Integrating Evidence and Context to Develop a Parenting Program in Low-Income Families in South Africa

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Abstract

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

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

Introduction

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

On the other hand, inconsistent and abusive parenting is linked to maladaptive behaviors in children as well as negative adolescent and adult outcomes (Patterson, DeBaryshe, & Ramsey, 1989). This is particularly concerning in low- and middle-income countries (LMICs) where children experience high levels of violent discipline and psychological aggression (UNICEF, 2014). For instance, in South Africa, a recent survey using child-report data in low-income contexts found lifetime prevalence rates of 55% for physical abuse and 36% for emotional abuse with caregivers as the primary source of abuse (Meinck, Cluver, Boyes, & Loening-Voysey, in press). These findings are supported by other surveys from LMICs that report that 75% of children between the ages of two and 14 years experience harsh parenting in the home (UNICEF, 2010). Furthermore, harsh discipline and corporal punishment are often considered normative parenting practices in LMICs (Lansford & Deater-Deckard, 2012).

Delivering programs that prevent violence against children during early childhood is increasingly becoming a global public health issue (Mikton, MacMillan, Dua, & Betancourt, 2014). Systematic reviews have demonstrated promising evidence that parenting programs may reduce the risk of child maltreatment and child behavior problems while improving positive parenting, parental mental health, and early child developmental outcomes in families with young children (Barlow, Johnston, Kendrick, Polnay, & Stewart-Brown, 2006; Chen & Chan, 2015;

Furlong et al., 2013). However, evidence is limited regarding the effectiveness of parenting programs in LMICs (Knerr, Gardner, & Cluver, 2013; Mejia, Calam, & Sanders, 2012). Furthermore, although a recent meta-analysis showed that evidence-based parenting programs may be equally effective when transported to another country, only one identified study was in a LMIC (i.e., Iran) (Gardner, Montgomery, & Knerr, 2015). In South Africa, the dissemination of evidence-based approaches is very limited; a review of current parenting programs implemented has shown that few are based on the theoretical frameworks that underpin effective programs or incorporate strategies known to be effective (Wessels & Ward, 2015).

It is important that parenting programs are culturally relevant to potential beneficiaries and practitioners in order to assure acceptability and effectiveness (Castro, Barrera, & Martinez, 2004). Local contextual factors in high-income countries (HICs) may influence the feasibility of parenting programs due to variations in culture (e.g., language, customs, beliefs, and family dynamics), accessibility (e.g., timing, location, and cost), and delivery (e.g., institutional support, facilitator training and supervision, and delivery mechanisms). These factors may affect the cultural acceptability, participant involvement, and implementation fidelity of programs when transported from one context to another (Berkel, Mauricio, Schoenfelder, & Sandler, 2011; Kazdin, 2000). Furthermore, the majority of the evidence-based programs have also been developed for and tested with middle-class, Caucasian families living in HICs (Lau, 2006). Non-Caucasian and low-income families in both HICs and LMICs often live in vastly different social and cultural circumstances than those who have participated in these studies (Kumpfer, Alvarado, Smith, & Bellamy, 2002). As a result, key components of parenting interventions developed for more privileged families may be perceived as culturally irrelevant or inappropriate by parents in LMICs or other ethnic and low-income populations (Martin-Storey, 2009). Furthermore, poverty and violence are far more widespread in low-income contexts, and both compromise parenting and increase the risk of harsh parenting (Kotchick & Forehand, 2002; Krug, Mercy, Dahlberg, & Zwi, 2002). Norms and values about parenting and family structure may also differ across

cultures, making direct implementation of Western-developed interventions potentially problematic (Kumpfer et al., 2002). For example, economic migration coupled with the HIV/AIDS pandemic in South Africa has resulted in an extended foster care system in which the primary caregivers are often neither biological parents nor blood relatives (Bray & Brandt, 2007). Changes in family circumstances, such as severe parental illness, absence and death, may also negatively influence the effectiveness of parenting programs (Foster & Williamson, 2000). Finally, due to licensing fees, program costs, training requirements, and the need for high-skilled professionals as practitioners, many evidence-based parenting programs are prohibitively expensive in LMIC contexts such as South Africa (Mikton, 2012).

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

Method

Stage One: Identifying Core Intervention Components

Stage One focused on identifying the core intervention components associated with evidence-based parenting programs. Although still in its nascent stage, there is an emerging body of literature examining the effective components of parenting programs, including systematic reviews, distillation studies, meta-analyses, and reviews on program implementation. First, we examined systematic reviews to identify parenting programs with strong evidence for improving parenting behavior and reducing child behavior problems (Barlow et al., 2006; Chen & Chan, 2015; Furlong et al., 2013; Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009). Interventions with robust evidence included the Incredible Years (Webster-Stratton, 2001), Parent-Child Interaction Therapy (Eyberg, Boggs, & Algina, 1995), Parent Management Training-Oregon (Forgatch, Patterson, & Gewirtz, 2013), and Triple P Positive Parenting Program (Sanders, 2008). These programs share a common theoretical foundation based on social learning which views harsh or ineffective parenting as contributing to the development of child behavior problems (Bandura, 1977). They also use similar approaches that focus on building positive parent-child relationships prior to learning nonviolent discipline strategies (Hanf, 1969). By improving the quality of parent-child relationships through positive parenting, children are less likely to misbehave. This reduces the needs of parents to enforce limits and use potentially violent disciplinary methods. Parents also learn to regulate their own emotions while replacing harsh and inconsistent parenting with nonviolent and consistent discipline strategies (Hutchings, Gardner, & Lane, 2004).

Next, we examined studies that used a distillation and matching model approach to determine the frequency of certain behavior change techniques or strategies in evidence-based treatments (Chorpita, Daleiden, & Weisz, 2005). While limited in their ability to establish causality or isolate the effect of a specific component, these studies provide an overview of the most common elements associated with positive intervention effects. For instance, in a survey of

322 randomized controlled trials of child mental health treatments (not limited to parenting interventions), the top five most frequently occurring practices in evidence-based programs addressing externalizing behavior problems included praise, time-out, tangible rewards, positive commands, and problem solving (Chorpita & Daleiden, 2009). As a result, these elements were considered to be essential techniques for inclusion in an evidence-informed parenting program.

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

We also considered additional implementation factors that might improve participation and engagement. In contrast to more didactic learning approaches, common delivery methods include group-based problem solving, collaborative facilitation processes, modeling with videos, and practicing skills at home (Snell-Johns, Mendez, & Smith, 2004). Providing adequate training and supervision of program facilitators was also identified as an additional program component to assure implementation fidelity and quality of delivery (Sethi, Kerns, Sanders, & Ralph, 2014). Lastly, providing incentives for recruitment, establishing strong community partnerships, and assuring that programs were accessible to low-income parents were identified as important factors to engage parents in programs (Axford, Lehtonen, Kaoukji, Tobin, & Berry, 2012).

We then convened a series of meetings with the authors to construct the following theory of change model, drawing upon the aforementioned systematic reviews, meta-analyses, and distillation studies as a basis for developing a parenting program in South Africa (Figure 1). Evidence-based parenting programs contain similar components, behavioral change techniques,

and delivery methods (Kaminski et al., 2008). These lead to proximal adult outcomes that include increased skills in positive parenting, improved monitoring and supervision, consistent limit-setting behaviors, reduced harsh or intrusive parenting, and improved skills in nonviolent discipline techniques (Furlong et al., 2013). Improvements in parenting behavior have also been shown to improve parental mental health such as maternal depression and parenting stress (Barlow, Coren, & Stewart-Brown, 2002; Bennett, Barlow, Huband, Smailagic, & Roloff, 2013). They may also increase parental sense of competence, self-efficacy, and social support (Armstrong, Birnie-Lefcovitch, & Ungar, 2005; Gardner, Burton, & Klimes, 2006; Leung, Sanders, Leung, Mak, & Lau, 2003). As parents gain more self-efficacy with nonviolent discipline as an effective child behavior management strategy, existing attitudes regarding the necessity for corporal punishment may also decrease (Galanter et al., 2012). These changes may directly affect more distal child outcomes including reduced child behavior problems and improved socio-emotional regulation (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010; Furlong et al., 2013). Due to the reciprocal relationship between child behavior and parenting, improvements in child outcomes may further improve parenting behaviors (Burke, Pardini, & Loeber, 2008). They may also reduce the likelihood of abuse due to increased compliance and prosocial behavior (Pardini, Fite, & Burke, 2008). Finally, improvements in parent and child outcomes contribute to the overall reduction in risk of child maltreatment (Chen & Chan, 2015).

INSERT FIGURE 1 APPROXIMATELY HERE.

Stage Two: Formative Evaluation

Stage Two used participatory approaches to engage community stakeholders in development of the program for low-income families in South Africa (Fraenkel, 2006). Cultural adaptation studies using similar methods have been employed successfully to adapt parenting programs for Latinos in North America (Martinez & Eddy, 2005; Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; McCabe & Yeh, 2009). For instance, a recent study actively involved Latino

immigrant parents in the formative stages of cultural adaptation of Parent Management Training in the United States (Parra Cardona et al., 2009). Likewise, the current study engaged South African parents and practitioners in in-depth interviews and semi-structured focus groups to identify local factors likely to increase program acceptability and reduce potential barriers to participation (Kazdin, 2000). We focused on three main research questions: (a) what are the perceptions of low-income parents and practitioners regarding content necessary for inclusion in parenting programs in South Africa; (b) what are the potential cultural and contextual factors that may affect program acceptability; and (c) what are potential barriers and enablers to program implementation and participation?

Method

Participants.

This qualitative formative evaluation was conducted in low-income, predominantly isiXhosa-speaking communities in Cape Town (isiXhosa is a local indigenous South African language spoken by the majority of Black South Africans in Cape Town). These communities are characterized by high levels of unemployment, crime, and HIV-prevalence, poor educational and health resources, and limited access to basic sanitation (Statistics South Africa, 2012). Data were collected from multiple sources in order to increase the trustworthiness of results: parent interviews (n = 11), parent focus groups (n = 10; 86 participants), and practitioner focus groups (n = 4; 29 participants). While the focus groups provided an opportunity to examine a diversity of parents' and service providers' perceptions and behaviors, the interviews allowed a more in-depth understanding of the perceptions of parents regarding content necessary for inclusion in parenting programs. Parents were recruited via referrals from local community organizations, by word-of-mouth, and through chain-referral sampling. Inclusion criteria required parents to be isiXhosa-speaking, aged 18 years or older, and self-identified as the primary person responsible for a child aged three to eight years. Practitioners were community workers recruited from local non-governmental organizations that provide services to disadvantaged children and families.

Inclusion criteria for practitioners required respondents to have previous experience of delivering family programs in low-income communities.

Procedure.

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

Interview.

Interviewers used an open-ended approach that followed an interview guide divided into three broad questions. The first question explored respondents' perceptions regarding content for inclusion in parenting programs in low-income communities. Interview participants were presented with a range of themes based on existing literature on the content of evidence-based parenting programs (i.e., discipline, communication, safety, responding to children's needs). They were then asked to describe the importance and relevance of each theme for inclusion in parenting programs delivered to low-income families in their community. The second question investigated how local cultural values might inform program acceptability. The third question

explored potential barriers and enablers of participation. The guide for focus groups was structured similarly to the interview guide, with the exception that respondents participated in an interactive exercise to identify important themes for inclusion in parenting groups. Respondents wrote different themes on notecards and then placed these themes closer or further away from an image of a family depending on how important they perceived them to be included in a parenting group. Each respondent had the opportunity to move the cards around and explain their reasoning for placement. Written transcripts were examined immediately following each interview and focus group in order to identify additional emergent themes (Corbin & Strauss, 2008). These themes were then included in subsequent data collection. For instance, investigating the role of fathers as caregivers was not originally part of the guides but rather included following the initial interviews and focus groups when this was raised as an important issue by respondents.

Data analysis.

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

management. These categories were then integrated using selective coding into a larger theoretical representation of the shared experiences and perspectives of the participants (Corbin & Strauss, 2008). Findings were then discussed within the research team with a particular focus on the validity and representativeness of individual themes. Finally, we selected data extracts to represent key themes identified from the data.

Results

The majority of respondents were female (parents: 95.9%; practitioners: 93.1%). Although both groups were middle-aged, parents were significantly younger than practitioners (parents: M = 38.43 years; practitioners: M = 44.90 years). They also lived in more crowded households than practitioners (parents: M = 6.80; practitioners: M = 4.69 members per household) and cared for more children (parents: M = 3.35; practitioners M = 1.97 children per household). Parents also experienced higher levels of economic hardship than practitioners. Almost half of the parent respondents were unemployed, about one-third reported that they had experienced household hunger more than five times in the past month, and over two-thirds lived in informal dwellings (e.g., corrugated tin shacks without running water). One quarter of the parents also reported having experienced violence as a child and almost half reported experiencing intimate partner violence in the previous month (Table 1).

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Thematic analyses of interviews with parents and practitioners identified seven themes regarding perceptions of content necessary for inclusion in parenting programs. The first three themes were in alignment with the existing literature and proposed theory of change model for evidence-based parenting programs: (a) learning how to manage child behavior problems, (b) addressing corporal punishment and discipline strategies, and (c) building positive relationships with children. Analyses identified additional themes that were more specific to the concerns of parents and service providers in low-income communities, and in particular, South Africa: (d)

keeping children safe in dangerous communities, (e) coping with stressful lives, (f) communicating about HIV/AIDS and bereavement, and (g) involving fathers in caregiving. Analyses also highlighted the importance of framing content within a local cultural context of social responsibility and respect. Finally, specific recommendations were made regarding potential barriers and enablers of participation and delivery.

Content for parenting programs.

Learning how to manage behavior problems.

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

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

Addressing corporal punishment and other discipline strategies.

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

Although corporal punishment was perceived as normative, parents reported a wide range of attitudes towards harsh discipline. Some respondents viewed corporal punishment as an integral part of a parent's responsibility to teach children appropriate behavior: "A child that is

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

Building positive relationships with children.

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

Respondents articulated the need to learn how to build positive relationships with their children as an important mechanism for improving child behavior and increasing cognitive and social development. Many parents described how playing with their children developed a sense of mutual trust and open communication. Others explained how using verbal encouragement increased child compliance: "I praise my child for the good he has done so he can do more good things" (parent #4, interview). However, many parents said that they lacked the skills or time to engage positively with their children: "I'd love to get some advice on how to play with a child. I'm just watching her if she plays on her own" (parent #10, interview). Likewise, others noted that parents struggled to praise their children: "Parents find it hard, as they were not praised themselves. How can they give what they never had?" (practitioner #3). Furthermore, respondents explained that many parents struggled to find the time to positively interact with their

children due to other domestic responsibilities: "In our culture, playing with kids is unheard of. There are lots of chores, so there is no time for playing" (practitioner #4).

Keeping children safe in dangerous communities.

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

Respondents expressed concern about child safety in communities characterized by violent crime, sexual violence, substance abuse, and delinquency. Perceived threats to child safety were due to two main factors: potential violence against children (particularly girls) and the negative influence on boys of other adolescents' deviant behavior. As a result, many parents highlighted the importance of learning techniques to encourage children to play near their homes or in other safe places. Some of these skills already existed in the community. For instance, some parents described how they used social networks to share child-monitoring responsibilities, "If I am not around, I leave them with my cousin. We look after them together" (parent #4, interview). Others articulated strategies that combined positive relationship-building and child safety: "I protect her by knowing what she likes most in the house. I tell her that I love her" (parent #7, interview). Nevertheless, child safety was perceived as a significant source of parenting stress and a high priority in potential programs.

Coping with stressful lives.

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

Respondents expressed the need to learn effective stress management techniques from parenting programs. Many parents described how severe socioeconomic deprivation contributed to elevated levels of anxiety and stress: "At my home nobody is working. When we have no food, stress is really gnawing me" (parent #22, focus group). Parents reported a sense of inadequacy in their ability to provide for their children: "It is very painful to see your child want something that you don't have" (parent #19, focus group). Respondents also expressed difficulties in coping with increased stress due to family conflict, illness, and bereavement. In addition, respondents

articulated the interconnectedness between high levels of stress and harsh parenting behavior, including yelling at their children, threatening abandonment, and violent discipline. Some parents shared that they avoided parental responsibilities and often resorted to alcohol and drug use as a means of coping with stress. Others reported positive coping mechanisms, including listening to music, talking to friends, and attending church. Moreover, respondents generally accepted the utility of sharing effective coping strategies as well as learning new techniques of stress reduction.

Communicating about HIV/AIDS and bereavement.

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

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

Involving fathers in caregiving.

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

Many respondents suggested that families would benefit from involving fathers and other male caregiver in parenting programs. However, many believed that men would resist

participation since childcare was perceived to be part of the female domain: “Fathers do not like to care. Any responsibility for the child is thrown to the mother” (parent #5, interview). Respondents also articulated concerns that it would be particularly challenging to recruit men for programs. Many stated that men might only be willing to participate in parenting groups exclusively delivered to men: “In our culture, men don’t talk openly in front of women” (practitioner #14). Nevertheless, they believed that increased male involvement in programs would improve child wellbeing as well as intimate relationships at home.

Cultural values.

Strengthening social responsibility and support.

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

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

Instilling respect or intlonipho.

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

Intlonipho (respect) was also perceived as an essential value for inclusion in parenting programs: “Respect is the first thing. Children must respect older adults and each other” (parent #15, focus group). Importantly, respondents viewed *intlonipho* as a value that must be actively

demonstrated by parents: "You, as a parent, must respect and then teach your kids to respect" (practitioner #11). Reciprocity was further emphasized in regards to teaching respectful behavior: "You must respect your children because your children look at your behavior. Things that you want her to do must be things you do yourself" (parent #30, focus group). Finally, respondents believed that parents would be more responsive to new parenting approaches that were presented within a larger context of how the skills might instill a greater sense of respect in their children.

Program feasibility.

Increasing accessibility for low-income families.

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

Overall, respondents perceived that parenting programs would benefit parents and caregivers in poor, underserved communities. Respondents indicated that programs would be especially relevant to those parents who were struggling to manage poor child behavior and stress. Nevertheless, parents and practitioners identified a number of potential barriers to participation. Finding time to attend group meetings was perceived as a key challenge for parents, especially those who were employed. Other barriers included lack of funds for transportation, poor weather conditions, parental or child illness, and childcare responsibilities with small children. However, some parents disagreed that childcare would be a barrier: "Even [though] I have got a child but that does not mean I can not attend. I just take the child and put him on my back" (parent #5, interview). Practitioners also considered the potential benefits of allowing children to attend sessions as an opportunity to practice skills directly. Others raised logistical issues related to having to manage unpredictable child behavior while facilitating group sessions.

When probed for potential solutions to these barriers, respondents suggested that providing food, childcare, and reimbursements for public transportation would be essential to enable participation by low-income families. Others recommended a versatile program format that could be delivered either through group sessions or individually at home for sick, old, or

disabled parents. Additionally, respondents proposed that practitioners conduct home consultations prior to program inception in order to orient parents to program goals and address potential barriers to participation. Parents also recommended that programs use text messages to remind participants about sessions and home activities. Finally, there was some disagreement about whether financial compensation was necessary to promote participation. While some respondents argued that parents would only participate if they were given money or food vouchers for attendance, others insisted that it would be sufficient to offer the programs free of cost, especially if parents were able to see the benefits of such programs in their lives. Nevertheless, it was generally agreed that some form of recognition, such as certificates of completion or prizes for full attendance, would incentivize attendance.

Improving delivery mechanisms of parenting programs.

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

When asked about preferred format of delivery, many respondents perceived the benefits of group-based formats that allowed participants to collaboratively solve childrearing challenges and share effective parenting strategies: "When parents are meeting and sharing difficulties, perhaps one comes up with a plan, which can end up fixing things inside your home" (parent #2, interview). However, other parents expressed reservations about communicating private matters in a group setting and preferred individualized consultation: "There are things that I can't talk about in a group" (parent #40, focus group). Practitioners emphasized that parenting programs would be more effective if they used a less didactic and more experiential approach to introducing new parenting skills: "You can have two ways of cooking a stew. Instead of using the old way, you can take another new way and try it. See how it tastes, how it feels" (practitioner #20). When probed as to whether role-plays would be an acceptable method of delivery, the response was mixed. While some believed that parents would resist role-plays, others saw the utility of practicing skills during the sessions before trying them at home. Finally, respondents recommended that programs contain culturally resonant forms of interaction in order to increase

acceptability and engagement. These included allowing participants to define a ritual to start sessions (e.g., prayer or songs) and using traditional stories, songs, and common children's games to introduce session topics and core parenting principles.

Discussion

Findings from Stage Two highlight the importance of considering contextual factors in the development of locally relevant parenting programs. Although respondents' attitudes towards corporal punishment were consistent with other qualitative research in Cape Town (Breen, Daniels, & Tomlinson, 2015), they also reported using positive parenting and nonviolent discipline strategies as well. These findings are similar to those reported in other studies in LMICs. For instance, surveys from 33 LMICs suggest that most parents utilize a combination of discipline strategies with young children that include both violent and nonviolent techniques (UNICEF, 2010). Although an average of 93% of the surveyed households reported using some form of nonviolent discipline at home, 75% of the households also used harsh physical or psychological discipline as a means of child behavior management control. Additionally, only 20% of the households exclusively used nonviolent techniques. Despite this, the majority of parents in these surveys also reported that they did not believe violent discipline was necessary to raise children.

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

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

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

Findings highlight the importance of ensuring that parenting programs fit within existing South African cultural systems. Parents' emphasis on *intlonipho* (respect) and social responsibility may be understood as expressions of *ubuntu*, the African value of collective humanism (Hanks, 2008). *Ubuntu* has been considered to be an important resource for resilience in low-income families in South Africa (Tom, 2010). Parenting programs that build upon existing

social networks may strengthen a sense of a collective responsibility towards children, thus improving supervision and care. Parents may resonate more with programs that emphasize effective ways to promote *intlonipho* as a parental goal for their children. It may also be useful to understand *intlonipho* as a reciprocal value in which respectful behavior is established through modeling (Bray, Gooskens, Kahn, Moses, & Seekings, 2010). Thus, South African families may identify more strongly with programs that integrate values of social responsibility and *intlonipho* as part of their delivery approach.

Stage Three: Integrating Evidence and Context

Stage Three synthesized the findings from the previous stages to integrate evidence within a local South African context (Table 2). The objective of this stage was to finalize program development by creating an intervention that was both culturally relevant and grounded in evidence of effectiveness (Castro et al., 2004). This stage involved three steps: (a) convening an intervention development workgroup, (b) creating program content, and (c) manualizing program protocols.

INSERT TABLE 2 APPROXIMATELY HERE.

Convening an intervention development workgroup.

We convened a series of workshops and consultations with experts in the field of parenting interventions to guide program development. Expert consultants included those with extensive experience of implementing and researching parenting programs in HICs and LMICs, local and international family-based intervention development experts, professionals involved in child protection and advocacy, and directors of community-based partner organizations in South Africa. We also consulted with local practitioners with experience implementing family-based interventions for vulnerable children. Three workshops were held to select, adapt, and augment previously identified evidence-based intervention content and integrate them with findings from the formative evaluation (Wainberg et al., 2007). We assessed each component identified from

Stage One regarding its contextual and cultural relevance, feasibility, and importance as a core function of our theory of change model (Figure 1). The expert committee also made recommendations on whether a specific component should be retained, adapted, or excluded, as well as whether additional locally identified components were necessary for inclusion. The intervention development workshops also assessed the extent to which the themes that emerged from the formative evaluation in Stage Two were in alignment with the literature. The expert committee considered whether the inclusion of context specific themes would affect the importance of maintaining fidelity to evidence-based approaches and components. We addressed this issue by minimizing the number of additional components while integrating contextual messaging within existing evidence-based content. For example, content regarding child safety in high-crime communities was included in the component on consistent limit-setting behaviors entitled, "Establishing household rules and routines." After the intervention development workshops, additional one-on-one consultations were conducted to provide ongoing feedback to program developers regarding intervention manualization and training of facilitators.

Creating program content.

The workgroups resulted in the development of an evidence-informed parenting program specifically tailored to low-income South African families – the Sinovuyo Caring Families Program ("Sinovuyo" means we have happiness in isiXhosa). This 12-session, group-based program incorporated contextual elements that were highlighted during the formative evaluation. As a culturally resonant mechanism for communicating evidence-based principles, the program was structured around the metaphor of constructing a "Rondavel of Support," or traditional hut familiar to South African families (Figure 2). Content focused on building mud walls (i.e., positive parent-child relationships) before adding a thatch roof to the rondavel (i.e., limit-setting and nonviolent discipline strategies). Parenting skills were framed within the context of teaching children respectful behavior (i.e., *intlonipho*) and the reciprocal role of parents in modeling this

behavior. Along with emphasizing child-led play, the program also encouraged parent-child involvement in daily chores and routines to take into account increased demands arising from domestic work in low-income households. Furthermore, the program addressed developmentally appropriate ways of communicating with young children about HIV/AIDS and bereavement as well as skills to increase child safety and monitoring in high-crime communities. Simple relaxation exercises derived from Mindfulness Based Stress Reduction were included to address elevated stress levels (Kabat-Zinn, 1994).

INSERT FIGURE 2 APPROXIMATELY HERE.

Core evidence-based delivery methods were designed to include group discussions on parenting principles, role-plays to practice parenting skills, take-home activities to apply skills with children, and group problem-solving around challenges experienced at home. In addition, the program included low-cost elements specifically designed for delivery in low-resource settings. Instead of producing locally relevant video vignettes – which would have been costly to produce and depend on the availability of resources to show them – the program created illustrated stories, or comic strips, to present examples of parenting behavior from which participants could identify principles. These scenarios depicted diverse family dynamics in both rural and urban South Africa as well as promoting the role of men as caregivers (Figure 3). The program also utilized text messages to remind participants to attend sessions and practice skills at home. Finally, although program delivery was primarily structured around parent group sessions, individualized home consultations were also included to accommodate participants who are unable to attend weekday sessions due to illness, disability, or employment. These home consultations also provided opportunities for one-on-one coaching involving parents practicing skills with their children.

INSERT FIGURE 3 APPROXIMATELY HERE.

Manualization of program protocols.

Once the program protocols were defined, the first author developed a facilitator manual in a format accessible to local, community-based facilitators. We used a consensus driven approach to translate the manual into isiXhosa (Sumathipala & Murray, 2000). This involved establishing a translation committee that included program developers and bilingual program facilitators (n = 8). The facilitators worked in teams of four, each translating separate sections of the manual into isiXhosa. Next, the teams exchanged translated sections and back-translated them into English. The translation committee then met to assess whether there were any inconsistencies in translation or terminology that required additional explanation by program developers. These discrepancies were resolved by consensus once the committee had discussed the translation and reached agreement on the correct terminology (Jones & Hunter, 1995). For instance, "time-out" was originally translated as "*ixesha lekhefu*" or "time to take a break." However, upon further consultation and piloting, the translation committee determined that "*ixesha lokuzipholisa*" or "time to cool down" would be more culturally appropriate, given local families' association of increased body heat with stress and agitation. Finally, the intervention workgroup reviewed the final manual for consistency with evidence-based practices prior to testing in a pilot feasibility trial (Lachman et al., in review).

General Discussion

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

evidence-informed, locally relevant parenting program for at-risk, low-income South African families.

This study provides a useful contribution to existing research on the cultural adaptation of evidence-based treatments across diverse settings (Lau, 2006). The formative evaluation allowed developers to target distinct contextual factors identified by practitioners and parents that may enhance participant engagement and intervention effectiveness. These factors were both cosmetic additions designed to increase cultural acceptability (e.g., the "Rondavel of Support" model) as well as additional content specific to South African families (e.g., communicating about HIV/AIDS). At the same time, it retained the common core elements of evidence-based parenting programs that have been shown to contribute to the reduction of harsh parenting and child behavior problems (Kaminski et al., 2008).

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

Our study had a number of limitations. In Stage One, the identification of program components was constrained by the limited empirical evidence of effective components based on systematic reviews, distillation studies, meta-analyses, and expert consultations. We recognize that other methods of identifying essential components may provide further insight into active core ingredients for parenting programs. This includes evidence from randomized microtrials on the efficacy of discrete parenting techniques (Leijten et al., 2015), factorial experiment trials that

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

Further research is required prior to wide-scale implementation and dissemination of the Sinovuyo program. Studies that combine qualitative and quantitative methodologies would provide valuable insight into the feasibility of the program in terms of cultural acceptability, implementation, and participant involvement. A randomized controlled trial would also allow testing of intervention effectiveness, as well as potential moderators and mediators of program effects. This would enable researchers to examine behavioral change mechanisms as well as whether specific subgroups respond to the intervention differently. Lastly, future research may benefit by continuing to actively involve policy makers, practitioners, parents, and children as equal partners in the development and evaluation process. This participatory approach may ultimately improve the cultural relevance and feasibility of parenting programs, thus increasing the likelihood of their effectiveness in reducing the risk of violence against children in LMICs.

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Table 1. Characteristics of interview and focus group participants.

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

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

Table 2. Integration of content from evidence-based parenting interventions and locally adapted or additional content for South African families (Wainberg et al., 2007).

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

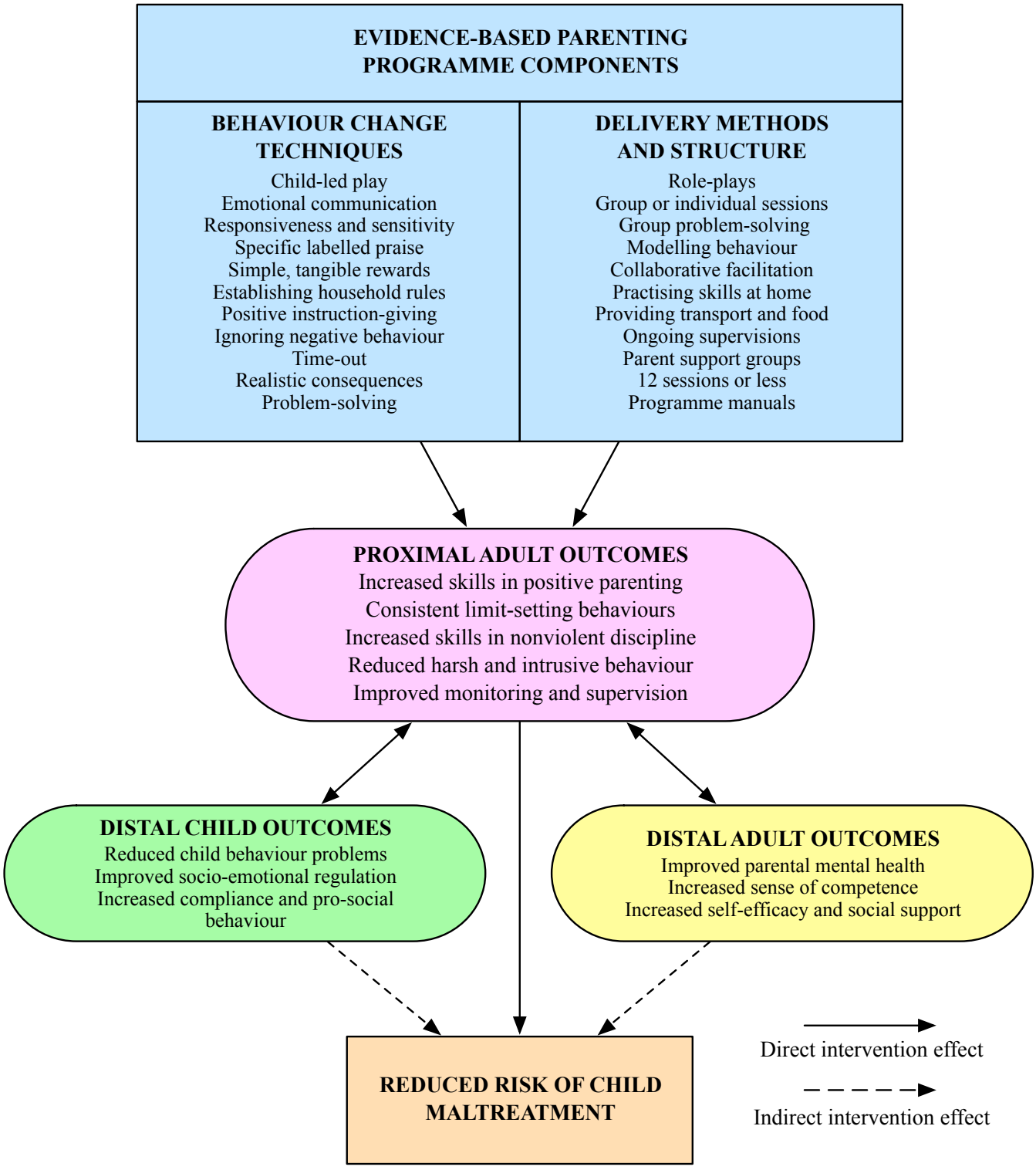

Figure 1. Parenting program theory of change to reduce risk of child maltreatment.

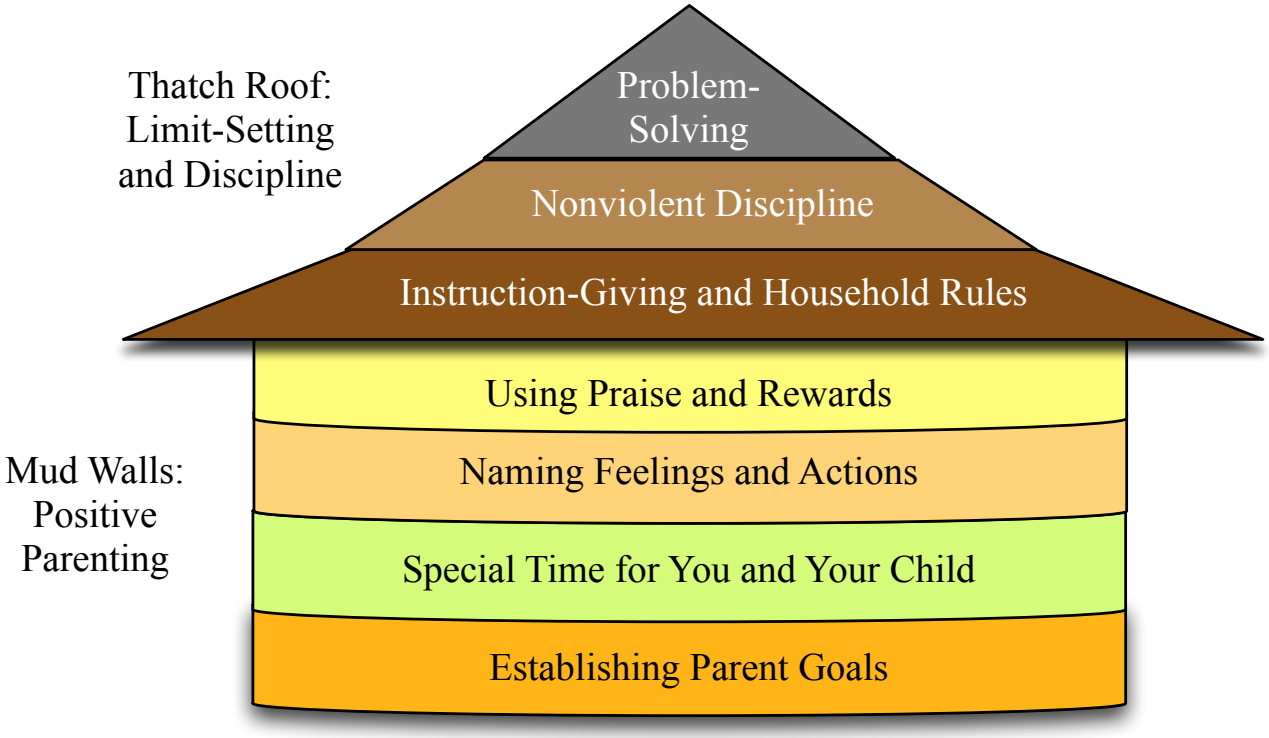

Figure 2. "Building a Rondavel of Support" program model for the Sinovuyo Caring Families Program.

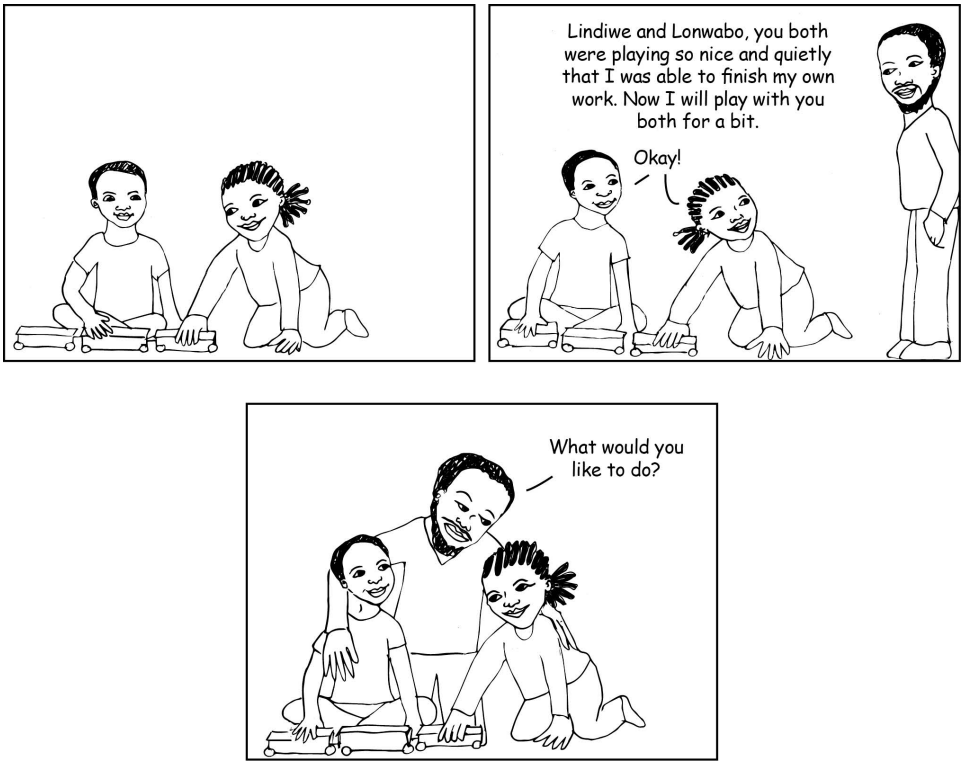

Figure 3. Illustrated story modeling the use of praise, simple rewards, and child-led play.