

ORIGINAL RESEARCH

“It Has Changed”: Understanding Change in a Parenting Program in South Africa



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Abstract

BACKGROUND Poor parenting that leads to child maltreatment during adolescence presents a major public health burden. Research from high-income countries indicates that evidence-based parenting program interventions can reduce child maltreatment. Much less is known, however, about how beneficiaries of these programs experience this process of change. Understanding the process that brings about change in child maltreatment practices is essential to understanding intervention mechanisms of change. This is particularly important given the current scale-up of parenting programs across low- and middle-income countries.

OBJECTIVES This study aimed to provide insight into how caregivers and adolescents attending a parenting program in South Africa perceived changes associated with abuse reduction.

METHODS Semi-structured interviews were conducted with caregivers and adolescents ($n = 42$) after the intervention, as well as observations of sessions ($n = 9$) and focus group discussions ($n = 240$ people). Participants were adolescents between the ages of 10–18 and their primary caregiver residing in peri-urban and rural program clusters in the Eastern Cape Province of South Africa. Data were coded in Atlas.ti, and thematic content analysis was conducted.

FINDINGS Based on participant perceptions, the Sinovuyo Teen parenting program workshops catalyzed change into practice by creating an environment that was conducive to learning alternatives. It did so through prioritizing a process of mutual respect, openness, and being valued by others, giving legitimacy to a respectful reciprocity and new ways of spending time together that enabled caregivers and teenagers to shift and normalize more positive behaviors. This in turn led to reductions in physical and verbal abuse.

CONCLUSIONS This study's findings may be of use to policymakers and practitioners who need to understand how parenting programs support parents and teenagers in increasing positive parenting approaches and changing potentially harmful practices. It additionally highlights the importance of assessing the experiences of both parents and teenagers attending such programs.

KEY WORDS adolescence, child maltreatment, parenting programs, qualitative study, South Africa.

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This study and intervention are additionally supported by the European Research Council (ERC) under the European Union's Seventh Framework Program (FP7/2007–2013) with ERC grant agreement 313421, the John Fell Fund (grant number 103/757), the Leverhulme Trust (grant number PLP-2014-095), and the University of Oxford's Economic and Social Research Council Impact Acceleration Account.

Conflict of Interest: J.D. and L.C. were involved in the design of the Sinovuyo Teen program. No profit or financial gain will be made from this program. All authors had access to the data and a role in writing the manuscript.

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INTRODUCTION

Poor parenting skills during adolescence is a key risk factor for child maltreatment.¹ A range of associated health impacts include ongoing violence perpetration,² mental health problems, substance use, and HIV infection.^{3,4} Additionally, failure to acquire necessary development during adolescence can have long-term adverse effects on individuals, families, and wider communities.⁵ As such, harsh and abusive parenting of adolescents comprises a major public health burden.

Research has increasingly recognized the positive impact of investment in adolescent health for those living in resource-poor settings.⁵ Evidence-based interventions have been developed as a response to the need to support parenting globally.¹ A growing body of research indicates how evidence-based parenting programs are effective for younger children.^{6–8} As such, a range of policies have widely promoted parenting programs,⁹ including legislation relating to family support in South Africa.¹⁰ There is, however, limited evidence for the effectiveness of these programs for adolescents.

Parenting interventions have largely been implemented and tested in higher income countries where support for parents and child protection services are already well established.¹¹ In low- and middle-income countries (LMICs) the risk factors to child development are often more acute because of poverty and its associated factors.¹² However, well-known, evidence-based programs present challenges in LMIC implementation, including licensing cost and need for qualified staff.¹³ UNICEF and the World Health Organization (WHO) have provided institutional support to developing countries in an attempt to address this inequity between high-income countries and LMICs in terms of access and rollout of interventions.^{14,15} However, a hierarchy of knowledge persists; “one review of reviews on child maltreatment prevention found 298 studies, of which all but 2 were from high-income countries.”¹⁶ To date there are no known randomized trials of a parenting program to prevent abuse of adolescents⁴ in LMICs.⁶ As such there remains a pressing need for more evidence-based parenting interventions to be implemented, evaluated, and tested in LMIC contexts.^{17–20}

In their systematic review and synthesis of qualitative research on parenting programs, Kane *et al.*²¹

identified a dearth of information concerning the mechanisms that makes parenting programs meaningful and helpful to parents. Although randomized controlled trials (RCTs) are considered one of the most rigorous designs for evaluating the effectiveness of an intervention, other knowledge is required to understand how the intervention is delivered and why it achieves (or does not achieve) its outcomes.²² Qualitative research on parenting programs that does exist commonly focuses on “sensitising policymakers and practitioners” to the relevance and accessibility of parenting programs.²¹ Recent studies of participant perceptions focus on barriers and facilitators, or how to practically implement programs.²³

This paper responds to the demand for “more primary qualitative studies of parents’ perspectives about parenting programs”²¹ by providing insight into how caregivers and teenagers attending a program in South Africa understood the changes that took place in their relationships. Understanding the process that brings about change in parenting practices is essential to understanding how such interventions work as they are scaled up across LMICs.

The Sinovuyo Teen Parenting Program. Sinovuyo Teen (meaning “we have joy” in isiXhosa) is an evidence-informed Parenting for Lifelong Health (http://www.who.int/violence_injury_prevention/violence/child/plh/en/) program for at-risk families with 10–18 year olds. After 2 rounds of piloting that had promising results,²⁴ the final program comprises 14 workshop sessions. It uses a group-based format in weekly sessions attended by 1 primary caregiver and his or her teenager. Session content is additionally provided via home visits for those who miss group sessions. Delivery uses a nondidactic, collaborative learning approach, with activity-based learning, role play, illustrations, home practice, and rituals based on traditional practices of sharing a meal, singing, and sitting in a circle formation.

Sinovuyo Teen was designed by Oxford University and the University of Cape Town in collaboration with nongovernmental organization Clowns Without Borders South Africa and with input from 50 international experts and local families. A local nongovernmental organization trains local community members to deliver the program (“facilitators”) under their supervision. Participants attending the 2015 program were recruited either through referrals from local services (schools, social workers, chieftains) or via brief risk screening

¹⁶In accordance with WHO definition of *adolescence* as the period of growth that occurs between the ages of 10–19, the term *adolescents* will be used—or used interchangeably with *teenagers*—throughout.¹⁶

questionnaires to calibrate family stress and “shouting and fighting.”

The cluster randomized controlled trial took place in 2015–2016 in 40 settlements around King William’s Town, South Africa.²⁵ A total of 1104 (552 parent–teenager dyads) in 20 villages and peri-urban geographic areas received the program (with a further 270 dyads, the control group, not receiving the program). Immediate post-test results of the RCT indicated reductions in harsh and abusive parenting and improvements in involved parenting and supervision. Long-term RCT results are forthcoming.

METHODS

Study Design. This qualitative study was undertaken in partnership with UNICEF Office of Research—Innocenti.

Ethical protocols for this study were approved by the University of Cape Town (PSY2014-001) and University of Oxford (SSD/CUREC2/11-40). Verbal consent was obtained from each participant and from all caregivers of participating adolescents. Additional written consent was also obtained before interviews. Participants were assured of confidentiality. The moderator of the interview or focus group discussion explained the purpose of the study and its procedures. Respondents were assured that their participation was voluntary and that they could withdraw at any stage without consequence. There was no payment for participation.

Setting and Participants. This study was conducted in the Eastern Cape Province of South Africa. Data were collected in 20 rural and township clusters within a 2-hour driving distance from King William’s Town. This area is largely Xhosa-speaking and affected by severe poverty, high HIV prevalence, and limited service delivery.

Data Collection. We triangulated interviews, focus groups, observations, and facilitator notes from workshops. Semi-structured interviews were conducted with $n = 42$ (21 parent–teenager dyads) from the intervention group located in 10 clusters, of which 3 were peri-urban settlements and 7 were rural. Interviews were conducted from February–July 2016. Purposeful sampling at the cluster level was first performed to achieve a representative cross section of setting. Individual-level sampling from each cluster then considered the following dimensions to increase variability: gender, age, participation, and attendance (Table 1).

Interviews were conducted in participant homes in isiXhosa and lasted around 45 minutes. All in-

Table 1. Sample Characteristics for Qualitative Study Examining Participant Experience

Female caregivers	96%
Female adolescents	52%
Nature of relationship with adolescent	
Mother	37%
Grandmother	26%
Aunt	22%
Great-grandmother	4%
Uncle	4%
Cousin	7%
Rural cluster	74%
Average age adolescents	14
Average age caregivers	51
Total no.	42

terviews were recorded, translated, and transcribed with the exception of 2 adolescent respondents, who did not want to be recorded. Two semi-structured interview guides were piloted and refined for clarity and focus: 1 for caregivers and 1 for adolescents. Sixteen focus group discussions ($n = 240$); facilitator reports on workshops ($n = 280$); workshop observations ($n = 9$ workshops); and field notes were sources of additional data.

Focus group discussions (FGDs) were held in November 2016. Sampling was first done at cluster level for the purposes of including as much representational diversity as possible. FGD guides were developed, piloted, and clarified before use. Discussions were moderated in isiXhosa by trained research assistants, lasted around 90 minutes, and were noted.

Data Analysis and Validation. Braun and Clarke’s 6 steps of conducting thematic analysis were applied.²⁶ Themes were considered significant where there was consistency across and within study participants and/or when they deepened understanding and captured something important in relation to the research question. Data were uploaded and coded in Atlas.ti (Version 1.0.50 [282]; Scientific Software Development GmbH, Berlin, Germany). Coding disagreements were resolved between authors through discussion. Member checking took place during data collection with respondents to ensure consistency with meaning and accuracy.

Validation exercises were carried out on September 21, 2016, in King William’s Town, South Africa, with 7 caregivers from 4 clusters (2 rural, 2 peri-urban). This was to “check” the accuracy and interpretation of findings to ensure transparency. Findings from the validation exercise corroborated and emphasized aspects of the analysis represented here

but also introduced nuanced additions. Analysis resulted in the emergence of 2 main themes and several subthemes, which are discussed next.

RESULTS

The Epidemiology of Violence.

Violence and Discipline. At baseline, both caregivers (10 of 21) and teenagers (4 of 19) described a high level of violence in their homes. They gave frequent references to verbal abuse (“shouting”) and physical abuse (“beating”). Physical violence was often associated with discipline (8), sometimes referred to as “physical punishment” [Interview (Int) 22], and described as a routine form of household discipline.

Abuse & Stress. Controlling forms of verbal abuse and punishments were described as the most common means of communication by teenagers and caregivers alike. Caregivers (12) identified that they did not know how to communicate effectively with their teenagers without shouting [Int33]. Some retrospective comments from caregivers described physical curtailment as the only means available to them:

“If you raise your voice to a child or beat her, she will completely ignore you. I was like that before.... For example, do you see that room divider?... She broke it when I beat her. I beat her like I was beating an adult. I had a nasty temper...” [Int21]

In other cases, violent discipline was seen as protection for children against other threats within the home. During validation work, female caregivers explained that if the child stops misbehaving, then the father will not have to punish them and “the mothers will not have to fight for them.”

Some respondents retrospectively described that conflict at home before the program occurred in relation to family stressors such as food insecurity: “When we were hungry, she used to say that we dish for ourselves. When the young one comes hungry and wants food, she would tell her that she is busy. And the young one would cry.” [Teenager (T), Int2]

A few caregivers (3) contextualized their use of physical violence in relation to difficult marital relationships causing stress to themselves as individuals “... if I have fought with my husband I should not bring out my stress to the child.... I should not make her a punching bag whilst she is an innocent bystander.” [Int31]. Parental stress was also described by teenagers as a barrier to communication and understanding: “Mom was very confused person and

hectic. But after Sinovuyo she is normal and does listen. But before she did not listen.” [Int8]

Mechanisms of Change.

New Ways of Spending Time Together. Focused time together was identified as a primary contributor to positive relationship change across genders and age groups (17 of 21 caregivers [CG], 14 of 19 T). Both caregivers and teenagers noted the practice of spending “special time” together in particular as a “new” practice at home that resulted from attending workshops: “The thing I loved is that we attended as parents and their children. Not children on their own.” [Caregiver, Int31]

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

Related to this, the experience of workshops was characterized as “fun” by 18 of 19 teenagers—a word they used more than any other else to define the program. Caregivers made reference to “playing” and “laughing” and “talking” (Int3, Int4).

Workshop observations corroborate “having fun” as a key modality of interaction and the social adhesive effect this had on relationships and group dynamic. In combination with the structured program routine of discussion, exploration, practice at home [Int20], and reflection, this modality enabled learning that was different from daily experiences of most families.

Participants described a process of “mutual understanding” [Int29] and “mutual respect” [Int24], allowing them to explore different ways of relating. This was also apparent in home practice discussions in which participants (12 CG, 12 T) reported mutually practiced praise: “I learned that I should compliment my child when he has done well and he can do the same to me” [Caregiver, Int9]. Some teenagers also identified using praise outside the home to improve other relationships [Int2, Int42].

New Communication Strategies. Spending time together was identified as enabling healthier forms of communication: “It has changed. We can spend time together chatting.... We used to greet each other in passing.” [Caregiver, Int7]

“The thing I loved the most is learning to spend time with my mom, becoming close and talking about things.... I never used to want to be at home. But now I find it important to spend time with a parent and be open with her. And tell her my problems.” [Teenager, Int36]

Communication practices were often identified (16 CG, 14 T) as the most notable characteristic of

positive change in caregiver-teenager relationships: “We share our problems. And that makes us close.” [Teenager, Int26]

“We sit down and talk and it is really nice. He tells me about what goes on at school and he has really pushed himself. He even plays cricket, they received a trophy and I would praise him.” [Caregiver, Int5]

Alternative communication patterns were practiced for the first time in the safe space of the workshop. As such they describe something that was different to previous unquestioned practices of communication in households:

“As black people we do not speak of other things. We do not want to speak to our children about crucial matters. They taught us to communicate with our children, spend time with them and not side-line them on issues... They were very difficult to accept first, because they are certain things one hides from children... ” [Caregiver, Int11]

Caregivers described previous communication as guided by controlling behaviors designed to bolster parental authority and protect children from “problems”: “...as Xhosas we did not share our problems with our children.” [Int25]

Although the practice of these skills was new, some caregivers (5) and teenagers (3) described an awareness of communication alternatives that predated their workshop attendance: “I joined because I wanted to change my communication with friends. I used to be a bully against them, but now I no longer do that.” [FGD14, Teenager]

New communication patterns included caregivers sharing “moods” without vulnerability: “Sinovuyo taught us that when you share...like when a child needs something for school he must not be afraid to tell you, and he must get to know what sort of person you are, even your moods. And you have to ask him about the daily activities of school.” [Caregiver, Int39]

Participants identified that better communication improved problem solving (3 teenagers) and planning around risk (6 CG, 4 T). Caregivers highlighted new communication strategies as an alternative to violent discipline (8): “These children are disruptive. But now speaking to him is a priority rather than beating him, because now he listens when you instruct him.” [Caregiver, Int1]

Several caregivers applied the same logic to changes in discipline that involved “shout[ing]”:

“I learned that there is not [a need] to shout to a child in order to get your point across. I should be calm, sit him and gather the facts. So that he could be at ease to tell me. I should not raise my voice at him and beat him. However I must show him that I am disappointed in what he did.” [Int41]

Replacing Violent Discipline (Caregivers) and Aggressive Behaviors (Teenagers). Almost all of the interviewed caregivers attributed workshop attendance with a reduction in verbal abuse (20 of 21), and most referred to similar reductions in physical abuse (15). This was repeated to a significant extent amongst teenagers; 11 of 19 reported a reduction in verbal abuse and 9 identified a reduction in physical abuse, although there were discrepancies in how these were reported by caregivers and teenagers.^b

“Sinovuyo came with a big thing, because it educated us as people of a village. It gave us knowledge of thing[s] we had no clue about. Things that upbuilds, like how to nurture a child we discovered them there in Sinovuyo. Children should be treated equally. You must not hassle a child by beating him.” [Int39]

After program workshops, both caregivers and teenagers identified an awareness of stress and the opportunity to practice ways of managing stress (by, for example, “taking a pause” [Int1]) as a key contributor to changing patterns of violent discipline (3 CG, 3 T), with others describing a general improvement in anger and stress management (7 CG, 6 T). Some teenagers (6) reported reductions of aggressive behavior with peers and siblings: “I used to be aggressive on other kids but now I don’t do that anymore.” [Int2]

In interview, several participants (21 of 40) used the language of “right” to describe changes in their behavior, explaining that they had new “empowerment” [Int15] and confidence (“Perhaps I am the one who is changing the character of a child” [Caregiver, Int21]) in carrying behaviors they found to be more positive forward.

The challenges of having included 1 caregiver and 1 adolescent from each household may have implications in terms of program diffusion in the household as well as the sustained effects of the changes reported here, especially if the dyad is in the minority

^bVerbal abuse was generally more freely discussed; for example, 42 occurrences of codes for verbal and 27 for physical abuse appear within caregiver interviews.

at home. Ascertaining how the practices described here are sustained (or not) therefore warrants follow-up research.

A minority of participants reported no change (5 CG, 4 T), and others reported ongoing concern (6 CG, 3 T) despite program attendance. These examples are important to note—not as anomalies to what has been noted earlier, but as evidence of the varied experience of the program. The consequences of this type of experience of parenting interventions requires further research to understand the possible effects on participants who did not experience desired change. Such research may yield suggestions about the components of parenting programs that could be modified—for example, those affecting length or delivery—or associated areas of concern including the provision of ongoing social support.

DISCUSSION

The mechanism of change suggested through these findings implies that participants experienced significant behavioral changes during and in the 6 months after attending the Sinovuyo Teen program.

It is important to note that this study has several limitations. It is not known whether it is possible to generalize these results beyond the sites in the Eastern Cape of South Africa, where the data were collected. Though the findings of this study may be transferable to other LMIC contexts in a limited capacity, the impact of parenting culture and the socioeconomic context in which any program is being implemented are specific and need to be carefully calibrated during the program adaptation stage.

Additionally, there may be other mechanisms for change built into the delivery of the program in this trial. Further investigation may help to identify these. The self-report nature of the data we collected during this study is at risk for bias, particularly social desirability bias. Socially desirable responses may, however, have been minimized by assurances of anonymity to respondents and by having an external interviewer who was not involved in screening, recruitment, or delivery of the program.

However, the study also has important findings for understanding parenting and parenting support in South Africa. As a starting point, our findings do reflect a high frequency of child abuse in the Eastern Cape, and 34% of 16 year olds in South Africa report been beaten by a caregiver.²⁷ As such they align with Jewkes's data on childhood in rural South Africa, where "... physical punishment was particularly

common."²⁸ Violent discipline and high stress levels were key and interrelated features of family homes.²⁷ In particular, caregivers contextualized violence as a result of limited knowledge of alternatives or as unintentional acts arising from feeling overwhelmed. For some, violent discipline was an attempt to manage factors they had limited control over, such as food insecurity, or to protect adolescents from male household members.

A range of structural determinants were identified as influencing the nature of familyhood in South Africa, and these are important to understand in any assessment of beneficiary experiences of a parenting program. The systemic marginalization of black South Africans—particularly in former "homeland" rural areas—remains unreconciled into the democratic age.²⁹ Along with chronic poverty, this has had acute implications on familial structures^{30,31} as well as on perpetuation of violence as a result of disempowerment.^{32,33} Intergenerational poverty, high levels of unemployment, illness linked to HIV/AIDS, and poor living standards have been associated with stress and frustration.^{27,34,35} In this study, participants report reliance on informal networks of support (evidenced through references to how the household is perceived by other family or community members [Caregiver, Int3]), and the importance of the social networks (which provides "tea and food and... talk" [Caregiver, FGD1]) that have been established through the program. This suggests an associated need to preserve a good reputation of their households in the context of poverty and poor infrastructural development to maintain access to social support in the event of a crisis, and the use of physical discipline of children in an attempt to ensure this.³⁶

Our findings suggest that parenting workshops allowed caregivers and teenagers to explore alternatives to harmful behaviors that they already thought were damaging. Spending dedicated and focused time together, first through the novel experience of attending workshops together and then through bringing workshop ideas and questions home, created a forum for positive exchange and different communication practices. Workshops were both "safe," integrating known aspects such as eating together, and also characterized by the modality of "fun." This created a fertile environment for thinking critically about behaviors and brainstorming and sharing ideas about how to catalyze change.

The emphasis on "fun" should be understood in relation to families perceiving parenting as a continued effort toward survival. In particular, parenting

was described by participants as a protective function shielding adolescents from “problems” over which parents had little agency.²⁷ Relevant literature identifies that “spending time” is largely understood through a mutuality of care-chores.²⁷ Reversing familial power structures by, for example, encouraging teenagers to lead adults during workshop physical exercises engages a sense of play and experimentation as an opportunity to test adult and child boundaries. Literature supporting the act of “play” as an ideal conduit for learning in early childhood may resonate here³⁷ and suggests that fun may be a modality worth exploring in the delivery of parenting programs.

Alternative forms of communication were the primary vector through which relationship improvements were understood by participants. Literature from South Africa suggests that caregivers may have had preexisting notions that their previous approaches were ineffective but were unsure about how to shift these in “an era where corporal punishment is no longer legal, and the absence of something effective to take its place.”³⁶ However, more research would be useful in developing further understanding in this area, especially as we lack research on caregiver-teenager communication dynamics in sub-Saharan Africa³⁸ beyond sexual risk taking and HIV.^{34,39-42}

Caregivers and teenagers reflected on improvements when they “sat down together” and talked. This may reflect potential for nurturing mutual empathy, in contradistinction from authoritarian modes of communication that had been reported before attending workshops. Facilitator notes reflect that in 1 rural family, 1 teenager was better able to keep his curfew when his caregiver explained to him the reason for being home before 6 PM was to bring the cows in. Investing in communication can affect adolescent feelings of being respected. Adolescents and caregivers described the feature of praise as central to their new way of interacting. In isiXhosa “Ukuncoma ngokugqibeleleyo” suggests that this kind of praise is heartfelt and genuine, with no conditions attached.

The mutual benefit of improved communication reported by both caregivers and adolescents extends the notion of a type of respectful reciprocity²⁷ and may be consistent with the increase in social awareness during adolescent development.⁴³⁻⁴⁵ Our findings suggest that the program gave legitimacy to this reciprocity through enabling caregivers and teenagers to retrieve a sense of being valued and being able to confer value on others in the “fun” space of the workshop without fearing consequences. Although literature commonly refers to “parenting support pro-

grams,” these should rather be understood as “parent and adolescent programs” so that the mutual participation and benefits are marked from the outset. This is consistent with changes in how caregivers and adolescents relate, as reported by Bray³⁴:

“...this generation of children—especially young Africans—is taking advantage of a greater latitude in the structures and norms governing family dynamics to nurture relationships that contain certain qualities, for example trust, open communication, reciprocity and mutual respect.”

Positive practices were experienced as “new” in caregiver-teenager relationships but were actually consistent with personal ideals that had been buried by poverty and stress. Literature suggests that this prior knowledge may have been overlaid with controlling behaviors toward others to shore up an eroded sense of agency.⁴⁶ Reports of both caregivers and teenagers practicing these skills outside of the workshop (caregivers) and in friendship groups (teenagers) up to 6 months after attending workshops suggest the potential for the ongoing sustainability of these skills and some suggestion of confidence in carrying them forward.

The findings described here thus resonate with literature from the WHO that reports that “many evidence-based parenting programs are not specifically geared toward violence or maltreatment prevention; instead, they are designed to encourage healthy relationships, improve parental strategies, and decrease child behavior problems.”⁴⁷ These findings also reinforce why it is important to engage both caregivers and teenagers in evaluating parenting interventions, namely because this methodology supports an understanding in dynamic shifts as they are experienced by both parents and teenagers. This includes gaining insight into ongoing risks that are reported at home, which may be useful in further refining programs.

Further studies may also yield insight into other possible mechanisms for change—such as the “fun” element espoused by Clowns Without Borders, which may not be captured by others who are not experts at helping people to laugh.

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The caregivers and adolescents who contributed their time and trusted us to honestly represent their experience of participating in the Sinovuyo Teen parenting program contributed invaluable content to this study. We are additionally grateful to the many research assistants in South Africa and Oxford who contributed to the execution of this study.

APPENDIX ANONYMIZED DATA

Interviews:

Int1: 30 March 2016, Caregiver, F, 31-40 years old, Dyad 1, rural
 Int2: 30 March 2016, Teen, F, 10-14 years old, Dyad 1, rural
 Int3: 3 March 2016, Caregiver, F, 51-60 years old, Dyad 2, rural
 Int4: 3 March 2016, Teen, F, 15-18 years old, Dyad 2, rural
 Int5: 9 March 2016, Caregiver, F, 41-50 years old, Dyad 3, rural
 Int6: 9 March 2016, Teen, M, 10-14 years old, Dyad 3, rural
 Int7: 30 March 2016, Caregiver, F, 51-60 years old, Dyad 4, rural
 Int8: 30 March 2016, Teen, M, 15-18 years old, Dyad 4, rural
 Int9: 21 March 2016, Caregiver, F, 41-50 years old, Dyad 5, rural
 Int10: 2 April 2016, Teen, M, 15-18 years old, Dyad 5, rural
 Int11: 1 May 2016, Caregiver, M, 18-30 years old, Dyad 6, rural
 Int12: 1 May 2016, Teen, M, 10-14 years old, Dyad 6, rural
 Int13: 13 April 2016, Caregiver, F, 51-60 years old, Dyad 7, rural
 Int14: Teen, F, 15-18 years old, Dyad 7, rural
 Int15: 13 April 2016, Caregiver, F, 51-60 years old, Dyad 8, rural

Int16: 16 April 2016, Teen, M, 10-14 years old, Dyad 8, rural
 Int17: 19 February 2016, Caregiver, F, 51-60 years old, Dyad 9, rural
 Int18: 19 February 2016, Teen, M, 10-14 years old, Dyad 9, rural
 Int19: 19 February 2016, Caregiver, F, 41-50 years old, Dyad 10, rural
 Int20: 19 February 2016, Teen, M, 15-18 years old, Dyad 10, rural
 Int21: 6 February 2016, Caregiver, F, 41-50 years old, Dyad 11, rural
 Int22: 6 February 2016, Teen, F, 10-14 years old, Dyad 11, rural
 Int23: 6 February 2016, Caregiver, F, 41-50 years old, Dyad 12, rural
 Int24: 6 February 2016, Teen, M, 15-18 years old, Dyad 12, rural
 Int25: 5 March 2016, Caregiver, F, 51-60 years old, Dyad 13, rural
 Int26: 7 May 2016, Teen, F, 10-14 years old, Dyad 13, rural
 Int27: 25 April 2016, Caregiver, F, 71-80 years old, Dyad 14, peri-urban
 Int28: 7 May 2016, Teen, F, 15-18 years old, Dyad 14, peri-urban
 Int29: 27 May 2016, Caregiver, F, 61-70 years old, Dyad 15, peri-urban
 Int30: 27 May 2016, Teen, M, 15-18 years old, Dyad 15, peri-urban
 Int31: 16 February 2016, Caregiver, F, 41-50 years old, Dyad 16, peri-urban
 Int32: 27 February 2016, Teen, F, 10-14 years old, Dyad 16, peri-urban
 Int33: 29 April 2016, Caregiver, F, 61-70 years old, Dyad 17, peri-urban
 Int34: 29 April 2016, Teen, F, 10-14 years old, Dyad 17, peri-urban
 Int35: 16 February 2016, Caregiver, F, 51-60 years old, Dyad 18, peri-urban
 Int36: 26 April 2016, Teen, F, 10-14 years old, Dyad 18, peri-urban
 Int37: 16 February 2016, Caregiver, F, 61-70 years old, Dyad 19, peri-urban
 Int38: Teen, F, 10-14 years old, Dyad 19, peri-urban
 Int39: 9 March 2016, Caregiver, F, 31-40 years old, Dyad 20, rural
 Int40: 16 March 2016, Teen, M, 15-18 years old, Dyad 20, rural
 Int41: 21 March 2016, Caregiver, F, 41-50 years old, Dyad 21, rural
 Int42: 24 March 2016, Teen, M, 10-14 years old, Dyad 21, rural

Focus Group Discussions:

FGD1: 17 November 2015, Caregivers (rural)
FGD2: 17 November 2015, Adolescents (rural)
FGD3: 18 November 2015, Caregivers (rural)
FGD4: 18 November 2015, Adolescents (rural)
FGD5: 19 November 2015, Caregivers (peri-urban)
FGD6: 19 November 2015, Adolescents (peri-urban)
FGD7: 20 November 2015, Caregivers (peri-urban)

FGD8: 20 November 2015, Adolescents (peri-urban)
FGD9: 24 November 2015, Caregivers (rural)
FGD10: 24 November 2015, Adolescents (rural)
FGD11: 25 November 2015, Caregivers (peri-urban)
FGD12: 25 November 2015, Adolescents (peri-urban)
FGD13: 26 November 2015, Caregivers (rural)
FGD14: 26 November 2015, Adolescents (rural)
FGD15: 27 November 2015, Caregivers (rural)
FGD16: 27 November 2015, Adolescents (rural)

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