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Acceptability and cultural appropriateness of a parenting programme to reduce violence against adolescents in Tanzania delivered at scale: Implications for scale-up

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ABSTRACT

Although parenting programmes may be effective at reducing violence against children (VAC), there is a limited understanding on how acceptable and appropriate such programmes are among parents/caregivers ('caregivers') when delivered at scale. This paper explores the acceptability and cultural appropriateness of a parenting programme for caregivers and their adolescent girls, Parenting for Lifelong Health for Teens (PLH-Teens), which was delivered at scale in rural and semi-urban Tanzania. This paper employed a qualitative research design involving 18 focus group discussions (FGDs) with caregivers ($N = 120$) and adolescent girls ($N = 60$). Participants reported that the programme was acceptable, culturally appropriate, and beneficial. The use of participatory approaches and in-person group sessions was appealing to caregivers. However, several challenges hindered consistent engagement. These factors ranged from initial community mistrust about the programme, social norms on parenting, and group interactions to individual-level participant factors, stigma, and feeling of shame for being selected to join a programme. Overall, PLH-Teens programme was perceived as addressing the real parenting needs of caregivers and their adolescents. There is a need to address the challenges families experienced as these could hinder the acceptability, sustainability, and continued scale up of PLH-Teens in future programme delivery.

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SDG1: No poverty; SDG3: Good health and wellbeing; SDG5: Gender equality

Introduction

Parents and caregivers (or 'caregivers') play a central role in the wellbeing and development of children (Sherr et al., 2020; Ward et al., 2020). While caregivers and the broader family can be the great

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source of support for children, evidence also shows that they can also be a great source of harm (WHO, 2023). Common perpetrators of physical and emotional violence against children (VAC) are caregivers, other adult relatives, and teachers (UNICEF, 2011). In Tanzania, over 72% of children aged 13–24 have experienced physical violence (aggressive behaviour from caregivers towards children), before they reach age 18 (UNICEF, 2011). While this percentage is high, corporal punishment is normative in Tanzania (UNICEF, 2011). VAC has short- and long-term physical and mental health consequences for children (Gardner et al., 2023) and thus finding ways to prevent and reduce VAC is critical, particularly via approaches that are acceptable and appropriate for families.

There is substantial evidence from around the world that parenting programmes reduce VAC by improving parenting skills, reducing adolescents behaviour problems, and by indirectly reducing associated risk of VAC such as youth violence, delinquency, and substance use as well as parental mental health difficulties (Cluver et al., 2018). Parenting programmes, such as Parenting for Lifelong Health for Teens, have been found to impact VAC and other positive outcomes for adolescents in low- and middle-income country (LMIC) settings (Cluver et al., 2018; Lachman et al., 2020). Due to their substantial evidence base, parenting programmes are now recommended as a critical intervention to scale-up to help address the sustainable development goals (Sanders et al., 2022). However, caregiver involvement in parenting programmes may be influenced by their perceptions of the programme and whether they believe it fits with their existing parenting practices and cultural views. This is particularly the case for parenting programmes as they aim to shift fundamental beliefs and norms around parenting (Brown, 2022; Davin, 2020).

As a result, scaling up evidence-based parenting programmes to new and large populations requires careful consideration of various contextual factors as well as the target beneficiaries (Barker et al., 2016; Shenderovich et al., 2021). This is particularly important for programmes developed and implemented in different settings and for different populations. Insights from the parenting programme literature suggest that involving caregivers in designing and planning is key for programme success (Bornstein et al., 2022). However, for large-scale evidence-based programmes that have been adapted to new settings, caregivers may not be involved in the design of the actual intervention. To ensure that evidence-based parenting programmes tested in other contexts are acceptable, appropriate, and culturally relevant to families in Tanzania, this paper explores the views of caregivers and adolescent girls who received the large-scale delivery of the Parenting for Life Health programme (PLH-Teens). In this study, we focus on an example of horizontal scale-up, meaning delivery to more participants, using ExpandNet terminology (Ghiron et al., 2021).

To assess the acceptability, appropriateness, and cultural relevance of the scale-up of PLH-Teens in Tanzania, Proctor's taxonomy of implementation outcomes was used (Proctor et al., 2011). Proctor's taxonomy outlines eight implementation outcomes: adoption (the extent of programme uptake), acceptability (participant satisfaction), appropriateness (programme fit), feasibility (the extent to which the programme can be delivered successfully, including consideration of its benefits and challenges), fidelity (adherence to the programme theory and model), cost (time and resources required), penetration (the extent to which programme delivery is embedded within existing services and systems), and sustainability (the practicality of long-term delivery) (Proctor et al., 2011). Drawing on Proctor's implementation taxonomy, we conceptualise 'acceptability' as participants' (caregivers and adolescents) satisfaction with the parenting programme components and delivery mechanisms; 'cultural appropriateness' as participants' views on the perceived fit and relevance of the programme to their parenting in the Tanzanian setting and for addressing VAC. This study has implications for adaptation and scale-up of parenting programmes in Tanzania and other LMIC settings.

Parenting for lifelong health for teens (PLH-Teens)

Since 2017, PLH-Teens has been implemented in Tanzania by Pact Tanzania (Pact), a non-governmental organisation, as part of the USAID-PEPFAR funded DREAMS initiative, which provided a package of services for over a million orphans and vulnerable children in sub-Saharan Africa

(Pepfar & GirlEffect, 2016). As one of the interventions included in the DREAMS initiative, PLH-Teens aims to reduce adolescent exposure to violence in the home and community by improving positive parenting and caregiver-adolescent communication while reducing familial conflict, harsh discipline, and parenting stress as well as adolescent conduct problems, risky behaviour, and mental health challenges (Cluver et al., 2018). PLH-Teens was originally developed and rigorously tested in a South African trial, which found reduced VAC, improved positive and involved parenting, and reduced poor supervision, caregiver endorsement of corporal punishment, mental health problems, parenting stress, and substance abuse (Cluver et al., 2018).

In 2020 and 2021, Pact implemented a locally adapted, HIV-enhanced version of PLH-Teens, locally known as the Furaha Caring Families Programme for Parents and Teens (or Furaha-Teens), for adolescent girls aged 9–14 and their caregivers. The focus of the programme on only adolescent girls, rather than adolescent girls and boys, was due to the choice by USAID-DREAMS to focus on the specific needs and challenges of adolescent girls in sub-Saharan Africa. In our study, a caregiver refers to any adult aged 18 years and above living with child and is responsible for their social support, independent of their biological relationship. PLH-Teens was delivered by trained schoolteachers and community facilitators. The programme engaged caregivers and adolescents in 14 weekly in-person group sessions of approximately three hours in length using non-didactic, participatory methods including discussions, role-plays, problem-solving, and experiential activities.

While Pact was responsible for the overall implementation of the programme in Tanzania, Clowns Without Borders South Africa (CWBSA), a non-governmental organisation that supports the implementation and capacity of organisations delivering PLH-Teens in Africa, provided training to implementers – facilitators (those who delivered sessions to families) and coaches (those who provided supervision and ongoing support to facilitators). Facilitators and coaches were recruited by and worked for six local implementing partners (LIPs) who were responsible for delivering PLH-Teens. In 2020–2021, Pact scaled-up PLH-Teens with 444 community-based facilitators and 70 coaches to reach 75,061 participants ($N = 38{,}802$ adolescents and $N = 36{,}259$ caregivers) in eight DREAMS councils across three regions of rural and semi-urban Tanzania. The 2020–2021 delivery of PLH-Teens is the focus of the present study.

Methods

Data collection occurred from 2020 through 2021 in the Mbeya, Shinyanga, and Kagera regions of Tanzania. Study participants were caregivers and their adolescents aged 9–14 years, who received PLH-Teens in 2020 and 2021.

Participant recruitment

Since we were interested in understanding participants' views of, and their experience with the PLH-Teens programme, we recruited individuals who had completed the programme. Participants were recruited with the help of the LIPs that supported Pact in delivering PLH-Teens. The first round of focus group discussion (FGD) participants were selected purposively based on their region to maximise variation in participant characteristics and then through snowball sampling as a strategy to capture other individuals who had already received the programme. Facilitators provided a list of participants who received the programme. Using the list, six caregivers per region were asked to invite two others to participate in the FGDs. The researchers approached potential participants and sought their permission to engage in the research. Caregivers provided consent and adolescents provided assent.

Data collection

A total of 18 FGDs of approximately 90–120 min were conducted with caregivers (12 FGDs) and adolescents (six FGDs). FGDs were conducted by graduate researchers with experience doing

qualitative research and who were familiar with the study context. Each FGD comprised of 10 participants, resulting in a total of 120 caregivers and 60 adolescents. All FGDs were conducted in Kiswahili using semi-structured interview guides. The FGDs with caregivers focused on the following research questions: 'Is the programme content and the delivery approaches culturally appropriate and acceptable?'; and 'What are the perceived benefits of the programme'. The research questions for the FGDs with adolescents were: 'What is the impact of the programme on their lives?' and; 'What is the adolescent experience with programme content and mode of delivery?'.

All FGDs were audio-recorded with the permission of participants. Caregivers were provided with refreshments and compensation for transportation costs (value of approximately 3 USD). Adolescents were provided with refreshments and the FGDs were held at their school. Ethical approval was obtained from the National Institute of Medical Research (NIMR/HQ/R.8a/Vol.IX/3459) and the University of Oxford (R64777/RE001; R48876/RE002).

Data analysis

Data were transcribed verbatim, translated into English, and analysed thematically with the aid of NVIVO 12 qualitative analysis software. Data analysis was done both inductively and deductively. Four researchers reviewed the translated transcripts and collectively generated a coding framework based on the research questions (deductive) and a thorough reading of a sample of the transcripts for emergent themes (inductive) (Braun & Clarke, 2006). The deductive aspects reflected the research questions, such as experience with the programme and impact. Following the creation of the coding scheme, 10% of the data were double coded to establish reliability among the researchers. Thereafter, data-driven coding was used to identify concepts, relationships, and broad themes (Creswell, 2003). Findings were then discussed by the research team to identify overarching themes. Data segments were extracted to represent the key themes and divergent viewpoints.

Results

A total of 120 caregivers (60 males and 60 females) participated in the FGDs. A total of 60 adolescents aged 9–14 years participated in six FGDs. The findings are presented in three overarching thematic groups: (1) perceived effectiveness and acceptability of the programme; (2) acceptability of programme delivery modalities; and (3) challenges to programme acceptability.

Perceived effectiveness and enhanced programme acceptability

There was widespread acceptability of the programme among caregivers, adolescents, and their communities. Participants articulated that the benefits they observed in their families because of participating in the programme serve to enhance the programme's acceptability. Adolescents and caregivers alike described how the programme was beneficial to them and worth attending. For instance, a female caregiver said:

> *I am happy that I joined the Furaha programme groups. I have received skills along with my child. [FGD, female caregivers]*

Adolescents similarly reflected positively on the impact of the programme and expressed their desire for the programme to continue and to serve future generations. For instance, adolescents made comments such as the following:

> *I would like to request that those sponsoring this programme to continue because it is educating us. We like it. In the beginning I struggled to understand but now I have understood. Am requesting it to be continuous so the next generation can benefit more from it, we really appreciate them because we have benefited a lot. [FGD, adolescents]*

This programme is giving knowledge and should continue until teachers, parents and the community learn to love and respect children and that children learn to respect and obey parents. [FGD, adolescents]

Further reflecting on the impact of the programme on individual behaviour, one adolescent said the following:

Am very grateful for this programme. I used to be a thief, I was rude and untidy … If they tell us they will be coming tomorrow to teach us I will remain at school … I mean even the next generation should get this program. [FGD, adolescents]

Adolescents explained that a particular factor that enhanced their view of the programme's acceptability was the receipt of tangible economic benefits from participating. The PLH-Teens programme was nested within the DREAMS HIV programme that had an economic strengthening component. Since most caregivers were struggling to meet their adolescents' economic needs, caregivers also reported that the parenting programme provided some relief from economic strain through the provision of school uniforms and other school materials needed by their daughters. One caregiver said:

I am happy with this programme … I like the fact that children are given school needs … she didn't have school shoes, uniform, and a bag … but this programme provided for her. [FGD, Female caregivers]

Due to the widespread acceptability of PLH-Teens, caregivers recommended that the programme should not be delivered only to adolescent girls, but it should also include boys and other adolescents in the family. Expressing a desire for the expansion and sustainability of the programme signals a great deal about caregivers' acceptability of the programme. For instance, male caregivers reported:

Because parenting challenges are everywhere and not just with girls, I would recommend that this programme should be expanded to all children in all areas to reduce child maltreatment and family problems. [FGD, Male caregivers]

While caregivers and adolescents alike expressed overall satisfaction with the programme's acceptability and effectiveness, male caregivers noted some additional reasons for their satisfaction. Male caregivers reported that they became role models in society because of the way they applied the skills acquired through the programme with their families and in their communities. Men who participated indicated that they are now perceived as advocates for adolescents and mentors for other caregivers who are struggling to parent their adolescents. Male caregivers described themselves as '*Kioo cha Jamii*' meaning a mirror through which others examine their own parenting skills. For instance, one male caregiver stated the following:

Like what I said before, we have become the image of the society … .And we now teach our peers who did not participate in the programme … . There are great changes in our families and some are asking why we have changed … But all that is as a result of this programme … Sometimes you get a neighbour beating his child and although you previously did the same, you tell him to stop because you are now a changed person … I have become mtetezi wa Watoto [a child defender/advocate] and whenever children are punished from the next home, they run to my home … when that happens, you sit with that parent and tell him that it's not right to beat a child. You teach him how to manage his anger … . We have become the mirror of society because of those parenting sessions. [FGD, Male caregivers]

Overall, caregivers and adolescents alike agreed that the programme was acceptable and appropriate and were anxious for the programme to continue in their communities.

Acceptability of programme delivery modality

Caregivers reported that PLH-Teens was culturally appropriate for their communities and that the sessions and the way session were delivered aligned well with their traditional parenting practices. At the beginning of the programme, male caregivers reported that they thought parenting issues and parenting programmes were for women. However, as they were more exposed to mixed

parenting sessions that included both male and female caregivers, men increasingly appreciated that they had a role to play in the parenting of adolescents and that it is important for them to enrol in parenting programmes. Male caregivers were encouraged when female caregivers welcomed them to the sessions and showed appreciation for their attendance:

> *Before joining those seminars, I was telling myself that "the parenting seminars are for women", but when I got here, I found four to five men. Women were very many and when they saw us, they were very happy, that "Aaaah the fathers were joining in too" … Now that encouraged me, and I said that there is nothing wrong with men coming to the parenting seminars. [FGD, Male caregivers]*

Caregivers also talked about communal parenting as a valued practice in their communities and described the cultural expectation that caregivers are responsible for each other's children. Male caregivers reflected on how the programme was aligned with communal parenting expectations in the following:

> *Those sessions were about how children are raised or should be raised. In that seminar, we were reminded that it is not only about our children that we should care for but also those of our neighbors … That is also emphasized in our traditions … .Those sessions have changed how we interact with our neighbors' children … I feel that I should also protect them and correct them when they go wrong. [FGD, male caregivers]*

Caregivers mentioned that the delivery of the programme through participatory approaches encouraged interactions in mixed caregiver-adolescent groups and prompted caregivers and adolescents to discuss the lessons learned after the sessions. Caregivers also indicated that they shared information about programme sessions with other caregivers in their communities who were not enrolled in the programme. In their communities, caregivers championed PLH-Teens and encouraged those who had not enrolled their adolescents in school to attend school to benefit from the programme. One woman explained that the following:

> *Whenever I meet a caregiver who has not joined the programme because their child was not in school, I usually advise them to take their children to school because it's a place where they learn many things and that's where many programs like this are accessed. [FGD, Female caregivers]*

Caregivers reflected positively on the programme components and mechanism of change. Participatory approaches, including role-plays and discussions, were viewed as enhancing community solidarity and allowed for collective reflections on common issues. Community solidarity was noted particularly among the FGDs with men:

> *Through those mixed groups, we got to know each other, men, women, and our children … We know each other very well, we have built a brotherhood we call and greet each other. [FGD, Male caregivers]*

In delivering these participatory approaches, caregivers also reported that skilled facilitators delivering the programme helped to clarify their concerns and encouraged their participation.

> *Now I was asking myself why they want us to seat with children like students … What are they trying to do to us? Also, at the start those exercises were very difficult because we were afraid, but those experts[facilitators] continued telling us to be cheerful, to continue trying, now we began to see it as a normal thing … that is the reason we are very happy with this programme. [FGD, Female caregivers]*

The delivery of the programme through role-plays and community stories was viewed as instrumental in supporting caregivers to internalise and reflect on their learnings from programme sessions but was also viewed as helping caregivers to put the skills learned into practice. Caregivers reported that the role-plays were fun and enabled them to practice important parenting skills such as listening to one's adolescents, parent-adolescents communication, and paying attention to their adolescents. Describing the usefulness of the role-plays, female caregivers reported:

> *I really liked practicing the plays because you are not supposed to shout at a child or do anything bad towards her … You should tell her in a polite manner to be patient … that impressed me that if you treat a child well, she will understand you and you will both have a good relationship. [FGD, Female caregivers]*

In addition to the way the programme was delivered, caregivers indicated that programme sessions were delivered at times that were suitable for them and their adolescents to attend. Usually, programme sessions were held in the afternoon after most families had completed their farm work and chores. The delivery of the programme through LIPs with community facilitators was also viewed as key for acceptability. The use of skilled facilitators from the same communities as participants was perceived to enhance programme trust and dismiss doubts on the legitimacy of the programme:

> *We knew everyone who was teaching us in the lessons, they were born here, they are people from here. We also knew the organization. That is why we decided to join with our children. We trusted that we had been given a programme that serves all people [Parents and their children]. [FGD, Female caregivers]*

Beyond programme delivery methods and details, who was in the group mattered to caregivers. Caregivers viewed the mixed caregiver-adolescent groups important in facilitating continued engagement with the programme at home through joint practice of the skills learned in the sessions. To illustrate, one female caregiver reported:

> *When we meet in groups we chat with each other. We also discussed and asked each other questions about the sessions. [FGD, Female caregivers]*

Adolescent participants were important 'connectors' and advocates for making the programme work as designed. Caregivers reported that adolescents were key participants at all stages of the programme. Adolescents encouraged their caregivers to enrol and to participate in the programme, reminding them to attend sessions, and on the teachings they had forgotten, as well as providing an overview of the sessions caregivers missed. A female caregiver gave an example of being pressured to enrol and engage in the programme by her adolescent in the following:

> *… My child was now forcing me to continue, she used to remind me when it was a lesson day. In the beginning [of programme], I feared that they would ask me to pay money to attend the sessions. But my child clarified that they just wanted us to participate and that there was no money. [FGD, Female caregivers]*

Other female caregivers described the role of adolescents in encouraging caregiver participation and engagement in the following:

> *I was happy to stay together with my child because when we came back home, she always remembered the exercises we had done, and she started singing the songs while I had forgotten them … Also, when we come back home, my daughter explained what she had learned to her younger siblings, she sings for them, and they became happy. He tells them to study hard so that they can join the program. [FGD, Female caregivers]*

In reflecting on mixed groups, male caregivers also reported that having adolescents in the same sessions enhanced trust and encouraged later discussions at home:

> *We were very happy to attend the sessions together. If I study alone without a child and come to tell her to do this or that, she may not believe me and may argue with me. But because we all learned together, when I say, do this or that she won't argue with me. That's why we share together, we have become one. [FGD, Male caregivers]*

> *I have seen why they put us together with our children in those lessons … when I forget something, she reminds me. [FGD, male caregivers]*

Mixed caregiver-adolescent groups were also believed to have prompted enhanced caregiver-adolescent communication, the sharing of ideas, and planning together as a family and ultimately challenging gender norms around interactions. Male caregivers reported that the mixed groups had enhanced their closeness with their adolescents, spouses, and even other families within their community.

> *The thing that I loved most was staying with the child in the sessions. The child gained a broad understanding and was free to express her thoughts in the family. Previously, [she] was afraid of expressing herself and giving advice. She thought that it was the responsibility of the father and mother to do all the advising but she has now understood that she is also free to share ideas in the family and is free to cooperate with parents in any family work. [FGD, Male caregivers]*

Mixed groups were also acceptable to caregivers as they viewed the sessions as enjoyable. Most female caregivers reported that although they had never played with their adolescents or laughed together, they learned how to do that through the parenting sessions and were increasingly engaging in fun activities with their adolescents:

> *The exercises we were given to do in our homes brought happiness because children started playing with their mothers. My children were laughing saying that they can't believe I have skipped a rope [skipping rope play] today. [FGD, Female caregivers]*

Fathers also shared similar views about the usefulness of role-plays:

> *So, it was like learning a game. We learned a lot of things … the examples were so many, and we had options on how to handle situations. We learned a lot of things through those games. [FGD, Male caregivers]*

As illustrated, adolescents, male caregivers, and female caregivers alike found the programme's delivery modality to be acceptable and appropriate. In particular, male caregivers felt welcomed and encouraged to attend; caregivers appreciated the role-play and participatory activities; the programme fit within families' schedules; and adolescent and caregiver mixed groups were viewed as enjoyable and impactful.

Challenges to the acceptability of the PLH-Teens programme

Although the programme was largely viewed as acceptable and appropriate to participants, caregivers did note some challenges with the programme. Some caregivers reported that they were not able to attend the programme sessions consistently due to reasons such as fear and community mistrust about the programme; stigma resulting from the programme enrolment criteria; expectations of greater financial benefits than were provided; and issues regarding gender norms around parenting.

Mistrust and questioning of the authenticity of the organisations delivering PLH-Teens was a notable barrier to caregiver participation. When the programme was initially implemented, there were community rumours that the programme was linked to the freemason cult, which was very detrimental to programme enrolment and continuation among some families. After hearing about this from the community, programme implementers tried to dispel these beliefs through community meetings. A female caregiver explained the following:

> *The first challenge, after being told to register children to the programme was the belief that we [caregivers] were going to sacrifice our children to freemason cult and therefore we will never see them again … I was afraid. But later I realized that this organization [NGO] had the intention of helping my child. I am grateful to God as I have been empowered. [FGD, Female caregivers]*

Relatedly, some caregivers reported that they had been discouraged by other community members from joining the parenting programme. This discouragement made many caregivers worried about the programme and led to much consideration as to whether to enrol their families. In speaking this experience, a female caregiver said:

> *People were saying that it was not a trustworthy organization for helping children … . Previously another organization came here and took children away … they are the same people, and they are back again … some caregivers took away their children and refused to consent for them to register to participate in the programme [FGD, Female caregivers]*

In addition to fear and community mistrust, some caregivers and adolescents articulated that there was some stigma associated with programme enrolment due to the selection criteria. The selection of adolescent girls into the DREAMS programme and PLH-Teens was based on economic vulnerability and identified risk for poor sexual and reproductive health outcomes, including HIV. Some caregivers shared that this selection criteria resulted in stigmatisation of adolescent girls and their caregivers.

I mean for sure it is sad, sometimes other parents discouraged us very much. Those children were selected by teachers, but you could hear other children telling them, "Go away, you poor person", you just see how he shoves off another child. [FGD, Female caregivers]

Similarly, an adolescent reported:

They were calling us poor and orphans for joining the programme and that our poverty would lead us to death. [FGD, adolescents]

Participants shared that some adolescent boys made fun of the selected adolescent girls and perceived them as poor and gullible for being selected to join the programme. Reflecting on the selection into the programme, adolescent girls reported:

The boys were saying, "women are stupid and that is why they put you in the programme" … they would take pens and start writing on our bags and cutting with razors those bags that we were given by the project. [FGD, Adolescents]

While there were largely positive accounts by caregivers on the adolescent-caregiver mixed-group format of the programme, some caregivers perceived having caregivers and adolescents together in sessions as culturally inappropriate initially. Caregivers were initially unhappy with this approach as they were not used to interacting with their adolescents in formal settings and feared that they would cause too much familiarity and lead to the adolescents disrespecting caregivers. However, as the programme continued and facilitators described the value of the mixed groups, caregivers noted that their perspectives began to shift and that they started to appreciate having adolescents in the group sessions. To illustrate, a female caregiver reflected on mixed group model in the following:

At first the experience of being put together with the children was not good. We were afraid of what could happen. The children were shy, because they had a mentality that if they said something that is not right, they would be rebuked … We [caregivers] also felt that if we speak and say something that is not correct, the children will laugh at us. [FGD, Female caregivers]

Caregivers indicated that a significant contributing factor to their original discomfort with having caregivers and adolescents in the same session was due to the sexual reproductive health content. Many caregivers reported feeling embarrassed when sexual health-related topics were covered in mixed group sessions, especially on condom use and HIV risk and prevention.

I don't know if it was our misunderstanding about that session or what … That session on teaching a child to wear a condom is something that did not, please parents. … Mm it was uncomfortable for us … .How do you teach her to wear a condom when she is just a young girl, I mean she is my child. We did not take that session well. [FGD, Male caregivers]

Another factor that limited the acceptability of the programme was a mismatch between what some participants expected to receive from participating in the programme and what they were actually given for their participation. There was a general expectation by some caregivers that whenever they are invited to participate in a community programme, they should be paid for attending. The expectation of greater monetary benefits than the wider DREAMS project provided was articulated as an important factor in caregivers' decision not to participate in the programme or not to attend the sessions consistently. Caregivers reported that when they first joined the programme, they were discouraged from participating by caregivers not enrolled as there was no payment for participation and hence considered attending the session a waste of time. A female caregiver discussed her experience in the following:

As you continue learning you meet a person who discourages you by saying that we don't even have time to work, I mean we spend time roaming about instead of working on the farms. We encountered such challenges. [FGD, Female caregivers]

However, as many caregivers began to observe the benefits of the programme from families who attended, they changed their mind and decided to enrol in subsequent waves of delivery. One female caregiver explained this in the following:

> *I mean a person just sees you and asks, "where are you going" … You start explaining to the person that you have been called because of this and that. They ask if there was money and if they will be given money. That makes you ask yourself if it is worth going or not. But your heart tells you to just go and listen so that you see what will happen. At the end of the day, things turned out well and now some of those people[skeptics] are wishing their children had been selected. [FGD, Female caregivers]*

Finally, some male caregivers' perceptions regarding gender norms about parenting was a barrier to programme acceptability. There was a feeling among some male caregivers that parenting is a female role so parenting programmes are designed only for female caregivers as a result. There were also discussions about the expectation of male caregivers to work hard to provide for their families as the females took care of the children. Reflecting on barriers related to gender norms, male caregivers reported:

> *Attending a seminar like this is difficult for us fathers … Everyone is busy with work and don't have time to come to those seminars … Before I decided to join, I thought those parenting seminars are for women. [FGD, Male caregivers]*

In summary, there were a few challenges to acceptability noted by caregivers that will be important to address in future delivery of PLH-Teens and potentially other parenting programmes in Tanzania.

Discussion

This paper explores the acceptability and cultural appropriateness of the PLH-Teens parenting programme when delivered at scale in Tanzania. Caregivers and adolescent girls shared that, overall, PLH-Teens was acceptable and culturally appropriate to families in Tanzania. As the caregivers enjoyed the programme and began to see benefits in their relationships with their adolescents, they were motivated to encourage others to join the programme. The literature suggests that positive caregiver perceptions of a parenting programme is key for acceptability as well as sustainability when programmes are delivered at scale (Jukes et al., 2024; Koerting et al., 2013) It has been noted that while parenting programmes are effective in reducing VAC (Cluver et al., 2018; Lachman et al., 2020), low acceptability and uptake may hinder caregivers, and therefore their children, from benefiting from such programmes (Koerting et al., 2013; Weisenmuller & Hilton, 2021). Moreover, if caregivers do not consider a programme to be appropriate and acceptable, they are less likely to register and attend (Jukes et al., 2024; Koerting et al., 2013; Weisenmuller & Hilton, 2021).

Caregivers and adolescents believed that PLH-Teens were relevant to their families and culturally appropriate. For instance, caregivers indicated that the parenting skills they learned aligned with their cultural beliefs. Participants particularly liked the participatory approaches used to deliver the programme, and these approaches were considered appropriate for the Tanzanian context. Caregivers indicated that they left programme sessions feeling confident enough to practice the parenting skills learned via the role-plays at home. From applying the skills they learned, caregivers shared that they believed that their parenting skills improved, and they subsequently saw improvements in their caregiver-adolescent relationships.

Caregivers were eager to practice the role-plays they had learned with their adolescents. These findings are in line with other studies which have found that independent of the number of sessions attended, the more participants are satisfied with the programme and practice what they had learned in the programme sessions, the more they are likely to report acceptability (Jukes et al., 2024). Caregiver satisfaction with the programme has also been linked to positive changes such as improved parenting strategies and decreased adolescents problem behaviours (Giannotta et al., 2019).

Similar to caregivers, adolescents generally found the programme to be acceptable and appropriate. For instance, caregivers shared that adolescent participants actively engaged in programme sessions and played a role in reminding caregivers to attend the sessions and in reflecting on what they learned from programme sessions. As noted by Fleming et al. (2015) and as observed in our study, adolescent involvement in the sessions can boost parental engagement and should be encouraged in parenting programmes for a sustained parental engagement in the programme.

The use of skilled facilitators, most of whom were from the same communities as participants, seemed to enhance caregiver trust and acceptability of the programme, which was key for continued participation and engagement. Other studies have also found that caregivers are more likely to be involved in the programme if they perceived facilitators to be skilled, supportive, and understanding (Giannotta et al., 2019; Shenderovich et al., 2018). Despite the challenges raised, caregiver and adolescent participation in the programme was high, with the average participant receiving 91% of the sessions (Lachman et al., 2024). It is therefore important to ensure that parenting programmes employ skilled implementers who can deliver the programme at a high standard to participants. However, in as much as there could be benefits of using local facilitators with vast experience of delivering parenting programmes (Wamoyi et al., Forthcoming), this could also be a limitation as some participants may be unwilling to disclose information to them for fear of stigma.

The economic strengthening component of the programme was viewed by caregivers as a key support and enhanced the acceptability of the programme. Many caregivers liked the session on family budgeting and the economic support that they were provided through DREAMS project. However, some families viewed the economic support provided by the wider DREAMS programme as lacking – and something that could be improved in future implementation. Studies find an association between household poverty and intimate partner violence and VAC (Bamiwuye & Odimegwu, 2014) and therefore recommend that interventions address a combination of economic strengthening and parenting strategies in order to reduce VAC (Lachman et al., 2020). The benefits of incorporating economic support and skills into the programme may explain why reductions in parental stress are generally found among caregivers who participate in PLH-Teens (Cluver et al., 2020). However, caregivers did articulate that the PLH-Teens session on family budgeting encouraged open family communication around finances and efficient budgeting for available family resources. A study by Wamoyi et al. (2011a, 2011b) notes, parental inability to provide for their adolescents jeopardised their position as caregivers and challenged their powers for behavioural control. Altogether, the findings of this study, and other studies in the parenting programme literature, may suggest that parenting programmes could be strengthened in future by integrating economic strengthening components.

Despite the widespread acceptability of the programme, there were significant challenges that warrant investigation as they were perceived to have hindered enrolment, continued engagement, and the social standing of some of the families that decided to participate. Examples of these barriers are: social and gender norms on caregiver-adolescent interactions; expectation of financial benefits for participating in the programme; community mistrust; and stigma related to the programme recruitment criteria that was based on family vulnerability. Social and gender norms regarding caregiver interactions came up in two ways. First, despite caregivers indicating that they found the participatory approaches interesting and valuable, this approach was not uniformly liked by all participants. Some caregivers indicated that some of the programme design features did not align well with their cultural norms regarding parent–adolescent interactions and gender expectations. For example, mixed caregiver-adolescent groups were viewed as culturally inappropriate by some caregivers. Some caregivers felt embarrassed to make mistakes during the sessions; some were worried that their adolescents would make fun of them thus discrediting their parental power; and some were uncomfortable discussing sexual health topics with their adolescents, especially in a group setting. However, since the programme was designed for delivery through mixed groups, the facilitators explained the rationale for combining caregivers and adolescents in one session. Then, as the sessions continued, participants began to see the benefits of this delivery model.

These findings point to the need for programme implementers to clarify the rationale for the selected delivery models at the outset, especially in contexts where mixed groups may not fit with local social norms.

Second, the delivery of PLH-Teens in Tanzania was nested within a HIV prevention programme (DREAMS) (Pepfar & GirlEffect, 2016) and therefore involved adaptations to include sexual reproductive health content, such as adolescent HIV prevention. However, the addition of the sexual reproductive health components, especially on condom use, did not always sit well with caregivers. Discussion of sexuality is a culturally sensitive topic in Tanzania (Wamoyi et al., 2010) and many parents found it embarrassing to discuss such topics with their adolescents. Future parenting programmes with sexual reproductive health components should introduce such topics when caregivers and adolescents are ready for them to minimise shame that could discourage participants from attending. A key limitation of the programme was its delivery to only adolescent girls in the Tanzanian setting. As stipulated in the original PLH-Teens programme (Cluver et al., 2018), we recommend, as did participating families, that future delivery of the programmes should target both male and female children as they are both at risk of violence.

It is valuable to consider the barriers shared by participating families via the FGDs, such as the concerns around the inclusion of sexual and reproductive health content and participation of only female children. Our research has identified these and other programme adaptations from the original model in the current project (see Shenderovich et al., forthcoming). While the barriers shared by participants in our research might be novel to the delivery of an adapted version of PLH-Teens in the Tanzanian context, they could also be relevant to the delivery of the programme in other contexts, and demonstrate the need for ongoing investigations into family perspectives as programmes are adapted and scaled in new contexts for different populations. Those delivering PLH-Teens should consider the relevance of these findings for other contexts as well as continue to conduct qualitative investigations alongside caregivers to ascertain their perspectives in different contexts.

Some of the challenges observed in our study have been noted in other LMICs (Jukes et al., 2024; Weisenmuller & Hilton, 2021) and could signal potential unintended harms to families from participating that must be addressed as the programme is scaled in Tanzania and in other countries. To reduce VAC and to achieve positive parenting outcomes, there is a need to pay attention to programme acceptability and to address potential barriers to enrolment and engagement in the programme. Strategies to overcome these challenges might include: (1) conducting thorough community mobilisation to encourage participation in the programme; (2) employing well-trained and skilled facilitators from the same communities as caregivers to reduce mistrust as well as enhance acceptability and programme buy-in; (3) introducing and recruiting families in a way that does not single them out; and (4) considering the use of hybrid delivery when in-person attendance is challenging for parents. A randomised control trial evaluating the effectiveness of digital parenting intervention to prevent VAC is now underway in Tanzania (ParentApp) (Baerecke et al., 2024). If found to be effective, hybrid-digital delivery may mitigate some of the identified barriers related to in-person delivery(Jaggi et al., 2023).

Data credibility

We attempted to ensure the credibility of our findings via several approaches. First, we collected data from both caregivers and adolescents in three different regions, thus enriching our understanding of the programme's acceptability and appropriateness. Second, we engaged four researchers to ensure reliability in coding and theme development. The data collection team was familiar with the study context and had previously worked there in these contexts. Although researcher familiarity with context was advantageous, it may have resulted in a social desirability bias. To obtain insights into everyday caregiver-adolescent interactions and practicing of skills acquired, we recommend that future studies should combine interviews with observation of families during the delivery of programme sessions.

Reflexivity

The study team was composed of individuals with expertise in parenting, evaluating social programmes, qualitative research, and community-engaged studies. All the authors have been involved in the evaluation of PLH-Teens programmes for several years. This could have unintentionally resulted to a positive bias towards the programme and influenced how we explored our research issued and analysed our data. However, the use of data collectors who had no prior experience with the programme may have ameliorated this bias.

Conclusion

This study found that a parenting programme delivered through participatory approaches at scale was widely acceptable and culturally appropriate to caregivers and adolescents in Tanzania and was viewed by participants as beneficial for improving caregiver-adolescent relationships and reducing VAC. The PLH-Teens programme was perceived as addressing the real parenting needs of caregivers and their adolescents. However, there is need to address the reported challenges that could hinder programme participation, acceptability, sustainability, and its continued scale-up. Digital parenting approaches could be a possible solution to the challenges faced in the in-person parenting programme.

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Disclosure statement

Dr Lachman is the CEO of Parenting for Lifelong Health (PLH), a charitable organisation based in the United Kingdom that developed the programme which is open access and licensed under a Creative Commons 4.0 Attribution Share-Alike license. Dr Majengenja works for Clowns Without Borders South Africa, a South Africa-based charitable organisation that supports the dissemination of PLH programmes including Furaha Teens through technical capacity training. Ms Ndyetabura works for Pact Tanzania, the nonprofit organisation responsible for the delivery of the Furaha Teens program in Tanzania during this study. Dr Lachman, Dr. Wamoyi, Dr. Shenderovich have and/or are participating in a number of research studies involving the programme, as investigators and the University of Oxford, University of Cape Town, Cardiff University, NIMR and other partners receive research funding for these. Throughout our work on PLH programs, we have been adamant that we have no interests (vested or otherwise) in the outcomes, and we work together to hold each other to account on this. Other authors do not have any kind of conflict of interest.

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Availability of data and materials

Information and study materials are available on the webpage: https://www.spi.ox.ac.uk/furaha-adolescent-implementation-research-fair-study. Intervention materials can be found on the World Health Organization website: https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health.

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