“It empowers to attend.”
Understanding how participants in the Eastern Cape of South Africa experienced a parent support programme: A qualitative study

Jenny Doubt, Heidi Loening-Voysey, Lucie Cluver, Jasmina Byrne, Yulia Shenderovich, Divane Nzima, Barnaby King, Sally Medley, Janina Steinert, Olivia O’Malley

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“IT EMPOWERS TO ATTEND.” UNDERSTANDING HOW PARTICIPANTS IN THE EASTERN CAPE OF SOUTH AFRICA EXPERIENCED A PARENT SUPPORT PROGRAMME: A QUALITATIVE STUDY

Jenny Doubt, Heidi Loening-Voysey, Lucie Cluver, Jasmina Byrne, Yulia Shenderovich, Divane Nzima, Barnaby King, Sally Medley, Janina Steinert, Olivia O’Malley

ABSTRACT

Parenting interventions can dramatically reduce violence against children and improve a child’s future. Yet in the past, research has mainly focused on young children in high-income countries, and most of the research has only used quantitative methodology.

By contrast, this qualitative study focuses on teenagers and their caregivers who attended a parenting programme in South Africa, contributing to a small but growing body of research on parent support programmes for teenagers in low and middle-income countries.

The research examines the Sinovuyo Teen Parenting programme, which was developed and tested between 2012 and 2016 in South Africa. The main qualitative study was carried out in the last year (2015–2016) and is the focus of this paper. It complements a cluster randomized controlled trial.

This qualitative study captures the experiences of teenagers and parents who attended the Sinovuyo Teen Parenting programme in 2015. Importantly, the study gives an insight into how the caregivers and teenagers changed as a result of participating in the study.

The primary data set, based on interviews with teens and caregiver participants (n=42), was triangulated with data from focus groups (n=240), workshop observations (n=9), and facilitator notes from home catch-up sessions and workshops (n=280). Analysis identified three major themes: 1) Participant experiences of the Sinovuyo Teen programme – recruitment and workshop attendance; 2) Programme impact; and 3) The way forward – recommendations for researchers and programme implementers, in particular strategies for sustaining change.

Findings show that both caregivers and teenagers valued the programme and their participation fostered better family relations and reduced violence at home. Their views are important for practitioners, programme implementers and researchers working in violence prevention and child and family welfare. More research is needed, however, to show whether these changes can be sustained.

KEYWORDS

Parenting programmes, teenagers, child abuse prevention, South Africa, low-middle-income countries, qualitative research
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The caregivers and teenagers who contributed their time and trusted us to honestly represent their experiences of participating in the Sinovuyo Teen Parenting programme contributed invaluable content to this study. We are indebted to them for their trust in sharing their stories with us.

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GLOSSARY OF TERMS

**Child maltreatment** is defined according to the World Health Organization 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” (WHO, 1999). Child maltreatment occurs, on average, at higher rates in LMICs than in HICs (Ward et al., 2016) and it has serious consequences for child development. As the many studies of adverse childhood experiences from around the world have shown, children who have experienced abuse or neglect are more likely to: suffer mental and physical health problems throughout life; under-perform at school; have difficulties in jobs and relationships; abuse substances; and engage in risky sexual behaviours (and therefore to have unwanted pregnancies and contract HIV and other sexually transmitted diseases. This study refers to ‘child maltreatment’ and ‘child abuse’ interchangeably.

**Evidence-based Interventions**: Many evidence-based parenting programmes have similar components and delivery methods (Kaminski, Valle, Filene et al., 2008) and share common programmatic components and theoretical foundations, such as attachment theory (Bowlby, 1974) or social learning theory (Bandura, 1977), that are based in research.

Some studies suggest that where programmes include more evidence-based practices that have proven to be effective, they are more likely to achieve positive outcomes (Wessels and Ward, 2015).

This study refers to the Sinovuyo Teen programme as ‘evidence-informed’, in order to signal its inclusivity in encompassing participant perspectives in particular (Shlonsky, Noonan, Littell et al., 2011).

**Externalizing behaviours** are problematic behaviours that most commonly occur in children and can include stealing, cheating, aggression and rule-breaking (Liu, 2004).

“**Family support** is a set of (services and other) activities oriented to improving family functioning and grounding child-rearing and other familial activities in a system of supportive relationships and resources” (Daly et al., 2015:12).

**Harsh parenting** is negative parenting behaviour that is either physical or emotional, and includes corporal punishment and child maltreatment, which have been identified as major risk factors for more severe levels of child maltreatment (Stith, Liu, Davies et al., 2009).

**Parent** refers to “the main caregiver of the teen... not limited to biological or legal parents... This breadth is especially important given that significant numbers of children are reared by people other than parents” (Daly et al., 2015:11).

**Parenting** “is a functional term for the processes involved in promoting and supporting the development and socialization of the child (Richter and Naicker, 2013 cited in Daly et al., 2015:12).

“**Parenting support** is a set of (services and other) activities oriented to improving how parents approach and execute their role as parents and to increasing parents’ child-rearing resources including information, knowledge, skills and social support) and competencies (Daly et al., 2015:12).
“Parenting support is primarily focused on imparting information, education, skills and support to parents in two main forms:

- health-related interventions for parents and young children
- education and/or general support for parents” (Daly et al., 2015:17)

A Parenting programme is a “standard programme typically delivered in packages of sessions to parents” (Daly et al., 2015:9). They can be individual, group-based, or self-administered, so long as they are designed to improve parenting behaviour and parent-child relationships (Wessels and Ward, 2015). This study uses the terms ‘parenting programme’ and ‘parenting support programme’ interchangeably.

“Parenting interventions are programmes that are developed with the parents as the stated treatment group/participants” “Family interventions are programmes that are developed with the family as the stated treatment group [or participants]” (Kao, Gibbs, Clemen-Stone et al., 2012:613).

“Implementation is defined as a specified set of activities designed to put into practice an activity or programme of known dimensions. According to this definition, implementation processes are purposeful and are described in sufficient detail such that independent observers can detect the presence and strength of the specific set of activities related to implementation” (Fixsen, Naoom, Blase et al., 2005:5). Implementability therefore refers to the completeness and appropriateness of the set of activities required for the programme to be put into practice.

Involved parenting refers to parents spending time with children, such as playing games or attending school activities (Essau, Sasagawa and Frick, 2006).

A non-didactic, collaborative learning approach in the context of parenting programmes supports the social learning theory in which participants ‘are the experts’, and are encouraged to learn from each other, experientially.

Positive parenting practices include attentive, nurturing, warm and accepting behaviours towards children (Lachman, Cluver, Boyes et al., 2014). Others have characterized it as additionally being supportive, attentive and consistent parent behaviour (McKee, Roland, Coffelt et al., 2007).

Social desirability bias refers to the tendency of research subjects to give socially desirable responses instead of choosing responses that reflect their true feelings (Grimm, 2010).

Social learning theory: Popularized by Albert Bandura, this theory suggests that behaviour is learnt by imitating the behaviours that others model: “Most human behaviour is learnt observationally through modeling: from observing others, one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action.” (Bandura, 1977).

In parenting interventions based on social learning theory, facilitators model the desired behaviours, and parents, in turn, become role-models for their children.
1. INTRODUCTION

This paper examines experiences of caregivers and teenagers who, in 2015, participated in the Sinovuyo Teen Parenting programme, a parent support programme in South Africa. The paper highlights the caregivers’ and teenagers’ views on the programme, specifically what they thought were the programme’s most important components and how the programme supported them in fostering healthier relationships in and outside their homes. The caregivers’ and adolescents’ views are important for child protection and family welfare practitioners, and researchers. They let us know what worked well, what they learnt and what promoted effective learning (Proctor, Landsverk, Aarons et al., 2008).

This study understands parenting as a cultural practice comprising the “activities entailed in raising adolescents” and “the relationships between adolescents and the adults who care for them” (Bray and Dawes, 2016:8). Parents may include but are not limited to biological and legal parents, and as such encompass other relatives and non-kin (Daly, Bray, Bruckauf et al., 2015). Therefore, this study uses ‘caregiver’ instead of parent.

The study’s findings indicate that the parenting programme was well received by both caregivers and adolescents who attended and/or received programme content at home. In addition, the findings suggest that the programme promoted positive relationships and healthy behaviour changes in both caregivers and adolescents.

Recommendations emanating from this study include: firstly, to further investigate the sustainability of the change reported by caregivers and adolescents; secondly, to reconsider the recruitment process in order to avoid stigmatizing the teens and their caregivers and to build their trust; thirdly, to maintain the ‘fun’ aspect of workshops; and fourthly, to encourage caregivers to set up their own support groups after the programme ends.

The paper presents and discusses the findings of our qualitative study conducted in South Africa from 2015 to 2016. It is divided into six sections. Following the introduction, the second section puts the study in context, relating it to relevant literature on parenting programmes for teenagers in low- and middle-income countries (LMICs), and then introduces the Sinovuyo Teen Parenting programme. The third section details the methodology for the present study. The fourth section presents findings from our analysis of the data. The fifth section discusses the findings, drawing on relevant literature and making recommendations for parent support programmes in similar contexts and for further research. The conclusion includes possible limitations of this study. Works cited and appendices are found at the end.

2. WHY THIS STUDY? GAPS IN KNOWLEDGE ON EVIDENCE-BASED PARENTING PROGRAMMES FOR TEENAGERS IN LOW- AND MIDDLE-INCOME COUNTRIES.

The need to support parents: Parents play a key role in the development of children and teenagers. The ways in which children are parented is particularly critical in determining positive or negative consequences (Sherr, Marcedo, Cluver et al., 2017; Daly et al., 2015). Over the last decade, researchers, in partnership with governments, health workers and policy makers, have brought attention to the harm caused by harsh parenting (Macleod and Nelson, 2000), including cognitive
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Delay, mental and emotional health issues, engagement in risky behaviours, and increased public health costs (Mikton and Butchart, 2009; Anda, Felitti, Bremner, et al., 2006). Poor parenting skills can also lead to the risk of child maltreatment, including violence (Sherr et al., 2017; Daly et al., 2015; Knerr, Gardner and Cluver, 2013; Ward, Sanders, Gardner et al., 2016).

Parenting support programmes have become accepted as a critical strategy for improving parenting skills and preventing violence against children. These parenting support programmes should be multisectoral and must be rigorously tested (Altafim and Linhares, 2016; WHO, 2016; Ward, Makusha and Bray, 2015).

As a result, evidence-based parenting interventions are being developed to support parenting (Sanders and Podgeon, 2011). These interventions aim to reduce the risk of child maltreatment by enhancing positive parenting skills, providing non-physical forms of discipline, and increasing parents’ knowledge of child development (Knerr et al., 2013; Webster-Stratton and Reid, 2010; Mikton and Butchart, 2009; Prinz, Sanders, Shapiro et al., 2009; Barlow, Johnston, Kendrick et al., 2006). Evidence from different contexts and child age groups demonstrates good results for group-based parenting programmes that are grounded in social learning theory and help parents build skills in problem-solving and behaviour management (Barlow et al., 2006). As a result of this evidence, governments and organizations have increasingly promoted parenting programmes (WHO, 2016; WHO, 2009; Government of South Africa, 2005).

But there are gaps in parenting programming for adolescents in LMICs: A literature review reveals gaps in documented parent support programmes in LMICs (Altafim and Linhares, 2016; Calam and Sanders, 2012; Wessels, 2012; Fayyad, Farah, Cassir et al, 2010; Mejia (2012), WHO, 2009).

First gap: relatively few evidence-based parenting interventions exist in LMICs:

Despite the risk factors to child development, including “poverty and [its] associated health, nutrition, and social factors, often being more acute” in these contexts (Chen, 2013; Walker, Wachs, Meeks Gardner et al., 2007:145; Chen, 2013), there are relatively few evidence-based parenting interventions in LMICs. Well-known evidence-based parenting programmes such as Triple P, Incredible Years and the Nurse Family Partnership are difficult to implement in LMICs due to licensing costs and the need for highly-trained staff to deliver programmes (Sumargi, Sofronoff and Morawkska, 2014). In an attempt to address this, UNICEF and WHO provide institutional support to developing countries to roll out parenting programmes (Daly et al., 2015; Wessels, Mikton, Ward et al., 2013). The few relevant studies on parenting programmes that have been implemented in Africa include Families Matter!, an adapted and tested version of the parenting programme Parents Matter!, in which child-rearing is shared between biological parents and extended families (Poulsen, Vandenhoudt, Wyckoff et al., 2010). Other parenting programmes designed for LMICs contexts include Let’s Talk, which is delivered in the workplace of parents (Bogart, Skinner, Thurston et al., 2013), and Ububele, a home visitation programme designed for mothers of young children living in adverse conditions (Veitch, 2016).
Second gap: relatively few evidence-based parenting interventions offer support to parenting adolescents

Despite recognition of the positive impact of investing in adolescent health care (Sheehan, Sweeney, Rasmussen et al., 2017), most parenting programmes in both High-income countries (HICs) and LMICs have focused on parents of young children (Chu, Farruggia, Sanders and Ralph, 2012; Woolfenden, Williams and Peat, 2001).

Third gap: relatively little research establishing the effectiveness of parenting programmes in LMICs

Although parenting interventions have been tested to ensure that they are safe and effective in HICs, where support for parents and child protection services is already well established (Mikton and Butchart, 2009), a gap persists in evidence for the effectiveness of parenting programmes in LMIC. In a review of 12 published qualitative studies examining parenting interventions, none included LMICs (Koerting, Smith, Knowles et al., 2013). A systematic review of violence prevention programmes in LMICs reported on 12 studies globally and found only two in LMICs (Altafim and Linhares, 2016). Similarly, a look at reviews on child maltreatment prevention... found 298 studies, of which all but two were from high-income countries (Knerr et al., 2013).

Prior to this study, the research that had addressed these gaps included recent empirical studies and literature reviews (Knerr et al., 2013; Mejia, 2012) that suggest parenting interventions may be effective in improving child-parent interaction and parental knowledge, thereby reducing child maltreatment in LMICs settings (Knerr et al., 2013). Some research suggests that evidence-based programmes from HICs can be transferred to LMICs contexts (Gardner, Montgomery and Knerr, 2015; Knorr et al., 2013), while other research highlights the need for cultural adaptation of any transferred programme (Ward et al., 2016; Kumpfer, Magalhaes and Xie, 2012).

Fourth gap: there is limited qualitative research on parenting programmes

Where parenting programmes have been tested, the approach has generally been quantitative. The limited qualitative research on parenting programmes that exists commonly focuses on the provider of the programme, sensitizing policymakers and practitioners to the relevance and accessibility of parenting programmes to ensure they provide appropriate support to the direct beneficiaries (Kane, Woods and Barlow, 2007). Qualitative research on participant perceptions and experiences of family and parenting support initiatives, focuses on barriers to and facilitators to programme attendance (Mejia, Byrne and Pecnik cited in Daly et al. (Eds), 2015; Ulf and Calam, 2015; Smallegange, 2014; Konstantinos, 2014; Koerting et al., 2013; Ainbinder, 1998). Of those qualitative studies that consider ‘the users’ perspective’ (Kane et al., 2007), few include the perspectives of the children and teenagers involved. Similarly, scant evidence exists on the effectiveness of parenting programmes among teenagers (WHO, 2016; Knerr et al., 2013). The input of children, including teenagers, is important to consider in evaluating parenting programmes (Mytton, Ingram, Manns et al., 2013).

So why this study?: This study bridges gaps in the literature on parent support programmes for teenagers in LMICs by providing qualitative research that examines how both caregivers and teenagers experienced a parent support programme – the Sinovuyo Teen Parenting programme – in South Africa.

1 In addition to the Sinovuyo Teen trial, four parenting programmes have been implemented and tested through randomized controlled trials (RCTs) in LMICs (Lachman, Cluver, Ward et al., 2017; Sim, Puffer, Green et al., 2014; Annan, Bunderviet, Seban et al., 2013; Puffer, Annan, Sim et al., 2017).
The Parenting for Lifelong Health Initiative and Sinovuyo Teen Parenting programme

Parenting for Lifelong Health (PLH) is a collaboration involving researchers and child protection specialists from the universities of Oxford, Cape Town, Stellenbosch and Reading; UNICEF; and WHO.

PLH was established in 2012 to develop evidence-based programmes to support parents and reduce violence in LMICs, and to rigorously test these in randomized controlled trials (RCTs).

The Sinovuyo Teen Parenting programme (hereafter Sinovuyo Teen) is a PLH programme for at-risk families with teenagers aged 10–18 years (for details of the programme, see Appendix A). It was designed by the University of Oxford in collaboration with a non-government organization called Clowns Without Borders South Africa (CWBSA). Clowns also trained people from the local community to deliver the programme under their supervision.

The main aim of Sinovuyo Teen was to encourage positive parenting skills, which included better communication between caregiver and adolescent, consistent discipline and supervision as well as a reduction in harsh or abusive parenting. Secondary aims included a reduction in teenage externalizing behaviour (problem behaviour including physical aggression and disobeying rules) and a reduction in substance use and parenting stress (Cluver, Meinck, Shenderovich et al., 2016c).

The families participated in 14 parenting support workshop sessions, four of which were designed as separate sessions where caregivers and teenagers attended the same sessions but separately. The sessions used a non-didactic, collaborative learning approach, with activity-based learning, role-play, illustrations, home practice, and home practice discussions during which participants shared their experiences of the previous week at home.

Specifically, the programme content included understanding and practising structured praise and spending special time together; being aware of and managing emotions including anger; practising collaborative problem solving; setting rules and routines; managing household finances; and making plans to manage risks in the community and crisis situations.

Sinovuyo Teen was tested in one of the poorest provinces of South Africa, the Eastern Cape province, during three separate implementations from 2013 to 2016. The first and second implementations were both pre-post pilot tests and the third was an RCT (see Appendix B). Results showed reductions in harsh and abusive parenting and improved positive parenting (Cluver, Meinck, Steinert et al., 2018; Cluver, Lachman, Ward et al., 2016a; Cluver, Meinck, Yakubovich et al., 2016b). All implementations of the Sinovuyo Teen programme were simultaneously researched, so programme participants were recruited for the dual purpose of being programme participants and RCT respondents. The programme did not exist prior to being researched.

2 Sinovuyo means “we have joy” in isiXhosa
3 This study uses the World Health Organization’s (WHO) definition of adolescents - the phase of growth and development between childhood and adulthood, which includes any person between ages 10 and 19. This report will refer to ‘teens’ and ‘teenagers’, in accordance with the nomenclature used in the study.
4 Centre for Evidence-Based Intervention, Department of Social Policy and Intervention.
5 Clowns Without Borders South Africa (CWBSA) is an independent non-profit organization that seeks to improve the psychosocial condition of children, youth and families affected by crisis.
3. RESEARCH METHODOLOGY

3.1 Study design

A qualitative design explored how policy, service delivery, and social and economic factors have an impact on the effectiveness and scalability of the Sinovuyo Teen programme (See Appendix C). This paper reports specifically on sub-questions relating to participants’ experiences and perceptions of Sinovuyo Teen, whether the main outcomes of the programme were achieved and if so, how and for whom.

The qualitative study – which generated four working papers, including this one – complemented a randomized controlled trial (RCT)\(^6\) of the same programme.\(^7\) Data for the qualitative study was collected while the RCT was ongoing. This study was, therefore, not an evaluation of an existing programme. The Sinovuyo Teen programme was incubated, piloted and tested in South Africa and this qualitative study was part of the final testing in 2015. Programme participants were recruited to the programme knowing that they would also be research respondents. These respondents were purposely sampled from the individuals who were recruited into the RCT study and who received the Sinovuyo Teen programme. Recruitment into both studies was voluntary.

For the RCT, participants were recruited through referrals from social services and community leaders, as well as by door-to-door methods. Each household had to send one adolescent and their caregiver. ‘Caregiver’ was defined as the person who had the most responsibility for the adolescent and resided in the same household as the adolescent at least four nights per week. Participants completed a short screen test before being enrolled to assess stress and anger levels in the house. The programme was presented as an intervention to support families with adolescents rather than at-risk families to avoid stigma being associated with the programme.

3.2 Ethics

Ethical protocols for this study and the RCT were approved by the University of Cape Town (PSY2014-001) and University of Oxford (SSD/CUREC2/11-40).

3.3 Data collection

The primary data set for this study was composed of 42 semi-structured interviews with 21 caregiver-teen dyads. Our primary informants were purposefully selected (from the 270 dyads participating in the Sinovuyo Teen RCT) to represent a range of ages, genders and locations. Two teenagers who were interviewed did not agree to have their interviews recorded, so their views are not represented here. Two researchers and one research assistant conducted interviews. Interviews allowed in-depth exploration of respondents’ experiences and perceptions and included a visual mapping exercise whereby participants illustrated their households and families and their relationship with each of these members. The purpose of this exercise was to ascertain who else was significant to the caregiver and teen, and who potentially had influence over parenting practices. Interviews were conducted in participants’ homes in isiXhosa, the local language, by a qualified qualitative researcher, and did not last more than 45 minutes. All interviews were recorded, translated and transcribed.

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\(^7\) See https://www.unicef-irc.org/research/family-and-parenting-support/ for full set of papers relating to this qualitative study.
Interview data was triangulated with data from: separate focus group discussions with caregivers and teenagers (n=240 people); facilitator reports on workshops (n=280); workshop observations (n=9); and catch-up field and workshop observation notes. These additional sources of data were collected together with a larger team of research assistants and provided nuanced insight into the themes that emerged from the analysis of interview data. Data collection took place from November 2015 to September 2016 (see Appendix D for further details relating to data collection).

Verbal consent was obtained from each participant prior to focus group discussions and interviews. Additional written consent was also obtained prior to the interviews. Participants were assured of confidentiality. The moderator of the interview or focus group discussion explained the purpose and procedures of the study. Respondents were assured that their participation was voluntary and that they could withdraw at any stage without consequence. There was no payment for taking part in the qualitative study.

3.4 Data analysis and validation

Braun and Clarke’s (2006) six steps of conducting thematic analysis were applied to guide analysis of the primary data, in line with other similar qualitative studies (Kelleher, Connor, Clarke et al., 2012; Koerting et al., 2013). Any disagreements during analysis were resolved through discussion between the authors, thereby increasing reliability. Results were discussed at a validation meeting with seven caregivers, as well as with members of the study’s advisory board (see Appendix D for details on data analysis and validation work).

Analysis resulted in the emergence of three themes, which are presented in the findings section that follows. Notable frequencies for data items central to each of the respective three themes are stated throughout the findings, typically at the beginning of a sub-section. These describe the number of caregivers (out of a total of 21) or teens (out of a total of 19) who described a particular finding during their interview.

4. FINDINGS: GIVING VOICE TO PARTICIPANT EXPERIENCES

Analysis of our findings produced three themes, which will be discussed below: 1) Participant experiences of the Sinovuyo Teen programme – Recruitment and attending workshops; 2) Programme impact; and 3) Looking forward – Strategies for sustaining change and other recommendations for researchers and programme implementers.

4.1 Participant experiences: Recruitment and attending workshops

Describing their experience of the Sinovuyo Teen programme, participants offered observations on: 1) the recruitment process; and 2) their experiences of attending the Sinovuyo Teen workshops. These sub-themes are discussed in more detail below.

4.1.1 Being recruited into the Sinovuyo Teen programme

Participants from all clusters and across all ages were initially unclear (12 of 19 teenagers), or ‘lost and confused’ (caregiver, interview 1), about why they had been chosen to attend the Sinovuyo Teen programme and what the purpose of the programme was. Teenagers (11 of 19) retrospectively described feeling targeted for being unruly:
Teen: “I thought I was going to be taken away because rumours had it those cars were looking for naughty and disrespectful children.” [FGD10]

In some instances, a lack of understanding around the recruitment process gave rise to fear and suspicion:

Teen: “I was afraid because the others say they are going to be taken to the prison where the naughty children are staying” [FGD8]

Caregiver: “I thought it is the Department of Social Development because of this abuse of grants.” [FGD3]

Some teens also reported feeling stigmatized by recruitment strategies, such as being visited at their school by the vans used by the research team during the recruitment phase of the study and programme:

Teen: “I didn’t like those painted cars coming for me at school because the other kids would tease me.” [FGD2]

Feelings of being stigmatized, however, were not reported by all the teens. Others noted that the process made them think they were “special because these people were looking for me only and not my siblings. Plus the cars were so nice and colourful”. [Teen, FGD10]

Many caregivers queried whether the ‘right’ family members had been recruited into the programme, referring to family dynamics and composition.

During their interviews, participants were asked to create visual illustrations of their households in order to describe who had influence over teenagers (see Appendix D for details relating to the visual mapping exercise). These illustrations demonstrated that households were mostly complex and multi-generational. In one case, more than a dozen people were living in a single home. Almost three-quarters of respondents indicated that at least one family member with a key role in child-rearing lived outside the family home. In some cases, this included family members who did not live in the same village, township or province, and in other family depictions in mapping, key family members were not familial relations but neighbours. These maps showed family members often played many different parenting roles (see Appendix E for examples), and highlighted information about household demographics and relationships that are important to consider in relation to programme impact beyond the two participants per household who were recruited.

Almost all caregivers in the programme were female (see Table 2, Appendix D). However, regular anomalies, should be noted: despite being in the minority, fathers, brothers, grandfathers and uncles were all delineated in visual maps created by teenagers as occupying roles that were central to parenting and to guiding teens.

The recruitment process also gave rise to a number of expectations. Some teenagers expected to be taught respect during the Sinovuyo Teen programme [FGD6]; and 19 of 21 caregivers reported expecting guidance in rearing ‘difficult’ children:
Caregiver: “... I thought that they would guide me on how best to raise the child, and heal so would be instructed not to grieve me as a parent.” (Interview 9)

During their interviews, a range of participants expressed expectations of material gain, material support, and concrete poverty alleviation:

Caregiver: “... we were excited that it might be for poor people, coming to rescue us.” (Interview 25)

This was a view corroborated in focus group discussions. Teens often had an expectation of material gains, specifically schoolbooks. Caregivers, by contrast, had better defined expectancies of the programme, including employment. Caregivers also expressed the expectation of financial assistance:

Caregiver: “… as the child grant is going to be stopped, I will live on six-hundred rands and I do not how I will survive... I thought I will get financial assistance so I can build a better thing than this. As you see this place the way it is.” (Interview 3)

4.1.2 “We attended as parents and their children”: Workshop and home visit experiences

Participants identified factors that influenced their ability to attend workshops. Primary barriers to attendance reported by teenagers included school and work. Caregivers cited work, illness, care duties and funerals. Other reasons for absences, which were noted during catch-up sessions, included the weather, forgetting the session, not wanting to continue the programme and requiring assistance to attend workshops. This last point is illustrated by the following facilitator note about a catch-up she provided:

“... she welcomed me, she is still interested to attend the sessions but unable to walk, I promised her that the car will fetch her if she really wants to attend the next session... she was so participative and listening attentively, she also promised to attend the next session and to wait for the car to fetch her.”

Having to care for young children or ill family members was cited most often by caregivers as a reason for not being able to attend workshops. This was the case especially in rural clusters:

Caregiver: “But she [her teenager] could not attend, because the baby was still small. We’d alternate on weekly basis to who go to the program and who stays behind with the baby... The last session we went there together, even though the baby is small we did not want to miss it.” (Interview 35)

Aspects that facilitated attendance for both caregivers and teenagers included: receiving the programme at home (‘khaya – or home – catch-ups’); proximity to the venue where workshops were held; provision of transport to the workshop venue; and the pull factor of the programme itself.

Caregivers received approximately 50 per cent of the programme workshops via home catch-ups, a condensed version of the workshop adapted to be delivered to participants at home. Teenagers received 46 per cent of the workshops as catch-up sessions (Cluver et al., 2018). The lowest number of
catch-ups was delivered in a rural cluster (11 per cent of all sessions), whereas the highest proportion of participants to receive the programme at home (62 per cent) belonged to a peri-urban cluster.

Teenagers and caregivers did not always receive catch-up sessions together, as intended for 10 of 14 sessions. This was because the caregiver and teenager were often absent at different times, and/or the facilitators often decided how to give the catch-up sessions on the day, including who to involve at the participants’ home.

Although, there were different responses to the facilitator arriving in the home to deliver catch-up sessions, participants and facilitator notes recorded that in general facilitators were well received at home:

   Caregiver: “We are grateful for the patience Sinovuyo had, especially for running the extra mile for visiting you at home when you had missed a session.” [FGD 2]

Several caregivers and teenagers noted that the proximity of the workshops to their homes facilitated regular attendance. Others (5 of 19 teenagers) emphasized the role that providing transport played in their ability and willingness to attend workshops, especially those living in rural clusters. One caregiver noted that being collected and dropped off was particularly helpful for the elderly, a view echoed by other caregivers:

   Caregiver: “I didn’t know how I was going to get to the venue because I have a bad leg. But Sinovuyo promised to come fetch me home and they fulfilled that promise very well.” [FGD 1]

References to enjoyment or satisfaction with workshops was another motivation for continued attendance:

   Caregiver: “When something is of benefit you do not want to miss it. It empowers to attend. You’d want to be there most of the time.” (Interview 15)

Some focus group discussions also highlighted the warm relationships with the programme facilitators as a motivating factor to attend workshops [FGD7]. Others underlined meaningful relationships with other beneficiaries:

   Caregiver: “What made it easy for me to go to Sinovuyo on Tuesdays was that whatever situation my home was in – I found love there. The two days I was absent stressed me very much.

   Interviewer: You found friends there?

   Caregiver: Truly.” (Interview 39)

Participant experiences of the programme workshops were diverse, including two who said they did not enjoy the programme. On the whole, however, participants reported a positive experience (40 of a total of 42 participants, including all 19 interviewed teens) and highlighted, in particular, having ‘fun’ (25 of 42), their enjoyment of ‘exercise’ (11 of 42) and the value of acquiring new ‘knowledge’ (22 of 42).
Facilitators’ records of the workshops noted that sessions with the highest impact were those showing how to deal with anger and stress using communication, and those highlighting the importance of caregivers and teens spending ‘special time’ together. Participants corroborated this and noted in particular how they enjoyed being together: “We would come out of sessions with smiles on our faces,” one caregiver reported during interview, “it was an enjoyable place” (interview 41).

Teenagers (18 of 19) used the word ‘fun’ to characterize workshops more than any other word:

Interviewer: “In what way they were fun?

Teen: We had time to sing, we played and we were taught things that we had no knowledge of... Like when you are stressed, you need to have time out in order to reduce your stress.” (Interview 4)

Caregivers similarly described the experience of fun during workshops, making reference to playing and laughing and the socially adhesive effect on relationships and group dynamics during the workshop:

Caregiver: “The thing that worked for me the most is the gathering of many people in one venue talking and laughing.’ (Interview 3)

Both caregivers and teenagers emphasized the practice of spending ‘special’ – or dedicated – time together as a result of workshops:

Caregiver: “The thing I loved is that we attended as parents and their children. Not children on their own.’ (Interview 31)

Workshop observation verified that the physical exercise aspect of the programme was enjoyed across most clusters:

Caregiver: “We moved up, down, sideways thinking it is child’s play but we were actually releasing the stress.” (Interview 37)

Notably, facilitators asked teenagers to lead the physical exercise in the sessions; caregivers enjoyed watching their teens take on leadership roles, which, in some cases, teens did with great enthusiasm.

Caregivers and teens said they valued workshop activities that resulted in ‘learning’ (Interview 29):

Caregiver: “I like that role-play that was talking about a mother that ignores her child and concentrates on whatsapp. I learnt from that activity that my child comes first.” [FGD7]

Teen: “I liked the role-play of sugar daddy. I saw it as a lesson that having a sugar daddy won’t replace a father.” [FGD16]
The programme’s economic strengthening content was widely reported by both teenagers (14) and caregivers (13) as the most prominent take-away from workshops. Several caregivers reported an increased awareness of financial planning and saving as a result of these workshops:

Caregiver: “By use of budget, because if you have money you must budget. This enables you to save for the future, and you prepare for your child’s education.” (Interview 7)

Caregiver: “I no more borrow money from the loan-sharks.” (Interview 3)

Interviews are replete with concrete, detailed expositions from both teenagers and caregivers on how knowledge of budgeting changed participant households:

Teen: “She first writes what is needed, and put that money aside. Then reserves a hundred rand in case of emergency needs. The money that is left she saves.” (Interview 4)

Teen: “Sinovuyo taught me how to save and budget money. I did not spend money on the important things. We used to spend on clothes and not on food.” (Interview 40)

Participants often contextualized their appreciation of new financial skills by referring to the pervasive poverty that characterized their lives. Visual mapping depicted a variety of financial profiles within households and families, all of which are united by a need for financial support outweighing actual sources of income. Sources of occasional household income included odd jobs such as gardening and many different grants, including grants for disabilities, and for their own children as well as for foster children. The maps indicated that households received financial support from both male and female members, but that women were mostly the grant holders.

Many participants noted that the programme’s economic strengthening content was not only helpful in learning money management skills, but it also provided a joint activity during which caregiver and teen could spend ‘special’ time together. A caregiver and teenager from a rural area reported that they used their home practice on money management to also practise discussing rules together. Also, many caregivers and teenagers reported they continued to do budgeting and physical exercise together after the programme had ended.

Workshop observation records indicate participants were much more reticent discussing their practice at home where caregivers and teenagers were encouraged to ‘practise’ different skills from the programme every week. Records from across all 20 clusters capture reduced rates of participation in this core aspect of the programme and facilitator notes reflect participant reticence. Some respondents, however, refer to sharing workshop learning during ‘home practice’ with other family members and friends:

Caregiver: “My brother used to watch us, because he is talkative. We used to do the home-practice here at the table. He praised the budget, because it was very helpful to him.” (Interview 25)
Teen: “I wanted some of the home-practices to involve my friends at school. We would stay after school and do them.” (Interview 30)

Family interest in programme workshops was frequently noted (18 of 19 teens; 19 of 21 caregivers). Participants reported that many family members were interested in participating in the workshops.

Some participants felt their wider families were ‘being excluded’ (Interview 8) from workshops, while others noted that they attended with their siblings. Some participants were proactive about involving other family members:

Teen: “I used to voice record for my sister and friends so that they can hear what is happening in the sessions.” [FGD12]

This suggests that facilitators adopted different strategies to deal with participants who had not been recruited into the programme and study and yet were attending workshops. As has been noted elsewhere, the programme was not intended to be limited to one teenager and one caregiver; however, recruitment was restricted to one dyad per household in 2015 in order to accommodate the research trial taking place simultaneously.

At the other end of the spectrum, some family members who were not attending workshop sessions initially opposed their family members participating in the programme. This was sometimes expressed as a lack of interest in the programme or as suspicion of the programme’s intentions:

Caregiver: “They [other family member] thought that it was some illegal thing intending to take advantage of their children... Their lack of knowledge made them suspicious to the programme.” (Interview 11)

4.2 Programme impact

4.2.1 Narratives of “tru[e] change”: Changed relationships, teen behaviours and parental attitudes about discipline

Participants described the impact that the programme had on their lives by making reference to three related aspects: 1) Changed parenting relationships; 2) changed teen behaviours; and 3) changed caregiver practices of violent discipline.

Parent-teen relationship change was reported to have included altered communication styles (16 of 21 caregivers; 14 of 19 teens), spending more time together (17 of 21 caregivers; 14 of 19 teens), and the use of positive reinforcement for cooperative and helpful behaviours (12 of 21 caregivers; 12 of 19 teens).

Both teens and caregivers also reported that the programme had an impact on a personal level (17 of 21 caregivers; 14 of 19 teens), particularly on teen behaviours. For caregivers, the most notable programme impact was in attitudinal shifts on how violent discipline was understood and practised.

A minority of participants reported aspects that had not changed in either themselves or their counterpart (5 of 21 caregivers; 4 of 19 teens), and some reports of behaviour suggested the need for further support (6 of 21 caregivers; 3 of 19 teens).
4.2.2 “Sharing problems”: Positive relationship change between caregivers and teens

Participants expressed positive changes in their relationships as a primary take-away from the programme. Better communication was most frequently identified:

Teen: “We share our problems. And that makes us close.’ (Interview 26)

Caregiver: “We sit down and talk and it is really nice. He tells me about what goes on at school and he has really pushed himself. He even plays cricket, they received a trophy and I would praise him.” (Interview 5)

Some participants (9 of 21 caregivers; 9 of 19 teens) used their new communication skills to make plans for addressing specific risks in their communities.

Caregivers noted the shift from previous cultural communication patterns:

Caregiver: “As black people we do not speak of other things. We do not want to speak to our children about crucial matters. They taught us to communicate with our children, spend time with them and not sideline them on issues.” (Interview 11)

Caregiver: “… as Xhosa’s we did not share our problems with our children.” (Interview 25)

Caregiver: “They were very difficult to accept first, because they are certain things one hides from children.” (Interview 11)

After the programme, however, caregivers and teens remarked on the importance of spending time together and communicating about a range of topics and feelings:

Caregiver: “It has changed. We can spend time together chatting... We used to greet each other in passing. Sinovuyo made a big difference that changed that situation.” (Interview 7)

Teen: “The thing I loved the most is learning to spend time with my mom, becoming close and talking about things... I never used to want to be at home. But now I find it important to spend time with a parent and be open with her. And tell her my problems.” (Interview 36)

One teenager also referred to how their mother used to be a “very confused person and hectic... before she did not listen” (Interview 8).

Consciously spending time together was identified as a primary contributor to positive relationship change across genders and age groups. Another marker of improved relationships that both caregivers and teenagers identified was the use of praise or positive affirmation. Recorded with the same frequency, teens (12 of 19) and caregivers (12 of 21) mutually recognized how they each practised praise:
Caregiver: “[I] compliment my child when he has done well and he can do the same to me.” (Interview 9)

4.2.3 “Learning from one another”: Relationship change with others

The relationship changes noted between caregivers and teenagers were also described as benefitting other family members and others outside the home: “learning from one another as neighbours and giving each other advice” (Interview 7, caregiver). A number of teenagers (6 of 19) focused specifically on changes that they had implemented in how they related to siblings. Teenagers of different ages were also able to apply their new communication skills not only with siblings but also with their peers:

Teen: “I could not sit and chat with him. I could not do that with other people too. I secluded myself. But since I have spent time with many people at Sinovuyo I do now.” (Interview 20)

One teen went so far to name this as her motivation for joining the programme:

Teen: “I joined because I wanted to change my communication with friends. I used to be a bully against them, but now I no longer do that.” [FGD14]

4.2.4 “I can say I have changed”: Changed teen behaviours

In addition to reporting changes in their relationships, both caregivers and teenagers also described personal changes that they attributed to the programme:

Caregiver: “My husband likes to say, ‘You have gained maturity since going to Sinovuyo’. Because I do not shout anymore. And I’d concur and say, I am no longer going backward, I go forward. Yes, I have grown.” (Interview 15)

Teen: “I can say I have changed; I am no longer the person I was before.” (Interview 8)

Both teenagers and caregivers underlined changes to teenage behaviour in particular. “Learning how to give respect to an elder” (Interview 8, teen) emerged as an important sign that the teen’s behaviour had improved, as did the willingness of teens to ‘say sorry’ [notes from validation meeting] for bad behaviour, share household chores, and obey the curfew. Evidence also suggested that these positive behaviour changes were being applied in other relationships:

Teen: “I learnt that wherever I am or wherever I go what I should take with me is respect; have respect for everyone no matter what age... If someone does me wrong, I should not raise hell but keep calm.” (Interview 28)

Caregiver: “At first he did not want to do his chores, and was very rebellious—but things have changed.” (Interview 11)

Significant reports of changed attitudes to risky behaviours were provided by a range of male and female teens from the ages of 12 to 18 years and were confirmed by caregivers during focus group discussions:
“At home we had a problem of a child being on drugs and he came home very late and he didn’t eat supper because he smoked dagga. And he is getting worse and maybe it’s because he is an orphan. When Sinovuyo did these sessions, he changed his behaviour. He is doing the right things now.” [FGD7]

Workshop observation of session 12, which addressed planning to avoid risk areas in the community, revealed discrepancies about the places caregivers and teenagers considered ‘risky’ in their communities. These discrepancies extended to both rural and peri-urban clusters, but were more pronounced in peri-urban clusters. During one workshop observation (Cluster 1), for example, a heated disagreement took place about whether the school was safe. Caregivers agreed that it was, and teenagers disagreed. Further similar disagreements ensued about the safety of the swimming pool, taxi ranks and other places in the community.

Some participants noted no change from participating in the programme or raised areas of concern. These are important to note, not as anomalies to what has been noted above, but as evidence that the experience of the programme was varied. For example, a caregiver suggested that 14 weeks was not enough time to detect a change in her teenager’s behaviour. Another caregiver reported that her teen did not share problems with her or communicate effectively, both during and after the Sinovuyo programme:

Caregiver: “… You will ask until you get tired of it. Even at Sinovuyo while were playing another game they asked her what she was thinking. She does not talk at all.

Interviewer: So your relationship has not change, it remains the same as before?

Caregiver: Yes. Because I try my best to figure out what is wrong with her.”

(Interview 13)

4.2.5 “I beat her like I was beating an adult”: Preventing violent discipline

Undoubtedly one of the most prominent programme impacts was related to caregivers’ views on violent discipline. Caregivers frequently cited reductions in beating (15 of 21 caregivers) and shouting (20 of 21 caregivers), and changes in discipline (12 of 21 caregivers) as key programme impacts, although there were discrepancies in how these were reported by caregivers and teenagers. Overall, teenagers experienced reductions in violent discipline as contributing to more positive relationships:

Caregiver: “Sinovuyo came with a big thing, because it educated us as people of a village. It gave us knowledge of thing[s] we had no clue about. Things that upbuilds, like how to nurture a child we discovered them there in Sinovuyo. Children should be treated equally. You must not hassle a child by beating him.” (Interview 39)

Interviewer: What is it that she does that makes your relationship strong?

Teen: She no longer screams at us and she no longer beats us like she used to.”

(Interview 18)

Both caregivers and teens said that physical violence was often associated with discipline (or ‘physical punishment’ (Interview 22, teen)), although there was a range of approaches and views
on this. One young teenager, for example, clarified that violent discipline is only appropriate for younger children. Female caregivers explained that mothers sometimes used violent discipline to ensure teenagers stopped misbehaving in order to protect them from what was perceived as more aggressive forms of violent discipline from male family figures (notes from validation meeting).

Following the programme, some caregivers described an understanding of how shouting and beating contributed to ineffective discipline and poor relationships. The following quotes provide examples of this realization, and how they replaced violent forms of discipline and shouting with positive interactions, open communication and stress management:

Caregiver: “If you raise your voice to a child or beat her, she will completely ignore you. I was like that before... For example, do you see that room divider?... She broke it when I beat her. I beat her like I was beating an adult. I had a nasty temper. But then when I went to Sinovuyo, I learnt ways in which to nurture a child. Perhaps I am the one who is changing the character of a child.” (Interview 21)

Caregiver: “I was impatient, truth be told. Whenever I spoke to ... he would not listen to me and I ended up beating him... And now I have changed... These children are disruptive. But now speaking to him is a priority rather than beating him, because now he listens when you instruct him.” (Interview 1)

Caregiver: “I learnt that there is not [a need] to shout to a child in order to get your point across. I should be calm, sit him and gather the facts. So that he could be at ease to tell me. I should not raise my voice at him and beat him. However I must show him that I am disappointed in what he did.” (Interview 41)

Caregivers identified stress management as a key contributor to their ability to change patterns of violent discipline:

Caregiver: “The other one was that if I have fought with my husband I should not bring out my stress to the child...I should not make her a punching bag whilst she is an innocent bystander.” (Interview 31)

One of the strategies caregivers referred to in managing stress levels was “taking a pause – then the stress would disappear” (Interview 1, caregiver).

The programme’s impact on preventing violent discipline was not universal. Some teens reported no changes in their caregivers’ use of violence, which included the caregiver beating and shouting at them. Moreover, during a workshop observation of a role-play that featured a mother shouting at her teenage boy, some teens commented on how strongly they still related to the character’s experience because their caregivers still shouted at them in a similar way.

4.2.6 Reduced teen aggression

Reductions in aggressive behaviour were also reported by teenagers, who explained that they were no longer using violence with peers and siblings. This applied particularly to older teenagers of both genders.
One teenager reported understanding stress management in a similar way to how some caregivers described it, namely that taking a pause can “reduce your frustrations” (Interview 4). Another teenager explained that he used communication to solve problems as an alternative to fighting.

### 4.3 Looking forward: Sustaining behaviour change and social support

This final theme focuses on the need identified by the participants for ongoing programmatic and social support after the programme workshops ended.

#### 4.3.1 Participant strategies for fostering ongoing programmatic support

Some caregivers suggested that ongoing programmatic support was necessary to sustain the changes that they attributed to the programme because they had already observed how positive behaviour change in their teens had begun to ‘slip’ (caregiver, interview 19).

Caregiver: “There is a big change. And since there is no Sinovuyo, I am very worried… I am worried because I no longer found an outlet for my stress, and I miss the lessons that they gave us.” (Interview 27)

Views on this subject were, however, varied, as others noted that there was no longer any need for further intervention “because I am well informed now” (Interview 9, caregiver).

In some instances, caregivers discussed the opportunities for disseminating programme learnings to other families in their community themselves as a way of bringing these forward:

Caregiver: “In the community you can find a neighbour come crying to you asking for help because things are not going well at home with their child. Because of the knowledge I have gained here, I am able to give advice.” [FGD9]

One cluster announced during their focus group discussion that they would continue meeting as a group to share advice and experience:

“We decided not to stop Sinovuyo, we must continue with our group because other opinions helped us in the session.” [FGD11]

Some caregivers (9 of 21) and teenagers (11 of 19) used the occasional handouts provided during workshops to reinforce programme learning and remind themselves (or others) of the programme content.

#### 4.3.2 Implementing ongoing social support

Several participants commented on the support networks that they had been able to develop and benefit from as a result of attending workshops, and were anxious about the loss of those networks.

Sharing the programme with others was considered valuable and contributed to a positive overall experience for both caregivers and teenagers. Regular time with other participants provided the opportunity to develop positive relationships with each other. This was particularly noteworthy for lone and other vulnerable parents:
Caregiver: “I joined because it is hard to be a single parent. I wanted a third person to intervene in this. To help seeing whether I am doing a good or a bad job since we have problems at home.” [FGD1]

Caregiver: “Another thing is that a buddy can share his feelings at Rhonda. And if a buddy’s loved one has passed away and the buddy has no money we contribute. There was a woman in Sinovuyo whose son passed away; we contributed 10 rands each to make a party to ease her pain – she was comforted by our presence.” (Interview 39)

Although some teenagers also registered the positive effects of peer networking as a result of attending workshops, workshop observations suggest that this was inconsistent across groups, which may be a result of the wide age range of participating teenagers.

The researchers’ observational notes referred to the socially adhesive effect of starting workshops by sharing a meal. Participants and facilitators used eating time to chat, laugh and enjoy communal social activity. This often benefitted the workshop that followed.

In focus group discussion, one participant remarked that certain community members had begun to rely on each other independently of programme workshops, demonstrating the possibility of maintaining social networks outside the workshops:

Caregiver: “Sinovuyo has helped us build better friendships. I can now go and rest on ...’s bed and ask for tea and food and we talk.” [FGD1]

Similarly, more than half of both caregivers (12 of 21) and teenagers (13 of 19) continued to have contact with their programme ‘buddies’ three to six months after the programme ended. Sinovuyo participants were ‘buddied up’ for mutual support during, between and after workshops. The Sinovuyo buddies primarily served a purpose during implementation – one facilitator noted after doing a catch-up session that the participant had ‘already heard what happened at the session from her Sinovuyo buddy’. In a few cases, programme ‘buddies’ also continued to offer social support after the programme, particularly reminding participants what they had learnt during the sessions and also informing them about peer support networks in the community.
5. DISCUSSION

Drawing on relevant literature, this section examines findings from the three themes presented above and identifies implications for practitioners and researchers interested in parenting programmes. The discussion section is divided into three parts that focus on: 1) contextualizing the findings within the wider context of participants’ lives; 2) further assessing the change that was attributed to the programme; and 3) making recommendations for the implementation of future parenting programmes, especially those in South Africa and other LMICs.

5.1 Understanding parenting in context

The findings presented above suggest the need to consider the experiences of those who attend parenting programmes in the context of their extended families and communities as well as in relation to local parenting practices.

5.1.1 Understanding households and parenting in the Eastern Cape

This study took place in the Eastern Cape, one of the poorest provinces in South Africa. Households in this province have a high dependency ratio, with the main sources of income being the universal old age pension, foster child grants, and the means-tested child support grant. Across the Eastern Cape, up to 50 per cent of children reside in households without a single employed adult (Hall in Biersteker et al. (Eds.), 2013), with 58.4 per cent of the province benefitting from direct social assistance (StatsSA, 2015). The visual mapping data confirms this high level of dependency on social assistance within Sinovuyo Teen households, and also reflects intergenerational poverty (Adato, Carter and May, 2006).

Participants appreciated learning ways to budget jointly and to save sufficiently to start a small business (for example, buying chickens or a goat). This suggests that they had a need beforehand for financial guidance on how to use their cash transfers and regulate consumption between grants in South Africa (Collins and Leibbrandt, 2007). The budgeting content in the Sinovuyo Teen programme could therefore be planned to complement state-led social security provision, and would then be in line with emerging trends of combined social protection mechanisms (Boyes et al., 2014; Bandiera, Burgess, Das et al., 2013; Cluver et al., 2014; UNICEF, 2012).

Participants’ positive reaction to the programme’s budgeting sessions demonstrated that joint teen/caregiver discussions on budgeting can be beneficial to the extended family. The idea of reciprocity that Bray uses to characterize adolescents as they take on household responsibilities and gain more recognition as young adults amongst their kin also provides insight into why this particular session was received positively (Bray with Dawes, 2016).

Overall, the research showed that the engagement of other family members during the Sinovuyo Teen workshops was influenced by family structure, the facilitator delivering a home catch-up session, and different family members’ interest in the programme. Other qualitative studies have examined the lack of support from other family members as a barrier to continued programme engagement (Bayley, Wallace and Choudhry, 2009; Sarno Owens, Richerson, Murphy et al., 2007). This may have some relevance to the findings of our study: the programme may have challenged entrenched gender roles by supporting female caregivers as they practised new skills that they do not have the agency to apply in their homes. Understanding the broader family structure is therefore crucial to deciphering the mediators that potentially have an impact on the effectiveness of
parenting programmes outside of the workshop, within the home.

Within these diverse households, several entrenched gender roles and responsibilities did emerge. Women were identified as primary caregivers in most households, with an almost equal number of caregivers being grandmothers or mothers (see Table 2, Appendix D). Replacements for biological mothers and grandmothers attending programme workshops included siblings, aunts, other relatives and in a few cases neighbours, most of whom were women. This finding echoes dominant ideas about who takes on childcare in the absence of primary caregivers documented elsewhere (Bray and Dawes, 2016). It also reflects survey data on children living with parents in the Eastern Cape, which shows 40.4 per cent live only with their mother; 2.9 per cent live only with their father, 35 per cent live with neither parent, and 21.6 per cent live with both parents (StatsSA, 2014).

Fathers remained highly relevant to teenagers, even when they were not physically present. This was clear from both the visual mapping and interview data as well as in literature on this subject (Bray and Dawes, 2016). Our findings convey that men played financial support and influence roles inside and outside the home, although only a few men attended the programme workshops. Some efforts have been made to address the absence of fathers in parenting programmes, but these have focused on engaging men in programmes rather than analysing paternal perceptions (Panter-Brick, Burgess, Eggerman et al., 2014; Stahlschmidt, Threlfall, Seay et al., 2013; Bayley et al., 2009). Further research is therefore required in this area.

Entrenched ideas about parenting, especially in relation to modes of communication between caregivers and teenagers, are important to understand in relation to family structures. Current research shows a significant gap in understandings around caregiver-teen communication dynamics in sub-Saharan Africa (Bastien, Kajula, Muhwezi et al., 2011). Much of the literature on communication patterns between teenagers and adults in sub-Saharan Africa focuses on sexual risk-taking and HIV (Miller, Lasswell, Riley et al., 2013; Bray, Gooskens, Kahn et al., 2010; Wamoyi, Fenwick, Urassa et al., 2010; Armistead et al., 2004; Hutchinson and Cooney, 1998). Our findings corroborate the need to bridge the communication gap, and suggest that caregivers were often reticent to communicate with their children to try to protect them from their daily struggle to survive.

Understanding how parents and teenagers communicate is fundamental to supporting participants. The Sinovuyo Teen programme encouraged participants to try new ways of communicating. Our findings suggest that exploring more positive and open communication strategies was a key mechanism for unlocking other positive behavioural changes.

5.2 Assessing participant change

5.2.1 Replacing violent forms of discipline: Ripple effects and questions about the sustainable impact on abusive parental behaviour

Our findings captured the frequency and nature of child abuse in these particular communities of the Eastern Cape. They align with Jewkes’s analysis of childhood experience in rural South Africa, where “physical punishment was particularly common” (Jewkes, Dunkle, Nduna et al., 2010:838). In interviews, several caregivers made retrospective comments about having made ‘mistakes’ and
having ‘learnt lessons’ about their use of violence before attending the programme and commented on the benefits of not using violent discipline. **This demonstrates some parental confidence in bringing new non-violent skillsets forward.** Thus these findings suggest that the Sinovuyo Teen programme’s primary aim – to improve parenting and reduce violence against children – has to a certain extent been met in the short term. This study therefore contributes to the small body of literature addressing the “paucity of evidence demonstrating the effectiveness of these programmes [parent training] on actual abuse” (Barlow cited in Donnelly and Ward (Eds.), 2014:137).

Other studies have also noted the benefits perceived by parents of learning and implementing new parenting and discipline skills (Altafim and Linhares, 2016; Kelleher et al., 2012; Portwood, Lambert, Abrams et al., 2011). Questions remain, however, as to whether or not parental attitudes and practices are sustained over time. **Further research needs to examine the sustainability of the new practices that caregivers explored in the supportive context of the Sinovuyo Teen programme workshops.**

The cyclical nature of aggressive behaviour (Kaminer, Eagle and Crawford-Browne, 2016; Makhosazana Kubeka, 2008) was also highlighted, particularly by caregivers who reported that they had previously passed on stress in their relationships with their partners to their teens; and also in the teens’ self-reported changes in their own aggressive behaviours with younger siblings or peers. Future research should also investigate if parenting programmes are able to intervene to prevent incidences of **inter-generational violence** (Huesmann, 2012; Dubowitz and Beanett, 2007), for example, in maltreated teens who attend programmes such as this one with their caregivers but are also parents themselves. Related to this, our findings suggest how learnt anger management can have a positive **ripple effect** on family relationships, specifically on the stress levels that lead to aggressive behaviours in both caregivers and teenagers.

### 5.2.2 Changes beyond the reduction of violence

Our findings suggest a range of positive outcomes of the programme within participant households **beyond the reduction of violence.** These include overall improvements in parent-teen relationships, reductions in aggressive behaviours in teens and caregivers, management of parental stress, and awareness and planning around risk. These findings provide insight into a more comprehensive set of changes experienced by teenagers and their caregivers in attending a parenting programme that is designed to intervene in child abuse practices.

WHO (2009) reported that “many evidence-based parenting programmes are not specifically geared toward violence or maltreatment prevention; instead, they are designed to encourage healthy relationships, improve parental strategies, and decrease child behaviour problems” (cited in Altafim and Linhares, 2016:10). Our findings resonate with this literature, as they demonstrate how **new communication skills and a newfound practice of spending time differently practised in the supportive and ‘fun’ context of group workshops had an impact on caregiver-teen relationships.** Therefore, what literature commonly refers to as ‘parenting support programmes’ may well benefit from being understood as ‘parent and adolescent programmes’ so that mutual participation and benefits are marked from the outset.
Findings suggest that understanding the family structure and relationships are important for bringing about changes in teenage behaviours, in particular those relating to obedience, chores and respect. Conflict around obedience – or being “rebellious” (Interview 11) – may arise because teenagers have an increased need to test and formulate their own opinions on rules. This struggle is generalizable to a certain extent, as some literature suggests (Bray et al. (Eds.), 2010; Honwana and DeBoeck, 2005); however, the emphasis that teenagers in this study also placed on ‘respect’ suggested their adherence to a more specific traditional code of conduct. Caregivers, too, projected the positive impact of the programme on their homes as a renewed interest in nurturing the home: “I have learnt that I should also spend time at my house. This is the only place that I have and I should take care of it” (caregiver, Interview 5).

Caregivers as well as teenagers practised new communication skills across the age range of 10 to 18 years. This suggests that teenagers had an increased awareness of their social skills and how to deploy them to effect. This pattern may be consistent with the increase in social awareness that marks the teenage stage of development (Harrison, Smith, Hoffman et al., 2012; Selikow, Ahmed, Flisher et al., 2009; Mosavel, Ahmed, Ports et al., 2015; Stanton-Salazar and Urso-Spina, 2005).

5.3 Recommendations and reflections for future programmes based on participant experiences

When relating their experiences of the Sinovuyo Teen workshops, participants told integrated narratives that included descriptions of the recruitment process and their experiences of participating in the workshops, including how they received some programme content at home. This section analyses these findings in more detail, drawing on relevant literature in order to make recommendations for the implementation of this – or other – parenting programmes, both in South Africa and in other LMICs.

5.3.1 Recruitment

The results of this study give rise to three recommendations relating to recruitment in particular:

- Use recruiters who are known to families

The suspicion and fear, as noted by many participants during their recruitment into the research study and programme, may be mitigated by having someone known in the community assisting in the process. Part of the problem was due to pre-existing associations that vulnerable caregivers made about social workers and child welfare practices, and their misunderstanding about parenting programmes. Similarly, some teens felt stigmatized in front of their peers during the recruitment process. Other qualitative studies have also noted that fear, stigma, lack of information about services and distrust – including “being reported to child protection agencies... especially if they had used ‘corporal punishment’” – have acted as barriers to service access (Koerting et al., 2013:662). An Australian study also noted the reticence of mothers to share during a parent support programme because of previous exposure to government departments, and specifically of “having their child removed” (Kelleher et al., 2012:105).

Our recommendation is, therefore, that recruitment is carried out by someone who is known and trusted. This could be another caregiver or a community liaison person. Other interventions have made use of effective community liaison strategies to build trust amongst vulnerable populations
(Harachi, Catalano, Richard et al., 1997; Chavkin and Williams, 1989; Herrerias, 1988). Stahlschmidt et al.’s 2013 study on recruiting fathers found fathers were more likely to join a programme recommended by other fathers who they knew. Other studies have also noted the influence of pre-existing, good relationships with the target group (Koerting et al., 2013).

- **Invest time explaining the parenting programme during recruitment**

Facilitator programme notes cite that the initial reasons participants gave for attending programme workshops changed over time. This indicated that participants became more likely to attend once they decided the programme was of value to them, and understood that the role of the caregiver was not simply to accompany teenagers but was to participate alongside them. The initial impressions of the programme as “childish” (interview 22) were replaced by an appreciation of the learning that took place during workshops.

Besides making programme objectives clear during the recruitment phase, we recommend that those delivering the programme also explain the programme objectives in a comprehensive way. This will help ensure participants are given an adequate opportunity to familiarize themselves with the staff and programme concept prior to the workshops, which will also build trust. This investment may offer a return in terms of programme buy-in and have an impact on participant engagement from the outset. It also offers the opportunity to address any misconceptions about poverty alleviation and material gain.

- **Recruit the ‘right’ participants**

Analysis of our findings suggests the importance of recruiting caregivers who are most likely to influence the adolescents’ behaviour and will be receptive to learning and practising positive parenting skills. Other studies corroborate this need, arguing that a failure to do so may cause “premature dropout from services” (two UK studies by Barrett (2008; 2009) cited in Koerting et al., 2013). Several caregivers recommended that more family members attend the programme because families in this region are typically large, diverse and made up of extended family members. This is a valid point. Although recruiting more than one adolescent and one caregiver per family was not possible this time due to limitations posed by the research, if the programme is scaled up throughout South Africa this should be considered. For example, stakeholders have discussed delivering home-based sessions to groups of entire families. Further research is needed to determine how peer support, which group-based learning encourages, would fit in and what the impact would be on extended families.

5.3.2 Facilitate programme attendance

Researchers on parenting interventions implemented in both HICs and LMICs have detailed barriers to programme attendance, which are similar to our findings. These barriers can be broadly broken

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8 Populations on the fringes of social service provision are regularly sceptical of interventions and fear rupturing the social cohesion of their communities (Sarno Owens et al., 2007; Higson-Smith and Killian in Donald et al., (Eds.), 2000). These tensions are replicated across programmes, and this makes community engagement and collaboration during recruitment essential (Miller et al., 2013; Mytton et al., 2013; Turner and Sanders, 2007).

9 There is already a large body of literature that highlights recommendations for programmes’ recruitment and attendance efforts. Many of these recommendations speak to HIC contexts, where engagement with state infrastructure and personnel is feasible (Panter-Brick et al., 2014; Stahlschmidt, 2013; Whittaker and Cowley, 2012; Kelleher et al., 2012). Where recruitment focuses on marginal demographics, much of the language of recruitment relates to discourses of trust.
down into: socio-economic barriers (transport expenses, childcare problems); psychosocial barriers (stigma and mistrust); and beneficiary perceptions (feeling the programme is unnecessary) (Koerting et al., 2013; Whittakeer and Cowley, 2012; Peters, Calam and Harrington, 2005). Most reasons given for workshop absences, such as personal responsibilities, illness, funerals and community-based events, are difficult to avoid.

Three recommendations to facilitate attendance:

- **Identify community events when planning workshop dates**

  Community events, including funerals, should be respected in the scheduling of parenting programme sessions. Our findings suggest participants’ commitments to these events were more significant barriers to attending workshops than other literature suggests (see for example Friars and Mellor, 2009 cited in Koerting et al., 2013).

- **Consider the feasibility of home catch-up sessions**

  Participants noted that catch-ups provided to participants who had missed a session facilitated attendance. These were mostly conducted in or near participants’ homes, and, in some cases, at work. Our findings suggest that providing workshop content at home was not only important for those who missed a session but also, in some cases, provided an opportunity to involve other family members in programme content. Literature similarly identifies this as a priority: four of the 12 qualitative studies reviewed by Koerting recommend home visits or catch-up sessions (Koerting et al., 2013).

- **Consider the feasibility of transporting participants**

  Provision of transport to workshop sessions also facilitated workshops attendance, especially for people with poor mobility and in the rainy season.

Both transport and home catch-ups have cost implications, however, that are important to consider for the scale-up of low cost parenting programmes. Without resources to visit participants at home or work and to dispatch vehicles to their homes, attendance may have been much lower.

**5.3.3 There is value in maintaining a sense of fun in the programme**

Overall findings suggested that a balance of fun and serious learning is key to retaining participants and supporting behavioural change. The training organization, Clowns Without Borders South Africa (CWBSA), was particularly skilled at making sessions fun. For example, participants enjoyed the parts of sessions that reversed familial power structures, encouraging teens to lead adults during physical exercise. Also, engaging a sense of play was popular to test boundaries that define adulthood, childhood and adolescence. Moreover, ‘playing’ and ‘laughing’ helped stress management and contributed to the socially cohesive effect among participants. Looking at the impact of making workshops fun should be researched further.

Participants also appreciated the learning environment that the workshop provided. One qualitative systematic review describing primary themes emerging from parents’ experience of a parenting
programme identified the “acquisition of knowledge, skills and understanding” (Kane et al., 2007:788). In this study, teenagers also said they appreciated acquiring skills and knowledge.

Our findings, therefore, suggest that a balance between ‘fun’ and ‘serious’ learning seems to be key in engaging teenagers and caregivers during parenting support workshops.

5.3.4 Encourage caregivers to set up or maintain their own social support groups

Some participants, particularly caregivers, suggested that they would benefit from stronger social support networks (4 in 21 caregivers and only 1 in 19 teens). The teenagers may not have felt this need so much because they had access to social support networks through school as well as through the programme, whereas caregivers do not have a ready-made social network. During validation work, caregivers were unanimous in their preference for workshop over catch-up delivery of the programme. They felt that as a group they were able to learn from other people’s ideas, support each other and create friendships. These findings suggest the value of social support groups for caregivers, particularly those living in lower-resourced communities who have limited access to other support services. Sustained social support may help foster positive changes after the programme has ended. This could be particularly important in preventing caregivers resorting to harsh discipline.

Other qualitative studies identified sharing experiences in a group environment as “invaluable” (Barret, 2008 cited in Koerting et al., 2013:665). This helps reduce social isolation and provides acceptance and support, which has an impact on the ability of caregivers to “cope” (Kane et al., 2007:791). Parents attending the 123Magic parenting programme, “commented on the benefits of having the opportunity to listen and to share experiences with other parents” (Kendall, Bloomfield, Appleton et al., 2013 cited in Altafim et al., 2016:9). As such, extending social networks to isolated individuals and families is important (Kelleher et al., 2012).

Other studies identified a need to address programme sustainability and parental support in the long term, particularly where scale-up is hindered by a lack of infrastructure and trained personnel (McWilliam, Brown, Sanders et al., 2016; Barrera, Berkel and Gonzáles Castro et al., 2016; Shapiro, Prinz and Sanders, 2015; Al Hassan and Lansford, 2011). Studies suggest that significant cultural shifts in parenting do not happen in 14 weeks. Therefore, parenting programmes could be best placed within regular family support services. Many caregivers shared their experiences and learnings with others in their communities or maintained relationships within the parenting groups. This is an affordable way to create social support networks and should be encouraged.

All these recommendations should be considered by anyone interested in implementing this or similar programmes.
6. CONCLUSIONS

This study has limitations, notably in terms of whether the results can be generalized beyond the sites in the Eastern Cape of South Africa and whether self-reporting produced bias, particularly social desirability bias. This bias may have been minimized by assurances of anonymity to respondents.

Further research is recommended, particularly to look at how learning can be sustained in extended and multi-generational households. More research should also examine facilitators and barriers to programme attendance.

Further “real world implementation” (Lachman, Sherr, Cluver et al., 2016; Bray and Dawes, 2016; Whittaker and Cowley, 2010) research should be undertaken to capture the experience of the programme at scale, in the context of the participants’ daily lives. Moreover, research evaluations on programmes such as this should be embedded in existing structures from the outset to reduce confusion about why participants were targeted for the programme. Literature suggests that this type of confusion is common. A study of a family-based prevention programme in Washington DC notes that the lack of “a complete understanding of the program and its research components may have led some non-completers to feel distrustful of the program, and to be less committed to the research nature of the project” (Polizzi and Gottfredson, 2003:115).

Importantly, this study is a useful resource for practitioners and programmers to consider in deciding how best to deliver parenting programmes for teenagers in LMICs. This study additionally makes suggestions for further research based on the experiences of both caregivers and teenagers, particularly on the programme’s effectiveness and limitations. Table 1 summarizes the key recommendations based on the study’s findings.

Specifically, this study identifies if, why, and how this parenting programme was of value to teenagers and their caregivers. Our findings also capture the willingness of caregivers and teenagers to participate in and advocate for parenting programmes.

Overall, the Sinovuyo Teen programme was a positive experience. Findings suggest a range of outcomes in households participating in this group-based programme. These include improvements in parent-teen relationships; reductions in aggressive behaviours; management of parenting stress; awareness of risks and planning to avoid them; and the use of non-violent forms of discipline.

Underlining many findings are the changes in communication between caregiver and teen and their finding ways to spend time together. Some of the specific parenting skills they learnt include how to approach problems, discuss differences, use non-harsh forms of discipline and build stronger social networks. Findings from other studies that have also conducted in-depth ethnographic work have similarly identified post-intervention behavioural and communication changes amongst beneficiaries (Kane et al., 2007:790; Stewart-Brown, Patterson, Mockford et al., 2004).

Change is not a seamless and sudden transition, but it does show promise in creating healthier families. Our findings indicate the group-based format provided a social support network that has the potential to help maintain this change; but more research is required to evaluate this.
Context should be considered in planning the logistics of a parenting programme – both before and after implementation takes place. Regarding South Africa, considerations should include planning for barriers to attendance (such as illness, care duties and transport support), and an understanding of the extended family and how to benefit all its members. Ongoing communication between agencies involved in implementing parenting programmes will offer the opportunity for programme feedback so that these issues can be addressed during implementation.

Finally, the findings presented here emphasize not only the importance of further contributions to qualitative research that explores participant perceptions and experiences of parenting programmes, but also the value of including teenagers’ experiences alongside those of their caregivers.
Table 1: Recommendations based on analysis of experiences of parenting programme beneficiaries

<table>
<thead>
<tr>
<th>IDENTIFIED ISSUE</th>
<th>RECOMMENDATIONS BASED ON BENEFICIARY EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to make findings less caregiver-centric</td>
<td>Qualitative research needs to make further efforts to capture the teenagers’ experience through their own voices and to consider the experiences of the extended family.</td>
</tr>
<tr>
<td>How to expand the programme impact to more family members</td>
<td>The programme needs to intentionally benefit the wider familial home and those of influence. Further research into dissemination of lessons to other members of households is required.</td>
</tr>
<tr>
<td>How to involve men in parental roles</td>
<td>Parenting has multiple dimensions and parenting roles are not restricted to women. Research into effective ways of reaching men is required. This may include encouraging the involvement of male parental roles in specific workshops such as those dealing with economic strengthening materials, scripting inclusive role-plays and targeting recruitment messages.</td>
</tr>
<tr>
<td>New ways of communicating and engaging</td>
<td>Reciprocity and inter-generational communication models provide insight into non-violent parenting methods that are particularly effective in caregiver-teen relationships and useful in addressing power dynamics.</td>
</tr>
<tr>
<td>Expressed desire for strong focus on programme content on economic strengthening</td>
<td>Programmatic expansion could include a combination of social protection mechanisms such as cash + care. These could prove particularly relevant in the context of poverty.</td>
</tr>
<tr>
<td>‘Fun’ and ‘learning’</td>
<td>The balance between ‘fun’ and ‘serious’ learning is a key combination in engaging teenagers and caregivers alike during workshops.</td>
</tr>
<tr>
<td>Beneficiary fears around recruitment and inclusion in the programme</td>
<td>Recruitment strategies should take into consideration: 1) family ethnography and structure and 2) fears of association with the programme. This can be done by building trust between communities and implementing organizations as well as investing time in explaining the aims of the parent support programmes.</td>
</tr>
<tr>
<td>Transport and catch-up sessions enabling workshop attendance</td>
<td>Programmes should consider providing transport for participants with limited mobility (especially grandmothers) to promote attendance. Consideration of care and social responsibilities (such as funerals) will also improve attendance, as will catch-up sessions delivered at home.</td>
</tr>
<tr>
<td>Social networking for vulnerable, isolated communities</td>
<td>Vulnerable communities and families benefit from a social network. Reinforcing learning through sustained contact with service providers by embedding the programme in existing services can contribute to this, as can encouraging participants to set up their own groups post-implementation.</td>
</tr>
</tbody>
</table>
“It empowers to attend.”

Understanding how participants in the Eastern Cape of South Africa experienced a parent support programme: A qualitative study

Innocenti Working Paper 2018-14

WORKS CITED


“It empowers to attend.”
Understanding how participants in the Eastern Cape of South Africa experienced a parent support programme: A qualitative study

Innocenti Working Paper 2018-14


“It empowers to attend.”


APPENDICES

Appendix A: The 2015 Sinovuyo Teen programme

The 2015 Sinovuyo Teen programme contains a total of 14 workshop sessions. Four of the 14 sessions are designed as separate sessions, where caregivers and teenagers do not attend the same session together. Trained community facilitators from a variety of backgrounds deliver the programme in a group-based format in weekly sessions. The programme is designed for families to attend, however, for the purpose of the RCT trial in 2015, sessions were attended by one primary caregiver and his/her teenager. Workshop content is additionally provided via home visits (called ‘khaya catch-ups’) for those who miss group sessions. Delivery uses a non-didactic, collaborative learning approach, with activity-based learning, role-play, illustrations, home practice and home practice discussions, in which participants share their experiences of the previous week at home. Sinovuyo participants are ‘buddied up’ for mutual support during, between and after workshops. A meal is generally shared at the start of the workshops and transport is provided to those who need it.
### 2015 Sinovuyo Teen programme session breakdown

<table>
<thead>
<tr>
<th>Session</th>
<th>Configuration</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: Introducing the programme and defining participant goals</td>
<td>Joint (parent and teen together for entire session)</td>
<td>Introduce the programme and establish common ground rules and goals.</td>
</tr>
<tr>
<td>Session 2: Building a positive relationship through spending time together</td>
<td>Joint</td>
<td>Build a positive relationship while spending time with each other.</td>
</tr>
<tr>
<td>Session 3: Praising each other</td>
<td>Joint</td>
<td>Understand the benefits of praise and practising ways of praising.</td>
</tr>
<tr>
<td>Session 4: Talking about emotions</td>
<td>Separate (parent and teen separate for core lesson or for entire session)</td>
<td>Learn to identify, name and discuss emotions.</td>
</tr>
<tr>
<td>Session 5: What do we do when we are angry?</td>
<td>Separate</td>
<td>Manage anger and solve problems.</td>
</tr>
<tr>
<td>Session 6: Problem solving: Putting out the fire</td>
<td>Joint</td>
<td>Learn the techniques of problem-solving.</td>
</tr>
<tr>
<td>Session 7: Motivation to save and making a budget with our money</td>
<td>Joint</td>
<td>Learn how budgeting can help reduce stress about money; having goals can help us to save money.</td>
</tr>
<tr>
<td>Session 8: Dealing with problems without conflict I</td>
<td>Separate</td>
<td>Identify problem behaviours and focus instead on the behaviours you want.</td>
</tr>
<tr>
<td>Session 9: Dealing with problems without conflict II</td>
<td>Separate</td>
<td>Learn helpful alternatives to violent discipline.</td>
</tr>
<tr>
<td>Session 10: Establishing rules and routines</td>
<td>Joint</td>
<td>Establish family rules and routines.</td>
</tr>
<tr>
<td>Session 11: Ways to save money and making a family saving plan</td>
<td>Joint</td>
<td>Understand ways to save and the risks of borrowing money.</td>
</tr>
<tr>
<td>Session 12: Keeping safe in the community</td>
<td>Joint</td>
<td>Make a plan to keep teenagers safe in the community.</td>
</tr>
<tr>
<td>Session 13: Responding to crisis</td>
<td>Joint</td>
<td>Combine active listening, anger reduction and problem-solving to help parents and teens respond to abuse and crisis.</td>
</tr>
<tr>
<td>Session 14: Widening the circle of support</td>
<td>Joint</td>
<td>Plan how to move on from here and identify support structures that can help us.</td>
</tr>
</tbody>
</table>
Appendix B: Phases of testing the Sinovuyo Teen Parenting programme in South Africa

2012: Qualitative, 100 families in South Africa
   International consultation: 50+ experts, other manuals

2013: First draft manual:
   Pre-post test + qualitative N=60
   deep rural South Africa

2014: Second draft manual
   Pre-post test + qualitative N=240
   rural and peri-urban South Africa

2015: Third draft manual
   Randomized controlled trial + qualitative.
   N=1200, 40 villages, rural and urban South Africa
Appendix C: Qualitative research flow chart

1. RESEARCH TIMELINE: standardized quantitative questionnaires before and after each programme delivery

- Pre-Pilot
  2013: 30 dyads

- Pilot
  2014: 117 dyads

- Randomized Controlled Trial
  2015: 1200 dyads, 600 in programme

2. QUALITATIVE RESEARCH EVALUATION alongside quantitative methods, 4 key outputs

- Facilitator Publication
  - How do programme facilitators experience the programme?
  - What is the relationship between the intervention and existing service?

- Policy context Publication
  - What are stakeholders’ expectations and experience of the programme?
  - What are the policy implications for going to scale with a parenting programme?

- Beneficiaries Publication
  - How do participants experience the programme in the context of their wider lives?
  - Were the main outcomes of the programme achieved? For whom, why and how?

- Synthesis Report Publication
  - To what extent did the intervention achieve its primary outcomes?
  - How do policy, service deliver, social and economic factors impact effectiveness and scalability of the intervention?

3. QUALITATIVE METHODOLOGY USED FOR THIS PAPER

- Semi-structured interviews with 2014 and 2015 programme beneficiaries
- Focus group discussions
- Workshop observation
- Khaya catch-up observations
- Programme facilitator notes
Appendix D: Methodology

Data collection

Forty-two (21 dyad) semi-structured interviews were conducted with programme beneficiaries located in 10 clusters, of which three were peri-urban settlements and seven were rural. Participants were aware of the interviewer’s status as researchers undertaking an evaluation. Two teenagers who were interviewed did not agree to their interview being recorded. Interviews were conducted from February to July 2016. Purposeful sampling at the cluster level was first performed, in order to achieve a representative cross section of setting. Individual-level sampling from each cluster then considered the following dimensions: gender, age, participation, attendance. Sample characteristics of the informants for this study can be seen below in Table 2.

Table 2: Sample characteristics for qualitative study examining participant experience

<table>
<thead>
<tr>
<th>Sample Overview</th>
<th>Gender Caregivers</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>1</td>
<td>20</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>5%</td>
<td>95%</td>
<td>100%</td>
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</table>

<table>
<thead>
<tr>
<th>Gender Teens</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Percentage</td>
<td>52%</td>
<td>48%</td>
<td>100%</td>
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</table>

<table>
<thead>
<tr>
<th>Cluster setting (dyads)</th>
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<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>15</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Percentage</td>
<td>71%</td>
<td>29%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nature or relationship (dyads)</th>
<th>Grandmother</th>
<th>Mother</th>
<th>Aunt</th>
<th>G-Grandmother</th>
<th>Uncle</th>
<th>Cousim</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>7</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Percentage</td>
<td>33%</td>
<td>38%</td>
<td>14%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>100%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Teens</th>
<th>10-12 Yrs</th>
<th>13-15 Yrs</th>
<th>16-18 Yrs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Percentage</td>
<td>38%</td>
<td>33%</td>
<td>29%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Caregivers</th>
<th>18-30 Yrs</th>
<th>31-40 Yrs</th>
<th>41-50 Yrs</th>
<th>51-60 Yrs</th>
<th>61-70 Yrs</th>
<th>71-80 Yrs</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>1</td>
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<td>7</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>21</td>
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<td>10%</td>
<td>33%</td>
<td>33%</td>
<td>14%</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Two semi-structured interview guides were established for respondents: one for caregivers and one for teenagers. Both guides were piloted and refined for clarity and focus. Each guide covered content relating to the family and household; experience of the programme; opinions of other members of the family about the programme; reflection on relationships during and since the programme and recommendations.

The first section of the interview included a visual mapping component in which participants were invited to chart the members of their households and families on a piece of paper and identify the specific roles that individuals played in relation to parenting by using a series of symbols including: smiley face for emotional support; ‘RR’ for the provision of financial support; ‘R’ to note those figures...
in need of financial support and ‘+’ to note those who provide support in preparing young people for adulthood. Visual mapping provided insight into relevant family composition and dynamics. See Annex E for examples of the visual mapping exercise.

A total of 18 focus group discussions were held, 16 of which took place in eight different intervention clusters. This included three in peri-urban settlements, five in rural settings and two ‘piloting’ FGDs in a control village with teens and caregivers respectively. FGDs were held in November 2016. Participants were sampled according to the following dimensions: rural and urban location; age; gender; good and bad workshop attendance and level of engagement. Focus group discussions were moderated in isiXhosa by locally recruited research assistants who were trained in particular qualitative research techniques, including focus group discussion moderation. FGDs were moderated by two research assistants in each FGD and lasted about 90 minutes. In addition, two note takers and one quote taker were present at each FGD.

Focus group discussion guides were developed, piloted and modified for clarity before being used. Participants were asked about joining Sinovuyo before the sessions started; workshops; economic strengthening content and the future of the programme. Focus group discussions allowed us to explore a range of views and perceptions in a forum that also supported the exchange and exploration of ideas.

In addition, this study draws on data from:

- Facilitator reports on workshops in which they commented on each dyad.
- Workshop observations: Fifteen research assistants were trained in qualitative research observation skills and fulfilled data collection duties.
- Khaya catch-up notes and observations: Data captured by facilitators and specially trained research assistants who sporadically observed khaya catch-ups.
- Literature: As well as drawing on relevant literature, this study utilizes Rachel Bray and Andy Dawes’s 2016 publication on parenting in southern and eastern Africa, which was produced as part of the broader qualitative study represented here.
- Field notes further captured discussion dynamics and reflections, as well as observations of facilitators during workshops.

**Thematic analysis**

The procedure for undertaking thematic analysis followed the steps set out by Braun and Clarke (2006): Transcripts and other data items were first reviewed multiple times by two researchers through repeated close readings in order to note key ideas. Two researchers then worked through the entire data set in order to identify interesting and repeating patterns (‘codes’) across the data set. Codes were then collated into potential themes and sub-themes, which were reviewed by a third researcher. Themes were considered significant where there was consistency across and within study participants and/or when they deepened understanding and captured something important in relation to the research question (see Patton, 2008 for an example of this method). Themes were further refined through discussion between three members of the research team who worked to define and
name themes ahead of final analysis and writing up. Data was uploaded and coded in Atlas.ti (version 1.0.50 (282)). Visual data was similarly analysed using thematic analysis (Guillemin et al. 2014). Findings contain direct quotes from participants.

**Validation work**

Preliminary results were discussed with the advisory board supporting the qualitative research programme and, later, results were discussed in a validation meeting that took place with seven caregivers from four clusters (two rural, two peri-urban) on 21 September 2016 in King William’s Town. Member-checking took place during data collection with respondents in order to ensure consistency with meaning and accuracy. The purpose of this validation work was to ‘check’ the accuracy and interpretation of our findings as well as to ensure transparency (Maxwell, 1992; Flick, 2014). Results from the validation exercise corroborated and emphasized aspects of the analysis, but also introduced nuanced additions to existing findings.
Appendix E: Examples of participant families and households from the visual mapping exercises

Cluster 1:  

Cluster 9:  

Cluster 10:  

Cluster 4:
Appendix F: Anonymized data and cluster codes

Interviews:
Int1: 30 March 2016, Caregiver, F, 31 – 40 years old, Dyad 1, rural
Int2: 30 March 2016, Teen, F, 10 – 14 years old, Dyad 1, rural
Int3: 3 March 2016, Caregiver, F, 51 – 60 years old, Dyad 2, rural
Int4: 3 March 2016, Teen, F, 15 – 18 years old, Dyad 2, rural
Int5: 9 March 2016, Caregiver, F, 41 – 50 years old, Dyad 3, rural
Int6: 9 March 2016, Teen, M, 10 – 14 years old, Dyad 3, rural
Int7: 30 March 2016, Caregiver, F, 51 – 60 years old, Dyad 4, rural
Int8: 30 March 2016, Teen, M, 15 – 18 years old, Dyad 4, rural
Int9: 21 March 2016, Caregiver, F, 41 – 50 years old, Dyad 5, rural
Int10: 2 April 2016, Teen, M, 15 – 18 years old, Dyad 5, rural
Int11: 1 May 2016, Caregiver, M, 18 – 30 years old, Dyad 6, rural
Int12: 1 May 2016, Teen, M, 10 – 14 years old, Dyad 6, rural
Int13: 13 April 2016, Caregiver, F, 51 – 60 years old, Dyad 7, rural
Int14: [MISSING INTERVIEW TRANSCRIPT], Teen, F, 15 – 18 years old, Dyad 7, rural
Int15: 13 April 2016, Caregiver, F, 51 – 60 years old, Dyad 8, rural
Int16: 16 April 2016, Teen, M, 10 – 14 years old, Dyad 8, rural
Int17: 19 February 2016, Caregiver, F, 51 – 60 years old, Dyad 9, rural
Int18: 19 February 2016, Teen, M, 10 – 14 years old, Dyad 9, rural
Int19: 19 February 2016, Caregiver, F, 41 – 50 years old, Dyad 10, rural
Int20: 19 February 2016, Teen, M, 15 – 18 years old, Dyad 10, rural
Int21: 6 February 2016, Caregiver, F, 41 – 50 years old, Dyad 11, rural
Int22: 6 February 2016, Teen, F, 10 – 14 years old, Dyad 11, rural
Int23: 6 February 2016, Caregiver, F, 41 – 50 years old, Dyad 12, rural
Int24: 6 February 2016, Teen, M, 15 – 18 years old, Dyad 12, rural
Int25: 5 March 2016, Caregiver, F, 51 – 60 years old, Dyad 13, rural
Int26: 7 May 2016, Teen, F, 10 – 14 years old, Dyad 13, rural
Int27: 25 April 2016, Caregiver, F, 71 – 80 years old, Dyad 14, peri-urban
Int28: 7 May 2016, Teen, F, 15 – 18 years old, Dyad 14, peri-urban
Int29: 27 May 2016, Caregiver, F, 61 – 70 years old, Dyad 15, peri-urban
Int30: 27 May 2016, Teen, M, 15 – 18 years old, Dyad 15, peri-urban
Int31: 16 February 2016, Caregiver, F, 41 – 50 years old, Dyad 16, peri-urban
Int32: 27 February 2016, Teen, F, 10 – 14 years old, Dyad 16, peri-urban
Int33: 29 April 2016, Caregiver, F, 41 – 50 years old, Dyad 17, peri-urban
Int34: 29 April 2016, Teen, F, 10 – 14 years old, Dyad 17, peri-urban
Int35: 16 February 2016, Caregiver, F, 51 – 60 years old, Dyad 18, peri-urban
Int36: 26 April 2016, Teen, F, 10 – 14 years old, Dyad 18, peri-urban
Int37: 16 February 2016, Caregiver, F, 61 – 70 years old, Dyad 19, peri-urban
Int38: [MISSING INTERVIEW TRANSCRIPT – teen did not want to be recorded], Teen, F, 10 – 14 years old, Dyad 19, peri-urban
Int39: 9 March 2016, Caregiver, F, 31 – 40 years old, Dyad 20, rural
Int40: 16 March 2016, Teen, M, 15 – 18 years old, Dyad 20, rural
Int41: 21 March 2016, Caregiver, F, 41 – 50 years old, Dyad 21, rural
Int42: 24 March 2016, Teen, M, 10 – 14 years old, Dyad 21, rural
Researchers' observational notes on pilot interviews with three dyads: February 2016

Focus Group Discussions
FGD1: 17 November 2015, Caregivers (rural)
FGD2: 17 November 2015, Adolescents (rural)
FGD3: 18 November 2015, Caregivers (rural)
FGD4: 18 November 2015, Adolescents (rural)
FGD5: 19 November 2015, Caregivers (peri-urban)
FGD6: 19 November 2015, Adolescents (peri-urban)
FGD7: 20 November 2015, Caregivers (peri-urban)
FGD8: 20 November 2015, Adolescents (peri-urban)
FGD9: 24 November 2015, Caregivers (rural)
FGD10: 24 November 2015, Adolescents (rural)
FGD11: 25 November 2015, Caregivers (peri-urban)
FGD12: 25 November 2015, Adolescents (peri-urban)
FGD13: 26 November 2015, Caregivers (rural)
FGD14: 26 November 2015, Adolescents (rural)
FGD15: 27 November 2015, Caregivers (rural)
FGD16: 27 November 2015, Adolescents (rural)

Qualitative research locations:
Cluster 1: Peri-urban
Cluster 2: Rural
Cluster 3: Rural
Cluster 4: Rural
Cluster 5: Rural
Cluster 6: Rural
Cluster 7: Rural
Cluster 8: Rural
Cluster 9: Peri-urban
Cluster 10: Peri-urban