Community-wide change towards positive parenting

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Positive parenting leads to happier, safer children. Programmes that involve non-governmental organisations, caregivers and community members as a whole can help build non-violent, warm relationships between parents and their children. Such integrated interventions – which should also address poverty, joblessness, substance abuse, family violence and mental health – can reduce violence and contribute to equality and stability in South Africa's communities.

Key findings

- The delivery of four evidence-based parenting programmes alongside a social activation process in Touwsranten in South Africa's Western Cape province saw parents using less corporal punishment, their mental health improving slightly, and children showing fewer externalising and internalising behaviours.
- Caregivers who participated in the parenting programmes became more central and influential in their social networks, engaging more actively in discussions about parenting with other caregivers.
- A longitudinal data analysis showed that intimate partner violence, poor parental mental health and risky levels of alcohol use undermined the impact of the parenting programmes on children.
- Parenting plays a key role in children's depression, anxiety and behavioural problems.
- There was little change in parents' risky use of alcohol during or after the intervention.
- Community members of all ages found it difficult to identify positive aspects about their community; it was easier for them to speak about what was wrong or bad.
- Engaging with community members where health and social challenges were identified and appraised, helped find potential solutions to these problems. This method helped lead to activities to support change in Touwsranten.
- Participants said they had made small changes themselves and that they were keen to see change initiated in Touwsranten.

Recommendations

- Non-governmental organisations (NGOs) delivering parenting programmes, community health services and state-funded social welfare services should cooperate to address intimate partner violence, substance misuse and mental health issues of caregivers. This would support positive parenting and therefore better child outcomes. It would also lead to more secure, peaceful communities.
- Local clinics should provide mental health services and medication for parents who suffer from stress, depression, anxiety and other problems. This would support their parenting abilities.
- Interventions by NGOs to address the risk factors for violence should be complemented by government-led efforts to address the lack of economic opportunities and low employment levels. This could take the form of a basic income grant. Poverty leads to stress, which negatively affects relationships between parents and children.
- Caregivers should be offered programmes that help them to adopt positive parenting practices that foster warm, non-violent relationships with their children.

Introduction

In 2021, the Violence Prevention Forum,[1] a multi-year dialogue process involving policymakers, non-governmental organisations (NGOs), research institutions, development partners and the private sector, defined violence prevention in the following way:

> Violence prevention is the whole of society working deliberately and sustainably to remove sources of harm and inequality, and heal woundedness, by intentionally growing an ethic of mutual care and respect, to build peace.

The intervention described in this report supports and enables caregivers to have warm, non-violent relationships with their children. It is an example of violence prevention in action.

This report presents the technical detail about the intervention and findings from a multi-year assessment of parenting and child behaviour in a challenging socio-economic context. However, a study like this cannot adequately represent the value of the relationships between the researchers, the implementing partner, and the community. These relationships have been mutually supportive, and have enabled us to solve problems and learn together and from each other.

Note about terminology

The terms '*parent*', '*caregiver*' and '*parenting*' are used in this report. '*Parent*' and '*caregiver*' are used interchangeably to refer to adults who have a primary role in caring for children and may or may not be their biological relatives. Parenting refers to the behaviours and practices of caregivers in supporting the growth of the children for whom they care.

Externalising behaviours are those where the child makes their distress visible to others, for instance through fighting or stealing or related conduct problems.

Internalising refers to when a child's distress is kept internal, and may manifest as anxiety and depression.

This project has created a long-term, sustainable relationship between the Seven Passes Initiative and the Institute for Security Studies (ISS) that will enable knowledge to be built and shared between researchers, implementers and community stakeholders.

Setting the scene

Many South African parents are stressed and disempowered by the very difficult socio-economic circumstances in which they raise their children and the compounded effects of racialised intergenerational trauma and poverty. The safety and happiness of many South African children are undermined by violence in their homes and communities. Yet positive, non-violent parenting skills that help parents keep their children safe in and outside the home and reduce parenting stress can be developed and supported.

Between 2012 and 2020, the ISS, the University of Cape Town's (UCT) Psychology Department, and the Seven Passes Initiative (SPI) partnered to determine whether a social activation process combined with the delivery of the four Parenting for Lifelong Health (PLH)[2] programmes would positively change parenting practices in order to promote child safety in an entire population. The project sought to achieve this through various activities:

- Delivering four evidence-informed positive parenting programmes. These were each delivered multiple times throughout the duration of the project. They continue to be delivered in Touwsranten and surrounding communities in the Western Cape province.
- A social activation process to determine how caregivers in the community see positive parenting and establish a community-based and community-developed 'brand' and value-based commitments towards positive parenting that caregivers would like to be associated with.
- Assessing the impact of each of the elements of the intervention both individually and holistically over time.
- Assessing the impact of the project on social networks.

The findings will be used to inform the scale-up of the programmes in other communities, and have informed a costing model for the implementation of parenting programmes.[3]

Two advisory groups, one at local level and one at provincial level, made up of government officials, researchers and NGOs, received regular updates about the project, including the results of each wave of the survey, and provided input and advice.

Results of each wave of the survey were reported to the community of Touwsranten at meetings hosted by the Seven Passes Initiative. The researchers engaged regularly with the Seven Passes staff members (including the parenting programme facilitators) about the research process and findings. Throughout the course of the collaboration, parenting programme facilitators and the Seven Passes director presented the study and the impact of the parenting programme on individuals and families at national and provincial events.

Theory of change

The theory of change for this community intervention was that the delivery of four parenting programmes[4] (three of which are group-based), combined with a social activation process, would lead to a community-wide shift towards positive parenting. This would be achieved through two pathways:

- The delivery of four parenting programmes (three of which are group-based) would increase positive parenting, reduce corporal punishment, and increase parents' social support. This should lead to improved parental mental health, reduced parenting stress, and improved communication and relationships between caregivers and children.
- In parallel a social activation process would identify and amplify existing community values about positive parenting, undertake activities to support those values and disseminate messages of positive parenting and care widely across the community. This would increase uptake of the parenting programmes and enable community-wide change towards positive parenting.

The theory of change is informed by several assumptions: that the PLH programmes could be adapted to be contextually and culturally relevant, that parents would participate in the programmes, and that community members would take ownership of and lead the social activation process.

The study and findings in brief

The intervention was evaluated through an assessment of parenting and child behaviour at five intervals between 2012 and 2019 through community-wide surveys (with parents and children between the ages of 10 and 18), observations of parent/child interactions (for children from 0 to nine), focus groups and individual qualitative interviews, and a social network analysis. In summary, we found:

- A decrease in parenting stress.
- A decrease in children's externalising and internalising behaviours.
- A trend towards a reduction in the use of corporal punishment.
- A slight improvement in parents' mental health.
- Little change in parents' risky use of alcohol.
- An increase in positive parenting among Afrikaans-speaking caregivers.
- Caregivers who participated in the parenting programmes became more central and influential in their social networks by engaging more actively in discussions about parenting with other caregivers.
- A longitudinal analysis of data showed that intimate partner violence, poor parental mental health and risky levels of alcohol use undermined the impact of the parenting programmes on children. We also found that parental stress was associated with lower levels of positive parenting.

This means that if parenting programmes are to achieve a good return on investment, they should be delivered alongside other interventions that promote parental mental health, and prevent and respond to intimate partner violence and substance abuse, or they should be augmented and adapted to address these issues.

It is important to note that the community of Touwsranten is divided along lines of language (Afrikaans and isiXhosa) and because it was initially not possible to find isiXhosa-speaking people to be trained as parenting facilitators, the programmes reached only Afrikaans-speaking

parents. Since the end of the research period, an isiXhosa parenting facilitator has been trained and appointed.

The report provides a summary of the research methods and findings, followed by a discussion of the outcomes and their implications. It concludes with recommendations.

Research methods

This study consisted of a community audit to establish the number of households with children in the community (June/July 2012), followed by three waves of a community-wide survey of one caregiver per household (August 2012, March 2013, and January 2016). This was to assess parenting, child behaviour and factors impacting parenting and child behaviour in Touwsranten.

These first three waves of data served as a baseline preceding the delivery of the interventions, which comprised the delivery of the four PLH parenting programmes alongside a community activation process.[5]

Caregivers who participated in the parenting programmes became more central in their social networks by engaging more about parenting with other caregivers

A further two waves of data were gathered during the delivery of the intervention, in June 2017 and February 2019. These waves used the same tools as used at baseline to assess community-wide changes in parenting, and included changes in social networks and moderating and mediating factors.

The main difference between the data gathered in waves one and two from later waves is that in the first two waves of data collection, only caregivers of children aged 10 or over were included. The later three waves included caregivers of all children under age 18. In addition, in waves three to five, social network data was gathered.

The initial research design had envisaged two waves of data collection before initiation of the intervention. Since there was a two-year delay between the second wave of data collection and funding being secured for further research and intervention, a third wave of data was collected in 2016.

Alongside the surveys, focus group discussions and individual interviews provided in-depth understandings of how community members viewed the parenting programmes, the social activation activities, and their community as a whole.

Overall, the study aimed to determine if the intervention resulted in community-wide changes in parenting and child behaviour outcomes.

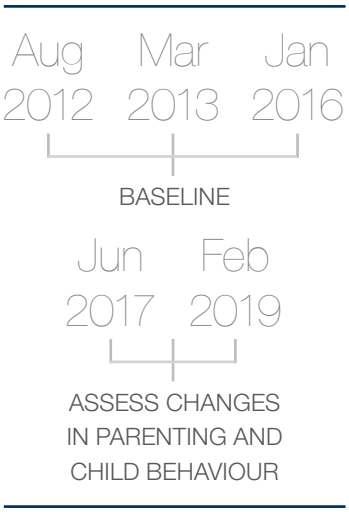


Chart 1: Project timeline

Activity	Date
Community-wide survey, wave 1	August 2012
Community-wide survey, wave 2	March 2013
Community-wide survey, wave 3	January 2016
Community meetings to develop a 'brand' around positive parenting	January 2016
First social activation activities	February 2016: Local street clean-ups; July 2016: Community-wide street clean-ups, distribution of the positive parenting manifesto and logo sticker to households, and painting of mural logo alongside community sports fields
Gelukkige Familie programme (PLH[6] for Young Children)	Delivered 17 times (to different groups of families) between March 2016 and October 2019
Mama-Baba programme (PLH for Infants)	Delivered continuously, as parents were enrolled, between April 2016 and December 2019
Prente Pret (PLH for Toddlers)	Delivered 10 times between May 2016 and July 2019
Gelukkige Familie (PLH for Teens)	Delivered six times between July 2016 and July 2019
Wave 4 (13 months after initiating delivery of parenting programmes)	June 2017
Wave 5 (19 months after wave 4)	February 2019

Source: authors

Note on ethics

Ethical approval for this study was provided by UCT's Research Ethics Committee in the Faculty of Humanities (reference number PSY2015-049). Amendments to the procedures and questionnaires were approved on 1 December 2015, on 28 November 2018 and on 1 December 2018. The collection and inclusion of the social network data was approved by the UCT Research Ethics Committee on 28 April 2016 (reference number PSY2016-003).

Procedures included informed consent for data collection, protection of confidentiality, secure data management and a protocol for responding to reported cases of child abuse and domestic violence. Consent by participants included consent to archive and make anonymised data available to future researchers, and to video parent/child interactions or to undertake interviews with children in the care of the adult participant (with assent from children).

How we showed our commitment to ethical research

- We ensured that the intervention responded to a need identified by parents and the implementing partner (the Seven Passes Initiative).
- The intention to undertake the study was presented at a community meeting, the Annual General Meeting of the Seven Passes Initiative, before the study commenced. After each successive wave of the survey the findings were presented in community meetings, and community input was solicited.
- The Seven Passes staff were kept informed about the study and findings via workshops and presentations throughout the research process.
- A provincial and a local advisory board of stakeholders from civil society and government were consulted at the outset of the project and kept updated throughout the study. Their questions and input were considered responded to.
- Caregivers who gave generously of their time to participate in the study received a small token of appreciation, ranging from a packet of biscuits in waves 1 to 3 to a R40 voucher for groceries or airtime in wave 5.

Why Touwsranten?

The choice of Touwsranten as a location for this study was determined by several factors. Firstly, Touwsranten is a small, relatively well-bounded and stable peri-urban community. The township is geographically separate from other communities (see Chart 3). Secondly, there are low rates of in- and out-migration, particularly among the Afrikaans-speaking population. Low levels of population change made it possible to track caregiving and child behaviour over time.

Thirdly, Touwsranten is home to a stable community-based organisation, the Seven Passes Initiative, which has, since 2008, been providing afterschool care and educational support to children of the community. The organisation had identified the need for parenting support, and the 2012 survey showed that 53.8% (n = 306) of parents wanted support with parenting.

Touwsranten at a glance

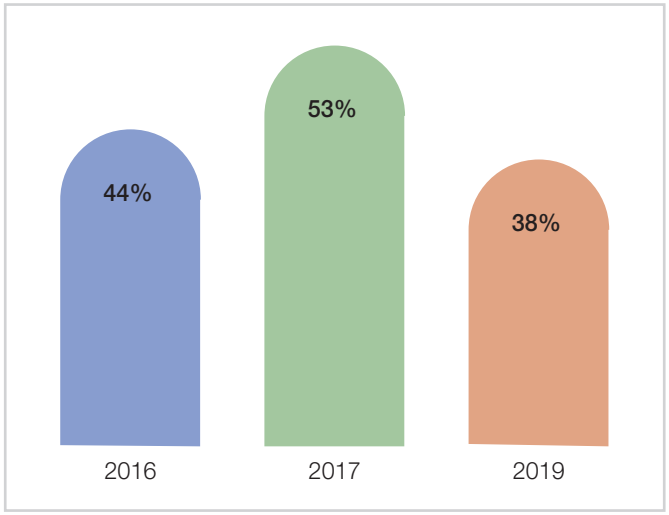
Touwsranten is a rural town in the Western Cape province of South Africa. The 2011 Census by Statistics South Africa put the total population of Touwsranten at 2 245. The census data also shows that in the year before the first baseline survey for this study, 769 adults were employed and 731 were unemployed, not economically active or were discouraged work seekers.

Only nine households in the community had a total annual income of between R153 801 and R307 600. The remaining families had much lower income levels (see Chart 2). From the community survey in 2016 we found that:

- 69% of caregivers received one government grant
- 10% of caregivers received two government grants
- 1% of caregivers received three government grants
- The 20% of caregivers who did not receive a government grant were either employed or received money from a partner or family member

There was little change in the percentage of caregivers who reported being unemployed between 2016 and 2019. The apparent reduction in unemployment in 2019 was a consequence of a large infrastructure project (road building) in the area that provided temporary employment.

Chart 2: Percentage of caregivers who were unemployed in Touwsranten 2016–2019



Source: authors

Like many South African towns, the township of Touwsranten lies a short distance (1.5km) from a more affluent white community, in this case Hoekwil. The 2011 Statistics South Africa census data puts the combined population of the two communities at 3 787, of whom 1 209 were under the age of 19.[7]

Most of the people who live in Touwsranten were born in the Western Cape, and would be considered 'coloured'. A very small percentage of the community were born in another province. Most adults had some secondary schooling, and in 2011 only nine had more than a matric qualification.

Noting that the isiXhosa community represented 4% of the total community, the 2013 survey found that among Afrikaans-speaking parents:

- Most families struggled with poverty: 60% reported running out of money to buy food four or more times in the past month.
- Thirty-nine (12.7%) of the children aged six to 18 suffered from anxiety or depression that should have been receiving treatment.
- Forty-seven (15.3%) of the children aged six to 18 experienced behavioural problems that likewise should have been receiving treatment.
- One fifth of parents reported such high levels of parenting stress that they were classified (according

Chart 3: Aerial view of Touwsranten

Source: Statistics South Africa

Note: The white dotted area demarcates where mostly isiXhosa-speaking community members reside. The Seven Passes Initiative is circled in green and the Touwsranten Primary School in yellow.

to the Parenting Stress Index)[8] as being at risk of perpetrating child abuse.

- Parents' inconsistent discipline and use of spanking and slapping were strongly related to children's behavioural problems, and to their anxiety and depression. In other words, parenting played a key role in the depression, anxiety and behavioural problems of Touwsranten's children.

Participants

The community-wide audit in 2012 found 304 households with children between the ages of six and 18.[9] This audit counted only households where children of those ages were living, because at that stage we did not intend to use the Parenting of Young Children measure to assess parenting of children under six.

In waves 1 (2012) and 2 (2013), one caregiver from each household where there were children between the ages of six and 18 was surveyed. The caregiver was asked to answer only questions about one child, preferably the youngest in the household (so that they would be less likely to age out of the study over the research period).

In 2016 all households with children aged 0–18 were included in the study and this accounts for the higher number of households in waves 4, 5 and 6. In waves 1 and 2 data was collected only from Afrikaans-speaking caregivers. Data was collected from all Afrikaans-speaking and isiXhosa parents in waves 3–5. Given the gap between waves 2 and 3, a second community audit was conducted in 2016.

Dwellings in Touwsranten are organised by plot. In 2016, 762 households were identified, 481 (63.1%) of which

had children living in them. The number of children per household ranged from one to six (M = 1.74; SD = 1.12). Based on reporting from caregivers who completed the community survey in wave 6, 838 children were identified in Touwsranten: 22 aged four to seven months, 159 aged 12–30 months, 325 aged 31 months to nine years, and 332 aged 10 and older.

One caregiver in each household with children under 18 was approached to complete a household survey. Four hundred and seventy-three caregivers were interviewed – 411 mothers and 62 fathers. Thirty-three caregivers refused to be interviewed – a refusal rate of 6.9%.

In waves 2–4 the ages of the focus children of the caregivers who were interviewed were divided into three categories: children aged six and over (287; 60.6%), children aged 1½ to five (135; 28.5%), and infants under the age of 1½ (51; 10.8%). Parents of children in the different age groups answered different questionnaires about their parenting skills to ensure that the questions were age-appropriate for caregiving.

Of the children who were the focus of the interview in wave 3, 240 (50.7%) were male and 233 (49.3%) were female. The sample included 365 Afrikaans- and 108 isiXhosa-speaking caregivers.

In waves 4 and 5, 322 and 444 caregivers were interviewed respectively.

Parenting played a key role in the depression, anxiety and behavioural problems of Touwsranten's children

Efforts were made to follow the same participants from waves 1 to 5. However, given the time difference between wave 2 and wave 3, many children had aged out of the study by 2016. Thus, while 89% of the participants in wave 1 also answered the questionnaire in wave 2, in wave 3 the sample was substantially different. However, most parents interviewed in wave 3 were followed through to wave 5.

The final analytic sample for waves 3 to 5 consisted of 536 caregivers, who answered a survey at least once. The findings from the baseline surveys were analysed separately to the findings from wave 3–5, to overcome difficulties presented by the loss of caregivers from the sample between waves 2 and 3.

Procedures

For all waves of the survey, fieldworkers were recruited from the community by the Seven Passes Initiative, since qualitative data indicated this was what participants preferred. Fieldworkers were trained in ethics and interviewing skills. In waves 1 and 2 fieldworkers administered paper questionnaires. For waves 3 to 5 fieldworkers were trained to use android devices to administer the questionnaires.

Questionnaires were electronically administered using the Mobenzi platform. This made it possible to link each fieldworker to a specific phone and to manage the daily survey submissions and analytics on the Mobenzi web console, thereby facilitating cleaning and data analysis in real time. Interviews took about two hours, and were conducted in private. A small incentive (biscuits) was provided to each caregiver interviewed. In wave 5 this incentive was increased to a R40 grocery or airtime voucher to be redeemed from a local shop.

Fieldworkers administered informed consent, and provided respondents with an information sheet in their home language about the study. They were also provided with a list of local organisations that provide support for intimate partner violence and substance misuse.

In 2013, six small focus group discussions were held. Three themes were explored in these discussions: what it had been like to complete the questionnaires; what methods of discipline were primarily used in the community; and what stressors affected parenting in the township.

Participants gave separate informed consent to participate in the focus group discussions. From these discussions we learnt that community members mostly experienced the interviews positively. They felt more comfortable speaking to people from their own community than if the fieldworkers had been from another community, and would have preferred the fieldworkers to be older and more mature than they were in the first wave.

We also learnt that some of the questions were difficult for caregivers to answer because they dealt with personally and sensitive subject matter, or because the caregivers

shared caregiving responsibilities with others and therefore did not see the children all the time. Finally, the focus groups suggested that there were higher levels of corporal punishment and alcohol use than were reported in the survey.

In 2017 and 2019 two focus group discussions and interviews were conducted with community members. In 2017 community members were recruited to participate through an announcement at a public meeting and flyers distributed throughout the community, inviting anyone who had been interviewed to attend. Fourteen women volunteered to participate, resulting in two focus groups: one for people over 60 and one for people younger than 60. To supplement this data, 12 individual interviews were conducted.

In 2018 the invitations to participate in focus groups did not yield any volunteers. This was probably a consequence of research fatigue in the community, since the timing of this qualitative data collection coincided with the survey. Twenty-seven participants were recruited to take part in individual interviews through door-to-door visits by the researchers who explained the purpose of the interview and invited an adult member of the household to participate.

In wave 1, 60% of families said they ran out of money to buy food four or more times in the past month

Both the focus group discussions and interviews sought community members' perceptions of the positive and negative aspects of community life, and knowledge of the social activation process. A small incentive was offered: all participants were given a R50 voucher for a local clothing store. Aspects explored included what was positive in the community, what was negative about the community and awareness of the social activation process.

For waves 3 to 5, seven fieldworkers were recruited from the community. For wave 3 and 4, an isiXhosa-speaking fieldworker was recruited from outside the community (because no isiXhosa-speaking fieldworkers who could read and write in isiXhosa were identified at the time). In wave 5 a local isiXhosa-speaking fieldworker was recruited.

Research instruments

The table in Appendix 1 presents a summary of the measures used to assess parenting, child behaviour, and other variables that impact caregiving.

Data analysis

For waves 1–3 (baselines), analyses were conducted using R (R Core Team (2021)) – a programming language and environment for statistical computing – with the aim of investigating whether the child and parental social risk factors within the Touwsranten cohort were stable over the three baseline surveys. In other words, whether we had a stable baseline against which to measure change. Both raw and standardised estimates are reported.

Most participants surveyed at wave 1 were followed up at wave 2 (89%). Wilcoxon signed-rank and McNemar tests were conducted to assess potential changes across waves 1 and 2 for participants who were assessed at both waves.

Given that the majority of participants in wave 3 were independent from those who were assessed at waves 1 and 2, Wilcoxon rank-sum and chi-squared tests were used to assess how participants at wave 3, independent of those surveyed at waves 1 and/or 2, differed from the remaining participants at waves 1 and 2. Where risk factors did not differ between waves 1 and 2, and 3, mixed-effect models were conducted to assess how such risk factors might change across three waves.

For waves 3–5 a series of longitudinal mixed-effect models were conducted using the lme4 package in R (R Core team (2020)) to investigate longitudinal trends in positive parenting, parental stress, child internalising and externalising behaviour within the Touwsranten cohort over three waves, as well as to identify the major covariates that impact such outcomes.

Additional models were conducted to test whether social activation and programme engagement impacted positive parenting, parental stress, and child internalising and externalising behaviour over the last two waves. Furthermore, trends in corporal punishment were assessed over the last two waves, using Mann-Whitney-Wilcoxon rank-sum tests, while the potential impact

of social activation and programme engagement on corporal punishment was assessed using Kruskal-Wallis tests and Spearman correlations respectively.

Given sample size differences across the waves, all model estimates were compared to findings from a smaller complete subset, representing those participants who partook in all three waves. The aim was to assess to what extent findings may be affected by sample biases, and in turn whether such findings could be generalised to the broader Touwsranten cohort.

Fieldworkers were recruited from the community, since qualitative data indicated this was what participants preferred

Estimates were considered consistent across samples if those of the complete subset fell within two standard deviations of full cohort estimates. Moreover, given the differences in scale ranges across variables, all model covariates were scaled. In addition, all model outcomes, excluding corporal punishment items which span over a narrower range, were logarithm-transformed to assist in interpreting model coefficients as percentage changes.

The intervention: PLH programmes

The intervention consisted of the delivery of the four Parenting for Lifelong Health programmes[10] alongside a social activation process. The PLH programmes were chosen because they covered all ages of children from birth to 18 years. In addition, these programmes had demonstrated effectiveness in 'gold standard' randomised controlled trials, and were accessible. Costs lie in training and coaching of facilitators, not materials; and training was available in South Africa. These programmes include:

- PLH for Infants (called Mama-Baba in Touwsranten): a home-visiting programme for pregnant women until the baby is six months old, with the goal of improving maternal attachment,[11] which has theoretical links to violence reduction and later child mental health.[12]
- PLH for Toddlers (called Prente Pret in Touwsranten): a group-based dialogic book-sharing programme with evidence for improving infant vocabulary and theory of mind[13] as well as improving parent-child attachment, all of which have theoretical links to violence reduction and child mental health.[14]
- PLH for Young Children (called the Gelukkige Familie Program in Touwsranten): a group and social learning theory-based intervention for parents of children aged two to nine, with evidence for reducing violence against children[15] and child conduct problems.[16]
- PLH for Adolescents (called the Gelukkige Familie Program in Touwsranten): a group and social learning theory-based intervention for parents and children aged 10–17, with evidence for reducing violence against children and a range of child conduct problems.[17]
- Parenting facilitators were recruited by the Seven Passes Initiative, mostly from the community, and were trained as full-time parenting facilitators. Training was provided by the developers of the parent-infant home visiting programme and the dialogic book-sharing programme; and by Clowns Without Borders South Africa for Parenting for Lifelong Health for Young Children and for Teens.

Parents were recruited into the parenting programmes in several ways:

- Parenting facilitators conducted door-to-door visits to inform parents about the programmes.
- The programmes were announced at school and community meetings.
- Flyers about the book-sharing programme were distributed in the community by the Seven Passes Initiative.
- Pregnant women were enrolled with the help of the local clinic, who informed them about the home visiting programme, and if they agreed, referred them to the Seven Passes Initiative.
- At the end of each programme cycle a celebration was held for participants, who were invited to bring friends and family as potential new recruits, and to show their support for the parents who completed the programme.
- In some cases, parents were referred to the programme by social workers.
- The group programmes were offered at the Seven Passes Initiative offices.

Social activation

A social activation process was undertaken by the Seven Passes Initiative to provide complementary support to the parenting programmes. This involved applying the Action Media participatory research methodology as well as other qualitative and participatory methods to support change related to positive parenting. This method has been applied towards empowerment and change processes related to health and wellbeing in marginalised communities in sub-Saharan Africa and elsewhere over the past two decades.[18]

Action Media involves a process of engagement with community members where health and social challenges are identified and clarified. These challenges are then appraised critically and creatively towards identifying potential solutions that include actions and communication processes. Complementary programmatic activities then draw on these insights to support change in the same or similarly affected communities.

Action Media studies have demonstrated the importance of engaging with positive values as a basis for leveraging change. By communicating about values, a vision for change and action for change in conjunction with related programmes, it has been shown that community members can make a positive difference to pressing health and social issues. For example, preventing violence against women and preventing stigma and discrimination towards people living with HIV.[19]

In early 2016 a group of 15 participants were recruited from the group of adult caregivers who completed a parenting questionnaire using a stratified random sampling technique. The sample included participants of different age groups, mothers and fathers of children corresponding in age with the target for the parenting programme, and residents of Afrikaans- and isiXhosa-speaking areas in the community.

In the four-day process, participants explored family and parenting contexts; community challenges and concerns; the physical and social environment of Touwsranten (mapping); parenting and family concerns; values and attitudes towards parenting and social challenges; and communication for change. The discussions were led by Dr Warren Parker, a social activation specialist.

It was established that participants were unhappy with their social conditions, including unemployment and petty crime, the lack of recreational facilities and drug abuse, particularly methamphetamine (tik), and alcohol abuse.

The things that participants did not like or were concerned about included the fact that children faced bullying, abuse and neglect. They were also said to lack role models and were ill-mannered. As the engagement evolved, participants clarified their positive values and identified what they considered to be the core principles of parenting, motherhood and fatherhood. Ways of communicating these values and principles were then explored. This led to the development of a parenting manifesto (see below), lyrics for two songs, ideas towards a logo and slogan, and posters and concepts related to actions for change.

We believe:

- In change in Touwsranten
- In positive parenting
- That our children are our first priority and that we must always encourage them
- That we should praise our children for good behaviour
- That we must always show love to our children
- That we must be an example in Touwsranten
- That respect is earned between all – between adults and children, between children and adults, between boys and girls, between men and women, between young and old, between rich and poor, and between different cultures
- That people in our community care for others and that the community must be involved with all projects
- That change takes courage and perseverance and we will not give up, even if it is difficult

Participants indicated that they'd made small changes themselves and that they were keen to see change initiated in Touwsranten. Initial ideas included repairing the broken playground areas and adding benches for parents. They also included displaying the logo at the local clinic and a notice board, and expanding the reach of the songs, manifesto and logo in the community. Taking action to address drug and alcohol abuse was also included. A steering committee was established to encourage and guide community members interested in participating in change processes related to parenting.

The communication concepts were further refined by the project team. A logo depicting children being held aloft by the community with the slogan '*Samewerking vir 'n beter gemeenskap*' (working together for a better community) was finalised. This was reproduced as a sticker and also as part of a design on T-shirts that included parenting slogans – '*Ek is 'n positiewe papa*' (I am a positive father), '*Ek is 'n positiewe mama*' (I am a positive mother) and '*Saamstaan vir positiewe ouerskap*' (Working together for positive parenting).

The manifesto was printed on heavy-duty paper for display in homes, including a place for a date and signature of family members. For teenagers who completed the programmes or participated in the social activation, specific manifestos were printed for them with the following statement: '*Tieners vir positiewe verandering*' (teenagers for positive change).

The lyrics of the two songs were retained as initially developed and were later set to music and recorded at a music studio. The song was sung at the Seven Passes annual general meeting and on a local radio station.

While the primary focus of the parenting facilitators was to support family-based parenting programmes, they also provided support to the steering committee by convening meetings, taking minutes and supporting resolutions for action. As community members themselves, they also contributed ideas and involved themselves in activities. Overarching support was provided by the Seven Passes Initiative, including modest funding and other resources for meetings and activities as well as overall coordination.

Regular support was also given in the form of ongoing participatory engagement and research including telephonic support, interactive workshops, focus groups and interviews. These were conducted as opportunities arose, with findings and ongoing support strategies being determined by the project team.

In the initial 12-month period, numerous activities were undertaken. These included street clean-ups, and household visits to share the manifesto and encourage its signing and display in the home along with the logo sticker on the front door. They also included painting murals including the logo at the town centre, repairing children's playgrounds, and engaging with community stakeholders including clinic staff, religious leaders and school principals.

Parents were concerned that children who faced bullying, abuse and neglect seemed to be ill-mannered

The steering committee undertook fundraising activities to complement support from the Seven Passes Initiative – for example, holding 'braai en slaai' (barbeque and salad) events where food was sold. The songs were sung during events, group get-togethers and activities.

While it was noted that some activities were challenging (for example, playground equipment continued to be damaged) and economic and social challenges persisted, there was a sense that tangible changes had been brought about and that the process should be continued. Activities undertaken during 2017 included a walking bus (where children walked together in groups) and Youth Day (supported by additional external funding), Mr and Ms Touwsranten and Women's Day events.

Activities continued through 2018 and 2019. Steering committee meetings were intermittent at times due to personal conflicts and disagreements about where activities should be focused. A few activities did not come to fruition – for example a fun run, producing a newsletter and setting up a gym. Despite these setbacks, numerous activities took place – including a high tea, games night, Youth Day activities, a second Mr and Ms Touwsranten event, and a parent-child fun day. Members of the steering committee and parenting facilitators also took part in a team-building activity.

While the parenting programmes followed well-established methods of implementation through the trained parenting facilitators, the social activation process evolved organically. Workshops conducted every six months with steering committee and group members, along with the parenting facilitators and members of the project team, provided an opportunity for reflection and stimulus and to assess qualitative outcomes.

The parenting programmes incorporated elements of the social activation process. For example, parents were encouraged to sign and display the manifesto in their homes and to affix logo stickers to their front doors, and participation in social activation events was encouraged. Caregivers who completed a programme received a branded T-shirt.

Findings

In this section of the report, we present the findings from the surveys, focus groups and interviews. We start with describing the analytic samples for the quantitative research, followed by the results.

Sample for waves 1–3

The cohort was made up of 462 parent-child dyads (parental age at wave 3 median [IQR] = 37 [31,44]), where all children were six years or older. Sixty-three of the parent-child dyads were interviewed across all three baseline waves, 155 dyads completed any two of the three waves, and 244 completed only one wave.

Most participants interviewed at wave 1 were followed up at wave 2 (201 participants, 83%), compared to only 63 participants who completed all three baseline waves (13.6%), suggesting a heterogeneous sample at wave 3 relative to waves 1 and 2.

The average child age was 11 years from waves 1 to 3, and child gender distributions were fairly equivalent across waves.

Sample for waves 3–5

The cohort was made up of 536 parent-child dyads, and included caregivers of all ages of children under 18 at wave 3.

The average child age was eight years at wave 3. Child gender distributions were roughly equivalent across waves, except for wave 5, which consisted of a greater proportion of males. Eighteen percent of the cohort attended a parenting programme at wave 4, and 15.5% at wave 5.

See Appendix 2 for a table providing the detailed characteristics of the sample.

Parenting and child outcomes across the first three waves

Responses to questions about parenting practices suggest that at baseline parents often used positive parenting strategies (which would make it difficult to detect a significant change over time). We found slightly lower levels of parental involvement (e.g. took part in their children's activities or played with their children), and that parents typically monitored their children reasonably well. Median scores suggest that spanking was fairly prevalent, but that slapping and beating with an object were infrequent.

Over the three waves, increasing numbers of parents reported poor mental health: 0 (0%) in the first wave, 0 (0%) in the second, and 43 (15%) in the third wave. Reports of alcohol use showed a similar pattern. In the first wave, 33 parents (14.6%) reported risky drinking patterns; in the second, 51 (21.8%) reported risky drinking; and in the third wave 60 (22.5%) reported risky drinking.

During the lifetime of the study one in five parents in the community attended a parenting programme

Reports of intimate partner violence among those parents who had a current partner were similar at the first (52, 23%) and second (71, 29%) and third (73, 26%) waves. Most parents in the first (120, 54%) and second (159, 66%) waves reported being in the high range for parenting stress, but this fell considerably by the time of the third wave to 14 (5%).

Children's outcomes seemed to deteriorate slightly from the first to second waves, and then hold steady

Chart 4: Changes in factors that impact parenting

	Wave 1 (n = 224)	Wave 2 (n = 242)	Wave 3 (n = 279)
Parents' poor mental health	0 (0%) n = 223	0 (0%) n = 242	43 (15%) n = 279
Risky levels of alcohol use	33 (14.6%) n = 224	51 (21.8%) n = 240	60 (22.2%) n = 270
Intimate partner violence	52 (23%) n = 224	71 (29%) n = 242	73 (26%) n = 279
High range for parenting stress	120 (54%) n = 223	159 (66%) n = 241	14 (5%) n = 279

Chart 5: Changes in child behaviour

	Wave 1 (n = 224)	Wave 2 (n = 242)	Wave 3 (n = 279)
Borderline or clinical range for internalising (depression and anxiety)	33 (14.8%) n = 223	36 (17.5%) n = 206	44 (17.4%) n = 253
Borderline or clinical range for externalising (aggression or acting out)	19 (8.6%) n = 222	39 (18.8%) n = 207	51 (20.2%) n = 253

Source: authors

(which may again represent greater trust in study confidentiality). At the first wave, 33 children (14.8%) were in the borderline or clinical ranges on the internalising subscale of the Child Behavior Checklist. This increased slightly to 36 (17.5%) at the second wave, and 44 (17.4%) at the third wave. Fewer children appeared to demonstrate externalising behaviour problems at the first wave where 19, (8,6%) were in the clinical or borderline range for externalising behaviour. In the seond and third wave 39 (18.8%) and 51 (20,2%) were reported to have externalising behaviours..

Next, trends over time were examined by comparing results from those parents who completed both wave 1 and wave 2, and then comparing the results from parents who either completed wave 2 or wave 3.

The comparison between reports of the same parents at waves 1 and 2 revealed that there were statistically significant but very slight deteriorations in parenting behaviours, except for slapping children and hitting with the hand, which appeared to reduce slightly in frequency. There were marked increases in the proportion of risky alcohol use (14.2% to 20.3%), and reported intimate partner violence (21% to 27%), and a slight increase in the proportion of parents reporting high levels of parenting stress (54% to 63%). Again, these probably suggest increasing confidence in the confidentiality of the survey.

Most parents reported high levels of parenting stress during waves 1 and 2 although this fell by the third wave

There were slight increases in children's internalising and externalising between waves 1 and 2, but with marked increases in the proportion of children reported to be in the clinical and borderline clinical ranges at wave 2. There was an increase in the proportion of children who might benefit from an intervention from 13.1% to 17.8% for internalising, and 7.5% to 19.1% for externalising.

When the changes at waves 2 and 3 were examined, there were no changes in parents' use of spanking

or slapping, mental health, or reports of intimate partner violence in the community. There was a statistically significant increase in reports of risky alcohol use, and a decrease in the proportion of parents reporting parenting stress.

There was a small but statistically significant change in overall use of positive parenting strategies, apparently driven by a decrease in poor monitoring and a slight increase in involvement. This might have been an effect of answering questions about parenting that led to a greater awareness about these issues. There was no change in rates of children's internalising or externalising disorders from wave 2 to wave 3.

Parenting stress, parental mental health, and corporal punishment were associated with children's internalising and externalising behaviour

Our earlier work examining relationships between variables at wave 2 reveals that parenting stress, parental mental health, and corporal punishment were associated with children's internalising and externalising behaviour. Intimate partner violence was also associated with children's externalising behaviour.[20]

Analyses of these three waves of survey data suggest that although there were changes that were statistically significant, overall, there was little or no substantive change. Some apparent changes may reflect increased trust in the confidentiality of the research team over the repeated waves of the survey, rather than actual changes in prevalence. For example, in the sample who completed both waves 1 and 2, increased reports of intimate partner violence, poor mental health and risky alcohol use.

Parenting and child outcomes waves 3-5

Although it appears that parent-reported positive parenting increased slightly over time, trend analyses, both unadjusted and adjusted for risks influencing parenting, showed that there was no significant change in parent-reported positive parenting over the study period.

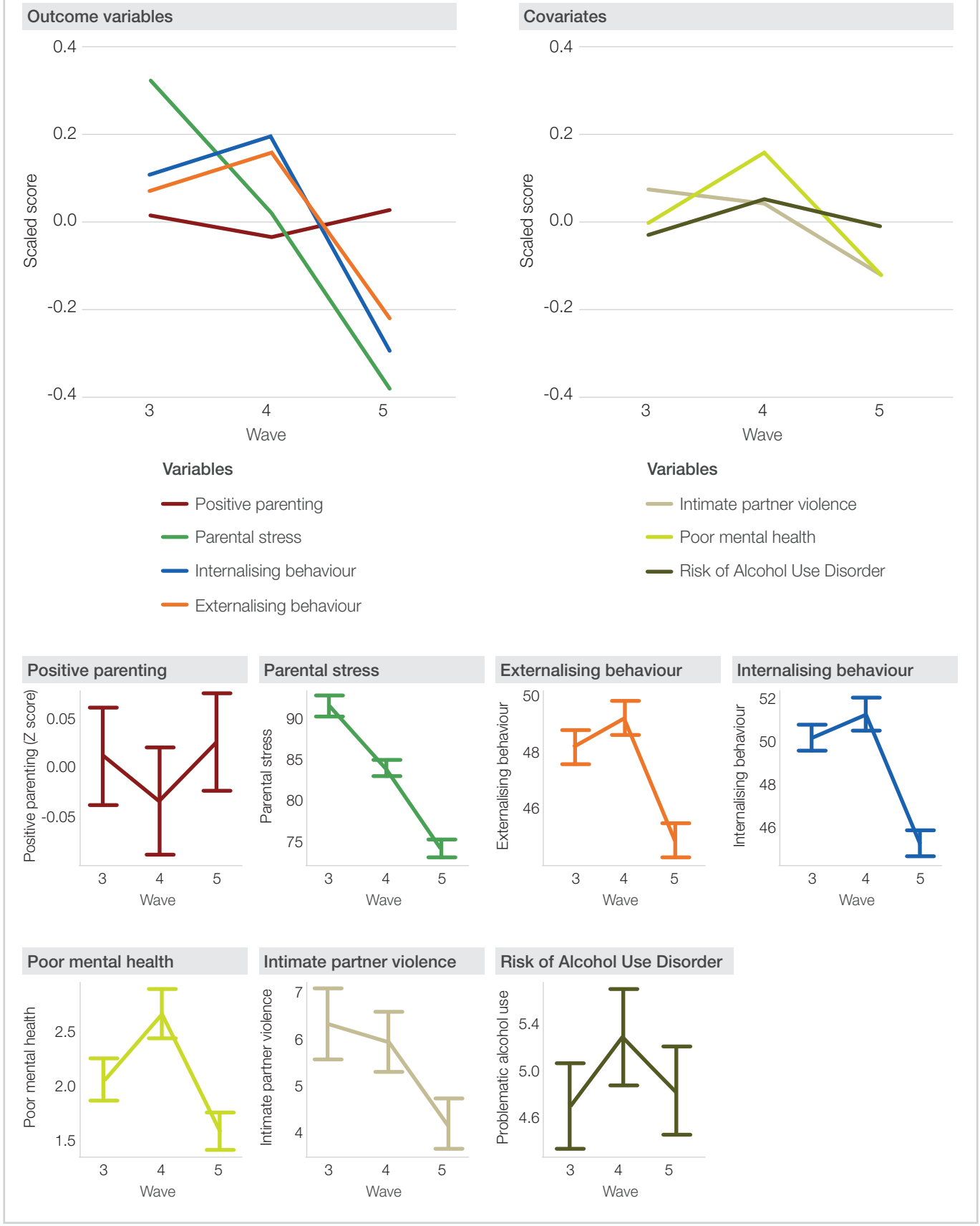
However, risks influencing parenting were statistically significant in the adjusted model. There was a 15% decrease in positive parenting by the second follow-up for parents with a male child, and a decrease as children got older (a 16% decrease for each year of child age), in addition to a 12% and 28% decrease in positive parenting with the presence of intimate partner violence and parental stress respectively. Positive parenting, as reported by the children aged 10 and older, also showed no change over time.

In terms of child outcomes, both children's internalising and externalising behaviour demonstrated significant decreases over time. Exposure to intimate partner violence, parents' poorer mental health, greater risky alcohol use and greater parenting stress were all associated with increases in both

Wave 1:	Wave 2:	Wave 3:
14.8%	17.5%	17.4%

CHILDREN WITH SERIOUS INTERNALISING BEHAVIOUR

Chart 6: Trends in major outcomes and covariates of interest



internalising and externalising. Further quantitative analyses were conducted, and the qualitative data examined, to try to explain these findings.

One possible explanation for improvements in children's outcomes might be declines in harsh parenting. Spanking levels did not significantly decrease from the first follow-up to the second for either older (>=six years) (Wilcox $V = 2069$, $p = 0.1$) or younger children (<six years) (Wilcox $V = 271$, $p = 0.09$), but a possible trend towards a decrease did appear when all the children were examined (Wilcox $V = 4447$, $p = 0.05$). In other words, when data from older and younger children was combined, a trend level decrease in spanking was found, but this was not the case when looking at younger and older children separately. Slapping and hitting with an object, however, did not decrease over time – though it was also clear that spanking was the most frequently used form of corporal punishment.

Children's internalising and externalising behaviour decreased significantly over time

Among the risks that may impact on parenting, perhaps most notable is the significant 5% decrease in parenting stress, a decline that remained robust in both unadjusted ($B = 0.90$, $p<0.001$) and adjusted ($B = 0.95$, $p<0.001$) models. Increases in positive parenting, and having an older child, were associated with decreases in parenting stress, but intimate partner violence, poorer mental health, and risky alcohol use, were all associated with increases in parenting stress.

In terms of engagement with the parenting programmes, attending less than 70% of a parenting programme was associated with using more positive parenting strategies, but, oddly, higher attendance was not. However, positive parenting at baseline (wave 3) significantly predicted 70% or greater attendance of a parenting programme at waves 4 or 5. Knowledge of and participating in the social activation strategies was not associated with programme attendance.

Analysis of the subset of parents who participated in all three waves of data collection also suggested that those who attended the parenting programme may have experienced an increase in social support around parenting, which may have reduced parenting stress.[21]

Findings from the qualitative research

The focus group discussions and interviews in 2017 and the individual interviews conducted in 2018 revealed similar trends. In general, community members of all ages found it difficult to identify positive things about their community; it was much easier for them to speak about what was wrong or bad.

The negative perceptions were even more pronounced among isiXhosa-speaking members of the community who felt marginalised, excluded from services and who experienced racial prejudice from the Afrikaans-speaking members of the community. These experiences and views are represented in the following extracts from the interviews:

> 'You see, here the most spoken language is Afrikaans. We are Xhosa speaking. Most of the things that take place at the schools and Seven Passes are done in Afrikaans. We don't know what they are saying, so how can we go there? They don't even tell us that there will be something happening. It is just for the Afrikaans people.' – *P4 Xhosa 2018*
>
> 'No. I know nothing. All the things that happen down there (i.e. coloured community) [are] only known by coloureds. We are never included. These light-skinned ones don't want anything to do with us. They have this sense of apartheid, they call us Kaffirs.' – *P2 Xhosa 2018*
>
> 'What I don't like about this place, for example people from Thembalethu just come and move in here and set up their shacks, it's just something that is happening, and no one is doing anything. That is why the crime is getting worse and rape is happening because so many foreigners are coming into this place and changing the way it was.' – *P11 Afrikaans 2018*

The things that were identified as positive, and negative, remained consistent between 2017 and 2018.

Positive things included:

- Sports activities
- The Seven Passes Initiative
- The primary school
- Churches

Negative things included:

- Poor services and facilities
- High levels of unemployment
- Substance abuse
- Theft and interpersonal violence, including domestic violence
- Harsh, neglectful parenting

A small number of interviewees were aware of the social activation process, and others spoke about the impact of the parenting programmes on their family members.

Interviewer: And have you seen a difference after the *Samewerking* group started?

Participant 10: Yes

I: Such as?

P10: Like the people who I would have thought like the children and parents, wouldn't be interested in it, they also got involved. And the parents who were enrolled in the parent programmes, they became more involved in their children's lives.

I: Did you see that with your own eyes?

P10: Yes, like my cousin, she never used to care about her children and after joining the programme she communicates better with them and cares well for her children. She has completely changed for the better and she has God in her life now too. (Community member, interview 2017)

Those who heard of the parenting programmes and participated in one said that they found the programme extremely helpful and would highly recommend it. Many said they learnt a lot and found the content applicable, although it was sometimes difficult to implement the content at home, especially once the programme was completed.

P18: It was positive because the child would point to the different pictures and learn like that. I mean for me it was something positive because it was something that connected us and made us bond because like for example when she would come out of school in the afternoons, then we would never really have bonded and she would run around or be bored. Now I know that I can go to the library and go get her books and now we know that 1 o'clock, for half an hour, it's book time. And now we are very close to each other.

P21: For me I was proud of myself because I could lift my parenting skills. I have more self-confidence. I feel more positive, and I don't have to worry, because as a mother we always blame ourselves for things that go wrong, but now I don't have that guilt for when things go skew. I must just be there for my child and be tuned in and the communication makes me very proud because we can talk to each other.

I: And did you find the things you learnt useful?

P21: Yes, I did, but not just for my child but also for other children in the community. Other children in the community have told my daughter that they love our relationship and wish that they could have that with their own mothers.

P22: I learnt different techniques, how to understand her better. How to set up house rules, how to shift their attention and such things.

I: And the things that you learnt, were they useful?

P22: Yes, they were. I also applied it to my classroom and used it then. Especially in that year, I had a very difficult boy in my class and I used the techniques on him. I gave him extra work, after school I offered to stay behind with him and help him with tasks and [it] strengthened our relationship. Beforehand, he was very difficult with me and I couldn't understand him, but after I applied that stuff then we grew closer and our bond got stronger.

Changes in social networks

An aspect of the theory of change for the intervention was that there might be changes in the social networks of parents for two reasons. First, they would have increased opportunities to mingle with each other through both the parenting programmes and the social activation activities. Second, parents who had completed parenting programmes might become trusted sources of support for parenting, and so further disseminate knowledge of positive parenting skills.

The social network analysis assessed whether the intervention resulted in change in the networks of Afrikaans-speaking female caregivers with children aged 1½ to 18 (n = 235; mean age 35.92 years).[22] The social network was measured based on a peer nomination procedure (study participants were asked, 'Who do you talk to about parenting?').

Parents who participated in the parenting programme found it extremely helpful and would highly recommend it

Attending at least one session of a parenting programme significantly predicted change in the caregivers' communication networks, indicating the spread of social influence through their network. The small subset of caregivers attending one or more sessions of a parenting programme showed greater activity and potential influence within the communication network, compared to caregivers who did not attend any programme sessions.

This subset of caregivers was more likely to reach out to other caregivers to speak about parenting after being exposed to the intervention, and both sought and received social support from other caregivers. The results indicate that through social networks, the parenting programmes do influence the behaviour of parents who don't attend the programmes.

Because of the increased likelihood of those who attended the parenting programmes speaking about parenting, and the significant socialisation effect, it appears that on average attendees may have influenced the behaviour of other network members more than non-attendees did. This suggests a means (community mobilisation) and a process (norm change via social networks) for amplifying the effects of individually oriented parenting skills training programmes, which may be more cost-effective than simply delivering standalone programmes.[23]

What this intervention and the findings tell us

In summary, we found no significant change in positive parenting. However, given that at baseline parents were overall applying many positive parenting strategies, this was not surprising. We did find a trend towards a decline in spanking – which may be associated with the parenting programmes.

The intervention was associated with declines in both internalising and externalising symptoms in children and a decline in parenting stress; in short, meeting the criteria for a violence prevention intervention, as defined by the Violence Prevention Forum.

The assumptions in the theory of change included that parents would attend the programmes and that the programmes could be adapted to the local context. By the end of the study period, 20.5% of parents attended a programme at least once, and some parenting programme attendance was associated with an increase in positive parenting.

At the time of writing in 2022, parents were still attending the programmes – though recruitment strategies weren't always as effective as the parenting facilitators would have liked. Even home visits didn't always have the desired effect on participation. Nonetheless, one in five parents attended the programme in a three-year period.

The Seven Passes Initiative's employment of skilled, trained facilitators has also enabled the organisation to deliver the programmes in nearby communities (such as Wilderness Heights and Kleinkranz). The 2022 parenting facilitators were training the young homework class facilitators who were part of the Seven Passes Initiative youth development programme. Training was also provided to facilitators elsewhere in the country, and in other African countries.

All the programmes were being delivered in Afrikaans and isiXhosa, and it appeared that the adaptations of

the names, the language and the songs and stories did resonate with parents. However, the positive discipline strategies remained a challenge for parents.

As far as the social activation process was concerned, while most parents had at least some awareness of the social activation programme, maintaining and convening it was extremely demanding for the Seven Passes Initiative, and community members (outside of the initiative) were reluctant to take ownership. Again, this was not unusual in a community whose members have little belief that their actions can bring about positive change.

A significant but not unexpected finding was that positive parenting, children's mental health and parenting stress are all negatively impacted by parents' mental health, substance misuse, and intimate partner violence in the home. Some of the factors that negatively affect positive change include parents facing a multitude of inter-connected stressors in the community (e.g. lack of employment opportunities, and intimate partner violence). These factors were compounded by substance misuse and mental health issues.

Through social networks, the parenting programmes do influence the behaviour of parents who don't attend the programmes

The local clinic provided no mental health services or medication, and trips to clinics that did provide services were expensive and time-consuming. There were very few alcohol-free options for socialising (outside of church activities), which could increase the risk for substance misuse.[24]

We can conclude the following from this study and the experience of delivering the parenting programmes and social activation process:

- Parents do want support with positive parenting.
- While it is hard to sustain engagement in social activation processes in a community where there is little hope and strong negative feelings about the community, identifying and amplifying values around positive parenting does support positive changes.
- Parenting programmes do bring about an increase in discussion about parenting among parents, and a change in parenting practices, even of those parents who do not attend the programme.
- It is possible to change parenting practices positively through the parenting programmes. In particular, it is possible to increase parental involvement and decrease the use of corporal punishment. It is also possible to reduce parents' stress about parenting. However, unless material conditions change for parents, and interventions support reductions in parental intimate partner violence, substance misuse, and mental health, it will not be possible to achieve an optimal return on investment for parenting programmes.
- It is possible for research institutions and community-based organisations to partner to assess the impact of interventions.

The limitations of this study include that it reflects the experience of only one community, so lacks comparability with other communities. However, this is to some extent offset by the strength of multiple waves of data collection.

In conclusion, our theory of change held: parenting programmes, alongside social activation, can shift parenting strategies in a more positive direction and improve children's outcomes. However, social activation processes need a great deal of support, and multifaceted interventions are required that simultaneously address parents' substance misuse, mental health and intimate partner violence.

Deep, sustainable change will require a material change in the lives of people in Touwsranten.

Notes

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Appendix 1

Chart 7: Measures used to assess parenting and child outcomes

Variable	Measurement tool	Contextual reliability
Parenting behaviour for caregivers of children 6–18 years, specifically to assess parenting associated with conduct problems. Sub scales measure a) poor supervision and monitoring, b) parental involvement, c) positive parenting, d) inconsistent discipline, and e) corporal punishment (Frick, Christian and Wootton, 1999)	The Alabama Parenting Questionnaire (APQ) Global Parent Report 42-item questionnaire for parents (Essau et al., 2006), has five different subscales, namely: (This scale consists of 42 items on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).	The Global Parent Report of the APQ has shown adequate reliability, with Cronbach's alphas greater than, $\alpha = 0.70$ for all subscales excluding poor monitoring and supervision ($\alpha = 0.67$) and corporal punishment ($\alpha = 0.55$) in an Australian study (Dadds, Maujean and Fraser, 2003). Furthermore, the APQ has been found to have moderate to adequate levels of reliability and validity in studies conducted in the US (Shelton, Frick et al. 1996), Australia and Canada (Elgar, Waschbusch, Dadds and Sigvaldason, 2007).
Children's emotional and behavioural problems	The Child Behaviour Checklist (CBCL) for children aged 6–18, and the pre-school CBCL (for children aged 1½–5) were used to assess children's emotional and behavioural problems (Achenbach and Rescorla, 2001; Achenbach and Ruffle, 2000; Ebesutani et al., 2010). The CBCL for children aged 6 to 18 is a 118-item self-completion scale for caregivers about the behaviour of their child (e.g., "drinks alcohol without parents' approval", "argues a lot", and "overeating"). The preschool Child Behaviour Checklist is a 99-item self-completion scale that assesses child outcomes for children 18 months to 5 years (e.g., "can't concentrate", "can't pay attention for long").	Initial studies suggest that the CBCL is robust in a variety of cultural contexts namely American, Dutch, Mexican and Norwegian (Albores-Gallo et al., 2007; Nøvik, 1999), and has demonstrated its capacity to distinguish between children with or without internalising and externalising symptoms across different contexts (Albores-Gallo et al., 2007; Nøvik, 1999). Furthermore, the internal consistency and test-retest reliability of the CBCL/4-18 scales are rated good to excellent in several samples – for instance, American, Mexican, Chinese; Norwegian and Spanish (Achenbach and Ruffle, 2000; Albores-Gallo et al., 2007; Nøvik, 1999; Rubio-Stipec, Bird, Canino and Gould, 1990). As such, the CBCL is a robust measure for assessing children's behavioural and emotional problems in a variety of cultural and language settings including South Africa (Achenbach and Rescorla, 2001; Calkins and Dedmon, 2000; Gross et al., 2006; Mesman, Bongers and Koot, 2001; Nöthling, Martin, Laughton, Cotton and Seedat, 2013).

Variable	Measurement tool	Contextual reliability
Parenting stress	The Parenting Stress Index short form (PSI-SF; Abidin, 1990, 1995) was used to assess parenting stress. This is a 36-item self-completion scale that quickly screens for stress in the parent-child relationship (e.g., "my child is not able to do as much as I expected"). It yields outcomes on three subscales, namely: 1) Parental Distress, due to personal factors such as anxiety, depression or conflict with an intimate partner; 2) Parent-Child Dysfunctional Interaction, indicating parental tolerance for child's conduct and the level of dissatisfaction with their interactions; and 3) Difficult Child, assessing parents' perceptions of their child's degree of autonomy (Haskett, Ahern, Ward and Allaire, 2006).	The PSI-SF is a well-researched measure that has been used extensively in a variety of contexts and samples, namely: • low-income, urban African-American mothers (n = 191) of infants and toddlers recruited from a primary health care facility (Hutcheson and Black, 1996), • children with disabilities (n = 725) from nine different states in America (Innocenti, Huh and Boyce, 1992; Smith, Oliver and Innocenti, 2001), • preschool children (n = 196) from low income families in rural United States (Reitman, Currier and Stickle, 2002), • the caregivers of children (n = 263) identified by the New England Consortium of metabolic programmes as suffering from genetic disorders (Waisbren, Rones, Read, Marsden and Levy, 2004), • Caucasian and African American families raising children 8–54 months old with Cerebral Palsy (Button, Pianta and Marvin, 2001). Acceptable test-retest reliability (an average score of .76) and high internal consistency (.85) were identified in the original validation study in rural and urban areas of Virginia (Abidin, 1995). The measure has been found to have good convergent and discriminant validity in non-clinical samples (Calkins & Dedmon, 2000; Irwin, Carter and Briggs-Gowan, 2002) and clinical samples (Silovsky and Niec, 2002). Moreover, the PSI-SF has been found to have high test-retest reliability and validity in a sample of children that are HIV positive in South Africa (Abidin, 1995; Potterton, Stewart and Cooper, 2007). Furthermore, changes in PSI-SF scores have been reported after the longitudinal evaluation of a parenting intervention programme in a rural (Cowen, 1998) and urban sample (Wolfe and Hirsch, 2003).

Variable	Measurement tool	Contextual reliability
Parenting of children 18 months to 5 years: Subscales for setting limits and supporting positive behaviour	Parenting Young Children Scale (PARYC; Subscales used had response options of 1 (*never*) through 7 (*almost daily in the past* month).	McEachern, Dishion et al. 2012 demonstrated that the PARYC scale had validity among high risk caregivers from rural communities in Charlottesville and Pittsburgh. The cross-cultural and test-retest validity of the PARYC measure has been demonstrated in the South African context (Ward, Wessels, Lachman, Hutchings, Cluver, Kassanjee, Nhapi, Little and Gardner, (2019). Parenting for Lifelong Health for Young Children: A randomized controlled trial of a parenting program in South Africa to prevent harsh parenting and child conduct problems. *Journal of Child Psychology and Psychiatry*, 61, 503–512. doi: 10.1111/jcpp.13129.
Caregiver's mental health	The General Health Questionnaire (GHQ) provided a measure of respondents' mental health. More specifically, it served as a screening tool to detect symptoms related to (1) depression, (2) anxiety, (3) somatic problems and (4) social withdrawal (Goldberg and Hillier, 1979). The questionnaire consists of 28 items (e.g., "Have you been getting scared or panicky for no good reason?" "Have you been getting edgy and bad tempered?"; Goldberg and Hillier, 1979). The response options were: 1 *(better than usual)*, 2 *(same as usual),* 3 *(worse than usual)*, or 4 *(much worse than usual).*	By using a binary scoring method any score greater than 4 indicated 'psychiatric caseness' (Goldberg and Hillier, 1979). The reported Cronbach alpha coefficients for the GHQ fall in a range of 0.79 to 0.95 in numerous studies (Jackson, 2007). Furthermore, the instrument has been shown to be a reliable and valid measure of psychological well-being in over 38 different contexts (Jackson, 2007), namely: the Netherlands, where the original validation study was conducted (Goldberg and Hillier, 1979), India (Sriram, Chandrashekar, Isaac and Shanmugham, 1989), Spain (Lobo, Pérez-Echeverría and Artal, 1986), Germany (Schrnitz, Kruse and Tress, 1999), Greece (Fichter, Xepapadakos, Quadflieg, Georgopoulou and Fthenakis, 2004), and the UK (Jones, Rona, Hooper and Wesseley, 2006).
Caregivers' use of alcohol	The alcohol subscale from the ASSIST was used to assess the risk level of the respondents' alcohol intake (e.g., "have you ever tried to control, cut down or stop using alcohol?") (Group, 2002; Humeniuk et al., 2010).	The ASSIST has been validated in a number of diverse settings, including the USA, Spain, India, Zimbabwe and South Africa (Humeniuk, Ali et al. 2008, Ward, Mertens et al. 2008, Rubio Valladolid, Martínez Raga et al. 2014, Sorsdahl, Myers et al. 2015). The ASSIST was found to have high internal consistency (α = 0.81 - 0.95), as well as convergent and discriminant validity in a sample (n = 200) of South African emergency centre patients (van der Westhuizen, Wyatt, Williams, Stein and Sorsdahl, 2016).

Variable	Measurement tool	Contextual reliability
Caregivers' exposure to intimate partner violence	Sixteen items from the Conflict Tactics Scale – Revised (CTS) (Straus, Hamby, Boney-McCoy and Sugarman, 1996) were used to assess levels of intimate partner conflict and violence. These items explored psychological and physical aggression. These ranged from mild to severe forms of aggression and violence (e.g., "My partner insulted or swore at me"; "My partner used a gun or a knife on me"). The CTS is the most widely used measure of intimate partner violence (IPV) (Newton, Connelly and Landsverk, 2001; Straus et al., 1996).	The measure was found to have good internal consistency and factor validity in diverse samples (e.g., 295 high-risk postpartum women; 1 266 Spanish women; 359 women imprisoned in Maryland's maximum security institution; Calvete, Corral and Estévez, 2007; Lucente, Fals-Stewart, Richards and Goscha, 2001; Newton et al., 2001). Moreover, the scale has been shown to have high internal consistency reliability, and construct validity in a number of male-dominated countries such as: South Africa (Swart, Seedat, Stevens and Ricardo, 2002), Thailand (Kerley, Xu, Sirisunyaluck and Alley, 2010), Botswana (Jankey, Próspero and Fawson, 2011), Mozambique (Lehrer, Lehrer and Zhao, 2009), Chile (Lehrer, Lehrer and Zhao, 2009), China (Hou, Yu, Ting, Sze and Fang, 2011), Israel (Haj-Yahia and Dawud-Noursi, 1998), as well as in fairly gender-equal countries (Straus and Mickey, 2012).
Child report of caregiver behaviour	Those children aged 10–17 whose caregivers gave permission for them to be approached and who themselves assented, completed the Child Report Questionnaire of the APQ. This questionnaire includes 37 items regarding the female caregiver's behaviour towards the child, and equivalent questions pertaining to the male caregiver's behaviour (Shelton, Frick and Wootton, 1996). The parent's positive and negative behaviours are explored, namely: (1) parental involvement, (2) positive parenting, (3) poor monitoring/supervision, (4) inconsistent discipline, and (5) corporal punishment (Essau et al., 2006). The information received from children provided an outcome measure both to evaluate the intervention, and to assess the parent's self-reported parenting practices.	The measure was found to have satisfactory factorial validity in a sample of 1219 German school-children, ages 10–14 years (Essau et al., 2006). Furthermore, this measure has good construct reliability and validity across the five dimensions (Frick et al., 1999; Shelton et al., 1996).

Variable	Measurement tool	Contextual reliability
Exposure to the intervention	**Social activation awareness** Questions relating to the social activation process were included in the survey administered in 2017 and 2019 to determine to what extent caregivers were aware of the committee's activities and the brand developed to amplify the positive parenting movement. Caregivers were asked to select which statements were applicable to them from a list of 16 statements (example items: "*You know about the social activation group*", "*You have attended a meeting held by the social activation group*", "*You talk about the social activation meetings at home?*", "*You have read and signed the positive parenting manifesto*"). This measure yields a score out of 16 which can be used to evaluate the level of exposure to the programme. **Parenting programme attendance** There are two measures of programme attendance: (1) a binary variable which is whether a caregiver attended at least one programme session and (2) a continuous variable which records the number of sessions a caregiver attended.	

Appendix 2

Chart 8: Longitudinal sample characteristics

Variable		Wave 3 (n = 453)	Wave 4 (n = 316)	Wave 5 (n=406)
Child gender	Male [n, %] Female [n, %]	221 (50%) 223 (50%)	154 (49%) 160 (51%)	210 (53%) 189 (47%)
Child age		8.39 (5.12)	9.73 (5.11)	10.10 (5.92)
All children				
Positive parenting (Z score)		0.01 (0.99)	-0.03 (0.96)	0.07 (0.91)
Corporal punishment	Spank hand	–	2.26 (1.30)	2.03 (1.21)
	Slap child	–	1.22 (0.69)	1.30 (0.88)
	Hit hand	–	1.32 (0.80)	1.29 (0.87)
Internalising (T score)		50.18 (11.80)	51.35 (13.36)	45.14 (11.26)
	Clinical [n, %]	63 (17%)	63 (21%)	24 (7.3%)
	Borderline clinical [n, %]	25 (6.6%)	20 (6.7%)	17 (5.2%)
	Healthy [n, %]	288 (77%)	217 (72%)	288 (88%)
Externalising (T score)		48.18 (11.12)	49.22 (10.95)	45.00 (11.40)
	Clinical [n, %]	33 (8.8%)	25 (8.3%)	20 (6.1%)
	Borderline clinical [n, %]	31 (8.2%)	25 (8.3%)	16 (4.9%)
	Healthy [n, %]	312 (83%)	251 (83%)	293 (89%)
Older children (>=6 years)				
Positive parenting		4.08 (0.63)	4.10 (0.65)	3.94 (0.55)
	Positive parenting	4.40 (0.72)	4.35 (0.75)	4.19 (0.76)
	Poor monitoring	1.94 (0.73)	1.79 (0.69)	2.13 (0.74)
	Involvement	3.90 (0.82)	3.84 (0.75)	3.81 (0.81)
Corporal punishment	Spank hand	2.76 (1.61)	2.33 (1.35)	2.10 (1.26)
	Slap child	1.30 (0.83)	1.18 (0.64)	1.29 (0.90)
	Hit hand	1.71 (1.31)	1.33 (0.84)	1.32 (0.94)
Internalising (T score)		49.51 (10.65)	50.07 (10.77)	47.08 (10.11)
	Clinical [n, %]	32 (13%)	23 (12%)	19 (8.1%)
	Borderline clinical [n, %]	12 (4.9%)	15 (7.6%)	11 (4.7%)
	Healthy [n, %]	201 (82%)	159 (81%)	205 (87%)

Variable		Wave 3 (n = 453)	Wave 4 (n = 316)	Wave 5 (n=406)
Externalising (T score)		49.51 (11.15)	50.60 (10.26)	48.63 (9.86)
	Clinical [n, %]	29 (12%)	19 (9.6%)	19 (8.1%)
	Borderline clinical [n, %]	20 (8.2%)	17 (8.6%)	14 (6.0%)
	Healthy [n, %]	196 (80%)	162 (82%)	202 (86%)
Younger children (<6 years)				
Positive parenting		4.16 (1.44)	3.86 (1.58)	5.25 (0.86)
	Setting limits	3.98 (1.60)	3.62 (1.77)	5.15 (0.98)
	Supporting positive behaviour	4.34 (1.59)	4.10 (1.57)	5.36 (0.99)
Corporal punishment	Spank hand	–	2.10 (1.18)	1.83 (1.07)
	Slap child	–	1.31 (0.78)	1.32 (0.84)
	Hit hand	–	1.29 (0.71)	1.21 (0.62)
Internalising (T score)		51.44 (13.66)	53.82 (17.04)	40.29 (12.52)
	Clinical [n, %]	31 (24%)	40 (39%)	5 (5.3%)
	Borderline clinical [n, %]	13 (9.9%)	5 (4.9%)	6 (6.4%)
	Healthy [n, %]	87 (66%)	58 (56%)	83 (88%)
Externalising (T score)		45.69 (10.66)	46.56 (11.76)	35.91 (9.86)
	Clinical [n, %]	4 (3.1%)	6 (5.8%)	1 (1.1%)
	Borderline clinical [n, %]	11 (8.4%)	8 (7.8%)	2 (2.1%)
	Healthy [n, %]	116 (89%)	89 (86%)	91 (97%)
Child-reported parenting		2.84 (0.31)	3.51 (0.34)	–
Poor mental health		2.06 (4.16)	2.69 (4.12)	1.55 (3.41)
	Poor mental health	82 (18%)	82 (26%)	48 (12%)
	Good mental health	371(82%)	234 (74%)	358 (88%)
Risk of alcohol use disorder		4.57 (7.67)	5.36 (7.42)	4.64 (7.21)
	High risk	8 (1.8%)	3 (1.0%)	7 (1.9%)
	Moderate risk	79 (17%)	58 (20%)	64 (17%)
	Low risk	366 (81%)	235 (79%)	298 (81%)

Variable		Wave 3 (n = 453)	Wave 4 (n = 316)	Wave 5 (n=406)
Parental stress		91.65 (26.9)	84.22 (18.6)	74.49 (22.2)
	High	133 (30%)	52 (17%)	51 (13%)
	Typical	270 (61%)	237 (76%)	256 (63%)
	Low	43 (9.6%)	22 (7.1%)	98 (24%)
Intimate partner violence		3.98 (10.3)	5.14 (10.5)	2.90 (7.63)
	Current partner: Exposure	136 (30%)	115 (42%)	96 (28%)
	Current partner: No exposure	150 (33%)	80 (29%)	142 (41%)
	No current partner	167 (37%)	80 (29%)	105 (31%)
Social activation	Indirect program engagement	–	2.57 (3.26)	2.06 (2.16)
	Community engagement	–	2.98 (1.53)	2.46 (1.53)
Programme attendance	No attendance [n, %]	–	259 (82%)	343 (84.5%)
	<70 attendance [n, %]	–	30 (9.5%)	34 (8.4%)
	>=70 attendance [n, %]	–	27 (8.5%)	29 (7.1%)

For continuous variables, mean and standard deviation displayed

Appendix 3

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Waves 3 – 5

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