GENDER & ADOLESCENCE: GLOBAL EVIDENCE

# What are the impacts of parenting programmes on adolescents?

## A review of evidence from low- and middle-income countries

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# Acronyms

| | |
|---|---|
| BFOOY | Bahamian Focus on Older Youth |
| CDC | Centers for Disease Control and Prevention |
| CHAMP | Collaborative HIV/AIDS and Adolescent Mental Health Programme (South Africa) |
| CImPACT | Caribbean Informed Parents and Children Together |
| COMPASS | Creating Opportunities through Mentorship, Parental Involvement, and Safe Spaces |
| DREAMS | Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (USAID) |
| EWA | Exploring the World of Adolescents (Viet Nam) |
| FMP | Families Matter! programme |
| FOYC | Focus on Youth in the Caribbean |
| FSI | Family Strengthening Intervention for HIV-affected Families (Rwanda) |
| GAGE | Gender and Adolescence: Global Evidence |
| GGI | Go Girls! Initiative |
| ILO | International Labour Organization |
| IMAGE | Intervention with Microfinance for AIDS and Gender Equity |
| IPV | intimate partner violence |
| LGBTQI+ | lesbian, gay, bisexual, transgender, queer/questioning, intersex + |
| LMIC | low- and middle-income country |
| NGO | non-governmental organisation |
| OCD | obsessive compulsive disorder |
| PAHO | Pan American Health Organization |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| RCT | randomised control trial |
| SRH | sexual and reproductive health |
| STI | sexually transmitted illness |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNICEF | United Nations Children's Fund |
| UNODC | United Nations Office on Drugs and Crime |
| USAID | United States Agency for International Development |

# Executive summary

Recognising the critical role of families in adolescents' development and well-being, and the widening set of challenges facing adolescents today, governments and non-governmental organisations (NGOs) in low- and middle-income countries (LMICs) are increasingly implementing parenting programmes to better equip families to support healthy adolescent development. In this review, we define parenting programmes as 'activities oriented to improving how parents approach and carry out their role as parents and to increasing parents' child-rearing resources, including, knowledge, skills and social support'.[1] Such programmes initially focused on the parents of young children; their expansion to parents of older children is relatively recent, and there is no synthesised analysis of their impact.

Qualitative research by the Gender and Adolescence: Global Evidence (GAGE) programme highlights the high priority adolescents give to warm and supportive intra-family relationships, but also the extent to which they experience violence from parents and caregivers. This review aims to understand how far parenting programmes are useful tools for policy-makers and programmers aiming to promote adolescent well-being and development. It also aims to synthesise what is known about gender-differentiated effects and gendered participation in these programmes – a topic that is under-explored in the literature.

## Study methodology

This rigorous narrative review presents evidence from 58 studies of 42 initiatives intended to improve the quality of parenting that adolescents receive. The review followed systematic search principles with a multi-pronged search strategy, involving database searches, handsearches of relevant websites, named programmes and specific authors, and targeted inquiries to experts. To be included, studies had to discuss an intervention in an LMIC aimed at the parents of adolescents, with a focus on improving the quality of parenting, to have been published since 2000 and to be in English or Spanish.

They also had to involve a valid comparison; beyond this, we did not require specific research designs or methodologies, as we were keen to include insightful studies from a range of approaches. However, 83% of studies included in the review were based on rigorous quantitative designs (randomised control trials (RCTs) and quasi-experiments) and almost all quantitative studies used previously validated scales for measurement. This high percentage of RCTs reflects the unusually high proportion of experimental and pilot initiatives. A substantial number of the studies (40%) included qualitative insights, indicating that mixed methods were common. Only six studies of four programmes were undertaken a year more after participants completed the programme, following participants for up to four years. Encouragingly, all showed lasting effects.

All studies examined parents' self-reported outcomes and just under half (48%) accompanied these insights with adolescents' reports of changes in their parents' behaviour and attitudes towards them, which sometimes confirmed and sometimes challenged changes reported by parents. The indicators used by each review varied significantly; hence we simply classify changes as positive, negative or no change, and present the numbers of each type of change on each indicator, rather than attempting any meta-quantitative analysis of changes.

A key limitation of this review – as with any review of evaluations – is the highly varied level of detail in which studies discussed programmes and the extent of reflection on factors that may have influenced impacts. In particular, journal articles (93% of studies examined), which are constrained by word limits, often lacked detailed reflection on findings or discussion of implementation insights. Despite efforts to contact study authors, we were only able to obtain additional details and insights on one programme (Families Matter!). The review includes detailed case studies of two well-documented programmes: Families Matter! and Sinovuyo Teen.

1 This definition draws on Daly, et al., (2015).

## Overview of programmes examined

The programmes examined took place in 32 countries, the vast majority in sub-Saharan Africa (37%) and Latin America and the Caribbean (35%), with East and South East Asia the next most represented region (11%). At least 10 programmes were initially developed with marginalised groups in the Global North and adapted to Southern contexts. More programmes were implemented in urban than rural areas, though locations were not always clearly specified. In Latin America and Sub-Saharan Africa, group education strategies dominated, with some examples of other methods and formats, particularly in Latin America. In the MENA region, small-scale experimental initiatives aimed at specific groups of parents (such as parents of adolescents with intellectual disabilities or mental health challenges) were the most common. These differences may reflect the specific programmes found through our search processes, rather than necessarily reflecting differences in approach between different regions.

Most programmes were small (72% had fewer than 500 participants), though it should be noted that most studies reported their sample size rather than total number of participants, while some studies examined the implementation in one country of much larger multi-country initiatives. This review includes studies from the three most widely implemented parenting programmes in LMICs (Families Matter!, Strengthening Families Programme/ Familias Fuertes and Parenting for Lifelong Health/ Sinovuyo Teen). One of these, Families Matter! has reached more than 1 million participants to date. These large scale programmes were all implemented through group education sessions, with some home visits in the case of Sinovuyo. The programmes delivered via other methods, such as home visits or phone support, were all very small-scale, and the studies examined did not comment on their scalability.

A third of programmes worked only with parents (or other main caregivers, referred to as parents in this review). More than a third (40%) worked with parents and adolescents together, while the remainder worked with each group separately, or did not specify this information. While programmes worked with parents of adolescents across the 10–19 years spectrum, the largest number of programmes were attended by parents of 12–15-year-olds.

In 75% of programmes, participants were either solely or mostly women; the impact of this female bias varied, depending on prevailing gender norms – where fathers were absent, the female focus had little effect; in settings where patriarchal gender norms prevailed, participants often identified the need for fathers to participate as a factor impeding effectiveness. Low levels of male participation were attributed to programmes being perceived as irrelevant or more suitable for women as 'primary caregivers', and in some cases to male migration, or to the demands of unpredictable work. One programme run in workplaces was predominantly attended by men, suggesting a possible route to better engaging fathers of adolescents. None of the studies commented on differences in learning or impact between biological parents and other caregivers (e.g. grandparents, aunts, or step-parents).

By far the most common mode of delivery was through group classes (80% of programmes), with a few programmes providing home visits, self-study booklets or telephone sessions, or combining these with group sessions. Programme design did not vary substantially by region, though the three largest scale programmes (Families! Matter, Strengthening Families Programme/ Familias Fuertes and Parenting for Lifelong Health/ Sinovuyo Teen), all of which are based on group sessions, were all implemented in Sub-Saharan Africa and Latin America (with some additional examples in other regions).

Programmes varied in duration from one day to a year, with the most common duration being 4 weeks (21% of programmes) and 12–16 weeks (40%). We found no clear relationship between programme length and impact. The largest scale programmes, honed through iteration over fifteen years or more, have developed a model whereby classes take place over two to three months; however, our study did also find lasting impacts from short workshops on SRH knowledge and behaviour. Only two programmes involved delivery of other services (microfinance and integrated family support/social work services). However, many programmes (particularly those focusing on sexual and reproductive health (SRH)), provided participants with information about available services.

## Key findings

**Parenting skills**. Forty studies of 28 programmes examined changes in parenting skills, such as general skills in communicating with adolescents and positive discipline. (We report separately on studies of communication around a specific issue, such as HIV or alcohol). Fourteen out of 18 studies reported increased

communication between adolescents and parents, and 12 out of 18 reported better-quality family relationships, with 6 out of 9 reporting reduced neglect. Both qualitative and quantitative studies identify improved communication as the most important factor underlying improvements in other adolescent well-being outcomes, such as reduced experience of violence, and improved mental health indicators. Where studies distinguished changes in communication between male and female parents and adolescents, more adolescents reported changes in communication with their mothers, probably reflecting higher levels of participation among mothers.

**Freedom from violence.** Eighteen studies of 14 programmes examined changes in attitudes to or perpetration of violence against adolescents. The programmes contributed to reduced acceptance of violent discipline (4 out of 5 studies), and reductions in parents' self-reported use of physical and verbal violence (10 out of 12 studies). Adolescents generally perceived less change than their parents and caregivers (in around half the studies, they perceived no reduction in violence). Discrepancies may reflect differences in parents' intentions or how they expected to react and, in some cases, low levels of violence at outset.

**Psychosocial well-being.** Twenty-six studies of 21 programmes examined aspects of psychosocial well-being. These evaluations highlight the importance of improved family dynamics in enhancing overall levels of psychosocial well-being and reducing problematic behaviour. Studies of nine programmes found increases in adolescents' psychosocial well-being (measured by indicators such as self-reported reductions in depression and stress, and increases in life satisfaction); nine also found evidence of reduced adolescent behaviour problems, such as aggressiveness and internet addiction. Seven studies found positive effects on parents' mental health, three of which also found positive impacts on adolescents' mental health. As with the studies investigating other themes, patterns of impacts were complex, with several studies showing changes on some indicators but not others.

**Substance abuse.** Ten studies of 9 programmes examined adolescent substance abuse-related outcomes; 56% of reported outcomes were positive, which is lower than for other issues covered in this review. These were primarily preventive programmes, and findings may reflect relatively low levels of substance abuse at outset and thus limited change in adolescents' behaviour. However, all studies found evidence that these programmes had increased parents' communication around substance abuse issues, and some also reported qualitative evidence of a reduction in parental use (and, in one case

Mother with her children in Afar, Ethiopia. © Nathalie Bertrams/2019

children's use) of drugs or alcohol. These studies did not disaggregate impacts by gender.

**Sexual and Reproductive Health (SRH).** Thirty-one studies of 23 programmes examined impact on SRH outcomes; 76% of all reported SRH outcomes were positive and 91% of programmes (21 out of 23) had a positive effect on at least one outcome. These programmes enhanced parents' own knowledge and self-confidence to discuss SRH issues with their children – an important building block for subsequent communication and support. Three programmes also changed parents' minds about the appropriateness of talking with adolescents about SRH issues, through greater understanding of adolescents' sexual development, and through practising skills in conversations about sexual health and risk prevention. Both before and after programme participation, communication patterns between parents and adolescents continued to be gendered, with mothers preferring to talk to daughters about SRH issues and fathers to sons; there was some evidence of programmes helping break down taboos about cross-gender and generational communication around SRH issues.

**Economic well-being.** Qualitative insights from the studies reviewed highlight the impact of poverty on parental stress and its detrimental consequences for adolescent well-being. Three programmes included financial management issues such as budgeting and saving in their parenting skills curricula. In all cases, this led to greater knowledge, and to greater communication around financial matters between parents and adolescents; in one case (Sinovuyo Teen in South Africa), it may have contributed to the recorded improvement in participant families' economic well-being. One programme offered both microfinance and parenting skills education – another promising model. Only one programme (School for Parents) offered parenting classes as part of integrated social support, including cash transfers and help with finding work and accessing public services. This contrasts with parenting programmes for the parents of younger children where such integration is more common and points to a potentially promising approach.

**Gender equality.** Six programmes (15%) explicitly aimed to change parents' gender attitudes or to encourage equal treatment of sons and daughters, or to help parents equip adolescents to negotiate gender-inequitable environments. Studies of three programmes found changes in attitudes or behaviour around gender roles, with the greatest change recorded in the programme with the strongest emphasis on gender equality. Two studies found changes in parents' perceptions of the appropriate age of marriage for daughters; one initiative did not set out to change attitudes and practices concerning gendered SRH communication but was effective in doing so. Evaluations of nine programmes disaggregated findings by gender of parents, adolescents, or both. Participant mothers tended to show greater increase in knowledge on SRH and legal rights issues (e.g. age of marriage) than fathers, probably reflecting their lower levels of education and access to information at outset. It is important to note that the limited coverage of gender issues in these studies may under-report activity in practice.

**Promising practices.** Although the studies reviewed did not compare the impacts of different strategies, qualitative feedback suggests a number of promising ways of promoting more effective parenting. These include group sessions involving opportunities to practise communication skills, joint parent-and-adolescent sessions that enable understanding of one another's perspective and to focus on improving family dynamics together, and video or audio material that models sensitive and effective communication, in general or on specific issues. Handouts, especially with significant visual content, have helped consolidate learning and spread new information to other family members. The few studies that probed facilitator training highlighted the importance of ongoing face-to-face support, and a manual for back-up, and suggested that pairing facilitators is often helpful. They also emphasised continued support for to ensure that facilitators cover all content (including content they may find challenging or embarrassing), and receive periodic support to maintain participatory learning environments. Other innovative practices worthy of greater exploration include developing 'buddies' who can help sustain learning and practice between sessions, and experimenting with provision of classes at a wider range of venues, including workplaces and religious institutions.

## Conclusions and recommendations

This review indicates that parenting education programmes can be an effective way to increase communication between adolescents and their parents and caregivers, to reduce harsh punishment and verbal/emotional violence, and to improve adolescents' psychosocial well-being. There

is also evidence that such programmes can help parents communicate more effectively with their adolescent children around SRH issues and substance abuse. The review also identified the following gaps, which if addressed could strengthen impact.

**Embed a stronger focus on gender equality.** The apparent lack of explicit attention to gender equality in many programmes is a missed opportunity to challenge embedded discriminatory gender norms and stereotypes that affect adolescents. This could involve a stronger emphasis in generic materials on understanding adolescence on recognising gender stereotypes, norms and inequitable practices; explicit attention to gendered power dynamics in interventions aiming to promote better communication around SRH issues; and (depending on the context) attention to issues disproportionately affecting adolescents of a particular gender, such as child marriage, sexual exploitation, or vulnerability to gang violence. There may be a trade-off between increasing the number of sessions and retaining parents in the programme.

**Engage fathers in parenting programmes.** Make greater efforts to engage fathers, possibly via shorter courses, timing courses so they do not clash with work commitments, or experimenting with fathers-only groups or home visits. Workplace-based programmes may offer a route to reaching fathers (as in the Let's Talk initiative in South Africa), as may offering sessions or support in social or faith-based settings. The growing number of initiatives engaging the fathers of young children in parenting education may also offer relevant lessons.

**Explore the potential to integrate parenting education more strongly with anti-poverty and social protection programmes.** This could help reduce parental stress and violence, and give parents more time or energy to communicate with adolescents. There may be lessons from large-scale programmes offering parenting support to parents of young children alongside a wider set of anti-poverty services, such as Chile Solidario and Chile Crece Contigo. Consider also offering parenting education in the context of skills training, job matching services, cash transfers or entrepreneurship support initiatives, as with the Sisters for Life parenting/ Intervention with Microfinance for AIDS and Gender Equity (IMAGE) programme in South Africa.

**Make greater efforts to ensure programmes are reaching marginalised groups.** Half the programmes in this review reported working with marginalised groups such as low-income families (15 programmes), parents of adolescents with intellectual disabilities (2 programmes), and parents of adolescents with mental health difficulties or addictive behaviour (3 programmes). None mentioned efforts to include, or tailor content to, parents of adolescents with other disabilities. Only one study mentioned that its SRH curriculum included homosexuality. Given that studies in high-income countries have shown that family support and acceptance is critical for lesbian, gay, bisexual, transgender, queer/questioning, intersex + (LGBTQI+) young people's mental health, it would be valuable to establish guidance on how programmes can sensitively discuss these issues in contexts where backlash may be strong and/or homosexuality is illegal.

**Enhance evaluation and reporting** to provide greater insights into the following:

- *The effectiveness of particular programme components or approaches* – for example, testing the impact of separate parent and adolescent groups compared with combined groups; the impacts of different programme and session durations; the impact of integrating parenting programmes with other services, compared to a stand-alone initiative; offering programmes in a wider range of locations; and innovations such as buddies to consolidate learning, or booster sessions after programme completion.
- *The quality and fidelity of implementation* (how closely facilitators stick to programme curricula and activities) and how this affects impacts.
- *The long-term impacts* – only 7 studies of 4 initiatives examined whether impacts had lasted beyond a year (the focus of those initiatives ranged from SRH knowledge and condom skills, to family communication around SRH and economic issues, and preventive support to families whose parenting practices had led them to court); all 7 studies found that they had. It would be worthwhile undertaking further follow-up of large-scale, longstanding programmes to identify the changes that have persisted and the factors that have led to lasting impacts. It would be particularly beneficial to explore the impact of efforts to change norms that affect parenting in more depth, and the value of booster sessions to maintain learning.
- *The indirect impacts of programmes,* such as whether there are any traceable impacts on adolescents' education (for example, resulting from reduced violence, improved mental health, or from greater parental communication with adolescents).

# 1 Introduction

There is an increasingly recognised crisis in adolescent well-being worldwide. Adolescents make up 76% of out-of-school children and young people (United Nations Educational, Scientific and Cultural Organization (UNESCO), 2018), with young women three times as likely as young men to be not in education, employment or training (International Labour Organization (ILO), 2017). Mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years, and globally, suicide is the third most common cause of death among 15–19-year-olds. The United Nations Children's Fund (UNICEF) estimates that every seven minutes, somewhere in the world, an adolescent is killed through an act of violence (UNICEF, 2017).

There is much evidence that children and adolescents who have received good nutrition, cognitive stimulation and warm, responsive parenting with consistent limit-setting are more likely to do well in education, be healthy as adults and less likely to engage in risky sex, substance misuse, and violent and criminal behaviour (Cunningham et al., 2008; Ward et al., 2015). As children move into adolescence, and experience rapid physical development (including puberty), brain development and social development, they negotiate new challenges that in turn require changes in parenting. Typically, adolescents' sexuality starts to develop, and they are exposed to a wider set of influences beyond family and school, including some that can encourage risky behaviour. However, as Ward et al. (2015: 69) argue, 'the evidence suggests that parenting remains critical to young people's sense of belonging, constructions of their sexuality, their interface with wider society and to their emotional and physical safety'.

Today's adolescents also need to develop skills for a rapidly changing world, including economic uncertainty and change, growing digitalisation, and challenges such as climate change. They often need to negotiate norms around gender relations, which are sometimes in flux and sometimes sticky, and which may conflict with their own aspirations. In low-income contexts with limited alternative opportunities, young people (particularly adolescent boys and young men) face pressures to get involved in organised crime and violence. Increasingly, adolescents are also navigating the online world, with the opportunities and risks it presents. All of these challenges require parental support and guidance, and, in some cases, specific knowledge, to help adolescents deal with them.

What being a parent[2] requires (and specifically the parent of an adolescent) is understood in profoundly different ways in different contexts. The accumulated science behind parenting programmes can be critiqued for assuming that studies conducted largely with marginalised populations in high-income contexts are universally applicable. However, as Bray and Dawes (2016) point out, there is evidence to support their conclusions from a range of contexts. In their study of East Africa and southern Africa, Bray and Dawes point out that the notion of 'parenting' is an external construct, and that understandings of good parenting in the region can be misaligned with those promoted by positive parenting programmes. They point to studies of parents' and caregivers' own views of their roles, which largely centred on provision of material needs and (in more collectivist societies) ensuring adolescents' acceptance by lineage and clans, as well as parents' limited emotional availability as a result of the pressures of poverty. Adolescents' ideas about good parenting were typically closer to those envisaged in 'parenting science', and emphasised adolescents' desire that parents and other relatives listen to them and provide guidance. Parents and children alike also emphasised respect, care for one another and reciprocity, in terms of parents and adolescents contributing to the household, financially or through household work.

## 1.1 What are parenting programmes and what do they aim to do?

Recognising the critical role of the family in adolescents' development and well-being, and the widening set of challenges today's adolescents face, governments and non-governmental organisations (NGOs) in low- and

2 Recognising the huge diversity of family arrangements globally, this report follows Daly et al. (2015) in using the term 'parents' to refer to adolescents' main caregivers, except where there is a specific reason to distinguish biological or legal parents and other caregivers.

middle-income countries (LMICs) are increasingly implementing parenting programmes (Knerr et al., 2013). In this review we define parenting programmes as 'activities oriented to improving how parents approach and carry out their role as parents and to increasing parents' child-rearing resources, including, knowledge, skills and social support' (this definition draws on Daly et al., 2015: 12). Parenting programmes are based on the premise that enhancing parents' understanding of children's and adolescents' development, and helping parents develop skills for more effective communication and guidance, are likely to have positive effects on their children's behaviour and well-being.

While many of the core skills that parenting programmes aim to help develop (e.g. communication, limit-setting and positive discipline) are relevant both to younger children and adolescents, adolescent-focused programmes also cover challenges specific to adolescents as they negotiate their place in the world. These include issues related to puberty and to sexual and reproductive health (SRH), substance use and other risky behaviour. A few programmes seek to help parents with newly emerging challenges such as internet/smartphone/video game addiction. Others aim to equip parents to support adolescents with specific mental health difficulties, such as anxiety and depression. These challenges are often gendered, in some cases reflecting restrictive gender norms that limit girls' mobility, social contacts and opportunities to fulfil their aspirations, or put pressures on boys to live up to stereotypical ideals of masculinity. As we will discuss later, a small minority of programmes (five) explicitly address gendered parenting of adolescents as part of their core 'curriculum', largely in relation to issues of sexuality and early marriage.

The programmes examined in this review primarily aim to build parents' knowledge and skills through short courses (of up to three months).[3] They are either geographically targeted, offered to families in a particular (usually deprived) community or neighbourhood or to families of adolescents facing a specific challenge (e.g. substance use, internet addiction). Some programmes also involve self-study, while a few provide individualised counselling or home visits. The primary target is parents, though some programmes involve adolescents in a few (or all) sessions, with the aim of practising skills, sharing learning or coming to an agreed understanding.

Parenting programmes are explicitly behavioural interventions – they aim to equip parents to fulfil their parental roles in a different way. While there is a legitimate question as to whether addressing perceived root causes of children's and adolescents' ill-being (such as poverty, discrimination and familial stress) would be more strategic than approaches that help parents function better in difficult circumstances (Daly et al., 2015), they are not mutually exclusive alternatives. Furthermore, childhood and adolescence are relatively brief windows in an individual's life, during which the quality of parenting and family relationships can have significant effects, while eradicating poverty and discrimination are long-term endeavours. Evidence on intergenerational cycles of violence and other forms of deprivation suggests that there is a strong case for approaches that aim to build more engaged and harmonious family relationships, as well as concerted efforts to tackle structural factors that underlie adolescents' and families' ill-being (Ward et al., 2015; Daly et al., 2015).

As already noted, the content of parenting programmes draws largely on a body of research around the associations between different elements of parenting (e.g. harsh or physical punishment, verbal engagement and dialogue with adolescents) and well-being outcomes, primarily undertaken with marginalised groups in the United States (US) and other high-income countries. Many parenting programmes in the Global South draw directly on initiatives developed to help prevent substance abuse, violence against children, or to promote better sexual health among disadvantaged groups in the Global North. More so with than non-formal initiatives that work directly with adolescents, there appears to be greater transplanting of parenting programmes and curricula from one setting to another, with local adaptation and indigenisation.

For example, of the 42 programmes examined in this review, at least 10 are iterations of programmes originally developed in the US;[4] more recent iterations draw on learning from other Southern contexts (for example, the Collaborative HIV/AIDS and Adolescent Mental Health

3 This contrasts with the findings of Knerr et al.'s (2013) systematic review, which focused on a wider age range, including parents of infants, and found that most programmes were delivered through home visits.

4 Let's Talk (from Talking Parents, Healthy Teens), CHAMP, Caribbean Informed Parents and Children Together (CImPACT), Exploring the World of Adolescents (EWA), Familias Fuertes, Familias Unidas, Families Matter!, Happy Families Programme, Imbadu Ekhaya, Russian–American Partners for Prevention, and Thai Family Matters.

Programme (CHAMP) has been implemented in South Africa in two different locations, and in Trinidad and Tobago; Familias Fuertes has been implemented in Chile, Bolivia, Colombia, Ecuador, Honduras and El Salvador).

Some of the studies in this review comment on these adaptation processes and the ways in which programmes have found local fit with different understandings of parenting in different contexts. There are important lessons to learn from these processes. At the same time, while questions as to whether parenting programmes represent a form of cultural imperialism are well-taken, it is important to give weight to the perspectives of adolescents. Primary research conducted by the Gender and Adolescence: Global Evidence (GAGE) programme across seven countries has found that adolescents consistently report high levels of violence from their parents and caregivers as one of the worst aspects of their lives; many also highlight their lack of voice in decision-making, and a sense of not being respected or listened to. From their perspective, if a programme is effective in reducing violence in their lives, or leads to parents treating them with more respect and having a greater say in their futures, its origin is rather less important.

**Box 1: Research questions**

The review aimed to answer the following questions:

1. What is known about the impacts of parenting programmes on:
   - relationships between adolescents and their families;
   - adolescents' development across a range of capability domains (education, health, economic empowerment, psychosocial well-being, bodily integrity, and voice and agency);
   - gender attitudes and norms, among participants, their families and the wider community?
2. Are the impacts of parenting programmes gendered?
3. What factors affect programme effectiveness?
4. What evidence is there on the long-term impacts of these programmes?
5. What evidence is there on the cost-effectiveness of parenting

## 1.2 Rationale for this review

GAGE's overall conceptual framework (GAGE consortium, 2019 forthcoming) identifies seven key pathways to promoting adolescent development, one of which is supporting parents. While supporting parents encompasses a range of policies, increasing parenting skills is a relatively neglected dimension in most discussions of adolescent development.[5] Most reviews of parenting programmes focus exclusively or entirely on high-income countries; the few that focus on impact in LMICs examine the impacts on younger children or do not disaggregate impacts on adolescents from those on younger age groups, which means that conclusions may be skewed towards approaches effective for younger children.[6] None explore the impact of initiatives specifically aimed at helping parents provide guidance and support during adolescence. Most existing reviews also focus on specific objectives, such as violence prevention.[7]

This review seeks to add to existing literature on parenting programmes by examining the impact of initiatives that either focus specifically on parenting skills for the parents of adolescents, or general parenting initiatives for parents of children of a wider age range, but where evaluations have reported impacts on adolescents.[8] It also brings a gender lens to analysis of parenting programmes, asking how far such programmes help parents challenge gendered inequalities and patterns of adolescent development (for example, by asking parents to reflect on their different expectations of sons' and daughters' behaviour). It also asks how far these parenting programmes (by design or in practice) replicate gendered caring roles.

A recent review of programmes aimed at promoting young children's development found that fathers are relatively neglected (Panter-Brick et al., 2014), though there

5 Support for parents is broader than parenting skills programmes, including policies such as financial support and provision of specialist services to support adolescents with specific needs as well as programmes to enhance parenting skills.

6 For example, Mejia et al.'s (2012) review focuses on parenting programmes for parents of children up to 12 years old, while Knerr et al. (2013) and the World Health Organization (WHO) (2007) report on programmes across a wide set of age groups, though with an emphasis on younger ages.

7 Examples include: Knerr et al., 2013; Wessels et al., 2013; Pisani Altafim and Martins Linhares, 2016; Coore Desai et al., 2017.

8 This review therefore does not include interventions aimed exclusively at the parents of children under 10 years, which often focus on parenting issues relevant in the early years. We only included programmes primarily intended for parents of children under 12 years, where the mean age of participants' children was at the upper end of the age range – i.e. 11 or 12.

**Box 2: Terminology**

In this report we use the term 'parent' to refer to adolescents' main caregivers, while recognising that many adolescents live with family members other than a parent. We have chosen to do this for simplicity and to avoid wordy terms such as 'parents and caregivers'. Where studies specified relationships, such as mothers, fathers, grandmothers etc., we have followed the studies using these terms. We chose not to refer to all parenting programme participants by the generic term 'caregiver', in part because it downplays the reciprocity that is a core part of parenting relationships in many contexts (Bray and Dawes, 2016).

are growing efforts to engage young men, in particular, in parenting programmes. In this review we examine how far adolescent-focused parenting programmes engage fathers and male caregivers.

Given GAGE's mandate, the review focuses on evidence of programmes from LMICs. As GAGE focuses on extremely marginalised adolescents in settings where government and other developmental resources are limited, the review aims to draw out lessons that are applicable in low-income contexts. Although we initially sought to include evidence of parenting programmes for adolescent parents, these programmes focus substantially on infant nutrition and care, and, in a few cases, on positive discipline for very young children, and are much more commonly delivered through home-visiting. They therefore differ substantially in focus and content from programmes that aim to build skills for parenting adolescents. We therefore focused this review on 35 named programmes and 7 un-named, mostly experimental initiatives that targeted parents of adolescents.

Figure 1 summarises the broad theory of change implicit in most parenting programmes. It shows the pathways by which parenting interventions are expected to help improve adolescents' well-being.

## 1.3 Methodology

### 1.3.1 Review methodology

This review used systematic principles to search for and assess material for inclusion. The search methodology comprised four main elements:

- **Database searches** were undertaken in Web of Science, PsycINFO, Ovid, and EbscoHost in September 2018 (see Annex 2 for search terms used). These searches generated 1,378 results. After removal of duplicates and screening for relevance, we assessed 317 studies for inclusion, of which 83 were initially considered to meet all review criteria; of these, we retained 48 after further scrutiny revealed that the others did not meet at least one key criterion. Key criteria were that the study must report on the outcomes of an intervention involving the parents of adolescents, have taken place since 2000 in an LMIC, and include a counterfactual of some kind; most excluded studies did not discuss an intervention, or focused on adolescent development but not parenting. Studies in English and Spanish were included (see Annex 2 for more detail of inclusion and exclusion criteria).
- **Handsearching.** In December 2018 we handsearched the websites of selected organisations known to (or expected to) have evaluations of relevant parenting programmes. We also undertook Google searches of programmes and authors identified through the database searches (see Annex 2 for a list of handsearches undertaken). This led to the inclusion of three additional studies. We undertook further handsearches in May 2019 to attempt to fill gaps on parenting programmes that aim to prevent radicalisation and involvement in violent extremis, but found no evaluations of such initiatives in LMICs.
- **Snowballing of references.** Systematic reviews on related topics were snowballed, as were the bibliographies of overview and conceptual literature on parenting programmes. This generated six new relevant empirical studies that had not been captured by other methods.
- **Targeted requests to key authors.** This resulted in the inclusion of one additional study and substantial additional information that provided a deeper understanding of the programme in question.

Studies were managed in EPPI-Reviewer and coded to extract information on geographical location, focus of initiative, social groups targeted, activities undertaken, outcomes for parents and adolescents, and observations about factors that influenced programme impact and effectiveness. All studies examined parents' self-reported outcomes and 58% of studies accompanied these insights with adolescents' reports of changes in their parents'

## Figure 1: Conceptual framework

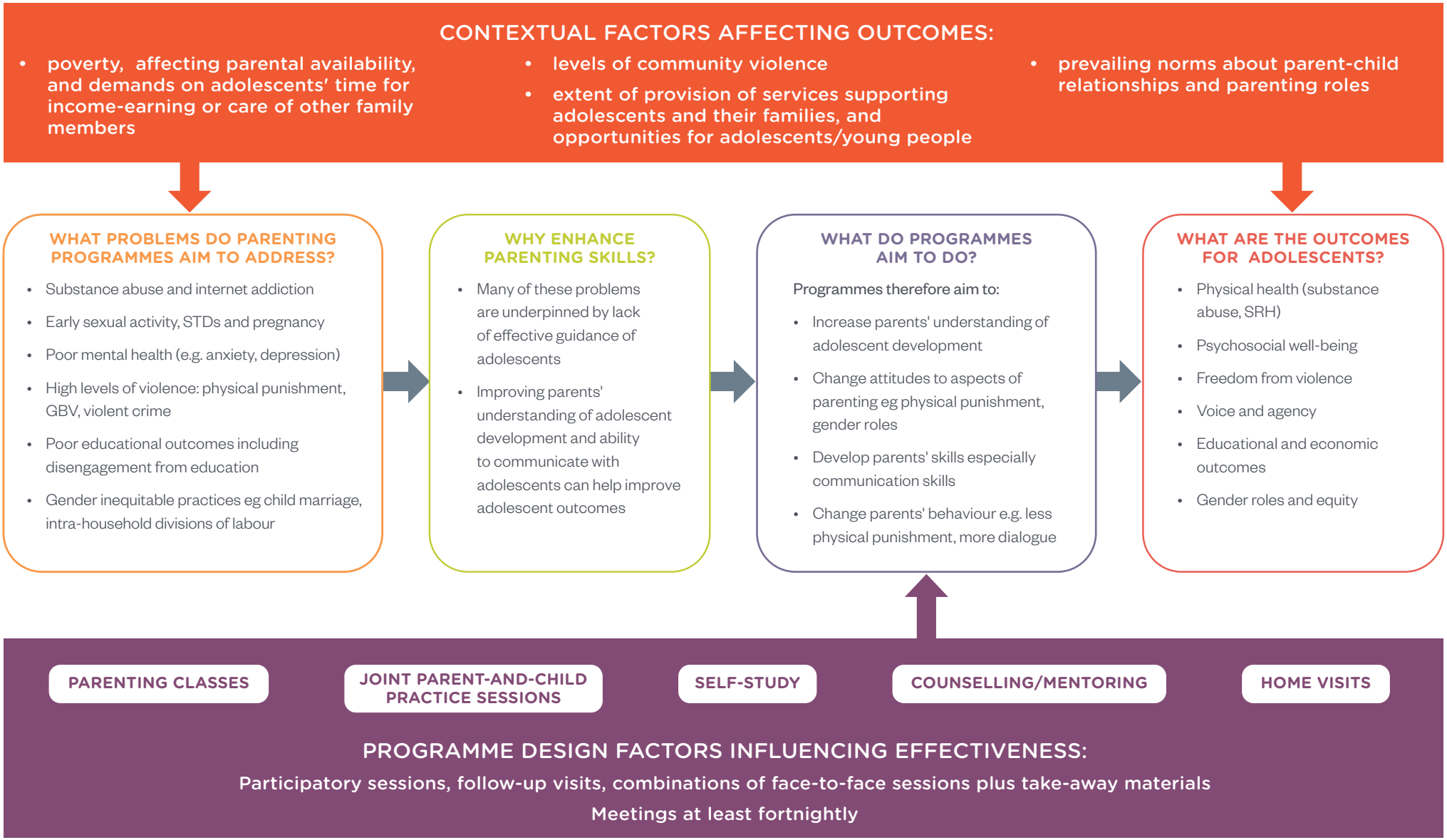


**Table 1: Summary of methodological approaches in studies reviewed**

| Research design or method | Number of studies |
|---|---|
| Quantitative | 38 |
| Mixed qualitative and quantitative | 13 |
| RCT | 22 |
| Quasi-experiment | 27 |
| Qualitative | 11 |

behaviour and attitudes towards them. The indicators used by each review varied significantly; we classified changes as positive (reflecting improved parent–child relationship, parents' or children's perceptions of improved parenting skills or better adolescent outcomes), negative (a perceived worsening in indicators since participation in the programme) or no change, and present the numbers of each type of change on each indicator, rather than attempting any meta-quantitative analysis of changes.

In total, the review examines 58 studies of 42 programmes, including different iterations of similar core programmes in different countries, and pilot and full phases.

## 1.3.2 Methodological overview of studies included in the review

Table 1 summarises the methodological approaches of the studies reviewed, and shows the very high proportion of studies (83%) using rigorous quantitative designs (randomised controlled trials (RCTs) or quasi-experimental studies). Approximately 40% of studies involved qualitative insights. This relatively low proportion reflects the dominance of psychological studies, particularly among the university-led initiatives. These were almost all experimental or quasi-experimental, and rarely involved qualitative components.

### Limitations

**General.** Any review of evaluations is fundamentally dependent on the information provided in those evaluations. While all studies reflect authorial decisions about the most important information to include, word limits on journal articles (which comprise 93% of the studies examined) may constrain the reporting of outcomes, the range of issues that can be discussed, and

**Table 2: Comparison of insights from parents' and adolescents' reports in the Sinovuyo Teen parenting programme in South Africa**

| | Caregiver report | | Adolescent support | |
|---|---|---|---|---|
| | Mean difference between two arms at post-test (relative to baseline value) | | Mean difference between two arms at post-test (relative to baseline value) | |
| Physical maltreatment | 44% reduction | P < 0.001 | 48% reduction | P = 0.008 |
| Mixed qualitative and quantitative | 61% reduction | P < 0.001 | 28% reduction | P = 0.018 |
| RCT | 7% increase | P < 0.001 | 4% increase | Not significant |
| Quasi-experiment | 17% increase | Not significant | 7% increase | Not significant |
| Qualitative | 27% reduction | P < 0.001 | 23% reduction | P < 0.001 |

*Note: Percentages report the intervention effect in terms of the mean difference between the treatment and control groups at post-test, relative to mean score at baseline.*
*Source: Loening-Voysey et al., 2018b: 14.*

insights into how programme implementation affected results. Despite efforts to contact authors for additional insights, the response rate was very low (only 1 out of 6).

**Geographical and population focus.** Despite efforts to obtain good geographical coverage, as we discuss in Section 2, the programmes studied were primarily in sub-Saharan Africa and Latin America; only three (7%) were in South Asia and only four (9%) in Middle Eastern countries. There were also a number of gaps in emphases and coverage: only four programmes (examined by 6 studies) took place in contexts affected by conflict, only two explicitly targeted parents of young people with disabilities,[9] and only one reported that programme content helped parents understand sexual orientation within broader content on SRH. No studies reported on efforts to prevent grooming into gangs or related criminal violence, or radicalisation into violent extremism, despite a growing number of initiatives in this area.[10] This probably reflects the time lag between initiatives taking root, and evaluation and publication of findings.

We were surprised to find limited gender disaggregation among adolescent outcomes and, indeed, relatively little gendered analysis of programme implementation and impacts (see Section 8 for more detail).

Fifteen initiatives explicitly focused on low-income families. Other programmes may also have done so, through a focus on disadvantaged geographical areas. In most cases, programme design appeared sensitive to families' timing and economic constraints, offering relatively short courses. Programmes with a specific focus (e.g. substance abuse, internet addiction, supporting parents of adolescents with specific mental health difficulties) were more frequently offered across socioeconomic groups. We found only one initiative where the curriculum explicitly addressed sexual orientation issues (Let's Talk, South Africa).

**Indicators used.** Just under half the studies drew on evidence from adolescents as well as parents. Clearly, reports from both parents and adolescents are important to triangulate findings, since each can have different perceptions of change and the impact of an intervention. For example, understandings of content can differ, parents' and adolescents' recall and time perspectives can vary, and social desirability biases may also operate differently for parents and adolescents. Box 3 illustrates a comparison of adolescents' and parents' views in the Sinovuyo Teen parenting programme in South Africa. On most indicators, parents reported greater change, though adolescents reported a greater reduction in physical maltreatment than parents did.

Several studies rely on parents' or adolescents' reports about changes in how they plan to behave or what they think they would consider acceptable behaviour. In practice, there is a risk that participants will not behave or think as they have stated during the study or the evaluation. Some studies mitigate this risk by considering past behaviour (i.e. asking how many times a behaviour has been displayed, or what behaviour has been displayed, in a relevant time period).

**Comparison between strategies.** Very few studies compared the effectiveness of different strategies; we thus discuss emerging insights on different strategies but without a rigorous basis of comparison. These evaluations give little insight into whether, for example, separate or combined sessions for parents and adolescents are more effective, or how course duration affects outcomes.

Understandably, evaluations focused on the specific initiative under consideration; they did not discuss whether the aims of improving adolescent well-being could be better served with a more structural approach. This highlights a limitation of a review of programme evaluations, which allows an understanding of whether programmes were effective according to their own objectives, but not whether an alternative approach might have led to more extensive, sustainable or lasting changes.

**Cost-effectiveness.** Only one study – that of Sinovuyo Teen – reported on cost-effectiveness. We are therefore unable to probe the suggestion that community-based parenting classes are generally cheaper to run than home-visiting programmes but more expensive than integrating parenting skills into existing programmes/services (e.g. economic strengthening initiatives) (WHO, 2018).

**Evidence of longer-term or less immediate impacts.** Only 6 studies of 4 programmes were undertaken

9 These two programmes were Sexuality Education Program for Mothers of Young Adults with Intellectual Disabilities (SEPID) and the programme reported by Kok and Akyüz, 2015.

10 In the UK, for example, the government's Prevent programme includes an online parenting course: Resilient Families; the Austrian NGO Women Without Borders has developed Mothers Schools parenting programmes to help mothers prevent their children's recruitment into extremist movements. As D'Estaing (2017) points out, there is a risk that a focus on parenting to prevent violent extremism can reflect the state shifting its preventive and protective responsibilities onto the shoulders of women.

Mother and child in Afar, Ethiopia. © Nathalie Bertrams/2019

more than a year after participants completed the programme, and half were undertaken within the six months immediately following participation. The long-term evidence is, however, positive:

- The three studies of Caribbean Informed Parents and Children Together (CImPACT) and its associated youth programmes found that increases in knowledge, condom self-efficacy and condom use skills were sustained at 18, 24 and 36-month follow-up (Gong et al., 2009; Chen et al., 2010; Stanton et al., 2015).
- The study of Suubi found that adolescents were more willing to talk to caregivers about SRH at 20 months than control group participants (Ismayilova et al., 2012).
- Paruk et al.'s (2009) study of CHAMP (Amaqhawe), undertaken two years after the programme ended, found that parents reported feeling better equipped for parenting, having greater levels of support in the community, and a stronger sense of community-level action and responsibility to promote children's well-being.
- Pereira et al.'s (2013) study of the School for Parents project in Brazil reported positive impacts on various parenting and child well-being indicators (reduced use of violence, greater engagement with children, enrolment of children in school, etc.) a year after participation in parenting classes.

The combination of a relatively short time horizon for evaluations and a focus on programmes' immediate objectives also means we have limited insights into potential longer-term or less immediate effects, such as whether improved communication and relationships within the household led to impacts on adolescents' educational participation or achievement.[11]

11 Two studies mentioned impacts on education: the study of Family Strengthening Intervention for HIV-affected Families (FSI-HIV) in Rwanda found qualitative evidence of positive impacts on education resulting from improved family dynamics and less stress and violence at home. The evaluation of Sinovuyo Teen had intended to measure impacts on educational motivation but baseline levels of motivation were so high (>98%) that no impact could be discerned.

# 2 Overview of programmes

In this review we discuss 58 studies of 42 programmes. This total includes separate studies of different phases of a programme. Studies of the local implementation of multi-country programmes were classed as separate programmes.[12] Seven of the initiatives examined were short-term experimental initiatives that were not named in the studies.

## 2.1 Geographical distribution

The 42 programmes took place in 32 countries (Figure 2), with almost three-quarters in sub-Saharan Africa and Latin America (Figure 2). Considerably more programmes (8) took place in one country (South Africa) than any other country.

Programmes were primarily based in urban areas (19 out of 42 programmes), with some in peri-urban or

**Figure 2: Distribution of programmes in this review**

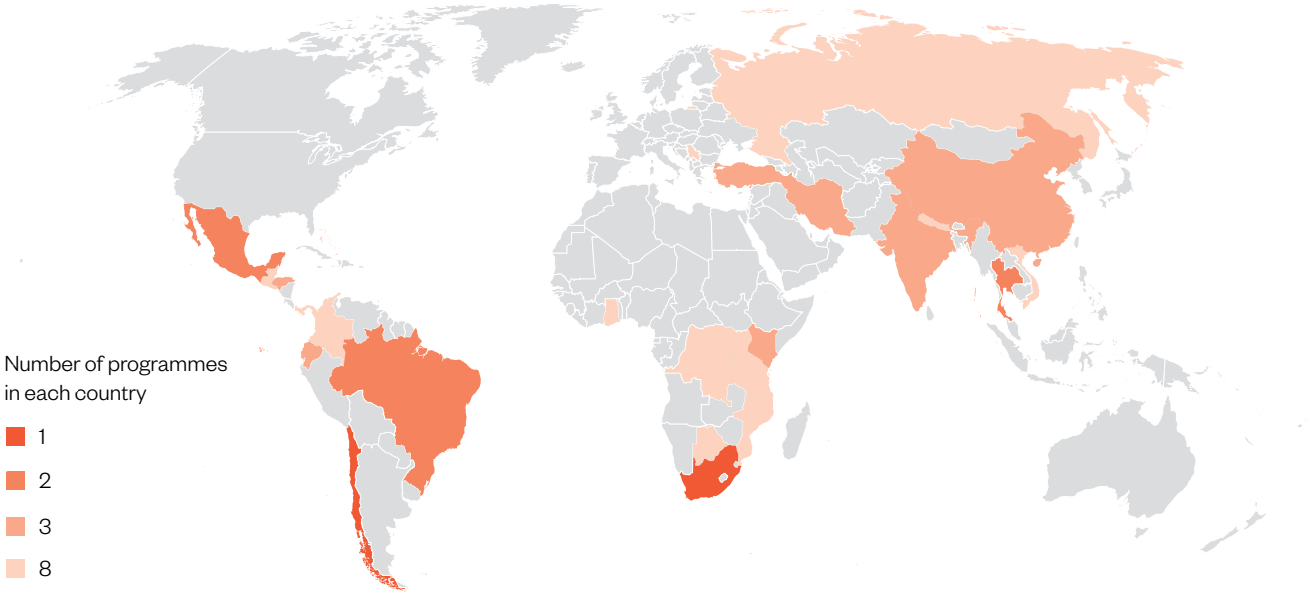



**Figure 3: Geographical distribution of programmes**

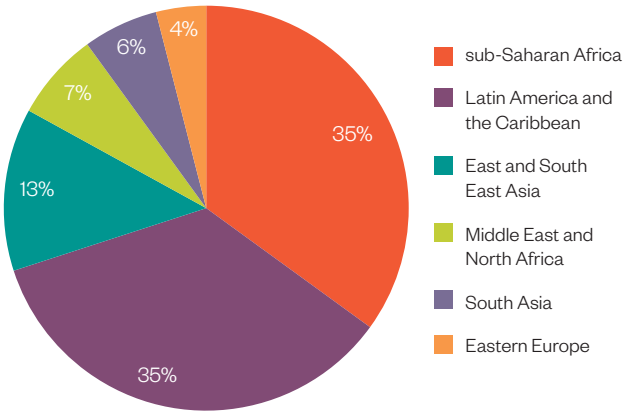



**Table 3: Locations of programmes**

| Setting in which programme took place | Number of programmes |
|---|---|
| Community | 14 |
| School | 11 |
| Unclear or unspecified | 6 |
| Community and home | 2 |
| Healthcare facility | 3 |
| Home | 3 |
| School and home | 2 |

12 In some large, multi-country programmes, evaluations are only available for a samples of countries. The map shows the countries where evaluations included in this review were undertaken.

rural sites too. Only 11 programmes were carried out exclusively in rural or peri-urban areas. Programmes were most commonly implemented in community settings or in schools. Of programmes delivered in home settings, Thai Family Matters and Ligue 132 also included remote components that were delivered via telephone (Table 4).

### Table 4: Overview of programmes discussed in this review

| Setting in which programme took place | Number of programmes |
|---|---|
| **Bahamian Focus on Older Youth (BFOOY) plus Caribbean Informed Parents and Children Together (ClmPACT), Bahamas** Stanton et al. (2015); Dinaj-Koci et al. (2015) | ClmPACT was carried out in one session where parents and their child watched a short video on SRH communication and parental monitoring together. Adolescents were either randomised to BFOOY, a HIV-focused initiative, or Health and Family Life Education, and parents were randomised to either ClmPACT or Goal for It (a parenting programme focused on career planning). This review reports effects attributed to ClmPACT. |
| **Breaking the Voice (Rak luk khun tong pood), Thailand**, Powwattana et al. (2018) | Aimed to reduce SRH risks among adolescent Thai girls such as HIV, sexually transmitted illnesses (STIs) and pregnancy, by educating mothers and daughters, separately and together. |
| **Collaborative HIV Prevention and Adolescent Mental Health Family Programme (CHAMP) – Amaqhawe, South Africa (pilot programme)**, Bhana et al. (2004) | Aimed to prevent HIV in adolescents. Delivered to families via a series of sessions using a participatory cartoon-based narrative, intended to facilitate discussion of culturally taboo and sensitive topics related to sexuality. The programme aimed to strengthen resilience at individual, family and community levels. The adaptation from the US version involved adding sessions on stigma and bereavement, and on parent and child rights and responsibilities. |
| **CHAMP-TT, Trinidad and Tobago** Baptiste et al. (2007) | Aimed to prevent HIV in adolescents by focusing on parents' roles in 'providing information, structure and values to help youth to cope with sexual possibility situations in their peer and friendship relationships'. It was delivered through a family group format, with input from a board of community members on programme content. Unlike other CHAMP initiatives, it did not involve the use of a manual or cartoon. |
| **CHAMP-VUKA, South Africa** Bhana et al. (2014) | CHAMP-VUKA aimed to improve psychosocial outcomes for HIV-positive adolescents and their parents via a participatory group programme using cartoons, which was delivered to adolescents and their families. |
| **CHAMP-Amaqhawe, South Africa (full programme)** Bell et al. (2008); Paruk et al. (2009) | Aimed to strengthen family relationships through a participatory programme delivered using a cartoon-based narrative. It aimed to improve knowledge and reduce stigma around HIV and to strengthen community networks and involve the community in designing and delivering the intervention. Adapted for the South African context from the US programme, it was piloted with 94 families; the third cartoon-based prevention manual was developed using findings from the pilot study. |
| **Choices-Voices-Promises, Nepal** Lundgren et al. (2018) | Delivered as three interventions aiming to reduce gender inequity among adolescents (Choices), families (Voices), and communities (Promises). Voices used videos followed by discussions to influence parents' gendered behaviour and attitudes around expectations for their children (e.g. division of household tasks and food, allowing equal homework time, and bringing hope to girls and boys). |
| **Creating Opportunities through Mentorship, Parental Involvement, and Safe Spaces (COMPASS), Democratic Republic of Congo (DRC)** Stark et al. (2018) | Implemented with refugees living in camps on the Sudan/Ethiopia border, conflict-affected communities in eastern DRC and displaced populations in north-east Pakistan. Stark et al. report on the programme in DRC, which aimed to reduce violence against adolescent girls via 'the provision of safe spaces, building life skills and social assets, engaging girls in relationships with mentors and engaging caregivers as support systems and advocates for girls'. |
| **Creative Stress Relief Programme for Parents, India** de Wit et al. (2018) | Aimed at fostering adolescents' autonomy and promoting their academic potential in a stress-free manner, and fostering parent connection with adolescents. Parents' learning took place via an interactive group format facilitated by a psychologist. |
| **Cuidate! Promueve tu salud**, (Take care of yourself! Promote your health), **Mexico** Villarruel et al. (2008) | This study randomised parents and adolescents to either an HIV risk reduction intervention or general health intervention (control). Both interventions included adolescent and parent education components through participatory sessions. |

| Setting in which programme took place | Number of programmes |
|---|---|
| **Escuela para Padres (School for Parents) Mexico** Nuño-Gutiérrez et al. (2006) | Consisted of weekly parent-only discussion sessions with 61 parents of high school students where topics included adolescent psychology and sexuality, parent–children relationships, family communication, self-esteem, and addiction prevention. |
| **Exploring the World of Adolescents + (EWA+), Viet Nam**, Kaljee et al. (2012); Pham et al. (2012) | A gender-focused programme modelled on the Vietnamese Focus on Kids curriculum, which in turn was based on the US Focus on Kids programme. It targeted female and male youth, parents and healthcare providers and aimed to improve HIV prevention and reproductive health. |
| **Family Strengthening Intervention for HIV-affected Families (FSI-HIV), Rwanda** Chaudhury et al. (2016) | A home-visiting, family-based intervention aiming 'to reduce IPV [intimate partner violence], family conflict and problems related to alcohol use to promote child mental health and family functioning within HIV-affected families in post-genocide Rwanda'. It was adapted 'from an existing evidence-based intervention to promote mental health among children'. |
| **Familias Fuertes**, Bolivia, Chile, Colombia, Ecuador, El Salvador, Honduras. Corea et al. (2012); Orpinas et al. (2014); Vasquez et al. (2010); Pan American Health Organization (PAHO) (2006) | An adaptation of the Strengthening Families Programme 10–14, originally developed in the US. It consists of interactive sessions for adolescents and their parents. It aims to help adolescents identify dreams and goals and works with families in group sessions to promote an effective balance between offering adolescents love, warmth and autonomy alongside parental discipline, structure and monitoring. |
| **Familias Unidas, Ecuador** Molleda et al. (2017) | Adapted for use in Ecuador following its development with Hispanic adolescents in the US. It focused on family functioning and prevention of adolescent behavioural problems 'by empowering parents to communicate, monitor, and build a trusting relationship with their adolescent'. The programme included a mix of family and parent-only sessions. |
| **Families Matter! Kenya, Tanzania** Vandenhoudt et al. (2010); Kamala et al. (2017) | Aims to improve parenting skills and parent–child communication about sexual risks. Its curriculum is 'designed to give parents and other primary caregivers the knowledge, skills, comfort, and confidence to deliver messages to their 9–12-year-old children about sexuality and practise positive parenting skills'. Though the studies included in this review took place in Kenya and Tanzania, it has also been implemented in South Africa, Zambia, Côte d'Ivoire, Botswana, Mozambique, Zimbabwe, DRC, Rwanda, Namibia, Nigeria and Malawi, and Haiti. |
| **Thai Family Matters, Thailand** Rosati et al. (2012); Byrnes et al. (2011); Cupp et al. (2013) | Adapted from the original US version of the Family Matters programme, Thai Family Matters focused on preventing HIV and substance abuse. It was led by parents in the home using booklets, supported by telephone sessions with health educators. Some booklets were for parents only, others were for parents to use with their children. |
| **Focus on Youth in the Caribbean (FOYC) plus Caribbean Informed Parents and Children Together (CImPACT), Bahamas** Chen et al. (2010); Gong et al. (2009); Deveaux et al. (2007) | An initiative intended to improve parental monitoring and communication and address HIV prevention in youth. In these studies, families either received CImPACT and FOYC (a youth intervention focusing on decision-making, communication, SRH and HIV), or CImPACT with a control for youth (Wondrous Wetlands), or FOYC with a family goal-setting programme instead of the HIV prevention programme delivered to parents (Goal For It). Programmes were adapted from initial development in the US. The studies report on CImPACT's effects at 6 months (Deveaux et al.), 24 months (Gong et al.), and 36 months (Chen et al.) following intervention. |
| **Go Girls! Initiative, Botswana, Malawi, Mozambique** Schwandt and Underwood (2013) | Based around an adult–child communication programme that aimed to improve adults' relationships with young people by building their communication, role modelling and relationship skills and providing guidance on appropriate levels of supervision. Indirectly aimed to increase community valuing of adolescents. |
| **Happy Families programme, Thailand** Annan et al. (2017); Puffer et al. (2017); Sim et al. (2014) | Adapted from the US-developed Strengthening Families Programme, aiming to improve parenting skills and mental health outcomes among Burmese migrant and displaced children in Thailand. It hosted parallel sessions for parents and their children with structured opportunities for positive interactions. |
| **Imbadu Ekhaya (Parents Matter!), South Africa** Armistead et al. (2014) | A family-based HIV prevention intervention, with parenting skills content based on the US-developed Positive Parenting Programme, and SRH communication skills content based on the Parents Matter! Programme. The programme covered general communication, SRH communication and gender roles through sessions with parents that included didactic and interactive components. |

| Setting in which programme took place | Number of programmes |
|---|---|
| **Let's Talk, South Africa** Bogart et al. (2013) | A worksite-based parenting programme that aimed to improve parent–child communication about SRH and HIV. It also aimed to improve parent condom use self-efficacy and behaviour. The programme was adapted from US-based Talking Parents, Healthy Teens. |
| **Ligue 132: telehealth prevention programme, Brazil** Valente et al. (2018) | A pilot telehealth prevention programme with 15 parents. Parents called a phone service, where they were randomised to the experimental or control group. The experimental initiative tested a brief motivational intervention to help parents modify risk behaviours (main components include: expressing empathy, reflective listening, avoiding argument, supporting self-efficacy, developing discrepancy, offering personalised feedback, and evoking the reasons for the change), and compared this with receiving informing on preventing adolescent drug use. |
| **Parceria project, Brazil** Pereira et al. (2013) | Aimed to teach parenting skills to women who have experienced IPV, 'with the goal of preventing behavioural problems in children exposed to domestic violence'. It used two manuals: one to develop coping strategies to prevent violence, one to develop parenting skills. This study examines implementation of Parceria project via home visits, with mothers who were expected to have a history of IPV and whose children had experienced multiple forms of maltreatment. |
| **Parenting for Lifelong Health: Sinovuyo Teen (pilot programme), South Africa** Cluver et al. (2016) | Delivered to parents and adolescents in joint and separate sessions. The programme resulted from a partnership between Clowns Without Borders South Africa, UNICEF South Africa and Oxford University. It aimed to prevent abuse of adolescents and improve mental health through strengthening family communication and positive parenting. Cluver's study reports on the pilot initiative. |
| **Parenting for Lifelong Health: Sinovuyo Teen (full programme), South Africa** Doubt et al. (2017); Cluver et al. (2018); Doubt et al. (2018); Loening-Voysey et al. (2018a); Loening-Voysey et al. (2018b) | Part of the Parenting for Lifelong Health initiative, a collaboration among UNICEF, WHO, NGOs and academics to develop and test evidence-based parenting programmes that are non-commercial and relevant to LMICs. It was implemented as an RCT following four stages of pilot testing, and was analysed in a qualitative study. It primarily aimed to reduce abusive parenting and improve positive parenting and monitoring of adolescents, and also to reduce problematic adolescent behaviours, parental depression and stress, and substance abuse. |
| **READY, Kenya** Puffer et al. (2016) | A family-based HIV- and mental health problem prevention intervention delivered in faith settings to parents and children. It focused on improving overall communication, and communication on economic, emotional, and HIV-related topics, and providing skills training for HIV prevention, economic empowerment, and promotion of psychosocial well-being. |
| **Russian–American Partners for Prevention, Russia** Williams et al. (2001) | An adaptation of the US-based Slick Tracy Home Team programme, which aimed to delay the onset of drinking alcohol as part of a 3-year public health trial. Implemented through schools, but involved parents using homework activities, and a fair for students and their parents where students present posters with alcohol-related messages. |
| **School for Parents programme, Brazil** Pereira Lima et al. (2007) | This programme worked with parents who had come into contact with the courts on account of poor parenting and child well-being concerns. It had 3 elements: the School for Parents, the Solidarity Family Project, and Parents at Work. School for Parents aimed to improve parents' knowledge of citizenship rights and duties (including around parenting), with professional support according to specific goals. The Solidarity Family Project supported families to access relevant public services. Parents at Work aimed to strengthen participants' access to employment and income-generation opportunities. The project also provided basic income while parents were taking part in these programmes. |
| **Sexuality Education Programme for Mothers of Young Adults with Intellectual Disabilities (SEPID), Turkey** Yildiz and Cavkaytar (2017) | A family education programme for mothers of young adults with intellectual disabilities. Delivered in four sessions via various techniques, including written materials, a family guidebook and post-session tests, it aimed to inform parents about their children's sexual development, about sexual abuse and child neglect, so that they could help children with safety skills and support them during sexual maturation. |

| Setting in which programme took place | Number of programmes |
|---|---|
| **Sisters for Life, South Africa** Phetla et al. (2008) | Part of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) project, which integrated microfinance with participatory education addressing HIV and gender awareness for women in low-income households. Project meetings included interactive education and empowerment activities and were followed by community mobilisation of participants to identify and respond to local issues. This study focuses on 'components of the program that encouraged participants to challenge barriers to engaging with young people about sex and sexual health'. |
| **Strengthening Families Programme: For Parents and Youth 10–14 (SFP 10–14), Guatemala, Honduras, Panama, Serbia** Maalouf and Campello (2014) | Aimed to increase parental empowerment, family communication, cohesion, support and trust, build family unity and bonds, increase self-esteem, and create a supportive network for parents and build peer relations for children. Piloted in Central America (Panama, Honduras, El Salvador, Guatemala and Nicaragua), south-east Europe (Albania, Serbia, Montenegro, Macedonia, and Bosnia and Herzegovina) and Brazil through a drug prevention programme of the United Nations Office on Drugs and Crime (UNODC). |
| **Suubi, Uganda** Ismayilova et al. (2012) | An adolescent-focused economic empowerment intervention. This study examines how family support components affect AIDS-orphaned adolescents' sexual risk-taking attitudes. |
| **Talking Parents, Healthy Teens, Ghana** Baku et al. (2017) | A one-month participatory parent training programme on knowledge, attitudes and communication about adolescent sexuality. |
| Un-named programmes | |
| **Bihar child–parent communication pilot project, India** Jejeebhoy et al. (2014) | Aimed to foster closer relationships between parents and adolescent children, and help them communicate more effectively on matters related to growing up or SRH. It ran separate sessions for mothers and fathers, and joint sessions with parents and adolescents. |
| **Internet addiction therapy programme, China** Zhong et al. (2011) | Aimed to reduce addictive behaviour by improving family functioning and was delivered via adolescent-only sessions, parent-only sessions and joint sessions. It involved a combination of pre-planned and responsive sessions. |
| **Morelos SRH communication programme, Mexico** Campero et al. (2010; 2011) | Consisted of participatory workshops aiming to improve communication between parents and adolescents, especially around prevention of STIs, unplanned pregnancy and birth control, and focused on encouraging condom use with emergency contraception back-up. |
| **Multi-family group therapy for internet addiction, China** Liu et al. (2015) | Aimed to strengthen parent–adolescent communication and relationships so that adolescents fulfil their psychological needs from family relationships rather than the internet. Each session covered specific topics and activities, connected across the sessions, and involved a family assignment. |
| **Parent education programme, Iran** Kaveh et al. (2014) | Aimed to improve life satisfaction for female students in governmental guidance schools in Shiraz, Iran. Parents received participatory educational sessions, a 5-volume booklet, and phone messages to reinforce content. The sessions covered effective communication between parents and children, analysis of parenting challenges, family roles, and understanding adolescence. |
| **Parenting psychoeducation intervention, Burundi** Jordans et al. (2013) | Offered in two sessions to groups of 20 parents whose children had been screened for elevated psychosocial distress. Aimed to increase awareness of children's psychosocial and mental health problems, and provide information on problem management strategies, adapted from a manual for parents on helping children cope with the stresses of political violence. |
| **SRH education for parents of adolescents with intellectual disabilities, Turkey** Kok and Akyüz (2015) | Delivered to parents of adolescents with intellectual disabilities at 2 Special Education and Rehabilitation Centres in Turkey. It involved a group format over several sessions, and covered topics including hygiene during sexual development, sexual behaviour control, protecting children with disabilities from sexual abuse, and communication with adolescents with disabilities. |
| **Quality of life therapy programme, Iran**, Abedi and Vostanis (2010) | Aimed to improve family functioning and reduce OCD symptoms and anxiety in adolescents referred to clinical services by increasing life satisfaction in adolescents' mothers. The group sessions used cognitive therapy techniques to develop life management and coping skills, and positive interaction and play with children. |

## 2.2 Participants

Programmes worked either with parents only, or with parents and adolescent children; most worked with both groups, either together or separately (Table 5). In 11 programmes, parents participated in separate workshops or programmes, and at certain points were brought together with their children for joint learning or to practise skills. Some programmes also used different methods across countries and time periods.

### 2.2.1 Age distribution of participants' children

Programmes targeted parents across the adolescent age range, with the largest proportion including parents of 12–15-year-olds (Table 6). In two programmes[13] that included parents of adolescents across a broader age spectrum, the actual average age of participating parents' children was 10 years.

### 2.2.2 Gendered participation in parenting programmes

Studies of 25 programmes reported a majority of female participants and studies of 7 programmes reported only female participants, which means that women were the sole or main participants in 32 of the 42 programmes (76%) (Figure 4). Only one study – Bogart et al.'s (2013) study of the Let's Talk HIV prevention intervention in South Africa – reported majority male caregiver participation at 64%. This may reflect the fact that the programme took place at worksites, indicating that this may be a promising way to increase male participation.

Unlike a new generation of parenting programmes aimed at the parents of young children, such as Program P (Promundo) and related programmes such as the Responsible, Engaged and Loving (REAL) Fathers Initiative, we did not find any reported examples of programmes making a specific effort to engage fathers. However, such efforts may go unreported and actual levels of participation may be higher. For example, around 25% of participants in Families Matter! globally are now fathers and other male caregivers.[14]

The primary reason for the dominance of female participants is that programmes usually seek to engage

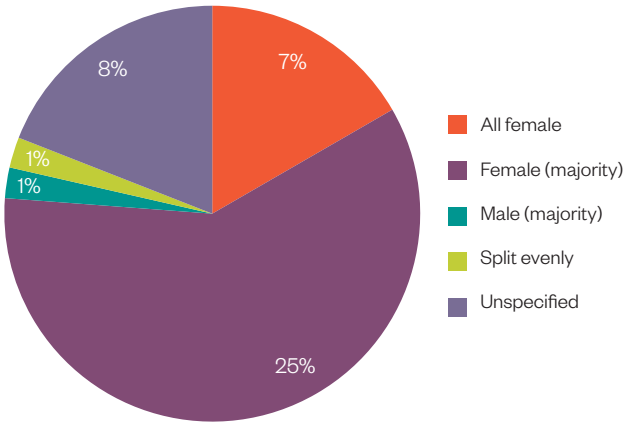
**Table 5: Distribution of programmes by parents and adolescent participation**

| Programme participants | Number of programmes |
|---|---|
| Parents only | 15 |
| Parents and children together and separately | 11 |
| Parents and children together | 7 |
| Parents and children separately | 6 |
| Unclear | 3 |

**Table 6: Distribution of ages of adolescents whose parents took part in parenting programmes**

| Age | Number of programmes | % of programmes |
|---|---|---|
| 10 | 18 | 43% |
| 11 | 22 | 52% |
| 12 | 26 | 62% |
| 13 | 27 | 64% |
| 14 | 29 | 69% |
| 15 | 25 | 60% |
| 16 | 19 | 45% |
| 17 | 16 | 38% |
| 18 | 11 | 26% |
| 19 | 3 | 7% |
| Children under 10 | 4 | 10% |
| Young adults over 19 | 1 | 2% |
| 'Adolescents' (unspecified age) | 3 | |

**Figure 4: Distribution of participants by gender (number of programmes)**




13 These were the quality of life therapy programme in Iran (Abedi and Vostanis, 2010), working with 10–18-year-olds, and a sexuality education programme in Turkey for parents of adolescents with intellectual disabilities, offered to parents of 10–19-year-olds (Kok and Akyüz, 2015).

14 We also found examples where men had participated in the parenting sessions but were not available or willing to participate in the evaluation, as for example in Cupp et al.'s (2013) study of Thai Family Matters, and the evaluation of Escuela para Padres in Mexico, where men were underrepresented in the evaluation, compared to their involvement as participants (Nuño-Gutierrez et al., 2006).

adolescents' main caregiver, which is most often a female. Studies of several initiatives reported low levels of interest from men, who perceived that women should attend; they were also deterred by the lack of livelihood components, given pressing poverty levels (Jejeebhoy et al., 2014). Some men were initially interested but unable to attend regularly due to the need to earn income (Campero et al., 2010).

**Marginalised groups.** In total, studies of 22 programmes reported that they worked with specific marginalised groups: 15 worked explicitly with poor families; 3 worked with parents of adolescents with disabilities or mental health challenges; 6 worked in contexts affected by conflict or with refugees; and 4 worked with people living with HIV. Together, these constitute half of the programmes reviewed. While no studies commented on the proportion of participants with disabilities, two (Sexuality Education Program for Mothers of Young Adults with Intellectual Disabilities (SEPID) and a related health education programme in Turkey) were developed for the parents of adolescents with intellectual disabilities, and the Sinovuyo Teen programme in South Africa aimed to be accessible to participants with learning difficulties (for example, by waiving the need for signed consent forms) (Loening-Voysey et al., 2018b). Others excluded participants they deemed unable to participate on grounds of disability, as in Exploring the World of Adolescents (EWA) in Viet Nam (Pham et al., 2012).

Other programmes may also have focused on marginalised groups but evaluations did not make this explicit. It is also important to note that it is not only people in poverty or facing other forms of disempowerment who may benefit from parenting education. De Wit et al.'s (2018) study tested an approach to supporting middle-class families in India who are raising adolescents in a context of very rapid change in globalisation, shifts in family structure, and substantial changes in norms related to parents' expectations of children and children's expectation about their future.

## 2.3 Programme activities and foci

Programmes were delivered using various methods. Most programmes were at least partly carried out using group classes, where parents engaged in discussions and participatory learning activities such as role play or condom demonstrations (Table 7). In some cases, group classes were accompanied by homework that parents had to carry out independently, or printed materials such as booklets; other delivery modes included phone-based counselling and home visits.

**Table 7: Distribution of programme delivery methods**

| Methods of delivery | Number of programmes (/42) |
|---|---|
| Group classes | 32 |
| Group classes and home visits | 2 |
| Home visits | 2 |
| Group classes and individualised support for parents | 1 |
| Group classes and parent self-study | 1 |
| Individualised support for parents and telephone session | 1 |
| Telephone session and parent self-study | 1 |
| Not available | 1 |
| **Learning methods** | |
| Discussion | 33 |
| Homework | 13 |
| Printed materials | 14 |
| Participatory learning activities | 28 |
| Phone calls | 1 |
| SMS (short message service) reminders | 1 |

Few programmes appeared to include components other than parenting education. Sisters for Life in South Africa provided access to microfinance (Phetla et al., 2008). The School for Parents programme in Brazil aimed to support parents' employment and income-generation activities through partnerships with available public services (Pereira Lima et al., 2007). We found no studies of programmes providing combined cash transfers and parenting education for the parents of adolescents, suggesting that there may be lessons from initiatives that provide a wider range of services (including parenting education) to the parents of younger children, such as the linked Chile Solidario and Chile Crece Contigo programmes (Daly et al., 2018).

This said, programmes with a focus on SRH in particular often provided information about health services and encouraged participants to make use of these services, from voluntary counselling and testing for HIV, to male circumcision and family planning services. One such example is the Families Matter! case study (see Box 5).

### 2.3.1 Programme foci

Most programmes had several areas of focus, with the most common being family relationships and communication (24 out of 42) and SRH (23 out of 42). Over half of the programmes that focused on SRH either included or had a specific focus on HIV (13 out of 23) (see Table 8).

There is no clear pattern of programmes aimed at the parents of particular age groups concentrating on specific issues. (Annex 4, Table 1). It is notable that HIV prevention is skewed to the younger end of the adolescent age range (10–12-year-olds), and that initiatives aiming to prevent child abuse and harsh punishment focus primarily on the parents of adolescents aged 14 and under.

**Table 8: Thematic foci of programmes**

| Areas of Focus | Number of programmes |
|---|---|
| Family relationships and communication | 28 |
| SRH (general) | 23 |
| HIV prevention | 13 |
| Prevention of violence and abuse | 14 |
| Mental health/well-being promotion | 20 |
| Substance abuse | 9 |
| Gender equity | 14 |
| Integrated social support | 1 |

## 2.4 Programme implementation, scale and duration

Compared to many other areas of development activity, an unusually high number of initiatives (around 75%) were implemented in partnership with research institutions, and involved an experimental study to test an approach. These were typically short courses, few of which were repeated or scaled up. Around 60% of initiatives (26 out of 42) were led by government departments or NGOs.

Programmes also varied in scale, from less than 100 parents or parent–youth pairs, to more than 5,000 (Table 9). Because so many programmes were experimental, this review includes relatively few large-scale initiatives.

**Table 9: Scale of programmes**

| Scale | Number of programmes |
|---|---|
| Under 100 | 18 |
| 100-500 | 16 |
| 501-5000 | 12 |

However, we may be underrepresenting the overall scale of some initiatives, for three reasons:

- Studies sometimes reported only on their sample, rather than the larger population that took part in a given initiative.
- The cumulative reach of some multi-country programmes is sometimes considerably larger than in these studies. For example, this review includes studies of the Families Matter! programme in Kenya (<500 participants) and Tanzania (<5,000 participants); overall, Families Matter! has reached over 1 million participants to date (Miller pers. comm.). The SFP 10–14 programme also reached fewer than 100 families in each country where it was piloted; however, in 2014 it had cumulatively reached 7,000 families across the 16 countries where it was piloted (Maalouf and Campello, 2014).
- There is evidence of informal sharing of learning in at least two programmes (Sinovuyo Teen (South Africa) and the Bihar parent–child pilot communication project). Insights are spread by participants, local facilitators and, in some cases, by community health workers, midwives and childcare workers (Jejeebhoy et al., 2014). In Sinovuyo Teen, there was some evidence of participants sharing learning with neighbours during home visits and more formally through church groups (Cluver et al., 2018).

**Programme duration**. Programmes varied from 1–2 days to 12 months. Most interventions lasted for either 4 weeks or 12–16 weeks (Annex 4, Table 2). No studies examined whether programme impact or effectiveness varied with duration, and our analysis suggests no strong relationship between programme duration and the number of positive outcomes.

# 3 Impacts on parenting skills

**Studies and programmes reviewed** (40 studies of 28 programmes)

Bihar child–parent communication pilot project (India); CHAMP (Amaqhawe) (South Africa); CHAMP-VUKA (South Africa); CHAMP-TT (Trinidad and Tobago); Creating Opportunities through Mentorship, Parental Involvement, and Safe Spaces (COMPASS) (DRC); Creative Stress Relief programme (India); Cuidate! Promueve tu salud (Mexico); Escuela para padres (Mexico); Familias Fuertes (Bolivia, Chile, Colombia, Ecuador, El Salvador, Honduras); Familias Unidas (Ecuador); Families Matter! (Kenya, Tanzania); Family Strengthening Intervention for HIV-Affected Families (Rwanda); Go Girls! Initiative (Botswana, Malawi, Mozambique); multi-group family therapy for internet addiction (China); Happy Families programme (Thailand); Imbadu Ekhaya (South Africa); internet addiction therapy programme (China); Let's Talk (South Africa); Ligue 132 (Brazil); Parceria project (Brazil); parenting psychoeducation intervention (Burundi); Sinovuyo Teen (full and pilot versions) (South Africa); READY (Kenya); School for Parents programme (Brazil); Suubi (Uganda); Thai Family Matters (Thailand); Strengthening Families programme (Guatemala, Honduras, Panama, Serbia).

**Main findings:**

- 14 out of 18 studies reported increased communication between adolescents and parents, and 12 out of 18 reported better-quality family relationships. Qualitative and quantitative studies both identify improved communication as the most important factor underlying improvements in other adolescent well-being outcomes, such as reduced experience of violence and improved mental health indicators.
- Studies of six programmes found increased parental monitoring and reduced neglect of adolescents; three found no change.
- Five studies found that adolescents reported greater improvements in parenting skills and parent–child relationships than parents did.
- By contrast, adolescents reported less change than parents did in relation to harsh physical or verbal punishment: three of the six reports from adolescents on verbal violence, and three of their seven reports on physical violence indicated no change (or only non-significant change) in parents' behaviour, while 8 out of 9 studies found that parents reported lower levels of harsh punishment. Qualitative evidence from parents also indicates a substantial change in levels of physical and emotional violence against adolescents.

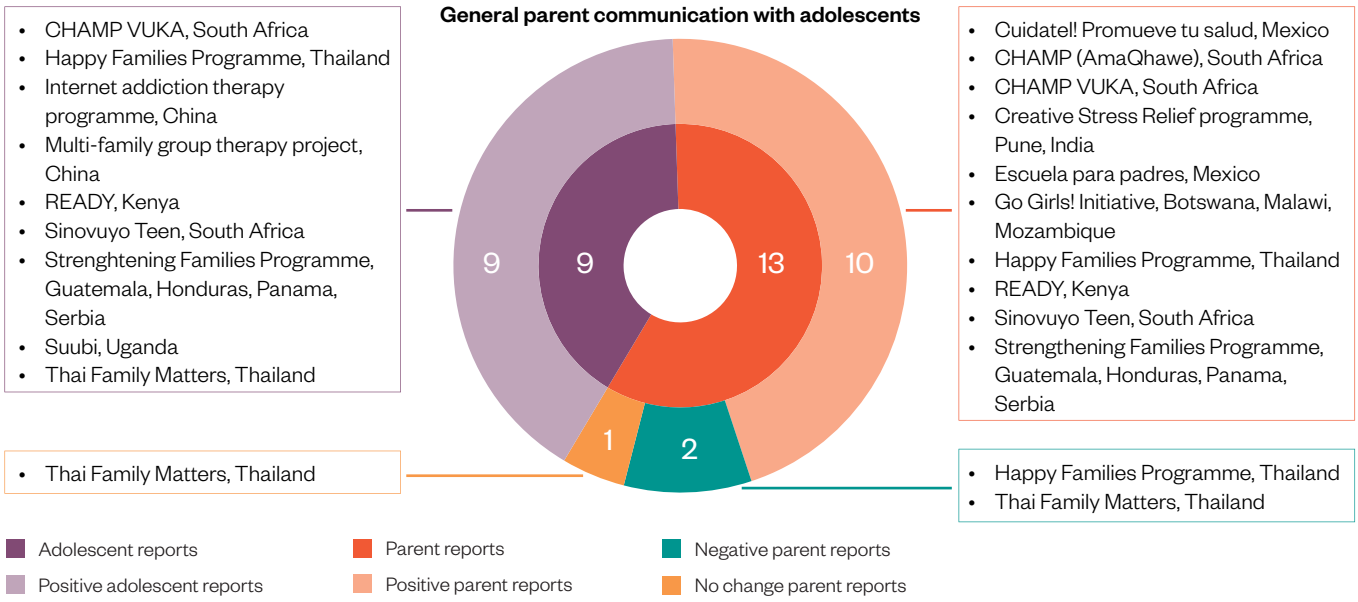
Forty studies of 28 parenting programmes examined their impact on parenting skills. This section focuses on programme impacts in relation to the following indicators:

- parents' communication skills, both in general and on sensitive issues;
- parents' and adolescents' perceptions of the quality of their relationship;
- positive discipline (including reduced use of harsh physical and verbal punishment);
- positive monitoring (and reduced neglect) of adolescents.

## 3.1 Parents' communication skills

A key element of positive parenting is communication between parents and adolescents. Eighteen studies of 14 programmes report on changes in general parent communication with adolescents. Figure 5 shows the distribution of reported outcomes. It is notable that all adolescent reports indicate increased frequency or improved quality of communication between parents and adolescents, while a quarter of parent reports indicate either no change or worsening communication. Eight studies measured both adolescent and parent reports on indicators of communication, while six studies drew from parent reports only.

## Figure 5: Parent and adolescent reports of programme impacts on general parent–adolescent communication




Three of the eight studies that drew on both parents' and adolescents' reports found that adolescents reported a greater improvement in communication than parents did. All studies were of programmes in Thailand – the Happy Families programme (Sim et al., 2014; Puffer et al., 2017) and Thai Family Matters (Cupp et al., 2013).

The study of the Go Girls! Initiative adult–child communication programme found that participants were significantly more likely to report improvements in communication with youth, positive role modelling, talking to youth about sex, and supervision of youth after participation than before. Adolescent participants were only asked about the quality of relationship with their parents (see next section) (Schwandt and Underwood, 2013).

Qualitative evidence highlights the acquisition of new communication skills and improved parent–child communication as a vital factor contributing to other positive outcomes. For example, qualitative data from the Sinovuyo Teen programme in South Africa shows both adolescents and caregivers drawing a link between improved communication and improved family relationships:

> Teen: *'We share our problems. And that makes us close.'*
>
> Caregiver: *'We sit down and talk and it is really nice. He tells me about what goes on at school and he has really pushed himself. He even plays cricket, they received a trophy and I would praise him.'* (Doubt et al., 2018: 22)
>
> *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, cited in Doubt et al., 2017: 771)

No studies explicitly examined whether programme participation was associated with increased influence of adolescents on family decision-making, though the improvements in family communication discussed earlier imply some greater space for adolescents to express their thoughts and wishes. One study also reported a shift to greater acceptance of adolescents' right to know information and take part in decision-making on issues that affect them (among mothers, but not among fathers), such as the age at which to marry (Jejeebhoy et al., 2014: 31).

Studies that have attempted to quantify the relative contribution of different factors to observed outcomes indicate that improved communication is generally the single most important factor in subsequent increases in well-being (Ismailova et al., 2012; Molleda et al., 2017). In addition to its foundational role in strengthening family relationships, stronger general communication facilitates increased communication on sensitive issues, such as SRH, sexual violence and substance abuse. These are discussed in more depth in Sections 4 and 5. Tables 3 and 4, Annex 4 show the relationship between improvements in self-reported parenting skills and positive outcomes in other areas of adolescent well-being.

Notably, all programmes showing positive adolescent-reported outcomes for parent use of positive discipline also led to reductions in adolescent reports of violence, behavioural problems, and positive mental health outcomes. Two-thirds of programmes showing positive parent-reported outcomes for knowledge and use of positive discipline also led to reductions in parent-reported use of violence against adolescents. Over half of programmes showing improved communication between parents and adolescents also led to positive outcomes for adolescent SRH and mental health, and over half of programmes showing improved parent–child relationships also led to improvements in adolescent mental health and behavioural problems.

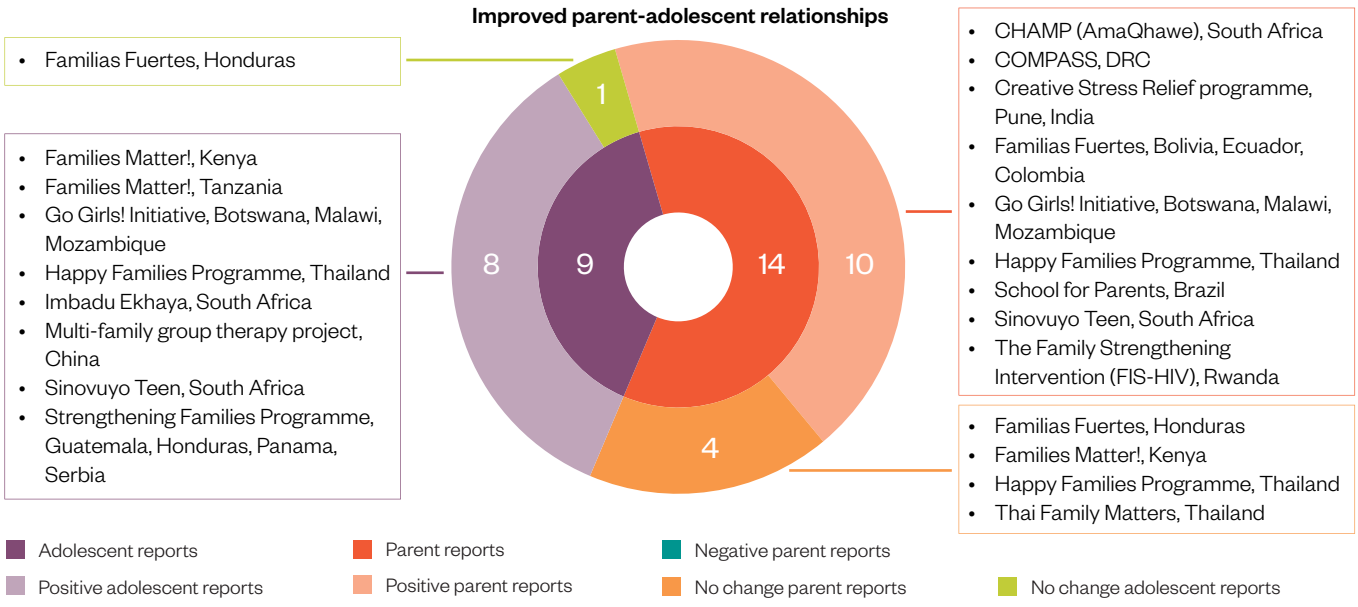
## 3.2 Improved parent–child relationships

Increases in the frequency and improvement in the quality of communication underpin perceptions among adolescents and parents that participation in parenting programmes had contributed to better-quality family relationships. Eighteen studies of 12 programmes reported on changes to parent–adolescent relationships, using indicators such as reported demonstration of warmth and affection, feelings of closeness, levels of family conflict, and quality time spent between parents and adolescents. Figure 6 summarises findings and shows that particularly for adolescents, most initiatives led to positive change.

Two studies (of Imbadu Ekhaya in South Africa and Families Matter! in Kenya) found that adolescents reported statistically significant improvements in parent–child relationships post-intervention, while their parents reported no significant change. For example, at the six-month follow-up of Imbadu Ekhaya participants, adolescents reported a significant improvement in parent–child relationships, while parents reported a slight decrease in positive interactions. The authors suggest this could reflect adolescents' perceptions of change in relationships occurring gradually, while parents report on their efforts to improve interaction immediately after an intervention, which may decline over time (Armistead et al., 2014).

One study – of the Go Girls! Initiative – delved into gendered differences in impacts on parent–adolescent relationships in detail. Schwandt and Underwood (2013) found that most adolescent girl respondents felt that their relationship with their mother had improved over the past year in all three countries (Botswana: 69%; Malawi: 55%; Mozambique: 64%). Less than 5% of respondents in any country indicated the relationship had worsened. In Botswana, girls whose mothers had participated in the programme were 2.8 times more likely to report improved relationship with their mothers than those who did not, and in Malawi this figure rose to 10.4 times. By contrast, less than half of girl participants in all countries reported that their relationship with their father had improved over the past year, and between 4% and 12% reported that it had worsened. This may indicate lower levels of fathers'

**Figure 6: Parent and adolescent reports of programme impacts on parent–child relationships**



participation in the programme, because where fathers did participate, girls were 2.5 to 5 times more likely to report an improved relationship. Schwandt and Underwood (2013) argue that the programme helped weaken gender-based barriers to communication between parents and children. As one male participant in Malawi put it:

> *At first, it was difficult for me to talk to my daughter – I could only discuss sensitive issues with my son. Now, I am able to talk freely with my daughter, and my wife is now able to talk to my son. All of this is possible because of the Go Girls! Initiative.*
> (Schwandt and Underwood, 2013: 1183)

Studies of three programmes cite the importance of increased 'quality time' or 'fun' spent between caregivers and adolescents in improving relationship outcomes. Qualitative data from the Sinovuyo Teen programme in South Africa demonstrates participants' appreciation of the 'fun' aspect of the programme's workshops in facilitating communication and openness in a 'safe' space (Doubt et al., 2017: 770). De Wit et al.'s (2018) study of the Creative Stress Relief programme in India observed that mothers reported spending more quality time with their adolescent children post-intervention and felt good playing and connecting with their children. The authors noted that this had a particularly significant impact in a context where parents often focus on their children's studies, leaving minimal time for play. The group-family session enabled parents to reflect on this together:

> *It was nice that in this group we were with parents who acknowledged that there were concerns about education and wanted to do something about it. And trying to do things differently together: that is important. To jointly see if we can be a bit more relaxed about it all.*
> (De Wit et al., 2018: 78–79)

Several studies highlighted the role of joint parent–adolescent discussion groups in promoting positive parenting. For example, the Familias Fuertes programme in Bolivia, Colombia and Ecuador involved seven small group discussion sessions for parents and adolescents (aged 10–14). Orpinas et al.'s (2014) study of the programme measured, among other areas, differences in pre- and post-intervention levels of 'positive parenting' (measured in terms of showing love, warmth and interest in the child's ideas and activities) and 'parental hostility' (measured by indicators of anger 'such as losing control, shouting, or hitting'). The findings showed that on average, across the three contexts, 75% of caregivers with low baseline positive parenting scores increased their 'positive parenting' and 68% decreased their 'parental hostility'; among those who reported more positive practices at baseline, 21% reported an increase in positive parenting, while 25% decreased 'parental hostility'.

The 2006 study by the Pan American Health Organization (PAHO) of Familias Fuertes, and Jejeebhoy et al.'s (2014) study of the Bihar parent–child communication initiative, also found positive change in parent–child relationships but could not attribute these changes to the intervention, given changes among the control group.

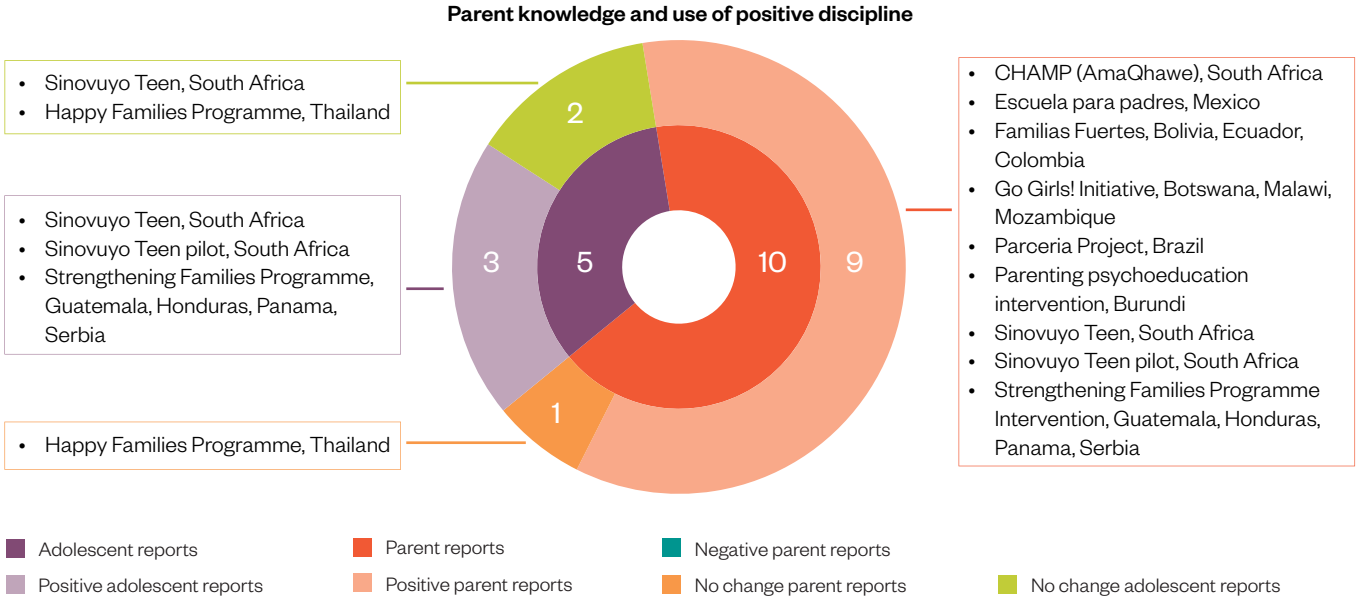
## 3.3 Positive discipline

Ten programmes (discussed in 15 studies) aimed to equip parents with positive disciplinary techniques, such as communicating clearly with adolescents, listening to their perspectives, praising adolescents for good behaviour, and using alternative sanctions to violence (such as requiring a child to right a wrong they have been involved in or removing a privilege). Figure 7 shows that in the vast majority of studies, data gathered from parents suggests that these programmes are effective in enhancing parent knowledge and use of positive discipline. While all but one study measuring both parent and adolescent reports (Cluver et al.'s 2018 study of Sinovuyo Teen in South Africa) found that parent and adolescent reports matched on this indicator, 8 of the 15 studies only measured parent reports, which is a clear limitation.

The studies reviewed suggest that various factors contributed to parents making an effort to interact with their children in a more engaged manner and use more positive forms of discipline. These factors include a combination of new knowledge and perspectives, practising new ways of relating and communicating through role plays, experiencing something fun and new together with adolescent children, and developing a support network of other families experiencing similar challenges and making similar changes.

Qualitative data gathered from CHAMP (Amaqhawe) in South Africa highlights the disempowerment some participants felt as a result of prevailing interpretations of children's rights rhetoric. Participants reported that the programme had helped them understand their own rights and responsibilities better:

**Figure 7: Parent and adolescent reports of programme impacts on parent use of positive discipline**




*Whatever you did, the child would threaten you by saying that she/he is going to take you to court. Well then it made us feel like we were useless and not a parent. You wouldn't feel like a parent to the child, but felt that the child was more powerful than you.*
(Paruk et al., 2009: 63–64)

*[Champ helped by] …teaching us parents how far children's rights go and how far parents' rights go. So… we were able to have a proper discussion with our children and there was good communication, and we felt like real parents, and the child was able to realise that she/he is still a child and this is a parent.*
(ibid.)

Studies often found a simultaneous increase in positive skills and a decrease in their negative counterparts, such as harsh verbal or physical punishment. For example, as participants in parent education programmes in Botswana, Burundi and South Africa observed:

*This program has helped me build a better relationship with my children. I used to be very strict with my children – I would beat them or yell at them. I attended the Go Girls! Adult-Child Communication program and now I can sit with them and tell them that I love them. I can give them advice without beating them or yelling at them.*
(Mother, Botswana, in Schwandt and Underwood, 2013: 1182)

*I learned how to collaborate with my children, even if they commit faults.*
(Mother, Burundi, in Jordans et al., 2013: 1855)

*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.*
(Mother, South Africa, in Doubt et al., 2017: 771)

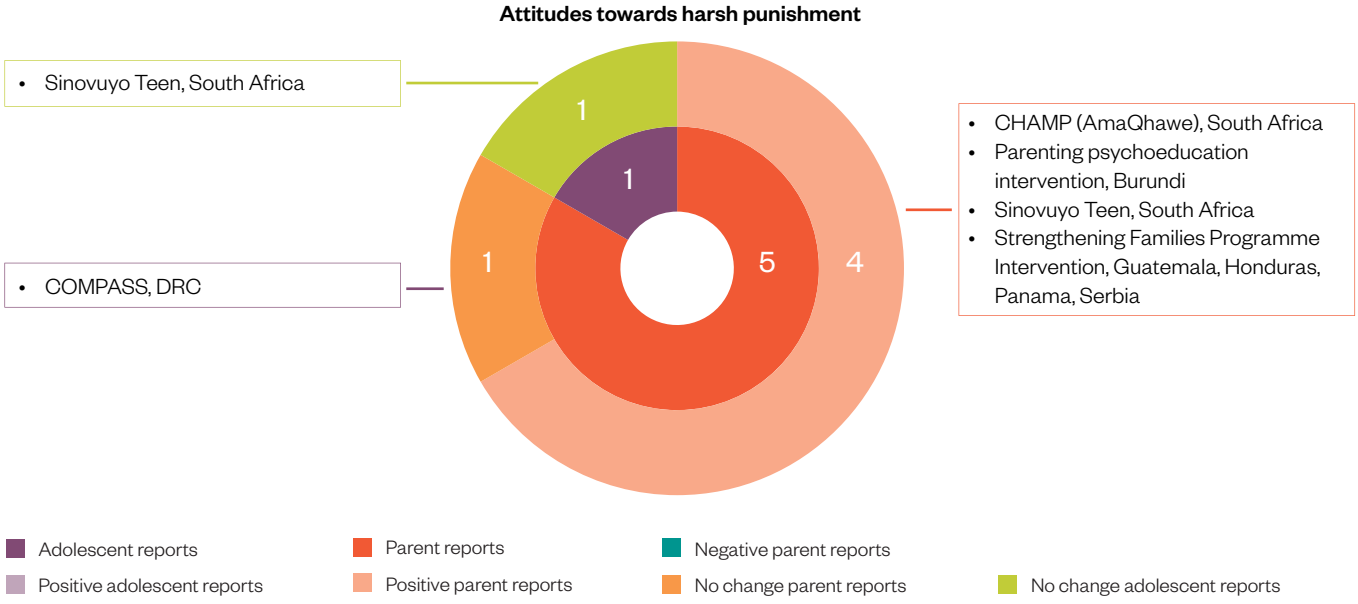
*[I] compliment my child when he has done well and he can do the same to me.*
(Caregiver: South Africa, in Doubt et al., 2018: 23)

### 3.3.1 Changes in attitudes towards harsh punishment

As Figure 8 shows, evaluations of four programmes found changes in parents' attitudes towards harsh physical or verbal punishment of adolescents, while one study found no significant change. For example, participants in a parent education initiative in Burundi described new attitudes they developed from taking part in parents' groups and learning about positive parenting:

*I learned of not ill-treating our children… not to give hard works that are not appropriate for their age.*
(Mother, in Jordans et al., 2013: 1855)

## Figure 8: Distribution of changes in attitudes towards harsh punishment




Notably, a number of participants in the CHAMP (Amaqhawe) parent-only intervention, and the full version of Sinovuyo Teen programme – both in South Africa – reported feeling greater confidence, and a sense of empowerment in newly learnt approaches to communicating with and disciplining their children (Doubt et al., 2017: 771).

Clarity around children's rights and parental authority was then highlighted by some as key to their changed attitudes towards harsh punishment and abuse of adolescents:

> *Okay, we realised that our rights were not taken away from us. But the problem was that sometimes when we thought that we were using our rights, maybe we were abusing the authority that we had over our children, or abusing our position as parents to our children. We were aware that it was our right to take care of our children, especially when a child has gone and you don't know where she/he has gone to, [we believed that] it is your right to shout at your child or to give your child a hiding. But we have learnt that we were abusing our authority over our children. We learnt that the treatment we gave our children sometimes had bad results.* (Paruk et al., 2009: 64)

Adolescents participating in Sinovuyo Teen (pilot) in South Africa reported no change in their own attitudes towards harsh punishment (Cluver et al., 2016a).

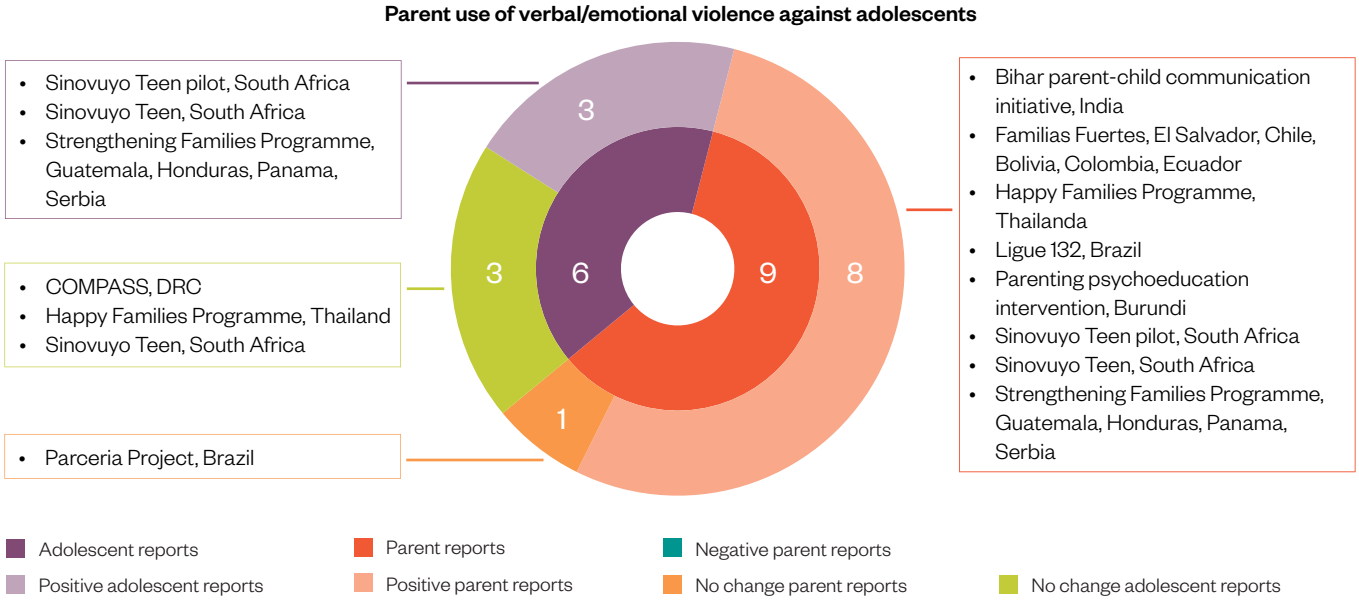
Stark et al.'s evaluation of COMPASS, which worked in the DRC with adolescent girls and their parents, also found no impact on parents' attitudes towards the physical discipline of children. This is probably because changing entrenched attitudes towards the use of corporal punishment would require more intensive contact, with alternative ideas and approaches, than one discussion group per month.

### 3.3.2 Impacts on parents' use and adolescents' experience of harsh punishment

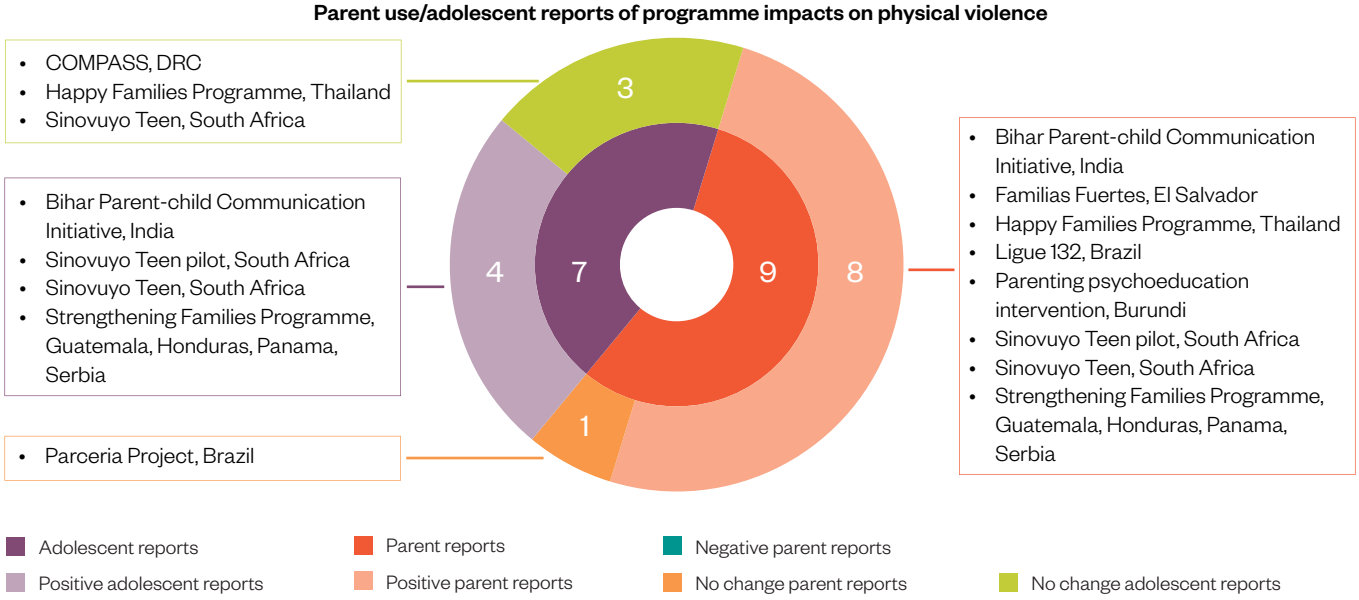
Figures 9 and 10 show parents' and adolescents' reports of programme impacts on harsh punishment – both physical and verbal/emotional. Most studies examined changes in both forms of violence, and thus we discuss programme impacts on both forms of violence together. In both cases, more studies examined parents' self-reported behaviour than adolescents' reports of changes in parents' practices.

Studies of 10 programmes measured impacts on parents' use of 'harsh punishment', such as yelling, swearing, slapping, beating (with hand), and beating (with soft/hard object). Eight of these 10 programmes led to a reduction in parent-reported verbal or physical abuse of adolescents, while one study reported no change in parent-reported use of harsh punishment. Examples of positive change include: substantial reductions in parents reporting behaviours such as yelling and hitting, as a result of participating in Familias Fuertes in Ecuador, Bolivia and Colombia (Orpinas et al., 2014); a statistically significant reduction in parent-reported violence against adolescents in almost all parent groups participating in

## Figure 9: Parent and adolescent reports of programme impacts on verbal/emotional violence




## Figure 10: Parent and adolescent reports of programme impacts of physical violence




the Strengthening Families programme in Guatemala, Honduras, Panama and Serbia (Maalouf and Campello, 2014); and an average 13% reduction in parent-reported violence against adolescents among participants in Happy Families in Thailand (Sim et al., 2014).

Mejia et al.'s (2016) study of the Familias Fuertes programme in Panama highlights how behaviour can sometime lag behind attitude change:

> *When I get mad, I yell and that is not correct. I need to change. We are too emotional. We do not sit down with our kids and talk. Today we just hit them and do not put into practice communication.* (Mejia et al., 2016: 61)

Participants identified stress reduction and anger management activities and parent–child discussion groups that promoted mutual respect as key ways these programmes helped them reduce their use of violence. For example, a participant in Sinovuyo Teen in South Africa articulated her learning as follows:

> *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.* (Doubt et al., 2017: 770)

Both adult and adolescent participants also highlighted that they had 'learned to take a pause' when they got stressed. As well as reducing adult violence against adolescents, adolescents also reported staying calm and not being aggressive to peers or siblings (Doubt et al., 2017: 771).

The evaluation of the Happy Families programme in Thailand also highlights qualitative evidence that the programme improved adult participants' stress and anger management capabilities and coping strategies:

*Some respondents identified their increased ability to 'control the mind' as the foundation to subsequent improvements in their interactions with children, partners, and community members. In particular, they attributed the decrease in their use of harsh punishment and conflict with their partner and neighbors to better emotion regulation since the intervention. (Sim et al., 2014: 3)*

The studies of both Sinovuyo Teen and Happy Families also report participants' perceptions of improved partner relationships and reduced conflict as a result of programme participation, though neither relate this directly to reduced abuse of children.

### 3.3.3 Differences between parents' and adolescents' perceptions of change

For both verbal and physical punishment, parents' and adolescents' reports show clear differences. While parental reports were almost entirely positive, with only one study (Parceria project in Brazil) finding no change in parent-reported behaviour, adolescents had a much more mixed view: three out of six adolescent reports on verbal violence, and three of their seven reports on physical violence indicated no change (or only non-significant change) in parents' behaviour. In one case, this disconnect reflected changing perceptions over time. Cluver et al.'s 2018 study of the Sinovuyo Teen programme in South Africa found that caregiver and adolescent reports were similar one month post-intervention, but diverged at the 5–9-month evaluation, when caregivers continued to report a reduction in physical and emotional abuse of their children, while adolescents reported no change (ibid. 7). In other cases, such as Happy Families in Thailand, discrepancies are not easily explained (Puffer et al., 2017).

## 3.4 Parental monitoring of adolescents

Studies of 10 programmes examined impacts on positive monitoring or supervision of adolescents (knowing their whereabouts, who they are with, etc.) or other indicators of neglect.[15]

As Figure 11 shows, studies of six programmes reporting on the neglect of adolescents found positive changes, two of which were reported by parents and adolescents, and the remaining four only measured outcomes via parent reports, while studies of four programmes found no changes. In the evaluation of the Families Matter! programme in Kenya, increases in parental monitoring – reported by parents (61%) and adolescents (62%) – were statistically significant (Vandenhoudt et al., 2010).

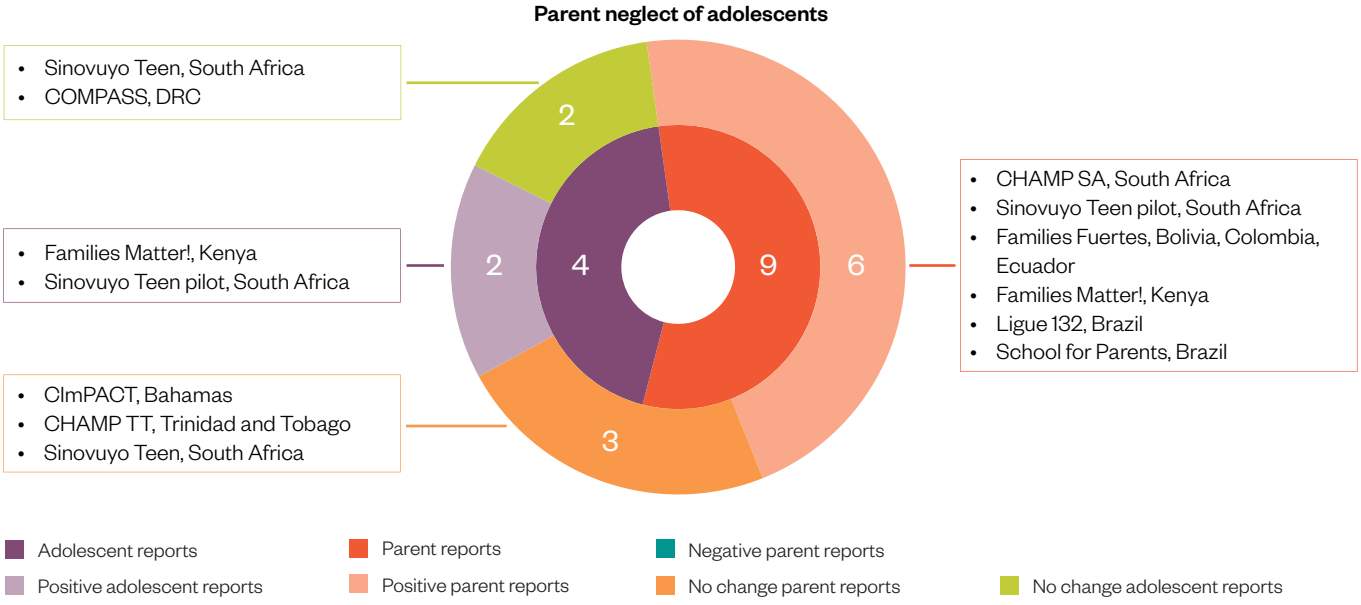
The studies of Sinovuyo Teen in South Africa (pilot and full programme) found differing results in terms of impact on monitoring of adolescents. Cluver et al.'s 2016 study of the pilot reported a decrease in 'poor supervision' and an increase in 'positive monitoring' by caregivers, while studies of the full programme found no impact. This divergence may reflect the timing of evaluations; the evaluation of the pilot measured results 2–6 weeks after the intervention and found positive change, while Cluver et al.'s 2018 evaluation of the full programme measured results 5–9 months post-intervention and recorded no change.

Two further studies found no significant impact on parental monitoring of adolescents. The evaluation of Familias Fuertes in Honduras found a slight, non-statistically significant increase in parental monitoring of adolescents (Vasquez et al., 2010). Dinaj-Koci et al.'s (2015) study of ClmPACT, an adolescent SRH education and parenting skills intervention in the Bahamas, suggests that the lack of change reflects high levels of parent-reported monitoring at baseline and thus limited scope for change.[16]

15 The evaluation of School for Parents, Brazil, which worked with families whose difficulties had led to court action, used indicators such as not reoffending in terms of child abandonment, neglect or abuse, and various indicators that parents were attending to children's well-being such as enrolling them in school. The evaluation of COMPASS in the DRC examined female adolescent reports of feeling uncared for by the person who should provide them with care in the past 12 months (Stark et al., 2018: 5).

16 The lack of adolescent reports may mean that changes were under-reflected (Dinaj-Koci et al., 2015: 652).

## Figure 11: Parents' and adolescents' reports of programme impacts on parent neglect of adolescents




### Box 3: Case study: Parenting for Lifelong Health: Sinovuyo Teen

The Sinovuyo Teen programme has been documented in several qualitative and quantitative evaluations, as well as reports outlining its development and evolution. The programme offers valuable insights into both the impacts that can be achieved by a well-designed programme for the parents of adolescents, and the process of iteration, piloting, analysis and further development.

**Programme purpose**

Parenting for Lifelong Health is a collaboration initiated in 2012 between WHO, UNICEF and academics from high-income as well as low- and middle-income countries. It is supported by donor partners, LMIC governments and the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID). It aims to develop and test a suite of child abuse prevention programmes for different child developmental stages (Cluver et al., 2016a). The Sinovuyo ('we have joy') Teen parenting programme was developed and tested in South Africa as part of this initiative, aiming to reduce abusive parenting and improve positive parenting and monitoring of adolescents. Secondary aims were to reduce problematic adolescent behaviours, parental depression and stress, and substance abuse. The programme was implemented as a randomised control trial (RCT) following four years and stages of pilot testing. It was also analysed in a qualitative study.

The programme was delivered to families of 10- to 18-year-old adolescents experiencing conflict (ibid.). The final version of the programme identified families for recruitment via local services, such as schools and social workers, using risk screening questionnaires to calibrate family stress (Doubt et al., 2017)

**Programme design, delivery and effect**

Sinovuyo Teen was designed in four stages by Oxford University and the University of Cape Town, in collaboration with an NGO, Clowns Without Borders (South Africa) (ibid.). The first phase, carried out in 2012, involved drafting the programme and consulting 50 international experts. The second phase involved piloting the programme with 30 parent–teen dyads in Hamburg, South Africa, in 2013 (Cluver et al., 2017). The programme was revised and delivered in King William's Town the following year to 115 parent–teen dyads as part of the third phase, a pre-post trial and qualitative study measuring self-reported change as a result of programme participation, and the experiences of programme facilitators. The third phase was delivered by locally recruited community members who were trained through the Isibindi model[i] by Clowns Without Borders (UNICEF, no date), alongside local social auxiliary workers

(Cluver et al., 2016b). The programme was delivered to beneficiaries of Isibindi child and youth care and families recommended by schools, social services, chieftains and through door-to-door recruitment.

The pre-post trial identified key lessons – for example, around recruitment of participants. Including participants through both community and service referrals and door-to-door visiting led to the identification of families in need, which may widen the scope beyond families in need of child abuse prevention services to those dealing with severe substance use, mental health problems, domestic violence or terminal illness. Another lesson was that implementation feasibility was strongly influenced by unanimous support from traditional leaders, government, and school principals (Cluver et al., 2016a).

The fourth and final stage of programme development involved a pragmatic cluster RCT[ii] carried out in 40 townships surrounding King William's Town in 2015 and 2016 (Cluver et al., 2017). This involved 552 parent–teen pairs; 270 received the intervention and 282 acted as a control. The evaluation assessed the extent to which the programme's intended outcomes were achieved. It was complemented by a qualitative study examining the factors that affected programme effectiveness (Doubt et al., 2017). Different families were recruited to participate at each stage.

The final version of the programme offered 14 weekly group-based workshop sessions, 10 of which were joint sessions for parents and adolescents, and 4 of which were delivered separately (Cluver et al., 2017). Those who missed group sessions were able to catch up via a home visit. The teaching method focuses on collaborative and activity-based learning, including role play, home practice, illustrations, and 'rituals based on traditional practices of sharing a meal, singing, and sitting in a circle formation' (Doubt et al., 2017: 768). Programme facilitators worked in pairs, which they considered good practice. It contributed to their confidence in delivering the programme, especially in home visits, as one facilitator was once threatened by an aggressive family member (Loening-Voysey et al., 2018a). The final trial found that caregivers attended 50% of the sessions on average and adolescents attended 64%, with 9% of caregivers and 5% of adolescents attending no sessions (Cluver, et al., 2017). All but four families received home visits to remedy this.

The programme demonstrated effectiveness across several parenting, family and violence prevention outcomes measured either 1 month or 5–9 months post-intervention; this included reduced alcohol and substance use by adolescents and caregivers, as well as reported improvements to family financial self-efficacy and budgeting (Cluver et al., 2017). A recent cost-effectiveness study of Sinovuyo Teen found that it cost US$1,837 per incident of physical or emotional abuse averted. Comparatively, the economic benefits of averting abuse in South Africa were estimated to lead to a lifetime saving of US$2,724, and therefore the programme was found to be cost-effective (Redfern et al., 2019).

**Gender**

The Sinovuyo curriculum aimed to influence attitudes towards gender norms in relationships and to reduce gender-based violence towards adolescents (Cluver et al., 2016a). For example, session 8, which instructs parents and adolescents separately about identifying and resolving problems without conflict, includes scenarios for the adolescent session with examples about a teenage girl wanting to date an older man, or a teenage girl wearing outfits her teacher disapproves of (Doubt et al., 2015). Session 13, on responding to crisis and abuse, includes role plays relating to a girl who has been abused by an uncle, and how parents should deal with the situation positively.

In the trial, 95% of caregivers who participated were female (Cluver et al., 2017). Engagement of other family members was dependent on the family structure, the facilitator delivering a home visit session, and family members' interest in the programme (Doubt et al., 2018). Sinovuyo may have challenged gender roles by supporting female caregivers to practise skills at home that they would not otherwise have had the confidence to apply. Some participants felt that it would not be feasible to involve fathers at all, and some felt that fathers would not attend a programme that involved games and songs, which are traditionally for women and children (Loening-Voysey et al., 2018). Some highlighted that fathers would be more likely to attend parenting meetings in urban than rural areas.

**Reach and scale-up**

The Parenting for Lifelong Health: Sinovuyo Teen programme is in the process of being adapted and scaled up by governments in Africa alongside national, international and local NGOs. There are plans for 200,000 families to participate in the programme in the DRC, Lesotho, South Africa, South Sudan, Uganda, Tanzania and Zimbabwe,

and it may also be replicated in countries as diverse as Afghanistan, Haiti, Israel, Lithuania and the Philippines. The programme has been adapted to local languages and cultures, and in some instances has been expanded to include additional components seen as locally desirable, such as menstrual hygiene or HIV prevention education (Cluver et al., 2017).

Clowns Without Borders South Africa has been providing training and supervision for the implementation of Sinovuyo Teen in three South African provinces and in other countries (Clowns Without Borders, 2016), with plans to support Parenting for Lifelong Health to expand to the following countries:

- **Lesotho** – intending to reach 30,000 clients with an HIV-enhanced version of the programme through 2016 and 2017, funded by USAID DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe);
- **Uganda** – intending to reach 20,000 clients by the end of 2017, (funded by USAID DREAMS), and to implement a home-based adaptation of the programme to support reintegration of 660 children from residential care facilities back to their families (funded by USAID);
- **DRC** – intending to reach 3,600 families in year 1, and continue programme delivery through to 2019 (funded by USAID);
- **South Sudan** – intending to reach 500 families in 2016 and 2017 (including younger children through Parenting for Lifelong Health – Teen) (funded by USAID), aiming to scale up further between 2017 and 2019;
- **Tanzania** – intending to reach 40,000 clients (under the USAID-funded Kizazi Kipya Project Pact) from 2017 to 2019 (ibid.).

Additional details on programme implementation and specific adaptations for translating programme activities to these other countries have not been presented in an academic study, though some notes are available in other formats. For example, a presentation at the Orphaned and Vulnerable Children (OVC) Conference in Washington DC outlined Lesotho's experience from 2016 to 2019 with Parenting for Lifelong Health – Teen, which reached 54,370 adolescent girls and young women with their caregivers (Mehale, 2019). Adaptations to the programme for Lesotho included renaming the programme from Sinovuyo to Rethabile (Happy Together), condensing the content from 14 down to 8 sessions, and strengthening the HIV modules to improve caregiver–adolescent communication and to promote adherence to medication among adolescents.

The curriculum for Parenting for Lifelong Health – Teen is freely available, as are the tools used in undertaking the research in South Africa (UNICEF, no date).

*i The Isbindi model has been implemented in communities across South Africa to train unemployed people in child and youth care to work in strengthening families and preventing child abuse (National Association of Child Care Workers, no date).*

*ii 40 communities, with on average 14 families each, were selected for the trial from within a 2-hr radius of the research team's base. The families were then assigned to receive either the intervention (270 families) or a control 1-day hygiene promotion programme, Sinovuyo Soap (282 families), to determine the intervention's effects.*

# 4 Impacts on psychosocial well-being

**Initiatives examined** (26 studies of 21 programmes)

Burundi parenting psychoeducation intervention; CHAMP Amaqhawe (South Africa); CHAMP-SA (South Africa); CHAMP-VUKA (South Africa); China group-family therapy for internet addiction; China family-based intervention for adolescent internet addiction; Escuela para padres (Mexico); Familias Fuertes (Honduras); Familias Unidas (Ecuador); Happy Families programme (Thailand); India parent support programme for intergenerational concerns; Iran parenting education programme; Iran quality of life therapy for parents; Parceria project (Brazil); Sinovuyo Teen (pilot and full programme) (South Africa); READY (Kenya); Rwanda family-based prevention intervention; Sexuality Education Programme for Mothers of Young Adults with Intellectual Disabilities (SEPID) (Turkey); School for Parents (Brazil); Strengthening Families (Honduras, Guatemala, Serbia, Panama).

**Main findings:**

*Psychosocial well-being*

- 88% of reported mental health outcomes were positive. Indicators included improved parental mental health (reduced stress and depression, greater self-esteem and life satisfaction), increased social support, adolescent life satisfaction, depression, and reduced behaviour problems.
- Parenting programmes that improve parents' mental health can also improve adolescents' mental health; our review found improvements in 3 out of 4 programmes that measured both. A key mechanism for improvements was through stress reduction activities and programmes encouraging people to spend more time together.
- 11 of 12 studies that examined impacts on adolescents' behaviour found positive changes: reductions in aggressive behaviour, fewer behavioural problems (such as swearing and stealing), and reduced internet addiction.

*Substance abuse*

- Compared with other issues, the proportion of positive changes related to substance abuse is lower (56%) and the proportion of studies finding no change is higher. This probably reflects the relatively young age of the adolescents whose parents participated and low levels of substance use reported at baseline. However, Sinovuyo Teen in South Africa found reduced substance abuse among adolescents.
- We also found evidence of increased parental communication with adolescents around substance abuse (in 3 out of 4 programmes examined) and reductions in parents' self-reported substance abuse (also in 3 out of 4 programmes). Qualitative studies found a link between reduced alcohol use and improvements in adolescent well-being.

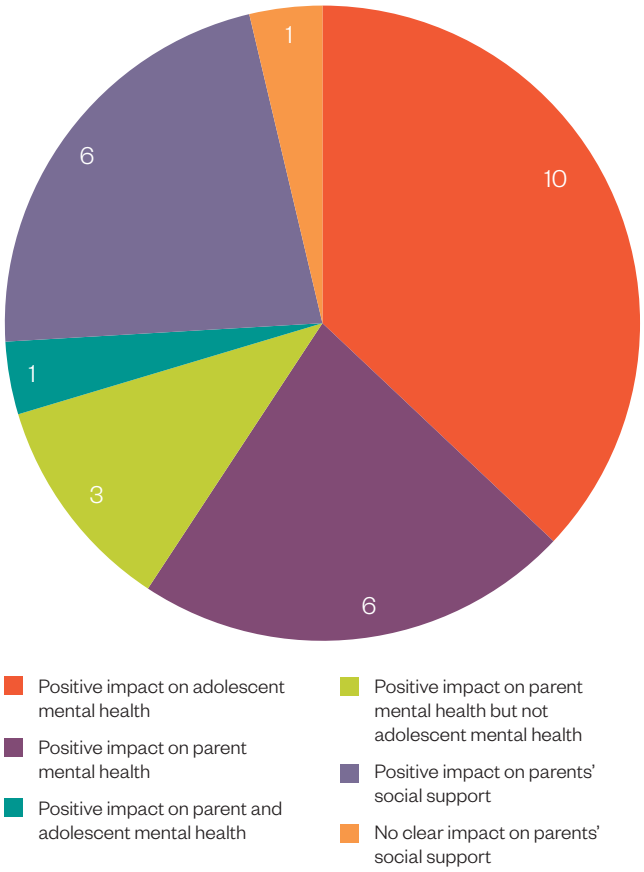
This section reviews the 26 studies of 21 parenting programmes that report on impacts on psychosocial well-being outcomes. It presents findings on parent and adolescent mental health outcomes, and studies that report on impacts on protective psychosocial factors for adolescents, behavioural problems, and two studies addressing adolescent internet addiction. The final section discusses impacts on adolescents' and parents' knowledge, attitudes and behaviour towards substance use.

## 4.1 Parents' mental health

Based on the hypothesis that improving parents' mental health should increase their ability to parent effectively, ultimately leading to better adolescent outcomes, six programmes examined in eight studies aimed to strengthen parents' psychosocial well-being. Nine studies of seven programmes also examined whether programmes had helped participants develop stronger social support networks.

Three studies – Abedi and Vostanis's (2010) study of an intervention focused on adolescents with obsessive

**Figure 12: Distribution of programme impacts on mental health**




compulsive disorder (OCD) in Iran, Pereira et al.'s (2013) study of the Parceria project in Brazil, and Doubt et al.'s (2018) study of the Sinovuyo Teen programme in South Africa – found improvements in both caregiver and adolescent well-being outcomes, while Cluver et al.'s (2018) impact assessment of the Sinovuyo Teen programme found positive effects on parental depression and stress but no change in adolescent depression or suicidality.

Abedi and Vostanis's (2010) evaluation of a quality of life therapy programme[17] for mothers of adolescents with OCD in Iran found significant improvements in mothers' overall life satisfaction and self-esteem. These paralleled increased adolescent life satisfaction and reduction in negative outcomes related to OCD. In Brazil, the Parceria project engaged mothers who were currently experiencing (or had previously experienced) intimate partner violence. Pereira et al.'s (2013) study found that the one-on-one sessions with a researcher contributed to an increased sense of well-being, parental competence and satisfaction in parental roles. These results mirrored positive outcomes in parenting skills and practices reported by both mothers and adolescents, as well as improved adolescent well-being and behaviour reported by mothers.

As discussed in Section 3, studies of the Sinovuyo Teen programme in South Africa found that it helped participants manage stress, which both adolescents and adults perceived as an important benefit. For example:

> *We had time to sing, we played and we were taught things that we had no knowledge of... Like when you are stressed, you need to have time out in order to reduce your stress. (Teen, interview 4)* (Doubt et al., 2018: 19)

> *Mom was [a] very confused person and hectic. But after Sinovuyo she is normal and does listen. But before she did not listen.* (Doubt et al., 2017: 770)

Parents who participated in the Creative Stress Relief programme in India also reported that they valued learning techniques for relaxing with their adolescent children and being playful, both to reduce frustrations with their children and improve their family relationships (de Wit et al., 2018).

Eight of nine studies that measured perceived changes in parents' social support and community networks found that participants felt the programmes had boosted these networks; two examples from South Africa indicate the types of changes that participants experienced:

> *I would say that with people that attended the programme, friendship and trust did develop. Since we met, we bonded so much that it came to a point where when you have a problem, you don't just sit down but you go to your friend that you met when you attended the programme. We are now able to help each other and phone each other as neighbours.* (Mother, participant in CHAMP (Amaqhawe), cited in Paruk et al., 2009: 65)

> *In the community you can find a neighbour come crying to you asking for help because things are not going well at home with their child. Because of the knowledge I have gained here, I am able to give advice.* (Caregiver, participant in Sinovuyo Teen, cited in Doubt et al., 2018: 26)

> *Sinovuyo has helped us build better friendships. I can now go and rest on [X]'s bed and ask for tea and food*

17 This aimed to help parents develop life management skills and change core attitudes to promote life satisfaction.

*and we talk.* (Caregiver, participant in Sinovuyo Teen, cited in Doubt et al., 2018: 27)

Paruk et al.'s (2009) study also found that these stronger social networks contributed to more community-level guidance of children – with parents more willing to challenge children from other families if they observed poor behaviour, and other community members more accepting of such guidance. Participants also reported that following CHAMP, they had organised to challenge the sale of alcohol to children by reporting it to the police.

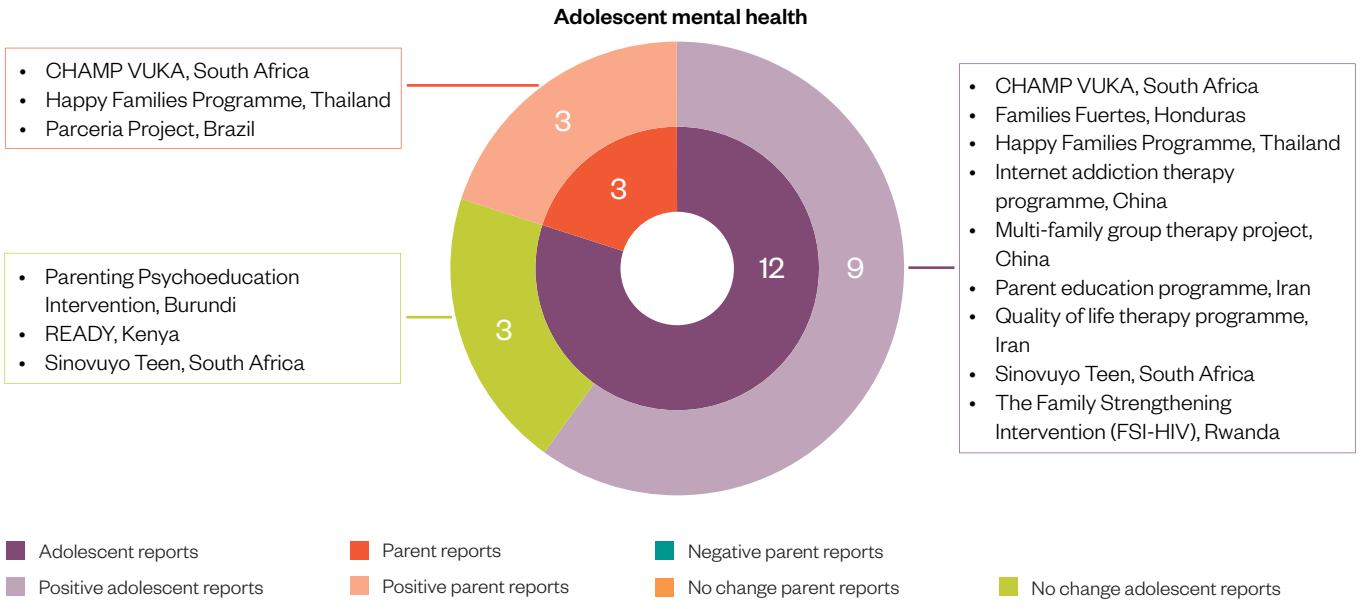
Two of the four studies that examined impacts on adolescents also found positive impacts on adolescents' social support networks (Bhana et al.'s 2014 study of CHAMP-VUKA and Doubt et al.'s 2018 study of Sinovuyo Teen, both in South Africa).[18] Only one study – Sim et al. (2014), on the Happy Families programme in Thailand – found limited impacts, with just a few parents reporting they had shared their experiences with other participants, though adolescents reported that their own social support networks had increased.

## 4.2 Adolescents' psychosocial well-being

Studies of 13 programmes reported on adolescent mental health and adolescents' perception of their familial and social environment. In addition to the parenting skills programmes discussed in previous sections, this set of programmes also includes four that aimed to help parents manage specific mental health or addiction issues that their children faced. Under the umbrella of adolescent mental health, the studies examined the impacts of interventions on indicators of adolescent depression, suicidality, life satisfaction, self-esteem, fulfilment of psychosocial needs, stress, and resilience. Ten studies also report on impacts on adolescent behavioural problems – including physical and verbal aggressiveness – and two on adolescent internet addiction. Joint parent–adolescent group sessions were the most common approach (8 out of 13 programmes); 4 included home visits, and for 2 this was the sole method of delivery. Figure 13 provides an overview of changes recorded.

Studies of 10 programmes found positive impacts on adolescent mental health indicators. For example, Kaveh et al.'s (2014) study of a parenting education programme in Iran aimed at improving adolescent girls' life satisfaction found significant positive change on all life satisfaction indicators (see Annex 3), with changes attributable to the programme. Abedi and Vostanis's (2010) evaluation of the quality of life therapy programme in Iran also found increases in adolescent life satisfaction on all indicators except for friendship and school, where no change was recorded. The evaluation of FSI-HIV (Rwanda) found reductions in rates of depression and anxiety among adolescents, which were sustained at follow-up after three months (Chaudhury et al., 2016). An evaluation of the

**Figure 13: Parent and adolescent reports of programme impacts on adolescent mental health**




18 Two studies of Sinovuyo Teen reported conflicting findings: Doubt et al.'s qualitative study found improved perceptions of social support for both parents and adolescents, while Cluver et al.'s (2018) quantitative study found improvements only for parents.

Happy Families programme (Thailand) found significantly reduced externalising of problems and attention problems compared with adolescents in the control groups (Annan et al., 2017). In studies that explored the reasons for positive change, participants attributed having fun together (within or outside sessions), learning how to spend quality time together, and reduced parental stress as contributing factors. This was more common in the broader parenting programmes than the programmes focused on parents of adolescents with specific mental health challenges.

Two studies found no impacts on adolescent depression or suicidality:

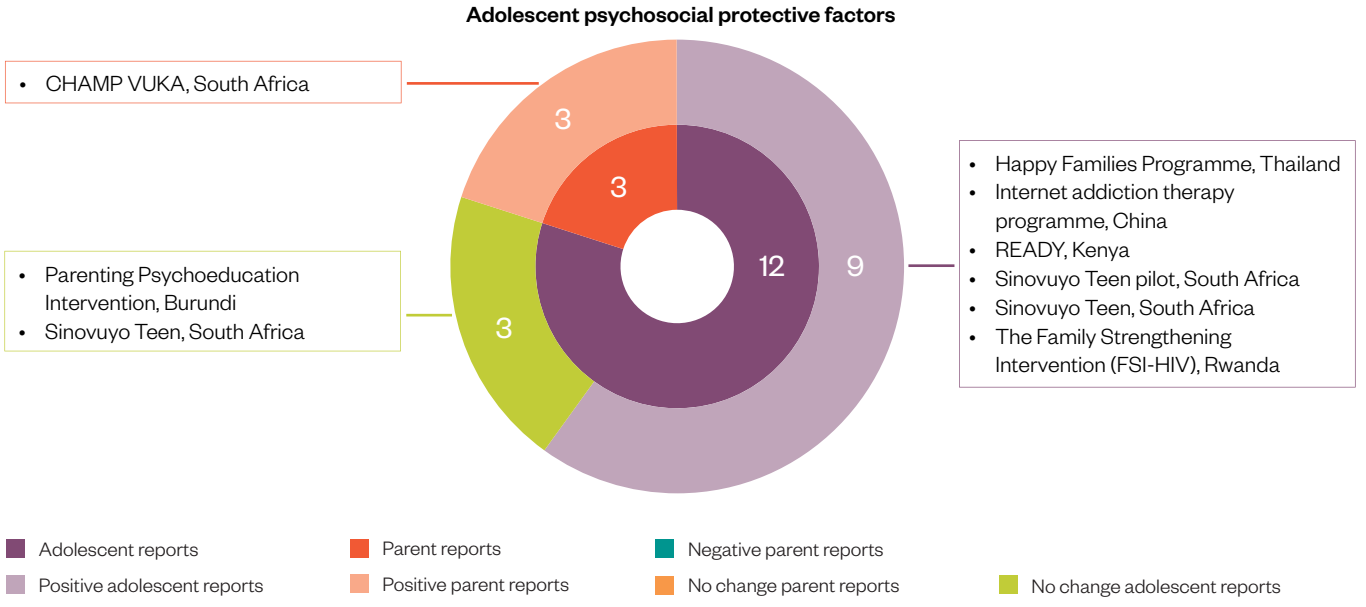
- The parenting education programme in Burundi for parents of adolescents with high levels of psychosocial distress found no impacts on adolescent symptoms of depression, though it had other positive effects, such as contributing to reduced behavioural problems among adolescent boys (Jordans et al., 2013).
- Cluver et al.'s (2018) impact assessment of the Sinovuyo Teen programme in South Africa found no effects on adolescent self-reported symptoms of depression or suicidality, despite reduced symptoms of depression among parents.

Studies of eight programmes reported on adolescent psychosocial protective factors, focusing mainly on indicators of resilience and reports of social support from family or peers. For example, Sim et al.'s (2014) study of the Happy Families programme in Thailand found a significant improvement in adolescents' self-reported resilience, which was maintained at the 6-month follow-up. In the READY programme in Kenya, adolescents also reported receiving increased social support from male caregivers at the 3-month post-intervention follow-up – a finding supported by male caregivers' reports of increased involvement in parenting, which doubled between the 1-month and 3-month follow-up (Puffer et al., 2016). By contrast, the studies of the Sinovuyo Teen programme and the Burundi psychoeducation programme found no increase in adolescents' self-reported social support. Studies of six of these programmes also reported on other adolescent mental health outcomes; these recorded consistent outcomes on adolescent mental health and psychosocial protective factors, with studies of four programmes finding positive impacts on both mental health and psychosocial protective factors, and two finding no change on either.

### 4.2.1 Behavioural problems

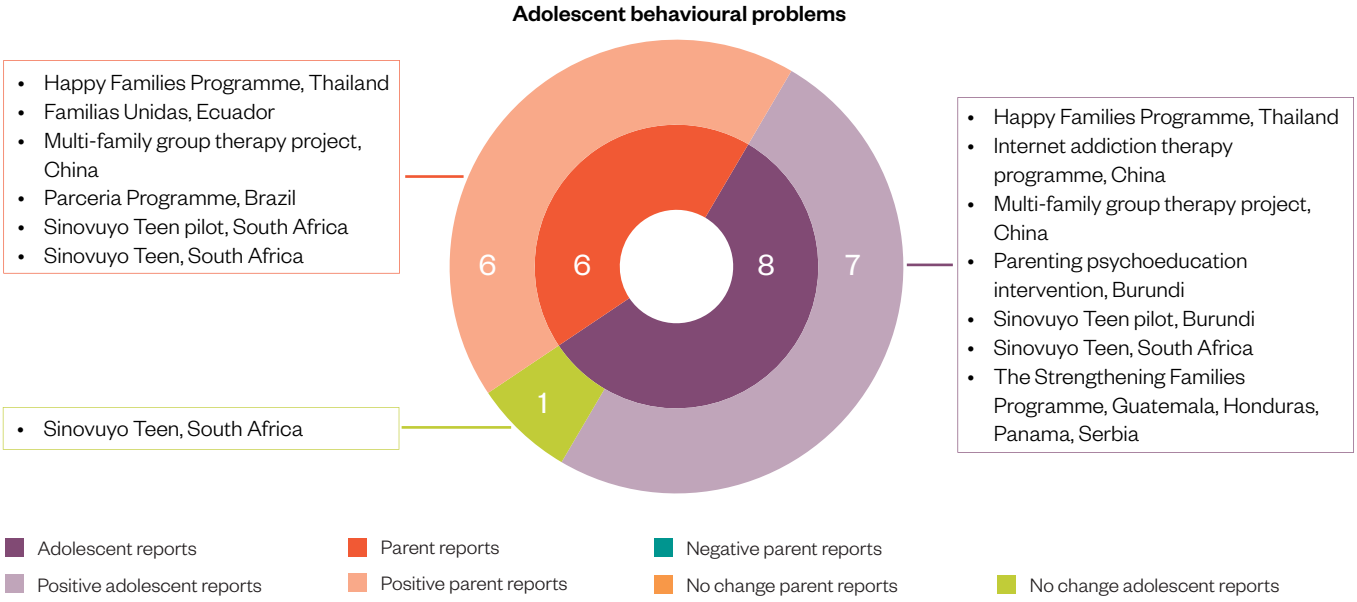
Twelve studies of nine initiatives report impacts on adolescent conduct or behavioural problems (including internet addiction, explored in Section 4.2.2); 11 found positive impacts, and 1 (Cluver et al.'s 2018 evaluation of the full Sinovuyo Teen programme) found no change in adolescent externalising problems.[19] The interventions assessed measured adolescent behaviour problems according to indicators that included rule-breaking,

**Figure 14: Parent and adolescent reports of programme impacts on adolescent psychosocial protective factors**




19 Cluver et al.'s study defines externalising behaviour as 'rule-breaking' and 'aggression' (2018: 5).

## Figure 15: Parent and adolescent reports of programme impacts on adolescent behavioural problems




disobedience, defiance, delinquency (such as swearing and stealing), and verbal or physical aggression.

Studies of all nine initiatives that found positive impacts on adolescent behavioural problems also reported one or more positive outcomes around improved parenting skills, parent–adolescent communication, relationships, and perceptions of parent provision of social support. For example, Molleda et al.'s (2017) study of the Familias Unidas programme in Ecuador found a positive correlation between increased parent–child communication and reduced adolescent behaviour problems. The study also measured the impact of parental monitoring of peers on adolescent behaviour problems and found no significant effect, reinforcing conclusions about the critical importance of improved communication.

Both Annan et al.'s (2017) study and Sim et al.'s (2014) impact evaluation of the Happy Families programme in Thailand found significant impacts on adolescent behavioural problems. The adolescent participants in this intervention were slightly younger than those in the other eight studies – with an average age of 10 years – and both parents and adolescents reported a significant decrease in adolescent externalising problems, including swearing and stealing. Qualitative data found that caregivers reported their children being more polite and obedient post-intervention, and they themselves made a connection between improved parent–adolescent relationships and better behaviour in their children (Sim et al., 2014: 19).

The study of the Parceria project in Brazil – the only one of this group to work with parents only (in this case, mothers) – found a significant increase in their sense of well-being and parenting skills. Measured by mothers' assessment, there was a significant improvement in adolescents' prosocial behaviour and a decrease in behavioural problems and problems in peer relationships (Pereira et al., 2013). The study concluded that when mothers felt good about themselves and confident in their parenting approaches, they dealt with their children's behavioural problems using more positive methods.

One study found no programme impacts on adolescent behavioural problems. This was Cluver et al.'s (2018) evaluation of the Sinovuyo Teen programme in South Africa, which (as mentioned earlier) also found no evidence of impacts on other adolescent mental health indicators. Given the positive effects on improving parenting practices, on parental mental health and on violence against adolescents, this lack of recorded impact may reflect the timing of the evaluation, given that improvements in children's outcomes from improved parenting practices may take some time to become apparent.

Four studies examined programme impacts on adolescent aggressive behaviour, and all found positive change. Adolescent participants were selected either because they demonstrated emotional or behavioural difficulties, or because they lived in contexts with high levels of household and community violence. All four studies found reduced parental abuse (verbal and

19-year-old married boy with his baby in Chittagong, Bangladesh © Nathalie Bertrams/2019

physical) of adolescents. Three programmes (the Sinovuyo Teen pilot and full programme, and Strengthening Families) included joint sessions with caregivers and adolescents, which Sinovuyo participants saw as enabling them to develop mutual respect. Qualitative data from Sinovuyo Teen (full programme) shows adolescents' self-reported reduction in aggressive behaviour:

> *I used to be aggressive on other kids but now I don't do that anymore.* (Doubt et al., 2017: 771)

Some adolescent participants described learning new ways to manage aggression (in similar ways to caregivers' description of learning stress and anger management), with one participant explaining that they had applied communication skills to avoid fighting, and another explaining how taking a pause can 'reduce your frustrations' (Doubt et al., 2018: 26–27).

The study of the Strengthening Families programme in Honduras, Guatemala, Panama and Serbia measured pre- and post-intervention changes in agreement with statements such as '*My parents/tutors and I can sit and solve the problem together without shouting or get angry at each other*', and found improvements on all indicators post-intervention (Maalouf and Campello, 2014: 621).

Jordan et al.'s study (2013) of the 'psychoeducation' programme in Burundi for parents of children diagnosed with emotional distress and conduct problems found that it led to reduced aggression in boys but not girls. It also found that sessions were only effective where parents attended the whole programme.

### 4.2.2 Internet addiction

Two studies of two programmes evaluated the effectiveness of family-based interventions for adolescents with internet addiction in China among 12–19-year-olds (who were predominantly male). Liu et al.'s (2015) study recruited participants with symptoms of addiction via advertising in schools, while the intervention Zhong et al. (2011) evaluated was carried out with hospital inpatients diagnosed with internet addiction.[20] Drawing on findings from previous programmes, both initiatives focused on family relationships, communication and support rather than specific activities to tackle internet addiction, through a combination of group sessions for parents and adolescents separately and together.

Both studies also recorded positive outcomes in adolescent well-being and mental health, as well as in improved family functioning and parent–child communication. At the end of the family group therapy

20 The studies used slightly different indicators to measure changes in internet addiction (see Annex 3). The validated scales were used with adolescents, hence this section is based on data drawn from adolescents.

intervention, Liu et al.'s study found that just one 1 out of 21 adolescents were still addicted to the internet (measured in terms of time spent on the internet) compared to 24 out of 25 who remained addicted in the control group; a 3-month follow-up showed that just two adolescents showed a relapse in the intervention group (Liu et al., 2015: 5). Zhong et al. (2011) found improved family communication, social trust and impulse control among participants.

The authors of the two studies suggest that enhanced family relationships and communication explained findings, as adolescents reduced fulfilment of their psychological needs through the internet in favour of other sources such as family (Liu et al., 2015: 5), experienced less loneliness and depression, and also helped them develop stronger impulse control (Zhong et al., 2011).

## 4.3 Impacts on substance abuse-related outcomes

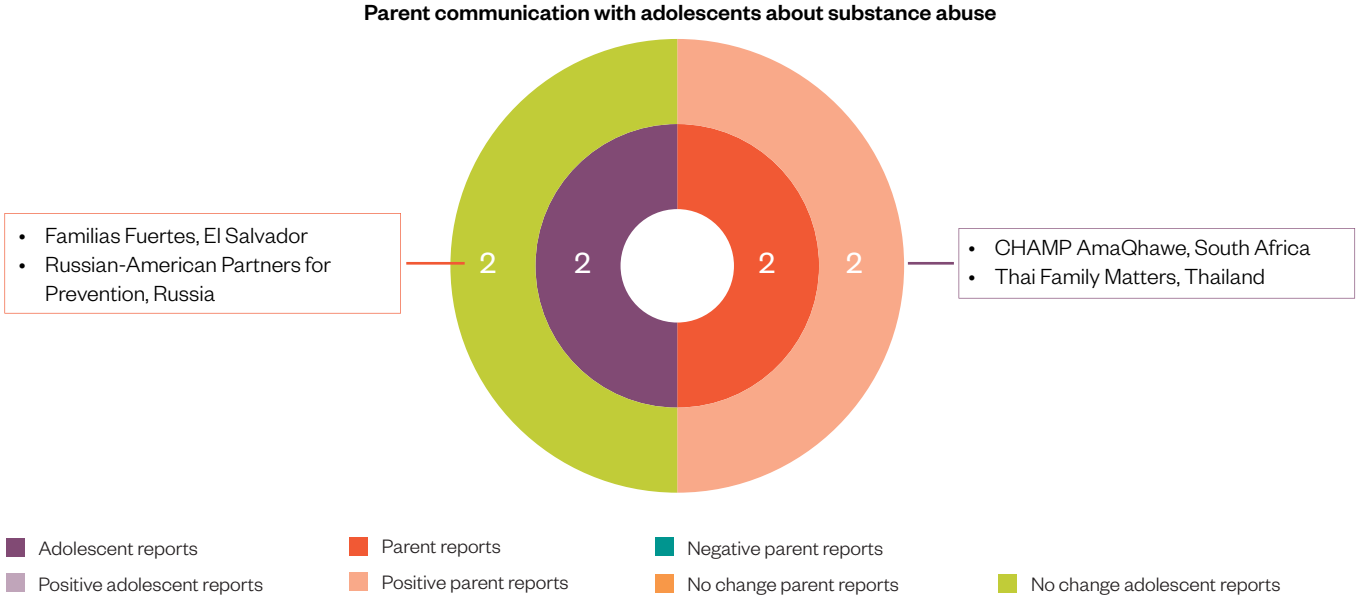
In this section we discuss insights from 10 studies of 9 programmes that aimed to increase parental communication with adolescents around substance abuse, and to prevent or reduce adolescent substance abuse. The wider literature indicates that family-based interventions can have a significantly greater effect in reducing adolescent alcohol and drug abuse than adolescent-only interventions (Liddle, 2004). These programmes were, however, more focused on prevention than reduction, and none of the adolescent participants were selected based on reports of substance abuse or diagnosis of addiction. Seven of the nine programmes worked with both parents and adolescents; the mean ages of adolescent participants varied from 10.5 years (Russian–American Partners for Prevention programme) to 14 years (Sinovuyo Teen pilot). None of the 10 evaluations provided gender-disaggregated data on adolescent outcomes.

### 4.3.1 Communication about substance abuse

Four studies reported on parental communication with adolescents about the risks of substance abuse, including alcohol, tobacco and drugs. Three of these studies, drawing on both parent and adolescent reports, found that parents engaged with their children in conversations about the risks of alcohol and drugs more frequently as a result of programme participation.[21] These programmes had varied foci (drugs, alcohol use), modalities (classes for parents and children, in the case of the Russian–American Partners for Prevention programme), parent-only classes (CHAMP, South Africa), and provision of booklets to mothers (Thai Family Matters). Child participants also varied in age (10–11 years in South Africa, 13–14 years in Thailand).

Two studies (of Familias Fuertes in El Salvador and Russian–American Partners for Prevention) recorded no impacts on parental communication about the risks

**Figure 16: Parent and adolescent reports of programme impacts on communication about substance abuse**




21 One – Williams et al.'s (2001: 318) study of the Russian–American Partners for Prevention programme in Russia – found reports of increased communication on one issue (rules on alcohol consumption), but no change in communication about the risks of alcohol abuse.

of substance abuse. This was a surprising finding in the context of other closely related positive outcomes, such as increased communication of parental rules around drinking (in the Russian–American Partners for Prevention programme). The lack of impact in Familias Fuertes may reflect minimal levels of usage at baseline (PAHO, 2006).

### 4.3.2 Adolescent substance use

Seven studies of six programmes reported on changes in adolescent substance use (Figure 17). Only two studies – both of the Sinovuyo Teen full programme in South Africa – found reductions in adolescent substance abuse. Cluver et al.'s (2018) study found that adolescent participants self-reported a significant decrease in past-month abuse 5–9 months post-intervention, while Doubt et al. (2018) found qualitative evidence of changed adolescent behaviour:

> *At home we had a problem of a child being on drugs and he came home very late and he didn't eat supper because he smoked dagga... When Sinovuyo did these sessions, he changed his behaviour. He is doing the right things now. (Doubt et al., 2018: 24)*

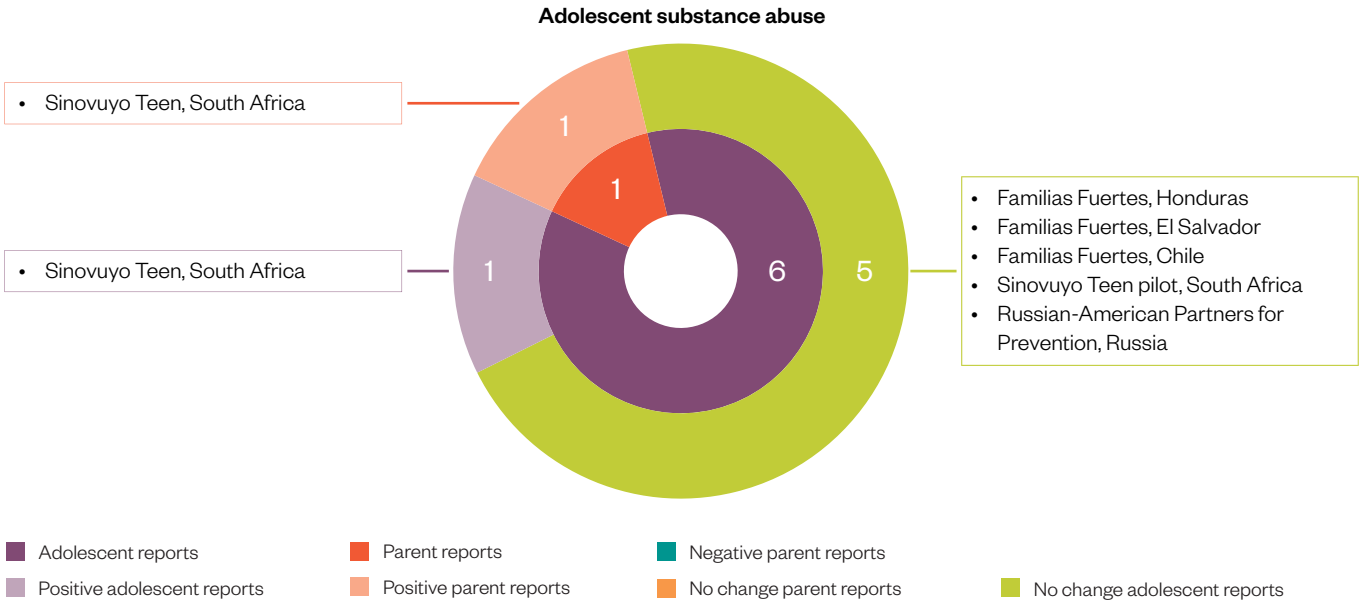
Cluver et al.'s (2016) study of the Sinovuyo Teen pilot measured results after significantly less time – 2–6 weeks post-intervention – and found no impacts. This could suggest that changes in this area take some time to emerge. The researchers considered the lack of significant change post-intervention surprising, given that adolescent aggressiveness and delinquency as well as caregiver substance use decreased.

Despite its lack of impact on adolescents' alcohol consumption, the evaluation of the Russian–American Partners for Prevention programme did find increased adolescent knowledge of substance abuse. At the 1–2-month post-intervention follow-up, adolescent participants showed a significant increase in knowledge about alcohol abuse, including its health impacts and the role of advertising in encouraging young people to start drinking (Williams et al., 2001: 319).

### 4.3.3 Parent substance abuse

Four studies reported on parent substance abuse. PAHO's study of the Familias Fuertes programme in El Salvador found that adolescents reported no change in caregiver substance abuse, while Cluver et al.'s 2018 study of the Sinovuyo Teen full programme found a reduction in both adolescent and caregiver self-reported substance abuse. By contrast, Cluver et al.'s (2016) study of the Sinovuyo Teen pilot found positive impacts on caregiver substance abuse, but not adolescent substance abuse. Finally, Chaudhury et al.'s (2016) evaluation of the FSI-HIV initiative (Rwanda) only measured parent substance abuse and found positive impacts on this indicator. They argue that FSI-HIV helped developed shared commitments to reverse the destructive effects of alcohol on families.

**Figure 17: Parent and adolescent reports of programme impacts on adolescent substance abuse**



# 5 Impacts on sexual and reproductive health issues

**Studies and programmes reviewed** (31 studies of 23 programmes)

Bahamian Focus on Older Youth (BFOOY) with Caribbean Informed Parents and Children Together (CImPACT) (Bahamas); Breaking the Voice (Thailand); CHAMP Amaqhawe pilot and full versions (South Africa); CHAMP-TT (Trinidad and Tobago); CHAMP-VUKA (South Africa); Cuidate! Promueve tu Salud (Mexico); Exploring the World of Adolescents (EWA+) Viet Nam; Familias Fuertes (Chile, El Salvador, Honduras); Families Matter! (Kenya, Tanzania); Focus on Youth in the Caribbean (FOYC) with CImPACT (Bahamas); Talking Parents, Healthy Teens (Ghana); Imbadu Ekhaya (South Africa); Indian child-parent communication pilot project; Let's Talk (Talking Parents, Healthy Teens) (South Africa); Morelos SRH communications study (Mexico); Sinovuyo Teen full version (South Africa); READY (Kenya); Sexuality Education Program for Mothers of Young Adults with Intellectual Disabilities (SEPID) (Turkey); Sisters for Life (South Africa); SRH education for parents of adolescents with intellectual disabilities in Turkey; Suubi (Uganda); Thai Family Matters (Thailand).

**Main findings:**

- 76% of all reported SRH outcomes were positive and 91% of programmes (22 out of 23) had a positive effect on at least one outcome.
- Studies of 4 programmes found an increase in parents' knowledge of sexual development, 6 found evidence of an increase in knowledge of sexual risks, and 5 found an increase in parents' condom use skills, with 1 study finding that parents shared knowledge about condom use with their children.
- Parent–child communication on SRH topics was the most commonly examined SRH issue. Parents report more positive outcomes or longer-lasting positive outcomes than adolescents (12 out of 16 programmes), though adolescents also reported positive outcomes in 6 out of 11 programmes.
- There is some evidence that mothers applied new communication skills around SRH more with daughters and fathers; a few studies found differences in the SRH topics girls and boys discussed with their parents. One programme aimed to boost girls' negotiation skills in sexual relationships by helping mothers and daughters feel more comfortable discussing SRH issues.
- Three studies found evidence of positive changes in parents' attitudes towards adolescents' contraceptive use, the need to teach adolescents about SRH issues, and their willingness to discuss sex and sexuality with adolescents.

Over half of the studies in this review (31 out of 58) assessed the impact of parenting programmes on issues related to adolescent SRH, making it the second most common topic of focus, just below the number that examined general parenting skills. Many of these programmes were motivated by an intention to help parents help their adolescent children develop skills and knowledge to avoid contracting STIs and promote healthy sexuality as part of broader public health efforts (for example, in response to the HIV pandemic). In addition, some programmes recognise that norms around sexuality are in flux, with urban adolescents in particular more likely to engage in premarital sexual activity. There is also recognition of a disconnect between the norms their parents grew up, and those that influence adolescents' behaviour today, with programmes thus intending to help parents guide adolescents through this unfamiliar terrain (Pham et al., 2012; de Wit et al., 2018).

Overall, findings were overwhelmingly positive, with only one study – that of Familias Fuertes in Chile (Corea et al., 2012) – reporting no change in any SRH outcomes, and all other studies reporting at least one positive change. Eighteen studies reported mixed results (a mixture of positive change and no change) or no changes on certain indicators. None reported negative effects. Assessment of impacts on parents' knowledge, behaviour and attitudes was considerably more common than assessment of changes among adolescents, and we therefore report impacts on parents in more depth.

## 5.1 Parents' knowledge of SRH and condom self-efficacy

Reflecting the fact that parents can only support their children around SRH issues if their own knowledge is up to date, evaluations of 13 programmes report on impacts on parents' knowledge about sex and sexuality, sexual risks, and condom self-efficacy (ability to use a condom appropriately).

Studies of four programmes that examined changes in parents' knowledge about **sexuality and sexual development** found positive effects for both mothers and fathers: EWA+ in Viet Nam (Kaljee et al., 2012), the SRH education programme for parents of adolescents with intellectual disabilities in Turkey (Kok and Akyüz, 2015), Jejeebhoy et al.'s (2014) study of a parent–child communication pilot project in India (though significance was lower among fathers), and Baku et al.'s (2017) study of Talking Parents, Healthy Teens, in Ghana. The scale of increase was particularly large in Talking Parents, Healthy Teens, where programme participation increased parents' likelihood of knowledge about adolescent sexuality by 16 times compared to the control group.

Studies of eight programmes reported on **changes in parental knowledge of sexual risk**s (such as STIs, including HIV, unwanted pregnancy, and adolescent risk of sexual abuse). Seven of these found positive effects on parental knowledge of SRH risks.[22] One study found no significant differences between the intervention and comparison groups post-intervention on mothers' knowledge about pregnancy prevention, though it found positive effects on other indicators, discussed below (Powwattana et al.'s (2018) study of Breaking the Voice in Thailand).

Three of these studies disaggregated findings by parent gender: a comparison of pre- and post-intervention surveys found that mothers participating in EWA+ in Viet Nam showed statistically significant increases in knowledge about pregnancy, STIs and HIV. However, increases in knowledge about pregnancy were not statistically significant among fathers, which may reflect mothers' greater responsibility for childcare and 'children's greater comfort communicating with their mothers' (Kaljee et al. 2012: 559). Kok and Akyüz's (2015) study of an SRH education programme for parents of adolescents with intellectual disabilities in Turkey identified statistically significant positive effects for both mothers and fathers on knowledge about protecting their child from abuse. One father stated:

> *Our children cannot mention their troubles or feelings like other children as you know. In fact, maybe they do but I don't know how the person with them perceives it. Indulgently or to benefit from him/her? This scares me.* (Kok and Akyüz, 2015: 166)

The evaluation of Sisters for Life (South Africa), which was only delivered to mothers, found positive effects on their knowledge and sense of personal responsibility to protect young people from HIV (Phetla et al., 2008). Three studies of other programmes that did not disaggregate impacts by parent gender also found positive effects on parents' knowledge about HIV as an SRH risk: Bhana et al., 2004, on CHAMP Amaqhawe South Africa (pilot), Bell et al., 2008) on CHAMP Amaqhawe South Africa (full programme), and Baptiste et al., 2007, on CHAMP-Trinidad and Tobago.

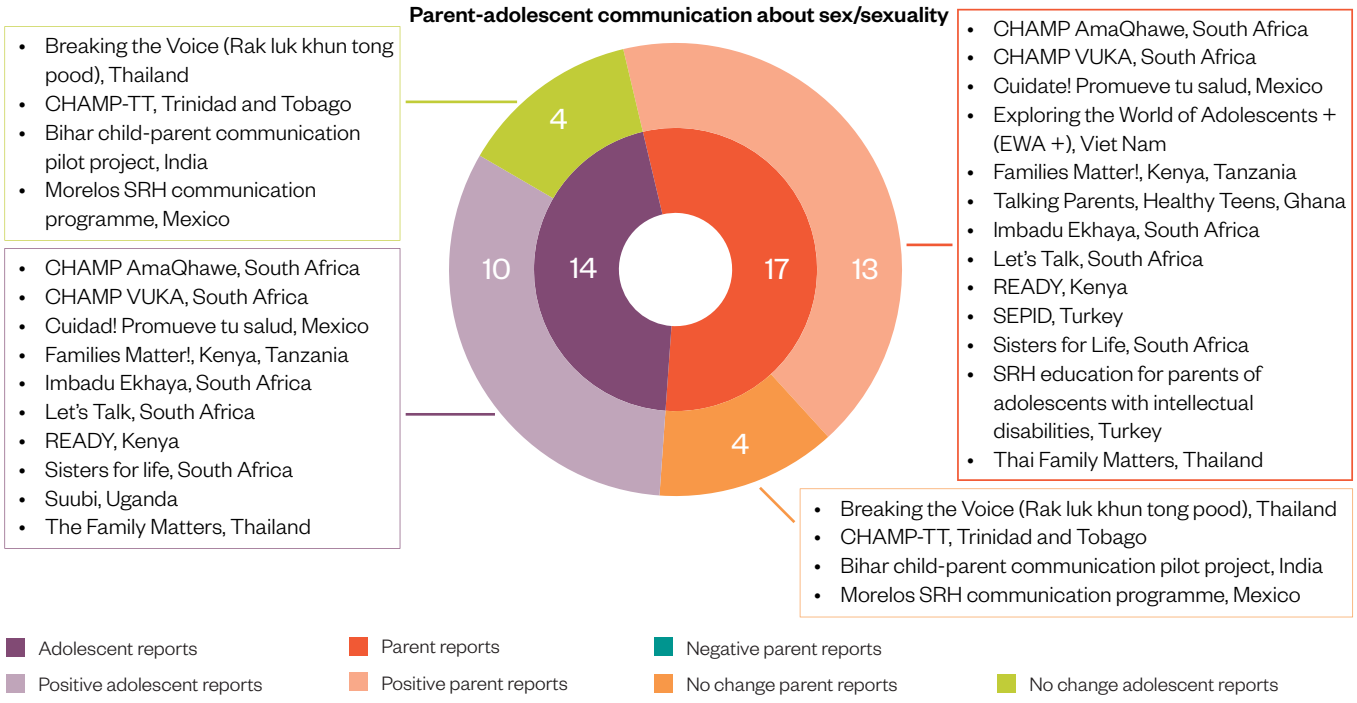
Five studies of four programmes found **positive effects on parents' condom self-efficacy**: Let's Talk, South Africa (though these were not statistically significant) (Bogart et al., 2013); CImPACT in the Bahamas (in conjunction with BFOOY and FOYC) (Deveaux et al., 2007; Dinaj-Koci et al., 2015); CHAMP-Trinidad and Tobago (Baptiste et al., 2007), which involved parents learning and then demonstrating proper condom use to youth; and EWA+ in Viet Nam, where condom use skills improved for mothers, but not significantly for fathers, who had higher baseline levels of self-efficacy in condom use (Kaljee et al., 2012).

## 5.2 Parents' ability to discuss SRH issues with adolescents

Parent communication with adolescents about SRH (as reported by parents, adolescents or both) was the most commonly measured outcome for programmes aiming to achieve positive impact on adolescent SRH (discussed in 17 programmes). Indicators included frequency of communication, comfort discussing SRH issues, number of issues discussed, parental responsiveness, and content of discussions (i.e. vague versus concrete discussion of risks). Studies examined a wide selection of possible topics. For example, the study of Let's Talk in South Africa assessed parent reports of whether they discussed any of 16 SRH-

22 These were: Bhana et al. (2004) and Bell et al. (2008)'s studies of CHAMP Amaqhawe in South Africa; Baptiste et al.'s (2007) study of CHAMP-Trinidad and Tobago; Kaljee et al.'s (2012) study of EWA+ in Viet Nam; Phetla et al.'s (2008) study of Sisters for Life in South Africa; Campero et al.'s (2010) study of the Morelos SRH communication programme in Mexico; and Kok and Akyüz's (2015) study of SRH education for the parents of children with disabilities in Turkey.

**Figure 18: Adolescents' and parents' reports of programme impacts on parent-adolescent communication about SRH issues**




and HIV-related topics before or after the intervention. Topics included physical body changes, pregnancy, decisions around sex, what sex is, preventing HIV, condom use, saying no to sex, recognising abusive relationships, and homosexuality (Bogart et al., 2013). Most studies found positive effects on parent–child communication about SRH (13 out of 17 studies that drew on parents' reports and 10 out of 14 that drew on adolescents' reports).

### 5.2.1 Gendered impacts on SRH communication

Of four programmes that disaggregated effects between mothers and fathers, three reported positive changes among both mothers and fathers in SRH communication with adolescents. The evaluation of Cuidate! Promueve tu salud in Mexico reported equally positive effects for mothers and fathers. Both expressed being more comfortable discussing sexual issues and sexual risks with their adolescent children. This effect was maintained at 6- and 12-month follow-ups (Villarruel et al., 2008). Puffer et al.'s (2016) study of READY in Kenya also found that both adolescents and parents reported increases in mothers' and fathers' communication with adolescents on sex- and HIV-related issues. Parent-reported effects were nearly three times larger than adolescent-reported effects; however, they weakened over three months to nearly the same level. The study of EWA+ in Viet Nam (Kaljee et al., 2012) also found improvement in communication about SRH among mothers and fathers, though the change was only significant for mothers.

Gender affected both the relationships in which participants felt comfortable discussing SRH issues, and the issues they felt comfortable discussing. On the whole, participants felt more comfortable communicating on sexual health and risk issues with same-gender children or parents. For example, some Sisters for Life participants claimed that discussing sexual topics with daughters was easier than with sons, and that they would instead use indirect messages for sons:

> *I use silent means like throwing condoms on his bed as a way of saying to him 'use condoms all the time'.* (Phetla et al., 2018: 8)

The evaluation of the pilot parent–child communication project in India found that although mothers reported increased comfort discussing SRH issues with daughters, there was a very limited effect on mothers discussing SRH issues with their sons (Jejeebhoy et al., 2014). Conversely, fathers reported greater improvements in communication with sons than daughters. The study of Suubi, Uganda, found that overall, female adolescents were less comfortable than male adolescents discussing sexual risk behaviour, but more comfortable discussing problems with parents after participating in the programme

Syrian family living in an informal tented settlement near Amman, Jordan © Nathalie Bertrams/2019

(Ismayilova et al., 2012). Campero et al.'s (2011) study of the Morelos SRH communication programme found that boys reported discussing emergency contraception, STIs and HIV with parents, whereas girls reported discussing condoms and pregnancy.

Evaluations of four programmes that worked only with mothers, and five others that did not distinguish parent gender,[23] reported positive changes in communication about sex and sexuality:

- Breaking the Voice in Thailand aimed to reduce risky sexual behaviour by increasing communication between mothers and their adolescent daughters to empower girls in sexual relationships to make decisions, prevent pregnancy and refuse unwanted sex. Following sessions where mothers and daughters discussed sexual topics together and separately, both reported an increased likelihood of discussing sexual matters frequently compared to pre-intervention; however, mothers' attitudes to sexual communication did not change significantly.
- Studies of two South African programmes, Imbadu Ekhaya (Parents Matter!) and Sisters for Life, found reports from both adolescents and mothers of positive effects on sexual communication.[24] In Sisters for Life, parent reports were more positive than adolescent reports (Phetla et al., 2008), and in Imbadu Ekhaya, the effect was weaker for adolescents at 6-month follow-up (Armistead et al., 2014). Armistead et al. attribute the reduced effect to topics having already been discussed and therefore less need for further discussion.
- Bogart et al.'s (2013) study of Let's Talk (Talking Parents, Healthy Teens) in South Africa, drawing on both adolescents' and parents' reports, found increased communication about SRH, measured by number of HIV- or sex-related topics discussed, comfort in discussing those topics, and willingness to discuss

23 Breaking the Voice (Thailand), Imbadu Ekhaya and Sisters for Life (South Africa) and SEPID (Turkey) worked with mothers only, while Let's Talk (South Africa), Families Matter (Kenya and Tanzania), Suubi (Uganda) and Talking Parents, Healthy Teens (Ghana) did not distinguish parent gender.

24 Armistead et al.'s (2014) study of Imbadu Ekhaya examined the number of sex-related topics discussed, breadth of discussions and parental responsiveness. The evaluation of Sisters for Life examined frequency of communication, comfort discussing issues, and content – which 'shifted from vague admonitions about the dangers of sex to concrete messages about reducing risks' (Phetla et al., 2008: 6).

condom use. Parents participating in the programme 'were nearly five times more likely to discuss the steps of condom use than were control parents' (Bogart et al., 2013: 7). The programme used role play and strategy suggestions to help increase parents' comfort in talking to their child about sex, including strategies such as 'how to open the conversation using "opening lines" and identifying "teaching moments," such as a dating scene in a television show)' (Bogart et al., 2013: 12).

- Both studies of Families Matter! (in Kenya and Tanzania) drew on parent and adolescent reports and found positive effects on acceptance of the view that adolescents are old enough to learn about sex, and on communication about sex education and sexual risk reduction (Vandenhoudt et al., 2010; Kamala et al., 2017). The increase was greater for parents than for adolescents, which could reflect recall bias, adolescents and parents understanding content differently, and social desirability biases, with parents feeling more pressured to give what they anticipated to be the 'correct' response.

Although positive findings predominated, eight studies of six programmes[25] found no effect or mixed effects. In the case of the Morelos SRH communication programme, this reflects discrepancies between qualitative and quantitative insights. The qualitative study found positive effects on parents' attitudes toward communicating with children about sex:

> Father (F): *Because, well, before this class [the workshop] I thought that the less we told kids about sex the better.*
> Interviewer (I): *And that idea has changed for you?*
> F: *Yes completely.* (Campero et al., 2010: 1145)

By contrast, Campero et al.'s (2011) quasi-experimental study reports an increase in male and female adolescent reports of discussing SRH topics with parents, but no statistically significant changes in frequency of communication.

Differences in findings from parents' and adolescents' reports or on different indicators were also fairly common. For example, studies of the parent–child communication pilot project in India and Thai Family Matters both found more positive reports from parents than adolescents. Although the feasibility study of Thai Family Matters had found an increase in mothers discussing sexuality with their children (Rosati et al., 2012), evaluation of the full programme found limited increases in communication frequency as reported by parents, and none according to adolescent reports at 6-month follow-up (Cupp et al., 2013). There was also no effect on reducing discomfort in discussing sex. Parent completion of the programme booklets was marginally associated with improved frequency of parent–child communication and significantly associated with reduced parent-reported discomfort around communication. This suggests that the greater engagement with material involved in completing the booklets may have increased parents' learning and ability to apply it to their communication with their children.

In the Bihar parent–child pilot communication project, although many more participant mothers and fathers (compared to non-participants) reported feeling more comfortable at endline than earlier about talking to their children about sensitive matters, in practice few parents reported actual increases in communication with their children on sensitive matters such as SRH. Difference in difference analysis confirmed that exposure to the intervention did not affect parent–child communication about sensitive matters (Jejeebhoy et al., 2014).

The studies of the CHAMP programmes found varying effects on different indicators, with more positive effects around HIV discussion but fewer effects on other topics. Bhana et al.'s (2004) study of CHAMP Amaqhawe (South Africa) reports increased frequency in discussing sex, while Paruk et al.'s (2009) qualitative interviews found that after participating in the programme, parents felt empowered to pass on information that could protect their children:

> *CHAMP gave us ways of proper communication within the family. That was the key in most issues. Now we find it easier to talk about anything, and it's also easier for my child to say — Mom, I'm not clear on this and that. And so, matters of relationships, including HIV issues, are now easy to talk about since we now talk as friends, you see!* (Paruk et al., 2009: 64)

Studies of the other CHAMP programmes also found mixed changes on different indicators, with at least one positive change per study:

25 The Morelos communication study (Campero et al., 2010; 2011); the parent–child communication pilot project in India (Jejeebhoy et al., 2014); Breaking the Voice (Powwattana et al., 2017); Thai Family Matters (Rosati et al., 2012; Cupp et al., 2013); CHAMP-TT (Baptiste et al., 2007); sexuality education programme, Turkey (Kok and Akyüz, 2015).

- Both parents and adolescents participating in CHAMP-VUKA reported improvements in caregiver–child communication, with parents also reporting increased comfort discussing sensitive topics (Bhana et al., 2014).
- The study of CHAMP-TT (Trinidad and Tobago) found no statistically significant changes for parent reports on discussing HIV or sex. Young people reported an increased frequency of discussion about HIV/AIDS with parents, but no statistically significant changes on other topics and no changes in their level of comfort around these discussions (Baptiste et al., 2007).

Finally, the study of parents of adolescents with disabilities in Turkey (Kok and Akyüz, 2015) found no change in communication with adolescents on SRH topics, despite finding overall improvements in parents' knowledge. However, parents still considered education around this topic useful. Fathers primarily reported needing information about control of sexual behaviour, communication and protection from sexual abuse, whereas mothers reported needing information about improving the self-care skills of their children in terms of coping with menstrual pad usage, pubic and axillary hair. This discrepancy may reflect a time lag between learning new knowledge and skills and putting them into practice.

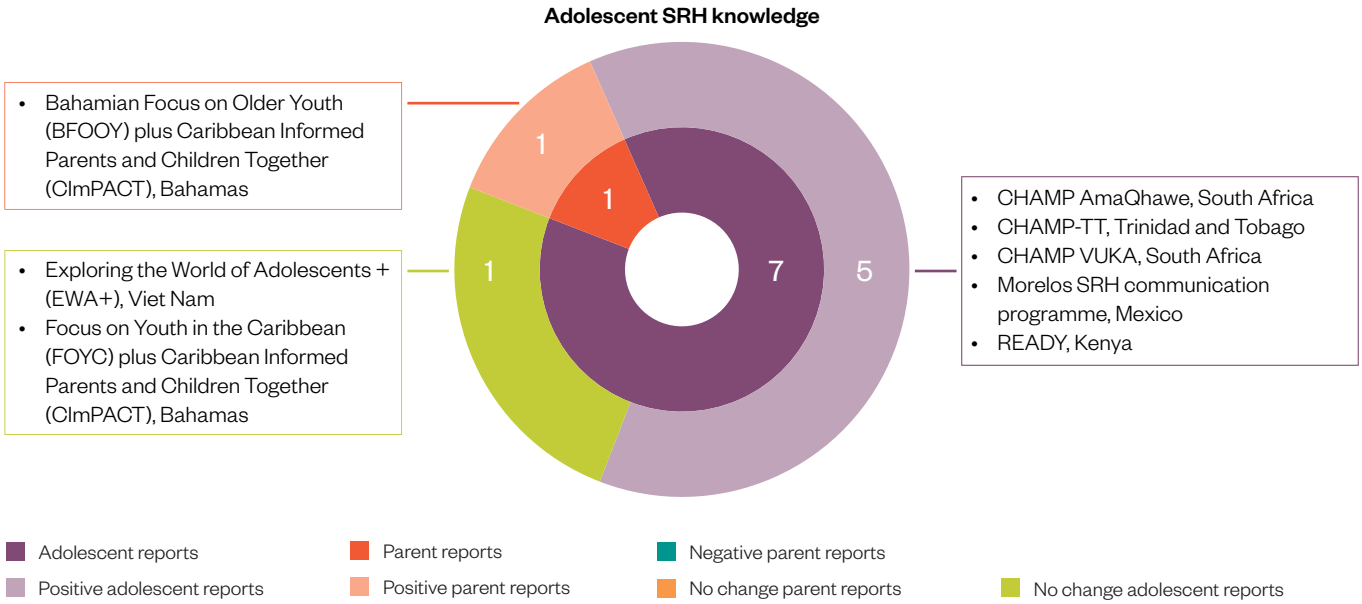
## 5.3 Adolescents' knowledge about SRH

Eight studies report programme impacts on adolescents' knowledge about SRH, all of which find at least some positive effect on knowledge of sexual risks and HIV, though two studies also find no change in certain settings. Examples include the following.

Evaluations of CHAMP in South Africa and Trinidad and Tobago found significant increases in adolescents' accurate knowledge of HIV/AIDS. CHAMP Amaqhawe (full and pilot versions) increased adolescents' and parents' knowledge of HIV transmission, and led to significantly lower levels of stigma among adolescents towards people with HIV (Bell et al., 2008). CHAMP-VUKA (South Africa) improved HIV treatment knowledge and adherence to medication, with a caregiver indicating that 'children realized that they were not the only ones on medication and became hopeful about their future' (Bhana et al., 2013: 7). Increasing adolescents' accurate knowledge is intended to strengthen their resilience to resist negative peer influences by improving self-esteem and self-efficacy (Bhana et al., 2004).

The evaluation of READY in Kenya (Puffer et al., 2016) found increased HIV knowledge in both girls and boys. EWA+ in Viet Nam had no effect on HIV knowledge;

**Figure 19: Adolescents' and parents' reports of programme impacts on adolescents' SRH knowledge**



however, it did lead to increased knowledge about pregnancy and contraception at 12 months follow-up, and increased knowledge on STIs at 3, 6 and 12 months follow-up (Kaljee et al., 2012). The Morelos SRH communication programme in Mexico also had a positive effect on adolescents' emergency contraception knowledge (Campero et al., 2010).

## 5.4 Parents' attitudes and behaviour towards adolescents' use of contraceptives

No studies directly reported on parents' attitudes towards adolescent sexual activity, but this is captured indirectly through indicators of parents discussing SRH and family planning with adolescents (as described earlier) and their attitudes and behaviours towards supporting adolescents' use of contraceptives. Studies of three programmes reported positive intervention effects on parents' attitudes and behaviour towards adolescent family planning:

- Baku et al.'s (2017) study of Talking Parents, Healthy Teens (Ghana) found a statistically significant increase in accepting attitudes towards allowing adolescents to use family planning services among parents who participated in the programme. Following training, no parents stated that they would prevent their adolescents using family planning services (compared to half of parents pre-training), and 83% were willing to allow adolescents to use family planning services (compared to 30% pre-intervention).
- The studies of the Morelos SRH communication programme found parents reporting giving their children condoms and advice on how to use them or helping them obtain them. The authors argue that this finding is important, since access to condoms is limited and the potential effects of parents helping adolescents obtain condoms have not previously been reported in Mexico (Campero et al., 2010; 2011).
- Cluver et al.'s (2018) study of Sinovuyo Teen (full programme) in South Africa found a significant increased intention to use family planning, as reported by caregivers and adolescents alike.

**Box 4: Evidence of programme impact on adolescents' experience of sexual violence**

Just two evaluations examined programme effectiveness in helping parents protect adolescents from sexual violence, or adolescents' experience of sexual violence. Stark et al.'s evaluation (2018) of the COMPASS programme in the DRC found that at 12-month follow-up, it had had no effect on girls' exposure to any form of sexual violence. The evaluation partly attributed this lack of impact to the crisis context (for which the parenting curriculum lacked relevance and applicability) and partly to the infrequent parent meetings (once a month), which was not sufficient to raise awareness and build commitment to act. A sister COMPASS programme implemented in Ethiopia also found no impact on girls' exposure to sexual violence but did find positive outcomes on girls' aspirations to delay marriage and childbearing (Stark et al., 2018: 9).

Cluver et al.'s evaluation (2016) of the Sinovuyo Teen pilot in South Africa aimed to investigate whether the programme had any impact on adolescents' experience of sexual abuse, but the numbers of adolescents reporting abuse were too small to draw clear conclusions.

The Families Matter! programme (Kenya and Tanzania) has also evaluated the impact of its new module on child sexual abuse. Research undertaken in urban Zimbabwe found that after taking part in sessions using this module, parents and children reported significantly higher levels of parental monitoring about child sexual abuse. Significantly more parents also reported conversations with people in their community about child sexual abuse and knowledge of where to access services if their child was abused (Shaw et al., 2019).

### Box 5: Case study: Families Matter! programme

Of the parenting programmes examined in this review, the Families Matter! programme (FMP) is exceptionally well-documented. This case study aims to provide more detail about additional knowledge which exists around FMP and insights about its implementation, which were often not available for other programmes.

**Purpose and reach**

FMP aims to reduce sexual risk behaviour among adolescents, and has been delivered to families in sub-Saharan Africa and Haiti. The programme promotes positive parenting and effective parent–child communication about sexuality and sexual risk reduction with the intention of delaying adolescents' sexual debut. It aims to give parents and caregivers the knowledge, skills, comfort and confidence to talk with their children effectively about HIV, violence prevention and response, and to increase their children's awareness and protective strategies against child sexual abuse and harmful gender norms that may lead to violence (CDC, 2019). While published studies of FMP, which are included in this review, refer to it as including parents of 9–12-year-olds, in practice the programme is often attended by adolescents up to age 14, and a second version has been trialled with parents of adolescents aged 15–19 ( Miller, personal communication, 2019).

The evaluations of FMP included in this review took place in Kenya and Tanzania. However, as of 2019, the FMP curriculum has been translated into over 20 languages and implemented in 14 countries, including Kenya, South Africa, Zambia, Côte d'Ivoire, Botswana, Mozambique, Tanzania, Zimbabwe, DRC, Rwanda, Namibia, Nigeria and Malawi, and Haiti (ibid.). It is implemented in countries that receive PEPFAR (President's Emergency Plan for AIDS Relief) funding as part of the Orphan's and Vulnerable Children (OVC) or Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) partnership, which aims to help countries curb the HIV epidemic (Saul et al., 2018). A core component of DREAMS involves interventions that economically strengthen the families of adolescent girls and young women and improve their ability to parent. In most countries, the parenting aspect is implemented via FMP or the Sinovuyo programme (see Box 3). At the time of this study, globally, FMP had been delivered to approximately 1 million families (Miller, personal communication, 2019).

**Programme design and delivery**

The programme is delivered to parents in small community-based groups (18-30 parents) using participatory adult learning techniques in consecutive weekly 3-hour group sessions. The programme currently offers seven sessions, though previously it had offered five or six. The sixth session was added in 2014 to specifically address issues of child sexual assault and gender-based violence, and the seventh to address the needs of adolescents living with HIV.

Parents practise the communication skills they learn. Programme delivery involves:

> *... group interaction activities such as proverb/poster discussions, large group discussions, brainstorming, role-plays (between adult participants, and between parents/caregivers and their child), songs and ice-breakers; narratives in an audio format that are played on a battery-operated CD player in low-resource rural areas and follow-up discussions; mini-lectures; participant handouts; and homework assignments.*
> (Miller et al., 2016: 411)

The seven-session enhanced curriculum incorporates 28 audio narratives, and 9 role-play exercises (Miller et al., 2016: 414). The programme is delivered through a capacity-building model, which provides guidance for FMP partner organisations on how to deliver it (Miller et al., 2013). Local partners have included government ministries, NGOs and faith-based organisations. Partners also collect monitoring data for FMP and have shown that the 5 to 6 session programme has high average retention rates of over 90% (Miller et al., 2013). The FMP study in Tanzania found a rate of 83% (Kamala et al., 2017) and in Kenya, 94% (Vandenhoudt et al., 2010). FMP does not use incentives to encourage participant attendance as they have been found either unnecessary or detrimental (Miller et al., 2013).

**Facilitation**

FMP is delivered by trained and certified facilitators, one male and one female per group. The programme materials include a support manual for facilitators as well as an Implementation manual which outlines everything needed

for program implementation and scale up including facilitator recruitment and training tools and logistics. A job description for FMP facilitators highlights their role as 'To mobilize, recruit participants and facilitate Families Matter Program! (FMP!), including ensuring effective referrals for biomedical and structural interventions'. Minimum qualifications include having a relevant diploma, at least one year's experience working in HIV/AIDS prevention, relevant communication and facilitation skills, and character traits which would make the applicant suitable to facilitating the programme.

**Cultural adaptation**

The FMP curriculum was first adapted for use in a western Kenyan context in 2003/04 from the US evidence-based intervention, the Parents Matter! programme (Miller et al., 2016), working with a multi-stakeholder team of potential recipients, researchers and service providers to develop the programme, and ensure it was relevant, realistic and effective. Renaming the programme during the adaptation process reflected the importance of caregivers other than parents in western Kenya at that time (Poulsen et al., 2010). Other changes included incorporating local statistics on HIV, STIs and unplanned pregnancies to illustrate the problems faced by youth, and the incorporation of songs and local proverbs into the programme on the recommendation of participants in the adaptation process. An outcome evaluation of the adapted FMP was conducted with 375 families; after one year, it found that the programme was well-received in the community and retained its effectiveness in increased parenting skills and parent–child communication about sexuality and sexual risk reduction (Miller et al., 2016).

FMP is adapted in every country to address the drivers of HIV. One example of effective adaptation is encouraging discussion of how traditional practices such as cross-generational marriage and female genital mutilation perpetuate unequal gender norms. For example, 'rather than [directly] condemning early and cross-generational marriage and female genital cutting, [FMP] invites participants to identify these as traditional practices which perpetuate unequal gender norms and increase the vulnerability of young women' (Miller et al., 2016: 412).

**Gender considerations**

The FMP curriculum has been adapted to strengthen the direct links to priority US Government goals for HIV, which have increasingly emphasised the ways that gender norms affect sexual relationships and risk (Miller et al., 2016). Over time, FMP has increased content on:

> *... the various gendered pressures – structural, normative, group and interpersonal – that young people face and the factors that, in the absence of guidance and support, can constrain their ability to make healthy choices.* (Miller et al., 2016: 414)

Updates during this process have included an increased focus on broader content about sex, relationships and gender. FMP now also includes content exemplifying good parent–child communication about gender and sexuality, and has added material on gender-based violence, transactional sex, and child sexual abuse (Miller et al., 2016). Content is also designed to encourage parents to empathise with adolescents both as they undergo bodily changes and as they respond to social norms about what it means to be a man or a woman in their community. The content is intended to help parents understand gendered pressures, such as to have sex before a young person is ready to, and the risks of sexual violence (both as potential victims and perpetrators). It encourages parents to discuss the issue of consent with sons and daughters alike (Miller et al., 2016), with audio narratives and role plays being key tools. For example:

> *... audio narratives and role-plays address the pressures to conform to norms of masculinity, which may include alcohol and drugs in the context of male group socialising, pressure to be sexually aggressive or else suffer social exclusion, and embarrassment to seek out information about sex.* (Miller et al., 2016: 414–415)

The audio narratives and role plays are also intended to increase parents' and children's understanding of gender-related risks, such as sexual exploitation. For example, female characters describe the temptations of taking a 'sugar daddy' in terms of their desire to avoid the pity of peers or be the last girl in school without a cellphone. The curriculum also encourages parents to identify with some of the factors that might make a relationship with an older male appealing. Role plays seek to prepare them for risk situations. For example:

*What would you do if... you are walking through the neighbourhood when the tailor calls you over and whispers in your ear that he's made you a beautiful dress: why don't you come into his workshop and try it on?*

*What would you do if... the neighbour who has been kindly paying your school fees since your father lost his job asks you to come over to his house that evening?*

Unlike some parenting programmes included in this review, FMP has managed to attract male participants. Males have been part of the programming in every country where the program is delivered. Men constituted approximately 10% of caregivers in the Kenyan evaluation (Vandenhoudt et al., 2010) and 28% in the Tanzanian evaluation (Kamala et al., 2017). Overall, approximately 15% of caregivers who have participated in the programme have been male (Miller, personal communication, 2019).

**Links to wider services**

FMP delivery includes direct links to services throughout all seven sessions. These links are tailored to each community where the programme is delivered, and include services for HIV testing and counselling, prevention of mother-to-child transmission, and voluntary medical male circumcision. Emphasis on these service referrals and linkages has been strengthened in the process of aligning the FMP curriculum with the 2011 World AIDS Day goals: for example, facilitators provide information on opening hours, and maps to facilities (CDC, 2014)

# 6 Impacts on gender equality

**Studies and programmes reviewed** (14 studies of 14 programmes)

Bihar parent–child communication initiative (India); Breaking the Voice (Thailand); ClmPACT (Bahamas); Choices-Voices-Promises (Nepal)'; COMPASS (DRC); EWA (Viet Nam); Families Matter! (Kenya, Tanzania); Go Girls! Initiative (Botswana, Malawi, Mozambique); Happy Families (Thailand); Imbadu Ekhaya (South Africa); Morelos SRH communication study (Mexico); parent psychoeducation project (Burundi); READY (Kenya); sexuality education project (Turkey).

**Main findings:**

- Six programmes had specific content aiming to raise awareness of gender issues, to encourage parents to treat their sons and daughters more equitably, or to help parents equip adolescents to negotiate gender-inequitable environments, particularly in sexual relationships.
- Evaluations of the three programmes that aimed to change general attitudes towards gender equality found a mixed picture, but overall limited change – probably reflecting the ingrained nature of gender norms and the relatively limited time spent discussing them. One programme led a greater shift, reflecting its strong emphasis on gender equality. One programme, despite not explicitly setting out to change gendered attitudes about SRH communication, was successful in doing so.
- Four programmes covered gendered risks such as adolescent pregnancy and child marriage. Studies of two found some evidence of reduced support for child marriage, and one found greater knowledge and communication around reducing sexual risks to avoid teenage pregnancy.
- Evaluations of nine programmes presented findings disaggregated by gender of the parents, adolescents or both. Mothers tended to show greater increase in knowledge on SRH and legal rights issues (e.g. age of marriage), probably reflecting their lower levels of education and access to information at baseline.

This section examines the gendered effects of parenting programmes. Specifically, we discuss how far these programmes seek to challenge or led to changes in inequitable gender norms and practices, and whether they had differential effects on male and female participants, both adults and adolescents. We also examine whether, through disproportionate participation of mothers, grandmothers and other female caregivers, gendered patterns of care for adolescents are being reinforced.

## 6.1 Extent of programmes' focus on gender-inequitable norms and practices

Six programmes included specific content that aimed to encourage parents to adopt more gender-equitable attitudes and behaviours in relation to their adolescent children and/or to help them support adolescents to manage gendered risks.[26] Three of these programmes had a relatively broad focus on gender equality (Bihar parent–child communication project, Choices-Voices-Promises, and Families Matter!); the other three incorporated material on gender inequality largely in the context of improving knowledge and communication skills around SRH issues.

Four programmes also aimed to educate parents and equip them to act more effectively on issues that solely or disproportionately affect adolescents of one gender. These were Breaking the Voice (which focused on teenage pregnancy); Choices-Voices-Promises; the Bihar communication project (which included content on child marriage); and COMPASS (which aimed to reduce sexual violence against adolescent girls). The two programmes

26 These were: Breaking the Voice; Bihar parent–child pilot communication project; COMPASS; Families Matter!; Imbadu Ekhaya; and Choices-Voices-Promises. In addition, EWA in Viet Nam included content on gender equality in sessions for adolescents, but not for parents.

Young adolescent girl in Jordan flying a kite. © Nathalie Bertrams/2019

that addressed internet addiction, which disproportionately affects boys, appear not to have included any discussion of the forms of masculinity associated with video gaming.

Two programmes, Breaking the Voice and COMPASS, were aimed solely at girls and their families, while one, the Go Girls! Initiative (despite its name), was offered to the parents of adolescent girls and boys to avoid provoking backlash associated with perceived favouring of girls.

Breaking the Voice, a programme in Thailand aiming to prevent teenage pregnancy by improving mother–daughter communication about sex, also had a strong focus on understanding gender norms and framed all its sessions around gender and power (see Box 7 for more detail).

This case study, and the Sinovuyo Teen case study, highlight the different ways that programmes have tried to ensure that parent education programmes address critical gender inequalities that affect adolescents' lives and development. We now summarise insights into the impacts of these programmes.

### 6.1.1 Attitudes to gendered communication on SRH issues

Two evaluations had particularly strong insights into changes in gendered communication about SRH issues. The qualitative component of the Morelos communication study (Mexico) found positive impacts on gendered parent attitudes towards parents discussing sexuality with children. In particular, it helped shift the view that it was unnecessary or improper to share information about sexuality and family planning with adolescent girls. The authors quote a participant mother:

**Box 6: Gender-focused content in the Families Matter! programme**

Over time, Families Matter! has increased content to help parents and children understand the development of gendered identities as children move into adolescence, and the gendered pressures they may face, including around alcohol consumption, pressure to be sexually active and the risks of sexual violence (both as potential victims and perpetrators) (Miller et al., 2016.) Families Matter! primarily does this through audio narratives that 'model good parent-child communication around gender and sexuality, often through the eyes of a child' (ibid. 5). These include a girl talking about how her parents communicate with her on sexual risks as she enters adolescence, and a boy talking about how his parents dispel myths about boys' inability to control sexual urges. For more detail, see Box 5 (Families Matter! case study).

**Box 7: Breaking the Voice: focusing on gender norms to promote mother–daughter communication**

Breaking the Voice was an initiative organised by researchers at Mahidol University, in Bangkok, which aimed to help mothers and daughters communicate around sexuality as part of a strategy to prevent teenage pregnancy. The initiative was grounded in an understanding of prevailing gender norms which emphasise the importance of male dominance, physical strength, and sexual power and control as key elements of masculinity, whereas sexual chastity, passiveness, and avoidance of sexual discussion are associated with females. At the same time, parents are often embarrassed to discuss sexual matters with their children, which can contribute to their older children's unpreparedness for effective communication and risk reduction in sexual relationships. Finally, norms around children showing obedience and respect to their parents, such as 'respect to mother's words without question' and 'follow mother's instructions', affect communication around issues related to sex.

Researchers undertook formative research with 58 mothers and 63 daughters aged 12–15 years in four high-density areas of Bangkok. They explored the kinds of communication mothers and daughters have around sexual issues, the kinds of issues they would like to discuss, their preferred style of discussion, and barriers to better communication. Mothers' preferences and concerns were grounded in broader Thai cultural values and norms, such as avoiding the shame and stigma of teenage pregnancy. Many also felt they lacked accurate knowledge and were keen to learn more, particularly around sexually transmitted illnesses. Girls generally prioritised changing attitudes towards communication about sexual issues, negotiation, assertiveness, and refusal skills; mothers and daughters alike suggested having some separate and some cross-generational sessions.

The research led to the development of a seven-week course, with one 3-hour session per week. Participants were recruited by advertising in health centres in Bangkok. Overall, there were 45 mothers, 45 daughters and a control group; changes in the intervention group were measured against responses of the control group. Every session is informed by concepts of gender and power; the first session examines gender roles in sexual relationships and Thai society, and provides mothers with specific advice on raising adolescent daughters. Subsequent sessions include discussions of feelings about sex; maintaining self-esteem in relationships, understanding sexual risks; and assertiveness in sexual relationships. Every session has a strong focus on practising communication.

While the study did not measure changes in gender norms or attitudes, it aimed to strengthen understanding of these norms as an input to greater self-awareness and more assertive communication about sex. Some findings indicate a shift towards more egalitarian norms. For example, daughters in the intervention group had significantly better perceived ability to prevent pregnancy and to be assertive than prior to the programme. Although the sexual risk score of daughters increased over the course of the intervention, the increase was less than for the comparison group. None of the changes in mothers' attitudes, knowledge or extent of communication were statistically significant though all indicated a shift towards more effective communication around sex. The authors suggest that this may reflect mothers' many years of absorbing prevailing norms, which can take longer to change than for adolescents with relatively less exposure.

*Source: Powwattana et al., 2018: 218*

> *I showed her [daughter] the pamphlets that they gave us, showed her the condoms. I showed her the pills. I said to her, "Look, I want you to read this about condoms because it is important. It isn't something just for men."* (Campero et al., 2010: 1148)

Another mother reported that participating in the workshop had helped shift her husband's view about the importance of discussing SRH issues with daughters. Both parents and adolescents reported more cross-gender communication about sexuality as a result of these workshops, with one mother explaining that she also talked to her daughter's boyfriend about family planning and emergency contraception; he was eager for information but had not been able to attend the workshops.

The evaluation of the Bihar pilot parent–child communication programme measured change in parents' attitudes to the sorts of issues they would be happy to talk to their sons and daughters about, and the information about SRH issues they felt children should receive in adolescence. Difference in difference analysis found that the programme made a significant difference to mothers' acceptance of girls being informed about menstruation and pregnancy, and boys being informed about

contraception. The increase among participant mothers was much greater than for the control group. Participant mothers also became significantly more accepting of the view that girls should have a say in their choice of marriage partner. The study found no such effects for fathers.

### 6.1.2 Attitudes to gender roles

Studies of Imbadu Ekhaya (South Africa) and COMPASS (DRC) found no significant change in parent endorsement of traditional gender roles.[27] Both studies attributed lack of programme impact to the ingrained nature of gender roles and norms; Stark et al. (2018) described the programme's small 'dosage' of one parent group discussion session per month for 13 months as insufficient to change entrenched gender norms. Similarly, Armistead et al. (2014) concluded that despite dedicated programme content on the ways that gender influences parents' expectations of and responsibilities for their children, and gender-based sexual risk, the relatively short time available for discussion of these issues (1 out of 6 sessions) was insufficient to change deeply ingrained norms. The study did find a small, non-significant decrease in parents' endorsement of traditional gender roles, indicating that this content may have had some impact.

Choices-Voices-Promises in Nepal was entirely focused on promoting equitable gender norms, among adolescents, their parents and their wider communities. This initiative showed parents videos about gender-equitable treatment of adolescents, and then held discussions with them (while their children attended a larger number of sessions aimed at changing adolescents' gender norms). Qualitative data from discussions with participant parents found evidence of positive shifts in attitudes towards more equal division of household responsibilities and opportunities to participate in community activities, whereas previously girls would have been confined to the home. The study also found evidence of growing support for equality in educational opportunities, mixed with recognition of norms that are shifting to accept a delay in marriage to accommodate completing education, while still upholding disapproval of girls remaining unmarried past the age of 25 (Lundgren et al., 2018).

### 6.1.3 Knowledge and attitudes concerning child marriage

Two studies reported on parents' attitudes, behaviours or knowledge concerning age at marriage for daughters, and both found mixed results. Jejeebhoy et al.'s (2014) study of the Bihar parent–child communication intervention found positive change in mothers' but not fathers' knowledge of the legal age for marriage. This may reflect lower levels of education among women, and less access to information as a result of prevailing norms in rural Bihar, which mostly confine women to the home. Thus, the information the programme introduced women to was more likely to be new to them, compared to men, who were more likely to have greater levels of knowledge at the outset. Lundgren et al.'s (2018) study of Choices-Voices-Promises (Nepal) found positive impacts on parents' attitudes about when they want their own daughter to get married – showing an average increase of 7 months delay on the age they had stated at baseline. However, there was no significant change in the proportion of parents who reported that they considered early marriage to be bad for the community. The limited impact on parents' attitudes may reflect the fact that the initiative had to be compressed as a result of the earthquake and political strikes in 2015.

## 6.2 Gendered impacts of parenting programmes

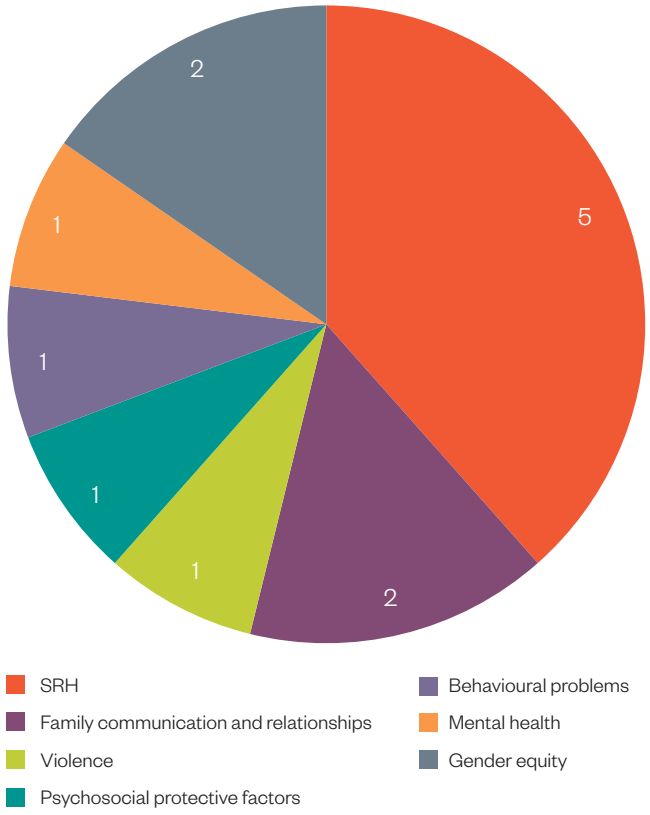
Beyond the programmes described in the previous section, which specifically aimed to change gender norms and gendered behaviour towards adolescents, a wider set of evaluations disaggregated findings by gender – sometimes merely reporting differences between male and female participants, sometimes grounding this in a deeper discussion of gender norms and inequalities.[28] Furthermore, one study (of the Morelos SRH communication initiative in Mexico) reported changes towards more gender-equitable attitudes even though it was not obvious from the programme description that the curriculum included any discussion of gender. Figure 20 shows the distribution of outcomes by topic.

These studies show limited evidence of gender-differentiated effects on adolescents. Studies of two programmes (EWA in Viet Nam and the Bihar (India)

27 Both studies measured gender roles, attitudes and norms in depth, making use of 15 questions in Armistead et al.'s (2014) study of Imbadu Ekhaya and 10 in Stark et al.'s (2018) study of COMPASS.

28 While some studies (five) found no gender differences in outcomes and thus did not report them, it is not clear in most studies whether the absence of gender-disaggregated evidence reflects a lack of noteworthy findings or the fact that the researchers did not disaggregate findings by gender. In a few cases, it also reflects a single-gender sample.

## Figure 20: Distribution of programmes with gender-disaggregated outcomes by topic



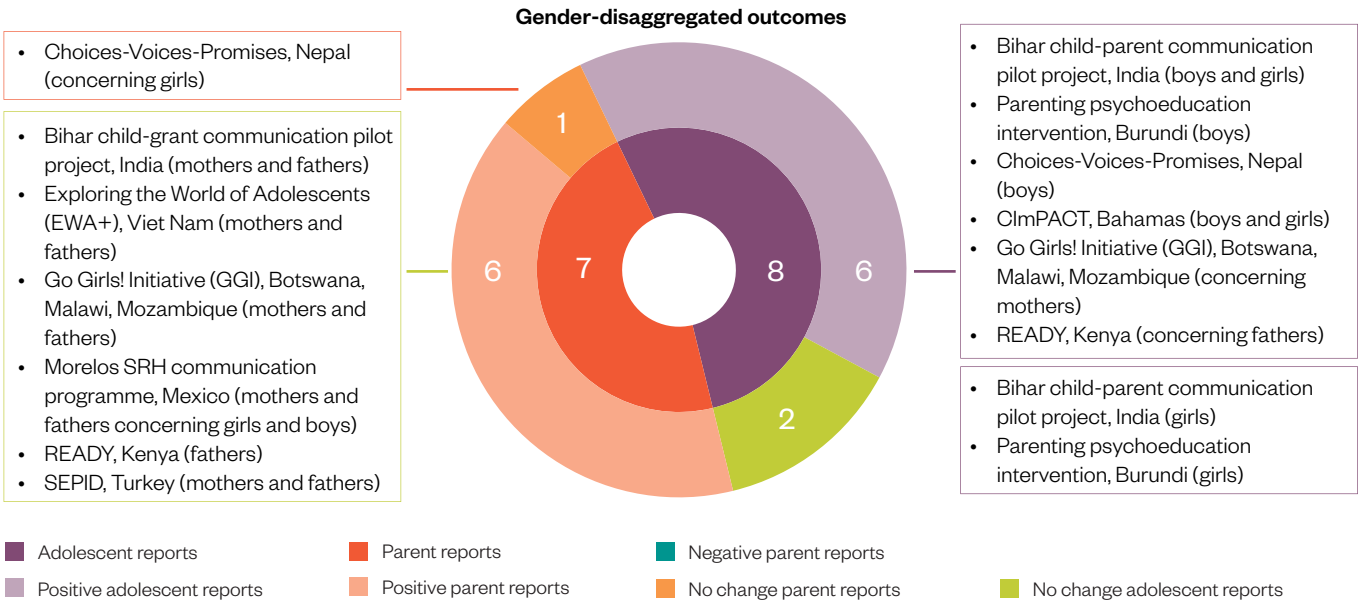

parent–child communication pilot) found greater levels of increase in knowledge for mothers than fathers, possibly reflecting women's generally lower levels of education and exposure to information at baseline.

## 6.3 Impact of participants' gender on outcomes

Most programmes were heavily dominated by female participants (75% of programmes were either primarily or exclusively attended by women). The impacts of women being the primary participants varies, with gendered differences in women's agency and control of parenting decisions.

Mothers participating in Familias Fuertes in El Salvador reported that the lack of male engagement with programme learning made it difficult for them to implement newly acquired skills at home (PAHO, 2006); some participants in Sinovuyo Teen in South Africa also felt stronger efforts should be made to engage fathers, who were more likely to punish adolescents harshly (Loening-Voysey et al., 2018b). This finding echoes insights from GAGE's qualitative work in Palestine, where adolescents recommended that their fathers as well as mothers attended parenting programmes, since gendered power dynamics in the home meant that fathers had ultimate say over adolescents' lives.[29] By contrast, where women had primarily responsibility for their adolescent children and fathers were absent or disengaged, lack of male participation did not affect their ability to implement new approaches. Overall, however, most women participants reported being able put new learning into practice, and studies that probed participants'

## Figure 21: Gender-disaggregated outcomes by parents' and adolescents' reports of programme impacts




29 Presentation by Bassam Abu-Hamad, GAGE masculinities workshop, 16 May 2019.

Mother and child in Afar, Ethiopia. © Nathalie Bertrams/2019

experiences generally found a high level of satisfaction (see Section 7 for further examples).

Studies that explored adolescents' perceptions of the impact of the programme on their relationships with their mothers and fathers found that they generally reported greater improvements in their relationships with their mothers (Go Girls! Initiative, Bihar parent–child pilot communication initiative). However, where fathers had taken part in the programme, adolescents reported a statistically significantly larger improvement in their relationship with their fathers (Schwandt and Underwood, 2013; Jejeebhoy et al., 2014). The study of READY in Kenya found an increase in the level of social support that adolescents reported their fathers providing, which was maintained at 1 and 3-month follow-ups. Although levels of male attendance were below 30%, it seems that some men absorbed learning from watching female kin put learning into practice (for example, by talking more gently with their children), or from the handouts the family brought home. READY also set all families an objective of spending five minutes together per day as 'special talk time', which may have contributed to spreading the learning (Puffer et al., 2016).

These positive examples constituted around a third of the programmes reviewed. With so many programmes aiming to promote better adolescent SRH outcomes, we would have expected a stronger emphasis on gender equality – though it must be recognised that descriptions of programme content are not always detailed enough to assess the level of discussion on gender roles and equality. We were particularly surprised not to find more initiatives like Choices-Voices-Promises or Bihar parent–child communication, which attempted to change parents' attitudes and behaviour on issues such as early marriage; or to prevent recruitment into gangs and other forms of violence.[30] It may be that this material is more commonly addressed through specific programmes focused on girls' empowerment (Marcus et al., 2017) or on violence prevention. This relative lack of emphasis on gender issues suggests there may be value in efforts to include a stronger emphasis on gender equality within parenting programmes. This could help parents understand ways in which they may inadvertently be discriminating between their children on grounds of gender, and the impacts this can have on their children's development and future life chances.

30 Two programmes also focused on internet addiction, which disproportionately affects adolescent boys and young men. However, the reports of these initiatives give no indication that they covered gendered drivers of addiction, including the emerging forms of masculinity associated with video gaming.

# 7 What contributes to positive impacts?

While very few of the studies systematically examined factors that enhanced or undermined programme impact, we can draw some insights from both the studies reviewed and other studies of non-formal education programmes.

## 7.1 Programme duration, frequency and completion rates

As Table 10 shows, the number of studies that reported levels of attendance, completion, and availability for follow-up differed for each indicator. Overall, this data suggests that where parents had decided to participate, levels of attendance and completion were relatively high.

There is little evidence of a link between programme duration and attendance rates. Programmes with high attendance rates (mean proportion of sessions attended by a participant 95%–100%) ranged from 4–16 sessions; programmes with mean attendance levels of 60% or below similarly ranged from 2–14 sessions. Nor did we find any relationship between programme duration and the proportion of positive outcomes reported. The relatively high attendance and completion rates may reflect extensive efforts to tailor programmes to context, via formative research and development of initiatives with other stakeholders, discussed in Section 7.2.

For longer programmes, uptake and participation rates were affected by low socioeconomic status of participating parents. Only 27% of potential participants joined the Bihar parent–child communication pilot project (Jejeebhoy et al., 2014), with others citing the lack of economic element as a reason. In the school-based Morelos SRH communication project in Mexico, parental poverty, work patterns and level of student drop-out from school all affected families' attendance and completion rates (Campero et al., 2011).

Three studies also reported limited availability for follow-up studies. Paruk et al.'s (2009) study of CHAMP (Amaqhawe) in South Africa suggested that this may have reflected the lack of incentives to take part in follow-up studies. Many follow-up studies provided some incentive (payment, reimbursement of transport costs, thank you gift), which may account for the number of studies with relatively high levels of parental availability for follow-up.

However, it was not only poor families that faced challenges completing programmes; middle-class professional families also found that work and other commitments presented challenges to full and timely attendance. For example, de Wit et al.'s (2018) study of the Creative Stress Relief programme in India found that parents often had difficulties committing to a three-hour weekly session on a Sunday, on top of full weekday commitments, leading to late attendance or absence. Around two-thirds of parents completed the programme.

Only one study (of the psychoeducation programme in Burundi) examined the relative impact of different levels of participation. It found no significant differences in adolescents' depression, aggression or perceived family social support between families who had completed the programme (attended both sessions) and those who had not, though outcomes were better where parents had attended both sessions. Where parents had attended one session, adolescents showed less aggression than control group participants (Jordans et al., 2013). Most studies of non-formal education programmes have found a strong link between levels of participation, learning, and behaviour change outcomes; further investigation of the extent of the links in parenting programmes would be beneficial.[31]

Few studies examined the relationship between the frequency of programme sessions and outcomes. Most programmes involved weekly sessions; the least frequent

**Table 10: Rates of participation, completion, and availability for follow-up, by study**

| Scale | High > 80% | Intermediate 50%-80% | Low < 50% |
|---|---|---|---|
| Attendance | 15 | 10 | - |
| Completion | 10 | 5 | - |
| Availability for post-study follow-up | 19 | 3 | 3 |

*At up to 6 months post-participation.*

31 Examples include GAGE's reviews of girls' clubs and masculinities programmes (Marcus et al., 2017; 2018).

sessions were the monthly parents' sessions run by COMPASS in the DRC. This programme was successful in helping parents develop warmer parenting styles. However, there was no impact on parent attitudes and behaviours on gender equity and corporal punishment, probably because the infrequent sessions were insufficient to change ingrained norms (Stark et al., 2018).

Jejeebhoy et al. (2014) draw similar conclusions about the length of time needed for norm change, though in their case, the Bihar parent–child pilot communication project took place over 4–6 months. Our overall findings suggest that some nuancing is required: as Sections 4 and 6 show, some relatively short programmes (8 sessions or fewer) have contributed to clear shifts in attitudes and behaviour around communication on sexual matters and harsh punishment of adolescents. In part, this reflects the participatory nature of most programmes, the space for discussion and reflection in a group context, and the provision of relevant information that helped catalyse norm change.

By contrast, the study of CHAMP-VUKA in South Africa, which held fortnightly sessions on Saturdays over three months – at participants' request – found positive impacts on adolescents' mental health and SRH knowledge, caregivers' perceptions of social support, and parenting skills (Bhana et al., 2014). This suggests that fortnightly sessions may be sufficient if participants are committed to attending and the quality of programme content and delivery is good.

The relatively high attendance and completion levels reflect a strong programme design, teaching and learning methods, and content. Often, programme design and content have been developed through formative research, discussion with multiple stakeholders, and careful adaptation of existing programmes to specific contexts and population groups. We discuss some of these promising design features and adaptations in the next two sections.

## 7.2 Tailoring programme design to context

**Group sessions.** More than three-quarters of programmes (79%) involved group sessions. Qualitative insights suggest that participants often greatly appreciated the group sessions, both as a chance to do something with their adolescent child away from everyday pressures, and to meet other families in similar circumstances. In part, participants' strong appreciation of the group sessions reflected the quality of facilitation and, in particular, efforts to create a welcoming and positive environment. For example:

> *What made it easy for me to go to Sinovuyo on Tuesdays was that whatever situation my home was in, I found love there. The two days I was absent stressed me very much.*
> Interviewer: *You found friends there?*
> Participant: *Truly.* (Doubt et al., 2018: 18)

> *The intervention has helped me to be open, to have someone I can trust and talk to, to socialize with others, has strengthened me, to build hope for the future, setting future goals, being resilient… comforted us and helped us feel like we are not alone. (Mother, FSI-HIV, Rwanda) (Chaudhury et al., 2016: 126)*

**Joint and separate sessions for parents and adolescents.** Holding group sessions for parents and adolescents to discuss sensitive issues, be open, and have 'fun' in a safe space was highlighted by participants in the Sinovuyo Teen programme in South Africa as very positive:

> *'The thing I loved is that we attended as parents and their children. Not children on their own'* (Doubt et al., 2018: 19).

> *We had time to sing, we played and we were taught things that we had no knowledge of… Like when you are stressed, you need to have time out in order to reduce your stress.* (ibid.)

A recurring theme throughout these studies was the value of joint sessions (for parents and adolescents, in which they shared perspectives and practised communication skills through role plays) and separate sessions. For example, READY sessions in Kenya started with an hour-long family session, which emphasised practicing communication, supported by facilitators who praised positive behaviour. Following this, adolescents met for another hour in gender-segregated groups for discussion and skills practice (e.g. how to use a condom). Concurrently, parents met together for 30 minutes to discuss applying their learning to marital relationships and parenting, before splitting into male and female discussion groups for the final 30 minutes (Puffer et al., 2016). Breaking the Voice in Thailand likewise involved a combination of joint sessions for girls and their mothers, and separate sessions where participants could discuss

specific issues related to being an adolescent or parent (Powwattana et al., 2018).

**Home visits.** Home visits, either as the core modality (Parceria project) or a 'catch-up' option for those who missed a scheduled session (Sinovuyo Teen), were appreciated by participants. As one put it: '*We are grateful for the patience Sinovuyo had, especially for running the extra mile for visiting you at home when you had missed a session*' (Doubt et al., 2018: 18). These home visits enabled a high 82% attendance rate, as just 53% of enrolled participants attended the actual sessions – mainly due to illnesses and funerals (Cluver et al., 2016a). Despite their popularity with participants, facilitators were much more sceptical of the value and cost-effectiveness of these catch-up visits, and recommended they be discontinued in future iterations of the programme (Loening-Voysey et al., 2018a). In the Parceria project, participants likened the home visits to '*having my own private psychologist*' (Pereira et al., 2013). This initiative, which provided parenting advice and support, resembled a series of social worker visits – a much more intensive model, but potentially an effective one for reaching particularly vulnerable families.

The appropriateness of home visits is likely to vary by context. In the Bahamas, for example, formative research recommended running the ClmPACT programme in community settings rather than people's homes (Deveaux et al., 2007). By contrast, some Sinovuyo participants felt that small group meetings in people's homes might be a better way to achieve high levels of programme completion than a combination of group meetings and home visits (Loening-Voysey et al., 2018a).

**Learning tools: handouts, self-study materials, and audio-visual materials.** Qualitative evidence also indicates that where programmes provided handouts, and/or were entirely based on self-study, these were often read by different family members, thus diffusing the learning (Paruk et al., 2009; Puffer et al., 2016), and proved helpful as conversation openers:

> *I did not talk to her before we came here; I got help from this program. We were given storybooks that had information on adolescence and on how we as caregivers should sit down with our kids and talk to them about such things.*
>
> *My older son would tell L (the child) to bring the book and they would read it and talk about it, so it has really helped me a lot.* (Bhana et al., 2014: 8)

**Self-study materials.** Studies of the Thai Family Matters and Russian–American Partners for Prevention programmes, which consisted of home-based booklet activities for parents, reported high completion and satisfaction rates. Rosati et al. (2012) found that the personal delivery of the first booklet of the Family Matters intervention to participants' homes made them feel the intervention was important. The subsequent delivery of booklets once a week meant that the required study felt manageable, with participants reporting that if all the booklets had been delivered at once they would have felt overwhelmed. By contrast, Valente et al.'s (2018) study of Ligue 132, a Brazilian telehealth programme, reported just 57% retention for parents, suggesting that telephone contact does not create a strong sense of obligation to continue participating, despite the intervention consisting of just four phone calls.

**Audio-visual material.** Use of audio-visual material (videos, audio narratives) was relatively common across the programmes studied. However, studies made little comment on their effectiveness as learning tools.

### 7.2.1 Programme adaptations

The initiatives examined implemented a range of strategies to adapt programme content and delivery to varied cultural and socioeconomic contexts, to increase relevance to participants, and to encourage programme completion. These strategies included the following.

#### Programme content

- **Strengthening local cultural content,** with reference to religion, anger and stress management practices (such as meditation) (Sim et al., 2014); in Sinovuyo, at participants' request, sessions started with a prayer. They also included local songs (Cluver et al., 2016a).
- **Increasing sensitivity to broader cultural norms** and the extent to which these both shape what is possible and are shaped by interventions. For example, the Happy Families programme framed discussions about reducing harsh punishment of children around 'meta-norms' such as 'loving kindness', around children's voice and participation, and the extent to which disagreement is seen as acceptable in family communication (Sim et al., 2014); Breaking the Voice took into account underlying cultural concepts, such as the expectation of obedience to one's parents (Powwattana et al., 2018).

- **Simplifying content, reducing overall programme duration, and reducing the number of issues covered per session** (Sinovuyo Teen; Happy Families).
- **Strengthening recognition of the impact of severe challenges such as poverty and displacement** on parenting through explicit discussion (Happy Families); Mejia et al.'s (2016) study of the adaptation of the Strengthening Families programme in Panama suggested more explicit discussion of 'families struggling with drugs, of dysfunctional families that are going through difficult times' (ibid. 62).
- **Including practical skills and strategies**. For example, parents in Happy Families reported some of the most valuable sessions as those on learning about family meetings, teaching good behaviour, setting goals and objectives, understanding the negative effects of drugs and alcohol, and using rewards. Child participants reported liking the sessions on communication skills and staying away from drugs and alcohol (Annan et al., 2017).

### Teaching and learning strategies

Key adaptations included:

- **Using role plays** (Sinovuyo, Strengthening Families, Happy Families) **and audio narratives** to model good communication and ways of raising sensitive issues (Families Matter!). One study suggested that it was important for video and audio material to model forms of communication that are not too far a shift from current patterns, so that they are believable and achievable (Mejia et al., 2016).
- **Adding mindfulness-based exercises for stress reduction** (Sinovuyo Teen).

**Participants' recommendations — not yet tried and tested!**

Some additional ideas recommended by participants in the Strengthening Families programme in Panama and Sinovuyo Teen in South Africa include:

- provide more support to help parents help children succeed at school;
- open up programmes to any family members who want to attend rather than a designated parent and adolescent;
- add material to help parents better support adolescents growing up in violent urban contexts.

- **Eliminating written handouts in contexts of low literacy and/or providing visual/cartoon-based content** (Happy Families, Let's Talk, CHAMP-VUKA and CHAMP Amaqhawe); allowing adolescents to complete portions of study tasks or reporting of changes that required writing (Let's Talk; Parceria project).
- **Introducing a peer-support system**. Sinovuyo Teen developed a group of 'Sinovuyo buddies' to help participants between sessions, as low literacy levels limited the use of written materials (Cluver et al., 2016a).

### Tailoring activities to participants' socioeconomic needs

Key adaptations included:

- **Providing food during the session**. This was intended to encourage bonding between participants – both within and between families – and to help them concentrate, as many were too hungry to do so (Happy Families, Sinovuyo, READY).
- **Providing small incentives** (e.g. toothpaste and cooking oil) at various points in the programme (Happy Families, Thailand).[32] Although some programmes (e.g. Families Matter!) have found incentives to be unnecessary or detrimental (Box 5), where incentives were provided, participants greatly appreciated it. As a participant in the Strengthening Families programme in Panama commented: '*I do not even have money for their lunchbox. We do not have a mattress, our little house is made from zinc and when it rains, water leaks in. It is difficult to be a parent without a roof*.' Another added: '*There was a day I did not have anything to eat and SFP 10 –14 gave me a bag of food. The bag was huge and it lasted for an entire month*' (Mejia et al., 2016: 62).
- **Providing on-site childcare for children** under 5, recognising that participants might have no one who could look after a young child, given their recent displacement (Happy Families, Thailand).
- **Including content on financial management and planning.** Four programmes included financial planning content in their curricula. The study of Suubi (Uganda) found that adolescents participating in these workshops reported that they had contributed to increased family communication around financial matters (Ismayilova et al., 2012). The evaluation of Sinovuyo Teen found evidence of reduced economic hardship, reported by both adolescents and parents,

32 Note: some programmes avoid providing incentives, which they consider to be counterproductive (see Families Matter! case study).

and of improved financial management, such as saving more and borrowing less (Cluver et al., 2016a). Two of the programme's 14 sessions focused on financial issues, which suggests that a focus on financial management can be integrated relatively easily into parent education programmes. READY (Kenya) also included content on economic issues, which led to a sustained increase in family communication on economic matters (Puffer et al., 2016).

  - Although participants sometimes joined programmes with the hope of improving their economic situation (Phetla et al., 2008; Doubt et al., 2018), and while the lack of economic components in most programmes was a deterrent (particularly to men's participation), many subsequently recognised the value of the learning from the programme. For example, though mothers initially joined Sisters for Life for its microfinance component, they highlighted newfound commitment to sexual communication as one of the primary benefits of the integration of the Sisters for Life curriculum into the microfinance package (Phetla et al., 2008: 5). As one participant stated, '*We need health talks. I realised that money alone is not enough. We should know about HIV so that our children can benefit*' (ibid.).

- This said, adding content on financial issues may be a strategy for making programmes more attractive to groups (particularly fathers) who are deterred from participation because they prioritise activities to improve household livelihoods.

### Innovating with programme location/hosting arrangements

As Table 2 (Section 2) shows, most parenting programmes took place in community settings, schools or other community buildings. Our review identified two innovations in programme hosting: working with churches (Kenya) and running programmes in workplaces (South Africa). Both have potential for widening the reach of parenting programmes, and to help shift norms towards more positive and engaged parenting to bringing influential stakeholders (church leaders and employers) on board.

### Promising practice: working with churches

READY in rural Kenya worked with Christian churches to offer parenting classes that covered general parenting and communication skills, alternatives to violent discipline, and communication around SRH and protection against HIV. Churches were chosen because 90% of the population in the project area identified as Christian, and churches represent trusted institutions where people seek support. They are also one of few places where all family members, of both genders, go together on a regular basis.

Attendance at church services and church-based groups was already part of people's weekend routines, though Sunday afternoon activities were normally geared to young people, which may have contributed to relatively low levels of attendance by adult men.

Each week, READY started with a joint session for parents and adolescents to practise communication skills, followed by separate sessions. As well as the joint sessions, READY held weekly discussion groups for church leaders to identify how they could provide teaching and support to families on the intervention topics, both during and after the programme. Leaders developed action plans to discuss with their congregation during the final intervention session. The evaluation concluded that working with churches to deliver parenting programmes has great potential in contexts where they are important social institutions (Puffer et al., 2016).

### Promising practice: running parenting programmes in workplaces

Let's Talk, a programme aimed at boosting adolescent and parent communication about HIV and SRH, was implemented in five municipal workplaces in Cape Town, South Africa. The programme was offered to parents with a child aged 11–15, and involved five 2-hour sessions. As well as positive impacts on parents' and adolescents' knowledge and communication about sexual health issues, the evaluation concluded that the programme had helped build capacity among Cape Town's peer educators, who gained the skills and knowledge to include a stronger emphasis on parent–adolescent communication in future work. Unusually, 65% of participants were men, suggesting that workplace-based programmes may be an effective way of reaching fathers (Bogart et al., 2013).

## 7.3 Facilitator training and quality

The quality of facilitation, and the importance of training and support, are widely recognised as critical to the effectiveness of non-formal education programmes. Studies in this review generally do not elaborate on the quality or effectiveness of facilitators, though several

mention how facilitators were trained or selected, or the importance of ensuring that facilitators were competent.

In most cases, facilitators were selected from local community members, often with some prior experience of facilitation, according to programme-specific criteria. For example, HIV-oriented programmes such as CHAMP-TT required prior experience of involvement in HIV education or youth non-formal education (Baptiste et al., 2007); women-only programmes such as Imbadu Ekhaya sought female facilitators (Armistead et al., 2014); Families Matter! ensures that sessions are facilitated by a pair of male and female facilitators (Miller et al., 2016). Let's Talk was unusual in drawing on Cape Town's pool of HIV peer educators (Bogart et al., 2013).

Although the duration of training and follow-up support varied, the most common reported duration was around 5 days' training. Participants then generally received follow-up support – in some cases via weekly supervision and coaching meetings (Familias Unidas; Sinovuyo Teen), in others every 2–3 weeks (Happy Families). These meetings were an opportunity to discuss challenges that had arisen and to develop solutions; they were also a chance for implementing organisations to discuss any concerns around programme fidelity (facilitators fully covering intended programme content). While none of the evaluations comment directly on the extent to which programme content was fully covered, the evaluation of Happy Families suggests that investment in the quality of supervision as well as in facilitator training would help ensure programme fidelity. It also recommends more investment in helping facilitators who encounter challenging situations (in this case, related to participants' mental health), possibly by increasing training in 'general clinical skills', peer support for facilitators, and creative use of technology to provide support (Annan et al., 2017). The qualitative studies of Sinovuyo Teen reported how valuable facilitators found the supervision meetings:

> *If we were not trained and just sent there to facilitate with a manual most of us would have struggled. The Monday [supervision] meetings gave us that courage, and also the manual played its part. But we could not have survived with the manual alone.* (Cited in Loening-Voysey et al., 2018a: 16)

The facilitators also praised the good quality of the manual: '*The manual to me was very specific... It made our work easy, because we went into the sessions knowing what to expect. It was specific and arranged in order*' (ibid.).

A few studies commented on what factors participants considered good facilitation or had helped engage them in the programme. These included:

- a friendly manner (Happy Families);
- information that led to participants appreciating the severity of HIV risk facing their children (Sisters for Life);
- flexibility and being willing to go beyond the programme sessions to help in cases of emergencies (Parceria project). It must be noted that this was an experimental programme provided by one researcher on home visits and thus was quite a different type of facilitation relationship to the group classes.

Overall, insights into the quality of facilitation and its impact on outcomes were slim, pointing to an area where more explicit analysis would be valuable.

# 8 Conclusions

This review has examined 58 studies of 42 programmes in LMICs (the majority in Latin America and sub-Saharan Africa) that aimed to enhance adolescent well-being by helping parents better understand adolescence, and improve their parenting skills. Most programmes had an additional purpose: to reduce violence against adolescents, to promote better SRH communication, to improve adolescents' mental health, or to reduce substance abuse. The programmes examined were mostly very small scale (less than 5,000 participants), with a strong representation of experimental initiatives.

Although most of the programmes were small, pilot initiatives, together they 'punch above their weight' in terms of learning. Two sets of studies looked at major parenting programmes that have been adapted and implemented in a wide range of contexts over the past two decades (Strengthening Families/ Familias Fuertes/ Happy Families; and Families Matter!). Together, the evaluations plus additional materials on these programmes provide a substantial body of learning about the impacts of parenting programmes and what leads to more effective practice. A more recent programme, Sinovuyo Teen, has also been rigorously studied, providing substantial evidence of effective practice, and has now been adapted and implemented in a number of other countries as part of USAID's DREAMS programme. Together, studies of these programmes represent consolidated insights about three of the largest-scale parenting programmes implemented in a range of LMICs. Families Matter! alone has now reached over 1 million families. There is also evidence that learning from parenting programmes is often spread informally within communities (Jejeebhoy et al., 2014; Cluver et al., 2018).

Overall, the studies examined in this review indicate the strong potential of parenting programmes to improve both parents' and adolescents' well-being. In brief, the evidence suggests that all programmes examined were associated with improved outcomes for adolescents or parents on at least one indicator, though as most studies examined change on multiple indicators, many had quite complex, sometimes contradictory, findings on different issues. The specific findings are summarised at the start of each section and in the executive summary, so they are not repeated here. Instead, we comment on some underlying themes, some promising emerging practices and some possible future directions, including knowledge gaps that could be filled by strengthening the breadth of ambition in monitoring, evaluation and learning.

## 8.1 A note on the nature of the evidence

The evidence in this set of studies was strongly focused on the overall impact of each initiative. No studies formally tested the effects of different approaches – for example, there were no RCTs with different arms testing the impact of different programme designs.[33] This may reflect the dominance in this review of large numbers of small initiatives, which generally set out to test an approach (a specific parenting curriculum) in a specific context or with a specific population group. There were also several multi-country initiatives that had been tweaked and enhanced over time, and adapted to local contexts through formative research. While this means there were no quantitative studies comparing different designs, there were some qualitative insights into the programme elements that people thought most valuable, such as a combination of joint and separate sessions for parents and adolescents, and role plays to practise communication skills.

Some studies compared the socioeconomic profiles of people who completed courses and/or were available for follow-up studies, and those who did not. While there appeared to be limited difference between these groups, there is some evidence that poverty and the need to work affected attendance and availability for follow-up studies, particularly for men. Studies were not able to look at levels of motivation and whether this affected dropout, or the extent of change in outcomes.

## 8.2 Key change strategies

The programmes examined in this review made use of four main change strategies: they *provided information*, such as accurate information on SRH issues, the legal age of marriage, or the impacts of harsh punishment on

33 One set of studies tested different interventions for adolescents alongside a consistent programme for parents – ClmPACT.

children's development. In some cases, just receiving this accurate information was enough to lead to new behaviour, such as discussing SRH information with adolescents. Programmes used different means to transmit new information, including facilitators presenting information themselves, and audiovisual materials that both shared knowledge and raised awareness of new ways to communicate. The few self-study programmes shared new information via booklets, or in one case, phone calls. These programmes were primarily focused on reducing use of alcohol, tobacco and drugs. The programmes that aimed to change parenting practices more broadly, or to improve communication around SRH issues specifically, were almost all group-based.

Most group-based programmes had a strong focus on *practising new forms of communication*. Most frequently this was scenario- and role play-based, and involved practising how a parent might respond if an adolescent had misbehaved, or communicating around issues that parents and adolescents found embarrassing such as protection from STIs and/or prevention of unwanted pregnancy.

Some programme curricula clarified that the group sessions *discussed prevailing norms and beliefs* around particular issues, such as the relationship between parents and adolescents, appropriate methods of discipline, the sorts of issues that parents and children could discuss, and gender norms and values (what constitutes expected behaviour of men and women, norms around sexual relationships, etc.) In so doing, they aimed to challenge common beliefs and practices and encourage participants to start to forge new norms of behaviour. As one participant in Sinovuyo Teen (South Africa) commented:

> *We do not want to speak to our children about crucial matters. They taught us to communicate with our children, spend time with them and not sideline them on issues.* (Parent quoted in Loening-Voysey et al., 2018b: 20)

Similarly, a participant in Sisters for Life commented:

> *In our culture we were taught that sexual matters are discussed privately. It was unacceptable that a parent would sit down with his/her child and tell them about sex. It was not accepted here in our village.* (Phetla et al., 2008: 512)

She then related how she and her co-participants agreed that times had changed and that norms must also change – as it is important for parents to talk with their children about a range of issues.

Some of the group programmes, either by design or as an unintended consequence, *strengthened community social networks*, providing both personal support and, in one case, leading to collective action to tackle challenges facing adolescents in their communities. Many adolescents in LMICs are growing up in very difficult environments, with challenges such as high levels of community violence, widespread availability of drugs, tobacco and alcohol, and, in some cases, a significant problem of sexual exploitation.

Strengthening parents' capacity to take action to reduce these challenges would seem a strategy with potential and worth further investment. In the one example among this set of studies – collective action to reduce sale of alcohol to adolescents in rural South Africa – it is important to note that the police service was responsive and clamped down on illegal sales. Strengthening parents' agency and capacity for collective action is clearly only one necessary element of providing a safer, more conducive environment for adolescent development; ensuring that the relevant authorities are prepared to act is also vital.

**Emerging innovations.** A few innovative approaches and practices, often tried only in one programme each, emerged from this review. These innovations covered: (1) approach (e.g. stress management techniques in Sinovuyo Teen and the Creative Stress Relief programme); (2) content – for example, materials on raising awareness of sexual exploitation and ways of preventing and responding (Families Matter!, COMPASS); and (3) household financial management (Suubi, Sinovuyo Teen). They also included measures to support attendance and concentration levels among poor participants, such as providing meals (Sinovuyo Teen, Happy Families) and take-home rations (Happy Families). Two programmes also experimented with new types of partnership and venues to deliver parenting education –churches (READY, Kenya) and workplaces (Let's Talk, South Africa). All of these innovations deserve more detailed scrutiny.

## 8.3 Recommendations

As well as the evidence of positive impacts discussed in this review, we identified the following gaps, which if addressed, could further strengthen the impact of parenting programmes.

**Embed a stronger focus on gender equality.** The apparent lack of explicit attention to gender equality in many programmes is a missed opportunity to challenge embedded discriminatory gender norms and stereotypes that affect adolescents. This could

17-year old boy in hospital with his parents in Bangladesh. © Nathalie Bertrams/2019

involve: a stronger emphasis in generic materials on understanding adolescence and on recognising gender stereotypes, norms and inequitable practices; explicit attention to gendered power dynamics in interventions promoting better communication around SRH issues; and, as relevant in particular contexts, attention to issues disproportionately affecting adolescents of a particular gender, such as child marriage and sexual exploitation (girls), or vulnerability to gang violence (boys). There may be a trade-off between increasing the number of sessions and retaining parents in the programme, which will need to be resolved according to the specifics of each context.

**Pay greater attention to engaging fathers in parenting programmes.** Much more should be done to engage fathers, possibly via shorter courses, timing courses so they do not clash with work commitments, or experimenting with fathers-only groups or home visits. Workplace-based programmes may offer a route to reaching fathers, as in the Let's Talk initiative in South Africa. Offering sessions or support in social or faith-based settings may be another route to reaching fathers.

**Explore the potential to integrate parenting education more strongly with anti-poverty programmes.** This could help reduce parental stress, which is often linked to violence in the home, and a lack of time or energy to communicate with adolescents. Draw on lessons from large-scale programmes offering parenting support to parents of young children alongside a wider set of anti-poverty services, such as Chile Solidario and Chile Crece Contigo.

- Consider offering parenting education in the context of *skills training, job matching services, cash transfers or entrepreneurship support initiatives,* as with the Sisters for Life parenting/ IMAGE microfinance programme in South Africa.
- Consider expanding *content on financial knowledge and management* within parenting programmes; this has been shown to be an issue on which adolescents and parents can collaborate, strengthening family relationships – and there is some evidence of it leading to improved family economic outcomes.
- Consider providing *more academic support*, given the protective effect of education against both poverty and other difficult life situations (Mejia et al., 2016).

**Explore the potential to include materials that help parents take collective action on issues that undermine adolescents' well-being in their communities, such as sale of alcohol to adolescents, availability of drugs, or norms that excuse sexual exploitation.** It is also important to recognise that addressing these challenges will often require the support of, and action on the part of, other community stakeholders and services such as the police, schools or community leaders.

**Make greater efforts to ensure that programmes reach marginalised groups.** Half of the programmes in this review reported working with marginalised groups, such as low-income families (15 programmes), parents of adolescents with intellectual disabilities (2 programmes), and parents of adolescents with mental health difficulties or addictive behaviour (3 programmes). None mentioned efforts to include, or tailor content to, parents of adolescents with other disabilities. Only one study mentioned that its SRH curriculum included homosexuality. Given that studies in high-income countries have shown that family support and acceptance is critical for LGBTQI+ young people's mental health, it would be valuable to produce guidance on how programmes can sensitively discuss these issues in contexts where backlash may be strong and/or homosexuality is illegal.

**Enhance evaluation and reporting** to provide greater insights into:

- *the effectiveness of particular programme components or approaches* – for example, testing: (1) the relative impact of self-study versus group-based education; (2) the impact of separate parent and adolescent groups compared with joint groups; (3) the impacts of different programme and session durations; (4) the impact of integrating parenting programmes with other services, compared to a stand-alone initiative; (5) the impact of offering programmes in a wider range of locations; and (6) innovations such as buddies to consolidate learning, or booster sessions after programme completion.
- *the quality and fidelity of implementation* (how closely facilitators stick to programme curricula and activities) and how this affects impacts.
- *the long-term impacts* – only seven studies of four initiatives (that ranged from SRH knowledge and condom skills, to family communication around SRH and economic issues, and preventive support to families whose parenting practices had led them to court) examined whether impacts had lasted beyond a year; all found that they had. It would be worthwhile undertaking further follow-up of large-scale, longstanding programmes to identify what changes have persisted and why. In particular, it would be worth exploring in more depth the impact of efforts to change norms that affect parenting, and the value of booster sessions to maintain learning.
- *the indirect impacts of programmes* – such as whether there are any traceable impacts on adolescents' education (for example, resulting from reduced violence, improved mental health, or from greater parental communication with adolescents).

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# Annex 1: Programme details

| | Area of focus | Country and geographical location | Method of delivery | Types of activities | Target group | Age of adolescent | Scale (number of parents reached) | Where the programme took place | Who carried out the intervention |
|---|---|---|---|---|---|---|---|---|---|
| Bahamian Focus on Older Youth (BFOOY) plus Caribbean Informed Parents and Children Together (ClmPACT) Stanton et al. (2015);<br>Dinaj-Koci et al. (2015) | Family relationships and communication, HIV, SRH | Bahamas<br>Urban | Group classes | Participatory learning activities, discussions, homework (BFOOY & Goal for it (GFI)), condom demonstration (ClmPACT) | Parents and children together (ClmPACT/GFI) and separately (BFOOY) | 14, 15 | 501–5,000 | School | University/ research institute and government |
| Breaking the Voice (Rak luk khun tong pood)<br>Powwattana et al. (2018) | SRH | Thailand<br>Urban | Group classes | Participatory learning activities, discussions | Parents and children together | 12–15 | <100 | Community | University/ research institute |
| Collaborative HIV Prevention and Adolescent Mental Health Family Programme (CHAMP) - Amaqhawe<br>Bhana et al. (2004) (pilot)<br>Paruk et al. (2009) (full) | Family relationships and communication, HIV, SRH | South Africa<br>Rural,<br>peri-urban | Group classes | Printed materials, discussions | Parents only | 10, 11 | <100 | Community | University/ research institute |
| CHAMP-TT (Trinidad and Tobago)<br>Baptiste et al. (2007) | HIV, SRH | Trinidad and Tobago<br>n/a | Group classes | Participatory learning activities, discussions | Parents and children together and separately | 11–13 | <100 | Healthcare facility | NGO/development organisation and university/ research institute |
| CHAMP-VUKA<br>Bhana et al. (2014) | Family relationships and communication, HIV, SRH | South Africa<br>Urban | Group classes | Participatory learning activities, Printed materials | Parents and children together | 10–13 | <100 | Healthcare facility | University/ research institute |
| CHAMP-Amaqhawe<br>Bell et al. (2008) | HIV, SRH | South Africa<br>Rural | Group classes | Printed materials | Parents only | Children under 10 and adolescents 10–13 | 101–500 | School, unknown | |

| | Area of focus | Country and geographical location | Method of delivery | Types of activities | Target group | Age of adolescent | Scale (number of parents reached) | Where the programme took place | Who carried out the intervention |
|---|---|---|---|---|---|---|---|---|---|
| Choices-Voices-Promises<br>Lundgren et al. (2018) | Gender equity | Nepal<br>Rural | Group classes | Participatory learning activities, discussions | Parents only | 10–15 | 501–5,000 | School, home | NGO/development organisation and university/ research institute |
| Creating Opportunities through Mentorship, Parental Involvement, and Safe Spaces (COMPASS)<br>Stark et al. (2018) | Violence and abuse prevention, gender equity, family relationships and communication | DRC<br>n/a | Group classes | Participatory learning activities, discussion | Parents and children separately | 10–14 | 101–500 | Unspecified | NGO/development organisation and university/ research institute |
| Creative Stress Relief Programme for Parents<br>de Wit et al. (2018) | Family relationships and communication | India<br>Urban | Group classes | Participatory learning activities, discussions | Parents only | 11–18 | <100 | School | NGO/development organisation and university/ research institute |
| Cuidate! Promueve tu salud<br>Villarruel et al. (2008) | Family relationships and communication, HIV, SRH | Mexico<br>n/a | Group classes | Participatory learning activities, discussions, homework | Parents and children separately | 14–17 | 501–5,000 | School | University/ research institute |
| Escuela para Padres (School for Parents)<br>Nuño-Gutiérrez et al. (2006) | Family relationships and communication, mental health/well-being, SRH, substance abuse | Mexico<br>Urban | Group classes | Discussions | Parents only | Unspecified | <100 | School | Government |
| Exploring the World of Adolescents + (EWA+)<br>Kaljee et al. (2012); Pham et al. (2012) | SRH | Viet Nam<br>Urban, Rural | Group classes | Discussions | Parents and children separately | 15–young adults over age 19 | 101–500 (Kaljee), 501–5000 (Pham) | Community | University/ research institute |
| Family Strengthening Intervention for HIV-affected Families (FSI-HIV)<br>Chaudhury et al. (2016) | Family relationships and communication | Rwanda<br>Rural | Home visits | Discussions | Parents and children separately | Children under 10 , adolescents 10–17 | <100 | Home | University/ research institute |

| | Area of focus | Country and geographical location | Method of delivery | Types of activities | Target group | Age of adolescent | Scale (number of parents reached) | Where the programme took place | Who carried out the intervention |
|---|---|---|---|---|---|---|---|---|---|
| Familias Fuertes (FF)<br><br>Corea et al. (2012) (Spanish); Orpinas et al. (2014); Vasquez et al. (2010); PAHO (2006) (Spanish) | Family relationships and communication, substance abuse; in El Salvador also: HIV, SRH, violence and abuse prevention | Bolivia, Chile, Colombia, Ecuador, El Salvador, Honduras Urban,<br><br>peri-urban | Group classes | Participatory learning activities, discussions | Parents and children together and separately | 10–14 | 100–500, <100 (Honduras and El Salvador) | School | NGO/development organisation; government<br><br>(El Salvador) |
| Familias Unidas<br><br>Molleda et al. (2017) | Family relationships and communication, mental health disorder/ well-being | Ecuador<br><br>Urban | Group classes | Homework, printed materials | Parents and children together and separately | 12–14 | 101–500 | School, home | University/ research institute |
| Families Matter!<br><br>Vandenhoudt et al. (2010) Kamala et al. (2017) | SRH | Kenya, Tanzania<br><br>Rural | Group classes | Participatory learning activities, discussions | Parents and children together and separately | Children under 10, adolescents 10–12 | 101–500; 501–5,000 | Community | NGO/development organisation |
| Focus on Youth in the Caribbean (FOYC) plus Caribbean Informed Parents and Children Together (CImPACT)<br><br>Chen et al. (2010); Gong et al. (2009); Deveaux et al. (2007) | Family relationships and communication, HIV, SRH | Bahamas<br><br>n/a | Group classes | Participatory learning activities, discussions, condom demonstration (CImPACT), homework (FOYC) | Parents and children separately | 10–12 | 501–5,000 total, 436 FOYC/ CImPACT | Community | University/ research institute and government |
| Thai Family Matters<br><br>Rosati et al. (2012); Byrnes et al. (2011); Cupp et al. (2013) | Substance abuse, SRH, HIV | Thailand<br><br>Urban | Telephone session, Parent self-study | Participatory learning activities, discussions, printed materials | Parents and children together and separately | 13, 14 | 101-500 | Home | University/ research institute and government |

| | Area of focus | Country and geographical location | Method of delivery | Types of activities | Target group | Age of adolescent | Scale (number of parents reached) | Where the programme took place | Who carried out the intervention |
|---|---|---|---|---|---|---|---|---|---|
| Go Girls! Initiative (GGI)<br><br>Schwandt and Underwood (2013) | Family relationships and communication | Botswana, Malawi, Mozambique<br><br>Urban, Rural | Group classes | Participatory learning activities, discussions | Parents only | 11–18 | 501–5,000 | Community | NGO/ development organisation and university/ research institute |
| Happy Families programme<br><br>Annan et al. (2017); Puffer et al. (2017); Sim et al. (2014) | Family relationships and communication, mental health/ well-being promotion | Thailand<br><br>Urban, Rural, Peri-urban | Group classes | Participatory learning activities | Parents and children together and separately | Children under 10, adolescents 10–15 | 101–500; 501–5,000 | Community | NGO/development organisation and university/ research institute |
| Imbadu Ekhaya<br><br>(Parents Matter!)<br><br>Armistead et al. (2014) | Violence and abuse prevention, gender equity, HIV, SRH | South Africa<br><br>Urban | Group classes | Participatory learning activities, homework | Parents and children together | 10–14 | <100 | Unspecified | NGO/development organisation and university/ research institute |
| Let's Talk<br><br>Bogart et al. (2013) | HIV, SRH | South Africa<br><br>Urban | Group classes | Participatory learning activities, discussions, homework | Parents only | 11–15 | <100 | Community | University/ research institute and government |
| Ligue 132<br><br>Valente et al. (2018) | Substance abuse | Brazil<br><br>n/a | Individualised support for parents, telephone session | Printed materials | Parents only | 10–18 | <100 | Remotely (i.e. phone) | University/ research institute |
| Parceria project<br><br>Pereira et al. (2013) | Violence and abuse prevention | Brazil<br><br>n/a | Home visits | Participatory learning activities, discussions, printed materials, homework | Unclear | 12–16 | <100 | Home | University/ research institute |
| Parenting for Lifelong Health: Sinovuyo Teen (pilot programme)<br><br>Cluver et al. (2016) | Violence and abuse prevention, family relationships and communication | South Africa<br><br>Rural, peri-urban | Group classes, home visits | Participatory learning activities, discussion, homework, printed materials<br><br>(for facilitators) | Parents and children together and separately | 10–18 | 101–500 | Community, home | Government, NGO/development organisation and university/ research institute |

| | Area of focus | Country and geographical location | Method of delivery | Types of activities | Target group | Age of adolescent | Scale (number of parents reached) | Where the programme took place | Who carried out the intervention |
|---|---|---|---|---|---|---|---|---|---|
| Parenting for Lifelong Health: Sinovuyo Teen (full programme)<br><br>Doubt et al. (2017); Cluver et al. (2018); Doubt et al. (2018); Loening-Voysey (2018a; 2018b) | Violence and abuse prevention, family relationships and communication | South Africa<br><br>Rural, peri-urban | Group classes,<br><br>home visits | Participatory learning activities, discussion, homework, financial planning workshop | Parents and children together and separately | 10–18 | 500–5,000 (270 Sinovuyo) | Community, home | Government, NGO/development organisation and university/ research institute |
| READY<br><br>Puffer et al. (2016) | Family relationships and communication, HIV, SRH | Kenya<br><br>Urban, rural, peri-urban | Group classes | Discussions | Parents and children together and separately | 10–16 | 101–500 | Community | NGO/development organisation and university/ research institute |
| School for Parents programme<br><br>Pereira et al. (2007) | Family relationships and communication, empowerment | Brazil<br><br>Urban | Group classes, individualised support for parents | Self-esteem and citizen rights knowledge workshop | Parents only | 10–18 | 501–5,000 | Unspecified | Government |
| Strengthening Families Programme: For Parents and Youth 10–14 (SFP 10–14)<br><br>Maalouf and Campello (2014) | Family relationships and communication, substance abuse, violence and abuse prevention | Guatemala, Honduras, Panama, Serbia<br><br>Rural | Group classes | Participatory learning activities, discussions | Unclear | 10–14 | <100 in each country | School | NGO/development organisation and government |
| Sexuality Education Programme for Mothers of Young Adults with Intellectual Disabilities (SEPID)<br><br>Yildiz and Cavkaytar (2017) | SRH | Turkey<br><br>Urban | Group classes | Participatory learning activities, discussions, printed materials | Parents only | Unspecified | <100 | Community | University/ research institute and government |
| Sisters for Life<br><br>Phetla et al. (2008) | Gender equity, HIV, SRH | South Africa<br><br>Rural | Group classes | Participatory learning activities, discussions | Parents only | Unspecified | 101–500 | Unspecified | University/ research institute and microfinance initiative |

| | Area of focus | Country and geographical location | Method of delivery | Types of activities | Target group | Age of adolescent | Scale (number of parents reached) | Where the programme took place | Who carried out the intervention |
|---|---|---|---|---|---|---|---|---|---|
| Slick Tracy Home Team Program<br>Williams et al. (2001) | Substance abuse | Russia<br>Urban | n/a | Homework, printed materials | Parents and children together and separately | 10 -11 | 501–5,000 | School, home | University/ research institute |
| Suubi<br>Ismayilova et al. (2012) | Economic empowerment, family relationships and communication, SRH | Uganda<br>Rural | n/a | Financial planning workshop, financial support | Parents and children together | 11–17 | 101–500 | Adolescents recruited from school, unclear where parent sessions were held | Unspecified |
| Talking Parents, Healthy Teens<br>Baku et al. (2017) | SRH | Ghana<br>Urban | Group classes | Participatory learning activities, discussions | Parents only | 12–17 | 101–500 | Community | University/ research institute |
| **Un-named programmes** | | | | | | | | | |
| Bihar parent–child pilot communication programme<br>Jejeebhoy et al. (2014) | Violence and abuse prevention, gender equity, family relationships and communication, SRH | India<br>Rural | Group classes | Discussions | Parents and children together and separately | 13–17 | 101–500 | Community | NGO/development organisation |
| Internet addiction therapy programme<br>Zhong et al. (2011) | Internet/videogame addiction, mental health | China<br>Urban | Group classes | Participatory learning activities, discussions | Parents and children together | 14–19 | <100 | Healthcare facility | University/ research institute |
| Morelos SRH communication study<br>Campero et al. (2010; 2011) | Family relationships and communication, SRH | Mexico<br>n/a | Group classes | Participatory learning activities, discussions, homework, subsidised materials | Parents and children separately | 15, 16 | 501–5,000 | School | University/ research institute |
| Multi-family group therapy for internet addiction<br>Liu et al. (2015) | Family relationships and communication, internet/videogame addiction, mental health | China<br>Urban | Group classes | Participatory learning activities, discussions, printed materials, homework | Parents and children together | 12–18 | <100 | Healthcare facility | University/ research institute |

| | Area of focus | Country and geographical location | Method of delivery | Types of activities | Target group | Age of adolescent | Scale (number of parents reached) | Where the programme took place | Who carried out the intervention |
|---|---|---|---|---|---|---|---|---|---|
| Parent education programme<br><br>Kaveh et al. (2014) | Mental health/well-being promotion | Iran<br><br>Urban | Group classes, parent self-study | Participatory learning activities, discussions, printed materials, SMS reminders | Parents only | 12–14 | 101–500 | School | University/ research institute |
| Parenting psychoeducation intervention<br><br>Jordans et al. (2013) | Violence and abuse prevention, family relationships and communication, mental health/well-being promotion | Burundi<br><br>Rural | Group classes | Discussions | Parents only | 10–14 | 101–500 | School | University/ research institute |
| Quality of life therapy programme<br><br>Abedi and Vostanis (2010) | Family relationships and communication, mental health/well-being promotion | Iran<br><br>Urban | Group classes | Discussions, homework | Unclear | 10–18 (average age 10) | <100 | Unspecified | University/ research institute |
| SRH education for parents of adolescents with intellectual disabilities<br><br>Kok and Akyüz (2015) | SRH | Turkey<br><br>n/a | Group classes | Discussions | Parents only | 10–19 (average age 10) | <100 | Community | University/ research institute |

# Annex 2: Review methodology

## A2.1 Keywords

After a period of testing, the following keywords were used in searches carried out in Web of Science, PsycINFO, Ovid, and EbscoHost.

| Intervention terms | Population terms | Country terms | Outcome terms | Impact/ evaluation terms |
|---|---|---|---|---|
| ((parent* or mother or father or family) N3 (intervention or program* or project)) or parent education | (Adolescen* or girl or boy or young wom$n or young m$n or teen* or youth) | *See below | (vulnerab* or disab* or norm or attitude or belief or practice or behavio*r or education or learning or knowledge or health or SRH or family planning or sexual activity or substance or drug or alcohol or violence or physical punishment or corporal punishment or abuse or aggress* or gang or wellbeing or family communication or relationship or harsh or warm or sensitive or self-confidence or self-esteem or depression or anxiety or (econom* adj2 (empowerment or wellbeing)) or voice or agency or empowerment or speak* up or spoke up or speak* out or spoke out or express* opinion or decision-making or (decision mak*) or (family conflict reduc*) or (family dynamics) or ((child neglect) or (child violence) or (child abuse) adj2 (reduc* or prevent*))) | impact or evaluat* or assess* or review* or Effect or effic* |

***Country terms***

(Africa OR (sub-Saharan Africa) OR (North Africa) OR (West Africa) OR (East Africa) OR Algeria OR Angola OR Benin OR Botswana OR (Burkina Faso) OR Burundi OR Cameroon OR (Cape Verde) OR (Central African Republic) OR Chad OR (Democratic Republic of the Congo) OR (Republic of the Congo) OR Congo OR (Cote d'Ivoire) OR (Ivory Coast) OR Djibouti OR Egypt OR Equatorial Guinea OR Eritrea OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR Guinea-Bissau OR Kenya OR Lesotho OR Liberia OR Libya OR Madagascar OR Malawi OR Mali OR Mauritania OR Morocco OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR (Sao Tome) OR Principe OR Senegal OR (Sierra Leone) OR Somalia OR (South Africa) OR (South Sudan) OR Sudan OR Swaziland OR Tanzania OR Togo OR Tunisia OR Uganda OR Zambia OR Zimbabwe OR (South America) OR (Latin America) OR (Central America) OR Mexico OR Argentina OR Bolivia OR Brazil OR Chile OR Colombia OR Ecuador OR Guyana OR Paraguay OR Peru OR Suriname OR Uruguay OR Venezuela OR Belize OR (Costa Rica) OR (El Salvador) OR Guatemala OR Honduras OR Nicaragua OR Panama OR Caribbean OR Antigua OR Barbuda OR Barbados OR Cuba OR Dominica OR (Dominican Republic) OR Grenada OR Haiti OR Jamaica OR (Kitts and Nevis) OR (Saint Kitts and Nevis) OR (Lucia) OR (Saint Lucia) OR (Vincent and the Grenadines) OR (Saint Vincent and the Grenadines) OR (Vincent) OR (Trinidad and Tobago) OR (Eastern Europe) OR Albania OR Armenia OR Belarus OR Bosnia OR Herzegovina OR Bulgaria OR Croatia OR (Czech Republic) OR Estonia OR Hungary OR Kosovo OR Latvia OR Lithuania OR Macedonia OR Moldova OR Montenegro OR Poland OR Romania OR Serbia OR (Slovak Republic) OR Slovakia OR Ukraine OR Asia OR (Middle East) OR (Southeast Asia) OR (Indian Ocean Island*) OR (South Asia) OR (Central Asia) OR (East Asia) OR Caucasus OR Afghanistan OR Azerbaijan OR Bangladesh OR Bhutan OR Burma OR Cambodia OR China OR Georgia OR India OR Iran OR Iraq OR Jordan OR Kazakhstan OR Korea OR (Kyrgyz Republic) OR Kyrgyzstan OR Lao* OR Lebanon OR Mongolia OR Myanmar OR Nepal OR Oman OR Pakistan OR Russia OR (Russian Federation) OR Indonesia OR Malaysia OR Philippines OR Sri Lanka OR Syria OR (Syrian Arab Republic) OR Tajikistan OR Thailand OR Timor-Leste OR Timor OR Turkey OR Turkmenistan OR Uzbekistan OR Vietnam OR West Bank OR Gaza OR Yemen OR Comoros OR Maldives OR Mauritius OR Seychelles OR (Pacific Islands) OR (American Samoa) OR Fiji OR Guam OR Kiribati OR (Marshall Islands) OR Micronesia OR (Northern Mariana Islands) OR Palau OR (Papua New Guinea) OR Samoa OR (Solomon Islands) OR Tonga OR Tuvalu OR Vanuatu OR LMIC OR (South-East Asia) OR Balkans OR (low-income countr*) or (middle-income countr*))

## A2.2 Inclusion/exclusion criteria

| Criterion | Indicator/ issue | Include | Exclude |
|---|---|---|---|
| Population | Location | Programmes in LMICs | OECD countries |
| Intervention | | Interventions aiming to improve parenting experienced by 10–19-year-olds (may include younger children)<br>Interventions targeting parenting skills or well-being of adolescent parents (under 20 years)<br>Group-based initiatives/ classes<br>Counselling focused on parenting issues<br>Parent mentoring programmes<br>Family-based programmes intended to improve parent–child relationships or communication, parenting skills | Programmes aiming to improve the parenting experienced only by children under 10 (e.g. early childhood programmes) unless those parents are themselves adolescents<br>Counselling/ therapy programmes without specific objective of improving parenting skills<br>Biomedical interventions<br>Programmes where parents are not the subject<br>Programmes focusing on breastfeeding (adult or adolescent parents)<br>Programmes focusing on prevention of mother-to-child transmission of HIV<br>Programmes focusing on a particular aspect of adolescent health (e.g. obesity, nutrition, dental care)<br>Programmes using parents to deliver a health intervention for adolescents without a focus on improving parent–child relationships or communication, or parenting skills (e.g. for depression, farm safety, etc.) |
| Comparator | Type of study design | Evaluations must include valid comparison. Normally the following research designs will be included: RCT, quasi-experimental study, studies making use of regression discontinuities or instrumental variables, qualitative study with valid comparison (e.g. intervention participants and non-participants) | Studies without a valid comparison<br>Studies that don't assess a programme or intervention |
| Outcomes | | Studies assessing changes in:<br>Interactions and relationships within family (e.g. communication, closeness)<br>GAGE capability domains (education, health, psychosocial well-being, voice and agency, bodily integrity, economic empowerment)<br>Gender norms and attitudes (e.g. to gender equality, girls' mobility, acceptability of gender-based violence (GBV), appropriate age of marriage, etc.)<br>Parenting knowledge, attitude, behaviours and adolescent knowledge, attitude, behaviour relating to family communication, adolescent sexual behaviour/risks, substance use, addiction to substances or gaming/internet<br>Parenting knowledge, attitude, behaviour towards discipline, other parenting skills, general competency<br>Development of child of adolescent parent | Studies with:<br>Biomedical health-specific outcomes (e.g. body mass index (BMI), cholesterol)<br>Adult parent-only outcomes (e.g. parent anxiety) without assessing parenting or adolescent-related outcomes<br>Breastfeeding practices |
| Study | Language | English<br>Spanish | Other languages |
| | Timeframe | Studies dated since 2000 | Articles published pre-2000 |
| | Type of document | Evaluations, reviews of evaluations, literature reviews on parenting programmes (for background use), descriptions of programmes (for additional context) | Case studies/ project descriptions for which no further information can be found. |

The websites of the following organisations and programmes/ projects were handsearched.

- Promundo – Program P
- Save the Children
- UNICEF, both Innocenti and other UNICEF sites
- University of Manchester
- World Bank
- Global Early Adolescent Study
- Search for Common Ground
- Oak Foundation
- Girls Not Brides
- Coalition for Adolescent Girls
- Population Council GIRL centre and other parts of their website
- Suubi
- Makani (Jordan)
- STEEP (Steps toward effective and enjoyable parenting) research practice project
- Motivation ( Parent and carer training in Malawi)
- Men Care +
- Men Engage
- Strengthening Families Programme 10–14 (SFP 10–14)
- Families And Schools Together (FAST)
- Familias Fuertes
- CHAMP (depending on country where it's implemented)
- Happy Families programme
- Sinovuyo Teen parenting programme
- Thai Family Matters
- Triple P Positive Parenting Programme

# Annex 3: Indicators and measurement scales used

## Parenting skills

| Study | Parent–child communication | Positive monitoring and neglect | Parent–child relationship |
|---|---|---|---|
| Armistead et al. (2014: 671), Imbadu Ekhaya | | 12 items from the **Inventory of Parental Involvement**[1] and 12 items created by the research team. | **Interaction Behavior Questionnaire**[2] |
| Baptiste et al. (2007: 344-345) CHAMP-TT | 14-item measure on how often they talk at home about sensitive topics such as alcohol, drugs, HIV/AIDS, having sex, and puberty and comfort level with such discussions.[3] | 13-item scale assessing the level of parental knowledge and awareness of youth's whereabouts, friends and activities.[4] | |
| Bhana et al. (2004: 38) CHAMP- Amaqhawe | 3 different scenarios presented in the form of vignettes measuring dimensions of passive, manipulative, aggressive or assertive parental communication styles.<br><br>**Hard to Talk About**: 7-item measure of things that parents have difficulty talking about with their children. | | |
| Bell et al. (2008: 4) CHAMP-SA | | **Parenting Styles Scales** (parental involvement, psychological autonomy, strictness, and punitive style).<br><br>**Caregiver Monitoring Interview** consisting of 4 parameters. | |
| Byrnes et al. (2011: 7) Thai Family Matters | 6 items adapted from literature reflecting mothers' report of their discussion of general issues with their child were used to assess general communication.[5] | | |
| Cluver et al. (2018: 5) Sinovuyo Teen | | **Alabama Parenting Questionnaire**[6] | |
| Cupp et al. (2013: 1389), Thai Family Matters | A 9-item general parent–child communication measure.[7] | | |

1 Hawkins, A.J., Bradford, K.P., Palkovitz, R., Christiansen, S.L., Day, R.D. and Call, V. (2002) 'The inventory of father involvement: a pilot study of a new measure of father involvement', *The Journal of Men's Studies* 10: 183–196

2 Robin, A.L. and Foster, S. (1989) *Negotiating parent–adolescent conflict.* New York, NY: Guilford Press

3 Adapted from: Gurerra, N.G. and Tolan, P.H. (1991) 'Metropolitan Area Child Study (MACS). Grant proposal'. Available from the second author at University of Illinois at Chicago; also adapted from Paikoff, R.L. (1995) 'Early heterosexual debut: situations of sexual possibility during the transition to adolescence' *American Journal of Orthopsychiatry* 65: 389-401

4 Adapted from: Gorman-Smith, D., Tolan, P.H.; Zelli, A. and Huesman, L.R. (1996) 'The relation of family functioning to violence among inner-city minority youth', *Journal of Family Psychology* 10: 115–129

5 Adapted from: Spoth, R.L., Redmond, C., Haggerty, K. and Ward, T.A. (1995) 'A controlled parenting skills outcome study examining individual difference and attendance effects', Journal of Marriage and the Family 57(2): 449–464; and Spoth, R.L., Redmond, C. and Shin, C. (1998) 'Direct and indirect latent-variable parenting outcomes of two universal family-focused preventive interventions: extending a public health-oriented research base' *Journal of Consulting and Clinical Psychology* 66(2): 385–399

6 Essau, C.A., Sasagawa, S. and Frick, P.J. (2006) 'Psychometric properties of the Alabama Parenting Questionnaire' *Journal of Child and Family Studies* 15(5): 595–614

7 See note 5 (Spoth et al., 1995)

| Study | Parent–child communication | Positive monitoring and neglect | Parent–child relationship |
|---|---|---|---|
| Dinaj-Koci et al. (2015: 650), CImPACT (Bahamas) | | An 8-item parental monitoring scale.[8] | |
| Ismayilova et al. (2012: 4–5), Suubi | Questions adapted from the Family Environment Scale/Family Assessment Measures (FES/FAM) scale.[9] | Questions adapted from the FES/FAM scale. | Questions adapted from the FES/FAM scale. |
| Jejeebhoy et al. (2014: 14), Pilot parent–child communication project in Bihar | | | In the past month, spent time regularly talking/joking with their children.<br>In the past six months, did something 'fun'/took their children on an outing. |
| Liu et al. (2015: 4), Multi-family intervention for adolescents with internet addiction | The Parent–Child Communication Scale.[10] | | 9-items from the Closeness to Parents Scale.[11] |
| Molleda et al. (2017: 787), Familias Unidas | Parent-Adolescent Communication Scale.[12] | Parent Relationship with Peer Group Scale.[13] | |
| Nuño-Gutiérrez et al. (2006: 521), Escuela Para Padres | | | Cómo es tu familia (How is your family).[14] |
| Orpinas et al. (2014: 386), Familias Fuertes | | Positive Parenting Style Scale[15] and Behavioral Affect Rating Scale.[16] | |
| Puffer et al. (2016: 8), READY | | Subset of items from the Alabama Parenting Questionnaire.[17] | |
| Puffer et al. (2017: 6), Happy Families programme | | The Parent Behavior Inventory (PBI) is a 12-item measure of parenting practices developed for this study. | The Parental Acceptance-Rejection Questionnaire (PARQ): ShortForm is a 24-item standardised measure of relationship quality. |
| Schwandt and Underwood (2013: 1181), Go Girls! Initiative | | | 'Has your relationship with your mother/father or closest female/male adult improved, stayed the same, or worsened in the past 6 months?' |

8 Adapted from: Small, S. and Silverberg, S. (1991) 'Parental monitoring, family structure, and adolescent problem behavior'. Paper presented at the biennial meeting of the Society for Research in Child Development, Seattle, WA

9 Tolan, P., Hanish, L.D., McKay, M.M. and Dickey, M.H. (2002) 'Evaluating process in child and family interventions: aggression prevention as an example' *Journal of Family Psychology* 16(2): 220–236

10 Barnes, H.L. and Olson, D.H. (1985) 'Parent–adolescent communication and the Circumplex model' *Child Development* 56(2): 438–447

11 Buchanan, C.M., Maccoby, E.E. and Dornbush, S.M. (1991) 'Caught between parents: adolescents' experience in divorced homes' *Child Development* 62(5): 1008–1029

12 See note 10

13 Pantin, H. (1996) *Ecodevelopmental measures of support and conflict for Hispanic youth and families*. Miami, FL: University of Miami School of Medicine

14 Adapted from: Organización Panamericana de la Salud (1996) 'Familia y adolescencia. Indicadores de salud'. Manual de aplicación de instrumentos. Washington DC: Pan American Health Organization (PAHO)

15 See note 4

16 Orpinas, P., Rico, A. and Martinez, L. (2013) *Latino families and youth: a compendium of assessment tools*. Washington DC: PAHO; also Taylor, Z.E., Larsen-Rife, D., Conger, R.D. and Widaman, K.F. (2012) 'Familism, interparental conflict, and parenting in Mexican-origin families: a cultural-contextual framework' *Journal of Marriage and Family* 74(2): 312–327

17 Shelton, K.K., Frick, P.J. and Wootton, J. (1996) 'Assessment of parenting practices in families of elementary school-age children' *Journal of Clinical Child Psychology* 25(3): 317–329

| Study | Parent–child communication | Positive monitoring and neglect | Parent–child relationship |
|---|---|---|---|
| Sim et al. (2014: 10), Happy Families programme | | PARQ[18]<br>Parent Behavior: Developed for this study. | Burmese Family Functioning Scale: Developed for this study. |
| Stark et al. (2018: 5), COMPASS | | Parental Acceptance Rejection Questionnaire (PARQ) scale:<br>24 statements. | PARQ warmth/affection subscale:<br>Scale derived from a subset of eight items from the full PARQ scale. |
| Valente et al. (2018: 3), Ligue 132 | | The parental styles inventory (PSI).[19] | |
| Vandenhoudt et al. (2010: 332–334), Families Matter | | Parental monitoring (knowing where children are, whom they are with, and when they will be back). | Parent-child relationship (quality of relationship), positive reinforcement (use of praise and rewards to reinforce good behaviour). |
| Vasquez et al. (2010: no page numbers), Familias Fuertes | | | The Family APGAR scale.[20] |

## Violence

| Study | Physical violence | Emotional violence |
|---|---|---|
| COMPASS: DRC, Stark et al. (2018: 5) | Being hit or beaten in the past 12 months. | Someone screamed at girl loudly or aggressively in the past 12 months. |
| Familias Fuertes: Chile, Corea et al. (2012: 729) | | Did they yell at their child because they were angry with him/her?<br>Did they yell at or insult their child when they were in disagreement? |
| Familias Fuertes: Bolivia, Colombia, and Ecuador, Orpinas et al. (2014: 386) | **Behavioral Affect Rating Scale**[21] | **Behavioral Affect Rating Scale** |
| Happy Families programme, Thailand, Puffer et al. (2017: 7) | **Discipline Module of the Multiple Indicator Cluster Survey (MICS)** – MICS items were originally adapted from the Parent-Child Conflict Tactics Scale.[22] | **Parent Behavior Inventory (PBI)** - Negative Parent-Child Interaction, including 3 items assessing indicators such as taking anger out on the child or feeling too stressed to spend time with the child.<br>**Discipline Interview** 8 items[23]<br>**Discipline Module of the Multiple Indicator Cluster Survey (MICS)** - MICS items were originally adapted from the Parent-Child Conflict Tactics Scale.[24] |

18 Rohner, R.P. and Khaleque, A. (2005) *Handbook for the study of parental acceptance and rejection.* 4th edn. Storrs, CT: Rohner Research Publications

19 Sampaio, I.T. and Gomide, P.I. Inventário de estilos parentais (IEP) – Gomide (2007) 'Percurso de padronização e normatização', *Psicologia Argumento* 25: 15–26

20 Smilkstein, G. (1978) 'The family APGAR: a proposal for a family function test and its use by physicians' *The Journal of Family Practice* 6(6): 1231–1239

21 See note 16

22 Straus, M.A., Hamby, S.L., Finkelhor, D., Moore, D.W. and Runyan, D. (1998) 'Identification of child maltreatment with the parent-child conflict tactics scales: development and psychometric data for a national sample of American parents' *Child Abuse & Neglect* 22(4): 249–70

23 Lansford, J.E., Chang, L., Dodge, K.A., Malone, P.S., Oburu, P., Palmérus, K., ... and Quinn, N. (2005) 'Physical discipline and children's adjustment: cultural normativeness as a moderator' *Child Development* 76(6): 1234–1246

24 See note 22

| Study | Physical violence | Emotional violence |
|---|---|---|
| Parceria (Partnerships) project, Pereira et al. (2013: 8) | **Parental Style Inventory** 42 items.[25]<br>**The Child Abuse Potential Inventory – Form VI** 160 items.[26] | The **Parental Style Inventory** 42 items.[27] |
| Parenting for Lifelong Health: Sinovuyo Teen pilot, South Africa, Cluver et al. (2016: 4–5) | **International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool.**[28] | **International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool.** |
| Parenting for Lifelong Health: Sinovuyo Teen full version, South Africa, Cluver et al. (2018: 5) | **International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool.** | **International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool.** |
| Strengthening Families, Honduras, Guatemala, Panama, Serbia, Maalouf and Campello, (2014: 620–621) | Three statements for parents and five statements for adolescents. | Three statements for parents and five statements for adolescents. |
| India child–parent communication pilot project (un-named): Jejeebhoy et al. (2014: 14–16) | Had beaten/slapped their children in the past six months | |
| Burundi parenting psychoeducation intervention (un-named): Jordans et al. (2013: 1853) | Family Social Support was assessed using a scale composed for the purpose of this study, consisting of 11 items adapted from the **A-SCAT**.[29]<br>Physical aggression and children's ability to deal with aggression were measured with a 9-item subscale of the **Aggression Questionnaire.**[30] | Family Social Support was assessed using a scale composed for the purpose of this study, consisting of 11 items adapted from the **A-SCAT**. |
| Brazil telehealth prevention programme (un-named): Valente et al. (2018: 3–5) | The **Parental Styles Inventory (PSI)** – seven parental practices style: negligence, inconsistent punishment, relaxed discipline, negative monitoring, physical abuse, moral behaviour, and positive monitoring. | |

| Study | Sexual violence |
|---|---|
| COMPASS: DRC, Stark et al. (2018: 5) | Experienced forced sex, coerced sex or unwanted sexual touching in the past 12 months (13–14-year-olds); experienced coerced sex or unwanted sexual touching in the past 12 months (10–12-year-olds) |
| Sinovuyo Teen pilot, South Africa, Cluver et al. (2016: 4–5) | **ICAST-C** and **ICAST-P subscales.**[31] |

## Neglect

| Study | Neglect |
|---|---|
| Families Matter! Kenya, Vandenhoudt et al. (2010: 332–334) | Parental monitoring: (knowing where children are, whom they are with, and when they will be back) 4 questions. |

25 Gomide, P.I.C. (2006) Inventário de Estilos Parentais [Parental Style Inventory]. Petrópolis: Vozes

26 Milner, J.S. (1986) *The child abuse potential inventory: manual.* 2nd edn. Dekalb: Psytec

27 See note 25

28 Runyan, D.K., Dunne, M.P., Zolotor, A.J., Madrid, B., Jain, D., Gerbaka, B., … and Youssef, R.M. (2009) 'The development and piloting of the ISPCAN Child Abuse Screening Tool—parent version (ICAST-P)' Child Abuse & Neglect 33(11): 826–832; and Zolotor, A.J., Runyan, D.K., Dunne, M.P., Jain, D., Péturs, H.R., Ramirez, C., … and Isaeva, O. (2009) 'ISPCAN Child Abuse Screening Tool children's version (ICAST-C): instrument development and multi-national pilot testing', *Child Abuse & Neglect* 33(11): 833–841

29 Harpham, T., Grant, E. and Thomas, E. (2002) 'Measuring social capital within health surveys: key issues', *Health Policy and Planning* 17: 106–111

30 Buss, A.H. and Perry, M. (1992) 'The Aggression Questionnaire', *Journal of Personality and Social Psychology* 63(3): 452–459

31 See note 28

| Study | Neglect |
|---|---|
| Happy Families Program, Thailand, Puffer et al. (2017: 7) | **Parent Behavior Inventory (PBI) 12 items.**[32] |
| Parceria project, Pereira et al. (2013: 8) | **Parental Style Inventory.**[33] |
| Sinovuyo Teen pilot, South Africa, Cluver et al. (2016: 4) | **International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool** (ICAST-Child, 18 items; and **ICAST-Parent**, 22 items).[34]<br>Child and parent subscales of the **Alabama Parenting Questionnaire.**[35] |
| Sinovuyo Teen full version, South Africa, Cluver et al. (2018: 5) | **International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool** (ICAST-Child, 18 items; and **ICAST-Parent,** 22 items).[36]<br>Child and parent subscales of the **Alabama Parenting Questionnaire.** [37] |
| Brazil telehealth prevention programme (un-named): Valente et al. (2018: 3–5) | The **Parental Styles Inventory (PSI)** 42 questions.[38] 'Neglect occurs when parents are not attentive to the needs of their children, are absent from the responsibilities, and interact without affection.' |

## Adolescent behaviour

| Programme | Adolescent aggressiveness | Conduct problems |
|---|---|---|
| Parenting for Lifelong Health: Sinovuyo Teen full version, South Africa, Cluver et al. (2018: 5) | **Child Behaviour Checklist** rule-breaking and aggression subscales.[39] | **Child Behaviour Checklist** rule-breaking and aggression subscales.[40] |
| Parenting for Lifelong Health: Sinovuyo Teen pilot, South Africa, Cluver et al. (2016: 4) | 35 items of the **Child Behaviour Checklist,**[41] with established validity in multiple countries. | 35 items of the **Child Behaviour Checklist,**[42] with established validity in multiple countries. |
| Burundi parenting psychoeducation intervention (un-named): Jordans et al. (2013: 1853) | 9-item subscale of the **Aggression Questionnaire.**[43] | |
| Familias Unidas, Ecuador, Molleda et al. (2017: 787) | | **Revised Behavior Problem Checklist.**[44] |
| Parceria project, Pereira et al. (2013: 8) | | **Strengths and Difficulties Questionnaire.**[45] |

32 International Rescue Committee (IRC) (2011) '*Children are puppets and parents move the strings': concepts of child and family well-being among Burmese migrant and displaced families in Tak province, Thailand.* IRC Thailand

33 Gomide, P.I C. (2006) Inventário de Estilos Parentais [Parental Style Inventory]. Petrópolis: Vozes

34 Runyan, D.K., Dunne, M.P., Zolotor, A.J., Madrid, B., Jain, D., Gerbaka, B., ... and Youssef, R.M. (2009) 'The development and piloting of the ISPCAN Child Abuse Screening Tool—parent version (ICAST-P)' Child Abuse & Neglect 33(11): 826–832; and Zolotor, A.J., Runyan, D.K., Dunne, M.P., Jain, D., Péturs, H.R., Ramirez, C., ... and Isaeva, O. (2009) 'ISPCAN Child Abuse Screening Tool children's version (ICAST-C): instrument development and multi-national pilot testing', *Child Abuse & Neglect* 33(11): 833–841

35 Essau, C.A., Sasagawa, S. and Frick, P.J. (2006) 'Psychometric properties of the Alabama Parenting Questionnaire' *Journal of Child and Family Studies* 15(5): 595–614

36 See note 34

37 See note 35

38 Sampaio, I.T. and Gomide, P.I. Inventário de estilos parentais (IEP) – Gomide (2007) 'Percurso de padronização e normatização' *Psicologia Argumento* 25: 15–26

39 Achenbach, T. (2000) 'Child behavior checklists (CBCL/2-3 and CBCL/4-18), teacher report form (TRF) and youth self-report (YSR)' in J. Rush, M. First and D. Blacker (eds.) *Handbook of Psychiatric Measures*. 1st edn. Arlington VA: The American Psychiatric Association

40 See note 39

41 See note 39

42 See note 39

43 Buss, A.H. and Perry, M. (1992) 'The Aggression Questionnaire' *Journal of Personality and Social Psychology* 63(3):452–459

44 Quay, H. C. and Peterson, D.R. (1993) *The revised behavior problem checklist: manual*. Odessa FL: Psychological Assessment Resources

45 Goodman, R. (1997) 'The strengths and difficulties questionnaire: a research note' *Journal of Child Psychology and Psychiatry* 38(5): 581–586

| Programme | Adolescent aggressiveness | Conduct problems |
|---|---|---|
| Happy Families, Thailand, Annan et al. (2016: 797) | | **Achenbach Child Behavior Checklist and Youth Self-Report** 113 items.[46] |
| Strengthening Families, Honduras, Guatemala, Panama, Serbia, Maalouf and Campello (2014: 621) | | 'I use steps taught to manage influence of friends when pressured and pushed to be put in troubles.'<br>'My parents/tutors and I can sit and solve the problem together without shouting or get angry at each other.' |

## Adolescent psychosocial well-being

| Study | Adolescent well-being and mental health |
|---|---|
| Burundi parenting psychoeducation intervention, Jordans et al. (2013: 1853) | The **18-item Depression Self-Rating Scale (DSRS)**[47] assessed depression symptoms over the past week on a 3-point scale. |
| Familias Fuertes, Honduras, Vasquez et al. (2010) | **Rosenberg Self-Esteem Scale (RSES).**[48] |
| Rwanda family-based prevention intervention, Chaudhury et al. (2016: 120) | **Center for Epidemiological Studies Depression Scale for Children.**[49]<br>Combined anxiety and depression: an **adapted Youth Self-Report** with a total score of 23.[50]<br>Irritability: a 27-item scale of which 21 were from the **Irritability Questionnaire.**[51]<br>Functioning: 25-item WHO Disability Assessment Schedule for Children validated with Rwandan children.[52]<br>Resilience: an adapted version of the **Connor-Davidson Resilience Scale** from local qualitative data.[53]<br>Pro-social behavior: a **20-item scale from local qualitative data.**[54] |
| Parenting for Lifelong Health: Sinovuyo Teen pilot, Cluver et al. (2016: 4) | **Child Depression Inventory** (CDI) short form 10 items.[55] |
| Happy Families, Thailand, Annan et al. (2016: 797) | **The Child Psychosocial Protective Factors Scale** 14 items on children's sources of support, positive social skills, positive emotional outlook, and negative self-esteem. Developed using local indicators and determinants of child well-being derived from qualitative research with Burmese caregivers and children prior to this study.[56] |

46 Achenbach, T.M. and Rescorla, L.A. (2001) 'Child behavior checklist. Youth self-report for ages 11–18 (YSR 11–18)' in Achenbach System of Empirically Based Assessment (ASEBA), *Manual for the ASEBA school-age forms and profiles*. Burlington VT: ASEBA

47 Birleson, P. (1981) 'The validity of depressive disorder in childhood and the development of a self-rating scale: a research report' *Journal of Child Psychology and Psychiatry* 22(1): 73–88

48 Rosenberg, M. (1965) *Society and the adolescent self image*. Princeton NJ: Princeton University Press

49 Betancourt, T., Scorza, P., Meyers-Ohki, S., Mushashi, C., Kayiteshonga, Y., Binagwaho, A., ... and Beardslee, W.R. (2012) 'Validating the Center for Epidemiological Studies Depression Scale for children in Rwanda' Journal of the American Academy of Child and Adolescent Psychiatry 51(12): 1284–1292; and Faulstich, M.E., Carey, M.P., Ruggiero, L., Enyart, P. and Gresham, F. (1986) 'Assessment of depression in childhood and adolescence: an evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC)' *American Journal of Psychiatry* 143(8): 1024–1027

50 Achenbach, T.M. and Dumenci, L. (2001) 'Advances in empirically based assessment: revised cross-informant syndromes and new DSM-oriented scales for the CBCL, YSR, and TRF: comment on Lengua, Sadowski, Friedrich, and Fischer (2001)' *Journal of Consulting and Clinical Psychology* 69(4): 699–702

51 Craig, K.J., Hietanen, H., Markova, I.S. and Berrios, G.E. (2008) The Irritability Questionnaire: a new scale for the measurement of irritability' *Psychiatry Research* 159(3): 367–375

52 Scorza, P., Stevenson, A., Canino, G., Mushashi, C., Kanyanganzi, F., Munyanah, M., ... and Betancourt, T. (2013) 'Validation of the "World Health Organization Disability Assessment Schedule for Children, WHODAS-Child" in Rwanda' *PloS One* 8(3): e57725. doi:10.1371/journal.pone.0057725

53 Connor, K.M. and Davidson, J.R. (2003) 'Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC)' *Depression and Anxiety* 18(2): 76–82

54 Betancourt, T.S., Meyers-Ohki, S., Stulac, S.N., Barrera, E., Mushashi, C. and Beardslee, W.R. (2011) '"Nothing can defeat combined hands (Abashize hamwe ntakibananira): protective processes and resilience in Rwandan children and families affected by HIV/AIDS' *Social Science & Medicine* 73(5): 693–701 doi:10.1016/j.socscimed.2011.06. 053

55 Kovacs, M. (1992) *Children's Depression Inventory (CDI)*. Toronto, ON: Multi-Health Systems Inc

56 Sim, A., Annan, J., Puffer, E., Salhi, C. and Betancourt, T. (2014) *Building Happy Families: impact evaluation of a parenting and family skills intervention for migrant and displaced Burmese families in Thailand.* Thailand: International Rescue Committee

| Study | Adolescent well-being and mental health |
|---|---|
| Sinovuyo Teen full version, South Africa, Cluver et al. (2018: 5) | **Children's Depression Inventory**[57] and **Mini International Neuropsychiatric Interview-Kid**[58] (reported by adolescents). |
| Quality of life therapy programme, Iran, Abedi and Vostanis (2010: 608–609) | **Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS)** 6-item scale used to assess the domains of life satisfaction in children and adolescents.[59]<br>**Revised Children's Manifest Anxiety Scale (RCMAS)** 37-item self-report questionnaire for children.[60] |
| Burundi parenting psychoeducation intervention, Jordans et al. (2013: 1853) | The 18-item **Depression Self-Rating Scale (DSRS)**[61] assessed depression symptoms over the past week on a 3-point scale. |
| Multi-family group therapy for internet addiction, China, Liu et al. (2015: 4) | Adolescents rated their psychological needs using a scale modified from the **College Students' Psychological Needs and Fulfillment Scale.**[62] |
| China family-based intervention for adolescent internet addiction, Zhong et al. (2011: 1025) | **Perceived Social Support Scale (PSSS)** 12 self-rated items.[63] |
| READY, Kenya, Puffer et al. (2016: 8) | **Rosenberg Self-Esteem Scale.**[64]<br>**Multi-Dimensional Anxiety Scale for Children** 10-item short version.[65]<br>**Children's Depression Inventory.**[66]<br>**Strengths and Difficulties Questionnaire.**[67] |
| Parent education programme, Iran, Kaveh et al. (2014: 13) | **Brief Multidimensional Students' Life Satisfaction Scale.**[68] |

## Parent/caregiver mental health

| Study | Parent/caregiver well-being and mental health |
|---|---|
| Familias Fuertes, Honduras, Vasquez et al. (2010) | **Rosenberg Self-Esteem Scale (RSES).** [69] |
| Sinovuyo Teen pilot, Cluver et al. (2016: 4) | **Center for Epidemiologic Studies Depression Scale.**[70] |
| Sinovuyo Teen full version, South Africa, Cluver et al. (2018: 5) | **Parental Stress Scale.**[71]<br>**Center for Epidemiologic Studies Depression Scale.**[72] |

57 Kovacs, M. (1985) 'The Children's Depression, Inventory (CDI)' *Psychopharmacology Bulletin* 21(4): 995–998
58 Lecrubier, Y., Sheehan, D.V., Weiller, E., Amorim, P., Bonora, I.,Harnett Sheehan, K., ... and Dunbar, G.C. (1997) 'The Mini International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: reliability and validity according to the CIDI' *European Psychiatry* 12(5): 224–231
59 See note 64
60 Reynolds, C.R. and Richmond, O.B. (1978) 'What I think and feel: a revised measure of children's manifest anxiety' *Journal of Abnormal Child Psychology* 6(2): 271–280
61 See note 47
62 Wan, J.J., Zhang, J.T., Liu, Q.X., Deng, L.Y. and Fang, X.Y. (2010) 'Development of college students' psychological need internet gratification questionnaire' *Studies of Psychology and Behavior* 8(2): 118–125 (in Chinese)
63 Blumenthal, J.A., Burg, M.M., Barefoot, J., Williams, R.B., Haney, T. and Zimet, G. (1987) 'Social support, Type A behavior, and coronary artery disease' *Psychosomatic Medicine* 49(4): 331–340
64 Rosenberg, M. (1965) *Society and the adolescent self image.* Princeton NJ: Princeton University Press
65 March, J.S., Parker, J.D., Sullivan, K., Stallings, P. and Conners, C.K. (1997) 'The Multidimensional Anxiety Scale for Children (MASC): factor structure, reliability, and validity' *Journal of the American Academy of Child and Adolescent Psychiatry* 36(4): 554–565
66 Kovacs M. Children's depression inventory: manual [Computer software manual]. Multi-Health Systems. 1992
67 Goodman R. Psychometric properties of the strengths and difficulties questionnaire. Journal of the American Academy of Child and Adolescent Psychiatry. 2001; 40(11):1337–1345. [PubMed: 11699809]
68 Huebner ES, Laughlin JE, Ash C, Gilman R. further validation of the multidimensional students life satisfaction scale. Journal of psychoeducational assessment. 1998;16(2):118-34.
69 See note 64
70 Radloff, L. (1977) 'The CES-D scale: a self-report depression scale for research in the general population' *Applied Psychological Measurement* 1: 385–401
71 Berry, J.O. and Jones, W.H. (1995) 'The parental stress scale: initial psychometric evidence' *Journal of Social and Personal Relationships* 12: 463–472
72 See note 70

| Study | Parent/caregiver well-being and mental health |
|---|---|
| Quality of life therapy programme, Iran Abedi and Vostanis (2010: 608–609) | **Quality of life inventory** 32 items.[73] |
| Parceria project, Pereira et al. (2013: 7) | **The Daily Rating Forms of Sense of Parental Competence and Sense of Well-Being.**[74] |
| Creative Stress Relief Programme for Parents, de Wit et al. (2018) | Qualitative interviews |
| Escuela Para Padres, Nuño-Gutiérrez et al. (2006: 521) | **Cómo es su familia** [How is your family] (parent version)[75] |

## Substance abuse

| Study | Adolescent substance abuse | Caregiver substance abuse | Communication about alcohol, tobacco, and other drug (ATOD) |
|---|---|---|---|
| 1. Familias Fuertes, Honduras, Vasquez et al. (2010)<br>2. Familias Fuertes, El Salvador, PAHO (2006: 25) | 1. The United States Center for Substance Abuse Prevention (CSAP) core measures in the Student Survey of Risk and Protective Factors, and from questionnaires developed by Hermida and Villa.[76] | | 2. Annoyance shown by certain members of family if they find the student consuming tobacco, alcohol, or other drugs and frequency of discussions about the risks of using drugs. |
| Sinovuyo Teen pilot, South Africa, Cluver et al. (2016: 5) | Two items from the WHO Global school-based health survey.[77] | WHO 'ASSIST' scale. [78] | |
| Sinovuyo Teen full version, South Africa, Cluver et al. (2018: 5) | WHO Alcohol Use Disorders Identification Test[79] and the WHO Global School-based Student Health Survey.[80] | WHO Alcohol Use Disorders Identification Test[81] and the WHO Global School-based Student Health Survey.[82] | |
| CHAMP-Awaqhawe, South Africa, Bhana et al. (2004: 38) | | | **Hard to Talk About:** a 7-item measure of things that parents have difficulty talking about with their children. |

73 Frisch, M.B. (2006) *Quality of life therapy: applying a life satisfaction approach to positive psychology and cognitive therapy.* Hoboken NJ: Wiley and Sons

74 Williams, L.C.A. (2009) O ensino de habilidades parentais a mães com histórico de violência conjugal [Teaching parenting skills to mothers with a history of domestic violence]. São Paulo: CNPq

75 Adapted from: Organización Panamericana de la Salud (1996) Familia y adolescencia. Indicadores de salud. Manual de aplicación de instrumentos. Washington DC: Pan American Health Organization (PAHO)

76 PAHO (2009) Evaluación de Impacto del Programa Familias Fuertes: Amor y Límites - Una intervención basada en videos para padres y jóvenes entre 10 y 14 años de edad: Cuestionnario applicado a los adolescents. Washington DC: PAHO

77 US Centers for Disease Control and Prevention (CDC) (2012) *Global school-based student health survey.* Atlanta: Centers for Disease Control and Prevention

78 Henry-Edwards, S., Humeniuk, R., Ali, R., Poznyak, V. and Monteiro, M. (2003) 'The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Guidelines for the use in primary care. Draft version 1.1 for Field Testing'. Geneva: World Health Organization

79 Saunders, J.B., Aasland, O.G., Babor, T.F., de la Fuente, J.R. and Grant, M. (1993) 'Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption–II' *Addiction* 88(6): 791–804

80 See note 77

81 See note 79

82 See note 79

| Study | Adolescent substance abuse | Caregiver substance abuse | Communication about alcohol, tobacco, and other drug (ATOD) |
|---|---|---|---|
| Rwanda family-based prevention intervention: Chaudhury et al. (2016: 119) | | Adapted Alcohol Use Disorders Identification Test (AUDIT)[83] adapted to suit the Rwandan context. | |
| | | Identification Test (AUDIT) adapted to suit the Rwandan context. | |
| Thai Family Matters, Byrnes et al. (2011: 7) | | | 'How often did you discuss with your son/daughter about drinking alcohol, smoking cigarettes or other drugs?' was used to assess ATOD communication frequency. |
| Slick Tracy Home Team programme, Williams et al. (2011: 317–320) | Four questions. | | Five questions. |

## Internet addiction

| Study | Internet addiction |
|---|---|
| Multi-family group therapy for internet addiction, China, Liu et al. (2015: 4) | Adolescent Pathological Internet Use Scale.[84] |
| China family-based intervention for adolescent internet addiction, Zhong et al. (2011: 1025) | Internet Addiction Diagnostic Criteria.[85]<br>Online Cognition Scale (OCS).[86] |

## Sexual and reproductive health

| Study | Sexual and reproductive health measures |
|---|---|
| Armistead et al. (2014: 671–672), Imbadu Ekhaya (Parents Matter!), South Africa | Parents and their adolescents were asked if they had discussed 8 basic sex topics (e.g. puberty, menstruation, sex, HIV). 16 items from a 21-item measure (plus 6 other items) were used to measure Imbadu Ekhaya specifically. Parent answers were measured on two subscales: comfort discussing sex, and openness to doing so. |
| Baku et al. (2017: 3–4), Ghanaian adaptation of Talking Parents, Healthy Teens | A questionnaire was used to assess the effects of the training on parents' knowledge and attitudes about adolescent sexuality. 25 questions on sexuality grouped under five topics: biological development, sexual risk protection, contraceptive use, risky sexual behaviours, and experimental sex. |
| Baptiste et al. (2007: 344–345), CHAMP-TT, Trinidad and Tobago | Paper/pencil measures were adapted from the original CHAMP programme for local families, self-administered and completed by parents and youth. Knowledge and awareness about HIV was assessed using 18 items which the participant had to say were true or false. A 5-point, 21-item scale was used to assess parent and youth condom self-efficacy. |
| Bhana et al. (2004: 37–38), CHAMP-Amaqhawe, South Africa pilot programme | 3 measures were used to assess outcome effects. **The AIDS Transmission Knowledge** measure is a 7-item scale that measures individuals' understanding of how HIV is transmitted. It is scored on the basis of whether a particular activity is safe or unsafe. **AIDS Myth Knowledge** is a 7-item scale that measures myths around AIDS transmission. **Stigma** was measured on an 8-item scale. |

83 Bohn, M., Babor, T. and Kranzler, H. (1995) 'The Alcohol Use Disorders Identification Test (AUDIT): validation of a screening instrument for use in medical settings' *Journal of Studies on Alcohol* 56(4): 423–432 doi:10.15288/jsa.1995.56.423

84 Lei, L.. and Yang, Y. (2007) 'The development and validation of adolescent pathological internet use scale' *Acta Psychologica Sinica* 39(4): 688–696 (in Chinese)

85 Tao, R., Huang, X., Wang, J., Zhang, H., Zhang, Y. and Li, M. (2009) 'Proposed diagnostic criteria for internet addiction' *Addiction* 105(3): 556–564

86 Davis, R.A. (2001) 'A cognitive-behavioral model of pathological internet use' *Computers in Human Behavior* 17(2): 187–195

| Study | Sexual and reproductive health measures |
|---|---|
| Bhana et al. (2014: 4–5) | Youth adherence to antiretroviral therapy (ART) was measured using one question about how often medications were missed and was derived from a pediatric AIDS clinical trial group. Youth knowledge was measured using an existing **HIV treatment knowledge** measure assessing HIV causality, transmission and treatment. HIV/AIDS illness stigma was measured using an existing measure assessing perceived stigma, disclosure and self-esteem. |
| Bogart et al. (2013: 3–4), Let's Talk, South Africa | Survey content was based on constructs used in the US-based programme Talking Parents, Healthy Teens. The survey was adapted based on qualitative interviews with parents and adolescents and a pre-test-post-test process evaluation of one intervention group. Communication about HIV and sex was assessed for parent reports using a questionnaire exploring whether 16 topics on HIV and sex were discussed with the child; adolescents reported whether they had ever discussed these topics with the parent. Comfort talking about sex was assessed from one adapted item from the **Speaking Extent and Comfort Scale (SPEACS)**,[87] which assesses general comfort with conversations with different people in one's network. Parents and adolescents were asked about their level of comfort talking about sex with each other on a 7-point scale. Parents' self-efficacy and confidence for condom use was assessed using a 7-item questionnaire. Parents were also asked about their behaviour using condoms in the past 3 months using a dichotomous variable of no condom use vs any condom use. |
| Campero et al. (2011), Morelos SRH communication study | Self-applied parent and adolescent questionnaires (similar in content and structure) addressing parent–child communication about sexual health, and questions about adolescents' sexual practices. Questionnaire was delivered at baseline and 6 months after. |
| Bell et al. (2008: 4), CHAMP Amaqhawe, South Africa, full programme | Several assessment tools were used, but the most relevant to SRH outcomes were the **AIDS Myth Knowledge**[88], **AIDS Transmission Knowledge Scale**, and **Stigma Scale**, which were administered to caregivers and youths. |
| Chen et al. (2010: 3–4), Focus on Youth in the Caribbean (FOYC) plus Caribbean Informed Parents and Children Together (CImPACT), Bahamas | The **Bahamian Youth Health Risk Behavioral Inventory**, a paper-and-pencil questionnaire adapted from the **Youth Health Risk Behavioral Inventory**, was used to collect data from adolescents in classroom settings. Protection Motivation Theory (PMT) constructs were assessed using 7 questions on condom use: self-efficacy, response efficacy and response cost; and intrinsic rewards, extrinsic rewards, severity and vulnerability. Levels of HIV/AIDS knowledge were assessed using an 18-item questionnaire. Condom use skills were assessed using 14 items. Self-reported likelihood to use a condom was used to assess intention to use a condom among all youth, regardless of sexual experience or intentions. |
| Cluver et al. (2018: 3), Parenting for Lifelong Health: Sinovuyo Teen, full programme, South Africa | 'Primary caregivers and adolescents completed self-report measures. Tablet-based questionnaires were completed in private, in the participant's chosen language and supported by data collectors. Family-level discussions on protecting adolescents from community violence were measured using an adapted version of the Parent Teen Sexual Risk Communication Scale.' |
| Corea et al. (2012), Familias Fuertes, Chile | Adolescent outcomes were measured with a 122-item Likert-style attitudes questionnaire divided into 11 subsections, including questions on risky behaviours relating to sexuality. |
| Cupp et al. (2013: 1389–1390), Thai Family Matters, Thailand | The measure of SRH discussion frequency was adapted from a 9-item parent–child 'communication about sex' scale. All 9 items were used for the child survey. Responses ranged from 1 (never) to 4 (a lot) on a 4-point scale about how frequently sex is discussed. For the parent survey a single item was used from this scale: 'How often did you discuss with your son or daughter about having sex?' Participants reported responses on a 4-point scale ranging from 1 (frequently) to 4 (never).<br><br>Comfort discussing SRH issues was measured using the following question for parents and their children: 'How comfortable or uncomfortable would you feel discussing with your son or daughter (or parent) about having sex?' Respondents rated the comfort level from 1 to 4. |
| Deveaux et al. (2007: 1132–1133), FOYC plus CImPACT, Bahamas | SRH outcomes were measured using the **Behavioral Inventory**, 'a cultural adaptation of the **Youth Health Risk Behavioral Inventory**. The first section of this inventory assesses demographic characteristics of the youth, and the second section assesses youth involvement in risk behaviours, including sexual, drug-related, and truant behaviours during the previous 6 months' using yes or no questions. Youth perceptions of risk and protective behaviours according to the factors that constitute the protection-motivation theory (PMT) were assessed using a 5-point scale. The sexual protective behaviours assessed relating to SRH were abstinence and condom use. |

87 Lyons, A.C. and Spicer, J. (1999) 'A new measure of conversational experience: the Speaking Extent and Comfort Scale (SPEACS)' *Assessment* 6(2): 189–202

88 Steinberg L, Lamborn SD, Darling N, et al. Over-time changes in adjustment and competence among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child Dev* 1994;65:754–770.

| Study | Sexual and reproductive health measures |
|---|---|
| Dinaj-Koci et al. (2015: 649–650), Bahamian Focus on Older Youth (BFOOY) plus ClmPACT, Bahamas | The condom use skills checklist was used as a validated and reliable proxy for parent condom skills. Parents' perceptions of youth condom use efficacy were measured on a 5-point scale adapted from the condom use self-efficacy items in the **Youth Health Risk Behavior Inventory** to assess whether parents believed that their youth could effectively use condoms to protect themselves from sexual risk. Parent–adolescent communication about sex was measured on a 5-point Likert-type scale (none, a little, some, a lot, extensive) assessing how much information the parent provided their child on sexual risk topics including HIV, condom use, and coping with sexual pressure. |
| Gong et al. (2009: 5–6), FOYC plus ClmPACT, Bahamas | HIV/AIDS-related knowledge was assessed using 14 items from 2 subscales: transmission knowledge and prevention knowledge. PMT perceptions included 2 behavioral domains: abstinence/ sexual initiation and condom use. Abstinence/sexual initiation perceptions and condom use perceptions were both assessed by 7 subscales corresponding with the 7 PMT constructs using a 5-point scale. Intention to engage in sex was measured using the question, 'How likely is it that you will have sex in the next six months?' Intention to use a condom was measured using the question, 'If you were to have sex in the next six months, how likely is it that you (your partner) would use a condom?'. Condom use was measured using the question, 'How often did you use a condom when you had sex?' with the following choices: (1) 'never used a condom', (2) 'used a condom sometimes' and (3) 'always used a condom'. Condom use was only assessed among the youth who reported having initiated sex. For analytic purposes, we were interested in consistent condom use ('always used a condom' response). |
| Ismayilova et al. (2012: 4–5), Suubi, Uganda | SRH outcome effects were measured using an adapted version of the Family Environment Scale/Family Assessment Measures (FES/FAM) scale and instruments measuring youth attitudes toward sex. 'All scales have been previously used in Africa with good psychometric properties.'<br><br>'Family sexual risk communication included two subscales: frequency of conversations with caregiver about sex, HIV, STIs, and puberty; and level of comfort discussing these topics with caregiver. Both scales included five items and each item was measured on a 4-point scale Family sexual risk communication included two subscales: frequency of conversations with caregiver about sex, HIV, STIs, and puberty; and level of comfort discussing these topics with caregiver. Both scales included five items and each item was measured on a 4-point scale.' |
| Jejeebhoy et al. (2014: 4), Bihar child–parent communication pilot project, India | Programme effects were measured using two study-specific questionnaires – one for mothers and fathers of 13–17-year-olds, and one for girls and boys aged 13–17. Questionnaires were adapted from those used in previous Population Council studies. SRH outcomes assessed included attitudes toward parent–child communication about SRH issues, awareness about SRH matters, and communication on SRH matters. 'Instruments for adolescents focused on parent-child interaction and socialisation, and questions were framed to correspond to or parallel the questions posed to the parents.' |
| Kaljee et al. (2012: 557), Exploring the World of Adolescents + (EWA+), Viet Nam | 'Four knowledge scales measured parental information about puberty and adolescent development, pregnancy and contraceptives, STIs, and HIV infection. Three scales were used to measure communication: (a) barriers to communication about sexual health (parent–child communication), (b) frequency of talking to child about sexual health topics, and (c) level of comfort in discussing sexual health topics with child. A self-efficacy for condom use scale was used to measure parents' perceptions of their own abilities to access and use condoms.' |
| Kok and Akyüz (2015: 160), SRH education for parents of adolescents with intellectual disabilities, Turkey | The semi-structured interview form was used to find out about problems and experiences of parents regarding the sexual development of their adolescent children with intellectual disabilities and how they cope with the problems they face. |
| Lundgren et al. (2018: 3), Choices-Voices-Promises, Nepal | Delaying marriage for girls was assessed using two measures: agreement with the attitude that marrying girls at an early age is bad for the community; and for parents with daughters, the age at which they wanted their daughter to marry. |
| Pham et al. (2012: 3–4), EWA+, Viet Nam | Adolescent SRH outcomes were measured using an evaluation instrument that was an expansion of previous instruments developed for the Vietnamese Focus on Kids programme. Outcomes measured included SRH knowledge (using 43 true/false items), Protection Motivation Theory (PMT) (using 10 scales with subscales for the constructs 'severity', 'vulnerability' and 'self-efficacy'), and intentions (using 5 items about intention to have sex in next 3 months) and behaviours ('Respondents were asked if they ever had vaginal sex (yes/no), if they had vaginal sex in the past 3 months (yes/no), number of lifetime partners (continuous), and frequency of condom use (always, more than half the time, half the time, rarely, or never).' |

| Study | Sexual and reproductive health measures |
|---|---|
| Powwattana et al. (2018), Breaking the voice (Rak luk khun tong pood), Thailand | Knowledge about pregnancy prevention and sexual communication in mothers was assessed using 20 true/false questions.<br><br>Mothers' attitudes were measured using 20 questions about feelings toward communication about sex.<br><br>The measure for sexual communication between mothers and daughters was adapted from an existing measure with 7 areas.[89]<br><br>Daughters' SRH outcomes: **Sexual Relationship Power Scale.**[90] Risky sexual behavior toward pregnancy was measured using a 17-item scale of least-to-most risky activities combined from the **Mokken Scale** measure of progression in non-coital sexual interaction[91] and the scale measuring progression to sexual intercourse.[92] |
| Puffer et al. (2016: 8), READY, Kenya | Two 7-item scales were used to measure **Frequency and Quality of Communication About Sex and HIV.**[93]<br><br>Proximal HIV risk indicators were measured using a 27-item **HIV Knowledge Questionnaire** with a focus on etiology and transmission. Other items measuring SRH outcomes included a Sex Self-Efficacy measure, including 3 items drawn from the **Self-Efficacy to Refuse Sexual Behavior Scale**[94] and 2 developed for this study related to condom use; and an 8-item **Sex Beliefs scale** related to acceptance of risky behaviours and associated beliefs.<br><br>Adolescent HIV risk behaviours were a secondary outcome measured using 2 indicators: (a) having ever had vaginal intercourse (asked to all youth), regardless of when it occurred; or (b) having had high-risk sex in the past 3 months, defined as not using a condom during at least one sexual encounter and/or having more than one sexual partner in that time period (asked to sexually active youths).<br><br>Brief qualitative interviews were conducted with a small subsample. |
| Rosati et al. (2012: 5), Thai Family Matters, Thailand | Outcomes were measured using post-implementation surveys, which contained 115 items for parents and 140 for teens. 19 parents and 19 teens also participated in 4 focus groups designed to gain a deeper understanding of families' experiences with the programme. |
| Stanton et al. (2015: 577), BFOOY/ClmPACT, Bahamas | Adolescents' self-perceived condom-use self-efficacy was assessed using 5 items on a 5-point Likert scale. Condom-use skills knowledge was assessed using the Condom-Use Skills Checklist: from among 16 items, students identified the 8 correct steps. HIV knowledge was assessed using 16 true/false questions about knowledge of disease transmission, prevention, treatment, symptoms, and effects of HIV/AIDS. Self-reported condom use was assessed using 2 questions: when youth last engaged in sex whether they used a condom; and when they had sex, in general, how often did they use a condom (always, sometimes, or never). Familiarity with the FOYC-BFOOY curriculum was assessed by asking adolescents to identify the correct meaning of the acronym SODA (correct response = 'Stop, Options, Decision, Action', which is the decision-making model invoked throughout the FOYC-BFOOY curricula). |
| Vandenhoudt et al. (2010: 332–334), Families Matter! Kenya | Authors examined parental attitudes toward sexuality education issue using 7 true/false measures and parent–child communication about sex and sexual risk reduction using 12 items. Questions administered to parents were reframed to allow pre-teens to report on the same measures. Questions used in the US evaluation of the Parents Matter! Programme (PMP) were pre-tested in Asembo.[95] |
| Vasquez et al. (2010: Table 1), Strengthening Families (Familias Fuertes), Honduras | The outcomes of Parents Talk About Risky Behaviors and Family Bothered by Risky Behaviors were measured using 3 items each on a 4-point scale. |

89 Rosenthal, D.A. and Feldman, S.S. (1999) 'The importance of importance: adolescents' perceptions parental communication about sexuality' *Journal of Adolescence* 22(6): 835–851

90 Pulerwitz, J., Gortmaker, S.L. and DeJong, W. (2000) 'Measuring relationship power in HIV/STD research' *Sex Roles* 42(7–8): 637–660

91 Jakobsen, R. (1997) 'Stages of progression in noncoital sexual interaction among adolescents: an application of the Mokken Scale analysis' *International Journal of Behavioral Development* 21(3): 537–553

92 DeLamater, J. and MacCorquodale, P. (1979) *Premarital sexuality: attitudes, relationships, behavior.* Madison WI: University of Wisconsin Press

93 Adapted from: Miller, K.S., Kotchick, B.A., Dorsey, S., Forehand, R. and Ham, A.Y. (1998) 'Family communication about sex: what are parents saying and are their adolescents listening?' *Family Planning Perspectives* 30(5): 218–222

94 Cecil, H. and Pinkerton, S.D. (1998) 'Reliability and validity of a self-efficacy instrument for protective sexual behaviors' *Journal of American College Health* 47(3): 113–121

95 Ball, J., Pelton, J., Forehand, R., Long, N. and Wallace, S.A. (2004) 'Methodological overview of the Parents Matter! Program' *Journal of Child and Family Studies* 13: 21–34

| Study | Sexual and reproductive health measures |
|---|---|
| Villarruel et al. (2008: 5–6), Cuidate! Promueve tu salud, Mexico | Parent–adolescent sexual risk communication was one of the primary outcome measures for this study, assessed using measures that had previously been translated and used in a prior study with Spanish-dominant Latino youth.[96]<br><br>8 questions were related to parent–adolescent communication on sexual topics[97] and 9 about how comfortable parents or adolescents feel when talking about sexual topics.[98]<br><br>Behavioral and control beliefs related to parent–adolescent sexual communication were assessed consistent with the theory of planned behaviour[99] and based on elicitation research with Mexican parents and results of earlier studies.[100]<br><br>Two behavioral beliefs and one control belief were also measured. |
| Yildiz and Cavkaytar (2017: 8), SEPID, Turkey | The **Sexuality Education of Individuals with Intellectual Disabilities Attitude Scale (SEIDAS).**[101] |

96 Villarruel, A.M., Jemmott, J.B. III, Jemmott, L.S. and Ronis, D.L. (2004) 'Predictors of sexual intercourse intentions and condom use among Spanish dominant youth: a test of the theory of planned behavior' *Nursing Research* 53(3): 172–181

97 Hutchinson, M.K. (1999) 'Individual, family, and relationship predictors of young women's sexual risk perceptions' Journal of Obstetric, Gynecologic, & Neonatal Nursing 28(1): 60–67; Hutchinson, M.K. and Cooney, T.M. (1998) 'Patterns of parent–teen sexual risk communication: implications for intervention' *Family Relations* 47(2): 185–194

98 Dilorio, C., Kelley, M. and Hockenberry-Eaton, M. (1999) 'Communication about sexual issues: mothers, fathers, and friends' *Journal of Adolescent Health* 24(3): 181–189

99 Ajzen, I. (1991) 'The theory of planned behavior' *Organizational Behavior and Human Decision Processes* 50(2): 179–211; Ajzen, I. and Fishbein, M. (1980) *Understanding attitudes and predicting social behavior*. Englewood Cliffs NJ: Prentice-Hall.

100 Jemmott, L.S., Villarruel, A.M. and Jemmott, J.B. III. (2000) 'Latino mother–son HIV risk reduction interventions'. Unpublished data

101 Sari, H. (2005) 'An analysis of Turkish parents' attitudes towards sexual education of students with mentally handicapped' (Paper presentation). Inclusive and Supportive Education Congress

# Annex 4: Supplementary tables

## Table A4.1: Foci of programmes by age of adolescents

| | Number of studies reporting age of adolescents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area of focus | Included children <10 yrs | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | Included young people >19 yrs | Unspecified |
| SRH general | 1 | 4 | 7 | 9 | 11 | 13 | 12 | 8 | 7 | 3 | 3 | 1 | 2 |
| HIV | 2 | 10 | 12 | 11 | 7 | 6 | 4 | 2 | 1 | 0 | 0 | 0 | 2 |
| Substance abuse | 0 | 5 | 5 | 4 | 7 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Child abuse/ harsh punishment | 0 | 5 | 5 | 6 | 7 | 8 | 4 | 4 | 3 | 2 | 0 | 0 | 0 |
| Gang activity/ violence | 0 | 2 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| School engagement | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 |
| Mental health promotion | 1 | 2 | 2 | 3 | 3 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Gender equity | 0 | 3 | 3 | 3 | 4 | 4 | 2 | 1 | 1 | 0 | 0 | 0 | 1 |
| Internet/ videogame addiction | 0 | 0 | 0 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 0 | 0 |
| Behavioural issues | 1 | 1 | 0 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 0 | 0 | 0 |
| Economic empowerment | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| Family communication | 4 | 14 | 16 | 18 | 18 | 18 | 12 | 10 | 8 | 4 | 0 | 0 | 3 |

## Table A4.2: Programme duration

| Programme duration (weeks) | Number of programmes | Percentage of programmes | Percentage (by number of months) |
|---|---|---|---|
| 1 or less | 2 | 5% | 28% |
| 2 | 1 | 2% | |
| 3 | 1 | 2% | |
| 4 | 8 | 19% | |
| 5 | 4 | 9% | 21% |
| 6 | 2 | 5% | |
| 7 | 3 | 7% | |
| 8 | 0 | 0% | |
| 9 | 2 | 5% | 33% |
| 10 | 3 | 7% | |
| 11 | 0 | 0% | |
| 12 | 9 | 21% | |
| >12 | 8 | 19% | 19% |
| >24 | 1 | 2% | 2% |

## Table A4.3: Distribution of parent-reported positive adolescent outcomes in programmes with increased positive parenting skills

| | Parent-reported adolescent outcomes | | | | |
|---|---|---|---|---|---|
| Parent-reported parenting skills outcomes | SRH knowledge and self-efficacy | Freedom from violence | Substance abuse | Mental health | Behavioural problems |
| Parent-reported communication with adolescents (general) | 17% | 33% | 17% | 33% | 33% |
| Parent-reported improved parent–child relationship | 22% | 33% | 22% | 11% | 22% |
| Parent-reported knowledge/use of positive discipline | 11/1% | 67% | 22% | 22% | 33% |
| Parent-reported positive monitoring and neglect of adolescents | 17% | 50% | 0 | 0 | 17% |

## Table A4.4: Distribution of adolescent-reported positive outcomes in programmes with increased positive parenting skills

| | Adolescent-reported adolescent outcomes | | | | |
|---|---|---|---|---|---|
| Adolescent-reported parenting skills outcomes | SRH knowledge and self-efficacy | Freedom from violence | Substance abuse | Mental health | Behavioural problems |
| Adolescent-reported parent communication with adolescents (general) | 57% | 14% | 14% | 71% | 43% |
| Adolescent-reported improved parent-child relationship | 29% | 29% | 14% | 57% | 57% |
| Adolescent-reported parent use of positive discipline | 0 | 100% | 33% | 100% | 100% |
| Adolescent-reported positive parent monitoring and neglect | 50% | 50% | 0 | 50% | 50% |

## About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org.uk for more information.

## Disclaimer

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Front cover: Young adolescent girl in Jordan flying a kite. © Nathalie Bertrams/2019

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