to compare intervention and control groups showed mixed results. On the one hand, there were moderate positive intervention effects for both parent-report and observational assessments of positive parenting behaviour. On the other hand, there were moderate effects for decreased frequency of

observed positive child behaviour in the intervention group compared to controls. Lastly, there were no clinically relevant differences between groups for any other outcomes.³²

Evaluation feasibility

This is the first study to show that it is feasible to conduct a high-quality RCT of a parenting programme for vulnerable families with children aged three to eight years in South Africa. Although limited by financial and human resource constraints, a rigorous study design was successfully implemented in order to reduce the risk of bias and potential confounding factors. These findings are remarkable given the many challenges encountered when evaluating interventions delivered to high-risk families (Dumka et al., 1997). Factors such as poverty, unemployment, low education, single marital status, and parental mental health problems – all characteristics of the pilot’s target population – have been associated with reduced study recruitment and retention (Heinrichs et al., 2005). The study’s recruitment rate may have been influenced by the high proportion of participants who were recruited from the implementing partner, a non-profit non-governmental organisation with a long history of service delivery in Cape Town. In addition, although parents received minimal incentives for participating in the study (i.e., transportation during screening, a small snack during observational assessments, and a certificate following completion of post-test assessments), the opportunity to

³² Paired t-tests comparing scores from baseline to post-test within groups were not reported in Paper 3 due to limits on word length. Analyses found significant improvements on many of the outcomes that did not demonstrate clinically relevant differences between groups. Parents in both the intervention and control groups reported reductions in child problem behaviour (intervention $t = 3.15, p < .01$; control $t = 3.17, p < .01$), and harsh parenting (intervention $t = 3.91, p < .001$; control $t = 5.26, p < .001$), and limit setting frequency (intervention $t = 3.26, p < 0.01$; control $t = 2.87, p < .01$). Likewise, observational assessments also showed improvement in effective parenting in each group from baseline to post-test (intervention $t = 2.66, p < .01$; control $t = 2.96, p < .01$). Finally, although there were no clinically relevant differences between intervention and control groups for observed reduced frequency of harsh parenting, only the intervention group showed significant reductions from baseline to post-test ($t = 2.47, p < .05$).

participate in the Sinovuyo programme could have been a sufficient motivation to remain in the study regardless of allocation status (Prinz et al., 2001). The next section examines the study's ability to reduce the risk of bias in greater detail.

Reducing the risk of bias

As a key aspect of randomised controlled trials, results demonstrate the feasibility of reducing the risk of bias on a number of important levels (Delgado-Rodriguez & Llorca, 2004). First, in order to increase the likelihood that there would be no systematic differences between participants in the intervention and control groups at baseline, we minimised selection bias by using random sequence generation and allocation concealment (Higgins & Green, 2011). We also implemented randomisation procedures at a centralised location away from the field office, used a computer random number generator, and concealed allocation from field research and intervention staff until all the participants were registered in the study. We also employed stratification during randomisation to reduce the risk of selection bias by grouping individuals according to child gender and age (i.e., groups of three to five, and six to eight year olds) (Kernan, Viscoli, Makuch, Brass, & Horwitz, 1999).

Second, we were able to reduce the risk of detection bias (i.e., how outcome measurements were obtained and analysed) by maintaining the blinding of outcome assessors and using multiple methods to assess parent and child behaviour (Higgins & Green, 2011). In order to reduce the likelihood of observer bias, outcome assessors should be blind to allocation status (Moher et al., 2010). The awareness of participant allocation status may influence the manner in which data is collected or reported (Delgado-Rodriguez & Llorca, 2004). However, this is often difficult to achieve in studies on behavioural interventions, and even more challenging during observational

assessments that occur in the homes of participants (Friedberg, Lipsitz, & Natarajan, 2010). Participants may inadvertently disclose their allocation status verbally during assessments, or data collectors may observe physical signs of participation in the form of certificates or other intervention materials (Haro et al., 2006). Nonetheless, this study was able to limit observer bias with only four reported instances of compromised blinding.

Third, this pilot study demonstrated the feasibility of using both observational assessments and self-report measures to reduce the likelihood of detection bias in the study. The combination of self-report and observational assessments illustrates that it is possible to use a robust approach to analysing parenting and child behaviour on multiple levels in low-resource settings. Many studies of parenting programmes in LMICs have relied exclusively on self-report measures to analyse effects (Knerr et al., 2013). However, self-report measures are vulnerable to response bias due to social desirability, cognitive burden, and method overlap (Morsbach & Prinz, 2006). For instance, parents may report less harsh parenting practices because of concerns regarding potential reprisals from local authorities (Chen & Chan, 2015). Likewise, participants in parenting programmes may report increased positive parenting practices as a result of increased knowledge of what behaviour is expected from them. Furthermore, self-report questionnaires often contain multiple scales that take a long time to complete, which may result in cognitive burden and reduced accuracy of responses (Tourangeau, 2000). Participants may also have difficulties recalling the frequencies of specific behaviours over an extended period of time. Finally, parents' perceptions of parenting or child behaviour may be influenced by their own mental

wellbeing. For example, parents who are depressed may have a negative perception of their parenting and child's behaviour (Lovejoy, Graczyk, O'Hare, & Neuman, 2000).

On the other hand, while observational assessments can reduce the risk of response bias in some aspects, they also have limitations that may introduce other sources of detection bias (Aspland & Gardner, 2003). Although there are few studies comparing the effect of observational assessments conducted in a clinical setting versus a participant's home, the location of observations may influence how parents and children behave during sessions (Gardner, 2000). Likewise, the presence of an outside observer and the nature of tasks observed may have an effect on participants' behaviour. The analysis of observational data may also be problematic. The method of data coding (i.e., frequency of behaviours, coder impressions, or timing of tasks) can influence the internal validity of a study. Furthermore, obtaining inter-rater reliability between data coders is often a lengthy and costly process that relies on well-trained assessors capable of accurately identifying a priori defined behaviours (Gardner, 2000). It is important to note that, although we were unable to validate the Sinovuyo Observation Coding System, this study was able to achieve an acceptable level of inter-rater reliability above the recommended threshold of 0.70.

Fourth, we managed to achieve minimal attrition bias (i.e., withdrawal from the study or incomplete data due to systematic reasons) (Young & Ansell, 2003). Results show high levels of study retention at post-test, thus suggesting that randomisation and assessment procedures were suitable to study participants. This was accomplished in spite of circumstances in which participants often changed contact information, moved to new households, or even migrated to other provinces during the study. Furthermore, analysis of incomplete data, or missingness, determined that the data was missing at

random in relation to the demographics, outcomes and allocation status. Chi-square tests also found no significant differences between allocation groups or participants with or without complete data. In addition, intention-to-treat analyses were conducted using multiple imputation, a statistically more robust method to account for missing data than traditional approaches such as mean imputation or “last observation carried forward” (Li et al., 2014). Moreover, as an added measure to examine the impact of missingness, sensitivity analyses found no differences between the incomplete and imputed dataset (White, Horton, Carpenter, & Pocock, 2011). Finally, we were able to examine the potential for clustering effects due to parenting sessions administered in clusters in the intervention group (Pals et al., 2008). Even though ICC analyses found no significant effect of clustering, we used multilevel analyses that included individuals nested within parent group assignment as an added measure to account for potential variance. Nonetheless, due to the small sample size, non-significant ICCs may still have had an effect on outcomes resulting in a potential Type I error (for ICCs within the intervention arm, see Table 12, Appendix J, page 457,) (Carter, 2010).

Fifth, the recruitment and randomisation procedures were sufficiently rigorous to reduce the likelihood of contamination bias between intervention and control groups (Delgado-Rodriguez & Llorca, 2004). This was a serious concern since the study participants lived in high-density, low-income neighbourhoods where social networks among families had the potential to compromise the integrity of the randomised control design. We attempted to counter potential contamination by using inclusion criteria that allowed only one individual per household or family to participate in the study. We also concealed allocation status from members in opposite arms of the study. Moreover, no members of the control group participated in parenting sessions until the study was

concluded. In support of the hypothesis that minimum contamination occurred, parents in the control group reported little or no knowledge of programme content, principles, and approaches when the programme was delivered after the post-test.

Finally, we reduced the likelihood of reporting bias by registering our trial protocol prior to study inception and following recommended guidelines regarding reporting on RCTs (Higgins & Green, 2011). The study's trial protocol was registered with Clinicaltrials.gov and the Pan-African Clinical Trials Registry using the SPIRIT guidelines as a framework (Standard Protocol Items: Recommendations for Intervention Trials) (Chan et al., 2013). This included a priori designation of primary and secondary outcomes, randomisation procedures, and data analysis strategy. Furthermore, we were able to implement this rigorous study protocol despite having limited financial resources and relying on a research team that included volunteer interns and community-based research assistants. In order to be as transparent as possible, we closely adhered to the CONSORT 2010 statement, including reporting on all primary and secondary outcomes, regardless of their clinical significance (Moher et al., 2010). Although we did not have a data monitoring committee for this pilot study, the analyses by the DPhil candidate were closely supervised by the principal investigators, Professor Lucie Cluver and Associate Professor Catherine Ward. Finally, the potential conflict of interest as a result of the DPhil candidate's role as main developer of the Sinovuyo programme and executive director of the implementing organisation, Clowns Without Borders South Africa, was disclosed in all publication submissions and conference presentations (Eisner, 2011).

Unaccounted bias

As with many RCTs of behavioural interventions, the study was unable to account for all elements of bias. While the aforementioned rigorous randomisation procedures may have reduced the risk of selection bias on one level, the recruitment strategy may have exposed the study to potential inclusion bias (Higgins & Green, 2011). The selective recruitment of RCT participants via referrals may have led to a non-representative sample of participants who were already receiving substantial services as part of our community partner NGO's orphans and vulnerable children programme (Delgado-Rodriguez & Llorca, 2004). These services included enrolment in early childhood development crèches and home consultations by community-based workers. Although we were not able to thoroughly examine reasons for exclusion or refusal to enrol in the study, this would have provided further information regarding potential inclusion biases. In addition, since it was not possible to blind participants to allocation status, the study may have been subjected to potential performance bias. This limitation is true of all studies on parenting programmes and other behavioural interventions. Although we attempted to reduce this bias by allocating participants to treatment groups after baseline data was collected, both service providers and participants were aware of their allocation status and the purpose of the study during intervention delivery and post-test data collection.³³

The study was also not able to account for the risk of detection bias due to the unknown validity of outcome measurements (Delgado-Rodriguez & Llorca, 2004).

³³ Potential inclusion biases were explored based on those who gave consent and completed the screening questionnaire (N = 90). With the exception of the screening criterion (i.e. parent-report of clinical levels of child problem behaviour based on the Eyberg Child Behaviour Inventory), independent t-tests and Chi-square analyses found no significant differences between included and excluded families for the following variables: caregiver age, gender, and educational status; child age, gender, and relationship to caregiver; household structure and number of children per household ($p > 0.05$).

Although the majority of psychometric scales demonstrated accepted levels of internal consistency, only one of the self-report assessments was validated for the target population (i.e., Beck Depression Inventory). Likewise, as a newly developed coding tool with no previous testing, the Sinovuyo Observational Coding System (SOCS) may have assessed the wrong constructs necessary to detect change in observed parenting and child behaviour. Its reliance on frequency coding may have resulted in an inaccurate measurement of the quality of parent-child interaction (Gardner, 2000). For instance, corporal punishment has been associated with short-term increases in child compliance and reductions in negative child behaviour, especially in LMICs (Gershoff, 2002; Lansford & Deater-Deckard, 2012). As a result, additional research is planned to further examine the internal validity and accuracy of the self-report and observational assessments using data from the both the pilot RCT and forthcoming main RCT.

Exploratory intervention effects

Exploratory analyses of outcomes showed mixed results regarding the intervention's impact on reducing the risk of child maltreatment. Although within-group analyses found reductions in harsh parenting in both intervention and control groups, there were no significant differences between allocation groups on self-report outcomes. It is possible that participants may have perceived corporal punishment as a socially unacceptable behaviour within the context of the study, and thus underreported behaviour at post-test regardless of allocation assignment (Straus et al., 1998). This is consistent with research demonstrating that parents with a history of child maltreatment may underreport harsh parenting and be less likely to exhibit harsh parenting during observational assessments (Bennett, Sullivan, & Lewis, 2006). In particular, parents' disclosure of harsh parenting behaviour may have been influenced by the fact that

during informed consent procedures researchers emphasised the need to refer families to child protection services if there was evidence of harm or abuse against children. Alternatively, results may have been influenced by a Hawthorne Effect as a result of participation in the study (Flay, 1986). In other words, the process of answering questions regarding corporal punishment may have prompted parents to re-examine their parenting practices and find alternative methods of discipline outside of the intervention (Stuart-Brown et al., 2004).

Results regarding positive parenting were more encouraging. Analyses found moderate treatment effects for parent-reports of increased frequency of positive parenting behaviour and observational assessments of improved child-led behaviour in comparison to controls. These initial results suggest the efficacy of the intervention's emphasis on positive parenting as the foundation of the "Rondavel of Support" model. Findings are also encouraging given evidence regarding the role of positive parenting as a protective factor in reducing the risk of child maltreatment (Deater-Deckard, Dodge, Bates, & Pettit, 1998). Moreover, the positive intervention effects found in both self-report and observational assessments contribute to the robustness of results (Aspland & Gardner, 2003). However, these findings must be treated with caution given the aforementioned potential reporting biases linked to social desirability and limited sample size.

The intervention's impact on child behaviour problems was less conclusive. Data from parent-report assessments showed non-significant but clinically relevant intervention effects in reducing the intensity of child behaviour problems. However, as mentioned above, this may have been influenced by respondent bias due to the programme's focus on helping parents manage difficult child behaviour (Aspland &

Gardner, 2003). On the other hand, observational assessments showed moderate intervention effects for reduced positive child behaviour and non-significant but clinically relevant effects for smaller reductions in negative child behaviour in the intervention group in comparison to controls. It is possible that cultural factors may explain these results. In cultures where corporal punishment is considered normative, children often exhibit higher rates of child compliance (Lansford & Deater-Deckard, 2012). Since child compliance was a core factor in the coding system for observed positive child behaviour, higher levels of positive behaviour in the control group at post-test may have been a result of coercive parenting (Mlotshwa, 2013). Furthermore, although the programme's theory of change included an emphasis on replacing corporal punishment with limit-setting and nonviolent discipline parenting behaviour, the study did not detect any significant improvements in these outcomes. It is plausible that improvements in positive parenting combined with reductions in corporal punishment may possibly have been experienced as permissive parenting, thus explaining the negative intervention effects on observed child behaviour (Baumrind, 1991). As a result, further research is necessary to disentangle this dynamic relationship between positive parenting, corporal punishment, and child behaviour in a South African context.

In summary, it is important to reemphasise that results from this pilot RCT are initial indications of effectiveness and should therefore be treated with caution. At this early stage of intervention development and testing, it is not possible to conclude that the intervention is either effective or ineffective at reducing the risk of child maltreatment (Altman & Bland, 1995). The small-scale pilot RCT lacked sufficient statistical power to detect significant intervention effects on most outcomes (Arain, Campbell, Cooper, & Lancaster, 2010). Although preliminary sample size calculations

were conducted, large confidence intervals indicate that the results may be imprecise due to wide variability within outcomes (Moore et al., 2011). Furthermore, the threshold of $d > 0.25$ for clinical relevance regardless of level of significance may also have resulted in a Type I error. Nevertheless, the study's strong feasibility and initial results regarding improvements in observed and self-reported positive parenting behaviour provide a useful platform for further research on the effectiveness of the intervention.

Paper #3: Process evaluation of a parenting program for low-income families in South Africa.

The third paper of this thesis was a mixed-methods process evaluation conducted alongside the pilot RCT. This study integrated quantitative and qualitative data to examine the feasibility of the Sinovuyo programme when delivered by community facilitators to highly vulnerable, low-income families. Programme feasibility was assessed according to three theoretical domains: acceptability, implementation, and participation. Quantitative data included participant attendance registers and facilitator self-report fidelity checklists, as well as parent-reports of programme satisfaction and engagement in home practice activities. Qualitative data included post-programme focus groups with the community facilitators ($n = 8$) and individual interviews with randomly selected parents ($n = 15$). We also analysed transcripts from parent and facilitator feedback during parent-groups and supervision sessions to further examine issues of feasibility.

Overall, quantitative results indicate a high degree of programme feasibility. Rates of enrolment, attendance, completion, and engagement were comparable to other studies on parenting programmes in HICs (Axford et al., 2012). Self-report checklists

also indicated that that community facilitators were able to deliver almost all of the manualised activities. Finally, satisfaction surveys indicated strong acceptability of the programme's structure, content, and delivery, as well as its ability to meet participants' goals and expectations.

Thematic analyses of qualitative data provided further understanding of quantitative findings (Palinkas, Horwitz, Chamberlain, Hurlburt, & Landsverk, 2011). Community-based group leaders demonstrated an overall competency in the programme's facilitation method, which included using a collaborative approach to engage parents in social learning techniques. Parents also reported a high level of receptivity and engagement in many of the approaches that strengthened existing parenting practices. These included spending special time with children, using praise and rewards to encourage positive behaviour, giving positive and clear instructions, and practising stress reduction activities. At the same time, results suggest potential dissonance between some of the evidence-based approaches developed in HICs and the local cultural context in South Africa. In particular, findings indicated initial resistance amongst parents and facilitators to more complex parenting strategies, such as nonviolent discipline techniques. Nevertheless, respondents said that the programmatic scaffolding of facilitation and participation as well as the cultural framing of content helped to overcome initial contextual and cultural barriers.

Delivering programmes to vulnerable families in low-resource contexts

Findings demonstrate the importance of supporting participation and engagement in group-based parenting programmes delivered to low-income families in LMICs. Previous research has linked low attendance and poor quality of participation to reduced intervention effectiveness in parenting programmes (Nix et al., 2009). Potential

barriers to participation include poverty, unemployment, social isolation, lack of community buy-in, and poor parental mental health (Heinrichs et al., 2005). In addition, structural factors such as programme length, accessibility, and appropriateness of materials can reduce engagement.

Study participants responded positively to various strategies that have previously been shown to be effective in overcoming these barriers. These included: (a) securing community buy-in through partnerships with local organisations (Mosavel, Simon, van Stade, & Buchbinder, 2005); (b) conducting pre-programme home visits to address parents' concerns regarding programme expectations (Ingoldsby, 2010); (c) emphasising child behaviour management as a primary programme goal for parents (Baker et al., 2011); (d) creating social networks between participants to maintain participation in latter stages of programme delivery (Eisner & Meidert, 2011); (e) create a collaborative and nurturing group environment by accepting and praising parents (Levac, McCay, Merka, & Reddon-D'Arcy, 2008); (f) allowing for flexible delivery to groups or individually at home to sustain the involvement of parents who missed sessions due to illness or time constraints (Koerting et al., 2013); (g) using text messages to remind parents to engage in home practice activities and attend group sessions (Murray et al., 2015); and (h) providing transportation, childcare, and food to overcome structural barriers to participation (Axford et al., 2012).

Results also suggest the utility of engaging community workers in the delivery of parenting programmes in low-resource contexts. Due to limited human and financial resources, programmes delivered in LMICs must often depend on paraprofessionals for service delivery (Lewin et al., 2010). However, the reliance on personnel who lack clinical expertise and knowledge may negatively affect implementation fidelity and

quality of delivery, especially when programmes require a high level of facilitation skills (Shapiro, Prinz, & Sanders, 2012). Qualitative data from this study suggests that the community facilitators experienced initial low self-efficacy in facilitating complex parenting skills. The low self-efficacy regarding nonviolent discipline strategies was perceived to be associated with reduced quality of delivery and participant engagement. On the other hand, as facilitators' confidence with programme content increased, they perceived an improvement in their facilitation skills, which also corresponded to parents' increased receptivity to parenting skills. Importantly, experiential training and ongoing supervision was identified as an essential mechanism for improving delivery. In particular, respondents highlighted the importance of modelling core delivery principles and skills by programme supervisors in order to strengthen competency. This is consistent with existing research on the role of training, ongoing supervision, and organisational support to maintain treatment fidelity and the quality of delivery (Sethi et al., 2014; Webster-Stratton, 2004) .

Finally, the qualitative results support the utility of integrating evidence-based approaches within a local cultural context in order to increase the likelihood of programme acceptability (Lau, 2006). Participants strongly identified with the cultural metaphors, idioms, and forms of expression created during the development phase of this thesis. These elements were used to communicate core programme principles and parenting skills while emphasising cultural values of kinship, collectivism, and respect (Sulamoyo, 2010). For instance, the Rondavel of Support model was perceived as an effective means of providing a culturally sensitive framework for the programme that resonated with isiXhosa-speaking families. Likewise, respondents reported that the illustrated stories depicting typical low-income South African families were helpful in

modelling parenting skills and engaging participants in collaborative problem-solving. While additional empirical research is necessary to determine whether or not these cultural components are essential to programme feasibility, these findings support the importance of conducting rigorous cultural adaptation studies prior to programme implementation (Barrera et al., 2013).

Relationship between outcome and process evaluation

This study illustrates the strengths of embedding qualitative research methods within RCTs of complex interventions (Lewin, Glenton, & Oxman, 2009). Findings provide further insight regarding the mixed results from the outcome evaluation. The qualitative results suggest strong fidelity and engagement with the positive parenting components of the programme. This coincides with findings from the pilot RCT indicating improvements in the frequency of positive parenting behaviour in comparison to controls. On the other hand, participants reported resistance towards nonviolent discipline strategies introduced in the latter stages of the programme. It is important to note that the group leaders also struggled to facilitate this content competently due to low self-efficacy and inexperience. As a result, the transfer of knowledge and skills from the facilitators to the parents suffered at precisely the point where the resistance to programme content was greatest. This may explain why the outcome evaluation did not detect any improvements in limit-setting behaviour. It also supports our post-hoc hypothesis that children may have perceived changes in their parents' behaviour as permissive due to reductions in harsh parenting in the absence of consistently applied alternative discipline practices. This may have contributed to the negative intervention effects regarding observed child behaviour.

Is the programme feasible at scale?

Although findings suggest that the Sinovuyo programme is feasible when delivered to an underserved population in South Africa, the potential to implement the programme at scale in LMICs may be limited. The strategies implemented to secure strong participation resulted in a cost of delivery of approximately £150 per family. This may be perceived as too expensive for policymakers in low-resource contexts where the primary policy agenda is focused on maximising programme reach to a large vulnerable population (Eaton et al., 2011). The extensive training and supervision necessary to sustain implementation fidelity and quality of delivery may further constrain the programme's scalability. At the same time, reducing the amount of training and supervision may negatively affect intervention feasibility and effectiveness. Furthermore, programmes that rely on underpaid staff may experience high rates of turnover, further compromising the sustainability of implementation (Elliott & Mihalic, 2004; Kelly et al., 2000). At the end of the pilot RCT, 25% of the community facilitators (2 out of 8) found more stable and higher paid employment elsewhere, constituting a significant loss of trained personnel. Programme implementation also required considerable logistical support from the implementing partner in order to coordinate activities on multiple levels. As a result, it may not be possible to replicate results at scale if the programme is implemented by a less committed, less organised, and less accountable organisation (Bradach, 2003).

Limitations

This study had a number of limitations in addition to the ones outlined above and in the three papers. Overall, the study was limited in its capacity to test only one strategy in building the evidence of effectiveness of parenting programmes in reducing the risk of child maltreatment in LMICs. One might argue that it would have been more efficacious to transfer an existing intervention with previously demonstrated evidence in reducing harsh parenting. Programmes such as PMTO, Triple P, PCIT, and the Incredible Years have been shown to be transferrable to other contexts and effective across diverse population groups (Forgatch et al., 2013; Gardner et al., 2015; Matos et al., 2009; Turner & Sanders, 2006; Webster-Stratton & Herman, 2010). One might have tested one of these programmes in its original format as illustrated in the Panama Study (Mejia, Calam, et al., 2015), or followed an in-depth participatory adaptation process as illustrated in the adaptation of PMTO adaptation for Latinos in the United States (Parra Cardona et al., 2012). However, our ability to transfer an existing parenting intervention was limited by high licensing fees and unwillingness of developers to allow extensive adaptation of their original programmes without their close involvement (Mikton, 2012).

On the other hand, one might question why the study did not evaluate an existing locally developed parenting programme that, while lacking evidence of effectiveness, had already demonstrated feasibility in a South African context. A recent review identified 21 parenting programmes that were being implemented in South Africa at the time of this study's inception (Wessels, 2012). Instead of importing evidence-based approaches derived from Western populations, it may have been more expedient to test one of these existing programmes. However, the same review found

that none of the local programmes were developed using evidence-based theoretical frameworks or approaches associated with programme effectiveness.

By striking a balance between our knowledge of effectiveness and the local contextual realities facing parents and service providers in South Africa, we chose a compromise between existing evidence-based interventions and locally developed programmes. Nevertheless, there remains insufficient research on whether this was the most effective and efficient approach. It is also possible that all three approaches might be equally efficacious or that each approach's respective utility may vary depending on context. Further research on cultural adaptation and intervention development in LMICs might benefit from comparing these alternative strategies in multi-arm trials, factorial design studies, or meta-analyses to further understand their benefits and drawbacks from a practical and methodological perspective.³⁴

The following sections examine additional methodological limitations of this study that require further discussion regarding its internal and external validity.

Limitations regarding internal validity: Assessment tools

The internal validity of this study was limited in regards to the sensitivity and accuracy of self-report and observational measurements. There are methodological and practical challenges to obtaining reliable and consistent measurements of harsh and abusive parenting (Barlow et al., 2006). While official child protection cases are often the most verifiable means of assessing child maltreatment, the monitoring and reporting system in South Africa is underdeveloped and unreliable, making data collection from

³⁴ At the present moment, there may not be sufficient studies of parenting programmes in LMICs to warrant meta-analyses of approaches. However, as more studies are conducted, this would be a valuable contribution to our knowledge regarding cultural adaptation and intervention development for underserved populations.

this source problematic (Makoe, 2009). Furthermore, child abuse is often underreported in self-report assessment or undetected in observational assessments for reasons of social desirability (Bennett et al., 2006). As a result, parents in both groups may have underreported their engagement in violent physical discipline.

In addition, since few of the self-report outcome measurements were validated in South Africa for isiXhosa-speaking population groups, it is possible that they lacked sufficient cross-cultural validity or sensitivity to change (Hui & Harry, 1985). Self-report questionnaires are developed with specific structure, wording, and response options that contribute to their individual construct validity (Fok & Henry, 2015). These can be interpreted differently across populations, thus reducing their accuracy in assessing outcomes. Given that parenting behaviour styles vary across cultures, assessment tools developed for families in HICs, such as the Parenting of Young Children Scale, may function differently in sub-Saharan African families that place high importance on respect and obedience (Evans, Matola, & Nyeko, 2008). Although we were able to report on the internal consistency of measures, this is generally considered a poor prediction of validity since Cronbach's alpha only assesses reliability at a single point in time. However, the availability of alternative scales with strong psychometric properties is extremely limited in LMICs. Thus, additional research is necessary to increase the cultural validity of existing measurements as well as to develop new assessment tools specifically for South African families.

The validity of observational assessments also requires consideration. Although analyses indicated acceptable levels of inter-rater reliability of the Sinovuyo Observational Coding Scale, it is potential that the coding system failed to accurately capture parent-child interaction and child behaviour. While observational assessments

occurred in the natural home environment, the controlled experimental procedures (i.e., playing, tidying, and eating a snack) may have failed to truthfully capture the quality of parent-child relationships (Aspland & Gardner, 2003). Moreover, post-hoc analyses found few significant correlations between observational and self-report measures at baseline (see Table 11, Appendix J, Page 456). This suggests that the observational coding system may be measuring entirely different constructs of behaviour than the self-report assessments. As mentioned above, the code for observed child positive behaviour on the SOCS included the frequency of compliance with instructions from parents. This may have been a result of coercive discipline since corporal punishment has been shown to increase immediate child compliance (Gershoff, 2002). In addition, the high frequencies of child compliance may have been due to high numbers of instructions given by parents – a key behaviour that the Sinovuyo programme attempted to reduce. It is possible that parents in the intervention group were giving fewer instructions, which provided fewer opportunities for children to comply. This may have explained why the coding system captured less frequent positive child behaviour scores in the intervention group in comparison to controls. Although it is not feasible to recode the observational videos from the pilot RCT, these issues have been taken into consideration during the current trial of the Sinovuyo programme in Cape Town ($N = 296$ families).

There are few alternatives to using observational assessments and parent-report questionnaires with this population and age group, and each method has its own limitations. For instance, assessments using teacher-report only capture children's behaviour in a specific context outside the home and are thus unable to measure parent behaviour. Although 88% of the children were enrolled in school, data collection of

from teachers was not logistically feasible given the variability of crèches and schools that the children attended in the community. Another alternative would have been to use a Parent Daily Report, which compiles daily or weekly parent assessments (Locke & Prinz, 2002; Patterson et al., 1982). Although this tool may obtain a more consistent and stable measurement of child behaviour and parenting, it is equally susceptible to reporting biases. In addition, child-report data may have been a more reliable source of information that could have been cross-analysed with parent-report and observational assessments (Lachman et al., 2014; Meinck et al., 2016). However, we determined that it would have been unfeasible and potentially unethical to conduct child-report assessments on harsh parenting with the younger children involved in this study (i.e., three to eight years of age) (Alderson & Morrow, 2004).

Limitations regarding internal validity: Analyses

The study's ability to accurately detect intervention effects was also limited due to its small sample size (Lancaster et al., 2004). High variance due to sample heterogeneity within groups often occurs in studies with small samples. This makes it difficult to specifically detect intervention effects (i.e., variance due to allocation) amidst other sources of variance (Hopkin et al., 2015). Although the inclusion of additional independent variables would have controlled for potential variances, this approach would have further reduced the study's power. Another strategy to reduce sample heterogeneity would have been to use a within-group design such as a crossover study. However, it was important to maintain a between-group design in order to determine the evaluation feasibility of conducting an RCT in a low-resource setting. As a result, this study used a third strategy by including baseline scores for outcome variables and parent group membership as predictive covariates in the ANCOVA

analyses (Hopkin et al., 2015). The inclusion of explanatory covariates may actually reduce noise and increase statistical power – especially if these covariates are highly correlated to the dependent variable but not to the independent variable (i.e., allocation status) (Safarkhani & Moerbeek, 2013).

The internal validity of the study was also limited by its partially nested design in which parents in the intervention arm were placed into parenting groups while those in the wait-list control arm were treated as individuals. When evaluating individually randomised group-based treatments, it is important to take in account potential within-group effects as a result of clustering (Pals et al., 2008). This is particularly relevant in interventions that use collective problem-solving strategies and rely on skilled facilitators to deliver content. Since different facilitators delivered the Sinovuyo programme to different groups of parents, it is possible that some parents received a higher quality of facilitation than others. Relationships between group members may have also contributed to potential within-group effects. As a result, intra-cluster correlations within groups may have increased the variance between groups resulting in potential Type I errors (Lee & Thompson, 2005).

In this study, multivariate mixed-effects models with random effects were used to account for the partially nested study design. This is considered a robust analytic approach to evaluating group-based interventions when the control arm participants are not in groups (Bauer et al., 2008). However, these results must be treated with caution since it is impossible to disentangle treatment effects from within-group effects. Intervention effects might have been due to the clustering of participants instead of the actual content of the Sinovuyo programme. Nevertheless, while the internal validity of the study may have been compromised, this design may have increased the external

validity of the study. Targeted parenting interventions such as the Sinovuyo programme are typically delivered to vulnerable parents recruited from the wider community and screened for potential risks of maltreatment. Thus, a comparison between groups of parents in the intervention arm with ungrouped parents in the control arm is the most realistic design in this context. On the other hand, if the programme were delivered to already existing groups of parents, a cluster RCT design would have been more appropriate (see Appendix J. for a more detailed discussion on possible statistical models that can be used to account for a partially-nested study design).

Limitations regarding external validity

Findings from this thesis are also limited in terms of external validity (Flay et al., 2005). Small sample sized studies that adapt or develop an intervention for a specific cultural group or context are particularly limited in this regard (Etz & Arroyo, 2015). This study's community-based approach to developing a parenting programme for low-income, urban isiXhosa-speaking families living in Cape Town may limit its generalizability to other contexts in South Africa and in other LMICs. For instance, the programme's integration of culturally specific isiXhosa metaphors may not resonate with other populations. Likewise, the group-based delivery method may not be relevant in communities where services are primarily provided via home visits (Kidman, Nice, Taylor, & Thurman, 2014). Furthermore, providing supervision to parent group facilitators, sending text message reminders, and reimbursing participants for transportation costs may not be feasible in rural contexts where resources are more scarce.

As has been mentioned in the three papers, findings may also not be applicable to male caregivers and employed parents due to the almost exclusive recruitment of

unemployed women. A number of factors may have contributed to this gender bias and unintended exclusion of employed caregivers. First, 100% of the referrals from our community partner were unemployed women. Second, the research project only hired female research assistants who conducted recruitment during working hours. Third, inclusion criteria required caregivers to live in the same household as their children for at least four nights per week and be available for weekday sessions. This may have excluded those with employment commitments during the week and men who were involved in their children's upbringing but lived in separate households (Bray & Brandt, 2007). Fourth, although the Sinovuyo programme incorporates examples of both male and female caregivers in its illustrations, caregiving is still considered part of a woman's domain in traditional South African culture (Panter-Brick et al., 2014).

The unintentional exclusion of male caregivers and working families in the pilot study is unfortunate since respondents during the formative evaluation phase highlighted the potential benefits of including both population groups in parenting programmes. A more concerted and directed recruitment strategy using male researchers and facilitators may have increased the participation of men. Furthermore, it may be necessary to adapt existing or develop new programme components to be more centred around roles and responsibilities of fatherhood as well as deliver the programme exclusively to men (Panter-Brick et al., 2014). Finally, more flexible delivery mechanisms that allow the programme to be implemented at workplaces and on weekends may increase accessibility for employed parents.

The study's recruitment of participants who were already enrolled in a local family support programme may also limit its external validity. On the one hand, this may explain why the pilot evaluation showed improvements in both allocation groups

on a number of outcomes. It is possible that the Sinovuyo intervention may have a greater effect when compared with families who are not receiving any social services. On the other hand, the collaboration with a local partner may have positively influenced programme participation and engagement. Strong organisational engagement may be an essential component of achieving programme feasibility (Mosavel et al., 2005). It is possible that the programme may be less feasible when delivered without this active support and engagement from local stakeholders.

Finally, while findings from the pilot RCT indicated a high feasibility of conducting an RCT in Cape Town, other communities may resist certain evaluation procedures. Some communities may reject randomisation of participants into a control group due to a desire for all members of the community to receive the same benefits (Etz & Arroyo, 2015). Randomisation on an individual level may also be challenging in certain contexts such as rural communities where contamination between allocation groups is a threat to internal validity (Isaakidis & Ioannidis, 2003). It may be more applicable to randomised participants at a village or municipal ward level in cluster RCTs (Puffer, Torgerson, & Watson, 2005). However, this may raise additional ethical and financial considerations regarding obtaining consent from multiple stakeholders, more complex logistical management of study procedures, and much larger sample sizes (Osrin et al., 2009).

Considering internal and external validity

One of this study's major strengths was its consideration of both internal and external validity during the early stages of intervention development and evaluation (Oakley et al., 2006). Although the evaluation was implemented with a tightly controlled and rigorous research design, the study was implemented in a real-world

setting using community-based facilitators and low-cost materials. Participants also represented a highly vulnerable population affected by HIV/AIDS, poverty, and intimate partner violence – all risk factors for child maltreatment throughout Africa (Meinck et al., 2014). Moreover, its mixed methods approach allowed for the evaluation of intervention outcomes and implementation processes. As a result, despite the limitations discussed above, many of the findings may be applicable to similar contexts in South Africa and other LMICs.

This raises important theoretical questions regarding distinctions between efficacy and effectiveness studies. Many behavioural interventions that are successful in efficacy studies fail in real-world settings (Glasgow, Lichtenstein, & Marcus, 2003). Concerned with the internal validity of findings, efficacy trials focus on determining the causal relationship between treatment group and outcomes under ideal circumstances (Fraser et al., 2009). Study populations are normally highly selective and homogenous, with rigorous inclusion and exclusion criteria (Flay et al., 2005). Efficacy studies also often involve programme developers in the practical aspects of implementation and evaluation, which includes close monitoring of the training and supervision of programme facilitators (Glasgow et al., 2003). Effectiveness studies are more concerned with the external validity of a study by measuring the practical importance of outcome effects, and whether an intervention may be suitable for a wider population (Fraser et al., 2009). Effectiveness studies often include both outcome and process evaluations. While continuing to examine outcome effects, they also focus on implementation processes, intervention acceptability, adherence to treatment, and cost-effectiveness (Bellg et al., 2004).

Future research on interventions in LMICs may require a shift in the way the field distinguishes between efficacy and effectiveness studies (Sussman, Valente, Rohrbach, Skara, & Pentz, 2006). Emphasising a study's internal validity at the expense of external validity might result in interventions that have no practical relevance beyond the initial RCT. In low resource settings such as LMICs, tightly controlled studies implemented under ideal conditions with a selective sample may be unrealistic, especially if the programme is eventually implemented with minimal institutional support. At the same time, the rigorous approach of efficacy studies is necessary to establish causality by controlling for confounding factors and limiting potential bias. For this reason, issues related to both internal and external validity should be considered from the beginning of the development and piloting process, and incorporated throughout efficacy and effectiveness trials (Glasgow et al., 2003). Moreover, intended service providers and beneficiaries, as well as policy-makers and funders responsible for dissemination, should be actively involved at all stages to facilitate acceptability, scalability, and sustainability (Jones & Wells, 2007).

Recommendations for further intervention development of the Sinovuyo programme

Additional intervention development of the Sinovuyo programme is recommended prior to subsequent testing. It may be necessary to strengthen the delivery of nonviolent discipline strategies that challenge social norms regarding parenting in South Africa. Although results suggest that the group leaders gradually improved their competency in facilitating content on nonviolent discipline, inexperienced facilitators may require additional training and support when initially implementing this aspect of the programme (Sethi et al., 2014). Additional sessions

may be also necessary to allow parents sufficient time to adopt these techniques into their daily parenting practices. An adaptation study of the Incredible Years Teacher Training Programme in Jamaica found that teachers required four additional sessions due to their lack of familiarity with core concepts and delivery methods (Baker-Henningham et al., 2012). Parents who express resistance to acquiring new skills may also benefit from additional coaching and support from facilitators. This may include practising these skills at home with their children in the presence of a facilitator. Finally, more in-depth adaptation may be necessary to find culturally sensitive approaches to facilitating nonviolent discipline. While the collaborative approach to problem-solving was perceived as acceptable to parents and service providers, it is possible that more traditional didactic methods of facilitation, or a combination of didactic and collaborative approaches, would be more effective with this population group (Cooper et al., 2014; Eyberg & Matarazzo, 1980).

As a result of these findings, the following adaptations were implemented before initiating a larger RCT in April 2014. First, content on nonviolent discipline was expanded in order to allow parents more time to integrate the associated skills in their child behaviour management approaches. Second, additional illustrated stories and exercises were included in the adapted version of the programme to strengthen skills acquisition around descriptive commenting, emotional labelling, and time-out practices. Third, due to perceived shortcomings in quality of delivery, facilitators received additional training to strengthen their competencies in delivering the nonviolent discipline components of the programme. Fourth, the programme was restructured so that sessions could be delivered on weekends for employed parents. Finally, programme

handouts were combined into a formal parent handbook in order to strengthen engagement and maintenance of skills.³⁵

In addition to these changes, further development of the intervention delivery components may be necessary to increase the programme's scalability and reach. Reducing the number of group sessions and eliminating the provision of transportation, childcare, and food would significantly lower the per-person cost of the programme. Likewise, simplifying the method of delivery may lessen the need for extensive training and supervision of personnel. However, without empirical data on the active programme ingredients, it is difficult to determine which components are necessary to maintain programme feasibility and effectiveness (Collins et al., 2005). Thus, more research is necessary to determine which are the effective components before instituting major structural changes to the intervention.

Implications for policy and practice

Despite the important benefits of conducting rigorous research on the effectiveness of interventions to improve child wellbeing, a large gap remains between science and practice in LMICs (Collins et al., 2011). This is particularly true with regard to the limited research on parenting programmes in LMICs (Knerr et al., 2013; Mejia et al., 2012). As mentioned above, the quality of research on parenting programmes currently being implemented is also severely limited in South Africa (Wessels, 2012). Very few programmes have been evaluated using rigorous research methods that control for potential confounding factors and reduce the possibility of bias.

³⁵ We were unable to implement one key recommendation for further intervention development: increasing the number of male caregiver participants. It was determined that the programme would require substantial revision to be specifically applicable to male-only groups. Furthermore, due to financial constraints, it was not feasible to train additional male facilitators or recruiters.

This is particularly concerning given the South African government's current policy agenda advocating for increased spending on family-based early intervention programmes to support child wellbeing (Department of Social Development, 2012). In a country where financial and human resources are scarce, it is imperative that these resources are allocated to programmes that have demonstrated both effectiveness and feasibility for target populations. Otherwise, limited resources may be spent on programmes that do not achieve desired outcomes because they fail to effectively target appropriate behavioural change mechanisms or cannot be implemented as designed (Durlak & DuPre, 2008; Michie, 2008).

Results from this thesis suggest a number of policy recommendations. First, given the large inequalities between the high proportion of child mental health problems and scarcity of evidence-based research in LMICs, it is of fundamental importance that policymakers and large funding bodies continue to support rigorous outcome evaluations that build evidence of effectiveness (Collins et al., 2011). This is particularly important with regard to interventions developed to prevent child maltreatment and improve child wellbeing – an area in which many programmes are currently being funded and implemented without high standards of evidence (Mikton & Butchart, 2009; Wessels et al., 2013). While previous studies have demonstrated the feasibility of RCTs of parenting programmes for families with infants (Cooper et al., 2009; Cooper et al., 2014; Vally et al., 2014), this is the first study in South Africa to use rigorous methods to evaluate a parenting programme for older children aged three to eight years. As a result, this study contributes to existing evidence that it is feasible to conduct a rigorous evaluation of a family-based intervention in South Africa and other LMICs.

Second, it is important that policymakers and funders provide sufficient institutional support to sustain the ongoing implementation of parenting programmes (Forgatch & DeGarmo, 2011). The Sinovuyo programme required considerable institutional involvement from the implementing partner in order to achieve high fidelity and participation. This included a highly organised project management team that coordinated the training and supervision of facilitators, the delivery of content via group sessions and home consultations, the provision of transportation and food for participants, the monitoring of programme participation and fidelity, and the establishment of a technically sophisticated text message reminder system. While this approach may have been feasible in a small pilot study, the eventual dissemination of Sinovuyo programme may require the development of a simpler delivery mechanism that can be integrated within ongoing social services. The ongoing training and supervision of programme facilitators is particularly important as the current capacity of the Sinovuyo programme is limited to six facilitators and one programme trainer in South Africa. As a result, the establishment of a training institute may be necessary to recruit, train, and supervise facilitators as well as monitor implementation and dissemination once intervention effectiveness is achieved.

Finally, parenting programmes developed for families in LMICs need to account for the complex family systems in which children are raised (Engle, Menon, Garrett, & Slack, 1997). Other family-based programmes might benefit from including multiple caregivers in programme activities. Although the individual RCT design did not allow for this, these programmes might be more effective if delivered on a neighbourhood level in order to strengthen social support mechanisms while increasing consistency of care. Interlinked delivery systems may also be necessary to support children who

experience high mobility between multiple households as well as geographical locations (Bray et al., 2010; Young & Ansell, 2003). Finally, it is important to recognise that many families consist of multiple children from across the developmental age spectrum. While specifically devised for parents with children aged three to eight years, the Sinovuyo programme may also have positive (or negative) impacts on older or younger children outside this age range – an area that requires additional testing. Alternatively, other interventions may be required to address specific needs of parents with infants and toddlers as well as those with adolescents (Ward et al., 2014). For instance, research on parenting programmes delivered to parents with infants and toddlers in South Africa has demonstrated positive results in decreasing intrusive parenting and improving child cognitive development (Cooper et al., 2009; Vally et al., 2014).

Recommendations for future research

The findings of this study lead to a number of recommendations for additional research. First, comparative studies examining different adaptation and development approaches would further advance our understanding of the transferability of evidence-based interventions and approaches across contexts. This could include meta-analyses or multi-arm trials that compare locally developed programmes, imported evidence-based programmes, and interventions that integrate local contextual factors with evidence-based approaches. In addition to examining their effectiveness on reducing the risk of child maltreatment and improving child wellbeing, these studies should ideally include comparative analyses of process evaluation outcomes. Future research is also necessary to ascertain the extent of modification necessary in order to achieve a balance between fidelity and adaptation. The field requires additional criteria for determining

whether adaptation is necessary, how much should be changed, and what constitutes a reasonable cost of investment in the adaptation process.

Second, additional research is necessary to establish more reliable measurements of child maltreatment and harsh parenting. These measurements should be optimised in order to reduce respondent biases and increase sensitivity to change. Potential approaches could integrate audio technology in self-report assessments in order to increase disclosure of abuse (Davies, 2005; Phillips, Gomez, Boily, & Garnett, 2010). Utilising developmentally appropriate indicators for young children may also increase the reliability of child maltreatment assessments (Ben-Arieh, 2005; Connolly, 2005). Furthermore, more innovative and sensitive observational assessments are necessary to accurately capture the quality of parent-child interaction. Although coder impression scales may be susceptible to biases and make it more difficult to achieve inter-rater reliability, they could provide a more nuanced assessment of relationships between parents and children (Dishion, Hogansen, Winter, & Jabson, 2004). Controlled observational experiments that record timed responses of specific parent-child interactions may also provide data that is less vulnerable to assessors' interpretations regarding the definitions of specific behaviours (e.g., timing the delay of child compliance after an instruction has been given, or measuring the amount of time a parent is able to engage in child-led play) (Leijten et al., 2015; Roskam, Brassart, Loop, Mouton, & Schelstraete, 2015).

Third, future empirical research involving larger sample sizes would provide more robust data regarding the Sinovuyo programme's effectiveness. An RCT of the programme with a similar population group is currently underway in Cape Town that includes a non-waitlist control group ($N = 296$ participants). This longitudinal design

will allow for the examination of behaviour change and intervention effects over multiple assessment periods. The increased sample size will also provide sufficient power for mediation, moderation, and subgroup analyses (Kraemer, Wilson, Fairburn, & Agras, 2002; Wang & Ware, 2011). In addition, future research is recommended to examine the Sinovuyo programme's transferability to other contexts both within South Africa as well as to other LMICs. As mentioned above, these studies should include both outcome and process evaluations in order to understand the complexities of transferring interventions across contexts (Moore et al., 2014).

Fourth, qualitative research is necessary to further understand how parents engage in specific skills delivered in parenting programmes. If conducted alongside empirical studies that quantitatively analyse mediation models, these studies could further contribute to our knowledge regarding theory of change mechanisms (Holtrop et al., 2014). It would be particularly relevant to investigate how programme content and delivery facilitates or reduces the engagement of parents in nonviolent discipline strategies, especially in contexts where corporal punishment is considered normative. In addition to in-depth individual interviews, potential methods could also include ethnographic research such as participant observation in individual homes or a specific community in order to track how parenting practices change over time (Palinkas, 2014).

Fifth, future research may also benefit from examining the intervention's impact on other child outcomes related to early childhood development (Mikton et al., 2014). This may include outcomes such as nutrition, health, cognitive stimulation, and education (Lannen & Ziswiler, 2014). Future studies could also investigate outcomes linked to resilience and child wellbeing, including coping skills, effective communication, and problem solving (Barry, 2009).

Sixth, additional research on the economic impact of the Sinovuyo programme would provide important insight regarding its scalability in low-resource settings. These studies would be extremely useful for policy makers and implementing organisations in South Africa and other LMICs. Potential methods to economically evaluate the programme may include cost-benefit analyses (i.e., evaluating the cost of implementing Sinovuyo against its long-term benefits and savings), cost-minimisation analyses (i.e., comparing Sinovuyo to other interventions), cost-utility analysis (i.e., Sinovuyo's impact on the quality of adjusted life-years), and cost-effectiveness studies (i.e., cost per unit reduction in harsh parenting or increased positive parenting) (Charles, Bywater, & Edwards, 2011). While cost-effectiveness studies would provide important information on the cost per unit to reduce harsh parenting (Edwards et al., 2013), cost-benefit analyses would increase our knowledge of the potential long-term savings of implementing a parenting programme during early childhood (Miller, 2015). For instance, a cost-effectiveness study on the Incredible Years programme in North Wales showed that the intervention cost ratio was £79 per point reduction on the intensity subscale of the Eyberg Child Behaviour Inventory (Edwards, C  illeachair, Bywater, Hughes, & Hutchings, 2007). Another study on the Incredible Years in Ireland demonstrated a EUR87 per point reduction of child behaviour problems (O'Neill, McGilloway, Donnelly, Bywater, & Kelly, 2013). This study also conducted a cost-benefit analysis estimating an expected once-off cost savings of participating in the programme of EUR6,250 occurring at 30 years of age. Moreover, reductions in services were sustained at 1-year follow-up with a 40% reduction in cost of service use in the intervention group (McGilloway et al., 2014). Finally, a cost-benefit modelling study in the United Kingdom found that implementing a parenting programme for a five-year

old with child conduct problems would save approximately £16,435 per family while only costing between £952 and £2,079 (Bonin, Stevens, Beecham, Byford, & Parsonage, 2011).

Seventh, additional research is necessary to further understand the relationship between implementation and effectiveness (Durlak & DuPre, 2008). With a larger sample size, we would be able to examine potential facilitators and barriers of programme enrolment and engagement (Dumas et al., 2007). This would provide useful information regarding population groups who might be at greater risk of programme dropout. Likewise, research on associations between programme participation and outcome effects would help identify whether a specific number of sessions is required to achieve positive results (Nix et al., 2009). Future research that includes observation assessments of programme implementation may also provide a more objective assessment of programme fidelity and quality of delivery (Eames et al., 2008). Given the emphasis of the Sinovuyo programme on the ability of facilitators to engage participants in collective problem-solving, these assessments would help us understand how quality of delivery relates to programme effectiveness (Eames et al., 2010; Eames et al., 2009).

Lastly, factorial research designs may increase our understanding of the active components necessary to optimise parenting programmes based on effectiveness, cost-efficiency, and scalability (Collins et al., 2014). Factorial experiments have numerous advantages over traditional RCTs. Factorial experiments allow for the testing of multiple components at the same time. They also enable researchers to examine interactions between discrete intervention components. For instance, it is possible that the active mechanism necessary for effective parenting programmes relies on an

interaction between increasing child-led play while decreasing negative instruction giving. In addition, factorial experiments require fewer participants than traditional RCTs. For example, testing the additive and interaction effects of five components in a traditional RCT would require 960 families in comparison to the 320 families required for a factorial experiment (Dziak, Nahum-Shani, & Collins, 2012). Finally, since including multiple conditions does not increase the cost of a factorial experiment, these experiments generally require less money to implement than individual RCTs. As a result, more components and combination of components can be tested without extra costs (Collins, Dziak, & Li, 2009).

Factorial research designs would also allow for the examination of specific programme components as well as implementation factors such as programme delivery and structure. For example, such studies could provide insight into which theory-based component (social learning vs. attachment theory, or a combination of the two) is the most effective approach for parenting interventions (Bandura, 1977; Bowlby, 1974). Likewise, factorial research may contribute to our understanding of which programme delivery components (e.g., length, format, or delivery point) are most effective and should therefore be included in parenting interventions. Furthermore, combining factorial experiments with economic evaluation studies would allow for the assessment of the cost-effectiveness and cost-benefit of specific components, thus permitting greater tailoring of interventions for specific contexts.

Conclusion and next steps

This thesis is the first study to rigorously develop and evaluate a parenting programme to reduce the risk of child maltreatment in low-income families with children aged three to eight years in South Africa. It demonstrates the practical utility of

systematically implementing the first two stages in the MRC framework for developing and evaluating complex interventions in a low-resource setting. Initial results indicating improvements in positive parenting suggest the potential effectiveness of the programme in reducing the risk of child maltreatment. Nevertheless, it is important to recognise that the process intervention development and evaluation is ongoing and iterative. This doctoral candidate is committed to conducting further research on parenting programmes and other child and family interventions to reduce violence against children in LMICs. The candidate is involved as a co-investigator in the current larger RCT of the Sinovuyo programme. Results from the post-test data of this study will be available in August 2016 with one-year follow-up data collection currently under way. The candidate is also a co-principal investigator of a study focused on adapting, implementing, and evaluating the Sinovuyo programme for families with children aged two to six years in the Philippines. This study will build on the learning experiences of the current thesis while continuing to examine issues of transferability of programmes across contexts. It will also establish a training centre in the Philippines in order to provide a foundation for countrywide dissemination embedded within a national conditional cash transfer system. This upcoming study thus aims to develop a sustainable model for transferring, testing, and disseminating parenting programmes in the Philippines that can be applied in other LMICs in the region. The candidate is also involved in a pump-priming study to develop an innovative and interdisciplinary programme of research on the optimisation of parenting interventions in LMICs. This project will examine the feasibility of conducting a large-scale factorial experimental trial of the Sinovuyo programme in South Africa. It will also begin testing the effectiveness and scalability of essential parenting programme components based on

content, delivery, and cost. Finally, these research projects are linked to a larger research initiative led by the World Health Organization and UNICEF called Parenting for Lifelong Health (PLH).³⁶ This initiative is focused on the development and testing of a suite of affordable and effective parenting programmes to prevent violence against children in LMICs. As a Steering Committee member of PLH, the candidate will be collaborating with international research partners while working towards securing funding for a five-to-ten-year programme of study on the dissemination of evidence-based parenting programmes throughout the Global South.

In conclusion, it is hoped that this thesis will contribute to the wider scientific community regarding the development, evaluation, and dissemination of evidence-based interventions to reduce violence against children in LMICs. It is this D.Phil. candidate's sincere wish that the results of this thesis will help increase our capacity to deliver programmes that are culturally relevant and based on strong evidence of effectiveness in order to provide parents with the knowledge and skills to raise their children in nonviolent and supportive ways. By improving parent-child relationships, young children growing up in adverse living conditions may develop the necessary resources to overcome significant barriers to optimal development and wellbeing. These positive relationships may reciprocally offer a source of nourishment and emotional wellbeing to parents who are at the forefront of providing care and support to their children. Thus, as the English translation of Sinovuyo implies, this ongoing work is one devoted to "creating happiness together for all."

³⁶ http://www.who.int/violence_injury_prevention/violence/child/plh/en/

CHAPTER EIGHT. BIBLIOGRAPHY

- Abidin, R. R. (1995). *Parenting Stress Index (PSI) manual* (3rd ed.). Charlottesville, VA: Pediatric Psychology Press.
- ACCESS. (2002). *Children speak out on poverty: Report on the ACCESS (Alliance for Children's Entitlement to Social Security) Child Participation Process: Soul City*. Cape Town: Children's Institute, University of Cape Town.
- Achenbach, T. M., & Ruffle, T. M. (2000). The Child Behavior Checklist and related forms for assessing behavioral/emotional problems and competencies. *Pediatric Review, 21*(8), 265-271.
- Akmatov, M. K. (2011). Child abuse in 28 developing and transitional countries: Results from the Multiple Indicator Cluster Surveys. *International Journal of Epidemiology, 40*(1), 219-227. doi: 10.1093/ije/dyq168
- Alderson, P., & Morrow, V. (2004). *Ethics, social research and consulting with children and young people*. London: Barnardo's.
- Allen, A. B., Finestone, M., Eloff, I., Sipsma, H., Makin, J., Triplett, K., . . . Visser, M. (2014). The role of parenting in affecting the behavior and adaptive functioning of young children of HIV-infected mothers in South Africa. *AIDS and Behavior, 18*(3), 605-616.
- Altman, D. G., & Bland, J. M. (1995). Absence of evidence is not evidence of absence. *British Medical Journal, 311*(7003), 485.
- Altman, D. G., Schulz, K. F., Moher, D., Egger, M., Davidoff, F., Elbourne, D., . . . Lang, T. (2001). The revised CONSORT statement for reporting randomized trials: Explanation and elaboration. *Annals of Internal Medicine, 134*(8), 663-694.
- Altman, M. (2008). Expanding early childhood services: Labour market challenges. *Agenda, 22*(78), 120-131.
- Amoateng, A. Y., Richter, L. M., Makiwane, M., & Rama, S. (2004). *Describing the structure and needs of families in South Africa: Towards the development of a national policy framework for families*. Pretoria: Human Sciences Research Council.
- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186. doi: 10.1007/s00406-005-0624-4
- Anderson, L. S. (2008). Predictors of parenting stress in a diverse sample of parents of early adolescents in high-risk communities. *Nursing Research, 57*(5), 340-350. doi: 10.1097/01.NNR.0000313502.92227.87 00006199-200809000-00006 [pii]
- Andrews, D. A., & Dowden, C. (2005). Managing correctional treatment for reduced recidivism: A meta-analytic review of programme integrity. *Legal criminology and psychology, 20*, 173-187.
- Ansell, N., & Van Blerk, L. (2004). Children's migration as a household/family Strategy: Coping with AIDS in Lesotho and Malawi. *Journal of Southern African Studies, 30*(3), 673-690.
- Antle, B. J., Wells, L. M., Goldie, R. S., DeMatteo, D., & King, S. M. (2001). Challenges of parenting for families living with HIV/AIDS. *Social Work, 46*(2), 159-169.

-
- Arain, M., Campbell, M. J., Cooper, C. L., & Lancaster, G. A. (2010). What is a pilot or feasibility study? A review of current practice and editorial policy. *BMC Medical Research Methodology*, 10, 67. doi: 10.1186/1471-2288-10-67
- Armstrong, M. I., Birnie-Lefcovitch, S., & Ungar, M. T. (2005). Pathways between social support, family well being, quality of parenting, and child resilience: What we know. *Journal of Child and Family Studies*, 14(2), 269-281.
- Aspland, H., & Gardner, F. (2003). Observational measures of parent - child interaction: An introductory review. *Child and Adolescent Mental Health*, 8(3), 136-143.
- Axberg, U., & Broberg, A. (2008). "The Incredible Years": Evaluation of the Webster-Stratton parent management training programme in Sweden. *International Journal of Psychology*, 43(3-4), 357-357.
- Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging parents in parenting programs: Lessons from research and practice. *Children and Youth Services Review*, 34(10), 2061-2071. doi: 10.1016/J.Childyouth.2012.06.011
- Bagner, D. M., & Eyberg, S. M. (2007). Parent-child interaction therapy for disruptive behavior in children with mental retardation: a randomized controlled trial. *Journal of clinical child and adolescent psychology : the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, 36(3), 418-429.
- Baker, C. N., Arnold, D. H., & Meagher, S. (2011). Enrollment and attendance in a parent training prevention program for conduct problems. *Prevention Science*, 12(2), 126-138.
- Baker-Henningham, H., Scott, S., Jones, K., & Walker, S. (2012). Reducing child conduct problems and promoting social skills in a middle-income country: Cluster randomised controlled trial. *British Journal of Psychiatry*, 201(2), 101-108. doi: 10.1192/Bjp.Bp.111.096834
- Bakermans-Kranenburg, M. J., Van Ijzendoorn, M. H., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, 129(2), 195.
- Baldwin, S. A., Murray, D. M., & Shadish, W. R. (2005). Empirically supported treatments or type I errors? Problems with the analysis of data from group-administered treatments. *Journal of Consulting and Clinical Psychology*, 73(5), 924-935. doi: 10.1037/0022-006x.73.5.924
- Balton, S. (2009). *Family-based activity settings of typically developing three-to-five-year old children in a low-income African context*. (Unpublished doctoral dissertation), University of Pretoria, Pretoria.
- Bandura, A. (1977). *Social learning theory*. New York: General Learning Press.
- Barbarin, O., Richter, L., & De Wet, T. (2001). Exposure to violence, coping resources, and psychological adjustment of South African children. *American Journal of Orthopsychiatry*, 71(1), 16-25.
- Barlow, J., Coren, E., & Stewart-Brown, S. (2002). Meta-analysis of the effectiveness of parenting programmes in improving maternal psychosocial health. *British Journal of General Practice*, 52(476), 223-233.
- Barlow, J., Johnston, I., Kendrick, D., Polnay, L., & Stewart-Brown, S. (2006). Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. *Cochrane Database of Systematic Reviews*, 3, 1-20.
-

-
- Barlow, J., Smailagic, N., Bennett, C., Huband, N., Jones, H., & Coren, E. (2011). Individual and group based parenting programmes for improving psychosocial outcomes for teenage parents and their children. *Cochrane Database of Systematic Reviews*(3), -. doi: 10.1002/14651858.Cd002964.Pub2
- Barlow, J., Smailagic, N., Ferriter, M., Bennett, C., & Jones, H. (2010). Group-based parent-training programmes for improving emotional and behavioural adjustment in children from birth to three years old. *Cochrane Database of Systematic Reviews*, 3. doi: 10.1002/14651858.Cd003680.Pub2
- Barrera, M., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: A progress report. *Journal of Consulting and Clinical Psychology*, 81(2), 196.
- Barry, M. M. (2009). Addressing the determinants of positive mental health: Concepts, evidence and practice. *International Journal of Mental Health Promotion*, 11(3), 4-17.
- Bastien, S., Kajula, L. J., & Muhwezi, W. W. (2011). A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health*, 8(25), 1-17. doi: 10.1186/1742-4755-8-25
- Bauer, D. J., Sterba, S. K., & Hallfors, D. D. (2008). Evaluating group-based interventions when control participants are ungrouped. *Multivariate Behavioral Research*, 43(2), 210-236.
- Baumrind, D. (1991). Parenting styles and adolescent development. In R. M. Lerner (Ed.), *Encyclopedia of adolescence* (Vol. 2, pp. 746-758). New York: Garland.
- Beardslee, W. R., Gladstone, T. R. G., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. *Pediatrics*, 112(2), E119-E131.
- Beck, A. T., & Steer, R. A. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluations. *Clinical Psychology Review*, 8, 77-100.
- Bellg, A. J., Borrelli, B., Resnick, B., Hecht, J., Minicucci, D. S., Ory, M., . . . Czajkowski, S. (2004). Enhancing treatment fidelity in health behavior change studies: Best practices and recommendations from the NIH behavior change consortium. *Health Psychology*, 23(5), 443-451. doi: 10.1037/0278-6133.23.5.443
- Belsky, J. (1980). Child maltreatment: An ecological integration. *The American Psychologist*, 35, 320-335.
- Belsky, J., Jaffee, S. R., Sligo, J., Woodward, L., & Silva, P. A. (2005). Intergenerational transmission of warm-sensitive-stimulating parenting: A prospective study of mothers and fathers of 3-year-olds. *Child Development*, 76(2), 384-396.
- Ben-Arieh, A. (2005). Where are the children? Children's role in measuring and monitoring their well-being. *Social Indicators Research*, 74(3), 573-596.
- Bennett, C., Barlow, J., Huband, N., Smailagic, N., & Roloff, V. (2013). Group-based parenting programs for improving parenting and psychosocial functioning: A systematic review. *Journal of the Society for Social Work and Research*, 4(4), 300-332.
- Bennett, D. S., Sullivan, M. W., & Lewis, M. (2006). Relations of parental report and observation of parenting to maltreatment history. *Child Maltreatment*, 11(1), 63-75. doi: 10.1177/1077559505283589
-

-
- Berkel, C., Mauricio, A. M., Schoenfelder, E., & Sandler, I. N. (2011). Putting the pieces together: An integrated model of program implementation. *Prevention Science, 12*(1), 23-33. doi: 10.1007/S11121-010-0186-1
- Bernal, G. (2006). Intervention development and cultural adaptation research with diverse families. *Family Process, 45*(2), 143-151.
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology, 23*(1), 67-82.
- Bernal, G., Jimenez-Chafey, M. I., & Domenech Rodriguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 361-368.
- Bernard, K., Dozier, M., Bick, J., Lewis - Morrarty, E., Lindhiem, O., & Carlson, E. (2012). Enhancing attachment organization among maltreated children: Results of a randomized clinical trial. *Child Development, 83*(2), 623-636.
- Berry, L. (2013). *South African Child Gauge 2013*. Cape Town: Children's Institute, University of Cape Town.
- Bhana, A. (2010). Middle childhood and pre-adolescence. In I. Petersen, A. Bhana, A. J. Flisher, L. Swartz, & L. Richter (Eds.), *Promoting mental health in scarce-resource contexts: Emerging evidence and practice*. Cape Town: Human Sciences Research Council.
- Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research, 10*(2), 141-163.
- Black, D. A., Heyman, R. E., & Slep, A. M. S. (2001). Risk factors for child sexual abuse. *Aggression and Violent Behavior, 6*(2-3), 203-229. doi: 10.1016/S1359-1789(00)00023-9
- Black, D. A., Slep, A. M. S., & Heyman, R. E. (2001). Risk factors for child psychological abuse. *Aggression and Violent Behavior, 6*(2-3), 189-201. doi: 10.1016/S1359-1789(00)00022-7
- Bonell, C., Fletcher, A., Morton, M., Lorenc, T., & Moore, L. (2012). Realist randomised controlled trials: A new approach to evaluating complex public health interventions. *Social Science and Medicine, 75*(12), 2299-2306. doi: 10.1016/j.socscimed.2012.08.032
- Bonin, E.-M., Stevens, M., Beecham, J., Byford, S., & Parsonage, M. (2011). Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: A modelling study. *BMC Public Health, 11*(1), 803.
- Bonn, M. (2007). Children's understanding of 'ubuntu'. *Early Child Development and Care, 177*(8). doi: 10.1080/03004430701269291
- Bornstein, M. H. (2012). Cultural approaches to parenting. *Parenting, 12*(2-3), 212-221.
- Borrego, J., Anhalt, K., Terao, S. Y., Vargas, E. C., & Urquiza, A. J. (2006). Parent-Child Interaction Therapy with a Spanish-speaking family. *Cognitive and Behavioral Practice, 13*(2), 121-133.
- Borrelli, B. (2011). The assessment, monitoring, and enhancement of treatment fidelity in public health clinical trials. *Journal of Public Health Dentistry, 71 Suppl 1*, S52-63.
- Borrelli, B., Sepinwall, D., Ernst, D., Bellg, A. J., Czajkowski, S., Breger, R., . . . Orwig, D. (2005). A new tool to assess treatment fidelity and evaluation of
-

-
- treatment fidelity across 10 years of health behavior research. *Journal of Consulting Clinical Psychology*, 73(5), 852-860. doi: 10.1037/0022-006X.73.5.852
- Bostock. (2002). 'God, she's gonna report me': The ethics of child protection in poverty research. *Children and Society*, 16, 273-283.
- Bowlby, J. (1974). *Attachment and loss* (Vol. 1). London: Hogarth Press and Institute of Psycho-Analysis.
- Bozalek, V. (1999). Contextualizing caring in black South African families. *Social Politics*, 6(1), 85-99.
- Bradach, J. (2003). Going to scale: The challenge of replicating social programs. *Stanford Social Innovation Review*, 1(1), 19-26.
- Bradley, R. H., & Corwyn, R. F. (2002). Socioeconomic status and child development. *Annual Review of Psychology*, 53, 371-399.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi: 10.1191/1478088706qp063oa
- Bray, R., & Brandt, R. (2007). Child care and poverty in South Africa. *Journal of Children and Poverty*, 13(1), 1-19. doi: 10.1080/10796120601171187
- Bray, R., Gooskens, I., Kahn, L., Moses, S., & Seekings, J. (2010). *Growing up in the new South Africa: Childhood and adolescence in post-apartheid South Africa*. Cape Town: Human Sciences Research Council.
- Breen, A., Daniels, K., & Tomlinson, M. (2015). Children's experiences of corporal punishment: A qualitative study in an urban township of South Africa. *Child Abuse & Neglect*, 48, 131-139. doi: 10.1016/j.chiabu.2015.04.022
- Brestan, E. V., Jacobs, J. R., Rayfield, A. D., & Eyberg, S. M. (1999). A consumer satisfaction measure for parent-child treatments and its relation to measures of child behavior change. *Behavior Therapy*, 30(1), 17-30. doi: 10.1016/S0005-7894(99)80043-4
- British Psychological Society. (2000). *Ethical Principles for conducting research with human participants: Code of conduct, ethical principles and guidelines*. Leicester: British Psychological Society.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. London: Harvard University Press.
- Burgoyne, R. W., & Saunders, D. S. (2000). Perceived support in newly registered HIV/AIDS clinic outpatients. *AIDS Care*, 12(5), 643-650.
- Burke, J. D., Pardini, D. A., & Loeber, R. (2008). Reciprocal relationships between parenting behavior and disruptive psychopathology from childhood through adolescence. *Journal of Abnormal Child Psychology*, 36(5), 679-692.
- Campbell, C., Nair, Y., & Maimane, S. (2007). Building contexts that support effective community responses to HIV/AIDS: A South African case study. *American Journal of Community Psychology*, 39, 347-363.
- Campbell, N. C., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths, F., . . . Kinmonth, A. L. (2007). Designing and evaluating complex interventions to improve health care. *British Medical Journal*, 334(7591), 455-459.
- Carter, B. (2010). Cluster size variability and imbalance in cluster randomized controlled trials. *Stat Med*. doi: 10.1002/sim.4050
- Casale, M., Cluver, L., Crankshaw, T., Kuo, C., Lachman, J. M., & Wild, L. G. (2015). Direct and indirect effects of caregiver social support on adolescent
-

-
- psychological outcomes in two South African AIDS-affected communities. *American Journal of Community Psychology*, 1-11.
- Casale, M., & Wild, L. (2012). The relationship between social support and the health of HIV-positive caregivers of children: A review of the empirical literature. *Vulnerable Children and Youth Studies*, 7(3), 260-282. doi: 10.1080/17450128.2012.668232
- Castro, F. G., Barrera, M., Jr., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, 6, 213-239. doi: 10.1146/annurev-clinpsy-033109-132032
- Castro, F. G., Barrera, M., & Martinez, C. R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*, 5(1), 41-45.
- Chaffin, J., & Bergdorf, D. (2011). *The impacts of economic strengthening programs on children*. New York: Child Protection in Crisis: Network for Research, Learning, and Action, Columbia University Program on Forced Migration and Health.
- Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., & Balachova, T. (2004). Parent-Child Interaction Therapy with physically-abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, 72, 500-510.
- Chalmers, I. (2003). Trying to do more good than harm in policy and practice: The role of rigorous, transparent up-to-date evaluations. *Annals of the American Academy of Political and Social Science*, 589, 22-40. doi: 10.1177/0002716203254762
- Chan, A. W., Tetzlaff, J. M., Gotzsche, P. C., Altman, D. G., Mann, H., Berlin, J. A., . . . Moher, D. (2013). SPIRIT 2013 explanation and elaboration: Guidance for protocols of clinical trials. *British Medical Journal*, 346, e7586. doi: 10.1136/bmj.e7586
- Charles, J. M., Bywater, T., & Edwards, R. T. (2011). Parenting interventions: A systematic review of the economic evidence. *Child Care Health and Development*, 37(4), 462-474. doi: 10.1111/J.1365-2214.2011.01217.X
- Chen, M., & Chan, K. L. (2015). Effects of parenting programs on child maltreatment prevention: A meta-analysis. *Trauma, Violence, and Abuse*, 17(1), 88-104. doi: 10.1177/1524838014566718
- Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology*, 77(3), 566-579. doi: 10.1037/a0014565
- Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Service Research*, 7(1), 5-20.
- Cluver, L., Orkin, M., Boyes, M., Gardner, F., & Meinck, F. (2011). Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty. *Journal of Acquired Immune Deficiency Syndromes*, 58(3), 336-343. doi: 10.1097/QAI.0b013e31822f0d82
-

-
- Cluver, L., Orkin, M., Gardner, F., & Boyes, M. E. (2011). Persisting mental health problems among AIDS-orphaned children in South Africa. *Journal of Child Psychology and Psychiatry*. doi: 10.1111/j.1469-7610.2011.02459.x
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Hillsdale, NJ: Erlbaum.
- Cohen, L. R., Hien, D. A., & Batchelder, S. (2008). The impact of cumulative maternal trauma and diagnosis on parenting behavior. *Child Maltreatment*, 13(1), 27-38.
- Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Womens Health & Gender-Based Medicine*, 11(5), 465-476. doi: 10.1089/15246090260137644
- Collins, D., & Leibbrandt, M. (2007). The financial impact of HIV/AIDS on poor households in South Africa. *AIDS*, 21(Suppl 7), S75-S81.
- Collins, L. M., Dziak, J. J., Kugler, K. C., & Trail, J. B. (2014). Factorial experiments efficient tools for evaluation of intervention components. *American Journal of Preventive Medicine*, 47(4), 498-504. doi: 10.1016/J.Amepre.2014.06.021
- Collins, L. M., Dziak, J. J., & Li, R. Z. (2009). Design of experiments with multiple independent variables: A resource management perspective on complete and reduced factorial designs. *Psychological Methods*, 14(3), 202-224. doi: 10.1037/A0015826
- Collins, L. M., Murphy, S. A., Nair, V. N., & Strecher, V. J. (2005). A strategy for optimizing and evaluating behavioral interventions. *Annals of Behavioral Medicine*, 30(1), 65-73. doi: 10.1207/S15324796abm3001_8
- Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., . . . Stein, D. J. (2011). Grand challenges in global mental health. *Nature*, 475(7354), 27-30. doi: 10.1038/475027a
- Conger, R. D., Conger, K. J., Elder, G. H., Jr., Lorenz, F. O., Simons, R. L., & Whitbeck, L. B. (1992). A family process model of economic hardship and adjustment of early adolescent boys. *Child Development*, 63(3), 526-541.
- Connolly, P. (2005). Children, assessments and computer - assisted interviewing. *Child Abuse Review*, 14(6), 407.
- Cooper, P. J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A., . . . Murray, L. (2009). Improving quality of mother-infant relationship and infant attachment in a socioeconomically deprived community in South Africa: Randomised controlled trial. *British Medical Journal*, 338, b974-b974.
- Cooper, P. J., Vally, Z., Cooper, H., Radford, T., Sharples, A., Tomlinson, M., & Murray, L. (2014). Promoting mother-infant book sharing and infant attention and language development in an impoverished South African population: A pilot study. *Early Childhood Education Journal*, 42, 143-152. doi: 10.1007/s10643-013-0591-8
- Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research : techniques and procedures for developing grounded theory* (3rd ed.). Los Angeles, Calif. ; London: Sage.
- Cornwall, A., & Jewkes, R. (1995). What is participatory research? *Social Science and Medicine*, 41(12), 1667-1676.
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: The new Medical Research Council guidance. *British Medical Journal*, 337, a1655.
-

-
- Creswell, J. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (Second Edition ed.). Thousand Oaks, California: Sage Publications.
- Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). *Best practices for mixed methods research in the health sciences*. Bethesda, MD: National Institutes of Health.
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, 16(3), 297-334.
- Currie, J., & Widom, C. S. (2010). Long-term consequences of child abuse and neglect on adult economic well-being. *Child Maltreatment*, 15(2), 111-120.
- Dahlem, N. W., Zimet, G. D., & Walker, R. R. (1991). The Multidimensional Scale of Perceived Social Support: A confirmation study. *Journal of Clinical Psychology*, 47(6), 756-761.
- Davies, M. (2005). Using computer - assisted self - interviewing (CASI) questionnaires to facilitate consultation and participation with vulnerable young people. *Child Abuse Review*, 14(6), 389.
- Dawes, A., Bray, R., Kvalsvig, J., & Richter, L. (2007). *Indicators of South African children's psychosocial development in the early childhood period. Report for UNICEF*. Cape Town: Human Sciences Research Council.
- Dawes, A., De Sas Kroppiwinski, Z., Kafaar, Z., & Richter, L. (2005). *Corporal punishment of children: A South African national survey*. Cape Town: Human Sciences Research Council.
- De Graaf, I., Speetjens, P., Smit, F., De Wolff, M., & Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting Program on parenting: A meta - analysis. *Family Relations*, 57(5), 553-566.
- Deater-Deckard, K., Dodge, K. A., Bates, J. E., & Pettit, G. S. (1998). Multiple risk factors in the development of externalizing behavior problems: Group and individual differences. *Development and Psychopathology*, 10(3), 469-493.
- Delaney, R., Serovich, J., & Lim, J. (2008). Reasons for and against maternal HIV disclosure to children and perceived child reaction *AIDS Care*, 20(7), 876-880.
- Delgado-Rodriguez, M., & Llorca, J. (2004). Bias. *Journal of Epidemiological Community Health*, 58, 635-641.
- Department of Health, & Medical Research Council. (2007). *Demographic and Health Survey 2003*. Pretoria: Department of Health.
- Department of Social Development. (2007). *HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011*. Pretoria: Office of the Deputy President.
- Department of Social Development. (2012). *White Paper on Families in South Africa*. Pretoria: Office of the Deputy President.
- Department of Social Development, Department of Women Children and People with Disabilities, & UNICEF. (2012). *Violence Against Children in South Africa*. Pretoria: Department of Social Development/Department of Women, Children and People with Disabilities/UNICEF.
- Dishion, T., Hogansen, J., Winter, C., & Jabson, J. (2004). *The coder impressions inventory*: Unpublished manual, Child and Family Center, Eugene OR.
- Dodge, K. A., Bates, J. E., & Pettit, G. S. (1990). Mechanisms in the cycle of violence. *Science*, 250(4988), 1678-1683. doi: 10.1016/j.chiabu.2015.02.021
-

-
- Du Plessis, B., Kaminer, D., Hardy, A., & Benjamin, A. (2015). The contribution of different forms of violence exposure to internalizing and externalizing symptoms among young South African adolescents. *Child Abuse and Neglect*.
- Dumas, J. E., Nissley-Tsiopinis, J., & Moreland, A. D. (2007). From intent to enrollment, attendance, and participation in preventive parenting groups. *Journal of Child and Family Studies*, 16(1), 1-26.
- Dumka, L. E., Garza, C. A., Roosa, M. W., & Stoerzinger, H. D. (1997). Recruitment and retention of high-risk families into a preventive parent training intervention. *Journal of Primary Prevention*, 18(1), 25-39.
- Dunkle, K., Jewkes, R., Brown, H., Gray, G., McIntyre, J., & Harlow, S. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*, 363(9419), 1415-1421.
- Dunne, M. P., Zolotorb, A., Runyanb, D., Andrevia-Millerc, I., Yuen Chood, W., Dunnea, S., . . . Youssefj, R. (2009). ISPCAN Child Abuse Screening Tools Retrospective version (ICAST-R): Delphi study and field testing in seven countries. *Child Abuse & Neglect*, 33(11), 815-825.
- Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, 41(3-4), 327-350.
- Dziak, J. J., Nahum-Shani, I., & Collins, L. M. (2012). Multilevel factorial experiments for developing behavioral interventions: Power, sample size, and resource considerations. *Psychological Methods*, 17(2), 153-175. doi: 10.1037/A0026972
- Eames, C., Daley, D., Hutchings, J., Hughes, J. C., Jones, K., Martin, P., & Bywater, T. (2008). The Leader Observation Tool: A process skills treatment fidelity measure for the Incredible Years parenting programme. *Child Care, Health and Development*, 34(3), 391-400. doi: 10.1111/j.1365-2214.2008.00828.x
- Eames, C., Daley, D., Hutchings, J., Whitaker, C. J., Bywater, T., Jones, K., & Hughes, J. C. (2010). The impact of group leaders' behaviour on parents acquisition of key parenting skills during parent training. *Behaviour Research and Therapy*, 48(12), 1221-1226. doi: 10.1016/J.Brat.2010.07.011
- Eames, C., Daley, D., Hutchings, J., Whitaker, C. J., Jones, K., Hughes, J. C., & Bywater, T. (2009). Treatment fidelity as a predictor of behaviour change in parents attending group-based parent training. *Child Care Health and Development*, 35(5), 603-612. doi: 10.1111/J.1365-2214.2009.00975.X
- Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., . . . Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *Lancet*, 378(9802), 1592-1603. doi: 0.1016/S0140-6736(11)60891-X
- Edwards, R. T., Céilleachair, A., Bywater, T., Hughes, D. A., & Hutchings, J. (2007). Parenting programme for parents of children at risk of developing conduct disorder: Cost effectiveness analysis. *British Medical Journal*, 334(7595), 682.
- Edwards, R. T., Linck, P., Hounscome, N., Raisanen, L., Williams, N., Moore, L., & Murphy, S. (2013). Cost-effectiveness of a national exercise referral programme for primary care patients in Wales: Results of a randomised controlled trial. *BMC Public Health*, 13, 1021. doi: 10.1186/1471-2458-13-1021
-

-
- Egeland, B. (2004). Attachment-based intervention and prevention programs for young children. *Encyclopedia on Early Childhood Development [online]*. Montreal, Quebec: Centre of Excellence for Early Childhood Development, 1-7.
- Eisner, M. (2011). Measuring conflict of interest in prevention and intervention research: A feasibility study. In T. Bliesener, A. Beelmann, & M. Stemmler (Eds.), *Antisocial behavior and crime: Contributions of development and evaluation research to prevention and intervention* (pp. 165-180). Cambridge, MA: Hagrefe Publishing.
- Eisner, M., & Meidert, U. (2011). Stages of parental engagement in a universal parent training program. *Journal of Primary Prevention*, 32(2), 83-93. doi: 10.1007/s10935-011-0238-8
- Elliott, D. S., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science*, 5(1), 47-53.
- Engle, P. L., Menon, P., Garrett, J. L., & Slack, A. (1997). Urbanization and caregiving: A framework for analysis and examples from southern and eastern Africa. *Environment and Urbanization*, 9(2), 253-270.
- Erdfelder, E., Faul, F., & Buchner, A. (1996). GPOWER: A general power analysis program. *Behavior Research Methods, Instruments, and Computers: A Journal of the Psychonomic Society, Inc*, 28, 1-11.
- Eshel, N., Daelmans, B., de Mello, M., & Martinez, J. (2006). Responsive parenting: Interventions and outcomes. *Bulletin of the World Health Organization*, 84, 991-998.
- Etz, K. E., & Arroyo, J. A. (2015). Small sample research: Considerations beyond statistical power. *Prevention Science*. doi: 10.1007/s11121-015-0585-4
- Evans, J. L., Matola, C. E., & Nyeko, J. P. (2008). Parenting challenges for the changing African family. In M. Garcia, A. Pence, & J. L. Evans (Eds.), *Africa's future, Africa's challenge: Early childhood care and development in sub-Saharan Africa* (pp. 165-184). Washington: World Bank.
- Eyberg, S., & Pincus, D. (1999). *Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory - revised: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Eyberg, S., & Robinson, E. A. (2000). *Dyadic Parent-Child Interaction Coding System: A manual*. Seattle, WA: The Parenting Clinic, Department of Family and Child Nursing, School of Nursing, University of Washington.
- Eyberg, S. M., Boggs, S. R., & Algina, J. (1995). Parent-Child Interaction Therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families. *Psychopharmacology Bulletin*, 31(1), 83-91.
- Eyberg, S. M., & Matarazzo, R. G. (1980). Training parents as therapists: A comparison between individual parent-child interaction training and parent group didactic training. *Journal of Clinical Psychology*, 36(2), 492-499.
- Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Update on empirically supported treatments for child and adolescent disruptive behavior disorders. *Journal of Clinical Child and Adolescent Psychology*, 37, 215-237.
- Eyberg, S. M., & Ross, A. W. (1978). Assessment of child behavior problems: Validation of a new inventory. *Journal of Clinical Child Psychology*, 7(2), 113-116.
- Fang, X. Y., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for
-

-
- prevention. *Child Abuse and Neglect*, 36, 156-165. doi: 10.1016/j.chiabu.2011.10.006
- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), 80-93.
- Fergusson, D., Stanley, L., & Horwood, L. J. (2009). Preliminary data on the efficacy of the Incredible Years Basic Parent Programme in New Zealand. *Australian and New Zealand Journal of Psychiatry*, 43(1), 76-79. doi: 10.1080/00048670802534382
- Fielding, N. G., & Lee, R. M. (1998). *Computer analysis and qualitative research*. London: Sage Publications.
- Fincham, D. S., Altes, L. K., Stein, D. J., & Seedat, S. (2009). Posttraumatic stress disorder symptoms in adolescents: Risk factors versus resilience moderation. *Comprehensive Psychiatry*, 50(3), 193-199.
- Flay, B. R. (1986). Efficacy and effectiveness trials (and other phases of research) in the development of health promotion programs. *Preventive Medicine*, 15(5), 451-474.
- Flay, B. R., Biglan, A., Boruch, R. F., Castro, F. G., Gottfredson, D., Kellam, S., . . . Ji, P. (2005). Standards of evidence: Criteria for efficacy, effectiveness, and dissemination. *Prevention Science*, 6(3), 151-175. doi: 10.1007/S11121-005-5553-Y
- Fok, C. C., & Henry, D. (2015). Increasing the sensitivity of measures to change. *Prevention Science*. doi: 10.1007/s11121-015-0545-z
- Font, S. A., & Berger, L. M. (2015). Child maltreatment and children's developmental trajectories in early to middle childhood. *Child Development*, 86(2), 536-556.
- Forgatch, M., & Patterson, G. (2010). Parent Management Training—Oregon Model: An intervention for antisocial behavior in children and adolescents. *Evidence-based psychotherapies for children and adolescents*, 2, 159-178.
- Forgatch, M. S., Bullock, B. M., Patterson, G. R., & Steiner, H. (2004). From theory to practice: Increasing effective parenting through role-play. *Handbook of mental health interventions in children and adolescents: An integrated developmental approach*, 782-813.
- Forgatch, M. S., & DeGarmo, D. S. (2011). Sustaining fidelity following nationwide implementation in Norway. *Prevention Science*, 12, 235-246.
- Forgatch, M. S., Patterson, G. R., & DeGarmo, D. S. (2005). Evaluating fidelity: Predictive validity for a measure of competent adherence to the Oregon model of parent management training. *Behavior Therapy*, 36(1), 3-13. doi: 10.1016/S0005-7894(05)80049-8
- Forgatch, M. S., Patterson, G. R., & Gewirtz, A. H. (2013). Looking forward: The promise of widespread implementation of parent training programs. *Perspectives on Psychological Science*, 8(6), 682-694. doi: 10.1177/1745691613503478
- Foster, C., & Williamson, J. (2000). A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS 2000*, 14, S275-S284.
- Fox, R. A., Platz, D. L., & Bentley, K. S. (1995). Maternal factors related to parenting practices, developmental expectations, and perceptions of child behavior problems. *Journal of Genetic Psychology*, 156(4), 431-441.
-

-
- Fraenkel, P. (2006). Engaging families as experts: Collaborative family program development. *Family Process*, 45(2), 237-257.
- Fraser, M., Richman, J., Galinsky, M., & Day, S. (2009). *Intervention research: Developing social programs*. New York: Oxford University Press.
- Friedberg, J. P., Lipsitz, S. R., & Natarajan, S. (2010). Challenges and recommendations for blinding in behavioral interventions illustrated using a case study of a behavioral intervention to lower blood pressure. *Patient Education and Counseling*, 78(1), 5-11. doi: 10.1016/j.pec.2009.04.009
- Friedman, S. R., Kippax, S. C., Phaswana-Mafuya, N., Rossi, D., & Newman, C. E. (2006). Emerging future issues in HIV/AIDS social research. *AIDS*, 20(7), 959-965.
- Furlong, M., & McGilloway, S. (2012). The Incredible Years Parenting Program in Ireland: A qualitative analysis of the experience of disadvantaged parents. *Clinical Child Psychology and Psychiatry*, 17(4), 616-630. doi: 10.1177/1359104511426406
- Furlong, M., & McGilloway, S. (2014). Barriers and facilitators to implementing evidence-based parenting programs in disadvantaged settings: A qualitative study. *Journal of Child and Family Studies*, 1-10.
- Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2013). Cochrane Review: Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years (Review). *Evidence-Based Child Health: A Cochrane Review Journal*, 8(2), 318-692. doi: 10.1002/ebch.1905
- Galanter, R., Self-Brown, S., Valente, J. R., Dorsey, S., Whitaker, D. J., Bertuglia-Haley, M., & Prieto, M. (2012). Effectiveness of Parent-Child Interaction Therapy delivered to at-risk families in the home setting. *Child and Family Behavior Therapy*, 34(3), 177-196. doi: 10.1080/07317107.2012.707079
- Gardner, F. (2000). Methodological issues in the use of observational methods for measuring parent child interaction. *Clinical Child and Family Psychology Review*, 3, 185-198.
- Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: Outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry*, 47(11), 1123-1132. doi: 10.1111/J.1469-7610.2006.01668.X
- Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. (2010). Who benefits and how does it work? Moderators and mediators of outcome in an effectiveness trial of a parenting intervention. *Journal of Clinical Child and Adolescent Psychology*, 39(4), 568-580. doi: 10.1080/15374416.2010.486315
- Gardner, F., Montgomery, P., & Knerr, W. (2015). Transporting evidence-based parenting programs for child problem behavior (age 3-10) between countries: Systematic review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology*, 1-14. doi: 10.1080/15374416.2015.1015134
- Gardner, F., Shaw, D. S., Dishion, T. J., Burton, J., & Supplee, L. (2007). Randomized prevention trial for early conduct problems: Effects on proactive parenting and links to toddler disruptive behavior. *Journal of Family Psychology*, 21(3), 398-406. doi: 2007-12912-008 [pii] 10.1037/0893-3200.21.3.398
-

-
- Gardner, M. J., & Altman, D. G. (1986). Confidence-intervals rather than P-values: Estimation rather than hypothesis-testing. *British Medical Journal*, 292(6522), 746-750.
- Gershoff, E. T. (2002). Corporal punishment by parents and associated child behaviors and experiences: A meta-analytic and theoretical review. *Psychological Bulletin*, 128(4), 539-579. doi: 10.1037//0033-2909.128.4.539
- Gershoff, E. T., Aber, L., Raver, C., & Lennon, M. (2007). Income is not enough: Incorporating material hardship into models of income associations with parenting and child development. *Child Development*, 78(1), 70-95.
- Gilbert, L. S. (2002). Going the distance: 'Closeness' in qualitative data analysis software. *International Journal of Social Research Methodology*, 5(3), 215-228.
- Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet*, 373(9657), 68-81. doi: 10.1016/S0140-6736(08)61706-7
- Gillies, P., Tolley, K., & Wolstenholme, J. (1996). Is AIDS a disease of poverty? *AIDS Care*, 8(3), 351-363.
- Glaser, B. G., & Strauss, A. L. (1999). *The discovery of grounded theory: strategies for qualitative research*. New York: Aldine de Gruyter.
- Glasgow, R. E., Lichtenstein, E., & Marcus, A. C. (2003). Why don't we see more translation of health promotion research to practice? Rethinking the efficacy-to-effectiveness transition. *American Journal of Public Health*, 93(8), 1261-1267.
- Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(11), 1337-1345.
- Govender, D. S., & Sookrajh, R. (2014). 'Being hit was normal': Teachers' (un)changing perceptions of discipline and corporal punishment. *South African Journal of Education*, 34(2), 01-17.
- Graham, J. W., Olchowski, A. E., & Gilreath, T. D. (2007). How many imputations are really needed? Some practical clarifications of multiple imputation theory. *Prevention Science*, 8(3), 206-213. doi: 10.1007/S11121-007-0070-9
- Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy*, 43(4), 531-548. doi: 10.1037/0033-3204.43.4.531
- Hanf, C. (1969). *A two-stage program for modifying maternal controlling during mother-child (M-C) interaction*. Paper presented at the Meeting of the Western Psychological Association, Vancouver, BC, Canada.
- Hanks, T. L. (2008). The Ubuntu paradigm: Psychology's next force? *Journal of Humanistic Psychology*, 48(1), 116-135. doi: 10.1177/0022167807303004
- Haro, J. M., Kontodimas, S., Negrin, M. A., Ratcliffe, M., Suarez, D., & Windmeijer, F. (2006). Methodological aspects in the assessment of treatment effects in observational health outcomes studies. *Applied Health Economics and Health Policy*, 5(1), 11-25.
- Hashima, P. Y., & Amato, P. R. (1994). Poverty, social support, and parental behavior. *Child Development*, 65(2), 394-403.
- Hawes, D. J., & Dadds, M. (2006). Assessing parenting practices through parent-report and direct observation during parent-training. *Journal of Child and Family Studies*, 15(5), 555-568.
-

-
- Heeren, G. A., Jemmott, J. B., 3rd, Sidloyi, L., & Ngwane, Z. (2012). Disclosure of HIV diagnosis to HIV-infected children in South Africa: Focus groups for intervention development. *Vulnerable Children and Youth Studies*, 7(1), 47-54. doi: 10.1080/17450128.2012.656733
- Heinrichs, N., Bertram, H., Kuschel, A., & Hahlweg, K. (2005). Parent recruitment and retention in a universal prevention program for child behavior and emotional problems: Barriers to research and program participation. *Prevention Science*, 6(4), 275-286. doi: 10.1007/S11121-005-0006-1
- Henry, M. (1990). More than just play: The significance of mutually directed adult - child activity. *Early Child Development and Care*, 60(1), 35-51. doi: 10.1080/0300443900600104
- Herth, K. (1998). Hope as seen through the eyes of homeless children. *Journal of Advanced Nursing*, 28(5), 1053-1062.
- Higgins, J., & Green, S. (2011). *Cochrane handbook for systematic reviews of interventions. Version 5.1.0 [updated March 2011]*. The Cochrane Collaboration.
- Hill, N. E., & Tyson, D. F. (2008). Excavating culture: Ethnicity and context as predictors of parenting behavior. *Applied Developmental Science*, 12(4), 188-197. doi: 10.1080/10888690802388110
- Hinshaw, S. P. (2002). Intervention research, theoretical mechanisms, and causal processes related to externalizing behavior patterns. *Development and Psychopathology*, 14, 789-818.
- Holtrop, K., Parra Cardona, J. R., & Forgatch, M. S. (2014). Examining the process of change in an evidence-based parent training intervention: A qualitative study grounded in the experiences of participants. *Prevention Science*, 15(5), 745-756. doi: 10.1007/S11121-013-0401-Y
- Hopkin, C. R., Hoyle, R. H., & Gottfredson, N. C. (2015). Maximizing the yield of small samples in prevention research: A review of general strategies and best practices. *Prevention Science*. doi: 10.1007/s11121-014-0542-7
- Hosegood, V., & Madhavan, S. (2010). Data availability on men's involvement in families in sub-Saharan Africa to inform family-centred programmes for children affected by HIV and AIDS. *Journal of the International AIDS Society*, 13(Suppl 2), S5. doi: 10.1186/1758-2652-13-S2-S5
- Hughes, J. R., & Gottlieb, L. N. (2004). The effects of the Webster-Stratton parenting program on maltreating families: Fostering strengths. *Child abuse & neglect*, 28(10), 1081-1097.
- Hui, C. H., & Harry, C. T. (1985). Measurement in cross-cultural psychology. *Journal of Cross-Cultural Psychology*, 16(2), 131-152.
- Humeniuk, R., Ali, R., Babor, T. F., Farrell, M., Formigoni, M. L., Jittiwutikarn, J., . . . Simon, S. (2008). Validation of the Alcohol, Smoking And Substance Involvement Screening Test (ASSIST). *Addiction*, 103(6), 1039-1047. doi: 10.1111/j.1360-0443.2007.02114.x
- Hutchings, J. (2013). *The Little Parent Handbook*. Bangor, Wales: University of Wales Bangor School of Education.
- Hutchings, J. (2014). *The Enhancing Parenting Skills (EPaS) 2014 programme: A behavioural intervention to support families in developing children's social competencies and dealing with common childhood problems*. Bangor, Wales: Children's Early Intervention Trust.
-

-
- Hutchings, J., Gardner, F., & Lane, E. (2004). Making evidence-based intervention work. In D. Farrington, C. Sutton, & D. Utting (Eds.), *Support from the start: Working with young children and their families to reduce the risks of crime and antisocial behaviour* (pp. 69-79). London: Department for Education and Skills.
- Hutchings, J., Gardner, F., Lane, E., Bywater, T., Daley, D., Whitaker, C., . . . Edwards, R. T. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomised controlled trial. *British Medical Journal*, 334(7595), 678-682. doi: 10.1136/Bmj.39126.620799.55
- Ijumba, P., & Padarath, A. (Eds.). (2006). *South African Health Review 2006*. Durban: Health Systems Trust.
- Ingoldsby, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies*, 19(5), 629-645. doi: 10.1007/S10826-009-9350-2
- Isaakidis, P., & Ioannidis, J. P. (2003). Evaluation of cluster randomized controlled trials in sub-Saharan Africa. *American Journal of Epidemiology*, 158(9), 921-926.
- Jewkes, R., Dunkle, K., Nduna, M., Jama, P., & Puren, A. (2010). Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth. *Child Abuse and Neglect*, 34(11), 833-841.
- Jewkes, R., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *Lancet*, 376, 41-48.
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33(7), 14-26.
- Jones, J., & Hunter, D. (1995). Consensus methods for medical and health services research. *British Medical Journal*, 311(7001), 376-380.
- Jones, L., & Wells, K. (2007). Strategies for academic and clinician engagement in community-participatory partnered research. *JAMA*, 297(4), 407-410. doi: 10.1001/jama.297.4.407
- Jones, M. L. (2007). Using software to analyse qualitative data. *Malaysian Journal of Qualitative Research*, 1(1), 64-76.
- Kabat-Zinn, J. (2013). *Full catastrophe living (revised edition): Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Bantam Books.
- Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology*, 36(4), 567-589. doi: 10.1007/s10802-007-9201-9
- Katz, I. (2007). *The relationship between parenting and poverty*. York, UK: Joseph Rowntree Foundation.
- Kazdin, A. E. (1997). Parent management training: Evidence, outcomes, and issues. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(10), 1349-1356. doi: 10.1097/00004583-199710000-00016
- Kazdin, A. E. (2000). Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. *Journal of Child and Family Studies*, 9(2), 157-174.
- Kazdin, A. E. (2001). Bridging the enormous gaps of theory with therapy research and practice. *Journal of Clinical Child Psychology*, 30(1), 59-66.
-

-
- Kazdin, A. E., & Wassell, G. (1998). Treatment completion and therapeutic change among children referred for outpatient therapy. *Professional Psychology: Research and Practice*, 29(4), 332.
- Kelly, J., Somlai, A., Di Francisco, W., Otto-Salaj, L., McAuliffe, T., Hackl, K., . . . Rompa, D. (2000). Bridging the gap between the science and service of HIV prevention: Transferring effective research-based HIV prevention interventions to community AIDS service providers. *American Journal of Public Health*, 90(7), 1082-1088.
- Kernan, W. N., Viscoli, C. M., Makuch, R. W., Brass, L. M., & Horwitz, R. I. (1999). Stratified randomization for clinical trials. *Journal of Clinical Epidemiology*, 52(1), 19-26.
- Kianifard, F., & Islam, M. Z. (2011). A guide to the design and analysis of small clinical studies. *Pharmaceutical Statistics*, 10(4), 363-368.
- Kidman, R., Nice, J., Taylor, T., & Thurman, T. R. (2014). Home visiting programs for HIV-affected families: A comparison of service quality between volunteer-driven and paraprofessional models. *Vulnerable Children and Youth Studies*, 9(4), 305-317. doi: 10.1080/17450128.2014.954025
- Kim, J., Cicchetti, D., Rogosch, F. A., & Manly, J. T. (2009). Child maltreatment and trajectories of personality and behavioral functioning: Implications for the development of personality disorder. *Development and Psychopathology*, 21(3), 889-912. doi: 10.1017/S0954579409000480
- King, E., De Silva, M., Stein, A., & Patel, V. (2009). Interventions for improving the psychosocial well-being of children affected by HIV and AIDS. (Review). *Cochrane Collaboration Systematic Review*.
- Kjøbli, J., & Ogden, T. (2012). A randomized effectiveness trial of brief parent training in primary care settings. *Prevention Science*, 13(6), 616-626.
- Klebanov, P. K., Brooksgunn, J., & Duncan, G. J. (1994). Does neighborhood and family poverty affect mothers parenting, mental health, and social support. *Journal of Marriage and the Family*, 56(2), 441-455.
- Knerr, W., Gardner, F., & Cluver, L. (2013). Improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries: A systematic review. *Prevention Science*, 14(4), 352-363. doi: 10.1007/s11121-012-0314-1
- Koerting, J., Smith, E., Knowles, M. M., Latter, S., Elsey, H., McCann, D. C., . . . Sonuga-Barke, E. J. (2013). Barriers to, and facilitators of, parenting programmes for childhood behaviour problems: A qualitative synthesis of studies of parents' and professionals' perceptions. *European Child and Adolescent Psychiatry*, 22(11), 653-670.
- Kotchick, B. A., & Forehand, R. (2002). Putting parenting in perspective: A discussion of the contextual factors that shape parenting practices. *Journal of Child and Family Studies*, 11, 255-269.
- Kraemer, H. C., Wilson, G. T., Fairburn, C. G., & Agras, W. S. (2002). Mediators and moderators of treatment effects in randomized clinical trials. *Archives of General Psychiatry*, 59(10), 877-883. doi: ynv10179 [pii]
- Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education and Behavior*, 30(2), 133-146. doi: 10.1177/1090198102251021
-

-
- Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The World Report on Violence and Health. *Lancet*, 360(9339), 1083-1088. doi: 10.1016/S0140-6736(02)11133-0
- Kumkale, G. T., & Albarracin, D. (2004). The sleeper effect in persuasion: A meta-analytic review. *Psychological Bulletin*, 130(1), 143-172.
- Kumpfer, K. L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science*, 3(3), 241-246.
- Kumpfer, K. L., Molgaard, V., & Spoth, R. (1996). The Strengthening Families Program for the prevention of delinquency and drug use.
- Kuo, C., Operario, D., & Cluver, L. (2012). Depression among carers of AIDS-orphaned and other-orphaned children in Umlazi Township, South Africa. *Global Public Health*, 7(3), 253-269. doi: 10.1080/17441692.2011.626436
- Labadarios, D., Maunder, E., Steyn, N., MacIntyre, U., Swart, R., Gericke, G., . . . Dannhauser, A. (2003). National food consumption survey in children aged 1-9 years: South Africa 1999. *Forum Nutrition*, 56, 106-109.
- Lachman, J. M. (2011). *Risk and protective factors associated with parental praise and parental supervision in high HIV-prevalent rural and urban communities of KwaZulu-Natal, South Africa*. (Unpublished master's thesis), University of Oxford, Oxford.
- Lachman, J. M., Cluver, L., Boyes, M., Kuo, C., & Casale, M. (2014). Positive parenting for positive parents: HIV/AIDS, poverty, caregiver depression, child behavior, and parenting in South Africa. *AIDS Care*, 26(3), 304-313. doi: 10.1080/09540121.2013.825368
- Lachman, J. M., Cluver, L., Ward, C. L., Hutchings, J., Gardner, F., Wessels, I., & Mlotshwa, S. (in revision). Pilot randomized controlled trial of a parenting program to reduce the risk of child maltreatment in South Africa.
- Lachman, J. M., Cluver, L., Kelly, J., Ward, C. L., Hutchings, J., Gardner, F. (2016). Process evaluation of a parenting program for low-income families in South Africa. *Research on Social Work Practice*. doi: 10.1177/1049731516645665
- Lachman, J. M., Sherr, L., Cluver, L., Ward, C. L., Hutchings, J., & Gardner, F. (2016). Integrating evidence and context to develop a parenting program for low-income families in South Africa. *Journal of Child and Family Studies*, 25(7), 2337-2352. doi: 10.1007/s10826-016-0389-6
- Lachman, P., Poblete, X., Ebigbo, P. O., Nyandiya-Bundy, S., Bundy, R. P., Killian, B., & Doek, J. (2002). Challenges facing child protection. *Child Abuse & Neglect*, 26(6-7), 587-617.
- Lancaster, G. A., Dodd, S., & Williamson, P. R. (2004). Design and analysis of pilot studies: Recommendations for good practice. *Journal of Evaluation in Clinical Practice*, 10(2), 307-312. doi: 10.1111/j.2002.384.doc.x
- Lannen, P., & Ziswiler, M. (2014). Potential and perils of the early years: The need to integrate violence prevention and early child development (ECD+). *Aggression and Violent Behavior*. doi: 10.1016/j.avb.2014.09.014
- Lansford, J. E., Criss, M. M., Laird, R. D., Shaw, D. S., Pettit, G. S., Bates, J. E., & Dodge, K. A. (2011). Reciprocal relations between parents' physical discipline and children's externalizing behavior during middle childhood and adolescence. *Development and Psychopathology*, 23(1), 225-238. doi: 10.1017/S0954579410000751
-

-
- Lansford, J. E., & Deater-Deckard, K. (2012). Childrearing discipline and violence in developing countries. *Child Development*, 83(1), 62-75. doi: 10.1111/j.1467-8624.2011.01676.x
- Lansford, J. E., & Dodge, K. A. (2008). Cultural norms for adult corporal punishment of children and societal rates of endorsement and use of violence. *Parenting: Science and Practice*, 8(3), 257-270. doi: 10.1080/15295190802204843
- Larsson, B., Fossum, S., Clifford, G., Drugli, M. B., Handegard, B. H., & Morch, W. T. (2009). Treatment of oppositional defiant and conduct problems in young Norwegian children: Results of a randomized controlled trial. *European Child and Adolescent Psychiatry*, 18(1), 42-52. doi: 10.1007/s00787-008-0702-z
- Latouf, N., & Dunn, M. (2010). Parenting styles affecting the social behaviour of five-year olds. *Journal of Psychology in Africa*, 20(1), 109-112.
- Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice*, 13(4), 295-310. doi: 10.1111/j.1468-2850.2006.00042.x
- Lazarus, S., Bulbulia, S., Taliep, N., & Naidoo, A. V. (2015). Community-based participatory research as a critical enactment of community psychology. *Journal of Community Psychology*, 43(1), 87-98.
- Lee, K. J., & Thompson, S. G. (2005). The use of random effects models to allow for clustering in individually randomized trials. *Clinical Trials*, 2(2), 163-173.
- Lehmann, H., & Toppich, J. (2009). [Communication of health risks: The example of HIV/AIDS prevention]. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*, 52(12), 1147-1150. doi: 10.1007/s00103-009-0973-7
- Leijten, P., Dishion, T. J., Thomaes, S., Raaijmakers, M. A. J., Orobio de Castro, B., & Matthys, W. (2015). Bringing parenting interventions back to the future: How randomized controlled microtrials may benefit parenting intervention effectiveness. *Clinical Psychology: Science and Practice*, 22, 47-57. doi: 10.1111/cpsp.12087
- Leijten, P., Melendez-Torres, G., Knerr, W., & Gardner, F. (2016). Transported versus homegrown parenting interventions for reducing disruptive child behavior: A multilevel meta-regression study. *Journal of the American Academy of Child & Adolescent Psychiatry*. doi: 10.1016/j.jaac.2016.05.003
- Leijten, P., Raaijmakers, M., de Castro, B. O., van den Ban, E., & Matthys, W. (2013). Effectiveness of the Incredible Years Parent Training to reduce disruptive behavior in ethnic minority and socioeconomically disadvantaged families. *Toward Improved Parenting Interventions for Disruptive Child Behavior*, 43.
- Leijten, P., Raaijmakers, M. A. J., de Castro, B. O., & Matthys, W. (2013). Does socioeconomic status matter? A meta-analysis on parent training effectiveness for disruptive child behavior. *Journal of Clinical Child and Adolescent Psychology*, 42(3), 384-392.
- Lempers, J. D., Clarklempers, D., & Simons, R. L. (1989). Economic hardship, parenting, and distress in adolescence. *Child Development*, 60(1), 25-39.
- Leung, C., Leung, S., Chan, R., Tso, K., & Ip, F. (2005). Child behaviour and parenting stress in Hong Kong families. *Hong Kong Medical Journal*, 11(5), 373-380.
- Leung, C., Sanders, M. R., Leung, S., Mak, R., & Lau, J. (2003). An outcome evaluation of the implementation of the Triple P-Positive Parenting Program in Hong Kong. *Family Process*, 42(4), 531-544. doi: 10.1111/j.1545-5300.2003.00531.x
-

-
- Leung, C., Tsang, S., Heung, K., & Yiu, I. (2009). Effectiveness of Parent-Child Interaction Therapy (PCIT) among Chinese families. *Research on Social Work Practice, 19*(3), 304-313. doi: 10.1177/1049731508321713
- Levac, A. M., McCay, E., Merka, P., & Reddon-D'Arcy, M. L. (2008). Exploring parent participation in a parent training program for children's aggression: Understanding and illuminating mechanisms of change. *Journal of Child and Adolescent Psychiatric Nursing, 21*(2), 78-88.
- Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology, 20*(4), 544-552.
- Lewin, S., Glenton, C., & Oxman, A. (2009). Use of qualitative methods alongside randomised controlled trials of complex healthcare interventions: Methodological study. *British Medical Journal, 339*(7723), 732-734. doi: 10.1136/bmj.b3496
- Lewin, S., Munabi-Babigumira, S., Glenton, C., Daniels, K., Bosch-Capblanch, X., van Wyk, B. E., . . . Scheel, I. B. (2010). Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database of Systematic Reviews*(3).
- Li, C. (2013). Little's test of missing completely at random. *Stata Journal, 13*(4), 795-809.
- Li, T. J., Hutfless, S., Scharfstein, D. O., Daniels, M. J., Hogan, J. W., Little, R. J. A., . . . Dickersin, K. (2014). Standards should be applied in the prevention and handling of missing data for patient-centered outcomes research: A systematic review and expert consensus. *Journal of Clinical Epidemiology, 67*(1), 15-32. doi: 10.1016/J.jclinepi.2013.08.013
- Locke, L. M., & Prinz, R. J. (2002). Measurement of parental discipline and nurturance. *Clinical Psychology Review, 22*(6), 895-929. doi: Pii S0272-7358(02)00133-2
- Lopman, B. A., Barnabas, R. V., Boerma, J. T., Chawira, G., Gaitskell, K., Harrop, T., . . . Gregson, S. (2006). Creating and validating an algorithm to measure AIDS mortality in the adult population using verbal autopsy. *Plos Medicine, 3*(8), 1273-1281. doi: 10.1371/journal.pmed.0030312
- Lorenc, T., & Oliver, K. (2014). Adverse effects of public health interventions: A conceptual framework. *Journal of Epidemiology and Community Health, 68*, 288-290.
- Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review, 20*(5), 561-592.
- Lundahl, B., Risser, H. J., & Lovejoy, M. C. (2006). A meta-analysis of parent training: Moderators and follow-up effects. *Clinical Psychology Review, 26*(1), 86-104. doi: 10.1016/j.cpr.2005.07.004
- Maccoby, E. E. (1992). The role of parents in the socialization of children: An historical overview. *Developmental Psychology, 28*(6), 1006-1017.
- MacKenzie, M. J., Nicklas, E., Waldfogel, J., & Brooks-Gunn, J. (2012). Corporal punishment and child behavioral and cognitive outcomes through 5 years-of-age: Evidence from a contemporary urban birth cohort study. *Infant and Child Development, 21*(1), 3-33. doi: 10.1002/icd.758
- Madans, J. H., Loeb, M. E., & Altman, B. M. (2011). Measuring disability and monitoring the UN Convention on the Rights of Persons with Disabilities: The
-

-
- work of the Washington Group on Disability Statistics. *BMC Public Health*, 11(Suppl 4), S4.
- Magnusson, K. (2014). Interpreting Cohen's d effect size: An interactive visualization. from <http://rpsychologist.com/d3/cohend/>
- Makoae, M., Warria, A., Bower, C., Loffell, J., Ward, C., & Dawes, A. (2009). Human Sciences Research Council/World Health Organization South Africa country report on the situation on prevention of child maltreatment study. *Report submitted to the Prevention of Violence, Department of Violence and Injury Prevention and Disability Noncommunicable Diseases and Mental Health*. Geneva: World Health Organization.
- Martin-Storey, A., Temcheff, C., Martin, E., & Stack, D. (2009). Interventions for childhood aggression in a cross-cultural context. *Psychology Developing Societies*, 21(2), 235-256. doi: 10.1177/097133360902100204
- Martinez, C. R., & Eddy, J. M. (2005). Effects of culturally adapted parent management training on Latino youth behavioral health outcomes. *Journal of Consulting and Clinical Psychology*, 73(5), 841-851. doi: 10.1037/0022-006x.73.4.841
- Matos, M., Bauermeister, J. J., & Bernal, G. (2009). Parent-Child Interaction Therapy for Puerto Rican preschool children with ADHD and behavior problems: A pilot efficacy study. *Family Process*, 48(2), 232-252.
- Matos, M., Torres, R., Santiago, R., Jurado, M., & Rodriguez, I. (2006). Adaptation of Parent-Child Interaction Therapy for Puerto Rican families: A preliminary study. *Family Process*, 45(2), 205-222. doi: 10.1111/j.1545-5300.2006.00091.x
- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, 311(6997), 109-112.
- Mboya, M. M., & Nesengani, R. I. (1999). Migrant labor in South Africa: A comparative analysis of the academic achievement of father-present and father-absent adolescents. *Adolescence*, 34(136), 763-767.
- McCabe, K., & Yeh, M. (2009). Parent-Child Interaction Therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child and Adolescent Psychology*, 38(5), 753-759. doi: 10.1080/15374410903103544
- McEachern, A., Dishion, T., Weaver, C., Shaw, D., Wilson, M., & Gardner, F. (2011). Parenting Young Children (PARYC): Validation of a self-report parenting measure. *Journal of Child and Family Studies*, 21(3). doi: 10.1007/s10826-011-9503-y
- McGilloway, S., Mhaille, G. N., Bywater, T., Furlong, M., Leckey, Y., Kelly, P., . . . Donnelly, M. (2012). A parenting intervention for childhood behavioral problems: A randomized controlled trial in disadvantaged community-based settings. *Journal of Consulting and Clinical Psychology*, 80(1), 116.
- McGilloway, S., NiMhaille, G., Bywater, T., Leckey, Y., Kelly, P., Furlong, M., . . . Donnelly, M. (2014). Reducing child conduct disorder behaviour and improving parent mental health in disadvantaged families: A 12-month follow-up and cost analysis of a parenting intervention. *European Child & Adolescent Psychiatry*, 23(9), 783-794.
- McKee, L., Roland, E., Coffelt, N., Olson, A. L., Forehand, R., Massari, C., . . . Zens, M. S. (2007). Harsh discipline and child problem behaviors: The roles of positive parenting and gender. *Journal of Family Violence*, 22(4), 187-196. doi: 10.1007/S10896-007-9070-6
-

-
- McLaren-Lachman, J. (2010). "Storytelling, Drama, and Mindfulness in Psychosocial Interventions for Children and Guardians Affected by HIV/AIDS in Southern Africa – Developing Pathways to Locally Sustainable Care". *South African Theatre Journal*, 24, 67-81.
- McLoyd, V. C., Jayaratne, T. E., Ceballo, R., & Borquez, J. (1994). Unemployment and work interruption among African-American single mothers: Effects on parenting and adolescent socioemotional functioning. *Child Development*, 65(2), 562-589.
- Meinck, F. (2014). *Physical, emotional and sexual child abuse victimisation in South Africa: Findings from a prospective cohort study*. Oxford: University of Oxford.
- Meinck, F., Cluver, L. D., Boyes, M. E., & Loening-Voysey, H. (2016). Physical, emotional, and sexual abuse of children in South Africa: Incidence, prevalence, perpetrators, and locations. *Journal of Epidemiology and Community Health*.
- Meinck, F., Cluver, L. D., Boyes, M. E., & Mhlongo, E. L. (2014). Risk and protective factors for physical and sexual abuse of children and adolescents in Africa: A review and implications for practice. *Trauma, Violence, and Abuse*. doi: 1524838014523336.
- Meinck, F., D., C. L., Boyes, M. E., & Ndhlovu, L. D. (2013). Risk and protective factors for physical and emotional abuse victimisation amongst vulnerable children in South Africa. *Child Abuse Review*, 24(3), 182-197.
- Mejia, A., Calam, R., & Sanders, M. (2014a). Examining the fit of evidence-based parenting programs in low-resource settings: A survey of practitioners in Panama. *Journal of Child and Family Studies*, 1-8. doi: 10.1007/s10826-014-0028-z
- Mejia, A., Calam, R., & Sanders, M. R. (2012). A review of parenting programs in developing countries: Opportunities and challenges for preventing emotional and behavioral difficulties in children. *Clinical Child and Family Psychology Review*, 15(2), 163-175. doi: 10.1007/s10567-012-0116-9
- Mejia, A., Calam, R., & Sanders, M. R. (2014b). Examining delivery preferences and cultural relevance of an evidence-based parenting program in a low-resource setting of Central America: Approaching parents as consumers. *Journal of Child and Family Studies*. doi: 10.1007/s10826-014-9911-x
- Mejia, A., Calam, R., & Sanders, M. R. (2015). A pilot randomized controlled trial of a brief parenting intervention in low-resource settings in Panama. *Prevention Science*, 16(5), 707-717. doi: 10.1007/s11121-015-0551-1
- Mejia, A., Leijten, P., Lachman, J. M., & Parra-Cardona, J. R. (2016). Different strokes for different folks? Contrasting approaches to cultural adaptation of parenting interventions. *Prevention Science*. doi: 10.1007/s11121-016-0671-2
- Mejia, A., Ulph, T., & Calam, R. (2015). An exploration of parents' perceptions and beliefs about changes following participation in a family skill training: A qualitative study in a developing country. *Prevention Science*, 16(5), 674-684.
- Menting, A. T., de Castro, B. O., Wijngaards-de Meij, L. D., & Matthys, W. (2014). A trial of parent training for mothers being released from incarceration and their children. *Journal of Clinical Child & Adolescent Psychology*, 43(3), 381-396.
- Meth, P. (2013). 'I don't like my children to grow up in this bad area': Parental anxieties about living in informal settlements. *International Journal of Urban and Regional Research*, 37(2), 537-555. doi: 10.1111/J.1468-2427.2012.01199.X
-

-
- Michie, S. (2008). Designing and implementing behaviour change interventions to improve population health. *Journal of Health Services Research & Policy*, 13, 64-69. doi: 10.1258/Jhsrp.2008.008014
- Michie, S., Johnston, M., Francis, J., Hardeman, W., & Eccles, M. (2008). From theory to intervention: Mapping theoretically derived behavioural determinants to behaviour change techniques. *Applied Psychology - An International Review-Psychologie Appliquee-Revue Internationale*, 57(4), 660-680. doi: 10.1111/J.1464-0597.2008.00341.X
- Mikton, C. (2012). Two challenges to importing evidence-based child maltreatment prevention programs developed in high-income countries to low- and middle-income countries: Generalizability and affordability. In H. Dubowitz (Ed.), *World perspectives on child abuse* (Vol. 10, pp. 97). Aurora, CO: International Society for the Prevention of Child Abuse and Neglect.
- Mikton, C., & Butchart, A. (2009). Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization*, 87(5), 353-361.
- Mikton, C., MacMillan, H., Dua, T., & Betancourt, T. S. (2014). Integration of prevention of violence against children and early child development. *The Lancet Global Health*, 2(8), e442-443. doi: 10.1016/S2214-109X(14)70233-5
- Miller, T. R. (2015). Projected outcomes of Nurse-Family Partnership home visitation during 1996-2013, USA. *Prevention Science*, 16(6), 765-777. doi: 10.1007/s11121-015-0572-9
- Milner, J. (1986). *The Child Abuse Potential Inventory: Manual*. DeKalb, IL: Psytech Inc.
- Mlotshwa, S. C. (2013). *Developing an observational assessment for evaluating the Sinovuyo Caring Families Parent Training Programme*. (Unpublished honours thesis), University of Cape Town, Cape Town.
- Moher, D., Hopewell, S., Schulz, K. F., Montori, V., Gotzsche, P. C., Devereaux, P. J., . . . Altman, D. G. (2010). CONSORT 2010 explanation and elaboration: Updated guidelines for reporting parallel group randomised trials. *British Medical Journal*, 340, c869. doi: 10.1136/bmj.c869
- Moncher, F., Prinz, R. (1991). Treatment fidelity in outcome studies. *Clinical psychology review*, 11, 247-266.
- Moolla, S. (2012). *Parenting: Risk and protective factors for mothers with a history of family violence*. (Unpublished master's thesis), University of Cape Town, Cape Town.
- Moore, C. G., Carter, R. E., Nietert, P. J., & Stewart, P. W. (2011). Recommendations for planning pilot studies in clinical and translational research. *Clinical and Translational Science*, 4(5), 332-337. doi: 10.1111/j.1752-8062.2011.00347.x
- Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., & Hardeman, W. Process evaluation of complex interventions: UK Medical Research Council (MRC) guidance, 2014. London: MRC.
- Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., . . . Baird, J. (2014). Process evaluation of complex interventions. UK Medical Research Council (MRC) guidance. London: MRC Population Health Science Research Network.
- Morrell, R. (2006). Corporal punishment in South African schools: A neglected explanation for its existence. *South African Journal of Education*, 21(4), 292-299.
-

-
- Morsbach, S. K., & Prinz, R. J. (2006). Understanding and improving the validity of self-report of parenting. *Clinical Child and Family Psychology Review*, 9(1), 1-21. doi: 10.1007/s10567-006-0001-5
- Mosavel, M., Simon, C., van Stade, D., & Buchbinder, M. (2005). Community-based participatory research (CBPR) in South Africa: Engaging multiple constituents to shape the research question. *Social Science and Medicine*, 61(12), 2577-2587. doi: 10.1016/J.Socscimed.2005.04.041
- Mueller, J., Alie, C., Jonas, B., Brown, E., & Sherr, L. (2011). A quasi-experimental evaluation of a community-based art therapy intervention exploring the psychosocial health of children affected by HIV in South Africa. *Tropical Medicine and International Health*, 16(1), 57-66. doi: 10.1111/J.1365-3156.2010.02682.X
- Murphy, D. A., Marelich, W. D., Armistead, L., Herbeck, D. M., & Payne, D. L. (2010). Anxiety/stress among mothers living with HIV: Effects on parenting skills and child outcomes. *AIDS Care*, 22(12), 1449-1458.
- Murphy, L. M. B., Koranyi, K., Crim, L., & Whited, S. (1999). Disclosure, stress, and psychological adjustment among mothers affected by HIV. *AIDS Patient Care and STDs*, 13(2), 111-118.
- Murray, K. W., Woodruff, K., Moon, C., & Finney, C. (2015). Using text messaging to improve attendance and completion in a parent training program. *Journal of Child and Family Studies*, 24, 1-10.
- Nama, N., & Swartz, L. (2002). Ethical and social dilemmas in community-based controlled trials in situations of poverty: a view from a South African project. *Journal of Community and Applied Social Psychology*, 12(4), 286-297.
- Nix, R. L., Bierman, K. L., & McMahon, R. J. (2009). How attendance and quality of participation affect treatment response to parent management training. *Journal of Consulting and Clinical Psychology*, 77(3), 429-438. doi: 10.1037/a0015028
- Noble, M., Barnes, H., Wright, G., & Roberts, B. (2008). *Small Area Indices of Multiple Deprivation for South Africa*. Paper presented at the UNU-WIDER Frontiers of Poverty Analysis Conference.
- Noble, M., Barnes, H., Wright, G., McLennan, D., Avenell, D., Whitworth A., & Roberts, B. (2009). *The South African Index of Multiple Deprivation 2001 at datazone level*. Pretoria: Department of Social Development.
- Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *Plos Medicine*, 9(11). doi: 10.1371/Journal.Pmed.1001349
- Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P-Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review*, 11(3), 114-144.
- O'Neill, D., McGilloway, S., Donnelly, M., Bywater, T., & Kelly, P. (2013). A cost-effectiveness analysis of the Incredible Years parenting programme in reducing childhood health inequalities. *The European Journal of Health Economics*, 14(1), 85-94.
- Oakley, A., Strange, V., Bonell, C., Allen, E., Stephenson, J., & RIPPLE Study Team. (2006). Process evaluation in randomised controlled trials of complex
-

-
- interventions. *British Medical Journal*, 332(7538), 413-416. doi: 10.1136/bmj.332.7538.413
- Oburu, P. O., & Palmerus, K. (2003). Parenting stress and self-reported discipline strategies of Kenyan caregiving grandmothers. *International Journal of Behavioral Development*, 27(6), 505-512.
- Ogden, T., Forgatch, M. S., Askeland, E., Patterson, G. R., & Bullock, B. M. (2005). Implementation of parent management training at the national level: The case of Norway. *Journal of Social Work Practice*, 19(3), 317-329. doi: 10.1080/02650530500291518
- Olds, D. L., Eckenrode, J., Henderson, C. R. J., Kitzman, H., Powers, J., Cole, R., . . . Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. *Journal of the American Medical Association*, 278, 637-643.
- Osrin, D., Azad, K., Fernandez, A., Manandhar, D., Mwansambo, C., Tripathy, P., & Costello, A. (2009). Ethical challenges in cluster randomized controlled trials: Experiences from public health interventions in Africa and Asia. *Bulletin of the World Health Organization*, 87, 772-779.
- Oveisi, S., Ardabili, H. E., Dadds, M. R., Majdzadeh, R., Mohammadkhani, P., Rad, J. A., & Shahrivar, Z. (2010). Primary prevention of parent-child conflict and abuse in Iranian mothers: A randomized controlled trial. *Child Abuse and Neglect*, 34(3), 206-213.
- Palin, F. L., Armistead, L., Clayton, A., Ketchen, B., Lindner, G., Kokot-Louw, P., & Pauw, A. (2009). Disclosure of maternal HIV-infection in South Africa: Description and relationship to child functioning. *AIDS and Behavior*, 13(6), 1241-1252. doi: 10.1007/s10461-008-9447-4
- Palinkas, L. A. (2014). Qualitative and mixed methods in mental health services and implementation research. *Journal of Clinical Child & Adolescent Psychology*, 43(6), 851-861. doi: 10.1080/15374416.2014.910791
- Palinkas, L. A., Horwitz, S. M., Chamberlain, P., Hurlburt, M. S., & Landsverk, J. (2011). Mixed-methods designs in mental health services research: A review. *Psychiatric Services*, 62(3), 255-263. doi: 10.1176/appi.ps.62.3.255
- Pals, S. L., Murray, D. M., Alfano, C. M., Shadish, W. R., Hannan, P. J., & Baker, W. L. (2008). Individually randomized group treatment trials: A critical appraisal of frequently used design and analytic approaches. *American Journal of Public Health*, 98(8), 1418-1424. doi: 10.2105/AJPH.2007.127027
- Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., & Leckman, J. F. (2014). Practitioner review: Engaging fathers: Recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*, 55(11), 1187-1212. doi: 10.1111/jcpp.12280
- Pardini, D. A. (2008). Novel insights into longstanding theories of bidirectional parent-child influences: Introduction to the special section. *Journal of Abnormal Child Psychology*, 36(5), 627-631.
- Pardini, D. A., Fite, P. J., & Burke, J. D. (2008). Bidirectional associations between parenting practices and conduct problems in boys from childhood to adolescence: The moderating effect of age and African-American ethnicity. *Journal of Abnormal Child Psychology*, 36(5), 647-662. doi: 10.1007/s10802-007-9162-z
-

-
- Parra Cardona, J. (2015). A randomized controlled trial with two differentially culturally adapted PT interventions for underserved Latino/a immigrants: Examining intervention outcomes according to level of adaptation. Manuscript under review.
- Parra Cardona, J. R., Domenech-Rodriguez, M., Forgatch, M., Sullivan, C., Bybee, D., Holtrop, K., . . . G., B. (2012). Culturally adapting an evidence-based parenting intervention for Latino immigrants: The need to integrate fidelity and cultural relevance. *Family Process*, 51(1), 56-72.
- Parra Cardona, J. R., Holtrop, K., Cordova, D., Jr., Escobar-Chew, A. R., Horsford, S., Tams, L., . . . Fitzgerald, H. E. (2009). "Queremos aprender": Latino immigrants' call to integrate cultural adaptation with best practice knowledge in a parenting intervention. *Family Process*, 48(2), 211-231. doi: 10.1111/j.1545-5300.2009.01278.x
- Patterson, G. R., Chamberlain, P., & Reid, J. B. (1982). A comparative-evaluation of a parent-training program. *Behavior Therapy*, 13(5), 638-650. doi: 10.1016/S0005-7894(82)80021-X
- Patterson, G. R., DeBaryshe, B. D., & Ramsey, E. (1989). A developmental perspective on antisocial behavior. *The American Psychologist*, 44(2), 329-335. doi: 10.1037/0003-066X.44.2.329
- Pearl, E. S. (2009). Parent management training for reducing oppositional and aggressive behavior in preschoolers. *Aggression and Violent Behavior*, 14(5), 295-305. doi: 10.1016/J.Avb.2009.03.007
- Pears, K. C., & Capaldi, D. M. (2001). Intergenerational transmission of abuse: A two-generational prospective study of an at-risk sample. *Child Abuse & Neglect*, 25(11), 1439-1461.
- Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. In D. Schetky & E. P. Benedek (Eds.), *Textbook of child and adolescent Forensic Psychiatry* (pp. 221-238). Washington DC: American Psychiatry Press.
- Pettifor, A., Rees, H., Kleinschmidt, I., Steffenson, A., MacPhail, C., Hlongwa-Madikizela, L., . . . Padian, N. (2003). Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. *AIDS*, 19(14), 1525-1534.
- Phillips, A. E., Gomez, G. B., Boily, M. C., & Garnett, G. P. (2010). A systematic review and meta-analysis of quantitative interviewing tools to investigate self-reported HIV and STI associated behaviours in low- and middle-income countries. *International Journal of Epidemiology*, 39(6), 1541-1555. doi: 10.1093/ije/dyq114
- Phiri, S., & Tolfree, D. (2005). Family and community-based care for children affected by HIV/AIDS: Strengthening the front line response. In G. Foster, C. Levine, & J. Williamson (Eds.), *A generation at risk: The global impact of HIV/AIDS on orphans and vulnerable children*. Cambridge: Cambridge University Press.
- Piquero, A. R., Farrington, D. P., Welsh, B. C., Tremblay, R., & Jennings, W. G. (2009). Effects of early family/parent training programs on antisocial behavior and delinquency. *Journal of Experimental Criminology*, 5(2), 83-120. doi: 10.1007/S11292-009-9072-X
- Potterton, J., Stewart, A., & Cooper, P. (2007). Parenting stress of caregivers of young children who are HIV positive. *African Journal of Psychiatry*, 10(4), 210-214.
-

-
- Prinz, R. J., & Miller, G. E. (1994). Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology*, 62(3), 645.
- Prinz, R. J., & Sanders, M. R. (2007). Adopting a population-level approach to parenting and family support interventions. *Clinical Psychology Review*, 27(6), 739-749. doi: 10.1016/J.Cpr.2007.01.005
- Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The US Triple P system population trial. *Prevention Science*, 10(1), 1-12. doi: 10.1007/S11121-009-0123-3
- Prinz, R. J., Smith, E. P., Dumas, J. E., Laughlin, J. E., White, D. W., & Barron, R. (2001). Recruitment and retention of participants in prevention trials involving family-based interventions. *American Journal of Preventive Medicine*, 20(1 Suppl), 31-37.
- Puffer, E. S., Green, E. P., Chase, R. M., Sim, A. L., Zayzay, J., Friis, E., . . . Boone, L. (2015). Parents make the difference: A randomized controlled trial of a parenting intervention in Liberia. *Global Mental Health*, 2(e15), 1-13. doi: 10.1017/gmh.2015.12
- Puffer, S., Torgerson, D. J., & Watson, J. (2005). Cluster randomized controlled trials. *Journal of Evaluation in Clinical Practice*, 11(5), 479-483. doi: 10.1111/J.1365-2753.2005.00568.X
- Rahman, A., Malik, A., Sikander, S., Roberts, C., & Creed, F. (2008). Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: A cluster randomised controlled trial. *Lancet*, 372(9642), 902-909.
- Raikes, H. A., & Thompson, R. A. (2005). Efficacy and social support as predictors of parenting stress among families in poverty. *Infant Mental Health Journal*, 26(3), 177-190.
- Ramphela, M. (2002). *Steering by the stars: Being young in South Africa*. Cape Town: Tafelberg.
- Reid, M. J., Webster-Stratton, C., & Beauchaine, T. P. (2001). Parent training in Head Start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science*, 2(4), 209-227.
- Reza, A., Breiding, M. J., Gulaid, J., Mercy, J. A., Blanton, C., Mthethwa, Z., . . . Anderson, M. (2009). Sexual violence and its health consequences for female children in Swaziland: A cluster survey study. *Lancet*, 373, 1966-1972.
- Richter, L. M. (1994). Economic stress and its influence on the family and caretaking patterns. In A. Dawes & D. Donald (Eds.), *Childhood and adversity*. Cape Town: David Phillip.
- Richter, L. M. (1999). Parenting in poverty: Young children and their families in South Africa. *Effective Early Childhood Education: Cross-Cultural Perspectives*, 191.
- Richter, L. M., Chikovore, J., & Makusha, T. (2010). The status of fatherhood and fathering in South Africa. *Childhood Education*, 86(6), 360-365.
- Richter, L. M., Foster, G., & Sherr, L. (2006). *Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS*. Toronto: Bernard Van Leer Foundation.
- Richter, L. M., & Morrell, R. (2008). Fathering: The role of men in raising children in Africa: Holding up the other half of the sky. In A. P. Marito Garcia & J. L.
-

-
- Evans (Eds.), *Africa's future, Africa's challenge: Early childhood care and development in sub-Saharan Africa* (pp. 151-164). Washington, DC: World Bank.
- Richter, L. M., & Naicker, S. (2013). *A review of published literature on supporting and strengthening child-caregiver relationships (parenting)*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.
- Roberts, C., & Roberts, S. A. (2005). Design and analysis of clinical trials with clustering effects due to treatment. *Clinical Trials*, 2(2), 152-162.
- Roman, N. V. (2011). Maternal parenting in single and two-parent families in South Africa from a child's perspective. *Social Behavior and Personality*, 39(5), 577-585.
- Roman, N. V. (2014). Parenting in a rainbow nation: A South African perspective on parenting. In H. Selin (Ed.), *Parenting across cultures: Childrearing, motherhood and fatherhood in non-Western cultures* (pp. 213-229). Heidelberg, Germany: Springer.
- Roskam, I., Brassart, E., Loop, L., Mouton, B., & Schelstraete, M.-A. (2015). Stimulating parents' self-efficacy beliefs or verbal responsiveness: Which is the best way to decrease children's externalizing behaviors? *Behaviour Research and Therapy*, 72, 38-48.
- Rotheram-Borus, M. J., Lee, M. B., Gwadz, M., & Draimin, B. (2001). An intervention for parents with AIDS and their adolescent children. *American Journal of Public Health*, 91(8), 1294-1302.
- Runyan, D. K., Dunne, M. P., Zolotor, A. J., Madrid, B., Jain, D., Gerbaka, B., . . . Youssef, R. M. (2009). The development and piloting of the ISPCAN Child Abuse Screening Tool-Parent version (ICAST-P). *Child Abuse and Neglect*, 33(11), 826-832. doi: S0145-2134(09)00199-9
- Safarkhani, M., & Moerbeek, M. (2013). Covariate adjustment strategy increases power in the randomized controlled trial with discrete-time survival endpoints. *Journal of Educational and Behavioral Statistics*, 38(4), 355-380.
- Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review*, 2(2), 71-90.
- Sanders, M. R. (2008). The efficacy of the Triple P-Positive Parenting Program in improving parenting and child behavior: A comparison with two other treatment conditions. *Behaviour Research and Therapy*, 46(4), 411-427. doi: 10.1016/j.brat.2008.01.001
- Sanders, M. R. (2011). Development, evaluation, and multinational dissemination of the Triple P-Positive parenting program. *Annual Review of Clinical Psychology*. doi: 10.1146/annurev-clinpsy-032511-143104
- Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology*, 68(4), 624-640. doi: 10.1037//002-006x.68.4.624
- Sanders, M. R., Waugh, L., Tully, L., & Hynes, K. (1996). *The Revised Family Observation Schedule. FOS-III*. Brisbane: University of Queensland.
-

-
- Schneider, B. H., & Foucault, D. C. (2009). Parenting values and parenting stress among impoverished village and middle-class small city mothers in the Dominican Republic. *International Journal of Behavioral Development*, 33(5), 440-450. doi: 10.1177/0165025409340094
- Schneider, H., & Lehmann, U. (2010). Lay health workers and HIV programmes: Implications for health systems. *AIDS Care*, 22 Suppl 1, 60-67.
- Schumacher, J. A., Smith Slep, A. M., & Heyman, R. E. (2001). Risk factors for child neglect. *Aggression and Violent Behavior*, 6, 231-254.
- Schünemann, H. J., Oxman, A. D., Vist, G. E., Higgins, J. P., Deeks, J. J., Glasziou, P., & Guyatt, G. H. (2008). Interpreting results and drawing conclusions. *Cochrane handbook for systematic reviews of interventions version*, 5(0).
- Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S., & Ratele, K. (2009). Violence and injuries in South Africa: Prioritising an agenda for prevention. *Lancet*, 374(9694), 1011-1022. doi: 10.1016/S0140-6736(09)60948-X
- Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B., & Stein, D. J. (2004). Trauma exposure and post-traumatic stress symptoms in urban African schools. *British Journal of Psychiatry*, 184, 169-175.
- Seedat, S., Van Nood, E., Vythilingum, B., Stein, D. J., & Kaminer, D. (2000). School survey of exposure to violence and posttraumatic stress symptoms in adolescents. *South African Journal of Child and Adolescent Mental Health*, 12(1), 38-44.
- Serbin, L. A., & Karp, J. (2004). The intergenerational transfer of psychosocial risk: Mediators of vulnerability and resilience. *Annual Review of Psychology*, 55, 333-363. doi: 10.1146/Annurev.Psych.54.101601.145228
- Sethi, S., Kerns, S. E. U., Sanders, M. R., & Ralph, A. (2014). The international dissemination of evidence-based parenting interventions: Impact on practitioner content and process self-efficacy. *International Journal of Mental Health Promotion*, 16(2), 126-137. doi: 10.1080/14623730.2014.917896
- Shadish, W. R., Cook, T. D., & Campbell, D. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston, MA: Houghton, Mifflin.
- Shaffer, A., Jones, D., Kotchick, B., & Forehand, R. (2001). Telling the children: Disclosure of maternal HIV infection and its effects on child psychosocial adjustment. *Journal of Child and Family Studies*, 10(3), 301-313.
- Shapiro, C. J., Prinz, R. J., & Sanders, M. R. (2012). Facilitators and barriers to implementation of an evidence-based parenting intervention to prevent child maltreatment: The Triple P-Positive Parenting Program. *Child Maltreatment*, 17(1), 86-95. doi: 10.1177/1077559511424774
- Shields, N., Nadasen, K., & Pierce, L. (2008). The effects of community violence on children in Cape Town, South Africa. *Child Abuse and Neglect*, 32(5), 589-601. doi: 10.1016/j.chiabu.2007.07.010
- Sipsma, H., Eloff, I., Makin, J., Finestone, M., Ebersohn, L., Visser, M. J., . . . Forsyth, B. (2013). Behavior and psychological functioning of young children of HIV-positive mothers in South Africa. *AIDS Care*, 25(6), 721-725.
- Siu, G. E. (2015). *Harnessing parental concern for good behaviour and respectability to reduce gender based violence and child maltreatment in central Uganda: Early results from a pilot parenting intervention*. Paper presented at the
-

-
- Violence Against Children in Low and Middle Income Countries: An Interdisciplinary Approach Conference, Oxford, United Kingdom.
- Sliep, Y. (2010). Ubuntu: Relational generosity. *Families, Systems, & Health*, 28(2). doi: 10.1037/a0020067
- Smit, R. (2007). Living in an age of HIV and AIDS: Implications for families in South Africa. *Nordic Journal of African Studies*, 16(2), 161-178.
- Smith, T., Domenech Rodriguez, M. M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, 67, 166-175.
- Snell-Johns, J., Mendez, J. L., & Smith, B. H. (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *Journal of Family Psychology*, 18(1), 19-35. doi: 10.1037/0893-3200.18.1.19
- South African Government. (2005). *Children's Act 2005*. Cape Town.
- South African Police Service. (2014). *Annual report 2012/2013*. Cape Town: SAPS Strategic Management.
- Spoth, R., & Redmond, C. (1996). A theory-based parent competency model incorporating intervention attendance effects. *Family Relations*, 139-147.
- Statistics South Africa. (2011). *Census 2011: Household Questionnaire*. Pretoria: Statistics SA.
- Statistics South Africa. (2012). *Census 2011*. Pretoria: Statistics South Africa.
- Steele, G. I. (2003). *The development and validation of the Xhosa translations of the Beck Depression Inventory, the Beck Anxiety Inventory, and the Beck Hopelessness Scale*. (Unpublished master's thesis), Rhodes University, Grahamstown, South Africa.
- Stein, A., Krebs, G., Richter, L., Tomkins, A., Rochat, T., & Bennish, M. (2005). Babies of a pandemic: Infant development and HIV. *Archives of the Diseases of Childhood*, 90, 116-118.
- Stith, S. M., Liu, T., Davies, L. C., Boykin, E. L., Alder, M. C., Harris, J. M., . . . Dees, J. E. M. E. G. (2009). Risk factors in child maltreatment: A meta-analytic review of the literature. *Aggression and Violent Behavior*, 14(1), 13-29.
- Stoltenborgh, M., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Alink, L. R. A. (2013). Cultural-geographical differences in the occurrence of child physical abuse? A meta-analysis of global prevalence. *International Journal of Psychology*, 48(2), 81-94. doi: 10.1080/00207594.2012.697165
- Straus, M., Hamby, S., Boney-McCoy, S., & Sugarman, D. (1996). The revised conflict tactics scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues*, 17, 283-316.
- Straus, M. A. (2001). *Beating the devil out of them: Corporal punishment in American families and its effects on children*. New Brunswick, NJ: Transaction Publishers.
- Straus, M. A., & Douglas, E. M. (2004). A short form of the Revised Conflict Tactics Scales, and typologies for severity and mutuality. *Violence and Victims*, 19(5), 507-519.
- Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W., & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect*, 22(4), 249-270. doi: S0145-2134(97)00174-9
- Streiner, D., & Geddes, J. (2001). Intention to treat analysis in clinical trials when there are missing data. *Evidence-Based Mental Health*, 4(3), 70-71.
-

-
- Stuart-Brown, S., Patterson, J., Mockford, C., Barlow, J., Klimes, I., & Pyper, C. (2004). Impact of a general practice based group parenting programme: Quantitative and qualitative results from a controlled trial at 12 months. *Archives of Disease in Childhood*, 89, 519-525.
- Sulamoyo, D. (2010). "I am because we are": Ubuntu as a cultural strategy for OD and change in sub-Saharan Africa. *Organization Development Journal*, 28(4), 41-51.
- Sumathipala, A., & Murray, J. (2000). New approach to translating instruments for cross - cultural research: A combined qualitative and quantitative approach for translation and consensus generation. *International Journal of Methods in Psychiatric Research*, 9(2), 87-95. doi: 10.1002/mpr.83
- Sussman, S., Valente, T. W., Rohrbach, L. A., Skara, S., & Pentz, M. A. (2006). Translation in the health professions: Converting science into action. *Evaluation and the Health Professions*, 29(1), 7-32. doi: 10.1177/0163278705284441
- Terao, S. Y. (1999). *Treatment effectiveness of parent-child interaction therapy with physically abusive parent-child dyads*. Stockton, CA: University of the Pacific.
- Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L. P., . . . Goldsmith, C. H. (2010). A tutorial on pilot studies: The what, why and how. *BMC Medical Research Methodology*, 10, 1. doi: 10.1186/1471-2288-10-1
- The British Psychological Society. (2000). Ethical Principles for conducting research with human participants *Code of conduct, ethical principles and guidelines*. Leicester: The British Psychological Society.
- The Parent Centre. (2010). *Positive Parenting Programme*. Cape Town: The Parent Centre.
- Thomas, R., & Zimmer-Gembeck, M. J. (2007). Behavioral outcomes of parent-child interaction therapy and Triple P—Positive Parenting Program: A review and meta-analysis. *Journal of abnormal child psychology*, 35(3), 475-495.
- Tom, C. L. (2010). *Raising a child with attention deficit/hyperactivity disorder: Exploring the experience of black parents*. (Unpublished master's thesis), University of Pretoria, Pretoria.
- Tourangeau, R. (2000). Remembering what happened: Memory errors and survey reports. In A. A. Stone, J. S. Turkkan, C. A. Bachrach, J. B. Jobe, H. S. Kurtzman, & V. S. Cain (Eds.), *The science of self-report: Implications for research and practice* (pp. 3-7). Mahwah, New Jersey: Earlbaum.
- Trentacosta, C. J., Hyde, L. W., Shaw, D. S., Dishion, T. J., Gardner, F., & Wilson, M. (2008). The relations among cumulative risk, parenting, and behavior problems during early childhood. *Journal of Child Psychology and Psychiatry*, 49(11), 1211-1219. doi: 10.1111/j.1469-7610.2008.01941.x
- Turner, K. M., Nicholson, J. M., & Sanders, M. R. (2011). The role of practitioner self-efficacy, training, program and workplace factors on the implementation of an evidence-based parenting intervention in primary care. *The Journal of Primary Prevention*, 32(2), 95-112. doi: 10.1007/s10935-011-0240-1
- Turner, K. M. T., & Sanders, M. R. (2006). Dissemination of evidence-based parenting and family support strategies: Learning from the Triple P - Positive Parenting Program system approach. *Aggression and Violent Behavior*, 11(2), 176-193. doi: 10.1016/J.Avb.2005.07.005
- UNAIDS. (2010). *Report on the global AIDS epidemic*. Geneva: UNAIDS.
-

-
- UNICEF. (2010). *Child disciplinary practices at home: Evidence from a range of low- and middle-income countries*. New York: UNICEF.
- UNICEF. (2014). *Hidden in plain sight: A statistical analysis of violence against children*. New York: UNICEF.
- UNICEF, & UNAIDS. (2011). *Children and AIDS: Fifth stocktaking report*. Geneva: UNICEF.
- UNICEF, & World Health Organization. (2010). *Policy requirement for HIV testing and counselling of infants and young children in health facilities*. Geneva: World Health Organization.
- United Nations Office on Drugs and Crime. (2009). *Guide to implementing family skills training programmes for drug abuse prevention*. Vienna: UNODC.
- Vally, Z., Murray, L., Tomlinson, M., & Cooper, P. J. (2014). The impact of dialogic book-sharing training on infant language and attention: A randomized controlled trial in a deprived South African community. *Journal of Child Psychology and Psychiatry*. doi: 10.1111/jcpp.12352
- Viljoen, S. (1994). *Strengths and weaknesses in the family life of black South Africans*. Pretoria: Human Sciences Research Council.
- Wainberg, M. L., Alfredo Gonzalez, M., McKinnon, K., Elkington, K. S., Pinto, D., Gruber Mann, C., & Mattos, P. E. (2007). Targeted ethnography as a critical step to inform cultural adaptations of HIV prevention interventions for adults with severe mental illness. *Social Science and Medicine*, 65(2), 296-308. doi: 10.1016/j.socscimed.2007.03.020
- Wainberg, M. L., McKinnon, K., Mattos, P. E., Pinto, D., Mann, C. G., dos Santos de Oliveira, C. S., . . . PRISSMA Project. (2007). A model for adapting evidence-based behavioral interventions to a new culture: HIV prevention for psychiatric patients in Rio de Janeiro, Brazil. *AIDS and Behavior*, 11(6), 872-883. doi: 10.1007/s10461-006-9181-8
- Wang, R., & Ware, J. H. (2011). Detecting moderator effects using subgroup analyses. *Prevention Science*. doi: 10.1007/s11121-011-0221-x
- Ward, C., Flisher, A., Zissiz, C., Muller, M., & Lombard, C. (2009). Reliability of the Beck Depression Inventory and Self-Rating Anxiety Scale in a sample of South African adolescents. *Journal of Child and Adolescent Mental Health*, 15(2), 73-75.
- Ward, C. L., Flisher, A., Zissis, C., Muller, M., & Lombard, C. (2001). Exposure to violence and its relationship to psychopathology in adolescents. *Injury Prevention*, 7, 297-301.
- Ward, C. L., Mikton, C., Cluver, L., Cooper, P., Gardner, F., Hutchings, J., . . . Wessels, I. M. (2014). Parenting for Lifelong Health: From South Africa to other low-and middle-income countries. *Early Childhood Matters: Responsive Parenting: A Strategy to Prevent Violence*, 49.
- Watters, J. K., & Biernacki, P. (1989). Targeted sampling: Options for the study of hidden populations. *Social Problems*, 36(4), 416-430.
- Webster-Stratton, C. (1989). *The Incredible Years*. Seattle, WA: Incredible Years.
- Webster-Stratton, C. (1998a). Parent training with low-income families: Promoting parental engagement through a collaborative approach. In J. R. Lutzker (Ed.), *Handbook of child abuse research and treatment*. New York: Plenum Press.
-

-
- Webster-Stratton, C. (1998b). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology*, 66(5), 715-730.
- Webster-Stratton, C. (2004). *Quality training, supervision, ongoing monitoring, and agency support: Key ingredients to implementing the Incredible Years programs with fidelity*. Retrieved from <http://www.incredibleyears.com/> on March 17, 2008.
- Webster-Stratton, C. (2006). *The Incredible Years: A trouble-shooting guide for parents of children aged 2-8 years*. Seattle, WA: Incredible Years.
- Webster-Stratton, C. (2009). Affirming diversity: Multi-cultural collaboration to deliver the Incredible Years parent programs. *International Journal of Child Health and Human Development*, 2, 17-32.
- Webster-Stratton, C., & Herman, K. C. (2010). Disseminating Incredible Years Series early-intervention programs: Integrating and sustaining services between school and home. *Psychology in the Schools*, 47(1), 36-54. doi: 10.1002/Pits.20450
- Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology*, 56(4), 558-566.
- Webster-Stratton, C., & Reid, J. (2003). The Incredible Years Parents, Teachers, and Children Training Series: A multifaceted treatment approach for young children with conduct problems. In W. Kazdin A., J. (Ed.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). New York: Guilford Press.
- Webster-Stratton, C., & Reid, J. (2010). Adapting the Incredible Years, an evidence-based parenting programme, for families involved in the child welfare system. *Journal of Children's Services*, 5, 25-42.
- Wessels, I., & Ward, C. L. (2015). A 'best buy' for violence prevention: Evaluating parenting skills programmes. *South African Crime Quarterly*, 54, 17-28. doi: 10.4314/sacq.v54i1.2
- Wessels, I. M. (2012). *Parenting programmes in South Africa: Investigating design and evaluation practices*. (Unpublished master's thesis), University of Cape Town, Cape Town.
- Wessels, I. M., Mikton, C., Ward, C. L., Kilbane, T., Alves, R., Campello, G., . . . Madrid, B. (2013). *Preventing violence: Evaluating outcomes of parenting programmes*. Geneva: World Health Organization.
- Western Cape Government. (2013). *Integrated Violence Prevention Policy Framework*. Cape Town: Western Cape Government.
- Whipple, E. E., & Richey, C. A. (1997). Crossing the line from physical discipline to child abuse: How much is too much? *Child Abuse and Neglect*, 21(5), 431-444.
- White, I. R., Horton, N. J., Carpenter, J., & Pocock, S. J. (2011). Strategy for intention to treat analysis in randomised trials with missing outcome data. *British Medical Journal*, 342, d40. doi: 10.1136/bmj.d40
- Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Stepping Stones Triple P: An RCT of a parenting program with parents of a child diagnosed with an autism spectrum disorder. *Journal of Abnormal Child Psychology*, 37(4), 469-480.
- WHO. (2008). *World Report on Child Injury Prevention*. Geneva: WHO.
-

-
- WHO. (2010). *Violence prevention: The evidence*. Geneva: WHO.
- Williams, P. (1996). Ubuntu in action: Befriending in high density areas in South Africa. *Crisis*, 17(1), 8-9.
- Wilson, P., Rush, R., Hussey, S., Puckering, C., Sim, F., Allely, C. S., . . . Gillberg, C. (2012). How evidence-based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P. *BMC Medical Research Methodology*, 10(1), 130. doi: 10.1186/1741-7015-10-130
- Wolf, F. M. (1986). *Meta-analysis: Quantitative methods for research synthesis*. Beverly Hills, CA: Sage.
- Wolfe, D. A., Sandler, J., & Kaufman, K. (1981). A competency-based parent training program for child abusers. *Journal of Consulting and Clinical Psychology*, 49(5), 633.
- Wong, J. J., Roubinov, D. S., Gonzales, N. A., Dumka, L. E., & Millsap, R. E. (2013). Father enrollment and participation in a parenting intervention: Personal and contextual predictors. *Family Process*, 52(3), 440-454. doi: 10.1111/Famp.12024
- Wood, D., Bruner, J., & Ross, G. (1976). The role of tutoring in problem solving. *Journal of Child Psychology and Child Psychiatry*, 17, 89-100.
- World Bank. (2010). Classification of economies based on gross national income (GNI) per capita. from <http://data.worldbank.org/about/country-classifications>.
- World Health Organization. (1994). WHO case definition of AIDS surveillance in adults and adolescents. *Weekly Epidemiological Record*, 69, 273-275.
- World Health Organization. (2001). *Prevention Of Child Abuse and Neglect: Making the Links Between Human Rights and Public Health*. Geneva: WHO.
- World Health Organization. (2010). *Violence prevention: The evidence*. Geneva: WHO.
- World Health Organization. (2011). *Guideline on HIV disclosure counselling for children up to 12 years of age*. Geneva: WHO.
- World Health Organization. (2014). *Global Status Report on Violence Prevention 2014*. Geneva: WHO, United Nations Development Programme, United Nations Office on Drugs and Crime.
- World Health Organization. (March 1999). *Report on the consultation on child abuse prevention*. Geneva: World Health Organisation.
- World Health Organization & UNICEF. (2008). *World Report on Child Injury Prevention*. Geneva: World Health Organization.
- Wright, G. (2008). Findings from the Indicators of Poverty and Social Exclusion Project: A profile of poverty using the socially perceived necessities approach. Key Report 7. Pretoria: Department of Social Development.
- Wright, G., & Noble, M. (2009). *The South African Index of Multiple Deprivation 2007 at municipality level*. Pretoria: Department of Social Development.
- Young, L., & Ansell, N. (2003). Fluid households, complex families: The impacts of children's migration as a response to HIV/AIDS in Southern Africa. *The Professional Geographer*, 55(4), 464-476.
- Zimet, G. D., Powell, S. S., Farley, G. K., Werkman, S., & Berkoff, K. A. (1990). Psychometric characteristics of the Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, 55(3-4), 610-617. doi: 10.1080/00223891.1990.9674095
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APPENDIX A. PUBLICATIONS AND PRESENTATIONS ARISING FROM THIS THESIS

Published:

Lachman, J. M., Sherr, L., Cluver, L., Ward, C. L., Hutchings, J., & Gardner, F. (2016). Integrating evidence and context to develop a parenting program for low-income families in South Africa. *Journal of Child and Family Studies*. doi: 10.1007/s10826-016-0389-6

Lachman, J. M., Cluver, L., Kelly, J., Ward, C. L., Hutchings, J., Gardner, F. (2016). Process evaluation of a parenting program for low-income families in South Africa. *Research on Social Work Practice*.

Ward, C. L., Mikton, C., Cluver, L., Cooper, P., Gardner, F., Hutchings, J., **Lachman, J.M.**, Murray, L., Tomlinson, M., Wessels, I.M. (2014). Parenting for Lifelong Health: From South Africa to other low-and middle-income countries. *Early Childhood Matters: Responsive parenting: a strategy to prevent violence* (Vol. 49). The Hague, Netherlands: Bernard van Leer Foundation.

Mejia, A., Leijten, P., **Lachman, J. M.**, & Parra-Cardona, J. R. (2016). Different strokes for different folks? Contrasting approaches to cultural adaptation of parenting interventions. *Prevention Science*. doi: 10.1007/s11121-016-0671-2

Under review:

Lachman, J. M., Cluver, L., Ward, C. L., Hutchings, J., Gardner, F., Wessels, I., Mlotshwa, S. (in revision with *Child Abuse & Neglect*). Pilot randomized controlled trial of a parenting program to reduce the risk of child maltreatment in South Africa.

Conference presentations:

Lachman, J. M. Cluver, L., Ward, C. L., Wessels, I. M., Hutchings, J., Gardner, F. (2015, May). *Building a Rondavel of Support: Using a systematic approach to culturally adapting evidence-based principles in order to develop a parenting program for disadvantaged families in South Africa*. Paper presented at the Society for Prevention Research 2015 Annual Meeting, Washington D.C., United States.

Lachman, J. M. Cluver, L., Ward, C. L., Gardner, F., Hutchings, J., Wessels, I. M. (2015, February). *Sinovuyo Caring Families Project: Development of a parenting programme to reduce the risk of child maltreatment in South Africa*. Paper presented at The First Annual Ugandan Child and Adolescent Mental Health Conference, Kampala, Uganda.

Lachman, J. M., Cluver, L., Ward, C. L., Mikton, C., Gardner, F., Hutchings, J. (2014, September). *Parenting for Lifelong Health Ages 2-9: Development and evaluation of a parenting programme to reduce the risk of child maltreatment in Cape Town, South Africa*. Poster presented at WHO and University of Cambridge Global Violence Reduction Conference, Cambridge, United Kingdom.

Lachman, J. M., Cluver, L., Ward, C. L., Hutchings, J., Gardner, F., Wessels, I. M., & Mlotshwa, S. (2014, August). Development of a parenting programme to reduce the risk of child maltreatment in low-income families in South Africa: Results from a pilot randomized controlled trial. *Journal of Child and Adolescent Mental Health*, 26(2), 32.

Lachman, J. M., Kelly, J., Ward, C. L., Cluver, L., Hutchings, J., Gardner, F. (2014, May). *Reducing Child Maltreatment in South Africa: Feasibility of a Locally Developed Parenting Program for At-Risk Low-Income Families*. Paper presented at the Society for Prevention Research 2014 Annual Meeting, Washington D.C., United States.

Lachman, J. M., Hutchings, J., Cluver, L., Ward, C. L., Gardner, F. (2014, April). *The Sinovuyo Caring Families Programme for Parents of Children Aged 3 to 8 Years*. Paper presented at the Centre for Evidence Based Early Intervention 2014 Annual Conference, Bangor, Wales

Lachman, J. M., Cluver, L., Ward, C. L., Hutchings, J., Gardner, F. (2013, November). *Feasibility pilot study of a locally developed parenting programme to reduce the risk of child maltreatment for families affected by HIV/AIDS and intimate partner violence in Cape Town, South Africa – the Sinovuyo Caring Families Project*. Paper presented at the 2nd Colloquium of the University of Cape Town Safety and Violence Initiative, Cape Town, South Africa.

Other relevant work arising from this thesis:

Lachman, J. M., Hutchings, J. (2014). *Sinovuyo Caring Families Project: Facilitator's Handbook, Second Edition* (S. Tsoanyane, T. Matikinca, A. Mgedle, N. Mdudu, V. Xhotyeni, B. Xamsana, & F. Menziwa, Trans.). Cape Town: University of Cape Town.

Lachman, J. M., Hutchings, J. (2014). *Sinovuyo Caring Families Project: Parent Handbook, First Edition* (S. Tsoanyane, T. Matikinca, A. Mgedle, N. Mdudu, V. Xhotyeni, B. Xamsana, & F. Menziwa, Trans.). Cape Town: University of Cape Town.

Other papers published or in review during this thesis:

Casale, M., Cluver, L., Crankshaw, T., Kuo, C., **Lachman, J. M.,** & Wild, L. G. (2015). Direct and indirect effects of caregiver social support on adolescent psychological outcomes in two South African AIDS-affected communities. *American Journal of Community Psychology*, 55(3-4), 336-346.

Lachman, J. M., Cluver, L., Boyes, M., Kuo, C., & Casale, M. (2014). Positive parenting for positive parents: HIV/AIDS, poverty, caregiver depression, child behavior, and parenting in South Africa. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 26(3), 304-313. doi: 10.1080/09540121.2013.825368

Cluver, L., **Lachman, J. M.,** Ward, C., Gardner, F., Petersen, T., Meinck, F., . . . Boyes, M. (2016). Development of a parenting support program to prevent abuse of adolescents in South Africa: Findings from a pilot pre-post study. *Research on Social Work Practice*. doi: 10.1177/1049731516628647

APPENDIX B. SINOVUYO CARING FAMILIES PROGRAMME FACILITATOR MANUAL AND PARENT HANDBOOK

The D.Phil. candidate is the primary author of the Sinovuyo Caring Families Programme facilitator manual and parent handbook that was developed during the intervention development phase of this study. The following is an excerpt from the first chapter of the facilitator manual which describes the approach and structure of the programme.³⁷

EXCERPT FROM THE SINOVUYO CARING FAMILIES FACILITATOR MANUAL

PROGRAMME OVERVIEW

The Sinovuyo Caring Families Programme is a group based parenting programme for families with children ages 2 to 9. It has been designed specifically for vulnerable families facing challenges with their children's behaviour to reduce the risk of child abuse and neglect in low-income communities. The core theme in the Sinovuyo programme is "Building a Rondavel of Support" to help parents manage their children's behaviour while promoting healthy parent-child relationships. The intention of this manual is to provide a guide for group facilitators to be able to deliver the Sinovuyo programme with fidelity. It is expected that facilitators will have attended an intensive training in programme delivery prior to facilitation, and that they provide facilitation under supervision.

WHAT IS THE PROGRAMME AIMING TO DO?

The overall goal of the Sinovuyo Caring Families Programme is to reduce the risk for child maltreatment and improve child behaviour in vulnerable families. "Sinovuyo" means "We are making happiness" in isiXhosa. That is our main objective! We know that lots of children are cared for by someone who is not their biological mother or father. So when we talk about 'parents' and 'parenting' we mean the caregiver of the child, whether that is a biological parent or not.

Important goals of the programme are to:

- Increase parenting knowledge, skill and sense of competence
- Improve positive parenting behaviour
- Improve parental supervision of children
- Decrease inconsistent and harsh discipline

³⁷ Complete versions of the manual and handbook can be obtained upon request.

- Improve child behaviour and wellbeing
- Improve caregiver mental health and social support
- Improve knowledge and use of social services for intimate partner violence, HIV and other illnesses
- Improve engagement in school and early childhood learning
- Improve adherence to medication and disclosure of illness

A COLLABORATIVE APPROACH TO PROGRAMME DEVELOPMENT

The Sinovuyo Caring Families Programme uses a collaborative approach at all levels of development and implementation. It was created in collaboration with the Universities of Cape Town, Oxford, and Bangor, the World Health Organisation, UNICEF, the South African Departments of Social Development, Health, and Basic Education, and Clowns Without Borders South Africa. The Sinovuyo programme was also developed in close consultation with parents and service providers living in Cape Town, South Africa, during extensive community-based participation research and piloting in 2012 and 2013 with local NGOs, Ikamva Labantu and the Parent Centre. The Sinovuyo programme is part of a larger initiative called Parenting for Lifelong Health (PLH). Its objective is to develop a suite of parenting programmes for low-resource contexts that reduce the risk of child maltreatment and promote healthy wellbeing of children.

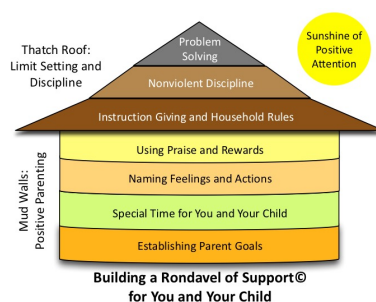
PROGRAMME CONTENT AND DELIVERY

BUILDING A RONDAVEL OF SUPPORT

The Sinovuyo programme uses the rondavel or traditional hut to demonstrate why it is important to build a strong, positive relationship with one's child. The mud walls symbolize positive and healthy parent-child interaction – spending special time with one's child, building language skills, talking about feelings, and praising and supporting good behaviour.

The mud walls make the foundation for good parenting. They are most important part of the programme.

As we move to the thatch roof, we focus on setting limits, establishing house rules, and dealing with problem behaviour. When parents spend more time building positive relationships with their children, they often need to do less punishing. The more time parents spend playing with and praising their children, their children will misbehave and seek negative attention less often. Parents and children feel supported and loved. Parents have less stress.



If the foundation of the rondavel is strong, the thatch roof will be easier to maintain.

If the walls are made poorly, out of bad, negative material, or if parents spend all their time worrying about the thatch roof (making rules, disciplining, and punishing their children) without building strong walls, the rondavel of support will fall down.

Children will feel disconnected and emotionally insecure and misbehave. Parents will feel stressed and unhappy. Finally, the “Sunshine of Positive Attention” symbolizes the importance for children to receive as much positive attention as possible from their parents.

CORE BUILDING BLOCKS

This programme uses culturally relevant approaches based on universal core principles, or “Building Blocks,” to build the Rondavel of Support found in evidence-based parenting programmes from around the world. The core Building Blocks include:

- Facilitators and parents working together for problem-solving
- Activities for parents to engage with their children that are at the right stage for the children
- Culturally sensitive ways of working together, including African storytelling, dance, and music
- The importance of child-led play and praise to develop nurturing relationships
- Establishing clear limits, house rules, and appropriate forms of supervision
- Alternative means of dealing with bad behaviour including ignoring, distracting, and redirecting
- How parents can look after themselves, care, and stress relief

There are also many building blocks throughout the programme that are connected to each session’s main theme. Although the programme includes some teaching of skills to help effective parenting, we mainly focus on *doing activities together* to learn through doing. We need to make sure that parents can practice their new skills and ways of doing things, because we remember things much better when we have done them ourselves.

OVERALL STRUCTURE

The Sinovuyo Caring Families Programme has the following components:

- Pre-programme home visits
- 12 group sessions on parenting skills
- Individualised in-home sessions for family requesting or needing additional support
- Final celebration or graduation ceremony at the end of the programme.

It is recommended that facilitators work in teams of two.

Each facilitator can support one another and also help with taking notes during the programme. It also helps share the client load when you are facilitating multiple groups. Before the beginning of the Sinovuyo programme, facilitators should do a pre-

programme home visit to get to know the parents' individual background and challenges (see below). During the programme, parent groups (10-15 participants per group) meet weekly to explore key themes of parent-child interaction, stress management, and relationship building. Each week, parents are given home practice activities that further their skills development with exercises to help reduce their stress to help them connect with their children. The facilitators also visit the homes of the participants to reinforce the activities learned during group sessions or follow-up with those who have missed a session. This is an opportunity for the staff to work one-on-one with caregivers and their children and provide additional support if necessary. Towards the end of the programme, the participants are given the opportunity to organise their own celebration to culminate the learning process. This celebration typically involves sharing experiences of the programme, singing traditional songs, traditional dancing, as well as storytelling. If parents want to, they can continue meeting in ongoing support groups to help each other as their children grow up! The support groups are also chances to address other issues facing the community including health care, school support and involvement, and government support.

SESSION CURRICULUM

The following is a brief overview of the twelve sessions in the programme. A more detailed description is provided in subsequent chapters.

Session 1: Building A Rondavel of Support In Your Family – Special Time For You And Your Child

Session 2: Special Time with Your Child – Say What You See

Session 3: Special Time with Your Child – Naming Feelings

Session 4: Praising Our Children

Session 5: Rewards (A Little Something Extra)

Session 6: Building A Roof On Our House: Giving Clear and Positive Instructions

Session 7: Keeping Our Children Safe' - Household Rules and Routines

Session 8: Ignoring Difficult Behaviours

Session 9: 5-Minute Cool Down Part One – A Structured Ignore for Aggressive Behaviour

Session 10: 5-Minute Cool Down Part Two – A Structured Ignore for Noncompliance

Session 11. Consequences and Problem Solving – Helping Our Children Develop Personal Responsibility

Session 12: Reflection and Moving On

DAILY SESSION STRUCTURE

Each session has a similar structure in which programme facilitators guide parents through a series of activities along a core central theme. While the content might vary from week to week, the core activities remain the same. We always start with welcoming activities, then move on to home practice discussion followed by introducing the core lesson. Each session ends with a new home practice assignment and closing ritual. At the beginning of each chapter, this manual provides an overview of the session to help facilitators remember these activities. We also provide a checklist with **core activities in bold** and supporting activities in normal font. This is to help facilitators prioritise the most important parts of the session. It is advised that facilitators try to complete all of the activities! But the most important thing is to make sure that the parents understand and can apply the core lesson of the session.

PRE-PROGRAMME HOME VISITS

It is important that the facilitators meet with each participant before beginning the programme. Pre-programme visits give parents the opportunity to learn more about the programme and ask any questions about their involvement. They also give you the chance to learn more about each parent who will be participating in the group. You may want to meet with the entire family, or at least the other adults in the household, to explain the Sinovuyo Caring Families Programme to everyone.

When a parent begins to change the way he or she interacts with the children in the household, it will also affect everyone else. Facilitators should bring a flyer of the Rondavel of Support to help explain the programme to everyone involved. You can also invite other members of the household to participate in the programme if they are interested. During the pre-programme home visits, facilitators should also ask as many questions as possible about the situation at home. How many children are in the household? Who else provides care for the children? What are some of the difficulties that the parent is facing with her or his child? Ask the parents to describe their expectations about the programme. Try to help them articulate specific goal for their children's behaviour.

Just like during Session One, these goals should be stated in a positive way.

For example, instead of saying, "I want my child to stop swearing at me," a parent should state the behaviour that she or he wants to see: "I want my child to talk respectfully to me." Finally, pre-programme home visits are opportunities to discuss any logistical matters with the parents about the time and place for the sessions, any transportation or childcare needs, or specific food requirements for the lunches during the programme.

After each pre-programme home visit, facilitators should create a participant profile.

These profiles will help you remember the individual situation each parent is experiencing. You can also update the profiles as the parent progresses through the programme. Make a note if there are any particular challenges or situations at home that might be important to remember when delivering the programme.

Suggested Structure for Home Visits:

- A. Introduce yourselves to the parent and the whole family if possible.
- B. Provide an overview of programme using the Rondavel of Support as an example.

(This can just be the basics like the programme will help you with your child's behaviour.)
- C. Discuss with the parent about life at home:
 - a. What is life like at home with your child?
 - b. What is your feeling about your child?
 - c. What are some difficulties that you are facing?
 - d. What are some of your child's strengths?
 - e. What are your goals, expectations, or hopes for you and your child from this programme? (Focus on the future and the positive behaviour.)
- D. Family background:
 - a. What is happening at home?
 - b. Who else lives there? Husband? Partner?
 - c. Who else cares for the child?
 - d. Does that person want to participate in the programme, too?
 - e. What kind of support network does the participant already have?
- E. Practicalities
 - a. Time and place of session
 - b. Transport and childcare needs (can they arrange someone to look after their child during the session?)
 - c. Food requirements
- F. Any other questions?

SINOVUYO PARENT HANDBOOK

There is a Sinovuyo Parent Handbook that goes with this facilitator manual. This handbook is for the parents to take home and use during the programme. We recommend that you distribute the handbook in weekly instalments so that the parents all progress through the programme at the same pace. At the end of each chapter of the handbook, there is a section where the parents report on whether or not they did their home practice. Facilitators explain to parents that they should put a check in the box if they do that activity each day. At the beginning of the next week, they will hand in their parent report. If they have completed all of their activities, you can give them a sticker or an extra biscuit or another simple and small reward!

Example of a Parent Home Practice Report

SESSION ONE PARENT REPORT

Name: _____

Child Name: _____

Please check the boxes if you completed your home practice on that day.

This will help you keep track on your progress during the week!

DID I...	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Spend 5 minutes Special Time with my child							
Tell my child the Strange Animal story							
Do the physical exercise in the morning							

SMS REMINDERS

Each week, we send out SMS reminders (texts) to the participants who have phones. These reminders reinforce key building blocks for the programme. They also help the parents remember to do their home practice and encourage them for trying. These reminders should be sent about midway between each session.

The SMS reminders are included at the end of each session in the manual.

GUIDE TO FACILITATING DAILY ACTIVITIES

WELCOMING ACTIVITIES

The welcoming activities establish a sense of regularity and consistency throughout the Sinovuyo programme. Each week, facilitators set up the room, welcome the parents, lead a song and physical exercise, and give parents the opportunity to check in on how they are feeling.

PREPARATION

It is very important for the facilitators to be well prepared. This shows respect for the participants and makes them feel welcome. For every session the facilitators should prepare as follows, working with your co-facilitator to do this:

- Re-read the session you will be giving and make sure you are absolutely clear on your goals for that session.
- Going through your reports from the last sessions, decide whether the programme needs adapting because of local needs.

-
- Allocate your time according to the needs of the group. Remember that you will have 2 and a half to 3 hours for the guardians, depending on local circumstances.

SETTING UP THE ROOM

Arrive early! Make sure you have plenty of time to set up the room and prepare yourself for each session. Facilitators should set up the room in a way that makes a comfortable environment to learn together as a group.

Chairs should be placed in a circle. Make sure there are enough chairs for everyone. A parent can feel rejected if she or he arrives and there isn't a chair for her or him.

Make sure you have all your materials necessary. These include:

- Tea, biscuits, milk, and plenty of sugar
- Bread and margarine for snack (or something else that is suitable)
- Flip chart, paper, and pens or markers, name tags
- Illustrated story posters
- Toys for group practices
- Blankets if it is cold or to help parents work on the ground
- Sheets of paper with parents' Building Blocks to refer to during discussion
- Parent handbook chapters for each participant
- Evaluation forms (weekly satisfaction surveys and facilitator checklists)
- Video camera if you are recording your session.
- Lunch if you are not getting an external cater to provide food
- Any other materials such as transportation vouchers, attendance registers, etc.

Be sure to check the manual each week to see if any extra materials are needed for the session!

WELCOME

Facilitators should welcome participants as they arrive and praise them for making the effort to attend each session. The warmth and kindness that you show a parent can make a huge difference on how he or she feels during the session. It also encourages parents to attend more frequently. If possible, it is also nice to provide some tea and a small snack (biscuits or simple sandwich) for those who arrive early to the session. In winter, this can also boost attendance and participation!

SONGS

Each session usually starts with a traditional children's song. Singing songs together at the beginning of a session can help create unity and openness necessary for further activities. Songs also help build a sense of community within the group. Everyone is coming from different backgrounds and experiences. It is also a traditional way of beginning meetings in many cultures.

PHYSICAL EXERCISES

We also begin each session with a short physical warm-up or exercise to help parents connect to their body and relieve stress or tension in the body and mind. When teaching the physical exercise with parents for the first time, we need to be patient and explain each movement clearly. Facilitators instruct parents in a series of movements moving through the body from head to toe.

It is okay to pause and gently correct postures and movements if necessary.

Many of the parents are not used to moving their bodies and may need encouragement and more guidance than you expect. If someone needs to sit down, one should encourage him or her to participate as best as they can from a sitting position. It is also very important to make sure the *movements are smooth* and the *breath is relaxed*.

As you lead the physical exercise each session, the parents will gradually become more comfortable with the movements. Facilitators should encourage parents to do the physical exercise at home on an ongoing basis. You can suggest that parents do it first thing in the morning.

EMOTIONAL CHECK-IN AND CHECK-OUT

After the song and physical exercise, facilitators lead the parents in an emotional check-in. This allows participants to simply share how they are feeling at the beginning of the session. At the end of each session, the parents will also have an opportunity to check-out as a way of transitioning back into the rest of their daily lives. Facilitators should model how to check-in or out by demonstrating before going around a circle:

1. Describe how you are feeling emotionally.
2. Describe where this feeling resonates in your body.
3. Describe the quality of that feeling or physical sensation in your body.

For example, “I am feeling happy. I feel this in my chest. It is an open and relaxed feeling.” Or, “I am feeling stressed. I feel this in my neck. It is a tightness.”

By connecting emotional feelings to physical sensations in the body, we help parents avoid getting caught up in the story about how or why they feel in a certain way.

This helps parents stay in the present moment.

Bringing awareness to one’s present experience can deepen one’s appreciation of the positive aspects in life and a sense of compassion towards one’s own challenges.

HOME PRACTICE

OVERVIEW OF HOME PRACTICE

Each week, participants are given activities to practice at home and strengthen what they have learned during the session. These activities are related to the core building blocks for each session.

This is an essential part of the programme!!!

Participants will only change their behaviour and attitudes if they practice changing them in their own lives.

Often parents will have difficulty doing the home practice.

They may face challenges or resistance from their children or other family members. They may also misunderstand a building block or do the parenting skills incorrectly. The job of the facilitators is to help guide the parents through group problem-solving to different solutions to challenges faced during the week. Facilitators should also use home practices to make sure everyone in the group understands a particular parenting principle or skill before moving on to the next one. You might find it necessary to spend an entire session problem-solving and doing group practices instead of introducing a new parenting principle. For example, if parents are struggling with understanding how to use Ignore with their children's negative attention seeking behaviour, you may want to repeat this session and redo all the illustrated stories.

It is important to go at your parents' pace!

Home practice discussions are also opportunities for parents to share successes and positive experiences during the previous week. They can also share changes that they have seen in their own lives or in their children's behaviour. Finally, facilitators should actively praise parents for trying and encourage those who have difficulties. Every parent will have both positive and negative experiences. Through praising the parents, you show them how to praise their children – praise them often!

It's our job to promote the positive while helping parents overcome their challenges!

HOW TO LEAD HOME PRACTICE DISCUSSION

After the welcoming activities, facilitators ask the parents to share their experiences doing the home practice with the group. Each session has a series of questions to help guide facilitators in exploring the home practice discussions. Ask the parents to focus on the core activity from the previous week. They should share one activity that they did and one thing that worked well for them. Parents can also describe one key idea from the last session that they used. Facilitators can help parents explore the challenges and difficulties they encountered with the home practice. It is also an opportunity for parents to share success stories with each other. Facilitators explore solutions with parents to difficulties in doing the home practice. Encourage parents to offer their own solutions as a group to overcome challenges.

Role-play these solutions as part of a Group Practice.

In summary, home practice discussions should follow these steps that are central to all problem-solving activities:

- Parents share experience
- Clarify that you understand exactly what happened
- Brainstorm solutions with parents
- Choose a strategy to use from solutions
- Practice applying the strategy in role-play
- Evaluate how it worked

Take notes!

One facilitator should lead the home practice discussion while another takes notes as to what each parent did during the week. This will allow you to reflect after the session about whether a parent needs extra help or maybe even a home visit to support his or her learning. The note-taker should also be ready to write down any new building blocks that come up during the home practice discussion.

INTRODUCING HOME PRACTICE

Every parent should have a chance to share his/her goal for home practice.

At the end of each session, facilitators introduce the next week's home practice to the parents. Set ***practical goals*** with parents about when, where, and what they will be doing with their children. Facilitators help each participant to identify specific and realistic goals for home practice, as well as troubleshoot when and how the practice will be accomplished.

It may be helpful to use the S.M.A.R.T. model to assure that the goals are practical:

Specific: Is the goal for home practice is specific as to what, where, when, who, and how (i.e. – I will spend 5 minutes a day with my before we prepare dinner).

Measurable: How will the participant know that she or he has accomplished the goal for home practice?

Attainable: Can the participant realistically do the home practice?

Relevant: Is the activity connected to the participant's goals and the specific home practice?

Timebound: When will the home practice be achieved?

Facilitators should make sure each participant goes home with a S.M.A.R.T home practice!

TEA BREAK

After Home Practice Discussion, we normally take a short tea break. This should be no more than 10 to 15 minutes. It is important to remember to boil the water before break so it is ready when you are! Facilitators should give the parents a 5-minute transition warning before the end of tea break to prepare them for the next part of the session.

ENERGIZER

After Tea Break, facilitators can lead a brief energizing activity with the parents. The energiser helps keep the parents alert and alive in their bodies, ready for the next part of the programme. This activity can be a quick game that the parents all know from their childhood. It can also be any of the suggested games in the manual.

CORE LESSON

Every session of the Sinovuyo programme contains a Core Lesson that follows the theme of the session. The Core Lesson focuses on a specific parenting principle or set of building blocks that construct the Rondavel of Support.

Facilitators should prioritize time for the Core Lesson.

It is important that you can work through each illustrated story and group practice with enough time to problem-solve any challenges in understanding the new concepts. Core Lessons begin with a group brainstorm for the specific parenting skill of the week. We make sure that we allow parents to come up with their own reasons for why a specific skill or approach would be helpful. Then we move on to examine illustrated stories that show families experiencing these skills either successfully or unsuccessfully. Finally, Core Lessons end with group practices to strengthen parents' understanding and capacity to do these skills at home.

STORIES

Sometimes, the Sinovuyo programme uses a traditional or adapted story to introduce the central theme in the core lesson. Storytelling is an ancient tradition that also connects participants to our heritage and ancestors imparting lessons, histories, and customs. There is a wonderful power of connection that occurs when telling and listening to stories. It creates a sense of community and family by bringing everyone together. They are helpful for facilitators to introduce different themes and to encourage participants to participate in discussions. It is very important to reflect on the story afterward with some guided questions provided.

GROUP BRAINSTORM

Group brainstorms are to help parents come up with their own reasons for using a specific parenting principle or approach. For instance, in Session One, we ask parents why adults should spend special time with their children. It can be tempting for facilitators to tell parents all the benefits of special time or praise or cool down. However, it is better that the parents discover it for themselves. They will “own” the reasons and feel empowered to use them with their children.

Ask open-ended questions.

As collaborators, our role is to guide parents by asking open-ended questions. These are questions that begin with “Why” or “How” or “What”? It allows for discussion of ideas and sharing of experiences. Facilitators can also follow-up with questions such as “Is that so?” or “Tell me more” to encourage parents to share more. If you ask questions that have a “Yes” or “No” answer, it usually ends discussion quickly. It is okay for parents to disagree. Our job is to guide them towards the benefits of positive parenting and setting limits without telling them how to get there.

We are like conductors of a big band or choir. We know the score but the parents need to play the music!

Introducing Building Blocks

During the group brainstorm (and at anytime during the programme), facilitators write down parents’ ideas to reinforce the collaborative process of learning. These are called ***Building Blocks*** to help build our Rondavel of Support. It is important that these Building Blocks come from the parents’ own suggestions instead of the facilitators.

Facilitators should label the Building Block with the specific parent’s name who suggested it. For example: “Nombuso’s Special Time makes children feel loved.”

Facilitators also can use “when” to identify the building blocks. For example, “when we praise our children for a specific behaviour, they will behave that way more often.”

Building Blocks can be identified at any time: during home practice discussion, brainstorms, illustrated story discussions, group practices.

Any time you hear a parent say a building block, praise them, and repeat the building block to emphasise it.

Facilitators need to be on alert whenever a parent stumbles upon a building block!

GROUP PRACTICES

Group Practices, or role-plays, give parents the chance to practice a new parenting skill in the safe environment of the group before trying it at home with their children. During Group Practices, parents have the opportunity to play “parents” and “children.”

This helps parents see the world through their child’s eyes.

Sometimes, a facilitator will demonstrate the group practice first. If you do this, you should play a “parent,” demonstrate a ***poor example of parenting first***. We do not want parents to think that the facilitators are magical super parents. By showing poor parenting behaviour first, parents can see how the parenting can only get better. They can also give suggestions for how the parent can improve.

Format for leading Group Practices:

1. Introduce that we are now going to practice spending special time with our child as a group.
2. Facilitators model poor parenting behaviour by showing a “parent” doing something wrong.
3. One facilitator acts as “Parent”.
4. Ask a participant to act as a “Child”. Choose this person in advance. Tell “Child” not to behave poorly.
5. Ask “Child” what her experience was like.
6. Group discussion on how one could do better.
7. Facilitator writes down Building Blocks based on parents’ suggestions.
8. Ask another participant to take the place of the “Parent” with original parent as “Child”.
9. New “Parent” uses one of the group’s solutions.
10. Facilitator stays physically close to the “Parent” to give support if necessary.
11. Allow the role-play to happen for about 2 minutes – *not too long*.
12. Ask Parent/Child about what the new scenario felt like.
13. **Practice in Groups:** parents practice *positive behaviour only* in small groups.
14. Facilitators walk around room helping parents out.
15. Group discussion on how the group practice went.

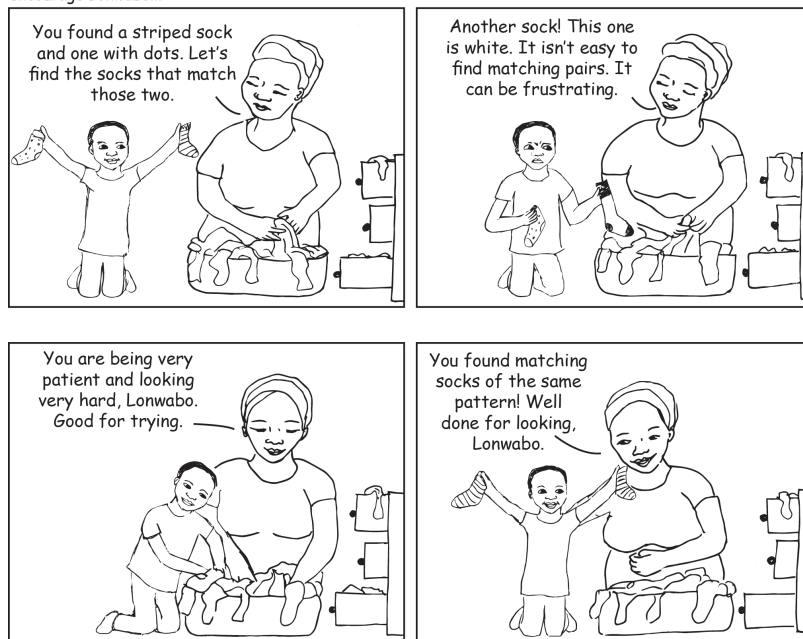
ILLUSTRATED STORIES

During the Sinovuyo programme we use illustrated stories to help parents understand how to problem-solve about specific parenting challenges. The Sinovuyo programme follows the lives of two families. These families have parents who are struggling to manage their children’s behaviour, much like the parents in the group. One family lives in a township or informal settlement near a city. There is a grandmother, a mother, and two children: Thabo (8 years old) and Nosipho (5 years old). The other family lives in a rural village. There is a father, a mother, and two children: Lindiwe (6 years old) and Lonwabo (4 years old). Like storytelling, the illustrated stories give parents the opportunity to learn about parenting through the lives of other families. These families might sometimes remind them of their own families. Sometimes they might have problems that they do not share.

All of them have to deal with challenging behaviour of their children.

The stories also have important building blocks that connect to the Core Lesson and help build the Rondavel of Support. They also help parents develop problem-solving techniques that they can use in their daily lives.

Here his mother tries a different approach to encourage Lonwabo...



Example of an Illustrate Story about praise from Session Three

Format for introducing an illustrated story:

1. Look at the story together and have parents explain story.
2. Go slowly through the story, panel by panel.
3. Some parents might have difficulty reading so you need to take your time.
4. Allow the parents to describe actions, behaviour, and emotions in each panel.
5. Use guided questions to explore story with parents.
6. Brainstorm possible solutions.
7. Group practice **one** solution in a role-play.
8. Check in with “child” and “parent.” Ask how each felt during the practice.

For illustrated stories, parents can try them out in group practice after discussing the story. If they are negative stories, the parents can practice the same scenario by using suggested solutions for a better way.

CLOSING

Each session ends with a closing activity. Facilitators should allow participants to decide how they would like to end the session. Sometimes parents will want to pray together or sing a song. No matter how your parent group decides to close the session, facilitators should make sure the following happens.

- Remind parents of the home practice.
- Distribute the Sinovuyo Parent Handbook chapter for the week.
- Ask parents to fill out weekly satisfaction surveys.
- Thank parents for coming and for giving their best effort.
- Check out

LUNCHTIME

After each session, we recommend that you provide participants with a nutritious meal. Parents often come from far away to participate in the programme. Many also do not have sufficient food at home to provide for everyone. Sometimes, the lunch during the programme is their only full meal each day. Lunchtime also gives an incentive for participants to attend each session. Try to keep the menu varied and nutritious. It is important to respect local customs when serving food. Some communities like to pray before eating together.

FACILITATOR REFLECTION AFTER EACH SESSION

It is important that facilitators make time to reflect on the session as soon as it is over. It is best to do this while your memory is still fresh. You can even do this while the parents are enjoying lunch. In the manual, there are some suggested questions that will help guide you in your reflection. Core questions to think about include:

- Did you manage to complete all the core activities? If not, why?
- What went well during the session?
- What could be improved upon?
- Are there any parents that need extra support? If so, in what way?

When filling out reports or reflecting about the session, discuss *why* things went well or didn't go well, not just what went well and didn't. If you can remember a particular part of the programme where you had difficulty, write it down so that it can be discussed during supervision. Facilitators should also complete any monitoring and evaluation forms regarding programme fidelity (facilitator checklists), participant engagement, and feedback.

It is important to name at least one good thing that you did and that your partner did during the session.

REVIEWING PARENT PROGRESS

We also recommend that you have a conversation about each participant directly after each session. Make notes in your participant profile folder about each parent's progress in the programme. You may decide that a particular parent needs more support. This could be in the form of a home visit or an individual conversation before or after a session. You can also use this time to call any parents who missed the session to arrange a home visit. When you review each parent's experiences, goals, and challenges, it will help you give him or her that individual attention that is so important for group-based programmes!

FACILITATOR BUILDING BLOCKS

This manual will guide you on what to do each week. It describes the activities in detail. It provides possible questions that you can ask for discussions and illustrated stories. It gives you a background on each parenting principle and lists building blocks that are important for parents to learn. However, the content of the programme is less than 25% of what it takes to deliver the Sinovuyo Caring Families Programme.

More than 75% of the benefit your parents will receive is in the delivery.

In other words, how you facilitate the programme is just as important if not more important than the content you deliver.

There are 6 core building blocks to facilitating the Sinovuyo Caring Families Programme in the best possible way:

1. Use a collaborative approach of learning.
2. Model the behaviour you want to see.
3. Go at your parents' pace.
4. Practice active listening.
5. Make Sinovuyo a happy place to learn.
6. Come prepared to each session.

USE A COLLABORATIVE APPROACH OF LEARNING

In many other programmes, facilitators tell participants what to do and why it is important. Parents are used to this because our education system is delivered in a didactic, teacher-knows-best manner. In the Sinovuyo programme, we do things differently. We like to think of this as a collaborative approach to learning. As facilitators, we are ***collaborators or partners*** working with parents to identify plans and practice solutions that will help each other improve life at home.

It is helpful to think of the parents as the experts.

Many of the parents will already be practicing lots of positive ways of parenting with their children. Others will be able to identify ways of improving their parenting on their own with guidance.

Our job is to help parents learn for themselves how to achieve their goals.

This sometimes means we have to work harder to ask the right sort of open-ended questions that will help parents understand the benefits of positive parenting and nonviolent discipline for their children.

When parents are able to teach themselves, they learn a skill that will help them for a long time after the programme ends.

MODEL THE BEHAVIOUR YOU WANT TO SEE

The modelling principle is at the foundation of how we deliver the Sinovuyo programme. If we lead sessions in a collaborative approach, praise parents often, practice active listening, and use positive instructions, parents will do the same with their children. Likewise, if we tell parents what to do, criticise or laugh at them, ignore their needs or concerns, or only say what we do not want them to do, they will do the same.

It is like the old saying, “practice what you preach.”

Facilitators need to model all the different building blocks in this programme:

- “Praise and Go,” means exactly that. Praise your parents and then stop there. No buts, ifs, or any other criticisms!
- Use transition warnings to help prepare parents for next activities or at the end of teatime.
- Give positive, specific instructions that say the behaviour you want to see in the parents.
- Ignore negative attention seeking behaviour, such as snide or obnoxious comments, but praise the same parent for the next positive behaviour.
- Use simple rewards to encourage parents to arrive on time for sessions, to complete their home practice, and when they accomplish something very challenging.
- Practice the relaxation activities to help reduce your own stress.
- Parents will learn from your example and begin to mirror your behaviour, too.

GO AT YOUR PARENTS’ PACE

The Sinovuyo Caring Families Programme introduces many concepts and practices that are completely new to parents. Sometimes, parents will initially resist learning a new approach with their children. Other times, they will have difficulty understanding some of the more complex practices like Say What You See or the 5-Minute Cool Down. Facilitators should always go at their parents’ pace when delivering the programme. Make sure that the parents in your group have learned a specific parenting skill before moving on to the next one.

Remember that building a Rondavel of Support is a step-by-step process.

If your parents haven’t mastered giving Positive and Specific Instructions, you cannot move on to Household Rules. Likewise, parents must understand how to use Ignore for negative attention seeking behaviours before they learn how to use the 5-Minute Cool Down for aggressive, destructive, and dangerous behaviours. This may mean that you repeat a session or take extra time problem-solving issues that come up during home practice discussion. If only a few parents are having difficulties, it may also mean that you have to schedule additional home visits for individuals.

It is more important that the parents can do a parenting skill accurately and correctly than that they get through the entire programme.

PRACTICE ACTIVE LISTENING

Active Listening is a core building block in the collaborative approach to facilitating the Sinovuyo programme. It is also important to model Active Listening so that parents begin to do the same with their own children. Isn't it wonderful how all of these Building Blocks fit together! ***We like to think of 4 key steps facilitating a discussion with the parents: Acceptance, Exploration, Connection, and Be Physical.***

1. Acceptance

Participants feel empowered to share when Facilitators ***accept*** whatever is said during a reflection. There is no wrong answer. Facilitators can show that they have really heard the participant by ***reflecting back*** or ***rewording*** what she/he says to the entire group.

This also clarifies that the Facilitators understand what is being shared.

2. Exploration

Take time to ***explore*** the experience fully with the participant. Sometimes we need to ask questions and really hear the details about something to understand it properly. Facilitators can bring a sense of ***curiosity*** to this part of discussion to explore where, what, who, and how of the emotional/physical/mental experience. ***Do not be afraid to go deeply into the experience!***

3. Connection

Facilitators ***connect*** the experience to the programme Building Blocks that help build our Rondavel of Support. In discussion with participants, the group may make their own connections on how a certain experience might ***inform*** other parts of their lives.

4. Be Physical

Active listening can also be physical.

The way you behave physically also shows that you are actively listening to someone. Facilitators should sit upright or even lean slightly forward to indicate that they are paying attention to the speaker. You can also make eye contact from time to time if appropriate given the cultural context. Nodding your head and smiling also is very helpful.

Stay focused on the person who is speaking. There may be other distractions in the room like a clock, or your facilitating partner, or someone else fidgeting, or even noises outside the room. As long as you keep your focus on the person speaking, he or she will feel heard.

Be patient. When people pause while talking, allow them time to come up with their own thoughts before asking if others have any ideas to contribute.

MAKE SINOVUYO A HAPPY PLACE TO LEARN

Parents will want to come to the sessions and participate in the activities if you create an environment that is welcoming, open, and respectful. Everyone likes a place that is warm and inviting. It can be helpful to think of the Sinovuyo programme as a family itself. The name means, “We are creating happiness,” in isiXhosa after all!

Tips for facilitators to make Sinovuyo a happy place to learn:

1. Invite parents to participate: Notice when someone is holding back and ask if he or she wishes to share an opinion or experience.
2. Make sure that everyone in the room can hear you (and each other).
3. Sit when you are talking: Be on the same level as the parents and sit among them.
4. Create a comfortable and welcoming place to meet.
5. Make sure there are enough chairs, the room is clean, use a fan in summer and a heater in the winter, etc. Even decorate the room if you want!
6. Establish language needs of the participants.
7. Notice if participants have physical challenges or disabilities that may require adjusting the way they participate in activities.
8. Respect whatever a parent shares
9. Try not to laugh even if it sounds ridiculous. Everything is an opportunity to learn a new building block.
10. Praise parents for their effort and dedication.
11. Model the behaviour you want from the parents.
12. Praise, respect, and reflect on parents’ contributions.

COME PREPARED TO EACH SESSION

The more you prepare for each session, the easier time you will have in delivering the material. You will feel more relaxed and be more receptive to the parents' experiences.

Read through the manual the night before each session. Write down any notes or reminders that might be helpful for particular activities. Sometimes, the parents will not initially understand what you are asking them if you say the exact words in the manual. It can be helpful to write different ways of asking the brainstorming questions. We like to think about this as "redialling a question." If you don't understand something or forget how to do an activity, ask your facilitating partner. You can also talk to your supervisor or mentor prior to the session.

Practice the songs, stories, energisers, and relaxation exercises. You can even try them out with your friends or families. They are fun and helpful for everyone!

Look through your participant profiles to review each parent's progress in the programme and to remember any special needs or concerns. This is particularly important for home practice discussions.

Arrive early so that you can prepare the space. You want to be relaxed, smiling, and ready to go when the parents arrive so it is important to give yourself plenty of time.

Decide who is going to be leading which specific activity and who is going to be giving support. Make sure you share responsibilities with each other and support each other collaboratively. Use a watch or clock to keep on time and within the amount of time that you have for each session.

Remember that this manual is just a guide. While it is very important that you follow the programme as it was designed, it is equally important that you find ways to make it your own Sinovuyo Caring Families Programme.

Lastly, remember to have fun!

APPENDIX C. ETHICS AND PROTOCOLS

Appendix C.1. University of Oxford CUREC2 Application

Section 1: Project Title, Researchers, and Contact Details

1. Person to whom IDREC/CUREC should direct correspondence.

*Principal investigator/supervisor/student researcher	
Title and name:	Professor Lucie Cluver
Appointment:	University lecturer
Department:	Department of Social Policy and Intervention
Institution:	University of Oxford
Address:	Department of Social Policy and Intervention Barnett House 32 Wellington Square Oxford, OX1 2ER
Phone:	+44 1865 270325
Fax:	+44 1865 270324
Email:	lucie.cluver@spi.ox.ac.uk
Will you need training to participate in this project?	
☐ Yes ☒ No	

2. Full project title and proposed starting date:

Title: PACCASA (Preventing Abuse of Children in the Context of AIDS in sub-Saharan Africa)
Starting Date: 30 August 2011

Office use only:	IDREC Ref. No. _____
Date of Approval: / /	
Application date: / /	
Approval Period: from / / to / /	
Signature of IDREC approver: _____	
Name (printed) and position of approver: _____	
Date applicant informed of approval: / /	

3. Are you submitting this project to another ethics committee or has it been previously submitted to an ethics committee?

- ☒ Yes - provide details.
☐ No

- University of Cape Town Research Ethics Committee
- University of Witwatersrand Public Health Research Ethics Committee
- Provincial Health Research Ethics Committees if established in Eastern Cape, Gauteng, KwaZulu-Natal (not yet in operation)

We have discussed this application with all the committees 1-3 mentioned above, and with the Director of Health RECs at the National Department of Health, and all have requested that we submit to them subsequent to obtaining approval from Oxford University.

4. Have you made use of professional/CUREC guidelines in framing your research project and preparing documentation?

- ☒ Yes - provide details.
☐ No – explain why not.

We have made sure to use the CUREC guidelines in framing our research project and preparing documentation with regards to recruitment, training and administration of the intervention and assessment, responding to participants experiencing acute distress, and recording details and making referrals in case of serious incidents.

The consent forms we provide clarify the purposes of this study, in addition to the nature of the research to be conducted and explicit statements regarding participants' rights to opt-out at any point.

Given that this study is taking place in South Africa, we have also used a number of other sources for guidelines, such as South African legislation including the Children's Act and national HIV/AIDS guidelines.

5. Researchers involved in this project

Title and name:	Professor Frances Gardner
Appointment:	Professor
Department:	Social Policy and Intervention
Institution:	University of Oxford
Address:	Department of Social Policy and Intervention 32 Wellington Square, Oxford OX1 2ER
Phone:	+44 (0) 1865 270334

Email:	frances.gardner@spi.ox.ac.uk
Role in this project:	co-Principal Investigator (PI)
Qualifications and relevant experience for this project:	DPhil; MPhil Clinical Psychology; previous implementation of randomised controlled trials in parenting interventions and researching impact of AIDS in South Africa
Will this researcher need training to participate in this project?	☐ Yes ☒ No

Title and name:	Dr Judy Hutchings
Appointment:	Professor of Clinical Psychology
Department:	School of Psychology
Institution:	University of Wales, Bangor
Address:	Nantlle Building Normal Site, Bangor, Gwynedd LL57 2PX,
Phone	+44 (0) 1248 383758
Email:	j.hutchings@bangor.ac.uk
Role in this project:	co-PI
Qualifications and relevant experience for this project:	MSc, DClinPsych Clinical Psychology; previous implementation of randomised controlled trials in adaptations of parenting interventions
Will this researcher need training to participate in this project?	☐ Yes ☒ No

*Associate researcher/student researcher	
Title and name:	Dr Mark Boyes
Appointment:	Postdoctoral Fellow
Department:	Social Policy and Intervention
Institution:	University of Oxford
Address:	Department of Social Policy and Intervention 32 Wellington Square, Oxford OX1 2ER
Phone:	+44 (0) 1865 270334
Email:	mark.boyes@socres.ox.ac.uk
Role in this project:	Research officer
Qualifications and relevant experience for this project:	PhD Clinical Psychology; previous experience with researching AIDS-affected families in South Africa
Will this researcher need training to participate in this project?	☐ Yes ☒ No

*Associate researcher/student researcher	
Title and name:	Caroline Kuo
Appointment:	Postdoctoral Fellow in Child/Adolescent Bio-behavioural HIV Research
Department:	Psychiatry
Institution:	Rhode Island Hospital / Brown University
Address:	12 South Main St. Box G-S121 4 th Floor Providence, RI USA 029030, Phone: +1 401 863 6630
Email:	caroline_kuo@brown.edu
Role in this project:	Consultant researcher
Qualifications and relevant experience for this project:	Previous experience with researching

AIDS-affected families in South Africa
Will this researcher need training to participate in this project? ☐ Yes ☒ No

*Associate researcher/student researcher	
Title and name:	Professor Mark Orkin
Appointment:	Professor
Department:	Public Management
Institution:	Central University of Technology
Address:	Room 218, ZR Mahabane Building Central University of Technology, Bloemfontein, South Africa, 9301,
Phone:	+27 (0) 83 310 3100
Email:	morkin@mweb.co.za
Role in this project:	Statistical consultant
Qualifications and relevant experience for this project:	Extensive experience in statistical analysis in South Africa, former Chief Statistician of South Africa
Will this researcher need training to participate in this project? ☐ Yes ☒ No	

*Associate researcher/student researcher	
Title and name:	Jamie Lachman
Appointment:	DPhil Candidate, Social Intervention
Department:	Social Policy and Intervention
Institution:	University of Oxford
Address:	Barnett House, 32 Wellington Square Oxford, OX1 2ER
Phone:	+44 (0) 1865 27032 Fax: +44 (0) 1865 270324
Email:	jamie.lachman@spi.ox.ac.uk
Role in this project:	Student researcher
Qualifications and relevant experience for this project:	Previous experience with researching AIDS-affected families in South Africa
Degree course (if relevant):	DPhil
Will this researcher be approved by the principal researcher as competent to obtain *informed consent from participants? YES	
Will this researcher need training to participate in this project? ☐ Yes ☒ No	

Section 2: Project Description

6. Description of project

Please give a description (300-800 words) of your project to supplement the information already provided in Section A of the checklist (CUREC/1), detailing those aspects of the project which involve *human participants, particularly any aspect which is beyond already established and accepted techniques. Please attach all other documents (e.g. questionnaire, recruitment advertisements, participant information, and consent forms) that you plan to use in the study. **Please note that detailed scientific background is not required unless directly relevant to ethical issues.**

The Centre for Evidence-Based Intervention and Centre for AIDS Interdisciplinary Research at Oxford University, in collaboration with the Government of South Africa (Directorate of HIV/AIDS at the Ministry of Social Development, the Sector of Maternal and Child Health at the Department of Health, and the Department of Basic Education) have identified a need for evidence-based research on psychosocial interventions for AIDS-affected families in South Africa.

The study has been devised with the input of the South African government departments (above) and with the National Action Committee for Children Affected by AIDS (NACCA). We have also consulted extensively with local and international NGOs, service providers such as social workers, nurses and medical personnel, and with HIV-affected groups of children and caregivers.

In sub-Saharan Africa, there are 12 million AIDS-orphaned children, and an estimated 50 million living with AIDS-affected caregivers (UNAIDS, 2010). New evidence shows that AIDS-affected children are at around three-times greater risk for physical and emotional abuse, domestic violence (Dunkle et al., 2004) and new analyses show higher levels of intentional neglect and exposure to domestic violence (Cluver, Orkin, Boyes, et al., 2011). Furthermore, lack of coherent ‘succession planning’ for child care arrangements and inheritance after parental death has resulted in high levels of abuse by relatives or foster carers (National Action Plan for Children Affected by HIV/AIDS, 2009).

However, to date, there are no known evidence-based child abuse prevention interventions for children in sub-Saharan Africa, or any for the specific needs of AIDS-affected children (King, De Silva, Stein, & Patel, 2009). The only systematic review of interventions to reduce violence against children in the developing world (Knerr et al., 2013), found i) a number of randomised trials of parenting interventions in developing countries, suggesting promising effects in this context; ii) however, none of the interventions were focused on harsh or abusive parenting; and iii) although many trials involved programmes transported from ‘Western’ settings, none had been previously tested in a randomised trial. A recent Cochrane review found parenting interventions in the developed world, such as Webster-Stratton’s ‘Incredible Years’ programme, most effective in reducing ongoing maltreatment amongst US families in child protection services (Barlow et al., 2006; Webster-Stratton & Reid, 2010). Also in the USA, early parenting support reduced maltreatment referrals in a high-risk population, maintaining positive effects over 15 years (Olds et al., 1997). Furthermore, a recent trial in South Carolina of an Australian parenting programme, Triple P, demonstrated reduction of violence against children when used as a universal prevention measure (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009), largely in low-income, multi-ethnic communities.

These studies demonstrate the importance of ensuring that interventions to prevent violence against children strengthen the child-caregiver relationship, a view echoed by many prominent organisations and commentators (United Nations Office on Drugs and Crime, 2009; WHO, 2008, 2010; World Health Organization, 2001). In the developing world, any sustainable intervention must also be low-cost and community-based. Furthermore, given the context of severely understaffed social services, it must be capable of being implemented by lay community health workers with sufficient fidelity to ensure effectiveness (Burgoyne & Saunders, 2000; Campbell, Nair, & Maimane, 2007; Friedman,

Kippax, Phaswana-Mafuya, Rossi, & Newman, 2006; Lehmann & Toppich, 2009; Phiri & Tolfree, 2005; Schneider & Lehmann, 2010). Finally, it is essential that core components of evidence-based parenting programmes focused on the prevention of child maltreatment are adapted both for the African context, and for the specific needs of AIDS-affected families.

There are currently no violence prevention (or indeed other) interventions for this large, high-risk population. Therefore, this proposal is to evaluate an innovative intervention, informed by evidence-based parenting principles, which is in the process of development through a collaboration between the South African government, UNICEF, national and local NGOs and communities, with the advice of researchers in child abuse prevention and AIDS-affected families. In order to ensure scalability and inclusion into national policy, it is essential that the development process includes government and major funders, as well as implementing NGOs who will roll out the intervention. Intervention development is currently under way, funded by a John Fell Fund grant (ref 103/757), and will be completed in January 2012.

This proposed study will adapt, develop, and evaluate a family-based psychosocial intervention for AIDS-affected children and their caregivers in sub-Saharan Africa. Developed in collaboration with NGOs, governments, and communities, it uses the latest available evidence demonstrating effectiveness of family-based parenting programmes. The program will be implemented and tested in South Africa by three NGO partners, all of which provide community-based support for AIDS-affected families: The National Association of Child Care Workers (a national NGO), Clowns Without Borders South Africa (a smaller NGO with sub-Saharan African reach through South Africa, Swaziland and Lesotho) and either Petals Daycare (a small community NGO in Matatiele, Eastern Cape) or Ikamva Labantu (a community NGO based in Cape Town).

The study will include four phases in either the Western Cape or Eastern Cape province of South Africa. The exact location (province and area within South Africa) for this study is still under negotiation with the South African government. We will inform IDREC once this is established.

Community collaboration

The study will be discussed, and regular research feedback given at community meetings, with local ward councillors, chiefs and religious leaders, all groups that have strongly supported our prior research in these communities.

Phase 1: Development

Phase 1 will involve qualitative study with individual interviews and focus groups ($n = 8$ semi-structured focus group sessions) to examine issues of cultural adaptation of intervention components, participant recruitment/retention, intervention structure, outcome measurements, and any relevant challenges that might occur. Participants ($n = 10$ per group) will be selected from AIDS-affected caregivers (ages 18 and up) and children (ages 8-17) who have previously participated in the Injabulo Intervention Programme as well as other parenting programmes in South Africa (Dlalanathi's Thandanani Time (www.dlalanathi.org.za) and the Salesian Institute's Life Choices programme (<http://www.salesians.org.za/lifechoices.html>)). Focus group sessions will also be conducted

with a Teen Advisory Group ($n = 14$ youth ages 13-20) that has participated in previous studies as well as a Caregiver Advisory Group consisting of AIDS-affected caregivers ($n = 10$ caregivers ages 18-65). These advisory groups will be active participants in the development phase but not involved in the evaluation study. Additional individual interviews will be conducted with community organisation managers, community health workers, and local government. Phase 1 will also involve the development of an intervention manual, which will be translated to and back-translated from the local language (isiXhosa or isiZulu).

Phase 2: Pilot Study ($n = 60$ dyads; 60 children ages 3-17, 60 adult caregivers over 18 years)

Phase 2 will involve a small-scale pilot randomised controlled trial of the adapted intervention. The pilot will establish appropriate effect sizes, inclusion and exclusion criteria, adherence, and recruitment and retention rates. Self-report scales will examine primary outcomes of child maltreatment and abuse. Secondary outcomes of child and caregiver mental and physical health, educational attendance, social support, parenting behaviour, and parent-child interaction will also be assessed. The pilot study will also examine issues of external validity by assessing implementation process and fidelity. Research will identify and address potential problems with acceptability, compliance, and delivery, and measurement protocols. Reports on the pilot will be disseminated in publications, and with stakeholders. Data for will be collected at pre-intervention, immediate post-test, and 6-months post intervention.

Randomisation will include a wait-list, the control group, which will receive the intervention at 12-months after the intervention but only if proven to be beneficial for participants. Randomisation procedure will use SealedEnvelopeTM, through the COHORT Statements (Altman et al., 2001), ensuring unbiased randomisation through correct sequence generation and allocation concealment.

Phase 3: Multi-site Cluster Randomised Controlled Trial (60 clusters, 30 per arm; $n = 1\ 200$ dyads, 1 200 children ages 3-17, 1 200 caregivers over 18 years)

The evaluation will use a cluster randomised controlled trial design with wait-list control families, within the UK Medical Research Council Framework for Complex Interventions (Craig et al., 2008). Stage 1 will pilot-test the intervention with qualitative focus-group evaluation, to indicate intervention and trial acceptability and accessibility ($n = 10$ focus groups). Stage 2 will randomly allocate 20 townships comprising 1 200 caregivers to intervention and wait-list control. Randomised controlled trials have now been used extensively in sub-Saharan Africa (Isaakidis & Ioannidis, 2003). Pre-test baseline sibling (where appropriate) and caregiver report will be collected, with follow-up at post-test and 6 months post-intervention. It is important to study effectiveness (whether the intervention works in real-world conditions) rather than efficacy (whether it works in ideal conditions) if we are to produce a reliable evidence base for sustainable interventions in the developing world.

Primary research questions will be the effectiveness of the intervention in: abuse outcomes
i) reducing reported physical, emotional and sexual abuse and intentional neglect of children; ii) improvements in positive parenting and parental praise; iii) improvement in

supervision of children; HIV-related outcomes iv) improved ‘succession planning’ for custody of children facing caregiver bereavement; v) increased planned disclosure of HIV-status to children; and child development outcomes vi) improved child mental health and educational attendance. The research will also test hypothesised linking factors to primary outcomes of vii) improved social support for caregivers and viii) improved caregiver mental health as well as ix) intervention attendance rates as a measure of engagement.

Assessments will include standardised questionnaires regarding physical health, mental health, and social outcomes for children and adults. These questionnaires will be shortened versions of the questionnaires used with ethical approval in the Young Carers Study and Orphan Resilience Study. Questionnaires will be administered using mobile phone format. Assessment on programme fidelity and acceptability will be conducted by video documentation, participant feedback forms, and focus group sessions.

We are aware of the stigma surrounding HIV/AIDS in sub-Saharan Africa, and are therefore using a validated Verbal Autopsy (VA) (Lopman et al., 2006). Though many children in our previous study were willing to disclose a parent’s AIDS-illness, we want to ensure that there is no unintentional disclosure. This will also allow us to identify AIDS-illness when parents have declined to disclose status to their children for fear of stigma or upsetting them. Under no circumstances will we disclose possible AIDS-morbidity or mortality to the child or anyone else.

Participants

Participants will be recruited into the study based on: (a) convenience sampling in high HIV-prevalence settings for focus groups; and (b) systematic household sampling for experimental trials. Researchers will work closely with the Department of Social Development and local community-based NGOs to identify and recruit affected families.

Children will be 3-17 years old at baseline. Random selection will identify one eligible child per household, in order to maintain representativeness of households while maintaining feasibility and reducing cost (Pettifor et al., 2003);

Caregivers will be 18 years and over, but in light of complex care arrangements for AIDS-affected children, we do not place restrictions on whether primary caregivers are biologically related to children. For ethical and intervention-based reasons, we would exclude study volunteers unless both the child and his/her adult primary caregiver agree to participate and meet the criteria.

Inclusion criteria for children include: 1) Age 3-17 at initial assessment; 2) Lives in the house at least four nights per week; 3) Has an adult primary caregiver who lives in the household, who provides consent, and who participates in the study; 4) Provides consent to participate in the full study including intervention and completing assessments. Inclusion criteria for adults include: 1) Age 18 or older 2) Serves as the primary caregiver of the child participant 3) Lives in the house at least four nights per week. 3) Provides consent to participate in the full study including intervention and completing baseline, immediate post-test, and 12-month follow-up assessments. Samples of participant information and consent forms are attached to this application for both children and adult caregivers. Once approved,

these information and consent forms will be translated into relevant local languages.

Phase 4: Dissemination

The research will analyse data, produce peer-reviewed publications and actively disseminate findings to policy-makers, NGOs, and communities within South Africa. Intervention effects at immediate post-test follow-up will be assessed with analysis of covariance and the conservative intention-to-treat method. Subgroup analyses will be done by gender and age for both caregivers and children. Focus groups will provide qualitative project feedback.

Dissemination will include presentations and policy briefs at national government policy forums, Executive Committee meetings with Directors-General at the Departments of Health, Basic Education, and Social Development, the National Committee for Children Affected by AIDS, and the SA National AIDS Commission. Findings will also be presented to governments and NGOs in Swaziland and Lesotho, and annual meetings of the Southern African Development Community Secretariat in Botswana.

7. Literature search

If the research involves significant risk to the human participants please describe what literature searches have been undertaken to obtain information to aid risk reduction/management.

There is an extensive body of work, both in the UK and South Africa, on ethical concerns in research with “vulnerable” children and young people. The proposed ethical guidelines for this study are informed by a number of sources. These include the ongoing academic debate on issues such as informed consent and confidentiality (Alderson & Morrow, 2004), the ethical requirements of the universities and research institutions involved in designing the research, and ethical guidelines from psychological research bodies such as the British Psychological Society (British Psychological Society, 2000).

Furthermore, key research guidelines and legislation in South Africa have been considered, including the Department of Health Research Ethics Guidelines 2004, the Department of Health Guidelines for Good Clinical Practice in South Africa, 2nd Edition 2006, the National Health Act 61 of 2003, the Children’s Act 38 of 2005, the Children’s Amendment Act 41 of 2007 and the Sexual Offences Act 32 of 2007. In addition, the research has consulted the World Health Organization’s Draft Ethical Guidance for Research with Children and Adolescents.

Section 3: Research Involving Contact With *Human Participants

If the project does NOT involve contact with*human participants, but only use of data about them, do NOT complete this section, but go to Section 4. If you are not completing Section 3 please delete it from your application to save paper.

8. Description of participants

How many participants will be involved in the project?

Phase 1: 54 children (ages 8-17); 50 adults (over 18 years)
Phase 2: 60 children (ages 3-17); 60 adults (over 18 years)
Phase 3: 1 200 children (ages 3-17); 1 200 adults (over 18 years)
Total: 1 314 children (ages 3-17); 1 310 adults (over 18 years)

9. Details of participants

- (a) What types of people will be recruited e.g. students, *children, people with learning disabilities? [Please see the [Glossary](#) on the CUREC website for information on how the meaning of *capacity to consent has been altered by the Mental Capacity Act 2005]

Children and their primary caregivers South Africa will be recruited to be part of the study. The participants will be identified with the assistance of the Department of Social Development and community-based NGOs. Children will be either single or double orphans, or living with a sick caregiver.

- (b) What will be the age range of participants?

Children: 3-17 Adults: 18 and up

- (c) How will the competence of participants to give *informed consent be determined?

The informed consent process will be conducted by our research staff, which has extensive experience working with vulnerable and AIDS-affected children and families. In addition, all staff will be trained in the ethical treatment of human participants. Staff members will also be trained in more advanced research topics such as protocol adherence, quality assurance, data management, and individual privacy. The consent process will take place in the language of the participant's choice.

Adults

Eligible adult participants will first provide informed consent for themselves and for their children, and children will then provide consent. The adult informed consent process involves presenting a detailed verbal and written description of the study as it is described on the printed information and consent forms. Staff will emphasise that participation is voluntary for both adults and children, and that participants (adults and children) can refuse to participate in either the intervention or research and/or can discontinue participation at any time without penalty. Interviewers will ask whether any participants have experienced any coercion to take part in the study; those that describe any pressure or coercion to participate will be excluded, and their family member (adult caregiver or child) will also be excluded. Potential participants will receive an item-by-item reading of the consent form by the study interviewer. Participants will be informed of the procedures for ensuring their confidentiality, including: the use of unique non-personally identifying ID numbers instead

of names on research materials, and maintenance of data in locked computer databases and in locked filing cabinets in locked rooms. Tracking and contact procedures for scheduling follow-up interviews will be explained. Participants will be reminded that they may receive information or referrals to health or social services without participating in the study. All participants will be given the contact numbers of the PI to answer questions about the study or one's rights as a human subject, as well as a 24-hour site contact number. All consenting and assenting participants will be offered a copy of the informed consent form.

Children

Full informed consent will be obtained from children ages 8-17 ("opt-in"). Due to the nature of the intervention, these participants will only be eligible where both child and caregiver wish to take part. For children ages 3-8, only informed consent from the child's primary caregiver will be obtained. In the context of low literacy levels in South Africa, all consent and information forms will be both provided and read aloud in participants' chosen language. Participants may consent to participate only after having read/ having heard the information sheet being read aloud, and having had the opportunity to ask questions. To ensure that children do not feel obliged to participate in the research, emphasis will be placed on their ability to refuse to participate, or to cease participation at any point during the research. Following British Psychological Society Guidelines (The British Psychological Society, 2000), any avoidance by children of the research or intervention situation will be taken as evidence of failure to consent. Any child who declines to participate before or after the interviewer has explained the project will not be included, even if the caregiver or nominated adult agrees to or encourages participation.

(d) What are the *defining criteria for participation in the study?

Inclusion criteria for children include:

1. Orphan (single or double) or vulnerable (caring for sick-caregiver)
2. Age 8-16 at initial assessment
3. Lives in the house at least 4 nights per week
4. Must have an adult primary caregiver who lives in the household, who provides consent, and who participates in the study
5. Provides assent to participate in the full study including intervention and assessments

Inclusion criteria for adults include:

1. Age 18 or older
2. Serves as the primary caregiver of the child participant
3. Lives in the house at least 4 nights per week.
4. Provides consent to participate in the full study including intervention and assessments

10. Recruitment of participants

- (a) Describe how, where, and by whom participants will be identified, approached, and recruited.

Participants will be recruited into the study based on: (a) convenience sampling in high HIV-prevalence settings for qualitative focus groups; and (b) systematic household sampling pilot for the pilot and main cluster randomised controlled trial. Random selection will identify one eligible child per household, in order to maintain representativeness of households while maintaining feasibility and reducing cost (Pettifor et al., 2003);

Caregivers will be 18 and over, but in light of complex care arrangements for AIDS-affected children, we do not place restrictions on whether primary caregivers are biologically related to children. For ethical and intervention-based reasons, we would exclude study volunteers unless both the child and his/her adult primary caregiver agree to participate and both meet the study criteria. Participants will be identified by partner community-based NGOs operating in South Africa and in collaboration with the South African Department of Social Development. Participants will be approached by community health workers and social workers who work with our partner NGOs in their communities. Families will also be able to self-identify through schools, clinics and community meetings.

- (b) If your research involves any use of *personal data obtained from a *third party, describe the steps you have taken to ensure that the *third party has arrangements in place to permit disclosure.

N/A

- (c) Will any *unequal relationships exist between anyone involved in the recruitment and the potential participants?

☒ Yes

If yes: (i) Describe the nature of the unequal relationship.

We will be interviewing children as young as 8 years old (3-8 year olds will not be interviewed but will use adult or sibling report), and as the interviewers are adults there exists an unequal age relationship. In addition, some of the children in this study will be affected by or infected with HIV/AIDS. Our previous studies indicated many young carer children are devoting much of their time to providing care due to household illness, and as a result may not be attending school. For these groups there may be delays or difficulties in education, with which comes the potential for decreased understanding of the methods and needs of research. Even without these difficulties, many children may be literate, semi-literate, or literate in a language other than their first language.

There is also the unequal relationship that may exist between researchers and HIV-positive adults. The adults who are sick enough with AIDS to require care from their children present us a group who may be experiencing depression or whose mental capacity may be affected by advanced stages of illness. It is crucial that, while recognising these inequalities, we make all attempts to reduce their impacts on children and adult participants. However, it

is also important to recognise that in a positive and child-centred research environment, children and adults can benefit from the opportunity to interact with adult facilitators

- (ii) Explain how ethical problems arising from the unequal relationship will be resolved.

All attempts will be made to ensure that the research is a positive and participatory experience for all participants, and that all consent is both voluntary and informed. All interviewers and intervention facilitators will have experience in working with vulnerable children and with AIDS-affected families.

To ensure that children do not feel obliged to participate in the research, emphasis will be placed on their ability to refuse to participate, or to cease participation at any point during the research (*See attached draft consent and information sheets*).

Following British Psychological Society Guidelines (2006), any avoidance by children of the interview situation will be taken as evidence of failure to consent. Children who refuse to participate, or who stop the interview, will still receive snacks and certificates. All research materials will be provided in English and a host of local languages (such as isiXhosa, siSwati, and isiZulu). Interviewers will explain all aspects of the project to children and answer any questions they may have in child's preferred language.

It is important to recognise that the inequalities between researcher and participant can also function as a positive attribute. For example, children reported in feedback for previous studies that they appreciated the opportunity to speak to a sympathetic, motherly adult about their lives. They often took the opportunity to ask our interviewers about issues raised by the questionnaire, such as how to get school-fees exemption. With this example, all children who could not afford school fees were also sent information and support letters to take to their schools when applying for exemption.

- (d) Describe any *financial or other rewards which will be offered to participants.

No financial rewards will be made for participation, although a nutritious lunch will be provided during data collection and intervention workshops, and all participants will receive a certificate on the conclusion of the study. Any participant who chooses to leave the study early will also receive a certificate. To date, we have consistently found a high level of willingness among rural and urban communities to participate in research studies.

11. *Participant information

It is essential that written information is easily understandable by participants. Failure to provide this information in appropriate lay language is the most frequent reason for delays in ethical approval.

- (a) Will participants receive **written** information about the project before giving their consent?
- ☒ Yes - please attach.

- Child focus group information and consent form

-
- | |
|--|
| <ul style="list-style-type: none">- Adult focus group information and consent form- Child information and consent form.- Adult information and consent form.- Child questionnaire.- Adult questionnaire. |
|--|

(b) Who will give the participants the information and how?

All information sheets and consent forms will be given by the research team to children and their caregivers or a nominated adult. All information sheets and consent forms will be read to participants in their preferred language to prevent illiteracy from hindering a participant's understanding about the methods and purpose of the study. All participants will be told they have the right to decline to participate, drop out at any time, and that all the results will remain confidential. Particular emphasis will be made on the process of random allocation and wait-list control. The information sheets will also outline the intervention structure and key expectations of participants' involvement.

Once consent has been obtained from both the child and caregiver or nominated adult, the questionnaire booklet will be read to the participant, and positioned so that both interviewer and participant can see the pack. The proposed study uses an innovative, low-cost technological data collection tool. Mobile-Assisted Self-Interviewing (MASI) was developed by Clyral as an alternative to Audio-Computer Assisted Self-Interviewing, as the use of laptops or PDAs had caused community resentment in extremely low-resource areas with high prevalence of illiteracy. In contrast, use and acceptability of cell phones is high, and low-end handsets are used. Trained fieldwork assistants explain the study, and in a group setting, read out questions whilst participants key in responses to their handsets. This provides privacy for participants, and also allows opportunity for private questions to be asked of a second fieldwork assistant, who can also help individuals. MASI supports multiple languages, and so can include English as well as local languages. If any participants are unable or uncomfortable with the use of cell phones, a paper-and-pen interviewer-assisted questionnaire will also be available in English and the local language such as isiXhosa, although ongoing studies report exceptionally high acceptability of MASI in South Africa.

During the first phase of the research project, a full pilot of the child and adult questionnaires and assessment methods will be undertaken by the research team. This will further allow scrutiny and participant input into improving the design and content of the questionnaire.

Following the baseline assessment, participants will once again be encouraged to ask any questions they may have regarding the research and intervention, and will be given an opportunity to have their responses destroyed rather than included in the study.

(c) Does the research involve deliberate *deception of participants? ☒ No

(d) Please describe the basis on which you have decided how long participants will have to think about the information provided before giving consent.

Participants may consent to participate only after having the information sheet been read to them and there has been an opportunity for questions. This way they are fully informed about the study and have had the chance to ask any questions that might have arisen. Participants will have the opportunity to consider consent for up to a week, before interviewers return for the baseline assessment and two weeks before the intervention begins. However, when we have previously offered participants periods of 24 hours to one week to consider consent, the vast majority have requested to participate immediately. In light of this, we propose that participants are offered the choice of whether to consent or refuse immediately, or to have 1-7 days to consider whether they choose to consent.

12. *Informed consent

(a) Will you obtain written consent?
☒ Yes - please attach *consent form.

All participants should be capable of giving their own consent, and we will not include any children or adults deemed incompetent. Special care will be taken to ensure that all participants are fully aware of and understand the research.

(b) List those researchers who will, with the authorisation of the principal researcher (or supervisor in the case of student researchers), secure the consent of participants.

All research assistants (RAs) will have extensive experience working with HIV/AIDS affected families and children. They will be thoroughly trained on gaining informed consent, and a random sub-set of interviews will be digitally recorded and reviewed independently, including review of informed consent procedures.

13. Consequences of participation

(a) What are the potential risks or actual ill effects of participation (if any) e.g. invasive procedures, distress, deception etc., and what will be done to minimise these risks

(i) to the participants?

The focus of this study is to strengthen and evaluate the impact of an evidence-based psychosocial intervention for AIDS-affected families. We do not anticipate that the interviews will cause any distress either to children or their caregivers. However, there is a possibility that general circumstances and the opportunity to discuss difficulties may well prompt distress. As a result, this study will do the following in order to reduce any risk of caregivers or children becoming distressed:

- As in all research with children, there is a possibility that participants will take the opportunity to disclose difficult living circumstances or abuse. This study recognises that researchers have a responsibility towards children who may disclose information showing them to be at risk of severe harm.
- In order to protect confidentiality of the participants from the stigma associated with HIV/AIDS, each interview will be conducted with as much privacy as possible.

Recent research in South Africa has carefully considered these issues. Guidelines have been established by a Human Sciences Research Council/ UNICEF study on children's psychological adjustment in South Africa (Dawes, Bray, Kvalsvig, & Richter, 2007) and in the South African Children's Institute/ Alliance for Children's Entitlement to Social Security Child Participatory Poverty Research (ACCESS, 2002). These promise confidentiality except when a child is shown through the research to be at risk, in which case (with the child's consent) they will be referred to organisations that can provide assistance (ACCESS study), or caregivers will be told (UNICEF study).

It is noted that the majority of researchers working with vulnerable children in South Africa consider it an ethical principle to provide help for children whom the research identifies as being in need. For example, research undertaken by the Medical Research Council Unit for Anxiety and Stress Disorders routinely refers children to child psychiatric services or to the University of the Western Cape Child Psychology Clinic where there is need for these services (Seedat et al., 2004; Seedat, Van Nood, Vythilingum, Stein, & Kaminer, 2000). A University of Cape Town study on child mental health referred children in need to social services, as does ongoing research in the Africa Centre on HIV+ caregivers and infants (Stein et al., 2005). Following these, and protocols devised from research studies with similarly vulnerable groups (Bostock, 2002) the following protocol is proposed which is identical to those in the Young Carers Study and Orphan Resilience Study (already approved by DREC, University of Witwatersrand, and University of Cape Town Research Ethics Committee):

- Informing all participants at the consent stage that everything said will be confidential unless it becomes clear that they are at risk of significant harm.
- If information is disclosed that suggests that any member of the household is at risk of significant harm, the researcher will discuss concerns with the child at the end of the interview.

If the members of the household consent, the caregiver will be informed (unless this is thought to put the child at risk), and the researcher will discuss the possibilities for referral to child welfare, health organisations, etc. If the child does not consent to sharing of information, and the harm is not considered to be significant, the child will be given information about self-referral agencies such as ChildLine SA. However, if the harm is considered to be significant, the researcher will consult with social services or other organisations. For example, where severe abuse is disclosed in data collection, children will be immediately referred to social or medical services. Where children report rape in the previous 72 hours, immediate action will be taken to ensure post-exposure prophylactic medication. If the decision is made to take action, the participant(s) will be informed (*Please see attached draft referral form*).

All households in the study will receive resource sheets of local health and social services and contact numbers of Lifeline, Childline, and HIV helplines. Weekly supervision meetings with all field interviewers will allow discussion of issues that arise. All referral/emergency protocols will be reviewed additionally by our external advisory groups.

(ii) to the researchers?

There are the general risks of working in poor areas, and we ensure that all RAs and fieldwork staff are trained in awareness and safety measures. We provide all staff with panic alarms. Staff members do not undertake assessments in any situation in which they feel uncomfortable or unsafe, and are encouraged to travel in pairs in areas which are less safe. All staff cars are equipped with tools, spare tyres, water and oil, and all staff members driving staff cars are trained in basic car maintenance. Our safety protocol developed for research in with HIV/AIDS affected families is attached.

(iii) to others (e.g. the university, family)?

None

(b) Is there a need for support or counselling?

- ☒ Yes - describe the form of support or counselling and how, when, and by whom it will be conducted.
- ☐ No

This study has an obligation to plan for the possibility of participants, child or adult, becoming distressed. All interviews and intervention facilitators will be trained and experienced in working with affected children and families. The research team will include a qualified social worker, who will be able to discuss or supervise discussion of any issues with the families and children following the interviews. As discussed above, if there is a need for a participant to access more extensive support (such as seeing a counsellor or attending a clinic), referrals will be made (*Please see attached draft referral form*).

- Is there a need for debriefing or follow-up discussion?

- ☒ Yes - describe the form of debriefing or follow-up discussion and how, when, and by whom it will be conducted.

We are obligated to any participant who may feel distressed after the study. All interviewers are trained and experienced in working with affected children and their families. If a participant is to become distressed, field researchers will be available to discuss any issues he or she may have, and make referrals if required. Field staff also contact the project manager by cell phone when they have a particular concern, or when a participant requires information or discussion.

- Are there any potential benefits to the participants?

- ☒ Yes - describe them below

For children and caregivers in AIDS-affected families, benefits may include evidence of an efficacious, community-led intervention to improve psychosocial wellbeing and family connections. The intervention also has the potential benefit of improving child-caregiver relationships, child and adult mental health, and social support mechanisms.

For communities and community-based provider organisations, benefits may include a model of an efficacious intervention that can be scaled up into services for AIDS-affected families. Community feedback is an important ethical principle in research with AIDS-affected communities. In previous consultations, communities have expressed strong preferences for feedback regarding research findings in order to prevent “parachute research”. We have developed a three-stage process for this, encompassing: i) initial meetings with traditional leaders (king, *iinduna* (headmen)), then community meetings to introduce the project; ii) community meetings at the end of the intervention stage in both of intervention and control groups to report on progress of the project; and iii) after the analysis stage, meetings with traditional leaders and community meetings to report back on findings of the study, as well as report-back to all local NGOs and provincial government.

For the policy-makers, the study has the potential to provide evidence of how to direct limited resources for maximum impact in support of AIDS-affected families.

14. *Adverse events

How will adverse events be monitored and reported?

Please see above for protocols connected to any disclosure by children during intervention and research process. Research staff and intervention facilitators will address any minor accidents or injuries which may happen as the research is taking place. Any adverse events will result in immediate contact with supervisors and in-depth conversations to discuss appropriate actions.

15. Monitoring

Explain how and by whom (e.g. supervisor in the case of student research projects) the ethical aspects of the project will be monitored to ensure that they conform to the procedures set out in this application.

Researchers and RAs will be trained in responding to child disclosure and in communicating with children by an independent social work lecturer. The PI (Dr Lucie Cluver) is a qualified social worker, and will monitor ethical processes on regular field visits.

Section 4: Research Involving Collection, Use, Or *Disclosure Of *Personal Data

Your project must meet the standards laid down in the Data Protection Act (1998) with respect to the collection, use, and storage of *personal data about *human participants. Please delete questions or parts of questions that you are not required to answer to save paper.

16. Need I complete this section?

Does the project involve the collection, use or disclosure of personal information including sensitive and/or genetic information? ☒ **Yes – you must answer questions in this section.** Go to Question 17.

17. Type of activity proposed

Does the research involve:

- (a) disclosure of personal information? ☒ Yes
(b) collection of personal information? ☒ Yes – **go to Question 18**

18. Collection of information directly from individuals

- (a) Does the project involve collection of information directly from individuals about themselves? ☒ Yes – answer the following questions:

- (b) Do the *participant information and the *consent form include the following:

The name of the study?	☒ Yes ☐ No
The name and status (e.g. doctoral student) of the researcher collecting the information and how to contact him/her?	☒ Yes ☐ No
The purpose of the study?	☒ Yes ☐ No
Declarations that the participant has read the participant information sheet?	☒ Yes ☐ No
Has had the opportunity to ask questions about the study and has received satisfactory answers to questions, and any additional details requested?	☒ Yes ☐ No
Understands that s/he may withdraw from the study without penalty at any time by advising the researchers of this decision?	☒ Yes ☐ No
Understands that this project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee?	☒ Yes ☐ No
Understands who will have access to personal data provided, how the data will be stored; and what will happen to the data at the end of the project?	☒ Yes ☐ No
Agrees to participate in this study?	☒ Yes ☐ No

Understands how to raise a concern and make a complaint?	☒ Yes ☐ No

(c) Are the consent form and participant information on headed letter paper which bears the name of the university and the name and address of the department to which the principal researcher is attached? ☒ Yes

(d) Are the participant and the researcher who secures the consent required to sign, print and date their names? ☒ Yes

19. Collection of information from a third party

(a) Does the project involve collection of information about an individual from a source other than the individual? ☒ No – Go to Question 20.

20. Form in which data are to be stored

Are the data to be kept:

(a) with an open identifier i.e. in non-anonymised form	☐ Yes ☒ No
(b) as anonymised but potentially identifiable data	☒ Yes ☐ No
(c) as anonymised, non-identifiable data	☐ Yes ☒ No

21. Use or disclosure of information about individuals

(a) Does the project involve the use or disclosure of information potentially or actually ascribed to an individual? ☒ Yes – answer the following questions

(b) Does the project involve use or disclosure of information without the consent of the individual whom the information describes? ☒ No – go to Question 22.

22. Data collection, storage, and disposal

(a) How many records will be collected, used or disclosed? Specify the information that will be collected, used, or disclosed e.g. date of birth, medical history, and number of convictions.

Number of records: The number of children (approximately 1 314) and the number of caregivers (approximately 1 310)

Type of information:

Qualitative: Focus group and individual interviews will be recorded, transcribed, and translated into English. No information regarding the identity of participants will be recorded with the exception of participant age and gender. Any mention of names will be anonymised.

Quantitative. We will be collecting child and caregiver date of birth, education history, what

kind of care/domestic work the children are engaged in, responses to standardised questionnaires regarding physical, psychological, social and educational outcomes, and sick person illness and symptoms. We will not place emphasis on HIV/AIDS illness but are prepared for private disclosure. We are mainly relying on symptoms and the Verbal Autopsy (VA) for confirmation of AIDS sickness.

Observational: We will be video recording intervention sessions to assess programme fidelity and acceptability. These recordings will be used strictly for assessment purposes and kept in a secure and locked cabinet.

- (b) How, where, and under what security arrangements will electronic and paper data be stored? Who will have and control access to the information?

Data collected on MASI handsets cannot be accessed unless key-coded when uploaded to a central network server. Electronic data will be stored on a password-protected computer, and paper data will be stored in locked cabinets. Availability of this data will be limited to lead researchers on this team.

- (c) When, how and by whom will the information be disposed of?

Information will be disposed of by lead researchers following completion of this study.

- (d) How will the privacy of individuals be respected in any publication arising from this project?

In reporting the findings of this study, we will omit names and only report locations in which the study took place. Data will be kept for a period of up to five years after collection in an anonymised version.

- (e) Have you explained in the *participant information and *consent form that maintenance of confidentiality of information is subject to normal legal requirements?
☒ Yes

23. Adverse and unforeseen events

How will adverse and unforeseen events relating to the collection, use, or disclosure of information be managed, monitored and reported?

Any adverse events will be reported to the Principal Investigator. All precautions will be taken to ensure confidentiality for all participants. We do not anticipate adverse events of this kind due to the confidentiality of the participants' information.

Section 5: Miscellaneous Issues

24. *Conflict of interest

- (a) Do researchers on this project have a financial or other interest in its conduct or outcomes? ☒ No

- (c) Are there any other potential conflicts of interest e.g. research findings that could compromise the researcher's relationship with the university? ☒ No

25. *Peer review

Has this project been peer reviewed?

- ☒ Yes – explain by whom (e.g. by a, tutor, supervisor, funding body etc.) and with what outcome

Phases 1 and 2 have been peer reviewed by the Fell Fund (ref 103/757).

26. Funding

List all bodies and individuals from whom funding has been or will be sought.

Source	Amount in £	Status of Funds	
		Available	Applied for
National Lottery Board (via Clowns Without Borders South Africa)	£20, 000	Yes ☒ No ☐	Yes ☐ No ☐
John Fell Fund	£44, 000	Yes ☒ No ☐	Yes ☐ No ☐
Oak Foundation	£345, 328	Yes ☐ No ☐	Yes ☒ No ☐

27. Reporting of results

- (a) Will the project outcomes be made public at the end of the project? ☒ Yes – describe the intended report and how and to whom it will be made available.

The research will be of interest to government officials from various departments, including the Departments of Social Development, Health, Basic Education, and Agriculture. The feedback of findings to government will take place at a national level (to NACCA steering committee meetings) in addition to provincial level and district level local government.

In addition, the study findings will be reported at key conferences (such as the South African AIDS Conference), and will be provided as a set of lay-term, one-page 'policy briefs' which will be sent to NGOs and will be downloadable freely on our website. Results will also be reported on the study website.

We will make all efforts to provide participant children and adults with "brief reports", regarding the progress of the research. This will focus on positives, and make no mention of HIV/AIDS in order to prevent unintentional stigma.

- (b) Will a report(s) of the project outcomes (for example, individual or group data) be made available to participants at the end of the project?

-
- ☒ Yes – describe report and how it will be made available.
☐ No – explain why not.
☐ N/A

Feedback to participants is a key part of a child and family-focused research design (Herth, 1998). At each stage of review and data collection, the study will create “brief reports” – easily understandable summaries of study findings in lay language. These will focus on findings relevant to NGOs and schools in their work with children. In ongoing pilot work, local NGO staff and teachers have requested training sessions rather than paper reports, and the research team will aim to deliver this where possible.

All participating children and families will also receive “brief reports” as described in section 27a.

28. Declaration by researchers

Full project title: PACCASA (Preventing Abuse of Children in the Context of AIDS in sub-Saharan Africa)

I/We, the researcher(s) agree:

- To start this research project only after obtaining approval from IDREC/CUREC;
- To carry out this research project only if funding is adequate to enable it to be carried out according to good research practice and in an ethical manner;
- To provide additional information as requested by IDREC/CUREC before approval is secured and as research progresses;
- To maintain the confidentiality of all data collected from or about project participants;
- To notify IDREC in writing immediately of any proposed change which would increase the risks that any participant is exposed to and await approval before proceeding with the proposed change;
- To notify IDREC if the principal researcher on the project changes and supply the name of the successor;
- To notify IDREC in writing within seven days if any serious *adverse event occurs in the course of research;
- To use data collected only for the study for which approval has been given;
- To grant access to data only to authorised persons; and
- To maintain security procedures for the protection of personal data, including (but not restricted to): removal of identifying information from data collection forms and computer files, storage of linkage codes in a locked cabinet, and password control for access to identified data on computer files.

Signed by principal researcher/supervisor/student researcher:.....

Date:.....

Print name (block capitals).....

29. Certification by *principal researcher/supervisor/student researcher and head of department

Full project title:

Certification by *principal researcher/supervisor/student researcher

I accept responsibility for the conduct of this research project.

I certify that all researchers and other personnel involved in this project are appropriately qualified and experienced or will undergo appropriate training to fulfil their role in this project.

Signed by principal researcher/supervisor/student researcher:.....

Date:.....

Print name (block capitals).....

Acceptance by head of department/ other senior member of the department if the principal researcher is the head of department

I have read the research project application named above.

On the basis of the information available to me, I judge the principal researcher/supervisor/ student researcher to be award of her/his ethical responsibilities in regard to this research. I am satisfied that the proposed project has been/will be subject to appropriate peer review and is likely to contribute to existing knowledge and/or to the education and training of the researcher(s) and that it is in the public interest.

Name of head of department/other senior member of the department (e.g. Chair of DREC, Director of Graduate Studies for student projects):

.....

Signature

Date.....

Appendix C.2. Changes to Ethical Protocol

09 November 2012

Dear Central University Research Ethics Committee,

Changes in Protocol for PACCASA Project

Please find below detail of changes made in the protocol for the PACCASA (Preventing the Abuse of Children in the Context of AIDS in sub-Saharan Africa) project being implemented by Dr. Lucie Cluver (Approval Ref SSD/CUREC2/11-40). This project has been granted ethical approval by CUREC and has been submitted for approval from the University of Cape Town Research Ethics Committee and the University of Witwatersrand Public Health Research Ethics Committee. Please find Oxford's ethical approval attached. The changes made from the original protocol include:

1. Location

The original protocol stated that the study would take place in either the Eastern Cape or Western Cape, pending government approval. We have decided to divide the study into two locations: 1) a rural study with children aged 9-17 in the Eastern Cape, and 2) an urban study with children aged 3-8 in the Western Cape. All further changes apply only to the Western Cape branch within the larger study.

2. Age of child participants

Original plan: The original age of child participants was 3 to 17 years.

Current plan: The Western Cape branch will work only with families with children aged 3-8, rather than aged 3-17 as initially proposed. We divided the groups by age due to different developmental challenges and appropriateness of interventions. In the urban site (Western Cape), we chose to work with the youngest group of children, ages 3-8 because: (a) age 3 is when behavioural difficulties begin to manifest and parents become aware that they may need parenting support; (b) this intervention is sufficiently early that it has the potential to have significant impact for both the parents and the children through improving parent-child relationships and reducing the maltreatment of the children in this sample.

3. Changes in implementation of study

(a) Phase 1: Development

Original plan: Focus groups were initially to include $n = 8$ semi-structured focus group sessions of 10 members per group. Focus group members were to include caregivers, AIDS-affected children, Teen Advisory Group ($n = 14$ youth affected by AIDS), and Caregiver Advisory Group ($n = 10$ caregivers aged 18-65).

Current plan: We will implement $n = 9$ semi-structured focus group sessions of 8 members per group for caregivers of children ages 3 to 8 and $n = 5$ semi-structured focus group sessions of 5 members per group for community health workers.

(b) Phase 2: Pilot RCT Trial

Original plan: The Pilot Randomised Controlled Trial was initially 60 parent-child dyads with children ages 3-17.

Current plan: The Pilot RCT Trial will be for 60 parent-child dyads with children ages 3-8. Selection criteria remain the same with the exception of using a cut-off of 10 on Eyberg Child Behaviour Inventory for selection of participants.

(c) Phase 3: Randomised Controlled Trial

Original plan: Phase 3 was initially to be a Cluster Randomised Controlled Trial with 30 sites ($n = 1\,200$ child-parent dyads).

Current plan: The randomisation for the trial in the Western Cape will be done individually in 6 sites. Study size has been reduced to $n = 144$ due to funding constraints.

4. Assessment

(a) Assessment of Programme Acceptability and Feasibility

Original plan: Acceptability assessments were initially going to include self-report of acceptability by caregivers and by children 8 years and older.

Current plan: Due to the change in child age, we will only be collecting self-reports from caregivers. We will also be administering observational assessments of parenting and child behaviour in the home of participants. These assessments will use the Sinovuyo Observational Coding Scale, developed for its ability to measure both child behaviour problems and parent-child interaction. It assesses the frequency of behaviours during a set of prescribed activities involving the parent and child: free play (10 minutes), tidying up (up to 5 minutes), and preparing and eating a snack (10 minutes). Two raters coded videos by assessing the frequency of the positive child behaviour (i.e., smiles, hugs, or compliance with instructions) and negative child behaviour (i.e., throwing toys, swearing, or noncompliance with instructions). Parenting categories were positive parenting (i.e., praise or physical affection), effective parenting (i.e., use of consequences, positive commands), and negative parenting (i.e., hitting, criticising, or indirect commands). Assessors also recorded the level of engagement in child-led play as an additional indication of positive parenting.

(b) Assessment of Primary and Secondary Outcomes

We will be using the following scales to assess outcomes:

Parent and child demographics

1. South Africa General Health Survey (Statistics South Africa, 2011)
2. Basic Necessities Scale (Wright, 2008) (Household poverty)
3. Hunger Scale (Household poverty)

Parent exposure to family violence

4. Revised Conflict Tactics Scale (Straus et al., 1996)
5. International Child Abuse Screening Tool – Retrospective Version (Dunne et al., 2009)

Child AIDS-related orphanhood, parent HIV-status and/or AIDS sickness

6. Verbal Autopsy Questionnaire (Lopman et al., 2006)

Parent substance abuse

7. WHO Alcohol, Smoking, and Substance Screening Tool (Humeniuk et al., 2008)

Government grants

8. Self-report of government grants received

Child behaviour problems

9. Eyberg Child Behaviour Checklist (Eyberg and Ross, 1978) (Parent-report)
10. Sinovuyo Observation Scale (Mlotshwa, 2013) (Observational)

Parenting behaviour

11. Parent-Child Conflict Tactics Scale (Straus et al., 1998) (Harsh and inconsistent parenting)
12. Parenting Young Children Scale (McEachern et al., 2011) (Positive parenting)
13. Family Observation Scale (observed parent behaviour)

Parent mental health

14. Parenting Stress Index – Short Form (Abidin, 1995) (Parenting distress)
15. Beck Depression Index-II (Beck and Steer 1996) (Parental depression)
17. Medical Outcome Study Social Support Survey (Sherbourne et al., 1991) (Perceived social support)

Please find the current adult self-report questionnaire attached to this letter. If there are any further questions, please do not hesitate to ask.

Thank you,
Dr Lucie Cluver, Principal Investigator, PACCASA

04 February 2013

Dear Central University Research Ethics Committee,

Changes in Protocol for PACCASA Project

Please find below detail of changes made in the protocol for the PACCASA (Preventing the Abuse of Children in the Context of AIDS in sub-Saharan Africa) project being implemented by Dr. Lucie Cluver (Approval Ref SSD/CUREC2/11-40).

This project has been granted ethical approval by CUREC and the University of Cape Town Research Ethics Committee (2012_12_01). Please find Oxford's ethical approval attached.

The changes made from the original protocol involve conducting observational assessments of child behaviour and parenting behaviour:

Original: We originally had planned to have research assistants code the Family Observation Scale (Psalich & Dadds, 2009) during the home visit observations.

Change: In order to assure inter-rater reliability of observational assessments, home visits will now be recorded on a video.

As a result, the following and additions have been made:

1. Information and consent forms detailing the process of observational assessments have been edited to reflect changes in study protocol (attached).
2. The observational assessments will follow a strict home visit protocol (schedule attached). This schedule has been translated and back-translated into isiXhosa to verify accuracy.
3. Research assistants fluent in isiXhosa will receive 50 hours training in administering the self-report questionnaire and observational assessments.
4. The video recordings will be stored on compact disc drives in a locked cabinet for a minimum of five years. Back-up recordings will be stored on a password-protected hard drive. Only senior members of the research team will have access to these recordings.
5. Video recordings may be used for educational purposes during training for further observational assessments. Names and identities for participants will be kept strictly confidential.

Please find the home visit protocol, information sheet, and consent form attached to this letter. If there are any further questions, please do not hesitate to ask.

Thank you, Dr Lucie Cluver, Principal Investigator, PACCASA

15 July 2013

Dear Central University Research Ethics Committee,

Changes in Protocol for PACCASA Project

Please find below detail of changes made in the protocol for the PACCASA (Preventing the Abuse of Children in the Context of AIDS in sub-Saharan Africa) project being implemented by Dr. Lucie Cluver (Approval Ref SSD/CUREC2/11-40).

This project has been granted ethical approval by CUREC and the University of Cape Town Research Ethics Committee (2012_12_01). Please find Oxford's ethical approval attached.

The changes made from the original protocol involve conducting in-depth interviews instead of focus groups with programme participants:

Original: We originally had planned to conduct three focus groups with 11 participants each.

Change: In order to reduce respondent bias, we will conduct 12 in-depth interviews with programme participants.

As a result, the following and additions have been made:

1. The interviews will follow a strict interview protocol (schedule attached). This schedule has been translated and back-translated into isiXhosa to verify accuracy.
2. Audio recordings will of the interviews will be transcribed and translated by a trained research assistant.
3. Audio recordings and transcripts will be stored on compact disc drives in a locked cabinet for a minimum of five years. Back-up data will be stored on a password-protected hard drive. Only senior members of the research team will have access to these recordings.

Please find the interview protocol attached to this letter. If there are any further questions, please do not hesitate to ask.

Thank you,

Dr Lucie Cluver
Principal Investigator
PACCASA

Appendix C.3. Ethical Approval Letters

University of Oxford CUREC_2 Approval

SOCIAL SCIENCES & HUMANITIES
INTER-DIVISIONAL RESEARCH ETHICS COMMITTEE

Hayes House, 75 George Street, Oxford. OX1 2BQ
Tel: +44(0)1865 614871 Fax: +44(0)1865 614855
ethics@socsci.ox.ac.uk www.socsci.ox.ac.uk

Co-ordinator of the IDREC
Social Sciences Divisional Office



Wednesday, 9 November 2011

Dr Lucie Cluver
Department of Social Policy and Intervention

Dear Lucie,

Research Ethics Approval

Ref No.: SSD/CUREC2/11-40

PACCASA (Preventing Abuse of Children in the Context of AIDS in sub-Saharan Africa)

The above application has been considered on behalf of the Social Sciences and Humanities Inter-divisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and accordingly approval has been granted.

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'K. Vernon'.

Kerry Vernon

cc: Gemma Roche, Department of Social Policy and Intervention

KV/EB

University of Cape Town Ethical Approval – Formative Evaluation Phase

UNIVERSITY OF CAPE TOWN



Department of Psychology
Research Ethics Committee
Rondebosch, 7701
Tel: 27 21 6504608 Fax: 27 21 6504104
E-mail: Lauren.Wild@uct.ac.za

04 May 2012

REFERENCE NUMBER: 2012_05_01

Researcher Name: Catherine Ward

Researcher Address: Department of Psychology, University of Cape Town

Dear Dr Ward

PROJECT TITLE: Developing an evidence-based parenting programme to prevent child maltreatment in the context of AIDS in South Africa

Thank you for your submission to the Department of Psychology Research Ethics Committee.

It is a pleasure to inform you that the Committee has **granted approval** for you to conduct the study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote your REFERENCE NUMBER in all your correspondence.

Yours sincerely,

A handwritten signature in cursive script, appearing to read 'Lauren Wild'.

Dr Lauren Wild

Acting Chairperson, Department of Psychology Research Ethics Committee

1 of 1

University of Cape Town Ethical Approval – Feasibility Pilot Phase

UNIVERSITY OF CAPE TOWN



Department of Psychology
Research Ethics Committee
Rondebosch, 7701
Tel: 27 21 6504607 Fax: 27 21 6504104
E-mail: Lauren.Wild@uct.ac.za

04 December 2012

REFERENCE NUMBER: 2012_12_01

Researcher Name: Catherine Ward

Researcher Address: Department of Psychology, University of Cape Town

Dear Dr Ward

PROJECT TITLE: Sinovuyo Caring Families Project

Thank you for your submission to the Department of Psychology Research Ethics Committee.

It is a pleasure to inform you that the Committee has **granted approval** for you to conduct the study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote your REFERENCE NUMBER in all your correspondence.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Lauren Wild'.

Dr Lauren Wild

Acting Chair, Department of Psychology Research Ethics Committee

1 of 1

Appendix C.4. Examples of Information Sheets and Consent Forms

Formative evaluation information sheet and consent form – practitioners³⁸

Dear Practitioner,

We are inviting you to participate in a discussion group because we want to learn more about your experiences interacting with parents as practitioners. We are really interested in your experiences and in any thoughts you have about parenting in this community. Your responses will help us understand your experiences related to your work as a practitioner as well as the most common challenges that you experience as a parent. We would also like to explore your interest in participating in future parenting groups especially designed for people in your community in order to support your parenting practices.

What is the purpose of this discussion?

The purpose of this discussion is to better understand how we can improve the lives of children and families in South Africa. We will be developing a family-based support programme to help families cope with stress and challenges in their daily lives.

Do I have to participate?

It is up to you to decide if you do not want to participate. If you decide to take part, you will need to sign this form. You can withdraw at any time from the focus group without giving a reason. There will be no penalty for withdrawing from the study.

What will happen if I take part?

You will have the opportunity to participate in a discussion session and/or individual interview. This discussion/interview should take about two hours.

- We will be asking you questions about your life and work in the community in order to help us develop a parenting programme that may help families like yours. You do not need to answer any questions that you do not wish to answer.
- During the discussion, we will be recording the session so that we accurately represent your answers. These recordings will be kept confidential and private, and will be destroyed once we have made a transcript.
- You can decide to stop the discussion at any time. There will be no penalty or denial of services if you decide to leave the study or programme.

What will happen to the information I provide?

Participation in this discussion/interview means that you share some personally identifying information with us such as your name, address, and phone number. This personally identifying information will never be given to others. You will be given a

³⁸ The information sheet and consent form for parents is very similar and thus was not included.

unique study number so that your name will not be known by anyone outside of the research team. This means that only the research team will have access to this information about who you are. The research team will protect your personal information and comply with all applicable laws. All of the information will be stored in a locked file cabinet or on a password-protected computer and only research staff working on this study can look at this information.

What will happen to the results of the research?

Any research publication will not identify you individually. After the study is finished, we would be delighted to share with you the results as soon as they are available.

Who has reviewed the study?

This study has received ethical approval from University of the Oxford's Central University Research Ethics Committee, and the Research Ethics Committee of the Department of Psychology at the University of Cape Town.

Who is responsible for this study?

Dr Catherine Ward from the University of Cape Town and Dr Lucie Cluver from the University of Oxford are the Principal Investigators for the study.

Benefits

You will receive no direct payment for participating in this study. We will provide a nutritious meal at the end of the session.

Questions

Please ask the research team if you have any questions or concerns about this study. You can also contact Dr Ward on 021 650 3422, or Rosalind Adams in the University of Cape Town Department of Psychology on 021 650 3417.

My signature here indicates that I understand what I am being asked to do, that I have been given an opportunity to ask questions, and that I agree to participate in these discussions.

Name of participant: _____ Date: _____

Witness: _____

My signature here indicates that I understand that the discussion will be recorded, that the discussion will be transcribed (written down), that my name and identifying information will not appear in the transcript, and that once the transcript has been made the recording will be destroyed.

Name of participant: _____ Date: _____

Witness: _____

Pilot RCT information sheet and consent form

Dear Sir or Madam,

You are being invited to take part in a parenting workshop and research study called the Sinovuyo Caring Families Project. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. The following information will be read and explained to you carefully, and you will have a chance to ask questions and discuss it with others. If there is anything that is not clear or if you would like more information, please ask us. Thank you!

What is the purpose of this study?

The purpose of this study is to better understand how we can improve the lives of children and families in South Africa. We will be looking at how a parent support programme might help improve your child's behaviour and help you cope with stress and challenges in your life. This programme involves 12 weekly sessions for caregivers.

Who can participate?

In order to participate, you must to be a caregiver of a child who is between the ages of 3 to 8. If you have more than one child between the ages of 3 to 8, we would like you to select the one with whom you are having the most challenges. This child needs to live in the same household as you for at least four nights a week. You need to be the child's primary caregiver (the main person who is responsible for the child). You also need to be having difficulties with your child's behaviour. We will be asking you some questions about this later. Lastly, in order to participate you will have to provide consent.

Do I have to participate?

NO – It is up to you to decide if you do not want to participate. If you decide to take part, you will need to fill in the enclosed form. You can withdraw at any time from the study without giving a reason. There will be no penalty for withdrawing from the study, and you will still be able to complete the workshop.

What would happen if I take part?

Consent and Screening:

- First, you will be given the opportunity to ask any questions that you have about the programme or research in private.
- When you understand everything about the programme, you will be asked to sign a consent form agreeing to take part in the study.
- It is up to you to decide whether you want to participate, but you must sign the form in order to participate.
- Then, we will ask you a few questions about your child's behaviour. This is to determine whether you are eligible for the study or not.

-
- If you are not eligible for the study, we will talk to you about some other resources that can help assist you with the challenges that you are facing.

Research visit 1:

- If you are eligible for the study, we will set a date to come and visit you at home. We will remind you of this date before the visit by phoning you and sending you an SMS.
- When we come to your home, we will visit for about two hours.
- During the visit we will ask you some questions about your life and feelings and your relationship with your child. This will take about one and a half hours.
- If there are any questions that you feel uncomfortable answering, you will not have to answer them.
- We will type the answers to the questions into a cell phone while we speak to you.
- As soon as we have completed the interview, your answers will be sent to a secure database that only our research team will have access to. Your answers will be removed from the cell phone.
- This means that no one else will ever be able to see the answers to your questions. Your answers will not be written down anywhere – they will only be in the database.
- We will also observe how you and your child are together. This will include some time for play, cleaning up, and preparing and sharing a meal. This will take about half an hour.
- We will video you and your child while we observe. We will use a cell phone to video. The video will be removed from the phone and put on a secure computer as well as stored on a CD in a locked cabinet. The video will only be seen by the research team. We may use some of the video for educational purposes – to train people to understand parenting better. Your names and identities will be kept confidential at all times. Otherwise, the video will not be seen by any other people.

Being part of the Sinovuyo programme:

- Everyone who agrees to participate in the study will be able to participate in a 12-week programme for parents to help them learn how to manage their child's behaviour.
- However, we can only do half of the participants right now. This means that half of you will get the programme from March to May, and half of you will get the programme from September to November.
- In order to be fair, who is doing the programme now will be chosen by a lottery system in a computer. We do not decide who will get the programme now and who will get it later. This will all be random by lottery.
- The group leaders will visit your home during the week before the programme to help prepare you for the programme.
- The programme will include activities both during the sessions and for practice at home. Although you will be encouraged to participate in the activities, you do not have to do anything you do not wish to do.
- Your child will not attend any sessions, but you will have some home practice activities to do with this child each week.

-
- During the programme, we may photograph or video some of the sessions to document how the programme is being implemented by the facilitators. If you do not want to have your photo taken, please tell us.
 - You can decide to stop the study or programme at any time. There will be no penalty or denial of services if you decide to leave the study or programme.
 - If you decide to leave the study, you will still be able to participate in the programme.

Research visit 2:

- After the first programme ends in May, we will visit you at home again.
- This visit will be the same as the visit that happened before the programme. We will ask you the same questions and watch you and your child together as we did at the first visit.

Focus group:

- We will also have a focus group so that you can tell us more about your experience during the programme.
- This will help us understand if there is any change in your life and your child's life.
- We will also ask you questions about whether you think the programme is useful, how we can improve it, and whether you think other families would benefit from it.

What will happen to the information I provide?

Participation in this survey means that you share some personally identifying information with us such as your name, address, and phone number. This personally identifying information will never be given to others. You will be given a unique study number so that your name will not be known by anyone outside of the research team. The answers to your questions will be typed into a cell phone, and as soon as the interview is complete, the answers will be sent to a secure server and will be removed from the cell phone.

Only the research team will have access to this information, and it will not be saved or written down anywhere else. We will take a video of you and your child together using a cell phone. This video will be put onto a secure computer and will be removed from the cell phone. The video will only be seen by the research team. We may use some of the video for educational purposes to train people to understand parenting better. Your names and identities will be kept confidential. Otherwise, the video will not be seen by any other people. The research team will protect your personal information and comply with all applicable laws. All of the information will be stored in a locked file cabinet and computer protected by a password. Only research staff working on this study can look at this information.

What will happen to the results of the research?

Any research publication will not identify you or your child individually. After the study is finished, we would be delighted to share with you the results as soon as they are available.

Who has reviewed the study?

This study has received ethical approval from University of the Oxford Central University Research Ethics Committee (ref: SSD/CUREC2/11-40) and the University of Cape Town Psychology Department Research Ethics Committee (ref: 2012_12_01).

Who is responsible for this study?

Dr Lucie Cluver, from Oxford University, and Dr Catherine Ward, from the University of Cape Town, are the Principal Investigators for the study.

Mr. Jamie Lachman, a doctoral student at Oxford, is the Research Manager and will be managing our research team.

Benefits

You will receive no direct payment for participating in this study. You will get to participate in 12 workshop sessions aimed at improving your child's behaviour and helping you cope with stress. We will also provide a nutritious meal every session. We will provide a certificate after you have completed the Sinovuyo programme. We will also provide you with a small gift after the second research visit.

Questions

If you have any questions or concerns about this study, please ask any member of the research team.

Sinovuyo participant consent form

You will be given a copy of this information sheet and consent form to keep.

Participation in this study is voluntary. This means you can refuse to be a part of this study. Also, you can decide to withdraw from this study at any point without anything negative happening or you losing any benefits you might have. If you wish to stop at any time, just tell anyone on the research team.

1. Have you read or been read this information and understood the information given here?

☐ Yes ☐ No

2. Have you had an opportunity to ask any questions of the research team, received answers, and been able to ask for additional information?

☐ Yes ☐ No

3. Do you understand that you can withdraw from the study without penalty at any time by telling any member of the research team?

☐ Yes ☐ No

4. Do you understand who will be able to see to your information, how this information is stored, and what happens to the information at the end of the study?

☐ Yes ☐ No

5. Do you understand that you will be recorded on video, and the video will *only* be used for educational purposes?

☐ Yes ☐ No

Please sign your name if you understand what is involved and agree to participate:

Signature of person giving consent

Please sign your name if you agree to being recorded by video:

Signature of person giving consent

Printed name

Name of child

Your contact number

Date

Place

Signature of person witnessing consent

Printed name

(only if participant has literacy problems)

Date

Place

Signature of researcher gaining consent

Printed name

Date

Place

Appendix C.5. Trial Protocol Registration

This study was registered on ClinicalTrials.gov (NCT01802294) and the Pan African Clinical Trial Registry (PACTR201402000755243).

ClinicalTrials.gov

ClinicalTrials.gov
Protocol Registration System



Protocol Registration Receipt
02/15/2013

Sinovuyo Caring Families Project - Pilot Randomised Controlled Trial (SCFP)

This study is currently recruiting participants.

Verified by Dr Catherine L. Ward, University of Cape Town, February 2013

Sponsor:	University of Cape Town
Collaborators:	University of Oxford Bangor University Ilifa Labantwana
Information provided by (Responsible Party):	Dr Catherine L. Ward, University of Cape Town
ClinicalTrials.gov Identifier:	

► Purpose

This pilot feasibility trial will evaluate the Sinovuyo Caring Families Program in a small-scale randomized controlled trial in Cape Town, South Africa (n=60 families). The pilot study will use a mixed-methods approach to intervention evaluation. Self-report and observed quantitative data for intervention and control groups will be collected at pre-test and post-test evaluation. Primary outcomes will include parent-reports and observations of child behavior problems. In addition, as an exploratory study, this phase will examine initial pre-post intervention effects for potential mediating factors of parenting behavior, parental stress, parental depression, and perceived social support. However, this phase will not test mediation effects due to small sample sizes. Quantitative assessments will also collect data on program fidelity, exposure/adherence, participant engagement, and satisfaction. Furthermore, qualitative focus groups with intervention participants and group leaders will examine issues of program feasibility, content, deliver, and satisfaction. Randomization will be done on an individual level and include a wait-list control group that will receive the intervention 3 months after the post-test evaluation. Results from the feasibility pilot study will be shared with intervention partners and advisory groups. If necessary, final program adjustments will be made prior to further testing. Results will also be disseminated to community forums, local organizations, government stakeholders, and via academic conferences.

Research hypotheses:

Hypothesis 1: Children in the intervention group will demonstrate reduced observed and parent-reported child behavior problems in comparison to the control group.

Hypothesis 2: Parents in the intervention group will demonstrate increased observed and self-reported positive parenting outcomes and decreased observed and self-reported harsh and inconsistent parenting outcomes in comparison to the control group.

Hypothesis 3: Parents in the intervention group will demonstrate decreased parental depression and parental stress outcomes and increased perceived social support outcomes in comparison to the control group.

Hypothesis 4: The Sinovuyo Caring Families Program will be implemented with an acceptable degree of program fidelity, exposure/adherence, and participant satisfaction.

Condition	Intervention	Phase
Child Behavior Parenting Child Abuse	Behavioral: Parenting Program	Phase 1

Study Type: Interventional

Study Design: Treatment, Parallel Assignment, Single Blind (Outcomes Assessor), Randomized, Efficacy Study

Official Title: Sinovuyo Caring Families Project - Pilot Randomised Controlled Trial of a Parenting Program to Reduce Child Behavior Problems in Xhosa Children Ages 3 to 8 in South Africa

Further study details as provided by Dr Catherine L. Ward, University of Cape Town:

Primary Outcome Measure:

- Eyberg Child Behavior Inventory [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
This 36-item examines externalizing behavior problems in children ages 2 to 16 using both an Intensity Scale and Problem Scale. Parents are asked how often a specific behavior occurs and whether the behavior is considered a problem. Based on the most typical child behavior problems, items include "has poor table manners," "acts defiant when told to do something," "physically fights with sisters and brothers," and "fails to finish tasks or project." The Intensity Scale rates frequency of occurrence based on a 7-point Likert scale (1 = never occurs to 7 = always occurs). The Problem Scale measures whether the parent identifies a specific behavior as a problem (0 = no; 1 = yes). Both scales are summed up to create a total Intensity Score and Problem Score. Clinical cut-off scores suggested for psychopathological problem behavior are 131 for the Intensity Score and 11 for the Problem Score (Eyberg, 1999).
- Family Observation Scale, 6th Edition [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
The FOS-6 measures both consistency and intensity of child and parent behavior. Coding systems use a Likert scale from 0-4 to record whether and how often a particular behavior occurred (0 = behavior did not occur and/or was of low intensity; 4 = occurred a lot and/or was of high intensity). Codes are identified according to different behavioral categories through global and interval coding. Observed parent behavior includes harsh parenting, lax parenting, and praise. Similarly, child behaviors are non-compliance, proactive oppositionality, complaint, and withdrawal. Frequency and intensity scores are calculating by summing the individual scores and then dividing by the total number of observation intervals. Final scores are then calculated from means to generate an overall rating as well as for each subscale (Sanders, 2000).

Secondary Outcome Measures:

- Parent-Child Conflict Tactics Scale (CTSPC) (Straus et al., 1998) [Time Frame: Pretest and Posttest]
[Designated as safety issue: No]
The CTSPC (27-items) contains subscales measuring psychological aggression (5-items, e.g. - "shouted, yelled, or screamed at"), physical assault (13-items, e.g. - "hit on the bottom with a belt"), and neglect (5-items, e.g. - "were too drunk to take care of your child") as well as nonviolent discipline (4-items, e.g. - "explained why something was wrong"). Parents respond according to a Likert scale based on the number of times in the past 3 months each activity occurs (1 = never to 5 = three or more times). The CTSPC produces an overall harsh parenting score as well as for each subscale by summing the responses. It also measures the prevalence of harsh parenting by creating a dichotomized variable (0 = never, 1 = all other responses).
- Parenting Young Children Scale (PARYC) [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
The PARYC (14-items) measures the occurrence of specific parental behavior towards children (e.g. - "notice and praise your child's good behavior") during the previous month on a 7-point Likert scale (0 = never, 7 = almost daily), as well as whether performing this behaviour is currently a problem or difficult (0 = no, 1 = yes). Items are summed to create total frequency and problem scores, as well as for each subscale.
- Parenting Stress Index-Short Form, Distress Subscale [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
The Parenting Distress subscale (12-items) rates parents' responses on a 5-point Likert scale regarding the frequency of stress related to parenting within the past 3 months (1 = Never; 5 = Always). Items include parenting stress due to marital conflict (e.g. - "taking care of children causes problems between me and my spouse"), sense of parental competence (e.g. - "I feel inadequate as a parent"), and lack of support (e.g. - "I feel alone and without friends"). Items are summed to create a total score.
- Beck Depression Inventory (BDI-II) [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
The BDI-II is a 21-item scale designed to assess the intensity of depression in both clinical patients and for the general population. Respondents are asked to choose from a series of statements describing various symptoms on a four-point scale (e.g. - "Sadness: 0 = I do not feel sad; 1 = I feel sad much of the time; 2 = I am sad all the time; 3 = I am so sad or unhappy that I can't stand it"). Responses are then summed ranging from 0 to 63, with higher scores indicating higher levels of depressive symptoms. Recommended cut-off scores are 0-13 for minimal depression, 14-19 for mild depression, 20-28 for moderate depression, and 29-63 for severe depression (Beck, 1996).
- Multidimensional Scale of Perceived Social Support (MSPSS, 12-items) [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
Participants report on the levels of perceived social support based on a Likert scale of 1 to 7 (1 = very strongly disagree; 7 = very strongly agree). The MSPSS includes subscales for family support (e.g. - "I get the emotional support and help I need from my family"), friend support (e.g. - "I can count on my friends when things go wrong"), and other support (e.g. - "there is a special person who is around when I am in need"). Responses are summed to create subscale and total scores from 12 to 84 with higher scores indicating higher levels of perceived social support.
- Parental Monitoring [Time Frame: Pretest and Posttest] [Designated as safety issue: No]

Other Pre-specified Outcome Measures:

- **Implementation Fidelity** [Time Frame: Posttest] [Designated as safety issue: No]
In this pilot study, implementation fidelity will be measured using group leader self-report checklists to examine the extent to which core intervention components are delivered. These checklists will include specific activities for each session, such as home practice discussion and role-playing exercises. They will also measure the extent to which core parenting program theoretical concepts – such as child-led play, specific praise and encouragement, and the use of time-out – are implemented. Additionally, the research team will perform periodic observational assessments (4 per group) to verify the group leaders' self-report checklists.
- **Program exposure, adherence, and engagement** [Time Frame: Posttest] [Designated as safety issue: No]
Participation attendance registers for each session will assess exposure of participants to the intervention components. Furthermore, weekly self-report activity checklists based on a Likert scale of 1-4 (1 = none of the time, 4 = all of the time) will measure the extent to which participants actively engage with program components such as home practice activities (Glasgow et al., 1999). Finally, at the end of the program, qualitative focus groups will explore participants' experiences and the barriers to program exposure, adherence, and engagement.
- **Participant Satisfaction** [Time Frame: Posttest] [Designated as safety issue: No]
Participants will complete weekly evaluations (7-items) examining satisfaction of session content, activities, facilitator teaching, and group discussion. Participant satisfaction surveys of the overall program (40-items total) will investigate parents' perceptions of whether the program fulfilled their expectations (10-items), acceptability of delivery and teaching methods (10-items), acceptability of theoretical parenting techniques (10-items), and evaluation of program facilitators (5-items per facilitator). Responses for weekly and overall surveys will be based on a Likert scale of 1 to 5 (e.g. – 1 = very unhelpful, 5 = very helpful). Items will be summed to create weekly satisfaction scores and an overall program satisfaction score.
- **Program feasibility** [Time Frame: Posttest] [Designated as safety issue: No]
The feasibility pilot study will conduct qualitative focus groups with intervention participants (n = 15 participants per group, 2 groups) and in-depth interviews with the community health workers and program mentors (n = 4 facilitators, n = 2 mentors) in order to explore program acceptability. These will occur during the post-evaluation and examine the following themes: 1) participants' observed change in parenting practices and child behavior at home during the program; 2) acceptability and appropriateness of program materials, delivery, and key program components; and 3) existing barriers to participation during sessions and engagement in home practice and other activities. Interviews will also explore facilitators' challenges in implementing the program.
- **South Africa General Household Survey** [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
Demographic factors include 1) caregiver factors: ethnicity, home language, age, gender, level of education, marital status, employment status, and source of income; 2) child factors: ethnicity, home language, age, gender, school attendance, relationship to caregiver; and 3) family factors: household size, household type, household members, number of siblings.
- **Economic Asset Index** [Time Frame: Pretest] [Designated as safety issue: No]
Economic Asset Index (EAI) measures relative household poverty based on methodology used in the

Demographic Health Survey (DHS) (Garcia-Moreno et al., 2006). This measurement has been used in over 55 countries, including South Africa, and by the World Bank to assess relative poverty from a variety of factors (Montgomery et al., 2000). The EAI examines adult reports of household ownership of consumer goods (television, radio, washing machine, car, etc.) and access to utilities and running water.

- National Food Consumption Survey [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
Parents will report positively or negatively on the occurrence of hunger during the past 30 days (e.g. – “the household has run out of money to buy food”).
- Revised Conflict Tactics Short Form [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
The Revised Conflict Tactics Short Form scale (CTS2S; 10 items) measures exposure to intimate partner physical and psychological violence (Straus, 2004). Adapted from the Revised Conflict Tactics (CTS2) scale (Straus et al., 1996), the measurement uses adult self-report on the frequency of negotiation, physical assault, psychological aggression, sexual coercion, and physical injury. Answers are coded on a Likert scale of 0 to 3 (0 = never happened; 3 = more than 3 times in the past year) with an additional response of 7 for incidences that happened more than a year ago. The CTS2S measures overall indication of intimate partner violence on a level of severity (sum of items) and p
- International Society for the Prevention of Child Abuse and Neglect's Child Abuse Screening Tools-Retrospective Version [Time Frame: Pretest] [Designated as safety issue: No]
This scale utilizes parent self-report of experiences during their own childhood (under 18 years old) to assesses the history of incidence of physical maltreatment (e.g. – “When you were growing up, did any person ever hit, punch or kick you very hard so they would hurt you?”) and sexual abuse (e.g. – “When you were growing up, did anyone expose their private parts (genitals) to you when you did not want them to?”) (Runyan et al., 2009). In this study, incidence of past history of child maltreatment will be scored as dichotomous variables for physical abuse and sexual abuse, as well as an overall indication of previous child abuse (0 = no abuse, 1 = previous abuse).
- World Health Organization Alcohol, Smoking and Substance Screening Tool (ASSIST) [Time Frame: Pretest and Posttest] [Designated as safety issue: No]
This 8-item measure screens for use, abuse, and dependence on variety of substances ranging from tobacco and alcohol to cannabis, cocaine, and amphetamines (Humeniuk et al., 2008). It has shown to have high reliability in multiple countries including Zimbabwe (Henry-Edwards et al., 2003). Responses are rated on a Likert scale of 1 to 5, ranging from never to daily use. Scores are summed to distinguish low risk, medium risk, and high risk of developing health or other problems from substance use (ASSIST manual, 2003).
- Government grants [Time Frame: Pretest and posttest] [Designated as safety issue: No]
The extent of government support grants for each family will be determined based on parental report of the major forms of social security transfers (5-items; Government Housing Subsidy, Old Age Pension, Child Support Grant, Foster Care Grant, Pension, and Disability Grant). A dichotomous variable will be created identifying whether the family received any grants. A separate predictor variable will be created specifically for child-related grants (Delaney, 2008).
- Parent Disability [Time Frame: Pretest] [Designated as safety issue: No]
Parental disability will be assessed using 6 items recommended by the Washington Group on Disability Statistics (see http://cdc.gov/nchs/washington_group/wg_questions.htm). These measure physical and psychological disability (i.e. – “do you have difficulty seeing, even if wearing glasses” or “do you have difficulty remembering or concentrating”) and have been extensively tested in South Africa (Schneider,

2009b, Schneider, 2009a) and internationally (Miller, 2010).

- **Parent Physical Illness** [Time Frame: Pretest and posttest] [Designated as safety issue: No]
Parental sickness will be measured using items from the Health Systems Trust South African Health Review 2006 (Ijumba and Padarath, 2006) and the South African Demographic and Health Survey (Department of Health and Medical Research Council, 2007) (16-items total). Participants will respond positively or negatively on the presence of chronic illnesses (asthma, epilepsy and diabetes), minor ailments (cold/flu and worms), and acute conditions (pneumonia, diarrhea and burns).
- **AIDS-related child orphanhood and parental HIV-status and/or AIDS-sickness** [Time Frame: Pretest and posttest] [Designated as safety issue: No]
This study will use parental reports of the Verbal Autopsy Questionnaire (VA; 18 items) to assess child AIDS-related orphanhood and caregiver AIDS-sickness, as well as other orphanhood causes and other sicknesses (Lopman et al., 2006). The VA has been validated in South Africa with a 76% positive prediction rate, 89% sensitivity, and 93% specificity (Hosegood et al., 2004, Kahn et al., 2000). This study will use a conservative approach requiring the presence of 3 or more AIDS-related symptoms defined by the World Health Organization (e.g. – oral candidiasis, respiratory tract infection, and persistent diarrhea) in order to determine caregiver HIV-status and/or AIDS-related parental mortality (WHO, 1994). To avoid potential stigmatization, items from the VA will be interspersed among items measuring other physical illnesses.

Estimated Enrollment: 60

Study Start Date: February 2013

Estimated Study Completion Date: June 2013

Estimated Primary Completion Date: June 2013

Arms	Assigned Interventions
Experimental: Parenting Program 12-week group-based parenting program (Sinovuyo Caring Family Programme) delivered in weekly sessions. Program is manualized.	Behavioral: Parenting Program Goal of the program is reduction in child behavior problems in high-risk South African families. Program will be delivered to caregivers responsible for the wellbeing of the child. Program activities will be delivered over 12 weekly group sessions with additional individualized in-home sessions. The groups (n = 15 participants per group) will meet weekly with community facilitators (n = 2 per group). Parenting skills will be developed during the sessions through role-plays, group-discussion, storytelling, and home practice activities. The program is manualized in isiXhosa. Other Names: Sinovuyo Caring Families Programme
No Intervention: Wait-list control	

Arms	Assigned Interventions
Wait-list control group. Program delivered 3 months after posttest.	

► Eligibility

Ages Eligible for Study: 18 Years and older

Genders Eligible for Study: Both

Inclusion Criteria:

- isiXhosa-speaking adults above the age of 18
- primary guardians of children aged 3-8 from Khayelitsha, Cape Town
- reside in the same household as child for at least 4 nights per week
- Score 11 or more on Eyberg Child Behavior Inventory Problem Scale

Exclusion Criteria:

- Severe mental health problems on Beck Depression Inventory
- Evidence of severe child maltreatment

► Contacts and Locations

Contacts

Catherine Ward, PhD	+27-21-650-3422	Catherine.Ward@uct.ac.za
Jamie M Lachman, MSc	+27 82 424 5691	jamie.lachman@spi.ox.ac.uk

Locations

South Africa

Ikamva Labantu Wellness Centre **Recruiting**
 Cape Town, Western Cape, South Africa, 7784
 Contact: Jamie Lachman, MSc +27 82 424 5691 jamie.lachman@spi.ox.ac.uk
 Sub-Investigator: Jamie Lachman, MSc

Investigators

Principal Investigator:	Catherine Ward, PhD	University of Cape Town
Principal Investigator:	Lucie Cluver, DPhil	University of Oxford

► More Information

Responsible Party: Dr Catherine L. Ward, Principal Investigator, University of Cape Town

Study ID Numbers: Griffin39

Health Authority: South Africa: Human Research Ethics Committee

Pan African Clinical Trial Registry



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08 February 2013

To Whom It May Concern:

RE: Sinovuyo Caring Families Project

As project manager for the Pan African Clinical Trial Registry (www.pactr.org) database, it is my pleasure to inform you that your application to our registry has been accepted. Your unique identification number for the registry is **PACTR201302000455414**

Please be advised that you are responsible for updating your trial, or for informing us of changes to your trial.

Additionally, please provide us with copies of your ethical clearance letters as we must have these on file (via email, post or fax) at your earliest convenience if you have not already done so.

Please do not hesitate to contact us at +27 21 938 0835 or email epienaar@mrc.ac.za should you have any questions.

Yours faithfully,

Elizabeth D Pienaar
www.pactr.org Project Manager
+27 021 938 0835



Appendix C.6. Certificates



Certificate of recognition for parents participating in the study.



Certificate of completion for parents participating in the Sinovuyo Caring Families Programme.

Appendix C.7. Referral Form

Name of Research Assistant:

Date of Interview:

Research ID:

Name of parent:

Gender of parent:

Name of child:

Gender of child:

Age:

Relationship to parent:

Address:

Phone number:

Presenting problems:

Current family conditions:

Action Taken:

Signed by Project Manager: _____

Date: _____

APPENDIX D. FORMATIVE EVALUATION INTERVIEW AND FOCUS GROUP GUIDE AND PROTOCOL³⁹

Appendix D.1. Interview and Focus Group Guide for Parents

Aim.

To gather the perceptions of parents regarding content necessary for inclusion in parenting programmes as well as potential barriers to participation in such programmes.

Approach.

This interview/focus group schedule uses an open-ended approach to soliciting views and feedback from participants in an un-biased and non-judgmental manner. Facilitators should guide the focus groups and interviews along the following steps while allowing the discussion to evolve as themes emerge that are important to participants. Each step begins with a “grand-tour question” followed by more specific questions that refer to evidence-based principles of parenting programmes, components, and delivery as well as specific cultural and local context issues.

- Step 1: Introduction of group interview and informed consent
- Step 2: Exploring what it means to be a parent/caregiver
- Step 3: Themes for a parenting group
- Step 4: Service delivery issues

Step 1: Introduction of group interview

We thank you for your participation in this interview. We have invited you here today because we want to learn more about your experiences as parents. We are really interested in your personal experiences and in any thoughts and feelings that you experience related to being a parent.

Your responses will help us understand your experiences related to your parenting efforts as well as the most common challenges that you experience as parents. We would also like to explore your interest in participating in future parenting groups especially designed for people in your community in order to support your parenting practices.

Step 2: Exploring what it means to be a parent/caregiver

Please describe what it is like to be a parent/caregiver in your community.

³⁹ All materials were translated into isiXhosa and then back-translated into English to assure accuracy of translations.

-
- Describe the experiences that give people the most satisfaction and happiness as a parents and caregivers in your community.
 - Tell us about what worries people the most about being a parent in your community.
 - Describe the daily challenges that parents experience in taking care of their children.
 - What are some ways that parents cope with daily challenges in their lives and as parents?
 - What are some ways that parents play or interact with their children?
 - What are some of the ways that parents discipline their children?
 - What are some of the ways that parents supervise their children to keep them safe?
 - What are the isiXhosa cultural values that influence parenting practices?

Step 3: Themes for a parenting group

What are some of the things you think would be included in a parenting programme?

Potential probes:

Children's needs:

- Responding sensitively to children's emotional needs;
- Learning about developmentally appropriate physical contact and affection to children;
- Helping children identify and express emotions.

Parent-child interaction:

- Learning skills that promote positive interactions or to play with children;
- Learning ways to communicate effectively with children.

Discipline and supervision:

- Learning ways to effectively discipline children;
- Learning ways to establish limits and supervise children to keep them safe.

Education and social behaviour:

- Learning how to teach children to share and cooperate, use good manners, and get along with peers, siblings, or adults;
- Learning how to help children with school as well as ways to interact with the schools as a parent;
- Learning how to communicate to children about health, HIV/AIDS, and succession planning.

Cultural values and approach:

- How would cultural values (i.e., the importance of *respect*) influence parenting practices?

-
- How would one connect to the support in one's family and community?

Step 4: Service delivery issues

Please describe how we might best provide a parenting programme to the community.

- What is the best way for parents to learn helpful ways of taking care of our children and coping with stress and difficulties in our lives?
- Who would most benefit from a parenting programme and how can we get them to participate? Who would have the most difficulty attending a parenting programme?
- In what setting would it be most ideal to have a parenting programme take place? At home? In a group? Both? How many sessions? When? Where?
- How can we engage and retain parents in a parenting programme? How can we get them to come to parenting groups and participate?
- What would be some of the challenges to getting parents to participate in a parenting programme and how could we overcome those challenges?
- What would be the best way to practice skills learned during the parenting programme? Role-playing; homework practising with child; observation?

Appendix D.2. Practitioner Focus Group Guide

Aim

To gather the perceptions of practitioners regarding content necessary for inclusion in parenting programmes as well as potential barriers to participation and implementation in such programmes.

Approach

The interview schedule uses an open-ended approach to soliciting views and feedback from participants in an un-biased and non-judgmental manner. Facilitators should guide the focus groups along the following steps while allowing the discussion to evolve as themes emerge that are important to participants. Each step begins with a “grand-tour question” followed by more specific questions that refer to evidence-based principles of parenting programmes, components, and delivery as well as specific cultural and local context issues.

- Step 1: Introduction of group interview
- Step 2: Exploring what it means to be a practitioner
- Step 3: Themes for a parenting group
- Step 4: Service delivery issues

Step 1: Introduction of group interview

We thank you for your participation in this group interview. We have invited you here today because we want to learn more about your experiences as a practitioner who works with parents. We are really interested in your personal experiences and in any thoughts and feelings that you experience related to being a practitioner.

The purpose of this focus group is to better understand how we can improve the lives of children and families in South Africa. We will be developing a family-based support programme to help families cope with stress and challenges in their daily lives. Your responses will help us understand your experiences related to your parenting efforts as well as the most common challenges that you experience as community health workers. We would also like to explore your interest in future parenting groups especially designed for people in your community in order to support parents.

Step 2: Exploring what it means to be a practitioner who works with parents and children

Please describe what it is like to be a community health worker who works with parents and children in your community.

- Describe the experiences that give you the most satisfaction and happiness as a practitioner.
- Tell us about what worries you the most about being a practitioner.
- Describe the daily challenges that you experience as a practitioner.

-
- What are some ways that you cope with daily challenges in your life and as a practitioner?
 - What are some ways that parents play or interact with children?
 - What are some of the ways that parents discipline children?
 - What are some of the ways that parents supervise children to keep them safe?
 - What are the isiXhosa cultural values that influence parenting practices?

Step 3: Themes for a parenting group

- What themes do you consider should be included in a parenting group for isiXhosa families?
- What are some of the things you think would be included in a parenting programme?
- Describe the importance and relevance of including the following themes (probes).

Children's needs:

- Responding sensitively to children's emotional needs;
- Learning about developmentally appropriate physical contact and affection to children;
- Helping children identify and express emotions.

Parent-child interaction:

- Learning skills that promote positive interactions or help parents play with children;
- Learning ways to communicate effectively with children.

Discipline and supervision:

- Learning ways to effectively discipline children;
- Learning ways in which parents can help establish limits and supervise children to keep them safe

Education and social behaviour:

- Learning how to teach children to share and cooperate, use good manners, and get along with peers, siblings, or adults;
- Learning how to help children with school as well as ways to interact with the schools as a parent;
- Learning how to communicate to children about health, HIV/AIDS, and succession planning.

Cultural values and approach:

- How would cultural values influence parenting practices?
- How would one connect to the support in one's family and community?

Step 4: Service delivery issues

Please describe how we might best provide a parenting programme to the community.

- What is the best way for parents to learn helpful ways of taking care of our children and coping with stress and difficulties in our lives?
- Who would most benefit from a parenting programme and how can we get them to participate? Who would have the most difficulty attending a parenting programme?
- In what setting would it be most ideal to have a parenting programme take place? At home? In a group? Both? How many sessions? When? Where?
- What sort of training would one need to be able to conduct parenting programmes as a community health worker?
- What would be some of the challenges to getting parents to participate in a parenting programme and how could we overcome those challenges?
- What would be the best way to practice skills learned during the parenting programme? Role-playing; homework practising with child; observation?

Appendix D.3. Focus group and Interview Protocol

Overview

As far as possible, the focus group and interviews must proceed according to the same steps in all sites (regardless of whether or not group or individual interviews take place). Where individual interviews may be necessary with the health and social workers, the process below will have to be adapted.

Personnel and equipment requirements

Each focus group session (not individual interview) must require the following:

- 1 experienced facilitator and 1 research assistant. Facilitators must be entirely familiar with the project's aims/methods. Research assistants will be fluent in English and isiXhosa as required.
- Facilitators will pose the questions, ensuring that they are understood.
- The research assistant will act as translator/note-taker to record responses and issues that stimulated debate. Their notes will provide essential back up in case the audio recording fails or does not capture sufficient detail.
- All equipment must be tested on site prior to the start of the session.
- 1 suitable quiet room required at each site to prevent noise interference in recordings

Practical arrangements

Information sheets and consent forms

Consent forms for participants must be created and administered prior to conducting the focus group or interview.

Location and practicalities

Focus groups should be conducted in a comfortable, quiet location that is as 'neutral' as possible to enable participants to express their views openly.

Refreshments

Refreshments must be served to welcome people and during breaks, and time allowed for people to get some fresh air.

Time required

The entire focus group session should be completed in 90 minutes. Within time, data collection should be broken down into sections of 45 minutes. Facilitators should make sure that they allocate sufficient time to welcome participants, serve refreshments, introduce everybody and do any "ice-breaker" exercises before beginning the focus group itself.

Preparation for the field

Translation of the questions

Prior to conducting the focus group facilitators (and translators) must translate questions from the current English version to isiXhosa and back-translate to ensure that meanings have been captured. Facilitators must also ensure local relevance by going through questions and inserting examples that are appropriate to the local context.

Recording the data

Facilitators should record as much as possible from the timelines. Audio recorders should be used to capture the process as well as discussion of issues. As a back-up to audio recording, and guide to transcriptions, note-takers should take handwritten notes on the following:

- Issues that prompt discussion and large differences of opinion amongst the group.
- Questions that are quickly understood and that elicit ready responses and a fair degree of consensus; in other words they seem relevant to the way participants are thinking about the issues.
- Those questions that do not elicit such responses may refer to indicators that are not part of, or are not prioritized within, indigenous/local knowledge systems.

Equipment required for focus groups in each site

- 1 digital audio recorder.
- Flip chart paper to make 1 timeline (see focus group procedure below).
- Flip chart paper and 1 stand for recording discussion in Step 1.
- 1 set of koki pens of different colours.
- 4 sets of pastel crayons.
- 15 large pastel papers.
- 1 audio speaker.
- 1 audio mp3player.
- Check sheets for recording responses on timeline.
- A meal, and a means to serve it.

APPENDIX E. BASELINE QUESTIONNAIRE FROM THE PILOT RCT STUDY⁴⁰

Section 1: Household Information and Demographic Information

1.1a Gender: 0 = Female 1 = Male

1.1b. Age: In years, for example “58 Y”.

1.1c Marital status: 1 = Single 2 = Partnered 3 = Married 4 = Separated
 5 = Divorced 6 = Widowed

1.1d Ethnicity: 0 = Black 1 = White 2 = Indian 3 = Asian
 4 = Coloured 5 = Other

1.1e Home language

- 1 L = isiXhosa/Xhosa
- 2 L = isiZulu/Zulu
- 3 L = Afrikaans
- 4 L = English
- 5 L = Sesotho
- 6 L = Setswana
- 7 L = Siswati/Swazi
- 8 L = Tshivenda/Venda
- 9 L = Xitsonga/Tsonga
- 10 L = Ndebele
- 11 L = Sepedi/Northern Sotho
- 12 L = Other (specify):

1.1.f. What is the highest level of education that you have successfully completed?

- 0 = No schooling
- 1 = Some primary school
- 2 = Completed primary school
- 3 = Some high school
- 4 = Completed high school
- 5 = Post-matric degree / Diploma
- 6 = Post graduate degree
- 7 = Other (specify):
- 8 = Don't know

1.2. Household Info

⁴⁰ This English and isiXhosa versions of this questionnaire were uploaded to the Mobenzi server and administered using handheld cell phone devices to collect data during the pilot RCT.

1.2a: What best describes your household: (circle one answer choice)

- 1 = dwelling/house or brick structure on a separate stand or yard
- 2 = town/cluster/semi-detached house (simplex, duplex, triplex)
- 3 = dwelling/house/flat/room in backyard
- 4 = informal dwelling/shack in backyard
- 5 = informal dwelling/shack not in backyard
- 6 = room/flatlet on a property or a larger dwelling
- 7 = caravan/tent
- 8 = other (specify)

1.2b. Which of the following does your household have:

☐ Running water (inside house)	☐ Telephone
☐ Running water (on site)	☐ Washing machine
☐ Running water (off site)	☐ Car
☐ Electricity	☐ Refrigerator
☐ Radio	☐ Personal computer
☐ Television	

1. 3. Household Members

Now I would like to learn about any people who stayed in this household at least 4 nights on average per week in the last 4 weeks.

Note to staff: Enter each person separately for 1.3.

1.3a: How many people including you stay in this household?

1.3b: What is . . . 's relationship to you (i.e. the caregiver – person number “1”)? Fill in the correct code for each person below the population/language group if applicable. For example, “12 rel”.

- 1 rel = husband/wife/partner
- 2 rel = father/mother/stepfather/stepmother
- 3 rel = grandparent/great grandparent
- 4 rel = parent in-laws
- 5 rel = brother or sister in-laws
- 6 rel = aunt/uncle
- 7 rel = biological or stepson/stepdaughter
- 8 rel = brother/sister/stepbrother/stepsister
- 9 rel = grandchild or grandnephew/grandniece
- 10 rel = great grandchild
- 11 rel = niece or nephew
- 12 rel = non-related child who was a neighbour's child
- 13 rel = non-related child who was a friend's child
- 14 rel = non-related foster child that you previously did not know through a

neighbour or friend
15 rel = cousin
16 rel = renter
17 rel = other (specify)

1.3c: How old is . . . ? Enter age in years, for example “58 Y” or if the person is under 1 year, write age in months, “8M”.

1.3d: What gender is ...?

1.4 Hunger Scale

1.4a: Does your household ever run out of money to buy food?

1.4b: Has it happened in the past 30 days?

1.4c: Has it happened 5 or more days in the past 30 days?

1.4d: Do you ever cut the size of meals or skip any meals because there is not enough food in the house?

1.4e: Has it happened in the past 30 days?

1.4f: Has it happened 5 or more days in the past 30 days?

1.4g: Do you or any of your children go to bed hungry because there is not enough money to buy food?

1.4h: Has it happened in the past 30 days?

1.4i: Has it happened 5 or more days in the past 30 days?

1.5. Employment and Income

1.5a: Are you currently working?

0 = no
1 = yes

1.5b: Do you part-time or full-time?

0 = part-time
1 = full-time

1.5c: Is your work informally (i.e. hawking or spaza) or formally (i.e. a regular job, contract, casual or piece work for pay, work in exchange for food or housing)?

0 = informal

1 = formal

1.5d: Does anyone else in your household have a job (including informal work)?

0 = no

1 = yes

1.5e: What is the main source of income for this household? Is it? (circle one answer choice)

1 = salaries and/or wages

2 = remittances (money sent from someone else)

3 = pensions and grants

4 = sales of farm products and services

5 = other incomes

1.6 Government Support

1.6: Now I want to ask you about social grants received by members of this household.

Yes/No/Don't Know

1.6a: *Ask only if there are person(s) in the household 15 years or younger.* Does anyone in the household receive a child support grant?

1.6b: *Ask only if there are person(s) in the household 21 years or younger.* Does anyone in the household receive a foster care grant?

1.6c: *Ask only if there are person(s) in the household 18 years or younger.* Does anyone in the household receive a care dependency grant?

1.6d: *Ask only if there are person(s) in the household 60 years or older.* Does anyone in the household receive an old age pension?

1.6e: *Ask only if there are person(s) in the household that are male and between 18 and 64 years OR female and between 18 and 59 years.* Does anyone in your home receive a disability grant?

1.6f: Does anyone in the household receive a government housing subsidy, such as RDP housing subsidy?

Section 2: Caregiver Strain and Health

The most important part of this survey is to learn about the types of challenges you face as a caregiver. The next set of questions will focus on learning more about the challenges you face in terms of your health, which can impact your ability to provide care for children in the home. The following questions ask for your views about your health. This information will help keep track of how you feel and how well you are able

to do your usual activities.

2.1. General Health

2.1a: In general, would you say your health is

- 1 = Excellent?
- 2 = Very good?
- 3 = Good?
- 4 = Fair?
- 5 = Poor?

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2.2a: Moderate activities, such as moving a table, or pushing around boxes in the home.

- 1 = Yes, limited a lot
- 2 = Yes, limited a little
- 3 = No, not limited at all

2.2b: Carrying shopping, walking distance, or carrying a child.

- 1 = Yes, limited a lot
- 2 = Yes, limited a little
- 3 = No, not limited at all

2.3 Physical Illness

We all get sick sometimes. We would like to ask about any illness you might have. These questions may be personal but this information will be valuable for government, that wants to better understand the health of parents in order to support them. Therefore, these questions are especially important for our survey. Remember, all your responses will be strictly confidential. If you become uncomfortable, remember you can always ask us to stop at any time.

Have you had any of these symptoms? Yes/No

- 2.3a Have you had general body pain (headaches, backaches etc)?
- 2.3b Have you had a cold or flu?
- 2.3c Have you lost weight and become very thin?
- 2.3d Do you have asthma?
- 2.3e Have you had a stroke?
- 2.3f Do you have heart disease?
- 2.3g Do you have diabetes?
- 2.3h Do you have BP or high blood pressure?
- 2.3i Do you have epilepsy?
- 2.3j Do you have any of the following symptoms: paleness, changing hair colour,

-
- burning sensations of feet, dry scaly skin?
- 2.3k Do you have jaundice where the whites of your eyes are yellow and no history of alcohol abuse?
- 2.3l Do you have shingles or a rash on your skin like a belt?
- 2.3m Do you have herpes zoster?
- 2.3n Do you have abscesses or sores?
- 2.3o Do you have two of the following: ulcers in the mouth, difficulty swallowing, or white patches inside the mouth?
- 2.3p Do you have cancer?
- 2.3q *Ask only if 2.3p is affirmative:* If you have cancer, where is the cancer?
- 2.3r Have you had pneumonia or bronchitis (really sick with cough, chest pain and yellow spit for at least 1 week)?
- 2.3s Do you have trouble breathing, cough lasting more than 2 days with fever?
- 2.3t Have you had TB within the last 5 years?
- 2.3u Have you ever been tested for HIV?
- 2.3v *Ask only if 2.3u is affirmative:* Was the result positive for HIV?
- 2.3w *Ask only if 2.3u is affirmative:* Do you use anti-retrovirals or ARVs?
- 2.3x *Ask only if 2.3u is affirmative:* Last time you went to the doctor, did they tell you your CD4 count? What was it?
- 2.3y Have you been bewitched?
- 2.3z Have you had any injury or burn?
- 2.3aa Do you have arthritis?
- 2.3bb Have you had acute diarrhea or loose stools for more than 2 days?
- 2.3cc Do you have anything else we haven't asked about?
- 2.3dd *Ask if the participant answered "Yes" to Q2.3cc* If yes, what do you have? (specify):

2.4 Physical Disability

- 1 = No, no difficulty
2 = Yes, some difficulty
3 = Yes a lot of difficulty
4 = Cannot do at all

- 2.4a Do you have difficulty seeing, even if wearing glasses?
- 2.4b Do you have difficulty hearing, even if using a hearing aid?
- 2.4c Do you have difficulty walking or climbing steps?
- 2.4d Do you have difficulty remembering or concentrating?
- 2.4e Do you have difficulty with self care such as washing yourself all over or dressing?
- 2.4f Using your usual language, do you have difficulty communicating or being understood?

2.4g Are you disabled? 1 = Yes 2 = No 3 = Unsure/Don't Know

Ask only if 2.4g is Yes

2.4h What kind of disability?

Section 3: Child in Study

Note: Guardian only answers for child participating in the Sinovuyo Family Programme.

Section 3.1 Child Demographics

3.1a. Age: How old is the child in the study? Years

3.1b. Gender: 0 = Male 1 = Female

3.1c. What is your relationship to the child?

- 1 rel = biological
- 2 rel = stepson/stepdaughter
- 3 rel = brother/sister/stepbrother/sister
- 4 rel = grandchild son/daughter
- 5 rel = great grandchild
- 6 rel = niece or nephew
- 7 rel = non-related child who was a neighbour's child
- 8 rel = non-related child who was a friend's child
- 9 rel = non-related foster child that you previously did not know through a neighbour or friend
- 10 rel = cousin
- 11 rel = other (specify)

3.1d. Enrolment: Is your child currently enrolled in school (grade school or pre-school crèche)?

Yes/No

3.1e. What level of school is your child enrolled in? *Check box for highest level achieved.*

0 = Pre-school Crèche 1 = Grade R 2 = Grade 1 3 = Grade 2
4 = Grade 3 5 = Grade 4 or above 333 = Not in school

3.1f Reason for non-enrolment: If not, what is the main reason?

Note: Only check one!

- 0 = Too old/young
- 1 = No money for school fees or other school expenses
- 2 = Illness
- 3 = Other

Section 3.2. Child's Parents

Ask only if respondent is not the biological father:

3.2a Is your child's biological father part of this household? 0 = Yes 1 = No

3.2b. If not, can you tell us where he is?

0 = Works away from home to provide financial support to household

1 = Uninvolved in household life

2 = Lives elsewhere, but is involved in household

3 = Death

4 = Other Write out what reason is

Ask only if 3.2b answers "3 for death".

3.2c Was the father's death due to

0 = Illness or other health problem

1 = Attacked or killed by a person

2 = Traffic accident

3 = Other

4 = Don't know

3.2d *Ask only if answers "Illness or other health problem"*

Was the health related reason due to:

0 = Heart disease

1 = Stroke

2 = Hypertension

3 = Diarrheal disease

4 = Diabetes

5 = Lung disease

6 = Asthma

7 = HIV/AIDS

8 = Other illness

999 = Don't know

3.3 Cause of Father's Death

Ask only if 3.2c. answers "Illness or other health problem." Check all that apply.

3.3a Did he lose weight and become very thin?

3.3b Did he have diabetes?

3.3c Did he have any of the following symptoms: paleness, changing hair colour, burning sensations of feet, dry scaly skin?

3.3d Did he have emotional problems?

3.3e Did he have epilepsy?

3.3f Were his eyes yellow and did he have a fever?

3.3g Did he have shingles or a rash on his skin like a belt?

3.3h Did he have high blood pressure?

3.3i Did he have abscesses or sores?

3.3j Did he have two of the following: ulcers in the mouth, difficulty swallowing, or

-
- white patches inside the mouth?
- 3.3k Did he drink too much alcohol?
- 3.3l Did he have cancer?
- 3.3m Did he have high blood pressure?
- 3.3n Did he have trouble breathing, cough lasting more than 2 days with fever?
- 3.3o Did he have TB within the last 5 years?
- 3.3p Did he have arthritis?
- 3.3q Did he have acute diarrhoea or loose stools for more than 2 days?
- 3.3r Did he have HIV?
- 3.3s Was he bewitched?

Ask only if respondent is not the biological mother:

3.4a. Is your child's biological mother part of this household?

3.4b If not, can you tell us where she is?

- 0 = Works away from home to provide financial support to household
- 1 = Uninvolved in household life
- 2 = Lives elsewhere, but is involved in household
- 3 = Death
- 4 = Other

3.4c. Was the mother's death due to

- 0 = Illness or other health problem
- 1 = Attacked or killed by a person
- 2 = Traffic accident
- 3 = Other
- 4 = Don't know

3.4d. *Ask only if 3.4c. answers "Illness or other health problem."*

Was the health related reason due to

0 = Heart disease	1 = Stroke
2 = Hypertension	3 = Diarrheal diseases
4 = Diabetes	5 = Pulmonary disease
6 = Asthma	7 = HIV/AIDS
8 = Other illness	999 = Don't know

3.5 Cause of mother's death

Ask only if 3.4c answers "Illness or other health problem." Check all that apply.

- 3.5a Did she lose weight and become very thin?
- 3.5b Did she have diabetes?
- 3.5c Did she have any of the following symptoms: paleness, changing hair colour,

-
- burning sensations of feet, dry scaly skin?
- 3.5d Did she have emotional problems?
- 3.5e Did she have epilepsy?
- 3.5f Were her eyes yellow and did she have a fever?
- 3.5g Did she have shingles or a rash on her skin?
- 3.5h Did she have high blood pressure?
- 3.5i Did she have abscesses or sores?
- 3.5j Did she have two of the following: ulcers in the mouth, difficulty swallowing, or white patches inside the mouth?
- 3.5k Did she drink too much alcohol?
- 3.5l Did she have cancer?
- 3.5m *Answer only if 6.3l is affirmative:* If he had cancer, where was the cancer?
- 3.5n Did she have high blood pressure?
- 3.5o Did she have trouble breathing, cough lasting 3-27 days with fever?
- 3.5p Did she have TB within the last 5 years?
- 3.5q Did she have arthritis?
- 3.5r Did she have acute diarrhoea or loose stools for more than 2 days?
- 3.5s Did she have HIV?
- 3.5t Was she bewitched?

Section 4: Child Behaviour (ECBI)

I would like to learn about your child's behaviour. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behaviour over the last month.

Below are a series of phrases that describe children's behaviour.

A. Enter the number describing **how often** the behaviour **currently** occurs with your child.

- 0 = Never
- 1 = Once in the past month
- 2 = Twice in the past month
- 3 = Three or more times in the past month
- 4 = Weekly in the past month
- 5 = Twice a week in the past month
- 6 = Almost daily in the past month

B. Enter either "yes" or "no" to indicate whether the behaviour is **currently a problem for you**.

- 4.1 Is slow in getting dressed
- 4.2 Eats slowly at mealtimes
- 4.3 Has poor table manners
- 4.4 Refuses to eat food presented
- 4.5 Refuses to do chores when asked
- 4.6 Slow in getting ready for bed

-
- 4.7 Refuses to go to bed on time
 - 4.8 Does not obey our family rules on own
 - 4.9 Refuses to obey until threatened with punishment
 - 4.10 Acts defiant when told to do something
 - 4.11 Argues with parents about rules
 - 4.12 Gets angry when doesn't get own way
 - 4.13 Has temper tantrums
 - 4.14 Cheeks adults
 - 4.15 Whines
 - 4.16 Cries easily
 - 4.17 Yells or screams
 - 4.18 Hits parents
 - 4.19 Destroys toys or other objects
 - 4.20 Is careless with toys and other objects
 - 4.21 Steals
 - 4.22 Lies
 - 4.23 Teases or provokes other children
 - 4.24 Verbally fights with friends own age
 - 4.25 Verbally fights with sisters and brothers
 - 4.26 Physically fights with friends own age
 - 4.27 Physically fights with sisters and brothers
 - 4.28 Constantly seeks attention
 - 4.29 Interrupts
 - 4.30 Is easily distracted
 - 4.31 Has short attention span
 - 4.32 Fails to finish tasks or projects
 - 4.33 Has difficulty entertaining self alone
 - 4.34 Has difficulty concentrating on one thing
 - 4.35 Is overactive or restless
 - 4.36 Wets the bed

Section 5 Parent-Child Relationships

Now I want to learn about the quality of your relationship with your child. It would help us if you answered all items as best you can even if you are not absolutely certain.

Please give your answers on the basis of your relationship with your child over the 3 months.

Please answer only answer these questions for your child who is part of the programme.

5.1 Parent-Child Conflict (CTSPC)

- 0 = This has never happened
- 1 = Not this past 3 months but happened before
- 2 = Once in the past 3 months
- 3 = Twice in the past 3 months
- 4 = Three or more times in the past 3 months

-
- 5.1a Have you explained to (Child X) why something was wrong?
 - 5.1b Have you put him/her in “time out” or sit by himself/herself inside?
 - 5.1c Have you shaken him/her?
 - 5.1d Have you hit him/her on the bottom with something like a belt, hairbrush, a stick or some hard object?
 - 5.1e Have you redirected your child to something positive when he/she was doing something wrong?
 - 5.1f Have you shouted, yelled, or screamed at him/her?
 - 5.1g Have you hit him/her with a fist or kicked him/her hard?
 - 5.1h Have you spanked him/her on the bottom with a bare hand?
 - 5.1i Have you grabbed him/her around the neck and choked him/her?
 - 5.1j Has any adult sworn or cursed at him/her?
 - 5.1k Did you beat him/her up, that is hit him/her over and over as hard as you could?
 - 5.1l Has anyone said they would send him/her away or kick him/her out of the house?
 - 5.1m Have you burned or scalded him/her on purpose?
 - 5.1n Have you threatened to spank or hit him/her but did not actually do it?
 - 5.1o Have you hit him/her on some other part of the body besides the bottom with something like a belt, hairbrush, stick, or some other hard object?
 - 5.1p Has any adult slapped him/her on the hand, arm, or leg?
 - 5.1q Have you taken away privileges or grounded him/her?
 - 5.1r Have you pinched him/her?
 - 5.1s Have you threatened him/her with a knife or gun?
 - 5.1t Have you thrown or knocked him/her down?
 - 5.1u Have you called him/her dumb or some other name like that?
 - 5.1v Have you slapped him/her on the face or head or ears?

5.2 Positive Parenting (PARYC)

Please give your answers on the basis of your relationship with your child over the last month.

Enter the number describing **how often** the behaviour **currently** occurs with your child.

- 0 = Never
- 1 = Once in the past month
- 2 = Twice in the past month
- 3 = Three or more times in the past month
- 4 = Weekly in the past month
- 5 = Twice a week in the past month
- 6 = Almost daily in the past month

- 5.2a Play with your child in a way that was fun for both of you?
- 5.2b Stand back and let your child work through problems s/he might be able to solve?
- 5.2c Invite your child to play a game with you or share an enjoyable activity?
- 5.2d Notice and praise your child’s good behavior?
- 5.2e Teach your child new skills?
- 5.2f Involve your child in household chores?

-
- 5.2g Reward your child when s/he did something well or showed a new skill?
 - 5.2h Stick to your rules and not change your mind?
 - 5.2i Speak calmly with your child when you were upset with him or her?
 - 5.2j Explain what you wanted your child to do in clear and simple ways?
 - 5.2k Tell your child what you wanted him or her to do rather than tell him/her to stop doing something?
 - 5.2l Tell your child how you expected him or her to behave?
 - 5.2m Set rules on your child's problem behavior that you were willing/able to enforce?
 - 5.2n Make sure your child followed the rules you set all or most of the time?

Section 6: Parental Mental Health

6.1. Depression (BDI-II)

Now, I want to learn more about how you have been feeling emotionally and mentally.

Please listen to each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the **past two weeks, including today**. Only choose one statement for each group

6.1a Sadness

- 0 = I do not feel sad
- 1 = I feel sad much of the time
- 2 = I am sad all the time
- 3 = I am so sad or unhappy that I cannot stand it

6.1b Pessimism

- 0 = I am not discouraged about my future
- 1 = I feel more discouraged about my future than I used to be
- 2 = I do not expect things to work out for me
- 3 = I feel my future is hopeless and will only get worse

6.1c Past failure

- 0 = I do not feel like a failure
- 1 = I have failed more than I should have
- 2 = As I look back, I see a lot of failures
- 3 = I feel I am a total failure as a person

6.1d Loss of pleasure

- 0 = I get as much pleasure as I ever did from the things I enjoy
- 1 = I don't enjoy things as much as I used to
- 2 = I get very little pleasure from the things I used to enjoy
- 3 = I can't get any pleasure from the things I used to enjoy

6.1e Guilty feelings

- 0 = I don't feel particularly guilty
- 1 = I feel guilty over many things I have done or should have done
- 2 = I feel quite guilty most of the time
- 3 = I feel guilty all of the time

6.1f Punishment feelings

- 0 = I don't feel I am being punished
- 1 = I feel I may be punished
- 2 = I expect to be punished
- 3 = I feel I am being punished

6.1g Self-dislike

- 0 = I feel the same about myself as ever
- 1 = I have lost confidence in myself
- 2 = I am disappointed in myself
- 3 = I dislike myself

6.1h Self-criticalness

- 0 = I don't criticize or blame myself more than usual
- 1 = I am more critical of myself than I used to be
- 2 = I criticize myself for all of my faults
- 3 = I blame myself for all of my faults

6.1i Suicidal thoughts or wishes

- 0 = I don't have any thoughts of killing myself
- 1 = I have thoughts of killing myself, but I would not carry them out
- 2 = I would like to kill myself
- 3 = I would kill myself if I had the chance

6.1j Crying

- 0 = I don't cry any more than I used to
- 1 = I cry more than I used to
- 2 = I cry over every little thing
- 3 = I feel like crying, but I can't

6.1k Agitation

- 0 = I am no more restless or wound up than usual
- 1 = I feel more restless or wound up than usual
- 2 = I am so restless or agitated that it's hard to stay still
- 3 = I am so restless or agitated that I have to keep moving or doing something

6.1l Loss of interest

- 0 = I have not lost interest in other people or activities
- 1 = I am less interested in other people or things than before
- 2 = I have lost most of my interest in other people
- 3 = It's hard to get interested in anything

6.1m Indecisiveness

- 0 = I make decisions about as well as ever
- 1 = I find it more difficult to make decisions than usual
- 2 = I have much greater difficulty in making decisions than I used to
- 3 = I have trouble making any decisions

6.1n Worthlessness

- 0 = I do not feel I am worthless
- 1 = I don't consider myself as worthwhile and useful as I used to
- 2 = I feel more worthless as compared to other people
- 3 = I feel utterly worthless

6.1o Loss of energy

- 0 = I have as much energy as ever
- 1 = I have less energy than I used to have
- 2 = I don't have enough energy to do very much
- 3 = I don't have enough energy to do anything

6.1p Changes in sleeping pattern

- 0 = I have not experienced any change in my sleeping pattern
- 1a = I sleep somewhat more than usual
- 1b = I sleep somewhat less than usual
- 2a = I sleep a lot more than usual
- 2b = I sleep a lot less than usual
- 3a = I sleep most of the day
- 3b = I wake up 1-2 hours early and can't get back to sleep

6.1q Irritability

- 0 = I am no more irritable than usual
- 1 = I am more irritable than usual
- 2 = I am much more irritable than usual
- 3 = I am irritable all the time

6.1r Changes in appetite

-
- 0 = I have not experienced any change in my appetite
 - 1a = My appetite is somewhat less than usual
 - 1b = My appetite is somewhat greater than usual
 - 2a = My appetite is much less than usual
 - 2b = My appetite is much greater than usual
 - 3a = I have no appetite at all
 - 3b = I crave food all the time

6.1s Concentration difficulty

- 0 = I can concentrate as well as ever
- 1 = I can't concentrate as well as usual
- 2 = It's hard to keep my mind on anything for very long
- 3 = I find I can't concentrate on anything

6.1t Tiredness or fatigue

- 0 = I am no more tired or fatigued than usual
- 1 = I get more tired or fatigued more easily than usual
- 2 = I am too tired or fatigued to do a lot of things I used to do
- 3 = I am too tired or fatigued to do most of the things I used to do

6.1u Loss of interest in sex

- 0 = I have not noticed any recent change in my interest in sex
- 1 = I am less interested in sex than I used to be
- 2 = I am much less interested in sex now
- 3 = I have lost interest in sex completely

6.2 Parenting stress (PSI-SF)

Sometimes parenting our children can be stressful. Can you tell us how true these are for you and your child over the past 3 months?

For this scale, 0 = Always; 1 = Often; 2 = Sometimes; 3 = Almost Never; 4 = Never

- 6.2a I feel that I cannot handle things
- 6.2b I spend all my time caring for my children's needs
- 6.2c I feel trapped by my responsibilities to my children
- 6.2d I feel unable to do new or different things
- 6.2e I am never able to do the things I like
- 6.2f I feel unhappy with the last thing I bought for myself
- 6.2g Quite a few things bother me
- 6.2h Taking care of children causes problems between me and my spouse
- 6.2i I feel alone and without friends
- 6.2j I expect not to enjoy myself with others
- 6.2k I am not as interested in people as I used to be
- 6.2l I do not enjoy things as I used to

6.3. Social support (MSPSS)

Now I want to learn about the people who support you when you face challenges. People sometimes look to others for companionship, assistance, or other types of support. I am going to read you several statements and I am going to ask how much you disagree or agree with them...

- 1 = Disagree very strongly
- 2 = Disagree a lot
- 3 = Disagree a little
- 4 = Neutral
- 5 = Agree a little
- 6 = Agree a lot
- 7 = Agree very strongly

- 6.3a There is a special person who is around when I am in need.
- 6.3b There is a special person with whom I can share my joys and sorrows.
- 6.3c My family really tries to help me.
- 6.3d I get the emotional help and support I need from my family.
- 6.3e I have a special person who is a real source of comfort to me.
- 6.3f My friends really try to help me.
- 6.3g I can count on my friends when things go wrong.
- 6.3h I can talk about my problems with my family.
- 6.3i I have friends with whom I can share my joys and sorrows.
- 6.3j There is a special person in my life who cares about my feelings.
- 6.3k My family is willing to help me make decisions.
- 6.3l I can talk about my problems with my friends.

Section 7: Exposure to intimate partner violence (CTS2S)

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason.

Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please answer how many times this happened in the past 3 months.

How often did any of the following happen?

- 0 = never happened
- 1 = once in the past 3 months
- 2 = twice in the past 3 months
- 3 = More than 3 times in the past 3 months
- 7 = Happened before but not in the past 3 months

-
- 7.1 My partner explained his or her side or suggested a compromise for a disagreement with me.
 - 7.2 My partner insulted or shouted or yelled or swore at me.
 - 7.3 I had a sprain, bruise, or small cut because of a fight with my partner.
 - 7.4 My partner showed respect for, or showed that he or she cared about my feeling about an issue we disagreed on.
 - 7.5 My partner pushed, shoved or slapped me.
 - 7.6 My partner punched me, kicked me, or beat me up.
 - 7.7 My partner destroyed something belonging to me or threatened to hit me.
 - 7.8 I went to the doctor or needed to see a doctor because of a fight with my partner.
 - 7.9 My partner used force (like hitting, holding down, or using a weapon) to make me have sex.
 - 7.10 My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force)

Section 8: History of child maltreatment (ICAST-R)

We would like to ask you questions about your early life, from when you were a small child to before you were 18 years old. The questions are about violent or upsetting things that can happen to children and young people. Everything you say is private. No one in your family, your neighbourhood, or the authorities will know what you tell us. We need to learn about the lives of many people in this country. Please answer all of the questions even if you think some of them do not apply to you.

8.1a When you were growing up (before age 18), did any person ever hit, punch or kick you very hard so they would hurt you?

- ☐ Yes ☐ No (Go to Question 4.2) ☐ Cannot remember

8.1b If yes, how often did this happen?

- ☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.2a When you were growing up (before age 18), did any person ever beat you very hard with an object like a stick, cane, whip or belt so they so they would hurt you?

- ☐ Yes ☐ No (Go to Question 4.3) ☐ Cannot remember

8.2b If yes, how often did this happen

- ☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.3a Before you were 18, did anyone ever stab or cut you with a knife or sharp object so they would hurt you?

- ☐ Yes ☐ No (Go to Question 4.3) ☐ Cannot remember

8.3b If yes, how often did this happen

☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.4a Many children have experiences where someone hurts their body on purpose, by hitting, beating or doing other acts. This might have happened to you. In general, how do you think about your childhood now?

- ☐ I was never hurt on purpose by anyone
☐ When people hit or beat me, mostly it was discipline and it was reasonable and justified
☐ When people hit or beat me, mostly it was discipline but it was NOT reasonable and justified
☐ When I was hit or beaten, mostly it was NOT discipline and it was NOT justified

8.5a In general before you were 18, how often were you physically hurt (beaten, hit, or other acts) compared with other children around your age at the time?

- ☐ A lot less than most children
☐ A little less than most children
☐ About the same as most children
☐ A little more than most children
☐ Much more than most children

8.6. Sometimes things happen that make children feel very frightened or worried. They may also be made to feel embarrassed or ashamed, or unloved. Please answer each of these questions about events that may have happened to you before you were 18.

8.6a When you were growing up (before age 18), did anyone expose their private parts (genitals) to you when you did not want them to?

☐ Yes ☐ No (Go to Question 4.7) ☐ Cannot remember

8.6b If yes, how often did this happen

☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.7a Before age 18, did anyone make you pose naked in front of other people or for photographs, video or internet webcam when you did not want to do this?

☐ Yes ☐ No (Go to Question 4.8) ☐ Cannot remember

8.7b If yes, how often did this happen

☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.8a Before age 18, did anyone touch your private parts (genitals), when you did not want them to?

☐ Yes ☐ No (Go to Question 4.9) ☐ Cannot remember

8.8b If yes, how often did this happen

☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.9a Before age 18, did anyone make you touch their private parts (genitals) when you did not want to do this?

☐ Yes ☐ No (Go to Question 4.10) ☐ Cannot remember

8.9b If yes, how often did this happen

☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.10a Before age 18, did anyone touch your private parts (genitals), when you did not want them to?

☐ Yes ☐ No (Go to Question 4.11) ☐ Cannot remember

8.10b If yes, how often did this happen

☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

8.11a Before age 18, did anyone ever have sexual intercourse with you, when you did not want them to? (By ‘intercourse’, we mean penis enters vagina or anus)

☐ Yes ☐ No (Go to Question 4.12) ☐ Cannot remember (Go to Question 4.12)

8.11b If yes, how often did this happen

☐ 1 or 2 times ☐ Between 3 – 10 times ☐ More than 10 times

Section 9: Substance Abuse (ASSIST)

Notes to interviewer:

Never: refers to not used in the last 3 months.

Once or twice: refers to using 1-2 times in the last 3 months.

Weekly: refers to using 1-4 times per week.

Monthly: refers to using 1-3 times in 1 month.

Daily or almost daily: refers to using 5-7 days a week.

Only ask 9.2 to 9.7 for substances that respondent answers affirmatively for 9.1.

9.1 In your life, which of the following substances have you ever used? YES/NO

- 1) Tobacco (dried leaves of tobacco plant e.g. cigarettes, snuff)
- 2) Alcoholic beverages
- 3) Cannabis (aka dagga, marijuana, grass, pot, ganja, hash, etc.)
- 4) Amphetamine-type stimulants (e.g.s MDMA, ecstasy, E, Tik, Meth , crystal meth, ice, speed)
- 5) Inhalants (e.g. sniffing glue, petrol, nail polish, poppers, etc)
- 6) Sedatives, sleeping pills or prescription drugs (e.g. benzos, mandrax (smarties), buttons etc)
- 7) Cocaine (aka coke, snow, chang, crack etc)
- 8) Hallucinogens (e.g. acid, LSD, mushrooms, shrooms, angel dust, DMT)
- 9) Opiates (e.g. heroin, opium, morphine)
- 10) Other drugs (tranquilisers, Rohypnol, roofies, date rape drug, downers)

9.2. In the past 3 months, how often have you ever used the substances you mentioned above?

0 = Never 1 = Once or twice 2 = Monthly 3 = Weekly 4 = Daily

9.3 During the past 3 months, how often have you had a strong desire or urge to use (1st drug, 2nd drug etc)?

0 = Never 1 = Once or twice 2 = Monthly 3 = Weekly 4 = Daily

9.4 During the past 3 months, how often has your use of (1st drug, 2nd drug, etc.) led to health, social, legal or financial problems?

0 = Never 1 = Once or twice 2 = Monthly 3 = Weekly 4 = Daily

9.5 During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (1st drug, 2nd drug, etc.)

9.6 Has a friend or relative or anyone else ever expressed concern about your use of (1st drug, 2nd drug, etc.)

0 = Never 1 = Once or twice 2 = Monthly 3 = Weekly 4 = Daily

9.7 Have you ever tried to control, cut down or stop using (1st drug, 2nd drug, etc)

0 = Never 1 = Once or twice 2 = Monthly 3 = Weekly 4 = Daily

Thank you for your valuable time and for sharing this information with me/us. We really value what you do as a caregiver. Again, we would like to say thank you for your time and for sharing this valuable information with us!

APPENDIX F. PILOT RCT QUANTITATIVE ASSESSMENT

SCRIPTS⁴¹

Appendix F.1. Script for Administering Recruitment and Screening at Baseline

[Research Assistant (RA arrives at parent's home for screening)]

RA: Good day, I am (INSERT NAME). I am from the Sinovuyo Caring Families Project. May I please speak to [parent of interest]?

[Parent/primary caretaker arrives]

RA: Good day, I am (INSERT NAME). I am from the Sinovuyo Caring Families Project. I would like to talk to you about a study that we are doing to learn how to support parents and their children.

[If parent is interested in the programme] **RA:** Thank you for your interest in the study, and for letting us give you some more information. We would like to go through an information sheet with you. This sheet explains the study and what we will be doing. Please feel free to ask any questions as we go along. We want you to understand everything about the study.

[RA: GO THROUGH INFORMATION SHEET]

RA: Do you have any other questions about the information we have given you so far? If you would like to take part in the study, you will need to sign this consent form. We will go through the form with you. Signing the consent form means that you agree to take part in the study.

[CONSENT] **RA:** Thank you for giving consent to participate in the study. We are grateful that you are willing to participate in this important study that will help to improve the lives of children and their families in South Africa.

[NO CONSENT] **RA:** Thank you for giving us the time to explain the study. We are sorry to hear that you do not want to participate in the study. Please could you tell us why you do not want to participate?

[RA: Please write down reason why parent does not want to participate.].

[If consent has been signed, move on to screening.]

RA: I will now ask you some questions about you and your child to see whether you can take part in the study. You do not have to answer any questions you do not want to

⁴¹ All scripts were translated into isiXhosa and then back-translated into English to assure accuracy of translation.

answer. I will work through the questions on this phone *[RA shows phone]*. I will type the answers to the questions into this phone while we speak to you. If you prefer, you are welcome to answer the questions on your own or we can do it with you.

When we have finished going through the questions, your answers will be sent to a secure database that only our research team will have access to. This means that no one else will ever be able to see the answers to your questions. Your answers will not be written down anywhere – they will only be in the database. You do not have to answer any questions that you are not comfortable answering. After we go through the questions, I will tell you if you can take part in the study or not.

[RA: Conduct Screening Questionnaire – Phone will tell you whether parent is eligible or not.]

[Not eligible – GIVE REFERRAL SHEET] **RA:** Thanks again for answering all the questions. Here is an information sheet that may help you with challenges that you may be facing. Thank you for your time, and for letting me into your home. Goodbye!

[Eligible] **RA:** Thanks again for answering all the questions. I am happy that you can take part in the study. Because you are able to take part in the study, I would greatly appreciate it if I could ask you some more questions about you and your child at another visit to your home. This visit will take no longer than 2 hours. Please can we set up a time to do this? When would you be available?

[RA: Set a time for the baseline questionnaire visit. Fill in reminder slip.]

RA: Here is a reminder slip for the visit.

[RA: Give parent the reminder slip.]

RA: I will also call you to remind you about the visit.

[RA: makes note of baseline visit appointment with address in appointment table]

RA: Please could I take a short video of you saying your name and your child's name? This video will help the research team and I to keep track of all the different parents that we will be talking to. No one outside of the research team will see this video.

[RA: Take a video of the parent using the cell phone.]

RA: Thank you very much! Do you have any questions before I leave? Thank you for welcoming me into your home. I appreciate your time.

Appendix F.2. Script for Administering Quantitative Assessments during Baseline

Data Collection

[RA: Arrive at the parent's home. Greet the parent and thank them for agreeing to meet with you again.]

RA: Hello **(INSERT NAME OF PARENT)**! Thank you so much for agreeing to meet with me today. I really appreciate it! How are you?

RA: Today, I would like to ask you some more questions about you and your child. This should take no more than 2 hours. Remember that everything you tell me is confidential. Also, it is your right to refuse to answer questions or take a break at any time. Do you have any questions before we begin?

[RA: Answer any questions that the parent may have. Conduct the baseline questionnaire.]

RA: We are now finished with the questionnaire. Thank you so much for your time and patience! We now need to schedule a time when I can come to your home to watch you and your child together. This is the visit where I will be recording you and your child doing different activities using the video camera on my cell phone. The visit will take about 40 minutes.

[RA: Schedule a time for the observational assessment]

RA: This video will be private. Only the research team will be able to see it. The video will help us to learn how parents and children are together. You and your child will both need to be at home during the visit. Also, we will need to have the visit in a quiet place in your home, and at a time when there are not a lot of people at home. I will bring a snack with us to this visit. When would be a good time for me to visit you and your child at home?

[RA: Schedule a time for the visit and write a reminder card for the parent]

RA: Here is a card to remind you of the date and time we will be coming to visit you. I will call you to remind you about this visit. Thank you so much for your time! We really appreciate it! Enjoy the rest of your day, and see you soon.

Appendix F.3. Scripts for Notifying Participants of Group Allocation⁴²

Script for control group.

My name is <insert your name> and I am calling from the Sinovuyo Caring Families Project. Thank you so much for your time and help in our research so far. We really appreciate your help in learning how to support families in South Africa.

We are sorry to let you know that you have not been selected to attend the programme at this time. Remember that this is like a lottery, and we can't choose who gets or doesn't get the programme.

It is important for the research that we can visit you again in July. This will really help us understand the lives of parents like you in South Africa. After this visit, you will be offered the opportunity to participate in the programme.

Remember, there is no penalty if you choose not to participate, but we really hope that you can join us! Thank you again! We will be in touch with you again in July. Have a wonderful day!

Script for intervention group.

My name is <insert your name> and I am a programme facilitator from the Sinovuyo Caring Families project.

Congratulations! You have been selected to receive our parenting programme. Thank you so much for your participation in our research so far.

Your time and effort is really appreciated and will help us to better understand how to help families in our community.

Now that you have been invited to attend the programme we would like to visit you and <insert child's name> so that we can introduce ourselves.

We would also like to give you more information about what the programme will be like and how it may benefit your relationship with your child and family.

⁴² Both notification scripts were administered by programme facilitators to maintain blinding of research team.

APPENDIX G. OBSERVATIONAL ASSESSMENTS TRAINING

MANUAL AND SCRIPT

Appendix G.1. Sinovuyo Observational Coding System Assessment Training

Manual (Baseline)

Overview

During this training we will discuss:

1. Background on observational assessment
2. Observational assessment script
3. Important points to remember when conducting assessments
4. Tips on videoing the assessment
5. Coding of observational data
6. What to take with to assessment

Background on observational assessments

Many studies only use questionnaires to collect information from participants. This method is easy to use, enables the collection of a lot of information on different outcomes, and is cost-effective. However, it has some disadvantages. For example, you may think that the answers given by a parent are accurate, but they may, in fact, be answering in a way that they think you might want them to answer. Parents may also underestimate or overestimate the changes that a programme has caused in themselves or their child. Also, questionnaires rely only on the parent's own understanding of the questions, which may be different to the intended meaning.

Observational assessment is a useful method to use together with questionnaires. It helps us arrive at a more accurate and objective estimate of the changes in parents and their children. This method involves observing the parent and child working through various predetermined activities in their home. This allows us to see first-hand the interaction between parent and child, in a way that is as natural as possible.

Observational assessment script

When observational assessments are conducted it is essential to follow a script. This script shows exactly how the assessment should be done. In the appendix, you'll see the script for the Sinovuyo Caring Families Project. You will receive a loose copy of the script too. If this script gets lost or damaged, please ask use for another copy. ***You must follow this script when doing observational assessments for this project.*** It is important that we follow the script exactly – this makes sure all visits are done in the same way, and will strengthen the quality of the data. Remember, we really want to have good quality data so that we can see how our work with families is making a difference!

Following a script may feel strange at first. The more you practice and work with the script, the more comfortable you'll feel using it. We will go through the script together and role-play it so that you feel comfortable with how the visit will unfold. In the appendix, you'll see the script that we will be using for the baseline round of assessments. ***The text in bold is what you need to say to the parent***, and the regular text contains instructions for you as the research assistant.

Important points to remember when conducting assessments

There are some important things to remember when you are doing observational assessments. Following these points will help create an atmosphere that is as natural as possible:

- The parent must feel comfortable during the observation. Following the script will help with this because it will ensure that the parent knows what is expected of them.
- Please use non-judgemental verbal and non-verbal behaviour. You should have a friendly, but formal approach when explaining the activities. Try and keep your way of speaking neutral and consistent.
- Take a neutral approach towards the interactions between the parent and child – think of yourself as an outsider looking in through the window. This will help make sure that the assessment reflects what really happens in the home on a normal day.
- If you give parents negative or positive feedback (either verbal or non-verbal) on how they are doing in the activities, it may change the way that the parent responds throughout the rest of the assessment.
- Please ignore the child as much as possible. Do not interact or be too friendly with the child. You are there to observe the way that the parent interacts and how the child behaves in as natural a way as possible. If you become too friendly with the child, it may change the way the parent and child behave together.
- Please ignore the child if he/she talks to you, asks you a question, sings you a song, etc.
- You must keep silent during the assessment (except to whisper prompts to the parent).
- A prompt should be whispered to the parent when it is time to move to the next activity. This ensures that it is the parent who instructs the child, otherwise the child may respond to you and not the parent.

Tips on videoing the assessment

We will be using cell phones to video the assessments. Below are some tips on how to film a good video – the better the quality of the actual video, the easier it is to code. If the space where you are working is dark, open the curtains and turn on the lights (if possible). Try and keep noise to a minimum – it is especially important to have the

television and radio turned off. Try to video the parent and child together. If the child runs around a lot, it is better to keep the parent in the video instead of moving the camera around a lot. If the parent starts to feel uncomfortable being recorded all the time, record the child for a bit. Try to video with the sun/light behind you. If you video with the sun behind the parent or child, it will be difficult to see what is happening in the video. Avoid zooming – it is best to see both the parent and the child in the screen, rather than a close-up of the child's face. Be extremely careful where you put your hands when holding the phone. Try to keep your hands away from the front of the voice receiver. This cuts out the sound, which makes it difficult for the coder to hear what the parent and child are saying.

Video length

It is very important that you stick to the time allocations for each of the set tasks. This helps to achieve consistency across videos. Keep to 10 minutes of playtime, no more than the 5 minutes of tidying up, and 10 minutes of snack preparation and eating. The video should be between 20 and 25 minutes long.

Coding of observational data

We will be coding the observational assessments to help us learn about the behaviour of the parent and child. Coding is done through using a system, which identifies all the behaviours that you are looking for in the videos. These things include smiles and laughs, the parent praising the child, the child whining, and the parent shouting. Whenever you see or hear specific behaviours, you count them up. We will code both the baseline videos and post-test videos to see if there has been a change in the specific behaviours of interest. When the script and provided tips are followed, the videos are clearer and more consistent. They are also more “natural” so we can see what is actually happening between the parent and child.

What to take with you to assessments

Before going to do an assessment, make sure that your cell phone is fully charged! You should also take the following with you:

- Details of the parent and child to be visited.
- Pen, Script, Toys in bag.
- Crayons and paper (leave 3 crayons and a pack of paper at each home).
- Food in bag (bread, margarine, polony, biscuits, juice).
- Gift parcel for parent.

Thank you for collecting this important data that will help us learn more about parent and child behaviour, and how our work with families is making a difference!

Appendix G.2. Observational Assessment Script (Baseline)⁴³

[When entering the home, talk to the parent only. Please be polite and friendly, but professional.]

RA: Hello, I am (INSERT YOUR NAME) from the Sinovuyo Caring Families Project. It's good to see you again! Thank you so much for letting me into your home today. I know we discussed this visit when we last met, but please let me review what we will be doing today. Remember, we will be focusing on (INSERT NAME OF CHILD) today. It is important that you know that I am only here to do research. Research is about collecting information that can help us understand something better. We want to learn more about parents and their children in South Africa. I am not able to give you advice on parenting or babysit and play with the child while you do the activities in this visit. We need it to be quiet during our meeting. This will allow us to capture what is said on the video camera.

[If the television or radio is on, ask the parent to switch it off.]

RA: Please turn off the TV and radio so that we can concentrate on what we are doing. If the phone rings, please take a message, unless it's an emergency, of course.

[In cases where families do not want to turn off the television/radio, please ask if you could conduct the assessment in another room.]

RA: During this visit, I will observe you and your child doing different activities together. I will be videoing these activities using this cell phone. The videos that we are collecting from parents are part of our research to help better understand parents and their children.

[Show the parent your cell phone.]

RA: The cell phone will be locked after the visit so that no one else can see it. The video will then be stored in a locked file that only the research team can have access to. Do you have any questions about the video?

[Answer any questions that the parent may have about the assessment.]

RA: Let me tell you about the different things that we will ask you to do with (INSERT NAME OF CHILD) during this visit. Don't worry, if you forget, I will remind you by whispering in your ear. First, you will have 10 minutes of playtime with (INSERT NAME OF CHILD). I have brought some toys in this bag for him/her to play with. When the 10 minutes is finished, I will whisper in your ear to let you know that it is time to move onto the next activity. This activity will be cleaning up the toys. Please tell (INSERT NAME OF CHILD) that it is time that the toys must be put away in the

⁴³ *Note: Italicised sentences instructions and not to be spoken by the research assistant.*

bag. Tell him/her that you want him/her to put the toys away. Make sure you have him/her put them away by himself/herself without any help from you. I will have to take the toys with me when I leave your home. After (INSERT NAME OF CHILD) has packed away the toys, it will be time to prepare and eat a snack together. I have brought some bread, margarine, polony, and juice in this green bag. Please prepare a sandwich for each of you and eat them together. There is no right or wrong way, just do what you normally do when you prepare a meal and eat with your child. You will have 10 minutes to prepare the snack and eat it. I will let you know when 10 minutes is up. After the snack, I will be finished watching you and your child together. Please try to keep (INSERT NAME OF CHILD) in the room with you. Remember, I will remind you about what is next during each step by whispering in your ear. Do you have any questions about what you will need to do with (INSERT NAME OF CHILD)?

I know this must feel quite strange, but please try to relax and act as natural as possible. When I watch you and (INSERT NAME OF CHILD) together, I won't be able to talk. I'm not being rude, it's just that I have to concentrate on the video. Do you have any questions about the way that this visit will work?

[Answer any questions that the parent may have. Make sure that the parent feels at ease before you start.]

RA: Let us begin. I will now turn on the video to record you and your child. Please could you get (INSERT NAME OF CHILD), and start with the first activity, which is playtime. Please tell (INSERT NAME OF CHILD) that he/she may play whatever he/she chooses. Let him/her choose any toy he/she wishes. You just follow his/her lead and play along with him/her. Here is the bag of toys that you will use.

[Hand parent bag of toys]

PLAYTIME – 10 MINUTES

[When 10 minutes in up, whisper in the parent's ear that it is now time to get the child to pack away the toys. If the parent asks you if they are doing the right thing, just say that they should do what they normally do – there is no right or wrong way.]

CLEAN-UP – NO MORE THAN 5 MINUTES

[When the child has packed up the toys, or if 5 minutes has passed and the child has still not packed away the toys, please whisper in the parent's ear that it is now time to prepare the snack.]

PREPARING AND EATING THE SNACK – 10 MINUTES

[Once the snack has been eaten, you can tell the parent that you have now finished watching him/her and his/her child and that you will turn off the video.]

RA: Thank you for working with me. I have now finished watching you and your child. I will now turn off the video.

[Turn off video.]

RA: Thank you for taking the time to be part of this study. It will help us learn more about the challenges and experiences of parents in our community. After we have finished with all of our assessments, we will be contacting you to let you know whether you will be participating in the parenting programme or receiving an information pack. This is done via a lottery system on the computer, which means that it is completely random - me and my colleagues don't choose who will receive the programme or information pack.

[Please thank and praise the parent, and give them their gift. Say goodbye.]

APPENDIX H. FEASIBILITY STUDY INTERVIEW AND FOCUS GROUP GUIDES

Appendix H.1. Post Intervention Interview Guide

Aim

To gather the views and experiences of parents on the relevance and feasibility of a locally developed parenting programme.

Approach

The interview guide uses an open-ended approach to soliciting views and feedback from participants of the Sinovuyo Caring Families Programme in an unbiased and non-judgmental manner. Interviewers should conduct interviews along the following steps while allowing the discussion to evolve as themes emerge that are important to interviewees. Each step begins with a “grand-tour question” followed by more specific probes and questions that refer to parents’ experience and views regarding the Sinovuyo Caring Families Programme’s efficacy, relevance, and acceptability, as well as specific cultural and local context issues.

- Step 1: Introduction of interview
- Step 2: Exploring parent’s experience during the programme
- Step 3: Exploring relevance and acceptability of specific parenting skills
- Step 4: Programme delivery issues
- Step 5: Research feasibility

Step 1: Introduction of interview

Thank you for your participation in this interview. We have asked to interview you today because we want to learn more about your experience as a participant in the Sinovuyo Caring Families Programme. Your response will help us understand what was helpful about this experience as well as those parts of the programme that may need improving or changing. We are really interested in your personal experience and in any thoughts and feelings that you may have. There are no right or wrong answers because your whole experience is really important to us. This interview will take about 60 minutes. We will be recording your responses on this audio recorder. All responses will be confidential and only viewed by the research team. Your name and identity will remain private. You will not be paid for this interview but we are happy to offer you a food parcel for your participation. Please remember that you have the right to stop this interview at any time if you feel like doing so, and you can skip any question that you don’t want to answer for any reason. Please let us know if you are confused with any questions we ask you. Before we begin, do you have any questions? Once again, we thank you for your participation!

Step 2: Exploring parent's experience during the programme

Interviewer should refer to programme notes based on the participant's specific goal. Interviewer can prompt the participant if she has forgotten. Interviewer should follow up on whether that goal was accomplished and how the participant knows that.

First, we would like to know more about your experience during the programme and how it has affected your family.

- What was the specific goal for your child that you discussed during the first session?
- What did you learn about parenting that you didn't know before the programme? How did you know that? What about the programme helped you learn that?
- How has your child's behaviour changed as a result of the programme?
- How has your own life changed as a result of the programme?
- How has the programme helped with other personal or family problems (for example, your marriage, your feelings in general)?
- If there were any contents that were not culturally relevant in an isiXhosa-speaking context, what were they and why?
- At this time do you feel the need for additional further parenting assistance? Please explain why.

Step 3: Exploring relevance and acceptability of specific parenting skills

Interviewer asks the participant questions regarding each skill that was covered in the Sinovuyo programme.

Parenting skills

- Rondavel of Support and Building Blocks.
- Spending special time with children.
- Using "say what you see" or descriptive commenting during special time.
- Naming feelings or emotions.
- Using praise and rewards.
- Giving instructions.
- Establishing household rules.
- Using ignore.
- Time-out.
- Consequences.
- Problem solving with children.
- Do you do anything else to discipline your child that was not part of the Sinovuyo programme? What is it?

Step 4: Programme delivery issues

Now we will talk about how the programme was delivered. Please comment on your experience with....

Programme approach

- Pre-programme home visits
- Songs and physical exercises.
- Home practice discussions.
- Role-plays/ group practices.
- Group brainstorm.
- Illustrated stories.
- Traditional stories.
- Home practice with your child.
- Parent handbook.
- Sinovuyo partner.
- Home visits, phone calls, and SMSes.

Attendance and size

- What difficulties did you have in attending all of the sessions? What came up that stopped you from attending all of the sessions?
- How did that affect your experience during the programme? When you missed a session, how did you feel about it? Were you able to keep up with the programme? How were you able to keep up with the programme?

Schedule

- What are your thoughts on the days and times that the sessions were organised?
- Do you think that there were enough sessions for you?

Space and refreshments

- What are your thoughts on the space for the programmes sessions at the Ikamva Labantu Wellness Centre?
- What are other settings where we might offer the programme?
- Do you have any suggestions for the food and snacks provided?

Step 5: Research feasibility

Now we will talk about how the research part of the project.

Recruitment

- How were you recruited for the study?

Information and consent

- What was your expectation for the project?
- Did you understand what you were coming for?
- Was the information clear?
- What was your understanding of the research project?

Screening

- Did you understand the screening process at Ikamva Labantu?
- What was your understanding of what was going on?
- How was the screening explained to you?

Answering questions on the phone

- How did you feel when asked personal questions by the researchers on the phone?
- How comfortable did you feel talking the researchers?

Home observations

- How did you feel when asked to play with your child while being videotaped?
- How did your child respond to this activity?

Programme preparation

- How could we better prepare parents for the programme?
- Is there anything that you would have liked to know about Sinovuyo before you started the programme?

Post-test

- Did you feel more comfortable talking to the researchers the second time they visited?

Final question

Is there anything else that you would like to say about your experience?

Appendix H.2. Post-intervention focus group guide

Aim

To gather the views and experiences of facilitators on the relevance and feasibility of a locally developed parenting programme.

Approach

The focus group guide uses an open-ended approach to soliciting views and feedback from facilitators of the Sinovuyo Caring Families Programme in an unbiased and non-judgmental manner. Interviewers should conduct focus groups along the following steps while allowing the discussion to evolve as themes emerge that are important to participants. Each step begins with a “grand-tour question” followed by more specific probes and questions that refer to facilitators’ experience and views regarding the Sinovuyo Caring Families Programme’s content and delivery.

Step 1: Session content

General brainstorm

- What worked well for you as a facilitator?
- What didn’t work well for you as a facilitator?
- How can the programme be improved?

Themes

Examine the importance and relevance for facilitators and parents of including the following themes. Explore challenges experienced delivering specific content and challenges faced with parents understanding and using material.

- Rondavel of Support.
- Special time with children.
- Say what you see.
- Naming feelings.
- Praise and rewards.
- Giving instructions.
- Establishing household rules.
- Using ignore, time-out, consequences.
- Problem-solving with children.

Approach

Describe your experienced in using the following facilitation methods.

- Using a collaborative approach.
- Pre-programme visits.
- Home practice discussions.

-
- Role-plays.
 - Group brainstorm.
 - Illustrated stories.
 - Building blocks.
 - Home practices.
 - Working with the manual.
 - Parent handbook.
 - Home visits.

Were there any other topics that you feel would be important to include in subsequent programmes?

If there were any contents that were not culturally relevant, what were they and why?

Step 2: Programme Logistics

General brainstorm

- Were there any challenges in delivering the programme to the participants?

Schedule

- What are your thoughts on the days and times that the sessions were organised?
- What about the group facilitator training times on Monday and Friday?
- Do you think that the number of sessions for the parents to learn about the building blocks was sufficient? In which areas would additional sessions be required? Why?

Space

- What are your thoughts on the space for the programmes sessions at the Wellness Centre?
- What are other settings where Sinovuyo might offer the programme?
- Do you have any suggestions for the food and snacks provided for parents?
- Do you have any suggestions for additional supplies?

Attendance and size

- How might Sinovuyo better recruit, engage, and retain parents in a parenting programme?
- What were some of the challenges facing parents in attendance? How could you overcome these challenges?
- How might we accommodate those who have difficulties in attending sessions? Those who are unwell? Those who are working?
- What about the group size? Too many? Too few?

Team dynamics

- What were any benefits or challenges of working as a team of group leaders?

-
- What were any benefits or challenges of having mentors as part of the teams?

Training

- Was the training sufficient for you to deliver the programme as it was designed?
- What are some ways that the training could be improved?
- Was participating in the programme as a parent useful as a training method? Why?
- What are some ways you could have been helped to be better prepared as a group leader?

Supervision

- What is most helpful about the supervision you have received?
- What about the peer supervision?
- What changes would you make in the way you get supervision?
- How useful was viewing the videos of the programme each week before supervision?
- What recommendations do you have for improving the way supervision is done? Amount of time? Use of videos/role plays?

Reporting and Referrals

- Do you have any recommendations for improving the reporting of home practice discussions and session reports?
- How might one improve the ability to support parents for other needs outside of the programme content?

Support Staff

- Are there any areas in which the management team might support delivery of the programme (communication, preparation, etc.)?

Final Question

- Are there any other ways to improve the delivery or structure of the programme?

APPENDIX I. ADDITIONAL ILLUSTRATIVE QUOTES FROM QUALITATIVE RESEARCH

This appendix contains additional illustrative quotes from the intervention development and process evaluation studies that were not included in the published papers due to word limitations. The illustrative quotes are organised by study, theme, and source of data. Although the extracts are not exhaustive, they are intended to provide the reader with more detail regarding the qualitative data collected during this thesis.

Appendix I.1. Illustrative quotes from the formative evaluation study conducted as part of intervention development.

Chapter Four (Paper One) included a formative evaluation to identify local contextual and cultural factors that may be relevant for programme development. This study identified the following topics that parents and service providers suggested were necessary to include in locally relevant parenting programs for low-income families in South Africa: (a) learning how to manage difficult child behaviour, (b) addressing corporal punishment and other discipline strategies, (c) building positive relationships with children, (d) keeping children safe in dangerous communities, (e) coping with parenting stress, (f) communicating about HIV/AIDS and bereavement, (g) involving fathers in caregiving responsibilities, (h) cultural values of social responsibility and respect, and (i) potential barriers and enablers of participation and delivery. Although these are discussed in detail in Chapter Four, the following section includes additional illustrative quotes for each theme.

Theme 1. Learning how to manage difficult child behaviour

“Then this one, nothing joyful with him. It’s the one who is disobedient. Then comes the small one. I am quite happy with this one, and what makes me happy about her is...when I have a stress, she comes to me and hugs me.” – Parent #2, Interview

“You can never feel yourself as a parent because they do not obey you, they do what they like. So at times you feel as if you are not a parent to these children, the way they act. Sometimes you give a child an order and does not do what he is supposed to be doing, you see yourself as not a parent to this child, he is not my resemblance.” – Parent #3, Interview

“They want fancy clothes when you don’t have enough money and they will cry in the stores, and they throw tantrums” – Practitioner #4, Focus Group #1

“It is said when a crab is moving sideways its young ones also move sideways. As you are not moving sideways you discover that your children are extremely moving sideways, they move out of the way. They have their own crooked ideas. Though there are parents who are really moving sideways and they expect them to be moving the straight path. So things we can discuss about as parents that you must be the first one to know the way of behaviour.” – Parent #5, Interview

“I have three boys. One of them is in school in grade 5, the other is in grade 1. When they get home there is nothing to do for them. They throw their school clothes and go and play. I call them to tidy up and ask them why they always throw their clothes all over. I tell them to put their clothes tidy and go and play. Every time they want me to tell them. They do not practice what I teach them. They are stressing me. I have a lot of stress.” – Parent #6, Focus Group #3

“You clean the house and then he will go mess up the house that you’ve cleaned. Do you see that it’s another job or you’ll say to your child, ‘Don’t do that,’ and he will do it and you’ll tell him not to open the cupboard, but he will.” – Parent #9, Focus Group #6

“It makes me very happy when you see them in your home trying to obey your rules, trying to follow them.” – Parent #8, Focus Group #10

“They don’t listen. They don’t want to cook, don’t want to clean. The younger one is worse.” – Parent #6, Focus Group #10

Theme 2. Addressing corporal punishment and other discipline strategies

“A parenting programme can be helpful because there are parents who are beating their children. You find out that some are just talking anything to a child, does not mind what to say. A person talks as if talking to the same age person, one even insulting, calling wrong names.” – Parent #4, Interview

“My grandmother used to beat us but I know I can’t beat them because they cry when you raise your voice” – Parent #6, Interview

“First you say, ‘No!’ Second again you say, ‘No!’ Third time I am forced to beat him.” – Parent #8, Interview

“When we grew up our mother was beating us. Even when you went out of the house but you are still cooking, and when you come back your cookings are dried up, you are beaten. So I thought that was the right thing, but as I learnt more I saw that when you are beaten you never be alright. The way I grew, my mother being so rough, I do not wish to raise my children that way. When I grew up my mother was rough and beating. I don’t wish my children that kind of raising a child.” – Parent #10, Interview

“I once beat my child and he had marks and I saw that it is not working. Now I have a chart with a star and a sad face. When he does something wrong I put a sad face on the chart and when he did good I put a star and I don’t beat him I look him in his eyes and talk to him.” – Parent #4, Focus Group #2

“I send my child outside when she did bad things to stand there until she is tired.” – Parent #5, Focus Group #2

“I do not just hit them if I do not like something. I tell her that I do not like what you are doing. If I tell her not to come home late at night... if she comes home late at night what should I do? I use the belt on her.” – Parent #7, Focus Group #3

“I tell her what she’s doing that you do not like, ‘Don’t do it because mama doesn’t like it.’ But our children don’t listen and continue to do wrong.” – Parent #8, Focus Group #3

“He likes to play and come home late, when it’s dark and I hit him for coming home late.” – Parent #11, Focus Group #3

“I stopped beating her because it seems as if I make her to do wrong or worse. Even now she has slowed down since I stopped beating her. My other child, the younger one, she also does the same thing – not sleeping at home. She has stopped for now because I didn’t beat her, I just watch her. And she has stopped. When I was beating her, she kept doing the same thing. During the week she goes to school but on weekends she doesn’t sleep at home. Now she has stopped and I don’t know if the reason is that I have stopped beating her. I don’t know.” – Parent #10, Focus Group #3

“I don’t beat my child. I took him out when he behaved well to somewhere and I also need to compare my rules and other parents rules. Maybe my child will be alright...” – Parent #8, Focus Group #5

“You mustn’t beat a child every day she makes mistakes, you must sit down with your child and talk to her.” – Parent #4, Focus Group #10

“Yes, sister, I shout. I don’t want to lie, I end up angry because I shout a lot, I shout and get tired if I ask her to go and fetch water and then go and play, I know that they are young, but I’m getting tired of growing my cousin’s children and my sister’s children.” – Parent #5, Focus Group #10

“I beat them because my parents were beating me” – Parent #7, Focus Group #10

“My mother beat me badly. I liked to play a lot after school and the school was not far from my home. We were three girls. We liked to play ball till we got tired, then I would go home and my mother would beat me. I know that didn’t stop me. I was playing every day, and my mother would beat me every day.” – Parent #6, Focus Group #10

“I grew up without parents. My mother died when I was ten years old. We were raised by my father’s family. They were beating me with a big cane, cups, plates on my head. I will sleep outside with a blood, and in the morning they will beat me again. Ooh, it was worse. I said I wish I could go back to Queenstown. So, I don’t want my kids to grow up the way I did.” – Parent #9, Focus Group #10

“I’ve got my punishment. Not with a cane. If she loves the TV programme or likes to watch cartoons, by that time she/he is not going to watch.” – Parent #8, Focus Group #10

“It is important to discipline your child just because you love him. Discipline is a child’s secret because when you discipline your child you make him understand what’s good and what’s bad. If you did not discipline your child, he will be nothing. When you discipline your child it becomes like a moral to him what you like and what you don’t. The bible says if you don’t discipline a child you don’t love him.” Parent #7, Focus Group #10

“A child can’t be a child for tomorrow or the future without discipline. Every child should be disciplined and it takes long time to do it. It never stops because it aims to self-control and to teach the values of life.” – Practitioner #3, Focus Group #11

“If my child has done wrong, yes you can beat the child because it’s part of life of a parent, that I must beat the child. My child I beat you because I want you to walk on the ways I love you.” – Parent #3, Focus Group #12

“I’m going to talk about discipline. Discipline is important. Sometimes you see a child walking on the street and you can see that he/she is not disciplined. You’ll find that it’s painful to you because discipline is important, even that a child must be disciplined.” – Parent #4, Focus Group 12

Theme 3. Building positive relationships with children

“There is not much time for playing. Most of the time they are in the street. Only at night after finishing to wash them or when...though there is not much I chat with them.” – Parent #1, Interview

“I sit down and hug them, kiss them and tell them that I love them. The small one comes close to her mother to be loved. I kiss them and tell them ‘I love you, understand?’ They say ‘yes mommy,’ then I hug them. Maybe that day I am delighted also. You know, when delighted you are also happy for your child.” – Parent#2, Interview

“Sometimes we play, like throwing each other with a ball or hide and seek in the house.” – Parent #3, Interview

“I do play with them, sometimes a skipping rope though they like dolls and watching cartoons, and also a computer. They like it most. Sometimes saying a word, printing a word. They like playing school matters. We write, read. So even when they come from school late, I would catch them lying here and writing. I become a teacher. I would keep on saying, ‘Very good,’ and they do for me school things.” – Parent #4, Interview

“My neighbour does show love to their kids. I would also love other parents to know how to show love to their kids.” – Parent #6, Interview

“It is important to tell your child that you love him. If you are just sitting keep on reminding him that he is loved. How can the child feel good if mother is not loving him? – Parent #8, Interview

“You must praise a child. If you do not praise him he becomes less confident. Praise the child for the good he has done so he can make more good things.” – Parent #8, Interview

“A child feels free when playing with you. Even if there were a kind of abuse done by a neighbourly father, it’s easy for her to come and talk to you about that because you often talk with her.” – Parent #9, Interview

“Playing with children is very important, I don’t even know how to explain. It is important that your child trusts you, knowing that you are his mother.” – Parent #11, Interview

“Praising children is universal and not specifically part of one culture.” – Practitioner #2, Focus Group #1

“Praise is important because you encourage, supporting like she can see that mother was happy for what I did. She will keep on doing it and show you that: ‘look, today I made another one.’” – Parent #7, Interview

“I’d love to get some advice from all of you on how to play with a child. I’m just watching her if she plays on her own. I just watch. She dances and does her own thing, and I laugh alone and don’t show her that I’m laughing at her.” – Parent #5, Focus Group #4

“It is important to play with children. Maybe children are playing, show them how to play so that they don’t break the toys. It can happen that kids hurt themselves. You can show children how to play. It is important to play with children, especially when you are with them.” – Parent #8, Focus Group #3

“You must also play with them and say, ‘My child, let’s play now.’ You must make time. You mustn’t say you are busy. You must try to make time to play with them.” – Parent #8, Focus Group #5

“Communication is very important because sometimes the child cannot talk with you with things because of lack of communication.” – Practitioner #9, Focus Group #11

Theme 4. Keeping children safe in dangerous communities

“I protect her by knowing what she likes most in the house. Telling her that I love her. At a certain time, you sit down. Hold your child to stay, not going out the whole day. A child must not be always in the street. She must be in the house.” – Parent #2, Interview

“Ja, when they play outside, you know they are not safe at all these times, because someone can call them, bribe them with money, rape them...” – Practitioner #1, Focus Group #1

“It is important to take care of your child, and you must know where she is playing and who she is playing with. You mustn’t stay in the house not knowing where your child is, and there there must be a time that she must come home at night. At this age of young kids, three, four, you see, they play a lot, neh? You must know that. Hey, it’s been a long time that he is gone. You must go out and check if she is still in that place she where she was at. It is important to take care of your child.” – Parent #4, Focus Group #4

“When my children are out I only give them 30 minutes and then I go check on them after that to see if they are playing near.” – Parent #10, Focus Group #5

“They must play in front of the house. When I call them, they must hear me. They must not be far. When I call you, you must be here.” – Parent #15, Focus Group #5

“You see a girl must be in the house before sunset because she is the one who must put the lights on.” – Parent #5, Focus group #12

“To protect the child, she must feel safe around you, she must know if anything happens she must run to you, and she or he must feel protected also goes with all this” – Practitioner #2, Focus Group #1

“It’s important that parents learn that supervise the child. Since we live in the country where there are lot of rapers and there are these gangsterisms and everything. We are

talking of children from two to eight but there are gangsterism. There can be someone shooting to someone then they can get an stray bullet. So it's important that a parent must know every child. The child is where, who is the child playing with and everything concerned" Practitioner #9, Focus Group #11

Theme 5. Coping with parenting stress

"To be a parent is a heavy load" – Parent #1, Interview

"When the child is sick sometimes he doesn't want to eat, and you feel stressed and you are not comfortable whether your child will be alright or not, you feel stressed even if you give him medication you don't see the difference and you feel like crying or praying." – Practitioner #2, Focus Group 1

"Other challenges are when a child is sick and when you don't money to buy clothes and friends are wearing expensive clothes. " – Parent #1, Focus Group #2

"When I am stressed I go to other person and tell her about the problem and the stress goes away." – Parent #2, Focus Group #2

"I drink and get relieved from whatever stress." – Parent #8, Focus Group #3

"The stress goes away when I talk to someone." – Parent #10, Focus Group #3

"When you are not working, it's obvious that you don't have money and you're a single parent. No one is helping you. You'll struggle in many things, even the grant money is not enough for the kids, so as a parent you have to try. You will never let your kids down. You try as a parent." – Parent #5, Focus Group #5

"If I've got money I buy Hunter's Dry, you see, drink it, and then go to his father to shout at him. That way I'm calming my stress down because the child is mad at me in the house and the father doesn't care. That way I will feel better and I will take my child and then sleep with my child." – Parent #4, Focus Group #6

"I clean... do washing, clean the house, do everything. And you must let me clean a lot so I can calm my stress. It doesn't want me to sleep, to cry or what. I must only work." – Parent #8, Focus Group #7

"I use snuff a lot. I'm telling you, it calms me down." – Parent #9, Focus Group #7

"I'm saying that when you are sitting with your children and you are a grandma, there is stress. You must just avoid it because once you are stressed you end up at home messing things. You forget what Tsidi told you, the mother went to look for a job and came back without getting it. Because of her stress, when she was swallowed by the crocodile, the child decided to leave it inside. Let it swallow her because when she is stressed she sends me here and there. So stress is important. You mess up many things when you are stressed. But when you have nothing, stress or no stress you end up on the wrong gear. Or when you are stressed you can find yourself sleeping and not waking up. Who will look after the kids? So the stress needs to be controlled." – Parent #8, Focus Group #7

"I don't think you can look after your child's needs if you are stressing, sometimes a lot of parents out there who came to the lord cause they can't cope with stress" – Practitioner #2, Focus Group #1

“Lord I’m here in this home and there is no health. I don’t have a life. I don’t feel happy at home even when I’m not there. Because I’m thinking about that person. He/she is making me fight with other people.” Parent #2, Focus Group #11

Theme 6. Communicating about HIV/AIDS and bereavement

“My mother died last of last year. I went with my child, and he saw she was sick. We brought her to the hospital. She passed away while we returned. He is asking me now, ‘Mama where is grandmother?’ I answer, ‘She’s not around my child, you’ll never see her again. We are going to bury her under the ground now.’ Even by the time we were in the graveyard I showed him and said, ‘Do you see, grandmother is sleeping here.’ His mind doesn’t come to the fact that grandmother is not just sleeping there. To him it’s as if she is going to show up again. Not believing what death is. When we go home he is pointing where grandmother is lying. But when we arrive in Cape Town, he will ask, ‘Mama when do we go to grandmother?’” – Parent #3, Interview

“Since he is not quite a healthy child, he would ask me about his medication and I explain, ‘This one for this, and that for that.’ He is always asking me about our next visit to his doctor. I just tell him on Wednesday. He would ask when is that Wednesday, and I tell him tomorrow but one.” – Parent #8, Interview

“To speak about difficult things. One parent said that she does not want to talk about things like HIV, talking about sex, all that. It can help other parents to hear some advices like how to talk to their children about things like that.” – Parent #7, Focus Group #5

“You must tell the child something is wrong. Like my child, this one has HIV. I sit down with her and tell her that, ‘Look Liyema, if Nonki asks you to fetch something, throw it away if not wearing gloves. You must put gloves on.’ Don’t hide anything.” – Parent #4, Focus Group #7

“My grandchildren, since they grow without their mothers they call me mom. And maybe the child does not know that you are not her biological child. My other friends share that with me. Her grandchild calls her mom. She does not know that it’s not her mother. The social workers are begging her to tell the child the truth. She said, ‘It’s not right.’ She does not know how to tell her. We say to her she must tell the child otherwise when she is dead her own kids will insult that child and tell her that she does not belong here. Then the child will have a grudge on you when you are in the grave. Because of the thing that you should have prevented.” – Parent #7, Focus Group #10

“The doctor said I must tell her I am not her biological mother. Her mother loved her but she had a problem. She had this disease and died. That is why she is taking pills at hospital is because her mother died. It was difficult but I tried to tell her and said, ‘Do you know what you take these pills for?’ She said, ‘Is not for asthma?’ ‘Do you sometimes hear people on TV talking about HIV?’ She said yes. Then I said, ‘Your mother died.’ I saw that she is shocked. But I tried to say to her, ‘You must not tell others what are the pills for. You must only say they are for asthma.’ She said ‘yes,’ and I said ‘You must continue telling them that. To other people you must tell them they are for chest. Although me and you knows what they are for.’ Then now I am free, I am relieved.” – Parent #9, Focus Group #10

Theme 7. Involving fathers in caregiving responsibilities

“Men would benefit because there are husbands who are growing their own children. They would benefit because they also need those teachings of how to grow a child.” – Parent #2, Interview

“With husbands, it’s difficult. In most cases they are ignorant. He would just say, ‘Oh never mind.’ Especially one who is drinking.” – Parent #3, Interview

“My husband helps me because whether I am not there and he is there I have no anxiety of hurrying and cooking and all that, because if I am not there he cooks for them. They even say they prefer their father than me because I never made eggs and Russians the way their father made it.” – Parent #4, Interview

“He loves his babies, Spoiling them. I don’t know whether it is the way of covering the past time where he was never going out with them. Sometimes going somewhere with them. On their way back carrying some goodies and all that. He is making them happy, training them.” – Parent #5, Interview

“Most of the time the fathers like not to care. Any responsibility happening to the child is thrown to the mother to take responsibility, but there are desperate fathers who love their children and would like to proceed with the project. But how to get them...I won’t tell lies, I do not know.” – Parent #5, Interview

“I am the only one to interact or play with my child. My husband shouts at the children.” – Practitioner #2, Focus Group #1

“Fathers need to learn how to play with children and the importance of playing with children. Maybe fathers can play with children while mother cooks.” – Practitioner #6, Focus Group #1

“It’s very important to work with the father. If the child grows up without knowing the father, that child will be very difficult. The child will be difficult like mine. But mine does have a father, the one that I am married to. So he calls my husband, father. It does not matter if he did not support the child. What counts is that he is the father.” – Parent #8, Focus Group #4

“He needs to communicate with the child, to protect, show love. He needs to share information, you know. The father must know the needs of a child and the father must protect. The father must teach respect.” – Practitioner #4, Focus Group #9

“The thing is we are short on fathers. We want them here so that we can talk with them about the ways of bringing up kids.” – Parent #5, Focus Group #10

“Women who come can send their partners. They can recruit their husbands.” – Parent #5, Focus Group #11

“Working together with the father. It’s important that a married person must work together. If you do something you must do it together. Do not argue, like older people. Don’t say in front of the child, ‘You like to take advantage, don’t do something you wouldn’t like to be done to you.’ If the father sees that it’s wrong, then it’s wrong. He must know that it is wrong. Mothers and fathers don’t fight in front of children. Children must not take sides, because that makes them to be violent and your home could be divided.” – Parent #11, Focus Group #12

“I can say the father is cruel cause I forbid him beating children. When beating he beats a child until sick. And that is the main source of quarrelling here in the house. Saying I don’t want him beating children, discipline children. Me, I know he is beating in a wrong way.” – Parent #1, Interview

Theme 8. Cultural values of social responsibility and respect

“Every child is mine. I cannot neglect a child doing wrong, for the sake of being not mine. I must approach him that...do not do a certain thing my child. If they are fighting, I must be a parent not waiting for the parent of the other one. Maybe he is not there that means children can injure each other whereas I am here, I see this is wrong. So I am capable of sorting it out and think ...what if the child was mine?” – Parent #3, Interview

“You are not supposed to be a parent of your child only. Be a parent to other children too.” – Parent #8, Interview

“We also teach them that when they see a mother or a father they must say mom or dad even if it’s not their biological parents just to show respect.” – Parent #2, Focus Group #2

“Being a parent is to take the responsibility of being a parent when you have children. You take each and every child as your own, just like in my own house. In my house it’s always full of children who come to my own children. They play and chat and eat. They do all those things. That is being a parent. You always talked to them when they do wrong there and there.” – Parent #3, Focus Group #3

“Yes, being a parent, you become a parent to other children. You don’t become a parent only to your own child.” – Parent #11, Focus Group #3

“You must respect your children because sometimes your children see you when you bring different men. Children look at your behaviour. Everything you do, they think is right. So, you must respect your children. Things that she shouldn’t do must be things you don’t do yourself... You mustn’t be like a crab fish, teaching your children to walk sideways while you do the same.” – Parent #3, Focus Group #3

“I think respect is very important. We like to stay in the house and teach him/her about the respect, because myself, I do not think that there is someone saying, “I know Noni is rude and doesn’t have respect”. I think I do teach respect at home.” – Parent #5, Focus Group #4

“And a child should not call other women by their child’s name, they should say “mama” to every woman. I would love my children to do that.” – Parent #6, Focus Group #4

“What makes me choose respect, parents, is because respect is the first thing. A parent must tell the kids, and they must start respect at home before they go outside. Because respect is respect, it starts at home. We say respect start at home. They must start respecting here at home so that they can respect another person outside. To respect.” – Parent #8, Focus Group #10

“I’m going to talk about respect. Respect is something important. First you must talk to the child about respect. For the child to know what respect is you must first talk to the child about what is respect. But it is important that you as the parent don’t forget to

summarize, point so that the name respect is not forgotten at home. For it to stay we praise the Christ that lives and hears. For everything.” – Parent #7, Focus Group #12

Theme 9. Potential barriers and enablers of participation and delivery.

“You can pull them even by food because we are starving.” – Parent #2, Interview

“The way I see it is that every parent has got a child. Even I, have got a child but that does not mean I cannot be attending because I have got a child. That is not an issue. If I just take the child, put him on my back and join what is going to help me.” – Parent #5, Interview

“The problem is if there is something I can’t answer, someone else in a group can answer it for me and so I can know it too. So, I won’t be thinking alone and will hear other people’s opinions. For me to see things in another way.” – Parent #3, Focus Group #3

“I would like to say this: there are things that I can’t talk about in a group, that I would like to talk to one person only.” – Parent #5, Focus Group #3

“People who are working do not attend things. They prefer weekends. They would rather not attend anything during the week because they get home tired. We are unemployed so we can make this time during the week.” – Parent #6, Focus Group #4

“If we can get those people that are drinking alcohol I think it could help them a lot because they don’t see how important kids are. They wake up thinking about their hangover and go and drink again, making hangover, then drink again and again, so they don’t have a chance to watch them. Do you understand?” – Parent #2, Focus Group #4

“If we could have transport because we are staying far. Some parents would want to come but they don’t have transport. Another problem is the time because some parents stay in the location.” – Parent #3, Focus Group #6

“I must come with my child if there are other children they will stay together.” – Parent #1, Focus Group #6

“The importance is to get views from other people. Maybe there’s something that I knew in a different way. But when you meet with other people it’s clear to you that it’s not the same as you thought. But when you hear from other people then you realize that they helped you.” – Parent #8, Focus Group #7

Appendix I.2. Illustrative quotes from the process evaluation study conducted to assess the programme feasibility.

Chapter Six (Paper Two) included qualitative data collection and analysis to assess the feasibility of the Sinovuyo Caring Families Programme. Thematic analyses of focus groups and interviews with parents and practitioners identified seven themes regarding programme acceptability, implementation, and participation. These included: (a) parents' receptivity to strengthening existing skills, (b) parents' initial resistance to new parenting skills, (c) contextualising content within a cultural framework, (d) reinforcing programme fidelity and improving quality of delivery by facilitators, (e) facilitators' challenges with nonviolent discipline techniques, (f) supporting participant involvement, and (g) engagement in the collaborative approach. Although these are discussed in detail in Chapter Six, the following section includes additional illustrative quotes for each theme.

Theme 1. Parents' receptivity to strengthening existing skills

"I've learnt a lot more different things in Sinovuyo, its more things for me. The most important thing I have learnt is the importance of not spanking your children. I have also learnt to be able to sit down and spend time with my child, play with my child, which was something I was not doing before. Balisa used to cheeky, and also it was easy for her to lie about something. So I used to spank her because of that. But now Sinovuyo has taught me that, when you spend time with your child, when you praise their good behavior that she does at the spot, and also give her a reward at the spot, it helps the child have a growing and trusting relationship between the two of you." – Participant #34, Interview

"I would say it is like, rewards are something that they are used to doing it. But it's just the way that they were doing it before, when they were praising children with big things. Sometimes they were praising children with things that they cannot afford, or promising children that they were going to take them out and then not doing it." – Facilitator #3, Focus Group

"The difference is now my children recognise and respect me as their mother because I'm not shouting them and they also say mama since you went to Sinovuyo you are the different person. It's the way I talk with them and also I spend a lot of time with them. I used to spend most of the time with the neighbours because I was running away from being frustrated by them. We just sit down and chat, share stories and even watch TV together. Sometimes we even look at the stories from Sinovuyo and analyse them. We also play the play station together and they teach me how to play it. I also share stories about them while they were still young and they would laugh at those things." – Participant #29, Interview

“Yeah, and even things like praising. They were just praising children, but not for specific things, not looking at them, not using their names, just saying, ‘yeah, that’s good’ while they were busy with something else.” – Facilitator #3, Focus Group

“So I have learnt that I have to praise each and every one of them when they are doing something. So all of them are always looking forward to the praise and also for their hug, they all want to get hugged by me at the same time. It has built the relationship that was broken before.” – Participant #18, Interview

“I will say praise helps a lot because he loves the praises a lot to a point where it encourages him to do the good behaviour. I will say that praise helps because most of the time he is only doing the right things because he wants to be praised.” – Participant #43, Interview

“Before the program I was praising and rewarding the child but I wasn’t taking it that serious that much. I didn’t know that it would make the child that happy and then after the program I was doing it a lot and my child was understanding a lot.” – Participant #2, Interview

“Instruction giving was similar to praise and rewards. They were doing it before, but the way that they were doing it was not the same as the way that we were doing it during the programme.” – Facilitator #2, Focus Group

“Before it was the way that I use to talk to her, I use to say do not leave this house before you clean up and make up the room and all that in a negative way. But now she listens because I give clear and positive instruction. Now I say when you come from school please take off your uniform and put it on nicely. She now put it nicely after taking it off. When I talk to her I talk very nicely. I also promise her with a reward if she does that very well.” – Participant #70, Interview

“I think establishing household rules was important because for some of the participants, there were rules at home and they were not following through. The rules were for the children, and it was new that the household rule must be for everyone in the house and they need to follow through. Like if the rule is that they must be home at 8 o’clock and the child comes home at 8:30, they do not follow through. Then the rules just fall apart and they do not do anything.” – Facilitator #1, Focus Group

“What I have learnt is that I have to let her lead the play. Now I ask from her what does she wants us to do and she tells me. And now she always wants to play with me to the point that I have to tell her sometimes that she must give me time to watch news in the TV. She even hugs me and kiss me. Before she use to even wipe her face when I kiss her.” – Participant #18, Interview

“Sinovuyo has helped me a lot in how to control my own anger, that if I am angry I need to calm myself down. And also Sinovuyo has taught me to live the life of a normal person, not being an animal like I used to be before. I sit down for at least five minutes and cool myself down. Then when I stand up from there, I will see that there is no more anger.” – Participant #34, Interview

“I would say that Special Time happens almost every day now. Almost every day before we sleep we spend time together, and we eat together and talk. Sometimes we sit and share stories together and talk about the rest of day.” – Participant #43, Interview

“Household rules have helped me to control my child, to tell my child about the time to come home. My child did not know what time she must come home so it has helped me in that situation. And she did not how to bathe herself, so it has helped me in that situation.” – Participant #2, Interview

Theme 2. Parents’ initial resistance to new parenting skills

“When we learned that we must not beat the kids. In our culture, it’s not normal. At first it was difficult, but now, when the time goes on, I saw that no, this is fine, this is the way.” – Participant #11, Interview

“At first, that thing, you must not beat the child. It was not normal to us. Afterwards I did understand. After the programme I did understand that you mustn’t beat the child. At first it was difficult not to beat the child when the child did something wrong, but now I understand that there are other ways.” – Participant #51, Interview

“Most of us are not used to playing with their kids, but most of us are not used to playing with their kids, with their parents. But I’ve learned from Sinovuyo that we must learn to do that, to play with our kids.” – Participant #65, Interview

“They said that before the programme, they didn’t know that that five minutes [special time] was very important. Then they said that they were hearing and learning things that they didn’t know about their child, things that are happening at school or whatever.” – Facilitator #3, Focus Group

“Yes, in the beginning, they were resisting special time. Special time was the first thing that we introduced when we started, when parents were still thinking and figuring out about this programme. At the beginning, it felt like they were not understanding this thing of special time. By the time the programme moved on, the children were used to having that special time, and they would day, ‘Hey, mama. It’s time for our special time now!’ – Facilitator #2, Focus Group

“Parents are not used to playing with their children. It is a new thing. I think it is a cultural thing. Because now as time goes by, they are used to playing with their children. They said, ‘I didn’t realize that when I buy a car for my child, I have to play with it with him.’ – Facilitator #1, Focus Group

“I was going to say the challenge that the parents had at the beginning was letting the child lead the play. I think it’s why we had to re-emphasize in the second session or something because mostly they are time with their children was the parent teaching the child. I thought that this and that and also the school time, homework time that’s what they usually refer to as the special time. So it took them time to let their child lead the play.” – Facilitator #4, Focus Group

“When we play they doesn’t want to stop. But the great thing is that every time we go to bed we are all happy.” – Participant #34

“At the beginning it was not normal for my child to have special time with her, but when the child goes on she got used to it and she was even asking me to come and play with her. And I would try to have time to go and play with my child.” – Participant #2, Interview

“[Descriptive commenting] was the other one that was a challenge. I think that is our culture, we are used to saying, ‘What are you doing? Are you driving?’ Not saying,

‘You are driving a red car, you are doing this and that.’ So, we had to remind them, ‘Did you talk about what you were seeing, what the child was doing?’ It was a bit challenging, and we had to ask.” – Facilitator #6, Focus Group

“For the parents, it is a very important thing to take notice of how the child is feeling. I say thank you to this lesson about the feelings because it really reflected to them as the parents about their own feelings, and they did feel that this is also important, firstly dealing with yourself and to know how do you feel before you notice some other person’s feelings.” – Facilitator #8, Focus Group

“The culture of black people, they don’t talk about their feelings ever. You can tell when someone is not ok, but they will say that they are fine. There are key words that will tell you that someone is not doing ok, like ‘nje’. We do not have those kinds of words like, ‘excited, mad’. when you say you are mad, people say, ‘What? Mad? You are what?’ You don’t express your feelings to other people, so how can you help your child to understand their feelings when you do not even deal with your own situation? It also affects you when your child expresses their feelings. Like it or not, it affects you and brings up your own feelings, too. So, black people are avoiding that.” – Facilitator #5, Focus Group

“Naming feelings was a challenge for some participants because they were always asking the child if a child is said, ‘Are you sad?’ instead of naming the feelings, ‘okay I can see that you are sad.’ And also for the participants, it’s hard for them to name their own feelings. Like ‘I’m happy because we are doing this.’ – Facilitator #1, Focus Group

“Sometimes she just says sorry for example when I tell her that I feel bad when she does not come in time from playing. She would say sorry granny I will not do that again.” – Participant #18, Interview

“Sometimes when I see he is sad, I ask him what happened and then I will hug him. Or even sometimes when he comes in with a very sad face or he’s angry then say that I see you’re angry, did anything happen?” – Participant #43

“The participants did understand ignoring difficult behaviour and were able to come up with examples from home and which behaviours are appropriate to ignore.” – Facilitator #8, Supervision

“This session during the home practice, they were talking about ignoring. I saw that they were able to ignore the behaviours and keep calm. Sizeka really stood out. When her child was crying in the morning when she was looking for a toy, she just kept ignoring until the child calmed down. Then she praised the child.” – Facilitator #6, Supervision

“It is hard for parents to know what behaviours we ignore for, what behaviours we use Time Out for, and what behaviours we need a consequence for. This week we had problems with Time Out being used inappropriately for things that we can ignore. The same thing is going to happen next week, where people are giving a consequence for things that can have time out.” – Facilitator #2

“My child used to do is get very angry. When is angry he used to throw tantrums and everything but at least now I see a great difference. I think what I have realized is that

he needs a lot of my attention and that's I do most now – I give him all the attention that he needs like special time.” – Participant #43, Interview

“At the beginning, it was not easy to ignore, but now I saw that it is working, so it is easy. Ignoring has helped me a lot because one day, he was going to school and he was crying for something that I don't know, so he was crying the whole morning. I ignored him, and when the transport came, he waved at me and said, ‘goodbye,’ because I ignored him while he was crying, so it did help me.” – Participant #11, Interview

“Cool down didn't work. The last time we did it, he was in the cool down and his brother was there and I was in the kitchen and I couldn't see what was happening. And then his brother was teasing him that he was in the cool down so now he cried a lot so at the time, I didn't know what to do.” – Participant #43, Interview

“I used to ignore her when she whines but now I've noticed that she does not whine anymore; she is afraid of the cool down mat and also that she is afraid of not getting the reward. It's fine now she is afraid of the cool down she does not do the behaviour that leads to that anymore.” – Participant #74, Interview

“Ignoring is not normal to our culture, but at the end I was doing it. I was used to it.” – Participant #2, Interview

“The ignoring helped me a lot because I was also always shouting at him, now I am not doing that, I am ignoring. At first it was difficult to use ignoring, but now it's not difficult. Practicing and the people who were in the programme has helped me.” – Participant #51, Interview

“Before [my child] used to play with many different kinds of children at the street and his behaviour was not good. He was not listening at all. And I used to shout at him. But now there is the big difference. I think it's because I used to spank him just the way I was also raised which was not working at all and now that I came to Sinovuyo I learnt that talking to the child works. I think now that I came to Sinovuyo, I think there is a difference in him, also that he was also attending with me at Sinovuyo made a lot of impact in the way he does things. Playing with other kids at Sinovuyo brought much joy to him. He sometime would even ask me to sing with him those songs with him.” – Participant #11, Interview

Theme 3. Contextualising content within a cultural framework

“Whenever we go home to the Eastern Cape, the first place we sleep is in a rondavel. It is the center of the family.” – Facilitator #6, Supervision

“The Rondavel was very important because it was starting from the foundation, how to bring up your child.” – Participant #13, Interview

“Everything has worked for me but the best thing that worked for me was the Rondavel. I did not know before that when you work with the child you have to follow the steps and the foundation is very important. It's the model that is helpful for me as the parent as I raised my children. I always think about the Rondavel.” – Participant #51, Interview

“The topics that the parents were coming up with they were taken as the blocks for that Rondavel. So that the Rondavel can go up. So when we talk, when we are discussing something with the other parents the thing they were talking about, it was taken as a

brick. And then it was put in the Rondavel. The Rondavel was also showing us when the child is maybe, we have got the naughty child is hyper so the Rondavel was showing us. So when we were learning about the Rondavel, the other parent would say a problem and then another would say a problem and then we would discuss it and this was the way we were learning about the Rondavel.” – Participant #52, Interview

“I’ve learned from the Rondavel how to raise your child and how to talk to our children, so that if he does something good, you must praise him so that he can continue doing that good thing.” – Participant #65, Interview

“The stories were also very nice. It’s something that use to happen even when we were growing up. They also bring the connection.” – Participant #18, Interview

“I used to read her stories even before. It’s just that she likes to listen. She likes to listen. She likes to listen, she likes stories. You can see in her face, and then she’s going to talk about the story all the way until... otherwise, it was helpful to me because I was going to explain even the words. She asks me this, ‘What is this?’ and I explain, ‘No, it’s a big beast,’ explain what kind of a thing, it’s a beast. So, she was learning from that a beast is something that is big and ugly.” – Participant #70, Interview

“Ever since I told him about the stories that I learnt from Sinovuyo, he loves them, he always wants me to tell him the stories. I see that he just enjoys spending time with me. He just loves spending time and talking to me as her mother.” – Participant #65, Interview

“Exercises, wow! And the songs, oh! Even if she’s crying or she’s cross, I just sing that song, do all these things and just start to laugh, like, fun, and she’s going to start laughing, whatever. And I say, ‘Ok, baby, it’s fine.’ I just sing this song, make the funny impression, faces.” – Participant #70, Interview

“In our culture, songs mean so much to our people, and when we come here and sing and dance it connects and makes the day and breaks the ice for whatever happens afterwards.” – Facilitator #2, Focus Group

“For me, it was when we were doing the song. I saw the way the parents were so dancing, I could see that it has been a long time since they were doing that. Especially the last one, she is the one who has serious problems at home, and she was dancing all the moves – they were so happy, and it was so nice to see them so happy. You can see that it is working not just for the children but for the adults as well.” – Facilitator #3, Supervision

“I loved the songs and the exercises especially Ram Sam Sam.” – Participant #18, Interview

“They have got respect now that I am not shouting, that I am sitting down and talking to them. Now they have got respect.” – Participant #52, Interview

Theme 4. Reinforcing programme fidelity and improving quality of delivery

“The manual was useful in terms of if you do your preparations well, then you get to understand what you need to do. It is big, but if you do your prep in a way that suits you, then it’s like studying for an exam. You don’t read word for word, but you understand what is being said.” – Facilitator #5, Focus Group

“The training session that we do on Mondays are what really helped us understand the manual even more.” – Facilitator #4, Focus Group

“I think all the training sessions were necessary because everything was new to us. But the 5-day training we received in February was not enough. It was too short for 12 sessions.” – Facilitator #3, Focus Group

“The training was practical and then we were going to do it during the week, since there was such a long time between the training and the programme, doing that Monday session helped remind us of everything we learnt.” – Facilitator #1, Focus Group

“When we get to the challenging the behaviours. Towards the middle of the programme. it would be useful just to strengthen our skills again.” – Facilitator #4, Focus Group

“I would refer to the book to find additional questions for the session. It was an open hand map.” – Facilitator #8, Focus Group

“Looking at the videos was very useful for me because its where I see what I did and what I can improve on. It also showed me where I missed certain points, so for the next session I would know to make sure to do it. It is where I watch myself and the whole group. It’s where we were able to catch mistakes me made, for example when we forgot to cover certain topics.” – Facilitator #3, Focus Group

“Watching the videos, sometimes when you are in the session you are not able to see everything that was done. In the video, you are able to see everything that is happening, so you can see both the hiccups and the great things that happen during the session, while when you are busy in the session you might be focused on one thing or the negative things and miss others.” – Facilitator #7, Supervision

“Also supervision is really helpful to stay on track because then one of the supervisors can watch me and remind me to stay on track with the session. So I can keep up with where the others are.” – Facilitator #8, Focus Group

“Supervision helps with confidence while delivering the program. The encouragement and praises. And the questions asked during the supervision, the way questions were asked to help us to think more about how to deliver the programme.” – Facilitator #4, Focus Group

“The group helped me. It was like they were like you can do it. You’re doing it right. You know just those compliments they make you even if I’m doing the home visit like okay I must do it you know I will do it I’m doing I’m doing a good job I’m. So it’s like that spirit amongst the team no judging. You know that was great.” – Facilitator #1, Focus Group

Theme 5. Facilitators’ challenges with nonviolent discipline techniques

“Instead of taking the ignoring as a part of a lesson, they think that they are not loving their children enough. They feel that as they do the ignoring, they will think that they are not good mothers themselves.” – Facilitator #8, Focus Group

“Before, to them it is like you are just letting the child continue with the bad behaviour. But then when they try it, they see that the time out is working. I am not ignoring the child, I am ignoring the behaviour, and this behaviour is one that needs me to ignore it.” – Facilitator #5, Focus Group

“It was a really difficult concept, even for us. I could feel that even for myself, the way that I delivered it, there was no separating the behaviours for ignore, for time out and that. I was not as convicted as a facilitator, so when I saw that resistance that they had, I saw that it was difficult even for me. We are not used to using these things, even as facilitators. We got it when you trained us, but when we tried to facilitate it, it created so much strain. We could see that they are listening to us but they are just not getting it. Even to the point that we had to do it again the next time we met. But what was great, we saw that they did get it.” – Facilitator #4, Focus Group

“I don’t think it was them not understanding time out, per se, or it was us not being able to deliver. I think from session 8, the sessions were long. Lots of content in the sessions. I think that’s what created the tension. By the time we got to this time out thing, there was a lot that was packed into their minds in a short space of time. So even us, we were not sure how to deliver because in our minds we had so much that we were worried about having to deliver, so we were rushed to deliver it.” – Facilitator #2, Focus Group

“What made Cool Down a little bit easier for us it’s like, you broke it into two parts, so it’s like it’s not overloaded on them so that is why they understand it.” – Facilitator #1, Focus Group

Theme 6. Supporting participation

“Doing home visits helps you know the participants before the program, really helped during the program. We could see things that were happening. Like with Nkosi, we could tell if there was something wrong, because we remembered what she said during a home visit.” – Facilitator #2, Focus Group

“[Pre-programme home visits] were very important, because while you are doing the home visits, it gives you the connection with them. When they meet us, they don’t see strange people when they come to the group. Gives a good first impression.” – Facilitator #8, Focus Group

“SMSes played a very important role. Made participants feel valued and special. Parents told us about that.” – Facilitator #2, Focus Group

“I think it will be important to include the whole family when we do the pre-program visits.” – Facilitator #4, Focus Group

“We had one participant whose husband did not like her participating in the programme because he did not understand what was happening here. But then we did a home visit where we got the chance to explain to him what the programme was all about. Then he did understand better and he was glad because then he knew what she was doing and where she was when she wasn’t at the house.” – Facilitator #8, Focus Group

“The people are so appreciative and are getting so much out of the programme. They are very eager to come. I think that it is also us, the group leaders, because now we know what we are doing, we are not panicking, so we are able to create that safe space for them, and they are very eager to come now.” – Facilitator #6, Supervision

“Home visits were useful and helping me because maybe when I missed a session the group leaders would come to the house and explain me what happened in the session and they would give me the handouts and tell me to do the home practice with the child so I don’t get behind when I go to the next session. – Participant #2, Interview

“So when I missed a session the group leaders usually came to the house just to make sure to give me feedback about what was done in the session so it helped me when I go to the session not to be lost and to be on the same page as those you attended the session before.” – Participant #43, Interview

“We [my Sinovuyo partner] still send each other SMSs and she is telling me that her child is doing fine. Sometimes it was helpful if there was something I didn’t understand, I was phoning her and asking what must I do.” – Participant #2, Interview

“Having a partner from Sinovuyo helped me a lot because sometimes I would forget and I would go to her and ask her to remind me what we learned from Sinovuyo.” – Participant #37, Interview

“I didn’t have a person who was telling me what they did in the programme when I was absent. They only told me about the programme when I’m there in the programme.” – Participant #39, Interview

Theme 7. Engagement in the collaborative approach

“I loved the role-plays and we were joining in the practises in the class. They were giving us more picture and idea of how you are going to do things at home. I also think it would be a good idea if we also act them here at home. That will also help my children. I would love if they can all be part of the Rondavel.” – Participant #18

“The illustrated story really worked because theory wise, you can really read something, but when you have to do it practically, that’s another story. So, the illustrated stories really worked.” – Facilitator #1, Focus Group

“To add to what she’s saying, the illustrated stories created curiosity, even with children at home. The children wanted to know what were you doing, and instead of telling about what was happening, they were able to show them on the illustrated story and say, ‘what do you see is happening here?’ and it helped that communication happen at home.” – Facilitator #2, Focus Group

“The illustrated stories even helped them to think and helped them to have a conversation about it. You can see that when we move onto the topics, they already have those questions in their head, and it makes it easy to understand and to talk about.” – Facilitator #4, Focus Group

“The illustrated stories and role-plays were very helpful for me because it helped me to always remember, especially to remember the acting in the picture because I don’t understand most of the words in Xhosa so now when people were acting, every time I would remember oh, this was the mother this was the child this is how they did it... The pictures were helping a lot even though I don’t understand the language in terms of reading and everything. But they were helping because every time I see the pictures now I have an idea of how this one reacts, this is how I am supposed to act, also what I said in the class.” – Participant #34

“The stories are helping a lot because I have a bigger picture because I can see the granny with the child and to see how he is sitting and how they are talking. Even to see how they are kneeling with the mother so it helps to understand that you have to go to that level when you talk to the child. The role plays were also helping a lot because it

helped you make sure how you had to do the practice that you had to do at home.” – Participant # 43, Interview

“The home practice discussion was also very helpful. It helps them to be accountable and to keep remembering that they need to practice with their child because they know that they are going to have to come and report back to the group.” – Facilitator #4, Focus Group

“Group discussion was helpful because in the group when a parent has got a problem, we were able to advise. Like the other parent had a problem with a child who didn’t want to be sent to the shops by her parents and wanted to be sent to the shops by a person on the street because they were going to give her a 5 bob. So we were able to advise the parent.” – Participant #2, Interview

“What I liked about the home practice was that it helped us to see which parents were still having trouble with a building block or with learning a skill. Because this is a building block, if you do not get it at this session, it is going to be difficult to take it to another level. When you see that so and so is struggling with this skill, then we role play it. Someone is the child, and the person who is struggling is the mother, so that she can practice the skill. Then the others give her support.” – Facilitator #5, Focus Group

“We learned the skill from exploring, asking those questions, ‘Your child was happy, so what did you do?’ Those questions helped the parents to be able to be honest. And also to accept what the parent says instead of saying, ‘No, you’re not supposed to do that.’ That also helped the parents.” – Facilitator #4, Focus Group

“You tell them what to do, and maybe they forget what you taught them. You ask them questions, and then you see, now they are getting it, or now we see that we need to do some brainstorming and role plays and all that.” – Facilitator #3, Focus Group

“My highlight for this week was when we were doing the home practice. I asked one parent what challenge she had when doing the home practice. One parent said, ‘I had a challenge. My child doesn’t want to get dressed in the morning and I feel I have to shout at him. But, I think of Sinovuyo and that I can’t shout or hit the child. But, I don’t know what to do. I am stuck.’ So, I brainstormed solutions with the parents, and another parent said, ‘What you have to do is, when the other children finish dressing up, praise the ones who finishes dressing early. Your focus must be on that child who finished.’ Oh, I was so impressed with that that we role played it with Mama Gladys being the parent. She was trying to ask the child questions, and the other parents were saying, ‘No, don’t ask questions! Focus on the child who is finishing on time!’” – Facilitator #3, Supervision

APPENDIX J. ADDITIONAL TABLES FROM THE PILOT RANDOMISED CONTROLLED TRIAL

Table 11. Pairwise correlations between parent report and observational outcomes at baseline

Measure	1	2	3	4	5	6	7	8	9	10
1 Harsh parenting, self-report ^a	1.00									
2 Positive parenting, self-report ^b	-.24	1.00								
3 Limit-setting, self-report ^c	.00	.60***	1.00							
4 Child behaviour, self-report ^d	.31*	.25	.48***	1.00						
5 Positive parenting, obs	.07	.11	-.14	-.03	1.00					
6 Effective parenting, obs	.05	-.20	-.25	-.08	.13	1.00				
7 Negative parenting, obs	.09	-.24	-.12	.00	-.01	.25*	1.00			
8 Child-led play, obs	.00	.09	-.17	-.09	.15	-.10	-.07	1.00		
9 Positive child behaviour, obs	-.12	-.19	-.28*	-.15	.31*	.66***	.40**	.12	1.00	
10 Negative child behaviour, obs	.39**	.01	.06	.17	.27*	.20	.36**	.01	.00	1.00

^a Parent-Child Conflict Tactics, ^b Parenting Young Children Positive Parenting, ^c Parenting Young Children Setting Limits, ^e Parenting Young Children Setting Limits, ^d Eyberg Child Behavior Inventory. * $p < .05$; ** $p < .01$; *** $p < .001$.

Table 12. Intra-cluster correlation coefficients and design effects within parent groups allocated to the intervention arm

Measure	CC	95% CI	Design Effect
Primary outcomes (self-report)			
Harsh parenting ^a	.00	.00 to .18	0.00
Positive parenting, frequency ^b	.00	.00 to .18	0.00
Positive parenting, problem ^b	.00	.00 to .18	0.00
Limit-setting, frequency ^c	.00	.00 to .18	0.00
Limit-setting, problem ^c	.00	.00 to .18	0.00
Child behaviour, intensity ^d	.00	.00 to .19	0.00
Child behaviour, problems ^d	.00	.00 to .18	0.00
Primary outcomes (observed)			
Positive parenting	.00	.00 to .27	1.01
Effective parenting	.01	.00 to .23	1.02
Negative parenting	.00	.00 to .21	0.00
Child-led play	.00	.00 to .21	0.00
Positive child behaviour	.06	.00 to .37	1.13
Negative child behaviour	.03	.00 to .28	1.05
Secondary outcomes (self-report)			
Parenting stress ^e	.00	.00 to .21	0.00
Parental depression ^f	.00	.00 to .21	0.00
Social support ^g	.00	.00 to .19	0.00

^a Parent-Child Conflict Tactics, ^b Parenting Young Children Positive Parenting, ^c Parenting Young Children Setting Limits, ^d Parenting Young Children Setting Limits, ^e Parenting Young Children Setting Limits, ^f Eyberg Child Behavior Inventory.

Table 13. Summary of results comparing different statistical models using an intention-to-treat analysis.

Note: In order to further explore the impact of using different statistical approaches to assess intervention outcomes, post-hoc analyses were run with the following models:

Model 1: analysis of variance examining differences in mean follow-up scores between intervention and control groups without any covariates; Model 2: analysis of covariance examining differences in mean follow-up scores between intervention and control groups controlling for baseline scores; Model 3: analysis of covariance examining differences in mean follow-up scores between intervention and control groups controlling for baseline scores and parent group assignment; and Model 4: multivariate mixed models with participants nested within parenting groups. Although results differ in terms of significance of effect sizes, findings for increased frequency of positive parenting are consistent across all statistical models (see Table 12). Nonetheless, Model 4 was chosen as the most theoretically sound analytical approach that accounted for the possible effect of clustering within the intervention group (Bauer et al., 2008).

Measure	Model 1		Model 2		Model 3		Model 4	
	ES ¹	95% CI	ES ¹	95% CI	ES ¹	95% CI	ES ¹	95% CI
Primary outcomes (self-report)								
Harsh parenting ^a	-0.06	-0.53 to 0.42	0.01	-0.46 to 0.49	0.02	-0.46 to 0.49	0.02	-0.46 to 0.49
Positive parenting, frequency ^b	0.72 ^{**}	0.23 to 1.21	0.70 ^{**}	0.21 to 1.16	0.74 ^{**}	0.25 to 1.23	0.63 ^{**}	0.02 to 0.69
Limit-setting, frequency ^c	-0.01	-0.48 to 0.47	-0.05	-0.53 to 0.42	-0.06	-0.54 to 0.41	-0.05	-0.53 to 0.42
Child behaviour, intensity ^d	-0.28	-0.76 to 0.20	-0.29 ⁺	-0.77 to 0.19	-0.28 ⁺	-0.76 to 0.20	-0.29 ⁺	-0.77 to 0.19
Child behaviour, problems ^d	-0.12	-0.60 to 0.36	-0.11	-0.58 to 0.37	-0.09	-0.57 to 0.38	-0.11	-0.58 to 0.37
Primary outcomes (observed)								
Positive parenting	0.14	-0.34 to 0.61	0.14	-0.34 to 0.61	0.10	-0.38 to 0.58	0.13	-0.35 to 0.61
Effective parenting	-0.23 ⁺	-0.70 to 0.25	-0.09	-0.57 to 0.38	-0.10	-0.57 to 0.38	-0.10	-0.58 to 0.37
Negative parenting	-0.15	-0.63 to 0.33	-0.34 ⁺	-0.81 to 0.14	-0.35 ⁺	-0.82 to 0.13	-0.34 ⁺	-0.81 to 0.14
Child-led play	0.52 [*]	0.04 to 1.01	0.50 [*]	0.02 to 0.98	0.48 [*]	0.00 to 0.96	0.57 [*]	0.09 to 1.06
Positive child behaviour	-0.61 [*]	-1.09 to -0.11	-0.56 [*]	-1.04 to -0.07	-0.56 [*]	-1.05 to -0.08	-0.56 [*]	-1.05 to -0.08
Negative child behaviour	0.30 ⁺	-0.18 to 0.78	0.37 ⁺	-0.11 to 0.85	0.28 ⁺	-0.20 to 0.75	0.30 ⁺	-0.18 to 0.78
Secondary outcomes (self-report)								
Parenting stress ^e	-0.27 ⁺	-0.75 to 0.21	-0.23	-0.71 to 0.24	-0.24	-0.71 to 0.24	-0.23	-0.71 to 0.24
Parental depression ^f	0.06	-0.42 to 0.53	0.12	-0.35 to 0.60	0.12	-0.35 to 0.60	0.12	-0.35 to 0.60
Social support ^g	0.09	-0.39 to 0.56	0.27 ⁺	-0.21 to 0.74	0.27 ⁺	-0.21 to 0.74	0.27 ⁺	-0.21 to 0.75

Model 1: ANCOVA examining differences between intervention and control groups;

Model 2: ANCOVA examining differences between intervention and control groups controlling for baseline scores;

Model 3: ANCOVA examining differences between intervention and control groups controlling for baseline scores and parent group allocation;

Model 4: Multivariate linear mixed models with intervention participants nested within parent group assignment, controlling for baseline scores;

¹ Bias corrected Cohen's *d* effect size. * $p < .05$. ⁺ Clinically relevant effect size ($d > 0.25$).

^a Parent-Child Conflict Tactics, ^b Parenting Young Children Positive Parenting, ^c Parenting Young Children Setting Limits, ^e Parenting Young Children Setting Limits, ^d Eyberg Child Behavior Inventory, ^e Parenting Stress Index-Short Form, ^f Beck Depression Inventory, ^g Multidimensional Scale of Perceived Social Support.

APPENDIX K. HEALTH AND SAFETY FORMS

Appendix K.1. Risk Assessment

Hazard	Risks involved	Control measure
Personal (e.g. theft, violence, crime, personal health)	South Africa has high crime rates (car theft, house break-ins, theft of personal possessions, violence to persons). We have developed a safety protocol for the PACCASSA/Sinovuyo project will be followed by all staff (including Project Managers – see attached). HIV and infectious disease risk in areas with high prevalence and deprivation	Drive with car doors locked at all times. Drive with car windows closed (use air-conditioner instead). Do not drive in dangerous areas at night; if you have to drive in dangerous areas by day, do so with caution and follow advice in anti-hijacking literature distributed by SA Police Service which we possess. Always travel with a fully charged mobile phone with emergency numbers in the address book. Do not flaunt possessions e.g. laptop/cell phone/jewellery/handbag in the street and ensure they are not visible in the car when driving or parked. Never give hitch hikers lifts or transport people that are not well known to you. Ensure that the place where you are staying is safely secured at all times. Accommodation has a burglar alarm, and panic buttons. If robbed and threatened with a weapon, never refuse to hand over items. Ensure that Oxford University Travel Insurance is in place to cover items stolen or damaged and health costs. The Occupational Health Services will be consulted prior to departure to ensure all necessary precautions regarding health care are taken. A dentist will also be consulted prior to departure. In addition, an emergency kit will always be carried when in the field. Care will be taken in the prevention of infectious diseases and advice has been sought on how to prevent transmission of airborne diseases like TB. All incidents and accidents will be reported to the Departmental Administrator immediately.
Travel (e.g. remote location, driving)	South Africa has high numbers of road deaths (approx. 1 000 people per month). Roads in remote areas can be of poor quality.	Ensure that the car is not faulty and can withstand poor road conditions (e.g. gravel) if driving in such an area. Ensure that driver is not tired or under the influence of drugs or alcohol and is fit to drive. Drive within the speed limits, keep distance from car in front, and be vigilant about poor drivers, pedestrians and animals on the road. The project vehicle is maintained and serviced regularly. Insurance is at maximum amount. Use reputable car hire companies and take out maximum insurance available for theft and car damage caused by accident (unfortunately they all have an excess these days) should the project

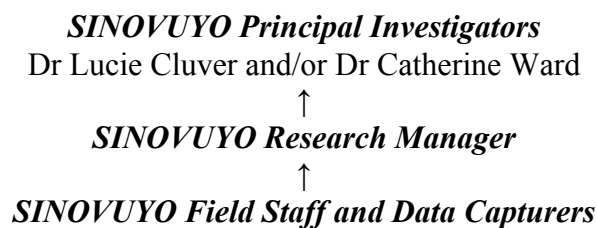
	Public transport may be unsafe for reasons of state of vehicles or crime	car not be available. Costs of damage to other people on the road (if involved in a crash) are covered by the Road Accident Fund. Whenever travelling, inform someone else of where you are going, when you are due there, contact details, and when you are due back. Means of public transportation may be unsafe in some areas. Safety of travel on public transport, particularly at night, should be informed by local knowledge and experiences.
Location (e.g. extreme weather, temperatures,)	It can get hot in the summer months.	Ensure protective clothing and sun screen is worn when in field and that enough liquids are consumed. Accommodation has air conditioning. Direct sunlight is to be avoided wherever possible to avoid sunburn and heat stroke.
Work environment (e.g. lone working, cultural differences)	Our research is conducted in township communities in Cape Town, South Africa. Due to the nature of these areas there are potential risks to staff safety due to crime and political unrest – including theft and violence to person. .	We have developed a safety protocol for reporting and responding to safety issues as they arise in field. All staff (including PMs) adhere to this protocol when in South Africa. The safety protocol is attached to this risk assessment form. We will be working closely with a community partner, Ikamva Labantu (www.ikamva.com), and the University of Cape Town. Both organisations have strict safety regulations with regards to access in township communities. We will be following these regulations as well as advice from specific community partners in regards to unrest and violence. Researcher will be accompanied in the field by an isiXhosa speaking field assistant who is familiar to the neighbourhoods and will facilitate cultural translation.
Other (e.g. manual lifting, sanitation, diet, hazardous substances, water-borne diseases)	None	None

Appendix K.2. Safety Protocol

Overview:

This document aims to outline a general procedure that will be implemented to ensure the safety of all *SINOVUYO* staff. All staff should read this document and sign the declaration. The structure for the reporting and documenting of any safety issues that might arise is outlined in the diagram below (contact details for the Principal Investigator and *SINOVUYO* Research Manager are included at the end of this document). Appended to this document are also procedures put in place regarding personal safety, driving safety, fire and floods (and other natural disasters), as well as climate safety.

Hierarchy for the reporting and documenting of any safety concerns



Procedure:

- Any staff safety concerns should be raised with Research Managers immediately. The Research Manager will make a decision about whether to deal with this immediately, to discuss with the Principal Investigator, or to discuss in the weekly staff meeting at each provincial site.
- The Research Manager and staff should discuss the issue and any possible safety procedures that could be implemented to address the issue.
- If a safety procedure is decided upon, the initial concern and the proposed procedure should be documented (using a copy of the attached Safety Documentation Form). This form should be sent to the Principal Investigators. If the Principal Investigators has any suggestions, recommendations, or concerns these will be communicated directly to the Research Manager.

If a safety procedure cannot be decided upon the Principal Investigators should be informed and a conference call will be arranged so that the issue can be discussed between the Principal Investigators and the Research Manager.

- Once the safety procedure has been approved by the Principal Investigators, the Safety Documentation Form should be appended to the office copy of the safety protocol (this document), this way a record of all safety concerns and staff responses is maintained.

SINOVUYO– Safety Procedures

Many of these safety procedures involve common sense and are relevant across all safety domains

Personal safety:

- Staff should carry a well-charged cell phone at all times in case of accident or emergency.
 - Where there is an immediate emergency and Research Managers are not on field or easily contactable, staff (e.g. RAs) should inform their field coordinators, who will inform the Research Managers.
 - Always inform another member of the *SINOVUYO* team about your destination and estimated time of return.
 - If requested, all *SINOVUYO* staff will be provided with a personal safety alarm.
 - Staff should carry ID cards and safety alarm where they are easily accessible (e.g. around their necks).
 - Staff should know the closest location to the local authorities to seek refuge if danger arises.
 - If possible, never leave a team member behind. It is best to intervene as a team.
 - If interviewing in a community in which you feel unsafe:
 - Inform your Research Manager.
 - Form ‘Interviewer Groups’ (and include a male field worker if possible).
 - If necessary a CPF escort can be arranged.
- 1) If needed, staff should discuss emergency SMS code for help with team members or PMs.
 - 2) Staff should work in teams of two (preferably with a male RA on each team) and within viewing distance of each other.
 - 3) Staff should be carrying maps of the areas in which they work to facilitate orientation and giving directions.

Dealing with participants:

1. Violent participants:
 - 1.2. Staff should **not** solve the matter independently.
 - 1.3. Staff should **not** respond violently (*so as not to promote escalating emotions*).

-
- 1.4. Do not confront a mob.
 - 1.5. Walk away and ignore the accusations.
 - 1.6. Inform Research Managers as soon as possible.
 - 1.7. If violent accusations result in physical harm, Research Managers should open an assault case at the police station.
 2. Unhappy participants:
 - 2.2. RAs should be aware of escalating emotions.
 - 2.3. When possible, re-address the objectives of the study, privacy guidelines for disclosure, and remind the participants that authorities in the areas are aware of the project study.
 - 2.4. If participant is not satisfied with the explanation, offer to make appointment with the project manager.
 - 2.5. Appease the unhappy participant by ensuring that their concerns will be heard and handled.
 - 2.6. Contact and inform project manager of the encounter.

Driving safety:

- Extreme caution should be used at all times when driving and all rules of the road should be obeyed.
- In rural areas there may be a significant number of cattle on the road and drivers should be aware of this.
- If requested, any person who will be driving a *SINOVUYO* project car will be provided with defensive driving training.
- Using a mobile phone while driving (texting or calling) is a criminal offence in South Africa.
- Staff should carry a well-charged cell phone at all times in case of accident or emergency.
- Always get enough rest before you drive the car to avoid falling asleep behind the wheel.
- When using the car for work purposes, another member of the *SINOVUYO* team should always be informed about your destination and estimated time of return.
- Valuables should never be left in the car.
- Your personal safety is more important than the car!

Climate:

-
- Heat: fieldworkers will be provided with sun screen, water bottles, and hats during the summer months.
 - Rain: fieldworkers will be provided with umbrellas and/or rain jackets.

Fire, floods, and natural disasters

- a. In any case of environmental hazard, consider your own safety and that of your team first.
- b. The Research Manager and Principal Investigator will make a decision, in consultation with the fieldwork team, about how best to deal with these.

Medical conditions of staff members

- All staff with chronic medical conditions such as epilepsy or diabetes are requested to wear medical alert bracelets.
- All staff are responsible for carrying their medication with them at all times and show their team members where it is kept and how to administer it in an emergency.

Taxi wars, riots, and political violence

In the event of taxi wars, riots, or political violence discuss any safety issues with Research Managers, but in any case where there is risk to staff, fieldwork will suspend or move to another area

Miscellaneous:

In various sites fieldworkers have been accused of being Satanists

- This is being addressed through: addressing concerns that have led to negative impressions of the project (e.g. that we're taking away legitimate/fraudulent grants), praying with the people who have accused fieldworkers of Satanism, working with local religious leaders to prevent any confusion about our affiliation
- All staff members are requested to register a telephone number of a relative or friend that can be contacted in case the member of staff is involved in an accident at work. Emergency numbers are to be kept on box.net so they are easily accessible for all members of the project.

For Research Manager

- The Research Manager should make sure all field staff have a copy of documented safety procedures amongst field protocols and ask staff to sign for confirmation of having read and accepted adherence to them. Staff should also

be encouraged to provide suggestions or highlight guidelines that are not working at team meetings.

- If re-addressing the objectives of the study has not always worked to calm down violent participants:
 - Inform the *indunas* and ward councillors about the encounter and request another community meeting (with *indunas* and local authorities - Community Development Forum staff, CDFs present).
 - Address some of the issues encountered and explicitly and patiently explain the **reason** for each questions (i.e. Who lives in my home) if necessary.
 - Prior assessments of communities is crucial (get information on safety, crimes, witchcraft, etc.), and know the village and culture.
 - Monitor your RAs, violent encounters can be traumatic. Offer psychological counselling (with local psychologists in hospitals) or debrief team members.
 - If necessary, give RAs crisis prevention training or safety training.

Safety Concern – Documentation and Response Form

Date concern raised: _____

- Safety Concern:
- Proposed Response:

Response approved by PI: Yes/No

Signed by Research Manager: _____

Date Approved: _____

SINOVUYO CARING FAMILIES PROJECT – Contact Details

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