TITLE: STRENGTHENING FAMILIES PROGRAMME (SFP) 10 -14: DEVELOPING A GUIDELINE OF ACTIONABLE STEPS TO FOLLOW IN CULTURAL ADAPTATION FOR USE IN SOUTH AFRICA.

UNIVERSITY *of the*
WESTERN CAPE

A Dissertation submitted in fulfilment of the requirements for the degree of Doctor Philosophiae in the Department of Psychology, University of the Western Cape

Student:	Warren R Jacobs
Student number:	3374961
Supervisor:	Prof. Mario Smith
Degree:	Doctor Philosophiae
Type of thesis:	Dissertation

December 2022

Keywords: pre-and early adolescents, systemic, family-focused, health risk behaviour, prevention, delaying onset, reducing, empirical evidence, family resiliency, adaptation.

University of the Western Cape
Private Bag X17, Bellville 7535, South Africa
Telephone: +27-21- 959 2255/959 2762 Fax: +27-21-959 1268/2266
Email: 3374961@myuwc.ac.za

GENERAL PLAGIARISM DECLARATION

FACULTY OF COMMUNITY AND HEALTH SCIENCES

Name: Warren R Jacobs

Student Number: 3374961

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ACKNOWLEDGEMENTS

I would like to express my gratitude first to God for granting me the strength, tenacity and fortitude to see this study through to completion.

I am humbled by the grace and favour that I experienced throughout this time. I am forever grateful to my Supervisor, Prof. Mario Smith, for his expert guidance and brilliance, his timely advice, meticulous scrutiny, and scientific approach that have helped me to a very great extent to accomplish this task. You taught me how to be methodologically sound and insightful.

A special thanks to Christel House South Africa (CHSA) for allowing me to conduct the study at this special school, and for those of the CHSA school that participated in the study, including the educators, learners and parents/caregivers and the subject matter experts.

To my colleagues in the Iowa State Extension Programme, at Iowa State University, I am forever grateful to you for permission granted to do this study and for all your advice and support.

The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.

To my loving wife Glynis and children, Chad, Nicole and Chelsea, thank you for your patience, love, compassion, support and understanding, without which I would not have survived this process, and for all the sacrifices made to make this dream possible. To my siblings and their spouses, I would like to say thank you for your support, belief and encouragement.

And finally, I want to acknowledge my belated parents, Connie and Derek Jacobs who gave me a sense of determination and purpose and have taught me that there is no progress without a struggle, I hope this makes you proud!

ABSTRACT

The age of first-time engagement in Health Risk Behaviours (HRBs) among adolescents in South Africa is reportedly younger. The identification and adaptation of empirically proven effective prevention programme is needed. The Strengthening Families Programme 10-14 (SFP:10-14) is a school-based, family intervention programme designed by the Iowa State University (ISU). Extension Programme team to reduce engagement in HRBs and promote positive functioning for parents and pre-and early adolescents. The SFP: 10-14 has been successfully implemented in the United States of America, and implemented in numerous countries. The adaptation of the SFP programme is guided by the cultural adaptation process for international dissemination. The dissemination process comprises of broad recommended steps. Application when adapting the programme to specific cultural contexts must be operationalized by the adaptation team. Attempts at adaptation for the South African context lacked a systematic approach and there was too much variation in the attempts to operationalize. The current study aimed to develop actionable steps that can guide contextual adaptation of the SFP: 10-14 programme for use in South Africa. The study was conducted in stages with each stage conceptualised separately using different designs and methodological elements. Phase One entailed a Systematic review to identify effective interventions. Phase Two was a modified Concept Mapping to identify contextual considerations for adaptation of the SFP 10-14. Phase Three entailed the development of operational steps for the adaptation of the SFP 10 – 14 programme. Ethics clearance was issued by the Senate Research Committee of the University of the Western Cape. The findings indicated that the SFP 10-14 was appropriate for adaptation. Actionable steps were distilled that operationalised the international dissemination process and articulated into a guideline for adaptation.

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LIST OF ACRONYMS

ACE	American Accelerated Education
APA	American Psychological Association
AOD	All Other Drugs
CAP	The Cultural Adaptation Process
CAPID	Cultural Adaptation Process for International Dissemination
CBPR	Community-based Participatory Research
CCI	Castro et al- Critical Issues
CDC	Center for Disease Control and Prevention
CHAMP	Chicago HIV Prevention and Adolescent Mental Health Project
CHSA	Christel House South Africa
CINAHL	The Cumulative Index to Nursing and Allied Health Literature
DoE	The Department of Education
EBP	Evidence-based Practice
EBI	Evidence-based Intervention

EBP	Evidence-based Practice
EBT	Evidence-based Treatment
EDU-MGT	Educational Management
EMCDDA	European Monitoring Center for Drugs and Drug Addiction
HBSC	Health Behaviour in School-aged Children
HDE	Higher Diploma in Education
HIV	Human Immunodeficiency Virus
HIV-AIDS	Human Immunodeficiency Virus- Acquired Immunodeficiency Syndrome
HRB	Health Risk Behaviour
ICF	International Classification Functioning
IMPACT	Informed Parent and Children Together
ITC	International Test Commission
MEDLINE	Medical Literature Analysis and Retrieval System Online
MSFP	Mindfulness Strengthening Families Programme

NDMP	The National Drug Master Plan
NIDA	The National Institute on Drug Abuse
NIH	National Institute of Health
OSA	Online Sexual Activity
PARE	Parent-Adolescent Relationship Education
PAS	Preventing Heavy Alcohol use in Adolescents
PBSC	Psychological and Behavioural Science Complete
PRISMA	Preferred Reporting Items for Systematic Review and Meta-Analysis
SAAF	The Strong African American Families
SACENDU	South African Community Epidemiology Network on Drug Use
SFP	Strengthening Families Programme
STD	Sexual Transmitted Disease
ToC	Theory of Change
UNICEF	United Nations International Children's Emergency Fund

UNODC	United Nations Office on Drugs and Crime
UWC	University of the Western Cape
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1Motivation for Study

Health risk behaviours by children and adolescents globally and in South Africa was identified as a major concern in the early 2000s (Flisher et al., 2006; Jernigan, 2001; Parry et al., 2004). Risk behaviour involves purposeful action resulting in losses or gains (Fischer et al. 2011). Risk behaviours are prevalent during adolescence when challenges of adapting to social, emotional and cognitive changes are increasing (Catalano et al., 2012; Dodge & Albert, 2012). This tendency can be understood as an adolescent's " transition from the safety net of one's parents to the bold and brave world of adulthood" (Dodge & Albert, 2012, p. 624). Ellis et al. (2011) described adolescence as a "window of vulnerability and opportunity" (p.603) .

There is a dramatic increase in the onset of health risk behaviours between pre- and early adolescents, (Reddy et al., 2013). Risk behaviour is usually studied in relation to adolescent development, because it is usually during this period of development that risky behaviour makes its debut (Bolland et al., 2016). Young people during this period experience substantial and often very stressful changes in their physical, cognitive and social functioning, which makes them more susceptible to the social challenges that they face (Fuhrmann et al., 2015; Fraga et al., 2016; Windle et al., 2008). Research shows that many health-risk behaviours are established during adolescence and often maintained into adulthood, significantly affecting health and wellbeing in later life (Adamson et al., 2007; Bolland, & Tomek, 2016; Sourander et al., 2007; Viner & Barker, 2005). Alcohol, tobacco and illicit drug use and sexual risk behaviour are common during adolescence, especially in South Africa (Pharoah, 2015; Plüddemann et al., 2010b; Reddy, 2007). There is evidence that these risk behaviours may cluster (Meader et al.,

2016). Similarly, early initiation of risk behaviour is associated with other risk-taking behaviours in later adolescence (Pettifor et al., 2015), and early adulthood (Ellickson et al. 2001; Guo et al., 2002; Stueve & O'Donnell, 2005).

Typically, pre-and early adolescents experience marked decrease in adult involvement, support and monitoring during this stage, and an increase in peer influence as the primary social element. These factors increase the potential exposure to risky situations and could contribute to the reported dramatic increase in risk behaviours (Jackson et al., 2012). Furthermore, peer influence has been shown to be a contributing factor of adolescent substance use and an adolescent's perceptions of engaging in risky behaviors (McDonough et al., 2015). Risk behaviours often include substance use (e.g. Windle et al. 2008), delinquency (e.g. Moffit et al. 2002), and other potentially health compromising behaviours (e.g. Pharaoh et al., 2014). Risks can take place in a number of domains such as violence, substance consumption, promiscuity and unprotected sex, etc. (Catalano et al., 2012; Fischer et al., 2011). Increases in risk behaviours were noted in alcohol and drug abuse (Flisher et al., 2006; Jernigan, 2001; Parry et al., 2004); unplanned pregnancies and unprotected sexual activities (McGrath et al., 2009); as well as interpersonal violence and delinquent behaviour (Flisher et al., 2010; Plüddemann et al. 2010a). This increase in risk behaviour amongst pre- and early adolescents remain major concerns in South Africa (Reddy et al., 2013).

Research shows that the consequences for young people engaging in these risk behaviours include alcohol related injuries, academic, behavioural and relationship problems, as well as the development of an unhealthy lifestyle and long-term health problems (Degenhardt & Hall, 2006; Plüddemann et al., 2010b; Yen & Chong, 2006). Unprotected sexual activity, reportedly can

contribute to a risk of teenage pregnancy and HIV infection that can have a severe impact on the lives of the young people involved (Ebersohn & Eloff, 2002). Research also indicates that earlier age of onset of risk behaviour can often be prognostic of poorer health and emotional outcomes into later adolescence and adulthood (Brook et al., 2004; Colman et al., 2007; Sourander et al., 2007).

High-risk behaviours, such as alcoholism, drugs and sexual risk behaviours have been viewed consistently since the early 90s as a threat to family homeostasis and stability (Landau & Saul, 2004). Thus, how a family deals with challenges is important for individual and family recovery (Walsh, 2012). Landau (2007) confirmed that "families of origin, families of procreation/choice, significant others, friends, and communities" are all possible sources of social support (p.66). There has been a consistent failure in the past to include a family-focused approach to address these challenges within the family setting (Sumter et al., 2009). Systems-based research has shifted the focus in recent years from almost exclusively on pathology to competencies and strengths within families (Walsh, 2012).

The high-risk behaviours in pre-and early adolescents is a unique crisis situation in the family context which may necessitate a unique approach when dealing with it (Walsh, 2012). The advantage of a family-focused intervention programme is that it views functioning in context, with processes linked to challenges; all in terms of an individual or family's particular resources and challenges (Greeff & Du Toit, 2009; Greeff & Holtzkamp, 2007). Reliable evidence posed by Greeff et al. (2006), indicated that parental practices of support, monitoring and communication are protective measures against risk behaviours and plays a vital role in recovery. Parental disapproval of risky behaviours and substance use, and successful parent-

child communication, is related to lower levels of engagement in adolescent risk behaviours (Spoth et al., 2004). Inversely, permissive parenting is associated with earlier onset of substance use (Varvil-Weld et. al., 2014). Walsh (2012) recommended that the clinical aspects relating to family resilience should remain a focus of research. He further suggests that research on health risk behaviours that focused on families could contribute to the body of knowledge concerning how human beings cope with adversity (Walsh, 2012).

There has been progress made on the development of programmes to delay, prevent and reduce risky behaviours in adolescents (Flisher et al., 2008). Numerous programmes were developed to address the increasing levels of health risk behaviours in youth (Reddy et al., 2011). The focus of these programmes included, but was not limited to harm reduction, skill development, and youth and peer group support. Howard et al. (2002) identified that these programmes merely focused on psycho-education that is not enough for behaviour change. A further criticism contended that stakeholders (youth, parents, educators, etc.) have not sufficiently been consulted when the programmes have been developed, which resulted in reduced buy-in (Harrison et al., 2000). Furthermore, the programmes appeared to have targeted either parents or youth, but not both as a unit (Spoth et al., 2004). Walsh (2012) showed that, although few studies have focused on the role of the family in individual coping, family survival contributes to the survival of individual members. Thus, there is a need for family-based interventions (Sumter et al., 2009).

Greeff (2000) argued that research is needed for a strong knowledge base from which to develop interventions, and it is believed that such research needs to include how families adapt to crisis situations (Walsh**,** 2012). Overall, there is substantially less research (and programming)

regarding delaying or preventing substance use and high-risk sexual behaviour in younger populations (Jackson et al., 2010). Few studies have also investigated the effects of the role of the family on individual resilience in stressful situations (Greeff & Aspeling, 2007; Greeff & De Villiers, 2008; Walsh, 2012). Most studies conducted, focused on an intra-psychic level and peer group influence (Spoth et al., 2004). Families offer a number of strengths and protective factors that can be harnessed in interventions and programming (Spoth, et al., 2001). Post 2010 there were more attempts at investigating family-based interventions with younger populations (e.g. Hodder et al., 2017).

The Strengthening Families: 10-14 programme (SFP:10-14) is an example of a programme that adopts a family focus (Spoth, et al., 2001). The family strengths-based approach of the SFP acknowledges the inherent strengths idiosyncratic to families, and contributes to helping individuals and families find their own strengths when the paths to such resources are uncovered (Kumpfer et al., 2008). SFP:10-14 has been implemented with encouraging empirical support for its proposed outcome of reducing onset of health risk behaviours amongst pre- and early adolescents. For example, SFP:10-14 has a longitudinal follow-up of participants over a period of 6 years, which has also repeatedly shown sustained effects in reducing AOD initiation and is therefore recommended for consideration to implement in South Africa (Burnhams et al., 2012). The programme has been adapted for various population groups within the USA (Kumpfer et al., 2008; Spoth et al., 2008a). The programme has also been adapted for use with other nationalities or in other countries suggesting a measure of universality in application (e.g., Allen et al. 2007; Coombes et al. 2009; Skarstrand et al. 2008). In addition, the SFP 10–14 prevention programme was twice as effective as the best

school-based alcohol prevention (Foxcroft et al., 2003; Spoth et al., 2000, 2001). Thus, SFP:10-14 was found to be effective and it has the further advantage of having been replicated in other cultural and international contexts.

The SFP:10-14 was one of the programmes that was strongly recommended for adaptation and implementation in South African context. Burhams et al. (2012) conducted a systematic review of existing literature on multi-focused substance abuse prevention programmes that specifically target the community, youth (age groups 10-15 and 16-19), and families. In their report, they outlined the methods of the research, programmes identified, and made some recommendations of potentially suitable programmes which could be adapted and implemented in the City of Cape Town (Burhams, et al., 2012).

Criticism raised indicates that many programmes from abroad have been initiated, but have not been adapted adequately for the South African context (Howard et al., 2002). Similarly, some programmes that are locally developed and applied lacked a rigorous empirical development and evaluation process (Burnhams et. Al., 2009). Pedlow and Carey (2004) recommended that evidence-based studies underpinned by methodological rigour are needed to evaluate and develop intervention programmes. In addition, empirical processes for adaptation were recommended to ensure that programmes developed in other contexts are adopted in a contextually sensitive and appropriate manner (Barrera & Castro, 2013).

In South Africa, however, there is very little concrete, accurate and detailed evidence that prevention programmes implemented are based on evidence–based practice. For example, Burnhams et al. (2009) found that youth–focused alcohol and other drug prevention programmes conducted in the Cape Town Metropole largely were not guided by evidence-based practice

(EBP) and were implemented in the absence of evidence on their effectiveness. This raised questions about the quality and effectiveness of prevention services and the success of efforts to prevent or delay substance use among young people in South Africa. EBPs are practices, interventions or programmes for which there is a large body of research evidence in support of its effectiveness (Myers et al., 2008). The need to offer a more comprehensive, family-focused programme aimed at reducing and or delaying the onset of risk behaviours in younger populations remains an urgent priority despite a proliferation of risk-prevention interventions for adolescents. Thus, there is a need for more comprehensive, and sustainable programming that covers a number of important issues from a systemic view with empirical evidence of usefulness for the South African context.

1.2 Problem Statement

Jackson et al. (2010) identified that research and development of programmes aimed at delaying or reducing substance use and high-risk behavior in younger populations remains a focus of further research. As mentioned before, Reddy et al. (2011) signaled an urgent and time-sensitive need to begin addressing the engagement in HRB amongst adolescents. Pharaoah et al. (2018) recommended that programming must 1) go beyond psychoeducation for behavioural change; 2) include a systemic focus that also draws on the family and the familial setting; 3) draw on existing programmes that are empirically validated, and 4) include consultation with youth and other stakeholders to increase buy-in and relevance. Domenech Rodríguez et al. (2011) recommended the adaptation of programmes with proven effectiveness. These authors recommended that a rigorous and empirical process must underpin adaptation in order to achieve contextually appropriate outcomes. Burnhams et al. (2012) identified the SFP 10-14 as effective

in delaying and reducing the onset of HRB's in pre-and early adolescents and recommended the programme for adaptation to the South African contexts.

As mentioned before, the SFP programme has been adaptation successfully for international application. The SFP programme published a process for international dissemination and cultural adaptation (Kumpfer et al., 2008). This dissemination process comprises of nine broad steps with recommendations in each step. The international dissemination process is widely accepted and it forms part of a continuum of adaptation approaches (Castro et al, 2010). The adaptation of the programme to specific cultural contexts is operationalized by the adaptation team. Reports on adaptations to other cultures and context focus on outcomes including the efficacy of the programme and process such as fidelity to the programme (Barrera and Castro, 2006). This poses a challenge as there is a lack of systematic reporting on the actionable steps followed to operationalize the guidelines contained in the international dissemination process. In turn replication is impacted and the opportunities to evaluate said processes for methodological rigour and coherence are lost.

Attempts at adaptation of the SFP programmes for the South African context lacked a systematic approach. There was great variation in the attempts to operationalize with a clear focus on clinical or practical considerations of the intervention at the expense of process and methodological considerations. The gap in the literature indicates a need for a systematic and empirically grounded adaptation process of family-based programmes to the South African context. The current study aimed to develop actionable steps from the International dissemination process that guides contextual adaptation of the SFP: 10-14 programme for use in South Africa. The study further aimed to formalize these actionable steps into a guideline that

can inform the evaluation of the conceptualization and implementation of proposed adaptations to the SFP programmes. The study used the SFP-10-14 programme as an illustrative case.

1.3 Rationale for Study

Burnhams et al. (2009) postulates that the impact of alcohol and substance abuse continues to ravage families, communities and society. The emotional and psychological impacts on families and the high levels of crime and other social ills have left many communities under siege by the scale of alcohol and drug abuse (Burnhams et al., 2009). The youth of South Africa are particularly hard hit due to increases in the harmful use of alcohol and the use and abuse of illicit drugs (Reddy et al., 2013). The SACENDU project (July, 2017), an alcohol and other drug (AOD) sentinel surveillance system in South Africa, reported an alarming increase in 10-14-year olds involved in AOD treatment in the Western Cape. They subsequently, promote intensifying effective programmes aimed at reducing or preventing AOD use by children or adolescents. For years, the predominant strategy for dealing with the drug problem among targeted population groups in South Africa had been that of supply reduction. However, the United Nations Office on Drugs and Crime (UNODC) and the WHO also started advocating its replacement with the strategy of primary prevention, i.e. preventing the onset of substance abuse/dependence and focusing on those at risk of developing substance abuse/dependence (e.g. World Health Organization, 2004b).

The South African Substance Treatment Act 70 (2008) also promotes such intervention programmes to focus on six core elements: First, the family structure of the persons affected by substance abuse and those who are dependent on substances must be preserved. Second, develop

appropriate parenting skills for families at risk. Third, create awareness about and educate the public on the dangers and consequences of substance abuse. Fourth, provide families and communities with information to enable them to access resources and professional help. Fifth, involve and promote the participation of children, youth, parents and families, in identifying and seeking solutions to their problems. Sixth, promote appropriate interpersonal relationships within the family of the affected persons (Substance ACT 70, 2008). The present study would address an urgent priority by actionable guidelines for the adaptation of family-focused intervention programmes aimed at reducing and or delaying the onset of risk behaviours in younger populations. This in turn will increase methodological rigour and coherence by empirically grounding the adaptation process.

In the Green Paper on promoting family life and strengthening families in South Africa (2011), the South African government also acknowledged the need for promoting family life and strengthening of the family as the most significant factor in reducing the HRBs in our youth. The Green Paper recognized that families are facing a fundamental crisis, and that many social ills and health risk behaviours our young people encounter are a result of weak family systems or non-existing families altogether. Guidelines and strategies for promoting family life and strengthening families include, among others, strengthening the coping and resilience of children and adults in relation to risks or threats experienced within families (Green paper, 2011). There is consistent evidence since the nineties that amongst middle- and high school aged adolescents, parental practices of monitoring and communication are protective measures against alcohol and drug use (e.g. Greeff et al., 2006; Resnick et al., 1997). Parental disapproval of risky behaviours and substance use, and successful parent-child communication, is related to lower levels of adolescent risk behaviours (Spoth et al., 2004). Thus, the present study would build on these

findings to action the intent expressed in the Green paper.

Burnhams et al. (2009) identified that in the new democracy, the extent of substance use and associated problems in the Western Cape and particularly the City of Cape Town, warranted the need to implement effective programmes targeting the prevention of substance use disorders. The National Drug Master Plan (NDMP) 2006-2011 advocated supply reduction with a focus on policing (Geyer & Lombard, 2014). The South African Government recognized the need for evidence-based interventions in the revised National Drug Master Plan (NDMP) 2013 – 2017 (Howell & Couzyn, 2015). This plan recommended a more comprehensive and integrated overall prevention strategy that could deliver and apply evidence-based solutions, designed to meet the defined needs of communities. Thus, the appropriate, effective, and efficient allocation of scarce resources was contingent on an evidence-based approach to intervention programmes and practices. It is accepted that when drug policies target specific problems and populations and are informed by sound scientific evidence, they can alter the course of drug use and even drug epidemics (Babor et al., 2010a, 2010b). Thus, the present study attempted to provide an empirical underpinning for the adaptation of the programme that in turn will enhance its efficacy.

EBP reach beyond geographical boundaries and consequently can be applied to the South African context, with only minor adjustments specific to age groups, linguistics, context, and cultural diversity (Myers et al., 2008). Botvin and Griffin (2004) concluded that interventions are likely to be most effective when culturally appropriate. Similarly, Tsarouk et al. (2007) encouraged practitioners to ensure that interventions respect and are sensitive to cultural diversity. Over the years, researchers and programme developers have been exploring how best to culturally adapt effective programmes to a specific environment or context and population.

The basic challenge faced by researchers and practitioners who would use research-based programmes is how to fit a programme to a special set of circumstances while remaining true to the core elements that made the programme effective in the first instance (Larson and Corrigan, 2008). Thus, the present study engaged with the challenge of adapting the programme whilst maintaining the integrity of the programme as contained in the international dissemination process. In short, the rationale for the present study was that it set out to develop actionable steps for the adaptation of the SFP:10-14 programme. The guidelines will embed an empirical process to achieve both methodological rigour as well as contextual relevance and sensitivity. The following section gives a brief overview of the SFP10-14 programme.

1.4. Brief Programme Overview of the SFP:10-14

Programme Description: The SFP 10-14 was developed as a major revision of the Strengthening Families Programme (SFP) originally developed in 1983 by Kumpfer et al. (1989) as part of a 3-year prevention research project funded by the National Institute on Drug Abuse (NIDA) (NIDA, 1997). The original SFP was designed to reduce vulnerability to drug abuse in 6-to 12-year-old children of methadone maintenance patients and substance-abusing outpatients (Molgaard et al., 2000).

The SFP was originally a 14-session family skills training programme designed to prevent drug use and misuse. Molgaard et. al (2000) reported that the SFP has been repeatedly evaluated over the past 20 years, including independent evaluations, showing improvements in parental and family functioning with positive impact on children's behaviours and mental health. There have been different age versions of SFP including SFP 3–5, 6–11, 10–14, 10–16, and 12–

16 years, all with the same format and theoretical underpinnings (Kumpfer et al., 2007). The only difference is that the universal versions for school-based implementation are shorter, such as SFP 10–14 years that is 7 sessions long, and the new SFP DVD 10–16-year group and home use versions that are 10 sessions long. The original SFP was designed to reduce vulnerability to drug abuse in 6 to 12-year-old children of methadone maintenance patients and substance-abusing outpatients (Molgaard et.al., 2000).

Programme Method: Strengthening Families 10-14 is a seven-session programme for families with young adolescents that aims to enhance family protective and resiliency processes and reduce family risk related to adolescent substance abuse and other problem behaviors (Molgaard & Spoth, 2001). The seven-session programme for families with young adolescents, aged 10-14 years is based on the biopsychosocial model and targets enhancement of family protective and resiliency processes and family risk reduction (Molgaard et al., 2000). Sessions are conducted once weekly for seven weeks. The first six are two-hour sessions including separate one-hour parent and child skills-building followed by a one-hour family session where parents and children practice the skills they have learned independently, work on conflict resolution and communication, and engage in activities to increase family cohesiveness and positive involvement of the child in the family. The final session is a one-hour family interaction session without the concurrent parent and child training sessions. Parents are taught means of clarifying expectations based on child development norms of adolescent substance use, using appropriate disciplinary practices, managing strong emotions regarding their children, and effective communication (Riesch et al., 2012). Essential programme content for the parent skills training sessions is contained on videotapes that include family interactions illustrating key concepts. Children are taught refusal skills for dealing with peer pressure and other personal and

social interactional skills (Molgaard & Spoth, 2001). During the family sessions, family members practice conflict resolution and communication skills and engage in activities designed to increase family cohesiveness and positive involvement of the child in the family (Molgaard & Spoth, 2001).

Spoth et al., (2014) reported that SFP 10-14 can be implemented and adapted for the prevention of not just substance abuse but also delinquency, HIV, obesity, diabetes, child maltreatment, and children's depression and other mental health disorders, with diverse populations. This is based on the finding that improvements in the family environment and interaction patterns can prevent many different health and psychological problems in youth (Hair, Moore et al., 2005). Parents and their children practice strengthening their family relations through exercises designed to improve their observation, monitoring, play, communication, discipline skills, and the parents also learn to manage the child differently and developmentally appropriately (Molgaard et al., 2000; Spoth et al., 2006).

Programme Facilitation: The seven-week SFP 10-14 universal prevention intervention is delivered to groups of families (Molgaard et al., 2000). Participants are divided into separate groups of parents/carers and children during the first hour of weekly sessions and meet for a refreshment break followed by the final hour when parents/carers and children come together in family groups. Facilitators use videos, interactive teaching and games specified in the programme manual to demonstrate and support the practice of parenting and other skills. Three facilitators are needed to conduct the SFP programme, one for the parent sessions and two for the youth sessions. Facilitators teach from materials provided during youth, parent, and family sessions. During family sessions, facilitators engage in less teaching as their role changes to

facilitator and coach. Each facilitator is responsible for three or four families and works with the same families each week. Facilitators for SFP 10-14 should have strong presentation and facilitation skills and experience working with parents or youth and they must attend a 3-day certified training by ISU-approved National Trainers (Molgaard et al., 2000).

Adaptations: Culturally adapted versions have shown positive effects in the United States for African American, multicultural, Asian and Pacific Islander, Hispanic, and American Indian families (Kumpfer et al., 2008; Kumpfer et al., 2015; Spoth et al., 2008a; Spoth et al., 2008). A Cochrane collaboration and the World Health Organization meta-analysis of universal alcohol prevention programmes in schools (Perron et al., 2009) found that a 7-session SFP 10-14 was twice as effective in reducing alcohol use as any other school-based intervention having at least years of follow-up data. Because of these positive results, the SFP 10-14 programme has been adopted for replication and evaluation in several countries in Europe, including four that have 1-2 years of pre- to posttest outcome results namely, Spain (Orte et al., 2008a,b), the Netherlands (Bool, 2006), Sweden (Skarstrand et al., 2013), and the United Kingdom (Allen et al., 2007). The SFP 10-14 was also adopted for replication in Latin American countries, including, Chile (Corea et al., 2012), Honduras (Vasquez et al., 2010), Panama (Mejia et al., 2015), and Ecuador (Orpinas et al., 2014).

Programme Outcomes: Plenty of evidence indicated the effectiveness of SFP (10-14) in the U.S., for several outcomes. Among the primary outcomes: delaying the use of alcohol and other drugs (e.g., Spoth, et al., 2004, Spoth et al., 2006, Spoth, et al., 2009), decreasing exposure to substance use (Spoth et al., 2012), prevention of new users (Spoth, et al., 2001), a long-term decrease of drug abuse (e.g., Spoth et al., 2009; Spoth et al., 2014), misuse of medications

(Spoth, et al., 2008), long-term academic success, and school engagement (Spoth, et al., 2008), and also effects on non-participating adolescents (Rulison et al., 2015). Moreover, some of the secondary outcomes were positive affect, support, involvement, and closeness (Coatsworth et al., 2015), as well as direct and indirect effects on the improvement of parenting practices (e.g., Cantu et al., 2010; Coatsworth et al., 2010; Orpinas, Reidy, et al., 2014), cohesion and family involvement (e.g., Chilenski et al., 2016, Riesch et al., 2012), and fewer depression-related symptoms in adulthood (Mason et al., 2017; Trudeau, et al., 2007). Long-term decrease of antisocial behaviors (Spoth et al., 2000), and risky sexual behavior (Spoth et al., 2014), long-term positive relationship (Spoth et al., 2019), and better problem-solving skills in the medium term (Semeniuk et al., 2010) were also observed.

The SFP:10-14 seven-session version for universal families of junior high school students has been developed and implemented in rural Iowa (Trudeau et al. 2012, 2015). Results of a randomized control trial with 5 years of follow-up found this SFP for 10- to 14-year-olds modality effective in significantly reducing alcohol and drug abuse (Spoth et al., 2014). Ten-year follow-ups of SFP 10 -14 to 22 years of age have resulted in two- to threefold reductions in lifetime diagnosed mental health problems like depression, anxiety, phobias, and personality disorders (Spoth et al., 2005, 2014). Long-term outcomes were also positive for reduced methamphetamine use (Spoth et al., 2005, 2014). New comparisons of the shorter SFP 10 to 14 to the longer SFP 3 to 5, 6 to 11, and 12 to 17 for higher risk families using the same populations and instruments found the longer version produced considerably larger outcome effect sizes (Kumpfer, et al., 2007).

Results in Europe were varied with mixed results found in Germany and the UK, positive results in Spain, and null findings reported in Poland and Sweden. In Germany, no significant difference was found concerning the following primary outcomes: first use of drugs, drug use in the past 30 days, the lifelong use of alcohol and marijuana (Baldus et al., 2016), and general drug use (Bröning et al., 2017). Secondary outcomes included significant improvement in children's behavioral problems (Bröning et al., 2017). In the UK, the results indicated a significant decrease in secondary outcomes, such as child conduct problems (Lindsay & Strand, 2013), youth difficulties in communication and emotional management, and parent emotional symptoms (Coombes et al., 2009). Significant decrease in the primary outcomes was also noted, such as misuse of alcohol and drugs (Coombes et al., 2009), as well as an increase in secondary outcomes, such as parents' mental well-being, parenting skills (Lindsay & Strand, 2013), and parenting limit setting, and prosocial behavior (Coombes et al., 2009).

Outcomes in Latin America were also varied. Secondary outcomes such as decreases in yelling, insulting, and loss of control in light of adolescent bad behavior were reported in Chile (Corea et al., 2012). Improvements in parenting practices and parental self-esteem were reported in Honduras (Vasquez et al., 2010). Positive changes in adolescent behavior, parenting practices, marital and family relationships were reported in Panama (Mejia, et al., 2015). Improvement in positive parenting and parental hostility were found in Colombia and Bolivia. Parental involvement, consistent discipline, parental monitoring, and parental communication about risky behaviors improved in Ecuador (Orpinas et al., 2014).

Concerning primary outcomes included null findings or a lack of evaluation of primary outcomes. For example, null results were found in Chile (Corea et al., 2012) and Honduras

(Vasquez et al., 2010). Primary outcomes were reportedly not evaluated in adaptations in Bolivia, Colombia, and Ecuador (Orpinas et al., 2014), as well as in Panama (Mejia et al., 2015). Replications of programme effects were demonstrated with universal, selective, and indicated populations of families (Kumpfer et al., 2008).

1.5. Aim and objectives of the study

The primary aim of the study was to operationalise the recommendations in the international dissemination process adopted and published for the adaptation of the SFP programmes. The study used the SFP: 10-14 programme as an illustrative case of proposed adaptation for use in the South African context. These recommendations primarily focused on the cultural appropriateness of the programme whilst maintaining the integrity of the original programme.

The recommendations for adaptation was formulated along objectives:

1) to identify effective programmes aimed at reducing or delaying onset of health risk behaviours in pre- and early adolescence from good quality literature;

2) to develop a concept map of suggested adaptations to the SFP 10-14 programme made by stakeholders;

3) to develop a guideline of actionable steps to follow in the adaptation of the SFP-programme that will still maintain the integrity of the SFP 10-14 programme protocols and the international dissemination process.

1.6 Theoretical framework

A modified version of the Cultural Adaptation Process recommended by Castro et al. (2010) was utilized in this study. In their article examining the issues and challenges of cultural adaptations, Castro et al. (2010) outlined several stage models including the process for international dissemination for SFP programmes published by Kumpfer et al. (2008). Castro et al. (2010) included the following published guides for the cultural adaptation process of evidence- based interventions: Barrera and Castro (2006); Castro et al. (2004); McKleroy et al. (2006); Resnikow et al. (2000) and Wingood and DiClemente (2008). Each of the models reviewed by Castro et al. (2010) serves to help practitioners understand the prevention needs of target communities, as well as to standardize and guide the cultural adaptation process. Castro et al. (2010) proposed that they could be placed on a continuum and distilled a cultural adaptation process that reportedly has greater universality. This process model was deemed appropriate and preferred for the present study as it was more comprehensive and was applicable beyond SFP programmes.

The cultural adaptation process comprised of nine steps: One, an initial assessment of the target population's risk factors and etiological precursor to such factors. Two, the careful selection of an evidence-based intervention which has a proven evidence of effectiveness, and which best fits the needs and requirements of the target population. Three, the establishment of an advisory group which can review the original intervention materials in order to determine the appropriateness of the selected intervention programme, and to determine the types of cultural adaptations that are needed. Four, identification of experts to assist in the cultural adaptation of programme components. Five, staff selection and training/supervision to ensure quality

implementation. Six, the production of a draft version of the programme which includes initial cultural adaptation changes (maintaining high fidelity to core elements). Seven, the production of a final culturally adapted programme which integrates feedback from previous stages. Eight, implementation of the culturally adapted programme and conscientious monitoring of programme fidelity. Nine, research and dissemination of study outcomes and the effectiveness of the culturally adapted version of the programme (Barrera and Castro 2006; Castro et al., 2010; Kumpfer et al. 2008; McKleroy et al. 2006).

1.6.1 Application of the Adaptation model in the present study.

1) Initial assessment of risk factors and etiological precursors. The narrative literature review was used to fulfil the criteria of the first step. It provided an account of the risk factors and etiological precursors of health risk behaviours in youth in the South African context. Based on the large volume of research conducted on health risk behaviours, this was an appropriate way to address the objectives of the first step in the adaptation process model.

2) Selection of an evidence-based intervention. The second step speaks to the careful selection of an evidence-based intervention which has a proven evidence of effectiveness, and which best fits the target population's needs and requirements. This step corresponded to the first objective of the study. Phase One entailed a systematic review conducted to identify programmes from good quality literature reporting on interventions aimed at delaying, reducing or preventing engagement in health risk behaviours.

3) Establishment of an advisory group. The third step entailed the recruitment of stakeholders into a group which can advise on the appropriateness of the selected intervention

programme and recommend the types of cultural adaptations that were needed. This step corresponded to the second objective of the study addressed in Phase Two. Youth, parents, and teachers were recruited to be part of the stakeholder review process and gave input into adaptation components. Thus, concept mapping was used to facilitate engagement with stakeholders as an advisory group. The insights of the advisory group were used to create concepts maps about proposed adaptations to the SFP:10-14 programme.

4) Identification of experts. The fourth step set out to identify experts to assist in the cultural adaptation of programme components. For the purposes of the present study, subject matter experts who were trained and experienced in youth development and education, were identified and recruited. They formed part of the concept mapping in Phase Two. Thus, concept mapping covered the third and fourth step in the adaptation model.

5) Staff selection and training/supervision. The essence of the fifth step was ensuring that staff involved with the adaptation were appropriately trained and competent. In this instance the primary researcher was responsible for the execution of the theoretical adaptation of the model. To satisfy this step, the primary researcher completed a 21-hour facilitator training course and is certified to facilitate the SFP 10-14 programme (**Appendix N**). The SFP programme developers offered the course which provided a basis for understanding of the programme that in turn would ensure quality implementation. By doing so the primary researcher was able to understand what was required for fidelity and what would be required for holding the integrity of the programme. This step was modified for the present study.

6) Production of a draft version. The sixth step entailed the production of a draft version of the programme which included an initial cultural adaptation change. This study did not attempt adaptation to the programme content. The modification of this step was to shift the focus from the adaptation of content to the process of adaptation to be followed that will produce a more contextually relevant adaptation. The present study aimed to make recommendations on factors that must be considered for adaptation of the SFP 10-14 programme for use in South Africa.

7) Production of a final culturally adapted programme: This step entails the finalization of the adaptation programme and it usually follows several attempts at piloting. This step was not applied in the current study.

8) Implementation: The eighth step refers to the implementation of the culturally adapted programme and conscientious monitoring of programme fidelity. This study did not include an implementation phase, but merely made recommendations of factors that need to be considered for adaptation of the SFP:10-14 programme should it be implemented in the South African context.

9) Research and dissemination of study outcomes: The ninth step involves research and dissemination of study outcomes. The step typically refers to research on the effectiveness of the culturally adapted version of the programme. This step in the present study was modified to reflect the dissemination protocol for the present study. This research will first be presented in the form of a monograph or dissertation.

The framework for cultural adaptation proposed by Castro et al. (2010) was modified and adopted as the theoretical framework of the study. The modification included the omission of the seventh and eighth steps as these related to implementation. The fifth, sixth and ninth steps were modified and applied in a reduced manner. Thus, the theoretical framework informed the conceptualization of the study, the formulation of research objectives and subsequent selection of methods in order to achieve methodological rigour and coherence.

1.7 Conceptual overview of methodology

The study was conceptualized as a multi-phase study. Each phase has its own methodological elements and feeds in the successive phases. Each phase also attempts to address specific objectives. The sections below provide a brief overview of the methodologies employed in each phase. Operational aspects of the methods are provided later with the results in order to have a greater sense of coherence and for ease of reporting.

1.7.1 Phase 0 – Narrative literature review.

This phase is the precursor to the formal methodology of the study. In this phase, an academic rationale is developed for the study that incorporates a narrative review of the literature, the formulation of a problem statement and a rationale for the study. This initial process forms the theoretical tenets underpinning subsequent methodological decisions. The conceptualisation of the study took place in 2013. Thus, the evidence provided from the body of literature will largely reflect published findings up to 2013. Literature published between 2013 and 2022 will be incorporated to demonstrate a clear link between the active phases of the study including conceptualisation, execution and subsequent write up.

1.7.2 Phase 1- Systematic Review.

This phase of the study addressed the first objective. Thus, the first phase set out to achieve the consolidation of literature reporting on family-based intervention programmes aimed at reducing or delaying the onset of HRBs in pre-and early adolescents. Through this filtration process, good quality literature was identified from which effective intervention programmes could be identified. This phase essentially aimed to establish a basis of empirical evidence for programmes and to identify how the SFP 10-14 programme fares against other programmes reported on in good quality literature. Thus, this phase required a filtration process that used methodological rigour and coherence as a basis for identification of good quality literature. To this end, systematic review methodology was adopted.

Systematic reviews are typically based on a defined search strategy that aims to detect as much of the relevant literature as possible. A Systematic review is a means of identifying, evaluating and interpreting available research relevant to a particular research question or topic (Greenhalgh, 2006). It is considered secondary research and the highest level of evidence (Wardlaw, 2010). Systematic Reviews identify high quality research evidence from identified databases and sources through an appraisal process (Green & Higgins, 2008). The use of overt, systematic methods in systematic reviews also reduce bias (Wright et al., 2007). These strict methodological processes followed in a systematic review allowed the researcher to provide filtered information on the topic, which means that a higher level of evidence was upheld (McGowan & Sampson, 2005). The meticulous recording procedure in the methodology enables other researchers to measure the quality of the review, as well as replicate the study as the methods of a systematic review are clearly defined (Hemingway & Brereton, 2009).

The systematic review protocol can be seen as a guideline to ensure that the review adhered to the highest level of quality in operations (Hemmingway & Brereton, 2009). The purpose of this systematic review was to identify empirical evidence about family-based intervention programmes for preventing, delaying and reducing engagement in health risk behaviours amongst pre-and early adolescents.

1.7.3. Phase 2 – Stakeholder Review

This phase of the study addressed the second objective. The aim of this stage was two-fold: a) to collect stakeholder' perceptions about the content that should be included in a family-based intervention programme to prevent, delay and reduce engagement in HRBs by pre-and early adolescents, and b) to develop a concept map of contextual factors that could inform adaptation.

The second phase attempted to enlist stakeholder participation in the brainstorming around the adaptation of the SFP:10-14 programme. This stage incorporated concept mapping as the major design element. Concept Mapping applies an action research approach in which the participants are actively engaged throughout the research process (Pokharel, 2009). This gives the participants an informed practical reality and experience (Ali et al., 2017). Concept mapping begins by asking participants a "brainstorming" question to which they provide short statements as answers. Concept mapping allows for both qualitative and quantitative methods to be used (Trochim & Linton, 1986; Trochim,1989, Wheeldon & Faubert, 2009).

This study used a modified version of concept mapping to identify qualitative concepts from sessions with identified stakeholder groups. A concept map was developed based on the

input of participants on adaptation of the programme. In this instance, the elements included in the concept map was considered in the subsequent adaptation of the programme in Phase Three.

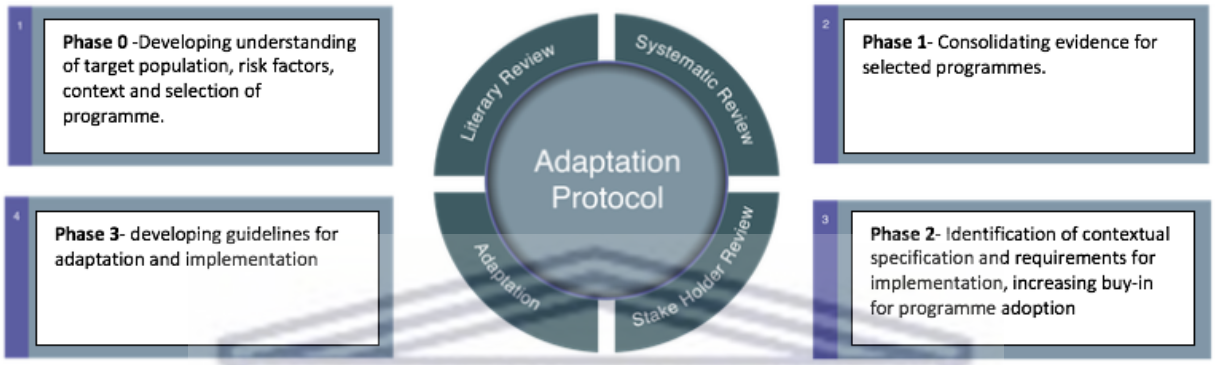
1.7.4 Phase 3: Adaptation guidelines.

Phase Three addressed the third objective of the study. Consequently, this phase included two sections: Section One identifies the decisions and recommendations made about the theoretical adaptation of the SFP-10-14 programme. The findings from the first and second phases informed the adaptation process. Section Two entails the development of actionable steps that will inform an adaptation guide for SFP 10-14 programme.

In short, Phase 0 entailed a narrative review to gain understanding of the target group, risk factors, and context issues, as well as the selection of programmes. Phase 1 consolidated evidence for effective intervention programmes and assessed where SFP featured in this body of evidence via a systematic review. Phase 2 engaged stakeholders to identify contextual specifications and requirements for implementation. This in turn increased buy-in for adoption of adapted programme. Finally, Phase 3 sets out to develop a guideline of actionable steps for adaptation and implementation. **Figure 1** below is a graphic representation of the phases of the study.

Figure 1

The Four Phases of the Current Study



1.8 Ethics

Registration and ethics clearance (Reg. No. 13/4/25) for this study was granted by the Senate Research Committee of the University of the Western Cape (**Appendix A**). The title, however, was changed as it reflected the focus or content of the thesis. The title change has gone through the higher degrees and ethics committees where the members determined that the revision of the title did not have any methodological implications and therefore, no further amendments were required. The title on the appendices reflect the title that was approved at the time of data collection.

Phase 2 and 3 had accompanying information letters/ brochures (**Appendices B-E**) that: 1) stipulated and explained the rights of the participants and the responsibilities of the researcher, and 2) emphasised that participation was voluntary, and that all participants were free to withdraw from the study whenever they wanted without loss of perceived benefits and risk of judgement for each stakeholder group. Participants completed consent and assent forms

indicating their willingness to participate in the study (**Appendices F-I**). The consent letters reflected the particular information related to the respective phases. The participants were not subjected to any danger or harm during the research process. All data and information stored in a password protected electronic folder.

1.8.1 Specific ethical considerations per phase

1.8.1.1 Phase One

The research in Phase one was non-reactive and data were collected from published articles that formed part of the public domain. I was able to legally access the databases subscribed to by the UWC library for my fieldwork as a registered student at UWC. The research process was transparent and detailed, and it is possible to replicate. General ethical responsibilities such as, maintaining objectivity and integrity; thoroughness in searching; adherence to the highest possible technical standards; indicating the limits of the findings and the methodological constraints that determined the validity of such findings, were maintained. The researchers involved in the fieldwork did not change their data or observations in accordance with the recommendations by Babbie and Mouton (2000). To ensure accountability, the fieldwork was managed by a team of reviewers under the guidance of the principal researcher. The quality and integrity of methodological rigour was enhanced by allowing the reviewers to replicate searches on each other's databases to ensure replicable and verifiable findings under the supervision of the primary researcher.

1.8.1.2 Phase Two

In Phase Two, permission from targeted stakeholders were obtained. Where necessary,

verbal permission from principals and the independent school's Board of Directors were requested to grant access to the school, and permission to conduct the research. Participation in the stakeholder review groups was voluntary. Participants had the right to withdraw at any time without fear of negative consequence or loss of perceived benefits. As mentioned before, information sheets documented the purpose of the study and the rights of participants. An additional briefing was facilitated with eligible participants to underscore the abovementioned. The principle of confidentiality was addressed in two ways. For focus groups, participants were required to sign a binding confidentiality agreement in which they undertook to not disclose the identities of other members and the nature of their contributions. As mentioned, data and content were kept in password protected folders to ensure only authorized access. All identifying details of participants were de-identified through assigning participant codes in order to promote anonymity. Everyone was asked to sign a consent and assent form and was supplied with an information sheet with a short summary of the aim of the stakeholder review group (and study), as well as contact details of the researcher, supervisor and university. Sign-up sheets were signed by each participant of the stakeholder review (**Appendix J-L**).

1.8.1.3 Phase Three

This phase was theoretical in nature. Two primary ethics considerations were applied. First, permission was obtained from the programme owners to adapt the SFP 10-14 for the South African context (**Appendix M**). The permission for adaptation was limited to theoretical adaptation and development of guidelines. The permission excluded implementation. The second consideration was ensuring that data and findings from the respective phases were applied and integrated without distortion. The maintenance of data integrity was further supported through

the adoption of a reflexive stance throughout the study.

1.9 Thesis organization

This thesis was organized into five chapters. The first chapter provide an introduction that outlines the motivation for and context of the study, a detailed summary of the SFP:10-14 programme, objectives of the study, the theoretical framework underpinning the study, an overview of the important methodological and theoretical decisions made in the study, as well as the ethical considerations pertaining to each phase of the present study. The second chapter summarises the narrative review of empirical research on the body of literature specific to HRBs in pre-and early adolescents, risk and protective factors relevant to this target group, as well as current intervention programmes implemented to reduce and prevent HRBs in pre-and early adolescents. Thus, the first two chapters constitute Phase 0.

As mentioned before, conceptualisation took place in 2013 and the execution of the study took place thereafter and was concluded in 2018. Therefore, the first chapter focuses on demonstrating how the body of literature informed the formulation of the study objectives drawing on publications up to 2018. Chapter Two aims to demonstrate knowledge of the body of literature and mastery of critical engagement with literature. The academic rationale developed in this chapter draws on literature up to 2013 to demonstrate how the conceptualisation was influenced by the body of literature at that time. The phased nature of the study makes it possible to also draw on literature up to 2018 that influenced methodological decisions. This chapter has an additional section that summarises literature published post 2013. In this summary there is a reflection on substantial changes in the literature post conceptualisation and execution. The aim

is to demonstrate an awareness of the current literature and identify trends and findings that may impact the write up of the study. Issues that would have resulted in significant changes in conceptualisation will be identified in this manner and considered critically in the discussion, conclusion, recommendations and limitations of the study.

Chapter Three reports on Phase One and objective one. The chapter reports on the operational steps and results of the Systematic review. Chapter Four reports on Phase Two and the second objective. The chapter reports on the operational steps and results of the stakeholder reviews. Chapter Five reports on Phase Three that includes the third objective. The chapter reports on the operational steps and results of the Adaptation, as well as guidelines for the adaptation of the SFP 10 – 14 programme. The chapter then concludes the thesis with a conclusion section, statements regarding limitations of the study, recommendations for further study, and the contributions of the study.

CHAPTER TWO: PHASE ZERO – NARRATIVE LITERATURE REVIEW

The aim of this chapter is to provide a broad overview of the existing literature on pre- and early adolescents HRBs and the current interventions used to prevent or delay the onset of the HRBs, as an academic rationale for the study. As mentioned in the first chapter the narrative review prioritizes publications relative to the conceptualisation of the study. The body of literature reviewed includes a number of areas such as: biopsychosocial aspects of adolescent risk-taking, risk factors, protective factors, evidence-based intervention strategies, and theoretical justification for family interventions. The chapter also provides an academic rationale for its selection to adapt to the South African context. An overview of the SFP 10-14 family-based intervention programme was also provided. Finally, the chapter concludes with a summary of the gaps that remain in the literature.

2.1 Biopsychosocial aspects of adolescent risk-taking

Seminal references identify adolescence as a developmental stage characterized by dramatic physical, cognitive, social and emotional changes (Spear, 2000). For most adolescents, it is a period marked by rapid physiological change, increased independence, a change in family

relationships that is more interdependent, prioritizing peer affiliations, initiation of intimate partner relationships, identity formation, increased awareness of morals and values, and cognitive and emotional maturation (Lerner & Castellino, 2002). This interdependent, individual and contextual evolution presents multi-system challenges constituting the basis of risk, resiliency, and opportunity in adolescence (Steinberg, 2014; Geidd, 2015).

The relationship between adolescence and risk-taking behaviour has been depicted as a dynamically evolving theoretical construct informed through biological, psychosocial, and environmental lenses (Sales & Irwin, 2009). In line with this ideology, the National Institute of Health (NIH) issued a report explicitly stating the need for a better understanding of the interaction between biology, environment, and behaviour, and stressed the utility of such an approach for advancing our understanding of behavior, particularly behaviours which place one at risk (Working Group of the NIH Advisory Committee, 2004). Adolescents are understood to be simultaneously biological and cultural beings (Miller, 2002). Culture is defined as a dynamic system of shared activities and meanings (Greenfield et al., 2003; Swanson, et al., 2003).

Biology is described as mutually informing the process of development (Lerner, 1992; Greenfield et al., 2003). Adolescence is a period marked with hormonal changes (increased reproductive/sex hormones, including estrogen, testosterone, etc. (Spear, 2000). Puberty is associated with increases in gonadal sex hormones and hormones have been postulated to play a role in brain development and in adolescent risk-taking (Irwin & Millstein, 1986; Shirtcliff, 2009; Steinberg, 2008). Hormones influence brain maturation of white matter (Asato et al., 2010; Perrin et al., 2008), and sex hormones contribute to the reorganization of dopaminergic neurons in the motivational system which can then lead to behavioral manifestations in puberty

(Shirtcliff, 2009; Sisk & Zehr, 2005; Steinberg, 2008). These factors make adolescence and puberty particularly vulnerable periods, especially for young females in regard to sexual decision-making.

The cultural meaning ascribed to physical maturation and the process of social redefinition during adolescence may vary significantly throughout cultural, social, and historical contexts (Steinberg, 2002; Swanson et al., 2003). Theorists and clinicians have historically differed in their chronologic definition of these sub-stages. Neinstein et al. (2008) designated early adolescence as approximately 10 to 13 years of age, middle adolescence as approximately 14 to 16 years, and late adolescence as approximately 17 to 21 years. Feldman and Elliott (1990) described early adolescence as 10 to 14 years, middle adolescence as 15 to 17 years, and late adolescence as 18 years to the mid-20s. Other prominent researchers separate youth into early adolescence (10 to 14 years), late adolescence (15 to 19 years), and young adulthood (20 to 24 years) (Irwin et al., 2002). Although there seems to be no accepted chronological definition for transitional age youth, there is however, a global consensus on two aspects: First, transition into adolescence starts much earlier (Ervin et al., 2002; Feldman & Elliott, 1990; Neinstein et al., 2008). Second, adolescence it associated with heightened risk-taking behaviour (Eaton et al., 2012), Health risk behavior was identified as a developmental characteristic of adolescence and included tobacco use, engagement in alcohol and/or other drugs (AOD), unsafe sexual behavior (e.g.; Burnhams et al., 2009; Pharaoh, 2015; Pharaoh et al., 2018; Plüddemann et al., 2010; Reddy et al., 2011; Steinberg, 2008).

This critical developmental period is conventionally understood as the years between the onset of puberty and the establishment of social independence (Steinberg, 2014). Despite the

rapid change, the majority of adolescents cope successfully with the demands of physical, cognitive, and emotional development during this time period (Cicchetti & Rogosch, 2002). In addition to the "positive growth" seen during adolescence, it is also a developmental stage recognized for turmoil and challenges, partly due to increased exploration and risk-taking typical of adolescence (Cooper et al. 2000; Visser & Routledge, 2007). Although considered to be a normative part of adolescence, risk-taking behaviours are nonetheless concerning to parents, peers, teachers, clinicians, researchers, and society, because these actions often endanger adolescents' current and future health and well-being (Sales & Irwin, 2009). In both western society and globally, adolescent achievement of independence and self-sufficiency is not universally prioritized over conformity to familial and cultural identity, expectations and obligations (American Psychological Association, 2017; Zimmer-Gembeck & Collins, 2003).

Adolescent risk-taking is concerning, because of the immediate danger it poses and the empirically supported pattern that behaviours established during adolescence often persist into adulthood (Park et al., 2006). The potential long-term consequences of engaging in the most prevalent adolescent risk-taking behaviours include substance abuse, cancers associated with tobacco use, unwanted pregnancies, sexually transmitted infections (STIs) including HIV, obesity or other health problems caused by problem eating (i.e., eating disorders), and serious criminal activity (Sales & Irwin, 2009). For instance, in 2010 the Monitoring the Future Study found that 41 % of high school seniors had consumed alcohol in the past 30 days, and over 35 % used marijuana in the past year, with 6.1 % using marijuana daily, and that the use of non-prescribed prescription-type drugs was high (21.6 % lifetime use) (Johnston et al., 2011). Specific to sexual behaviour, after a decade of declining adolescent pregnancy rates, in 2006 the numbers increased (Center for Disease Control and Prevention [CDC], 2008). In 2007 a report

by the CDC indicated that one in four adolescent females have had an STI, with rates doubling in certain subgroups (Forhan et al., 2008). In South Africa, statistics on prevalence rates of youth engagement in problem behaviours ranging from substance use and violence to academic failure are also very staggering (Reddy et al., 2011, 2013).

Risk behaviour is usually studied in relation to adolescent development, because it is usually during this period of development that risk behaviour makes its debut (Cooper et al. 2000; Visser & Routledge, 2007). Among youth rebelliousness, impulsivity, irresponsibility, and an inclination towards experimentation are characteristics often conceptualized as normative and transitory (Colman et al., 2007). Young people during this period experience substantial and often very stressful changes in their physical, cognitive and social functioning, which makes them more susceptible to the social challenges that they face (MacPherson et al, 2010; Moffit et al, 2002; Smith-Khuri et al, 2004; Windle et al, 2008). Risk behaviours are prevalent during adolescence when challenges of adapting to social, emotional and cognitive changes are increasing (Catalano et al., 2012; Dodge & Albert, 2012; Ellis et al., 2011; Fischer et al., 2011). Risk behaviour involves purposeful action resulting in losses or gains (Catalano et al., 2012; Fischer et al., 2011). This tendency, as mentioned before, can be understood as the adolescent's self-imposed rite of passage into adulthood (Dodge & Albert, 2012; Downey et al., 2010). It is a transition described as the 'window of vulnerability and opportunity (Ellis et al., 2011, p. 603).

Youth who start drinking early reportedly are at an elevated risk of using alcohol and hard drug abuse later in life (Brook et al, 2004; Colman et al, 2007; Sourander et al, 2007). The WHO (2002) observed the earlier age of onset of alcohol use by pre- and early adolescents as a problem and suggested using effective strategies to delay the onset of alcohol use. SACENDU

(2017) also reported an alarming increase in 10–14-year-olds involved in AOD treatment (Dada et al., 2017). The unhealthy behaviours that emerge during the pre- and early adolescent years may have effects on psychosocial functioning throughout later adolescence and adulthood

(Chowdhury et al., 2010; Hawkins et al., 1992). A potentially powerful predictor of progression to alcohol-related harm is age at first use (DeWitt et al., 2000). Evidence suggests that the earlier the age at which young people take their first drink of alcohol, the greater the risk of abusive consumption (Flisher et al., 2003; Hawkins et al., 1992). Similarly, DeWitt et al. (2000) reported that the development of serious problems in later adolescence was significantly correlated with early age of first-time use. Explanations concerning why early alcohol use increases the risk of later alcohol problems are varied. Some experts assert that early use interferes with important cognitive and social learning processes that determine healthy social functioning in later life (Parry, 2005). Others suggest that early use is simply a correlate of some unknown condition or circumstance (e.g., childhood psychiatric disorder) that is causally related to the manifestation of alcohol problems (Degenhardt & Hall, 2006; Pluddemann et al, 2010; Russel et al., 2008; Yen & Chong, 2006). A third position suggested that using alcohol in early adolescence increases the vulnerability to subsequent alcohol problems, because it occurs at a time when environmental conditions strongly support continued and more regular use (Flisher et al., 2006; Jernigan, 2001, Parry et al, 2004). These aspects combine to increase youth introduction to risky situations and thereby contribute to dramatic increases in substance use and antisocial activities (Smith-Khuri et al., 2004; Windle et al, 2008).

To determine prevalence of behavior, the US Centers for Disease Control and Prevention (Eaton et al., 2012) conducted national biennial surveys of health-risk behavior involvement

among high school samples, and twice conducted a similar survey among selected middle school samples. The Health Behavior in School-aged Children conducted in 43 countries in the WHO regions of the Americas and Europe targeted youth aged 11 to 15 and their responses to items about tobacco use, alcohol use, cannabis use, sexual behavior, fighting, bullying, physical activity, eating habits, body image, oral health (Inchley et al., 2016). Trends in behavior from both surveys were similar across the Americas and Europe. Overall findings from the CDC revealed that about one-third reported physical fighting, nearly all felt safe at school, nearly half had tried cigarette smoking, almost three-fourths reported at least one drink of alcohol during their life, and over 10% sniffed, breathed, or inhaled household substances (e.g., paint, glue) to get high (Eaton et al.,2012). Overall findings from the HBSC (Inchley et al.,2016) indicated a quarter of teens-initiated smoking before age 13, 5% reported weekly drinking at 11 years old and exceeding 15% by age 15. These two surveys seemed to indicate that health risk behaviors increase markedly from young to middle adolescence.

In South Africa, there is a dramatic increase in the onset of health risk behaviours between pre- and early adolescents (Reddy et al., 2013). Health risk behaviours by children and adolescents, who make up 21% of the country's total population in South Africa, is of major concern (Flisher et al., 2006; Jernigan, 2001; Parry et al., 2004, Reddy et al., 2013). The youth of South Africa are constantly exposed to risks, which promote risky behaviours such as, substance use and sexual risk behaviours (Plüddemann et al., 2008), as well as earlier initiation of sex (McGrath et al., 2009). Tobacco, alcohol and cannabis are the substances that are most commonly used by children and adolescents in South Africa. In a national survey, Reddy et al. (2013) reported the following lifetime (ever having used) prevalence rates of risk behaviour among learners in Grades 8–11 at public high schools: 49.1% for alcohol; 30.5% for cigarettes

and 12.8% for cannabis. In the same study, 41.1% of learners were sexually active and 16.4% had been pregnant or impregnated someone. Aggregated prevalence rates of substance use such as these, mask inter-provincial variations. For example, the Western Cape had significantly higher rates of current use for cigarettes (36.7% vs 21%), alcohol (53% vs 34.9%), and cannabis (16.2% vs 9.7%) and alcohol bingeing (41.1% vs 28.5%) compared to the national averages (Plüddemann et al, 2008). Plüddemann et al. (2010) reported lifetime use of methamphetamine of 9% among grade 8-10 learners in a school district of the city of Cape Town in 2006. A large number of adolescents have been reported to being admitted to substance abuse counselling and rehabilitation centres in the Western Cape (based mostly in the City of Cape Town), with their most common primary substance of abuse being cannabis and methamphetamine (Dada et al., 2012).

Drug use, specifically methamphetamine, has become prevalent amongst adolescents, and leads to sexual arousal and 'pleasurable consciousness states' (Morojele et al., 2006, p. 217). This is linked to high-risk sexual behaviours such as, promiscuity and unprotected sex (Crockett, Raffaelli, & Shen, 2006; Pluddermann et al., 2008). As mentioned previously Plüddemann et al, (2010) reported that the proportion of sexually active 11th grade learners in Cape Town was 57.8% for boys and 42.8% for girls respectively. High rates of risky sexual behaviour in terms of sex with multiple partners and unprotected sex has placed teenagers at increased risk of contracting HIV and other sexually transmitted diseases (STDs) and falling pregnant (Wilson & Donenberg, 2004). As the average age of puberty has decreased over the past few decades, sexual activity is "migrating down" to very young adolescents, placing them at increased risk (White et al., 2013;Windle, 2008). The risk of HIV amongst these young adolescents is

substantial. Delaying sex until later in adolescent years reduces risk considerably (Pluddermann et al., 2008).

Increased sexual risk behaviours has been exacerbated by adolescents being prematurely exposure to the world's allures through social media (Dodge & Albert, 2012). Television programmes, which contain sexual messages serve a high function with adolescents, who are interested in learning more about sexuality, yet find it a difficult subject to broach with parents (Eggermont, 2005). Computers and mobile phones with their easy connectivity and decreased costs, make adolescents a significant group adopting these new methods of communication (Atkinson & Newton, 2010). The majority of young people from Western countries have access to the internet (Behun et al., 2012; Skoog et al., 2009). Young people are therefore able to download sexually explicit material freely and anonymously with the attraction of having a space where parents need not be present (Atkinson & Newton, 2010; Skoog et al., 2009). Online Sexual Activity (OSA) includes a range of pastimes: recreation, entertainment, exploration, education and commercial endeavours to secure sexual partners (Atkinson & Newton, 2010).

Curiosity and sexual arousal are characteristic motives for adolescent boys viewing sexually explicit material online (Skoog et al., 2009). Fischer et al. (2011) reported that a clear link between exposure to risk-glorifying media content and risk-taking tendencies has been shown in several studies. With adolescents spending a third to half their waking hours at school, schools could have significant influence in educating adolescents about their sexuality (Wade, 2011). With regards to online risk behaviours, there has been an inclination for schools to turn a blind eye to what goes on beyond the school borders (Atkinson & Newton, 2010). It is imperative to raise awareness amongst young people of the likelihood of unexpected situations occurring and

to coach them into taking preparatory actions (van Empelen & Kok, 2006). Educational programmes need to be cognisant of the broad spectrum of sexual behaviour now displayed online by adolescents. The approach should be to empower adolescents to make informed decisions about risk with appropriate responses such as, blocking undesirable messages, capturing evidence and knowing when to report concerns as grooming online can be very subtle (Atkinson & Newton, 2010).

2.2 Risk Factors

Typically, pre-and early adolescents experience marked decrease in adult involvement, support and monitoring during this stage, and an increase in peer influence as the primary social element. These factors increase the potential exposure to risky situations and could contribute to the reported dramatic increase in substance use, unplanned pregnancies, unprotected sexual activities, interpersonal violence and delinquent behaviour (Jackson et al., 2010; Kann et al., 2016). Research shows that the consequences for young people engaging in these risk behaviours include alcohol related injuries, academic, behavioural and relationships problems, as well as the development of an unhealthy life style and long-term health problems (Degenhardt & Hall, 2006; Plüddemann et al., 2010; Russell et al., 2008; Yen & Chong, 2006). Studies indicate that earlier age of onset of risk behaviour can often be prognostic of poorer health and emotional outcomes into later adolescence and adulthood (Brook et al., 2004; Colman et al., 2007; Eaton et al., 2012, Kann et al., 2016).

The most important social relationships for all children and adolescents are those with their families and peers (Peake et al., 2013; Windle, 2008). Adolescence coincides with a changing

social environment when children start high school and are faced with increasing peer pressure and the loosening of parental monitoring as they are given greater autonomy**.** They gradually spend less time with their parents and the social environment exerts a much greater influence (Windle, 2008). Younger teens seem to be more susceptible to peer pressure and perceived peer norms for sexual risk behaviours and substance use (Pedlow & Carey, 2004). Social influence is a major factor in adolescent engagement in HRBs. Adolescents are more likely to engage in risky behavior when they are with their peers than when they are alone (Dishion & Tipsord, 2011; Gardner & Steinberg, 2005; Simons-Morton et al., 2005). These risky behaviours often include substance use (e.g. Windle et al. 2008), delinquency (e.g. Moffit et al. 2002), and other potentially health compromising behaviours (e.g. Eaton et al., 2012) which needs to be addressed.

Adolescents spend more time with their peers than with their families and are particularly sensitive to peer rejection (Peake et al., 2013; Sebastian et al., 2011; Somerville, 2013). Normative conformity might be prompted by an awareness of social norm that is, people make decisions on the basis of expected or acceptable behavior in social interactions (Somerville, 2013; Stallen et al., 2013). There is strong evidence for elevated risk for engagement in drinking, smoking, marijuana use amoung youth who exhibit elevations in emotion-based traits (Combs et al., 2012; Pearson et al., 2015; Robinson et al., 2014; Zapolski et al., 2009; Zapolski et al., 2010). Adolescents with low self-esteem and difficult relationships with their families, have a greater likelihood of turning to acceptance from delinquent peers (Wild et al., 2004). A sense of low self-esteem within family and school contexts, and high self-esteem in the sphere of peers was linked with the increase of multiple risk behaviours in adolescents (Heaven & Ciarrochi, 2008; Wild et al., 2004a). Lacasse et al., (2003) reported that when adolescents make a stand against

risky behaviour they chance jeopardising their peer relationships. Similarly, Atkinson and Newton (2010) found that engagement in HRBs assists in securing recognition in the peer group and simultaneously pushes against adult boundaries. Eggermont (2005) stated that sexual debut is connected to subtle forms of peer pressure where sexual activity is linked to the adolescent's belief that friends are sexually active. Peers exert an enormous influence on teens, especially from the age of 10 however, parents still remain a powerful influence in the lives of teens, countering peer pressure for risky behaviour (Pedlow & Carey, 2004; Moore et al, 2007). This increase in risk behaviour of pre- and early adolescents remain a major concern such as, alcohol and drug abuse (Flisher et al., 2006; Jernigan, 2001; Parry et al., 2004), unplanned pregnancies and unprotected sexual activities (McGrath et al., 2009), interpersonal violence and delinquent behaviour (Flisher et al., 2010; Plüddemann et al. 2010).

2.3. Protective Factors

Family factors, including quality caregiving and confident parents, who legitimately have the right to impact their child's health risk behaviours are important in predicting child outcomes (Cluver et al., 2007; Jaffee et al., 2007). Such parents are also successful at facilitating positive adolescent behaviours (Windle et al., 2008). Parental disapproval of risky behaviours and substance use, and successful parent-child communication, is related to lower levels of adolescent risk behaviours (Resnick et al., 1997; Spoth et al., 2004). Numerous studies confirmed the positive impact of appropriate parental communication and monitoring on delaying and preventing high-risk sexual behaviours (e.g. Kirby, 2001; Pedlow & Carey, 2004; Sumter et al., 2009). Henderson et al., (2009) agreed that family and parenting factors are among the strongest predictors of substance abuse and delinquency in adolescents. They suggest that

improved family relationships and parenting, specifically parental monitoring and more positive parenting-adolescent relationships, would mediate changes in teens' drug use over time (Liddle et al., 2009; Spoth et al., 2008). The impact that parents have on risky sexual behaviour has been underestimated. For example, research revealed that feeling connected to the family reportedly decreases the risk of becoming engaged in risky sexual behaviour (Moore, 2007; Saewyc et al., 2008). On the contrary, less availability of parental figures in the family is directly associated with risky sexual behaviour (Spoth et al., 2004).

Often parental monitoring is absent and children are left in the care of older siblings. A strong predictive relationship links ineffective child rearing in early adolescence with elevated levels of substance use and delinquent behaviour in later adolescence (Dishion & Patterson, 2006). Furthermore, reports claimed that parents who are over-involved and authoritarian or under-involved and permissive, increase the risk of early sexual behaviour (Howell, 2001; Longmore et al., 2009). The perceived absence of parental monitoring has been associated with contracting STDs, decreased condom use, risky sexual partners and increased substance use (Kim & Neff, 2010). Ideally, parent-teen communication should occur before sexual initiation as findings show that once youth initiate sex, it is difficult to return to abstinence (Pludderman et al., 2010). Encouraging parent-teen communication and assisting in appropriate monitoring of teens' behaviour is a vital intervention strategy (Pedlow & Carey, 2004). Parental involvement (preferably both parents) reportedly is associated with a later entry into sexual engagement (Kim & Neff, 2010). Similarly, parental involvement is associated with decreased likelihood of adolescents engaging in high sexual risk behaviours or drug use (Homma et al., 2012). It is evident that children who live in communities with strong support structures such as nurturing parents, school; teachers, and good interaction with peers, develop normally and exhibit healthy

behaviours and values (Buschgens et al., 2010; Ellis et al., 2012; Fergus & Zimmerman, 2005; Heaven & Ciarrochi, 2008).

2.4. Evidence -based Interventions

The pre- and early adolescent developmental stage does present particular opportunities to reinforce youth competencies and build coping skills, thereby reducing risks for other problem behaviours (Carnegie Council and Adolescent Development, 1995; Molgaard et al., 2000). Strong competencies, such as coping and decision-making skills, bonding to school, and positive parent-school involvement function as pre- and early adolescents' protective factors, reducing risk for escalating substance use and problem behaviours (Hawkins et al., 1992; Molgaard et al., 2000). Life skills education has gained increasing support as a strategy to address risk behaviour (Atkinson et al., 2004; Foxcroft et al., 2003). Experiential techniques and participatory methods such as, role-play, are employed to help young people gain knowledge; make positive, healthy decisions; examine attitudes; develop skills and avoid risks. Numerous programmes were developed to address the increasing levels of health risk behaviours in youth (Flisher et al., 2008; Reddy et al., 2011). These programmes included numerous foci including, but not limited to harm reduction, skill development, and youth and peer group support (Harrison et al., 2000). Howard et al. (2002) concluded that the focus on psychoeducation in intervention programmes was not enough for behaviour.

In South Africa however, there is very little concrete, accurate and detailed evidence that prevention programmes implemented are based on evidence–based practice (Myers et al., 2008, Pharaoh et al., 2018). In a study on youth–focused alcohol and other drug prevention

programmes conducted in the Cape Town Metropole, key findings suggest that most prevention programmes are not guided by EBP and are implemented in the absence of evidence on their effectiveness (Burnhams et al., 2009). This raised questions about the quality and effectiveness of prevention services and the success of efforts to prevent or delay substance use among young people in South Africa (Burnhams et al., 2009). EBPs are practices, interventions or programmes for which there is a large body of research evidence in support of its effectiveness (Myers et al., 2008). These EBPs reach beyond geographical boundaries and consequently can be applied to the South African context with only minor adjustments specific to age groups, linguistics, context, and cultural diversity (Myers et al., 2008). It is important to ensure that interventions respect and are sensitive to cultural diversity, because they are only likely to be most effective when culturally appropriate (Botvin & Griffin, 2004; Tsarouk et al., 2007). Over the years, researchers and programme developers have been exploring how best to culturally adapt effective programmes to a specific environment or context and population. The basic challenge faced by many researchers and practitioners who would use research-based programmes is how to fit a programme to a special set of circumstances, while remaining true to the core elements that made the programme effective in the first instance (Wegner et al., 2008; EMCDDA, 2010).

A further criticism of programme development is that stakeholders (youth, parents, educators, etc.) have not sufficiently been consulted (Howard et al., 2002). Harrison et al. (2000) identified that the lack of consultation result in reduced buy-in. Furthermore, the programmes appeared to have targeted either parents or youth, but not both as a unit (Sumter et al., 2009). Thus, there is a need for family-based interventions.

As mentioned before, there has been a consistent failure in the past to include a family-focused approach to address these challenges within the family setting (Sumter et al., 2009). Certainly, members of families are interrelated and interdependent parts of a whole. All family members have a stake in maintaining the delicate balance in their relationship patterns. The action of one member affects all others, and that member is in turn affected by the reaction of others. Thus, a family can be conceptualized as a system, because it is a "regularly interacting or interdependent group of items forming a unified whole (Miriam Webster English Dictionary)."

The high-risk behaviours in pre-and early adolescents is a unique crisis situation in the family context, which may in itself, therefore, necessitate a unique approach when dealing with it (Walsh, 2003). The advantage of a family-focused intervention programme is that it views functioning in context, with processes linked to challenges; all in terms of an individual or family's particular resources and challenges (Greeff & Du Toit, 2009; Greeff & Holtzkamp, 2007). Reliable evidence indicated that parental practices of support, monitoring and communication are protective measures against risk behaviours and plays a vital role in recovery (Greeff et al., 2006; Greeff & Aspeling, 2007; Greeff & De Villiers, 2008; Walsh, 2003). Parental disapproval of risky behaviours and substance use, and successful parent-child communication, is related to lower levels of adolescent risk behaviours (Spoth et al., 2004). Hawley (2000) showed that the clinical aspects relating to family resilience remain a focus of further investigation. Research that focused on families would contribute to the body of knowledge concerning how human beings cope with adversity. Walsh (2003) showed that, although few studies have focused on the role of the family in individual coping, family survival contributes to the survival of individual members.

Greeff (2000) argued that research that focus on family is needed for a strong knowledge base from which to develop interventions. Walsh (2003) stated that research about family adaptation to crisis situations is important for knowledge of treatment and preventative programming, but that such research is still limited and in its infancy. Overall, there is substantially less research (and programming) regarding delaying or preventing substance use and high-risk sexual behaviour in younger populations (Jackson et al., 2010). Most studies conducted, focused on an intra-psychic level and peer group influence (Burnhams, et al., 2009). Few studies investigated the effects of the role of the family on individual resilience in stressful situations (Greeff & Aspeling, 2007; Greeff & De Villiers, 2008; Walsh, 2003). Empirical support was provided for programmes that adopt a family focus. The next section provides theoretical support for family-based interventions.

2.5 Theoretical Justification for Family Interventions

This section will provide a review on theory of family systems in relation to interventions for delaying and preventing engagement in health risk behaviours. The following theories were identified as major roleplayers in providing a justification for working with the family: Bowlby's Attachment Theory, Bowen's Family Systems, and Bronfenbrenner's Social Ecology Model.

2.5.1. Attachment Theory.

Bowlby's (1979) conceptualization of attachment highlighted the primordial bond between caregiver and infant. A lack of early parent/child attachment was used to explain later vulnerability and psychopathology (Stronach et al., 2011). In developing his model of attachment, Bowlby relied on a class of social behavior designed around connections to and

separation from mother to distinguish normal from traumatic development (Bowlby, 1982; Mikulincer et al., 2003). Attachment theory postulates that children develop the ability to regulate their emotions through supportive, sensitive parenting and secure attachment (Bowlby, 1979,1982). Attachment organization is theorized to be an evolutionary mechanism that serves the individual in coping with stressful situations (Oshri et al., 2015). However, if parents are abusive or unavailable, children are likely to develop an insecure attachment style (e.g., anxiety), and seek to satisfy this need for acceptance and attachment with risky attachments or risky behaviors (Mikulincer et al., 2003). Thus, a marked decrease in adult involvement, support and monitoring leads to an increase in peer influence as the primary attachment and social element, and an increase exposure to risky behaviours (Jackson et al., 2012; McDonough et al., 2015).

The effects of child maltreatment on attachment is established in childhood (Stronach et al., 2011), with this effect remaining relatively stable through adulthood (Weinfeld et al., 2000). Adult relationship researchers extended the concept of childhood attachment into adulthood using two insecure attachment dimensions, anxious and avoidant (Oshri et al., 2015). Anxious individuals fear abandonment, are obsessive, and desire high levels of reciprocity with others, whereas avoidant individuals fear intimacy and closeness and avoid committed relationships (Oshri et al., 2015; Hazan & Shaver, 1987). Recent studies demonstrate that an insecure attachment style is a risk factor for engagement in high-risk behaviors (e.g., Allen et al., 2007).

Bowlby's attachment theory has tremendous parallels with Bowen's concept of family systems theory although Bowlby placed increased emphasis on the critical importance of secure attachments and its impact on a child's behaviour (Ecke et al., 2006). However, Bowen also

stressed the fact that a primary goal of childhood is differentiation of the self (child) from parent that happens through secure attachment (Skowron & Dendy, 2004).

2.5.2. Family Systems Theory.

Probably the major impetus for a focus on improvements in the whole family system as compared to individual therapeutic approaches was wielded by psychiatrist and family therapist, Murray Bowen (Bowen 1976). Bowen strongly believed that the family should be discussed as a functional system, rather than a collection of individuals (Wylie, 1990). In other words, the unit of treatment should be the family rather than single identified members, e.g. an at-risk teen. Bowen offered a view that the driving forces underlying all human behaviour comes from the push and shove between family members striving for balance between distance and togetherness. (Bowen, 1985; Haefner, 2014). Family systems theory provide a framework to view the health of an individual, especially children and adolescents, as crucial to the family system (Bowen, 1991).

Salvador Minuchin developed *Structural Family Therapy* based on Bowen's family systems theory based after his disappointing clinical experiences in treating adolescents individually in his inpatient clinic (Weaver et al., 2013). He would see improvements in symptoms, but the adolescents regressed and symptoms returned upon their return to their home life with their families (Weaver et al., 2013). Similar to Bowen's family systems theory, problems in the adolescent's functioning was hypothesized to be rooted within the family system and not any one particular member of the family (Weaver et al., 2013). For instance, permissive parenting is associated with causing earlier onset of risk behaviours in teens (Varvil-Weld et. al., 2014). However, Greeff et al., (2006), indicated that parental support, monitoring and

communication, serves as protective measures against adolescent risk behaviours risk behaviours.

Minuchin further also hypothesized that chronic relationship issues within and between the family members and inappropriate relationship boundaries within the family and not just problems resting with the adolescent were the major contributors to the teen's maladaptive behavioral patterns (Cotrell & Boston, 2002). His new therapy techniques, instilled in structural family therapy, were designed to collaborate with the family to create a more functional and satisfying family system as a protective factor against high risk behaviours (Weaver et al., 2013). There need to be appropriate boundaries between parents and children, so parents can exert an appropriate amount of power and control within the household (Cotrell & Boston, 2002).

2.5.3. Bronfenbrenner's Social Ecology Model.

Urie Bronfenbrenner's Ecological Systems Theory of Human Development (1979) examines the complex interactions and relationships between an individual and his/her multiple social and physical surroundings during adolescent development. His theory states that there are many different levels of environmental influences that can affect a child's development, starting from people and institutions immediately surrounding the individual to nationwide cultural forces (Bronfenbrenner, 1979). The interactions that individuals have with others and with these various environments are seen as key to human development. Bronfenbrenner (1979) identifies four ecological systems: the microsystem, the mesosystem, the exosystem, and the macrosystem. The microsystem (i.e., family, school, peers) is the immediate environment in which a person is operating. When microsystems interact, a mesosystem is formed and encompasses the relationship between two or more settings (i.e., relationship between school and peers). The

exosystem is an environment in which the individual is not directly involved, but that impacts him/her anyway (i.e., relationship between parents, caregiver's place of employment, local media, community agencies). For example, an adolescent does not have a direct decision-making role in his/her parents' relationship, but an argument between them may directly or indirectly impact the adolescent, who in turn may have a response in terms of behaviours. The final ecological system identified by Bronfenbrenner (1979) is that of the macrosystem. The macrosystem consists of larger societal structures and values (i.e., social, cultural, political, religious) that do not directly impact the life of an individual adolescent, but rather society as a whole.

Bronfenbrenner (1986) proposed an additional system, the chronosystem, which examines over time the influence of environmental changes on an individual's development. The chronosystem focuses on "normative" (i.e., entering school, puberty, marriage) and "non-normative" (i.e., death, divorce, chronic illness) transitions that can occur across the lifespan and may indirectly impact development by affecting family processes and responses.

These ecological systems are interactive and are characterized by roles, relationships, and norms. The relationship and interactions between these structures change as a function of development (Muuss, 1996). According to Bronfenbrenner (1979;1986), when the relation between different microsystems is compatible, development progresses smoothly. For example, when role expectations are similar across school and home, it is expected that youth will perform better than substantial differences in role expectations occur across settings (Bronfenbrenner & Evans, 2000; Bronfenbrenner and Morris, 2006).

Bronfenbrenner (1986) saw the process of human development as being shaped by the interaction between an individual and their environment. The specific path of development was a result of the influences of a person's surroundings, such as their parents, friends, school, work, culture, and so on (Bronfenbrenner & Morris, 1986). During his time, he saw developmental psychology as only studying individual influences on development in unnatural settings (Ceci, 2006). He later accounted for the influence of time, such as specific events and changes in culture over time, by adding the chronosystem to the theory (Berger, 2012). Furthermore, he eventually renamed his theory the bioecological model in order to recognize the importance of biological processes in development (Ceci, 2006). However, he only recognized biology as producing a person's potential, with this potential being realized or not via environmental and social forces (Ceci, 2006).

2.5.4. The Development of Family-Centered Interventions

Researchers that began to construct family-based interventions took into consideration the growing sentiment by Bowlby, Bowen, Minuchin, and others that children's problems are rooted in the way parents deal with or treat their children (Farmer & Geller, 2005). However, they needed effective intervention methods to improve family bonding, communication, organization, and reduce conflict. The inspiration for these effective techniques came from B.F. Skinner's operant conditioning techniques (Bandura, 1989; Staddon & Cerutti, 2003) teaching parents to use positive reinforcement (attention, praise) for wanted behaviors and ignoring unwanted behaviors was developed into highly effective clinical methods. Patterson & Banks's cognitive behavioral change theories or skills training (1989), developed to reduce psychopathology in children and families, became the basis of most of the effective parenting

and family skills training programmes listed as evidence-based family prevention and treatment programmes (Killeen & Hall, 2001). His family techniques were designed originally for individual families in clinics, but later, along with Marian Forgatch, he developed a group-based version (Patterson et al., 2004).

Family-focused interventions proved to be particularly effective in reducing drug use and intermediate risk factors, such as conduct disorders, aggression, and family conflict, as well as improving protective factors such as social competencies, peer resistance skills, family and school bonding, school performance, and family organization and cohesion (Kumpfer & Alvarado, 2003). However, the need to offer a more comprehensive, family-focused programme aimed at reducing and or delaying the onset of risk behaviours in younger populations in South Africa remains an urgent priority despite a proliferation of risk-prevention interventions for adolescents. Criticism raised indicates that many programmes from abroad have been initiated but have not adequately been adapted for the South African context (Howard et al., 2002). Then, there are programmes that are locally developed and applied locally without a rigorous empirical adaptation process. Thus, there is a need for more comprehensive, and sustainable programming that covers a number of important issues from a systemic view with empirical evidence of usefulness for the South African context. Thus, there was a need to consolidate the literature reporting on programmes in order to identify programmes that are multi-focussed from good quality research.

2.6 Summary Statement

In summary, there is an urgent and time-sensitive need for empirical research on programming to delay or reduce engagement in HRBs in pre- and early adolescents. The Strengthening Families Programme 10-14 has been identified as a suitable programme for adaptation and piloting in SA through a filtration process by Burnhams et al., (2012). The Medical Research Council and The City of Cape Town obtained permission to explore implementation of the SFP 10-14 in the local context in 2013 (N. Burnham, personal communication, June 10, 2013). This recommendation was based on the reported efficacy of the programme (Segrott et al., 2017), the strength-based, family approach (Burnhams, et al., 2009) and the successful adaptation to other cultures (Kumpfer et al., 2008).

Adaptation would be time efficient provided that the programme is adapted to make it contextually appropriate. It is imperative to ensure that interventions respect and are sensitive to cultural diversity, because they are only likely to be most effective when culturally appropriate (Botvin & Griffin, 2004, Pharaoh et al, 2018; Tsarouk et al., 2007). Over the years, researchers and programme developers have been exploring how best to culturally adapt effective programmes to a specific environment or context and population. The basic challenge faced by many researchers and practitioners who would use research-based programmes is how to fit a programme to a special set of circumstances while remaining true to the core elements that made the programme effective in the first instance (EMCDDA, 2010). Practitioners often have to find a compromise between the need to implement a prevention programme with greatest fidelity and the need to adapt the content to different cultural situations.

Adaptations of programmes can however be achieved successfully if practitioners follow specific guidelines for successful adaptation of programmes. To this end, Burnhams et al. (2012) recommended that the following steps should and must always be considered; 1) Developing understanding of the target population and community context; 2) Selection of a programme that matches well with the population and context; 3) Specification of essential programme elements and means for fidelity implementation; 4) Identification of incongruities between the programme and the new context; and 5) Documentation and evaluation of the adaptation process and outcomes related to the adapted intervention. Similarly, Castro et al. (2010) developed the Cultural Adaptation Process (CAP) based on a review of approaches to cultural programme adaptation. Kumpfer et al (2008) developed a protocol for international dissemination for the SFP programme that is a broad guideline for cultural adaptation. There is a large degree of overlap conceptually between these approaches and process models. The guidelines are largely accepted (Bell et al., 2007) and often used interchangeably (Barrera & Castro, 2006; Kumpfer et al., 2008, McKleroy et al., 2006, Wingood & DiClemente, 2008). The challenge lies in the general nature of these process guidelines. The actual adaptation is still at the discretion of the practitioner or researcher heading the process. Thus, the onus for operationalizing these guideline principles remain a focus of further research and it lacks clear actionable steps.

The present study attempted to operationalise the recommendations in the international dissemination process for the adaptation of the SFP programmes. The study aimed to develop a guideline of actionable steps to apply when adapting the SFP10-14 programme for use in the South African context.

2.7 Literature post study Conceptualisation period of 2013

This section identifies trends in the literature that were published post conceptualisation.

1) Health risk behavior in pre- and early adolescence

The prevalence of health risk behaviours among youth is on the increase both internationally and locally. It remains a public health concern. Some of these preventable health risk behaviours may be contributory causes of morbidity and mortality (Pharoah et al., 2018). Scientists have yet to reach consensus on what exactly drives youth risk taking, however, most agree on certain key components of adolescent risk behavior, including impulsivity, sensation seeking, self-regulation/impulse control, and response inhibition (Shoshani and Kor, 2021; Tesler et al., 2020). Higher levels of impulsivity in pre- and early adolescence have been associated with drug use and aggressive behavior in adolescence (Romer et al, 2017). Similarly, sensation seeking, or the tendency to seek out new or thrilling experiences, can also lead to increased unhealthy risk-taking behavior (Duell and Steinberg, 2019). Research has found that lower response inhibition in adolescents is related to more unhealthy risk behaviors, including early cigarette smoking, and alcohol use (Mashhoon et al., 2018; Tesler et al., 2020). Statistics on early initiation of alcohol in the US suggest that 15.5 percent of high school students reported that they had had their first drink of alcohol before age 13 (Kann et al., 2018). The onset of binge drinking and binge drinking episodes typically also occurs in early to mid-adolescence (Kann et al., 2018). Early substance use and rapid progression from first drink to first intoxication are both predictors of binge drinking (Chung, 2018). Substantial

research has identified and examined the effects of binge drinking, which include alcohol poisoning, alcohol-related blackouts and injury, physical and sexual assault, unprotected sexual behavior, and problems at school or work (Chung, 2018; Kann et al., 2018; Shoshani & Kor, 2021).

Ultimately, adolescent risk-taking behavior is influenced by many complex and interacting variables, including proximal and distal contextual factors (Maslowsky et al., 2019). Parenting practices including lack of monitoring or supervision of youth, permissive attitudes toward drug use, unclear expectations of youth behavior, and no or rare rewarding of positive behavior are also risk factors for the development of substance abuse problems during adolescence (Gentzke et al., 2019). Equally influential for underage drinking are peer substance use and peer pressure. In particular, selection of peers who engage in binge drinking has been associated with early initiation and increased frequency of substance use (Gentzke et al., 2019. Other social mechanisms that may contribute to high-volume alcohol consumption include peers providing access to alcohol and peer norms that are favorable to binge-drinking behavior (Chung et al., 2018). Factors associated with where an adolescent chooses to drink, including the level of supervision, privacy, safety, and remoteness, can also impact an adolescent's drinking behavior over time (Chung et al., 2018). Frequent exposure to alcohol advertising, particularly when these advertisements are targeted specifically at teenagers, contributes to social norms around underage drinking (Meisel & Colder, 2019). Furthermore, many studies have shown that media exposure, including portrayals of teenagers drinking on television, can increase adolescents' experimentation with alcohol (Gentzke et al., 2019.)

E-cigarette use popularity among adolescents increased dramatically in 2018 (Jackler et al., 2019). The US National Youth Tobacco Survey data, as presented by Gentzke et al. (2019), and Jamal et al. (2017), indicated that current e-cigarette use varies by biological sex and race/ethnicity. They further reported that in 2018, current use was higher for males in both high school (22.6%) and middle school (5.1%) compared with their female peers (18.8% and 4.9%, respectively) (Gentzke et al., 2019; Jamal et al., 2017). Furthermore, with respect to race/ethnicity, more white high schoolers reported current e-cigarette use (26.8%) compared with their black (7.5%) and Hispanic (14.8%) counterparts (Gentzke et al., 2019; Jamal et al., 2017). However, current e-cigarette use among middle schoolers was highest among Hispanic (6.6%) compared with white (4.9%) and black (3.0%) students (Gentzke et al., 2019). Risk factors associated with cigarette use include risk perceptions, social influences from family and friends, and individual affective characteristics such as depression and sensation seeking (Perikleous et al., 2018).

Research in the United States further documents greater early onset of sexual risk taking and alcohol and drug use among teenagers in mental health care compared to their non-troubled peers (Perikleous et al., 2018; Gentzke et al., 2019). Youth receiving mental health services report early sexual initiation, sex with multiple partners, and unprotected sex (Blakemore 2018; Maslowsky et al., 2019) and they experience individual, interpersonal, familial, and environmental factors that contribute to high-risk sexual behaviours (Blakemore 2018; Maslowsky et al., 2019).

Findings from comparative research studies in Europe indicate that males were more likely than females to use alcohol (Mehra et al., 2019), engage in binge drinking (Chodkiewicz et al., 2020), to have driven or walked under the influence of liquor and engaged in physical fighting (Shapiro et al., 2022). Thus, in the US and globally, youth risk behaviour, including risky sexual behaviour, drug and alcohol abuse, tobacco and e-cigarette use and violence, is a public health concern, and South Africa is no exception (Khuzwayo, et al., 2020). A range of behaviours place South African youth at risk (Daniels & Pharoah, 2021). Although numerous interventions have been conducted to mitigate risk-taking, young people continue to practice unsafe sex, binge drink and use illicit drugs, and are involved in violence (Shuro & Waggie, 2021). Furthermore, in South Africa, although the human immunodeficiency virus (HIV) infection rate is decreasing, youth are severely affected by HIV, violence and unplanned teenage pregnancy (Khuzwayo, et al., 2020; Shuro and Waggie, 2021). It is also widely acknowledged that the high prevalence of HIV and other sexually transmitted infections and rate of teenage pregnancy are fueled by high-risk behaviours (Daniels & Pharoah, 2021).

Research therefore indicates that in the US and globally, youth risk behaviour, including risky sexual behaviour, drug and alcohol abuse, tobacco and e-cigarette use and violence, remains a public health concern, and South Africa is no exception (Khuzwayo, et al., 2020). Daniels and Pharoah (2021) postulated that if prevention could start in early childhood years, it could assist young people and adolescents in making less risky health

behaviour decisions. Thus, intervention with pre and early adolescent remained an urgent focus of research.

2) Evidence for the SFP 10-14 programme

Since conceptualization, the SFP 10-14 programme had been utilized in epigenetic studies (Brody et al., 2013), overall review research (Kumpfer et al., 2015), child maltreatment studies (Kumpfer et al., 2013), cultural and gender adaptation studies (Kumpfer et al., 2015). The programme also released a home use DVD version of the Strengthening Families programme for ages seven to seventeen years old (e.g. Gudmundson, 2014; Kadoura, 2014; Kanse, 2014).

SFP 10-14 has been heralded as a universal prevention programme aimed at the entire population, regardless of the degree of exposure to risky factors (Kumpfer & Brown, 2019). Recent reviews that analyzed the effectiveness evaluation of SFP 10-14 using American samples, indicated that this intervention was one of the efficacious family-based interventions for preventing marijuana use (Ladis et al., 2019). The SFP 10-14 was reported promising for preventing alcohol use (Gottfredson et al., 2015; Fishbein et al., 2016). According to Gottfredson et al (2015), SFP 10-14 met most of the efficacy criteria of the Society for Prevention Research. As mentioned before, a wide range of evidence indicated the effectiveness of SFP 10-14 in the United States, including delaying the use of alcohol and other drugs, decreasing exposure to substance use, a long-term decrease of drug abuse, long-term decrease of antisocial behaviors and risky sexual behavior (Spoth et al., 2014; Coatsworth et al., 2015). Studies also reported positive

affect, support, involvement, and closeness, as well as direct and indirect effects on the improvement of parenting practices, cohesion and family involvement and better problem-solving skills (Reidy, et al., 2012; Chilenski et al., 2016; Spoth et al., 2019).

The SFP 10-14 programme has been successfully adapted for use in other contexts and cultures and has reflected positive outcomes (Bröning et al., 2017). Significant improvements in children's behavioral problems, a decrease in misuse of alcohol and drugs, and an increase in prosocial behavior were reported (Baldus et al., 2016; Mejia, et al., 2015). An increase in parents' mental well-being, parenting skills, parenting limit setting, parental monitoring, and parental communication about risky behaviors were reported post intervention (Orpinas et al., 2014).

In contrast to the initial positive findings, recent studies performed by independent groups, in the U.S. and Europe, showed SFP 10-14 lacked effectiveness in the reduction of substance abuse as one of the primary outcomes (Pinheiro-Carozzo et al., 2021). The decline effect between the initial and recent studies may be related to the programme content, which may be effective for some families living in specific contexts, but not for others; the randomness of the findings; the adoption of data analysis procedures different from those in the original studies; or failure to replicate the main components of SFP 10-14 i.e. fidelity (Pinheiro-Carozzo et al., 2021). Thus, the focus on the process of adaptation and rigorous process and summative evaluations of the implementation of the SFP 10-14 remains an important research gap (Gorman, 2017). No evidence has emerged to contradict the appropriateness of the SFP 10-14 programme,

which confirms the programme's suitability for adaptation and implementation in the South African context.

3). Impact of contextual matters on programme delivery

Since the onset of the COVID-19 pandemic, families across the world experienced extreme financial hardship, sudden loss of employment, long-term social isolation, and intense distress (Shroff et al., 2021). These intensified stressors have drastically increase risk for youth socio-emotional and behavioral health challenges, including risk for maladaptive means of coping with pandemic-related distress, such as self-injury, substance use, and eating disordered behaviors (Shapiro et al., 2022; Shroff et al., 2021). Dewa et al., (2021) reported symptoms of depression, levels of anxiety, and at-risk behaviours of youth had increased in relation to the pandemic, regardless of inconsistency in youth psychopathology pre-pandemic. Countless youths were unable to consistently fulfill basic needs due to the pandemic, undermining their capacity to fulfill higher-level needs as well (Gervais & Jose, 2020). Gervais & Jose (2020) also speculated that it is possible that these losses might have increased their reliance on maladaptive coping. For instance, one of Maslow's higher-level needs, i.e., poor family connectedness, predicts greater use of maladaptive coping (e.g., substance use and self-harm behaviors) in adolescents (Gervais & Jose, 2020). Similar research suggests links between loss of basic needs, such as homelessness and food insecurity, and maladaptive coping strategies (Shroff et al., 2021). For example, youth have shown greater likelihood of engaging in disordered eating behaviors when living in households with food insecurity, worrying about not being able to afford food or running out before obtaining more money than youth living in food-secure households (Oberle et al., 2019). Similarly,

youth more frequently reported engaging in substance use, binge drinking, and non-suicidal self-injury, if they had experienced homelessness (versus those with no homelessness history) (Cutuli, 2018). Furthermore, recent episodes of homelessness have predicted greater alcohol use and abuse in adolescents (Dewa et al., 2021). The COVID-19 pandemic has increased the frequency of these kinds of environmental stressors, including food insecurity or homelessness, for a large number of families (Shroff et al., 2021). As such, risk for associated adolescent behavioral and emotional difficulties may be important to monitor during and after the pandemic (Chaffee et al., 2021).

In a prospective cohort study of public high school students in Northern California, Chaffee et al. (2021) observed a decline in physical activity frequency during the stay-at-home orders related to the COVID-19 pandemic, but no change was observed in the frequency of substance use (ie, e-cigarettes, other tobacco, cannabis, and alcohol). The Chaffee et al (2021) study helps address a critical gap in the understanding of how stay-at-home restrictions have had unintended implications for health-related behaviors in youth. Research revealed that no change was found in the prevalence of substance use among adolescents associated with stay-at-home orders (Boschuetz et al., 2020), which contrasts with recent studies that reported increases in alcohol and cannabis use among adults during the pandemic (Pagoto & Conroy, 2021).

West et al, (2020) postulated that there is a need for studies examining the long-term implications of increased parental substance use for children given that social learning and parental role modeling may shift adolescents' beliefs about substance use. Researchers find it surprising that adolescents continued previous substance use at a time

when face-to-face social interactions were restricted, which raises questions about the social context in which adolescents were using substances, and how and where they obtained substances during stay-at-home orders (Boschuetz et al., 2020; Pagoto and Conroy, 2021). Pagoto and Conroy (2021) iterated that the stay-at home orders and the COVID-19 pandemic in general are natural experiments that have affected multi-level contexts (eg, social, school, community) in unique and unprecedented ways.

In South Africa, the COVID-19 pandemic has been associated with reduced access to health services and worsening health outcomes for youth (Duby et al, 2022). Through their analysis of data from a combination intervention study for adolescent girls and young women in South Africa, Duby et al (2022) sought to examine the way in which implementation and service provision were impacted by the COVID-19 pandemic and related restrictions and described the adaptation implementers made to respond to this context.

Implementers described various ways in which the COVID-19 pandemic and related restrictions had limited their ability to implement the intervention and provide services as planned, and as a result, intervention recipients' access to psychosocial services was disrupted (Duby et al., 2022). Furthermore, Duby et al. (2022) noted that implementers also described several ways in which they attempted to adapt to the pandemic context, such as offering services remotely or door-to-door. Pillay et al (2021) indicated that several waves of COVID-19, and the ensuing lockdowns and government-imposed restrictions, have significantly disrupted existing health services and interventions. These included interruptions in supply chains, diversion of resources,

patient and provider fears of infection, transport challenges, closure of facilities, staff shortages, and paring down of services (Pillay et al, 2021). Despite attempts to respond to the context and adapt services, overall COVID-19 negatively affected implementation and service provision, and heightened issues around community acceptability of the programmes (Otieno et al, 2021). Future research is therefore needed to shed light on the specific contextual features, such as the current Covid pandemic, that affect programming for high-risk behaviours among youth (Pagoto and Conroy, 2021).

4). Changes in theories

One of the keys to successful scalable intervention implementation is to culturally adapt interventions (Faregh et al, 2019). Castro et al (2010) postulated that Cultural adaptation is "the systematic modification of an evidence-based treatment (or intervention protocol) to consider language, cultural, and context in such a way that it is compatible with the client's cultural patterns, meaning, and values". Li et al. (2017) indicated that incorporating cultural elements, including spiritual beliefs and social norms, and take account of the local context and needs of the target population can improve service users' attitudes toward the intervention. Several studies have highlighted considerations for incorporating culture in the implementation of mental health interventions in low-and-middle-income countries (Fendt-Newlin et al, 2020; Ramaiya et al, 2017; Zubieta et al, 2020), but these studies focus on non-technology supported intervention. Relatively few cultural adaptation studies for digital mental health interventions have been conducted within this context, leaving a critical gap in the literature. Abi Ramia and colleagues (2018) culturally adapted a digital mental health

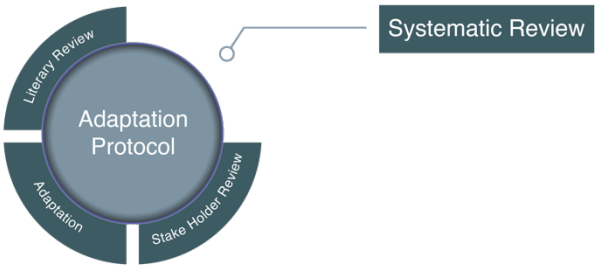
intervention in Lebanon through learning participants' receptiveness to the programme, its content, implementation, and prospective use with local communities and stakeholders. Garabiles and colleagues (2019) completed a cultural adaptation to enhance the acceptability, relevance, comprehensibility of the intervention and its content (e.g., storyline, illustration, and characters) while maintaining the completeness of the therapeutic components. Previous work adopted a framework for guidance on what elements should be adapted (Davidson et al, 2020) and rationale behind adaptations (Garabiles et al, 2019) to ensure the thoroughness of the cultural adaptation within the digital format. According to Garabiles, et al (2019) digital mental health intervention adaption must meet community needs without the reliance on explanations and modifications by human supports, which highlights the importance of creating intervention material that can stand alone (Schueller et al, 2018). Several models are known for cultural adaptation with distinguishing features (Domenech et al, 2011), such as tailoring for specific ethnic groups (Whitbeck et al, 2006, Podorefsky et al, 2001), therapeutic process and skills (Hwang 2006), elements within the intervention (Bernal et al, 1995), specific domains that have a poor fit between the intervention and the community (Lau, 2006), and heuristic considerations including patient engagement, mechanism, and treatment outcomes (Barrera & Castro, 2006). Frameworks applied for cultural adaptation of digital mental health intervention, however, incorporates the same models that is the basis for ongoing adaptation studies, including the Ecological Validity Model (Bernal et al, 1995), Heuristic Framework (Barrera & Castro, 2006), Integrative Cultural Adaption Model (Barrera & Castro, 2013), Formative Method for Adapting

Psychotherapy (Hwang 2006), and the four-point Framework recommended by Manson (1997).

There has been no other major changed in theories formulating the impact of systemic approaches on intervention or adaptation, thus, the theoretical framework for the study remains appropriate and unchanged. In summary, the trends post conceptualization did not detract from or vacate the premises on which the study aims were formulated namely:

1. Engagement in HRBs amongst adolescents remain a concern
2. Family-based interventions are still recommended
3. Evidence for the SFP 10-14 still supports its relevance and effectiveness including its suitability for adaptation.
4. Mixed results were reported in some contexts that reportedly were attributable to a confluence of factors including the lack of systematic reporting on the process of adaptation, and the methodological rigour followed in the actioning of the adaptation.
5. Contextual changes and challenges such as increased digitization will be flagged for inclusion in the write up of those sections of the study that deal with contextual considerations.

CHAPTER THREE: PHASE ONE – SYSTEMATIC REVIEW



3.0. INTRODUCTION

This first phase of the study addressed the first objective, which was to consolidate the literature reporting on effective programmes aimed at reducing or delaying onset of health risk behaviours in pre- and early adolescence. The consolidation process entails the identification of good quality literature with specified databases and timeframes. To this end, systematic review methodology was adopted for Phase One. The chapter was divided into two sections: Section A reports on the methodological decisions taken in the execution of the study; Section B reports on the operations of the systematic review and results of the study.

3.1 SECTION A: SYSTEMATIC REVIEW METHODOLOGY

Section A reports on the systematic review methodology employed, review questions and scope. The chapter starts by defining a review protocol that specifies the research question being addressed and the methods that will be used to perform the review.

3.1.1 Objective

Phase one addressed the first objective which was to identify programmes that are effective in delaying, reducing or preventing engagement in Health Risk Behaviours amongst pre-and early adolescents,

3.1.2 Review Question

What empirical evidence is summarized in the existing body of literature on family-based programmes that are effective in delaying, reducing or preventing engagement in Health Risk Behaviours (HRBs) amongst pre- and early adolescents including

- Multi-focused prevention programmes,
- Programmes that address various levels of risks, and
- Programmes that specifically target youth age groups 10-14.

3.1.3 Review Scope

The aim of this systematic review was to identify effective intervention programmes from good quality literature reporting on family-based programmes that prevent, delay and reduce engagement in health risk behaviours amongst pre- and early adolescents. The review filtered the evidence from original empirical research conducted anywhere in the world.

3.1.4 Operational steps

1. Formulate key words that will guide the database search

2. Formulate inclusion and exclusion criteria

3. Select databases for the search strategy

4. Conduct a comprehensive data base search

5. Identify suitable manuscripts based on their titles

6. To screen manuscripts for suitability based on the extent to which abstracts evidence the inclusion criteria

7. To evaluate manuscripts for inclusion in the review

8. To extract data from final review articles

3.1.5 Design: Systematic Review

Systematic Review methodology was selected for this phase, as previously mentioned. This systematic review is based on a defined search strategy that aims to detect as much of the relevant literature as possible. The generic principles along which the methodology was applied, are outlined below.

3.1.6 Study Selection Criteria

The inclusion and exclusion criteria guided the systematic review, and thereby ensured that the research question was focused and reduced bias in the selection of studies. The primary researcher in consultation with the supervisor established inclusion and exclusion criteria prior to execution of the review in keeping with the recommendation of Steward (2014) who recommended that the criteria be defined before the identification of studies. The

formulation of strict inclusion and exclusion criteria were thus important prerequisites before the review process was initiated because it assists in the identification of quality articles that is relevant for the review as recommended by Teing (2006). Bronson and Davis (2011) proposed that the criteria include a specific time period, target group and also specifies the types of studies, i.e. peer- reviewed, grey literature, qualitative, quantitative nature etc, that are being considered.

3.1.6.1 Inclusion Criteria

Time period: Articles published over a ten-year period from January 2002 through December 2012 were considered for this review. Reviews typically focus on recent research and use a five- year *time* period as parameter (Moher, 2015). The time period for this review was extended to ten years in order to capture the trends over the last decade prior to the execution of the study.

Target group: The target group for the review was determined by conducting a preliminary search to assess whether there were studies conducted on pre-adolescence. The initial age group was framed as pre-and early adolescents between the ages 10 – 14 years. Most of the international studies found in the provisional search included children from the age of 10 years to 16 years old. The number of studies conducted in the South African context with this target group was limited. As a result, the target group for the present study was set to include children aged 10 -16. The target group was not restricted by gender or language of origin.

Type of study: Studies that used an evaluation or intervention design were considered for this review. The review question focused on empirical evidence summarized in the existing body of literature on programmes that are effective in delaying, reducing or preventing engagement in

Health Risk Behaviours amongst pre- and early adolescents. Family-based studies that evaluated interventions aiming specifically at preventing and reducing alcohol and all other drug related misuse as well as generic interventions (e.g., drug education programmes) were eligible for inclusion in the review.

Text selection: Articles must be peer reviewed and full texts must be available. Articles had to be published in English.

3.1.6.2 Exclusion Criteria

Articles before 2002 were excluded based on recency as defined by the time period. Studies written in languages other than English were excluded. Studies that involved children under the age of 10 and over the age of 16 were excluded. Studies which primarily focused on adolescents without family members were excluded. Non-full-text articles as this was a prerequisite for implementing the SR methodology. Pay-for view publications were also excluded as the content or focus of the review constituted a large body of literature that ensured that core content would be accessed. The risk of missing out on literature integral to the execution of the review was minimal. The focus of the review was on readily accessible literature published in mainstream journals and enlisted in the databases searched.

3.1.7 Levels of Review

The current study utilized the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA), introduced by Moher et al. (2009). PRISMA identifies four levels of review to be included in systematic reviews, i.e., identification, screening, eligibility and summation. The current review was conducted according to these four levels.

3.1.7.1 Identification

Identification entails finding records in identified data bases using their titles. Identification included the development of keywords, selection of databases, and the development of a comprehensive search strategy. This informed the execution of the search and the identification of suitable titles.

Keywords: The identification of keywords and databases is an essential step to ensure that relevant and sufficient quality articles is sourced, before the search for potential or relevant research begins. This step is reliant on identifying and using appropriate keywords. Keywords are phrases used to elicit articles pertaining to the research topic. An initial list of key words was compiled drawing on index terms identified in the narrative review. Synonyms of the index terms were added to improve the strength and comprehensiveness of the list of key words.

The initial list included the following index terms: Risk-taking; unsafe sex; sexually transmitted diseases – prevention; high- school students; prevention; teenagers – sexual behaviour; at-risk youth; parenting; youth-substance abuse; youth and alcohol; parent and child; drug abuse-prevention; youth-sexual behaviour; teenagers; youth development programme; life-skills; family focused intervention; brief-family intervention; alcohol-drinking; alcohol-prevention and control; harm reduction; behaviour modification; substance abuse; risk factors; "peer pressure in adolescence; teen pregnancy; youth and alcohol treatment; family life education. An initial limited search of MEDLINE and CINAHL was conducted to test the keywords for productivity and yield.

Based on their respective yields, a pre-final list of fourteen keywords was compiled: Health risk behavior, high risk behavior, sexual risk behavior, risky behavior, at risk, preadolescent, preteens, youth, teenager, families, parent and child, family, parenting, caregivers. This list of keywords was linked together with Boolean operators such as AND, and OR. According to Terre et al. (2006), this significantly increases the power and efficiency of the search. The Boolean phrases were tested and adjusted accordingly, and the final list of keywords are listed below:

- **Line one:** "health risk behaviour" [All Fields] And "high risk behaviour" [All Fields] OR "sexual risk behaviour" [All Fields] OR "risky behaviour" [All Fields] OR "at risk" [All Fields] AND
- **Line two**: "preadolescent" [All Fields] And "early adolescent" [All Fields] OR “preteens” [All Fields] OR “youth” [All Fields] OR “teenager” [All Field] AND
- **Line three:** "prevention" [All Fields] And "intervention" [All Fields] OR “reducing” [All Fields] OR “treatment” [All Fields] AND
- **Line four:** “families” [All Fields] AND “family “ [All fields] OR parent and child” [All Fields] OR “parenting” [All Fields] OR “caregivers”.

Databases: A two-step search strategy was utilized in this review. First, the *databases* contained in or subscribed to by the library of the University of the Western Cape in 2013 were used in this review. The UWC library (lib.uwc.ac.za) catalogues the databases by discipline with each discipline comprised of a list of databases that are considered primary or secondary for that discipline. The databases included: Academic Search Complete, PsychArticles, SocINDEX,

SportsDiscus, Psychology and Behavioural Science Complete (PBSC), Cochrane, BioMed Central, Pubmed, CINAHL, Psych Info, Science Direct, Biblioline Pro-African Wide NiPAD, Ebscohost, and SA ePublications. The databases were selected based on their indexing as primary databases for Health, Education and Social Sciences within the UWC library configuration. The configuration is based on a crosstabulation of the titles listed in the respective search engines for these databases.

Second, Reference mining was applied to identify additional records from the reference lists of related articles identified in the database search. Bronson and Davis (2011) recommended reference mining to reduce potential publication bias.

The database search was conducted by the principal researcher and five field workers. Reviewers completed a comprehensive search of identified databases during the current review for this study. First, the titles of potential articles identified from the database search were reviewed on the perceived relevance of the title to the review question. The selected titles were then recorded and ranked in a table (**Table 3.1**) and the recommendation regarding its further inclusion in the review.

3.1.7.2 Screening

The abstracts of titles included in the identification level were retrieved for further screening. *Screening* entails the evaluation of abstracts relative to the ascribed inclusion and exclusion criteria. Each abstract was given a recommendation for further inclusion or exclusion from the reviews. An abstract summary sheet was used to record information on the author and title of the article, the type of design used, the study population, methodology and outcomes.

3.1.7.3 Eligibility

Full texts of all included abstracts were retrieved and assessed for eligibility for inclusion in the final review. *Eligibility* includes the assessment of the methodological rigour and coherence of the articles i.e. quality. A critical appraisal tool is used to evaluate the quality of the articles (Letts et al., 2007). A critical appraisal tool that assessed intervention or evaluation studies that could report on the efficacy of programmes was required as per the inclusion criteria is design specific. The rigour of the assessment is increased when the critical appraisal tool was design-specific (Grant, 2009; Shea, 2007). Therefore, in a response to the need for a more generic and inclusive tool, the SFS scoring system was selected.

The SFS scoring system developed by Smith et al., (2015) was used. The SFS scoring system consists of six versions. Version C of the SFS was selected for the present review, because it specifically assessed intervention studies (**Appendix Q**). Version C consisted of forty-two questions spread over seven sub-sections. In addition, the identified appraisal tool was more detailed and provided clearer assessment criteria for methodological rigour and coherence. This was preferred above more brief tools that did not operationalize methodological rigour and coherence in such an explicit manner. A more detailed and stringent tool also helped to offset the impact of universal conventions in the reporting of intervention studies that may increase scores on brief appraisal tools. Version C of the SFS was piloted successfully which supported it capacity to function in the required or desired wat in the present study (Munnik et al., 2015; Smith et al., 2015*)*.

Each article had the potential to obtain a total score that was expressed as a percentage. Based on the overall score, the article was assigned a quality descriptor that was categorised as

either weak (<40%), moderate (41-60%), strong (61-80%), or excellent (>80%). In order to be included in the review, full text articles had to obtain a threshold score of 50% and above. The critical appraisal tool was designed to be quite comprehensive. Therefore, the cut-off score of 50% could be set as to not exclude articles due to a too stringent requirement as per the recommendation of Smith et al. (2015). All full text articles that satisfied the threshold score proceeded to the data extraction process. The scores for each of the eleven identified articles/programmes were captured on a rating form.

3.1.7.4 Summation

Summation entails extracting the data from the included studies. The next level of the research process included two operational steps, i.e. *data extraction* and *meta-synthesis*, both of which is summarized below. *Data extraction* is a process within which thematic foci or categories of data can be taken from the included literature. Data was extracted and recorded in tabular form. The tables were designed to provide a general descriptive summary of the purpose of the study, study type, theoretical orientation, implementation of the study, assessment of the sample group, ethical considerations, instruments used, data analysis, result of the study, and conclusions drawn.

Meta-synthesis proposedly enables new interpretations of research and the development of new theories through the extension of knowledge (Thorne et al., 2004). Schreiber et al., (1997) adequately describe meta-synthesis as "bringing together and breaking down findings, examining them, discovering essential features and, in some way, combining phenomena into a transformed whole" (p.314). Sandelowski, Docherty, and Emden (1997) describe three types of meta-synthesis approaches namely, a) descriptive meta-synthesis, where a broad description of

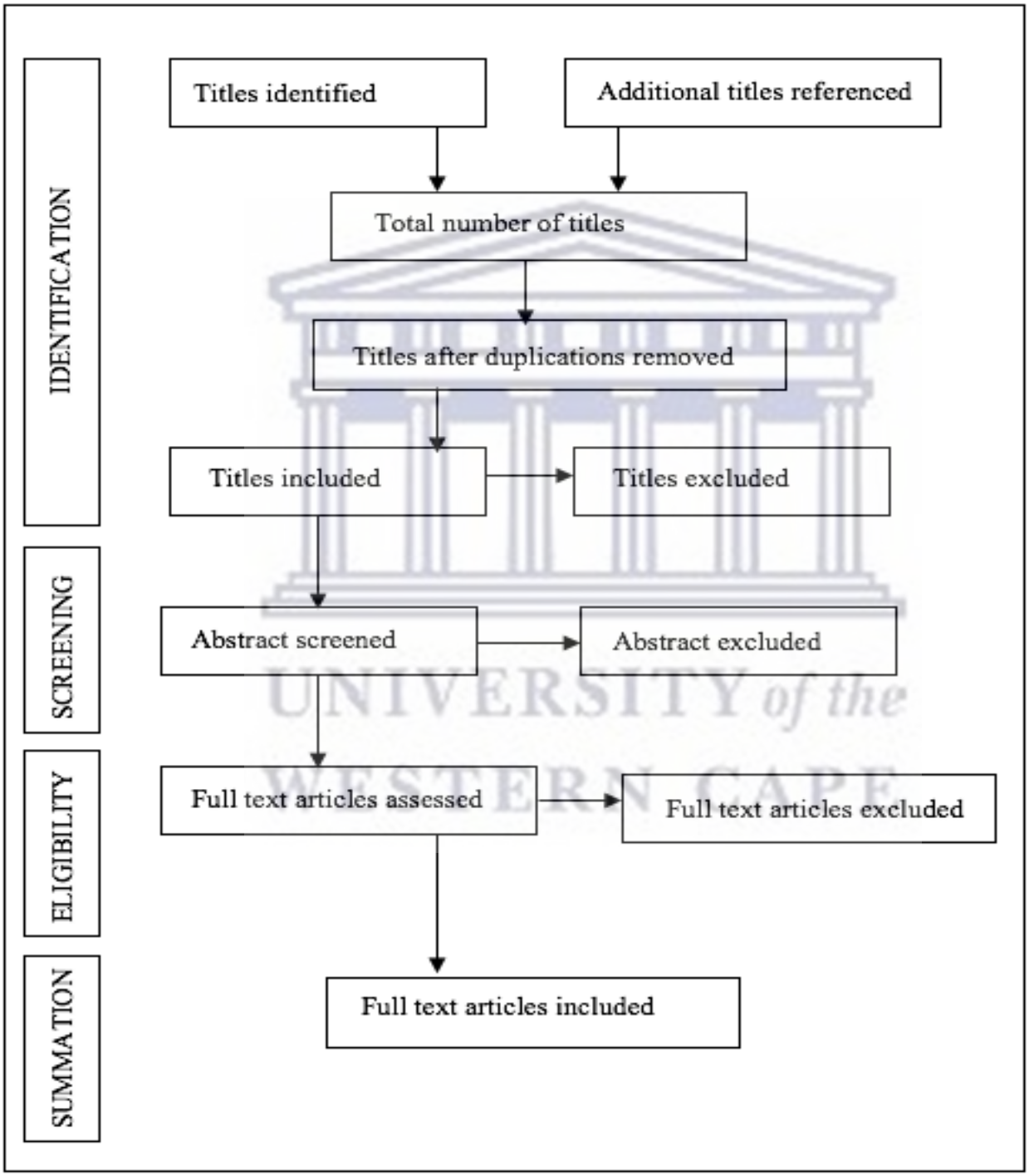
the research phenomenon forms the basis of the analyses; b) theory explication, the reconceptualising of the original phenomenon, and c) theory building, used when findings are brought together on a theoretical level to assist in the formulation of a tentative altered theory.

This review used *descriptive meta-synthesis* as the primary method of data analyses, which involved the ranking of the included articles on methodological rigour scores i.e. strengths and weaknesses as measured by the critical appraisal tool, and the tabularisation of the extracted data (Downe et. al., 2007; Thomas & Harden, 2008). Ranking allows the researcher to assess whether the design utilised is coherent to the aims and purpose of a particular study, as well as whether the findings and conclusions are supported by the data. Fundamentally, ranking articles based on scores does not imply stronger validity, but overall improved methodological rigour and coherence. The present study ranked studies based on the critical appraisal scores that reflected comprehensiveness of the reporting on family-based interventions preventing or delaying HRB's in pre- or early adolescents. The data extracted from articles included in the review were tabularised to facilitate ease of summation.

Figure 2 below is a graphic representation of the PRISMA flowchart that illustrates the levels of the review. The PRISMA flowchart was adapted to demonstrate alignment and flow of the levels of review.

Figure 2

PRISMA Flowchart



3.1.8 Method of Review

The method of review stipulates the manner in which fieldwork is executed (Greenhalgh, 1997; Teing, 2006). Smith et al. (2011) postulate that a review team should include at least one person with methodological expertise and at least one person with expertise in the field of study who will assume responsibility for 1) the overall coordination of the study, and 2) making important methodological decisions, such as to identify the selection criteria and the critical appraisal tool for the review. The primary researcher was a subject expert and the supervisor had expertise in the methodology.

There are different opinions as to how many reviewers are required in a systematic review (e.g., Steward, 2014; Teing, 2006), there is consensus that a review team needed a minimum of two reviewers. As mentioned before, this review team included 6 reviewers including the primary researcher and five additional reviewers. The other five reviewers were honours level Psychology students who received basic training in systematic review methodology as part of their coursework and employed the methodology as part of their supervised independent research project. The principle researcher and his supervisor were subject specialist in the area of child and family research, and thus satisfied the recommendation of including subject specialists in the review team. In addition, the supervisor, an expert in the systematic review methodology, acted as an external auditor in the preparation and execution of the review.

There were two aspects to the method of review namely, preparation of reviewers and management of the fieldwork. The procedure followed for the preparation and general management during the reviews is outlined below, while the management of the review per operational step will be discussed in section B which reports on the review.

3.1.9 Preparation for reviews and general management strategy

The primary researcher's supervisor briefed the reviewers in an initial workshop explaining the nature of systematic reviews before the reviews commenced. The content of the workshop included: systematic reviews as a methodology, the protocols followed in systematic reviews including phases of the review, the search strategy, levels of the review, and analyses of the data i.e. the use of a critical appraisal tool and meta-analyses as a method. The specific aims and objectives of the review were explained to reviewers to ensure a more comprehensive understanding of the topic under review. Similarly, background information and problem formulation were explained.

To enhance the rigour of the strategy, each reviewer was allocated the same electronic database (e.g. Ebscohost) to conduct searches with the identified keywords and phrases during the final stage of the workshop. The reviewers had the opportunity to discuss challenges, discrepancies and to ask questions to cement their understanding regarding the systematic review methodology. This contributed to the calibration of fieldworkers/ reviewers. In addition, the search aided in the discovery of key words and the adjustment of methods used by the reviewers.

Reviewers used their discretion to determine relevance of articles to the study, based only on the abstracts. To improve reliability, reviewer pairs sent the results of this process to each other for second checks. All reviewers conducted a pilot to achieve calibration and ensure that the processes were understood.

During the actual review, the primary researcher facilitated team meetings in which reviewer appraisals were discussed. Reviewers were also given the opportunity to present and discuss their findings after each operational step of the review process. All disagreements or

differences noted in terms of search strategy or inconsistencies in the method of review were given voice and opportunity to be resolved. In addition, reviewers had the opportunity to share their understanding, and demonstrate how they applied the principles or obtained the score by referring back to the process or the article. Thereafter, a discussion was held and a consensus reached to resolve any dilemma. All of the initiated discussion enhanced the rigour of the process. Thus, at each level of the review, reviewers were provided an opportunity to adjust their findings. Additionally, feedback was provided to ensure that there was final comprehension of the operational steps and adherence to the protocol as per the recommendation of Kahn (2003).

3.2 SECTION B: SYSTEMATIC REVIEW & RESULTS

This section outlines the process results and descriptive meta-synthesis. The descriptive meta-synthesis provides a summary of the core themes and findings of the articles.

3.2.1 Process Results

The process results report the outcomes at the operational steps included in the first three levels of the review i.e. ***identification, screening*** and ***eligibility*** or quality appraisal. **Figure 3.1** includes the totals obtained at each of the operational steps.

3.2.1.1 Identification

Initially, the search yielded 1151 articles. An additional 6 articles were added from mining reference lists. The total number of titles yielded was 1157. The next step was to remove all duplications. A total of 89 duplicates were removed and 1068 titles were reviewed. A total of 982

titles were not deemed appropriate at face value and was excluded from the review. The main reason for exclusion was that the titles were not focused on family-based interventions aimed at reducing or delaying the onset of HRBs in pre-and early adolescents. Only 86 titles were retained at the end of the first step and their abstracts were retrieved for screening purposes.

3.2.1.2 Screening

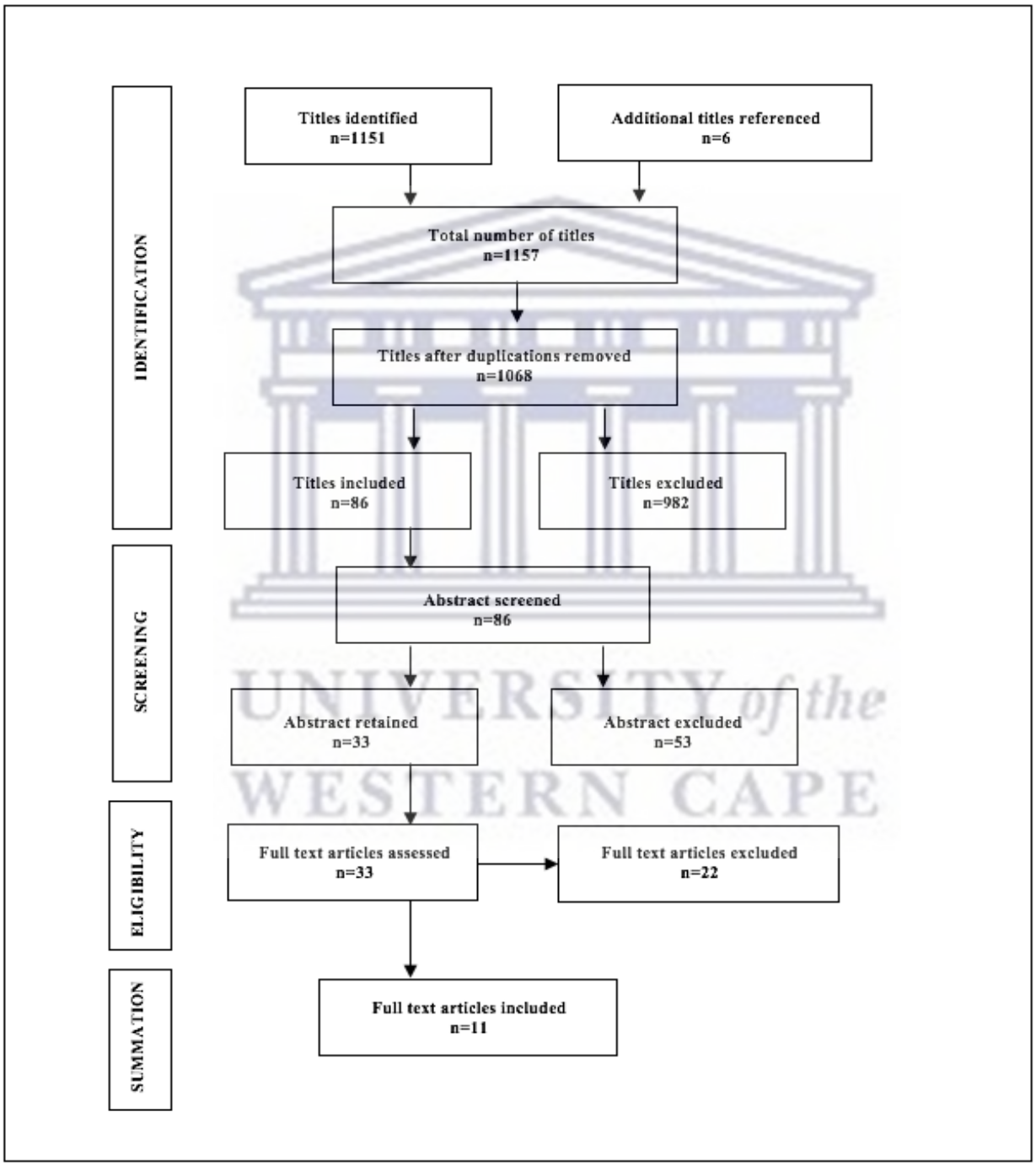
Eighty-six (86) abstracts were screened for further inclusion based on the inclusion criteria specified. Fifty-three (53) abstracts were excluded for the following reasons: age of the participants was too young or too old, some of the articles were focused on youth-only /parent-only preventions, and some were treatment strategies only, some were systematic reviews, and outcomes other than high risk behaviour. Thirty-three (33) were thus included for evaluation with the critical appraisal tool.

3.2.1.3 Eligibility

The scores for each of the 33 identified articles/programmes were captured in a rating form. Eleven articles satisfied the threshold score of 50% and was therefore included in the summation.

Figure 3.1

Totals Obtained at Each of the Operational Steps.



3.2.1.4 Ranking

The final ranking of the eleven articles is shown below in **Table 3.1** in descending order.

Table 3.1

Ranking of Articles/Programmes

Author	Programme	Ranking	Rating % Obtained	Total Score (=55)	Quality
Kumpfer et al., 2012	ISFP-IRE	1	84%	46	Excellent
Coatsworth et al., 2009	SFP/MSFP	2	78%	43	Strong
Stormshak et al., 2011	EcoFit	3	75%	41	Strong
Caldwell et al.,	Father & Sons	3	75%	41	Strong
Koning et al., 2009	PAS	4	71%	39	Strong
Beharie & Kelogerogiannis, 2011	HOPE	4	71%	39	Strong
Brody & Murry, 2004	SAAF	5	69%	38	Strong
Wu & Stanton, 2003	ImPACT	5	69%	38	Strong
Mckay et al., 2004	CHAMP	6	65%	36	Strong

Bauman et al., 2002	Family Matters	7	64%	35	Moderate
Lederman et al., 2008	PARE	8	58%	32	Moderate

As seen in **Table 3.1,** three quality descriptors were achieved, excellent, strong and moderate. Only one study received and "excellent" quality rating, while the majority of the ncluded studies were 'good". The study that was ranked in first place, SFP 10-14 (Kumpfer et al., 2012), an empirically-validated family-based preventive intervention, obtained the highest ranking of 84% with a quality score of 46 out of a total score of 55, indicating an excellent quality rating.

There were eight studies ranked, 2 to 6, that obtained a quality descriptor of "good." The studies that ranked second to fourth obtained scores above 70% suggesting that these articles reported consistently on the expected evaluation criteria (Coatsworth et al., 2009).

The three studies ranked 5th and 6th scored between 65 and 69% suggesting that they reported on most of the evaluation criteria. This secured a good quality description. The remaining two studies, ranked 7th and 8th, scored between 50% and 64% and obtained a moderate quality description. These articles reported on the key criteria for methodological rigour in intervention studies, but lacked detail resulting in lower scores.

Overall, the scores and ranks still demonstrated a range similar to the number of included articles. This suggests that there was variation in the reporting despite the conventions for

reporting on intervention studies in author guidelines and journal requirements. The variation can be attributed to the more comprehensive appraisal tool which enabled a greater level of discrimination between articles and the quality of reporting.

Five studies (Brody & Murray, 2004; Coatsworth et al., 2009; Koning et al., 2009; Lederman et al., 2008; Wu & Stanton, 2003) used controlled randomized designs, of which one was a longitudinal community-based study. Three studies (Caldwell et al., 2011; Kumpfer et al., 2012; McKay et al., 2004) used quasi-experimental design. Two studies (Bauman et al., 2002; Stormshak et al., 2011) used a randomized experimental design, and a final study (Beharie & Kalogerogiannis, 2011) used a random intercept model for its intervention programme. All studies reported on using intervention or experimental designs that provides further evidence that they satisfy the inclusion criteria. These designs are typically characterized by stringent control with clear conventions for reporting. This contributed to the higher scores obtained on critical appraisal.

3.2.2 Descriptive Meta-synthesis

The extracted information is presented in the tables below under the following headings; Intervention programme description and efficacy/results. Intervention Programme Description includes number of programmes, target HRB, aims/objectives, target group, duration, setting, facilitation. There were eleven studies identified, all with a family focus. One study targeted fathers and sons (Caldwell et al., 2011), and another focused specifically on mothers and children (Brody & Murray, 2004). Two studies were variations of the SFP 10-14 programme (Coatsworth et al., 2009; Kumpfer et al., 2012).

3.2.2.1 Target Behaviour/ HRBs

The HRBs targeted included various at-risk behaviours. Programmes were focused on teaching participants about teen alcohol and substance prevalence and reducing and preventing alcohol consumption and misuse. Furthermore, teen communication with parents about sex and safe sex practices and abstinence from sex was also promoted and addressed. Aggressive behaviours and violence avoidance was a final focus of these family-focused interventions.

There were two studies which addressed general risky behaviours (unspecified) of teens (Brody et al.,2004; Caldwell et al., 2011). Five studies targeted substance including alcohol as a health risk behavior. One study mainly addressed the reduction of alcohol consumption (Koning et al., 2009). Bauman et al. (2001) focused on both alcohol and smoking prevalence and Beharie and Kalogerogiannis (2011) addressed the issue of HIV-AIDS and alcohol misuse.; and two studies focused on reducing risky behaviour and substance use (Duncan et al., 2009; Wu et al., 2003). Two studies primarily addressed safe sex habits or sex abstinence (Lederman et al., 2008; McKay et al., 2004). Kumpfer et al. (2012) focused on delaying or decreasing substance use, and addressed other risky adolescent behaviors, such as antisocial behavior, risky sexual behavior, and aggression and hostility. **Table 3.2** illustrates the target HRBs addressed by the included studies.

Table 3.2

Target HRBs

Intervention Programme	Target health-risk behaviours
PARE - Lederman et al., 2008	Programme designed for parent - adolescent dyads for middle school minority youth. This interactive programme focuses on role-playing resistance skills and parent-child discussions aimed to promote teen communication with parents about sex and promote safe sex practices in adolescents.
Family Matters - Bauman et al., 2002	Parent - adolescent dyads for students aged 12-14 within the general population. Phone calls were conducted to teach participants about teen alcohol and smoking prevalence rates and to offer participants educational resources.
CHAMP - McKay et al., 2004	This programme is designed for 4th and 5th graders in inner city communities with high rates of HIV. The family focused three level programme offers developmentally timed discussions for parents and children to practice skill building, abstained from sex, and increase family communication.
ImPact - Wu & Stanton, 2003	ImPact is designed for Black youth aged 12-16 to increase family communication and parental monitoring and to decrease substance use and adolescent risk reduction through a Focus on Kids intervention.

SAAF - Brody & Murray, 2004	This programme is designed for rural African American mothers and 11-year-old to create a culturally responsive family-based prevention programme to reduce adolescent risky behavior and increase family communication.
HOPE - Beharie & Kalogerogiannis, 2011	HOPE is targeted to high risk families and youth aged 11-14 in homeless shelters. Peer educators facilitate evidence-based curricula around HIV and alcohol misuse prevention. The programme was successful in offering an informal social support network for families living in homeless shelters.
PAS - Koning et al., 2009	This programme is designed for first year high school students (12 yrs. old) and their parents in the Netherlands. The programme uses social cognitive theory to reduce alcohol consumption.
Father & Sons - Caldwell et al., 2011	Father and Sons was conducted with black families in Flint, Michigan. This programme focuses on improving father and son communication, enhancing parenting attitudes and behaviors among fathers and avoidance skills for sons, reinforcing cultural awareness for both, and developing family strategies against youth risky behaviors
EcoFit - Stormshak et al., 2011	Ecological approach to family intervention and treatment for middle school youth and their families. This programme aims to prevent

	externalizing behaviors and youth substance use by engaging parents in a family centered intervention
SFP/MSFP - Coatsworth et al., 2009	Included mindfulness parenting approaches into existing SFP 10-14 framework. This programme is aimed to reduce youth risky behavior and substance use through the family network.
SFP 10-14 –Kumpfer et al., 2012	SFP 10-14 is an evidence-based 7-week family skills training programme that involves the whole family in three classes run on the same night once a week. The programme is targeted for youth aged 10-14 and their families to increase family communication, an authoritative parenting approach, delay and or decrease teen substance use, and other risky adolescent behaviors.

3.2.2.2 Outcomes – Aims and Objectives

The outcomes of the included studies included: 1) reducing adolescent risky behaviours such as, teen alcohol and substance use, child sexual risk behaviours and smoking; 2) increasing healthy safe sex practices, communication with parents and children, and parental monitoring; and 3) preventing and delaying the onset of risk behaviours such as substance use, sexual initiation and violent behaviours.

The programmes aims and objectives included: promoting healthy safe sex practices (Lederman et al., 2008), reducing alcohol and smoking use (Bauman et al., 2002), reducing

sexual risky behaviours (McKay et al., 2004), determining parent monitoring interventions (Wu & Stanton, 2003), creating culturally sensitive family-based prevention (Brody & Murray, 2004), educating and tailoring support to families (Beharie & Kalogerogiannis, 2011), evaluating and comparing effectiveness of risk-behaviour prevention (Koning et al., 2009; Coatsworth et al., 2009; Stormshak et al., 2011), preventing substance use, violent behaviour and sexual initiation (Caldwell et al., 2011). SFP10-14 addressed a range of risky behaviours, and focused on increasing effective communication between parents and pre and early adolescents, and thereby establish the parents' influence over the pre-and early adolescents' behaviours (Kumpfer et al., 2012). **Table 3.3** illustrates the target Aims and objectives addressed by the included studies.

Table 3.3

Aims/Objectives

Intervention Programme	Aim/Objectives
PARE - Lederman et al., 2008	To promote teen communication with parents about sex to promote healthy safe sex practices in adolescents
Family Matters - Bauman et al., 2002	To reduce teen alcohol and smoking use through educational resources, understand prevalence of teen smoking and drinking.
CHAMP - McKay et al., 2004	To reduce child sexually risky behavior through a two-pronged approach: 1) strengthening family's ability to assist youth in

	preventing time spent in sexual possibility situations while supporting youth decision making and 2) refusal skills in order to reinforce abstinence from sex.
ImPact - Wu & Stanton, 2003	To determine whether the addition of a parental monitoring intervention (Informed Parents and Children Together [ImPACT]) alone or with "boosters" could enhance (either broaden or sustain or both) the effect of a small group, face-to-face adolescent risk reduction
SAAF - Brody & Murray, 2004	To create a culturally sensitive family-based prevention programme to reduce adolescent risky behavior, substance use, and strengthen the family unit through communication and parental monitoring
HOPE - Beharie & Kalogerogiannis, 2011	Educate and tailor support to families and youth (age 11-14) residing in homeless shelters, regarding HIV and alcohol abuse prevention.
PAS - Koning et al., 2009	To evaluate the effectiveness of two preventive interventions to reduce heavy drinking in first- and second-year high school students.
Father & Sons - Caldwell et al., 2011	Focuses on preventing substance use, violent behavior, sexual initiation among sons, and enhancing parenting techniques.

EcoFit - Stormshak et al., 2011	Evaluate efficacy of implementation of the ecoFIT model in the school system to prevent problem behaviors and substance use in middle school years.
SFP/MSFP - Coatsworth et al., 2009	To compare MSFP effectiveness to SFP 10-14, a universally designed programme to reduce adolescent risky behavior and substance use
SFP 10-14 –Kumpfer et al., 2012	Reduce risky behavior and substance use in adolescents, increase communication with parents to support and guide youth, universal programme for ethnically diverse general populations at all educational and economic levels

3.2.2.3. Target Group

The included studies targeted middle school and 1st year high school youth and their families from inner city, urban and rural areas. The approach to target groups in these studies were varied. One study focused primarily on minority groups of middle school aged youth and families without the specification of race (Lederman et al., 2008); three studies identified Black/African American youth (aged 11-16) and families as target group (Brody & Murray, 2004; Caldwell et al., 2011; Wu & Stanton, 2003); one study specifically targeted 4th and 5th graders from inner-city communities (McKay et al., 2004); another study included high risk youth (aged 11-14) and families (Beharie & Kalogerogiannis, 2011); one study specifically

focused on 1st year high school students (aged 12) as target group (Koning et al., 2009); and four studies ideally targeted pre-and early adolescents in middle school (aged 10-14) and families (Bauman et al., 2002; Coatsworth et al., 2009; Kumpfer et al., 2012; Stormshak et al., 2011). The focus of the researcher's study is also targeted towards predominantly black and coloured youth in the elementary and high schools, ages between 10-14. **Table 3.4** illustrates the target group addressed by the included studies.

Table 3.4

Target Group

Intervention Programme	**Target Group**
PARE - Lederman et al., 2008	Parent - adolescent dyads of middle school minority youth and their parents
Family Matters - Bauman et al., 2002	Parent adolescent pairs of middle school youth and their parents in the general population
CHAMP - McKay et al., 2004	4th and 5th graders living in the same inner-city community with high rates of HIV
ImPact - Wu & Stanton, 2003	Black youth aged 12-16 and their parents
SAAF - Brody & Murray, 2004	Rural African American mothers and their 11-year-old

HOPE - Beharie & Kalogerogiannis, 2011	High risk families and youth aged 11-14 residing in homeless shelters
PAS - Koning et al., 2009	first year high school students (aged 12) and their parents living in the Netherlands
Father & Sons - Caldwell et al., 2011	Black families in high risk, urban areas (e.g. Flint, Michigan)
EcoFit - Stormshak et al., 2011	Middle school youth and their families
SFP/MSFP - Coatsworth et al., 2009	Middle school youth aged 10-14 and their families
SFP 10-14 –Kumpfer et al., 2012	Middle school youth aged 10-14 and their families

3.2.2.4 Programme duration

The programme duration for each of the included studies varied. The studies with the shortest duration included: one study (Stormshak et al., 2011) conducted over 3 sessions; one study (Lederman et al., 2008) conducted over 4 weeks, with 4 main sessions and then 3 booster sessions, with each session being 2.5 hours long; another study (Bauman et al., 2002) conducted using 4 phone interviews over 15 weeks for total of 4 hours and 25 minutes; and another study (Koning et

al., 2009) conducted over 4 sessions in the first year and a booster session a year after. Then there were two studies with longer durations, including one study (Caldwell et al., 2011) conducted over 15 weeks and 9 hours of homework that needs completion over a 2-month period; and another study (McKay et al., 2004) conducted in 12 sessions (90 minutes each) over 12 weeks. There were two studies (Beharie & Kalogerogiannis, 2011; Wu & Stanton, 2003) conducted over 8 weeks with follow-up sessions after 6 and12 months. Three studies (Brody & Murray, 2004; Coatsworth et al., 2009; Kumpfer et al., 2012) were conducted over 7 weeks, with each week's session being 2-hours. SFP 10-14 (Kumpfer et al., 2012) has the availability of 4 booster sessions. **Table 3.5** illustrates the programme duration addressed by the included studies.

Table 3.5

Programme Duration

Intervention Programme	Programme Duration
PARE - Lederman et al., 2008	4 weeks with 4 main sessions and 3 booster session. Each session was 2.5 hrs
Family Matters - Bauman et al., 2002	4 booklets were completed followed by 4 phone interviews over a series of 15 weeks. The sum of the 4 phone calls totaled, on average, 4 hours and 25 minutes.
CHAMP - McKay et al., 2004	12 sessions over the course of 12 weeks, 90 minutes per session

ImPact - Wu & Stanton, 2003	8 sessions over the course of 8 weeks with 6 and 12 months follow ups
SAAF - Brody & Murray, 2004	7-week sessions with 2 hours of programming per week
HOPE - Beharie & Kalogerogiannis, 2011	8 sessions over the course of 8 weeks with 6 and 12 months follow ups
PAS - Koning et al., 2009	4 lessons in 1st year and booster lesson in next year. 1 baseline measurement with 10 and 22 months follow ups
Father & Sons - Caldwell et al., 2011	15 sessions and 9 hours of homework over a 2-month span
EcoFit - Stormshak et al., 2011	3 brief sessions using motivational interviewing
SFP/MSFP - Coatsworth et al., 2009	7 sessions over the course of 7 weeks, 2 hours of programming per week
SFP 10-14 –Kumpfer et al., 2012	7 sessions over the course of 7 weeks, 2 hours of programming per week. 4 booster sessions are available.

3.2.2.5 Programme Setting

In terms of location, studies were either school-based and took part in an after-school environment, or they were administered in various community facilities (public libraries, community centres, family organisation centres, churches, park district buildings etc.), with one study taking place within a family homeless shelter (Beharie & Kalogerogiannis, 2011). The programmes were conducted with varied social class or socio-economic backgrounds. It is noted that SFP 10-14 (Kumpfer et al., 2012) was the only programme that was preferably conducted with youth and families across socio-economic backgrounds including urban, suburban and rural areas from different counties. Two other studies were conducted with low income, inner-city communities (McKay et al., 2004; Wu & Stanton, 2003); three studies were conducted in public middle schools (Koning et al., 2009; Lederman et al., 2008; Stormshak et al., 2011); two studies were specifically conducted with African American families (Brody & Murray, 2004; Caldwell et al., 2011); and the final study was conducted in both rural and urban areas (Coatsworth et al., 2009). Of the 11 studies, 9 were based in the USA, one based in Ireland (Kumpfer et al., 2012) and another in the Netherlands (Koning et al., 2009). **Table 3.6** illustrates the programme setting addressed by the included studies.

Table 3.6

Programme Setting

Intervention Programme	Programme Setting

PARE - Lederman et al., 2008	After-school prevention education curriculum for middle-school students and their parents on school campuses led by trained counselors.
Family Matters - Bauman et al., 2002	Adolescents 12– 14 years of age living throughout the contiguous states of the United States, and their families, were entered into a randomized experimental design.
CHAMP - McKay et al., 2004	4th and 5th graders, drawn from the same inner-city community. Groups consisted of 10 families per group.
ImPact - Wu & Stanton, 2003	low-income, community-based, in-town settings. Youths located in and around 35 housing developments, community centers, and recreation centers in Baltimore, Maryland.
SAAF - Brody & Murray, 2004	Rural African American families with a son or daughter in early adolescence. Programme was conducted at community facilities.
HOPE - Beharie & Kalogerogiannis, 2011	Inner-city youths and their caregivers who resided in family shelters.
PAS - Koning et al., 2009	Youth and parents from a total of 20 public schools from different regions in the Netherlands were willing to participate.

Father & Sons - Caldwell et al., 2011	The Fathers and Sons Project, based in Flint, MI, is a unique programme for African American fathers and their 8-12-year-old sons who are not living in the same home.
EcoFit - Stormshak et al., 2011	The programme is housed in public middle schools and intended to be embedded in the school system in order to influence change across both families and schools.
SFP/MSFP - Coatsworth et al., 2009	About 250 families Families of 6th and 7th grade students in four school districts in rural and urban areas of central Pennsylvania were invited to participate in this study
SFP 10-14 – Kumpfer et al., 2012	The families came from a variety of socioeconomic backgrounds, urban, suburban and rural areas from counties; Cork, Limerick, Kerry, Galway, Roscommon Sligo, Mayo, Donegal, Kildare, Meath, Westmeath, and a number of areas across the Irish capital Dublin.

3.2.2.6 Facilitation

Each of the included studies handled facilitation of the programme quite differently, with some requiring specifically trained professionals, and others used community members, parents and even older youth as facilitators. Three of the studies utilized trained health professionals and specialists (Bauman et al., 2002; Lederman et al., 2008; Stormshak et al., 2011;); One study

utilized a mental health professional plus a community member or parent to administer the programme (McKay et al., 2004); One study specifically utilized African American community members as liaisons for the programme (Brody & Murray, 2004); one study implemented the programme using their own staff members as facilitators (Beharie & Kalogerogiannis, 2011); another programme made use of group a leader and older youth as co-leader for their programme (Wu & Stanton, 2003); and another study utilized one facilitator with an observer, specifically a male/female pair to facilitate their programme (Caldwell et al., 2011). One programme specifically required a minimum of first degree as qualification to present the programme (Coatsworth et al., 2009); and another utilized particular alcohol experts, mentors and teachers to conduct the intervention (Koning et al., 2009). SFP 10-14 (Kumpfer et al., 2012) included professionals from a wide range of disciplines, including programme managers and programme funders, and at a practitioner level, addiction counselors, social workers, probation officers, youth workers and community police, to ensure buy in, in terms of strategic service development and resource allocation. **Table 3.7** illustrates the programme facilitation addressed by the included studies.

Table 3.7

Facilitation

Intervention Programme	Facilitation
PARE - Lederman et al., 2008	Trained health educators and counselors facilitated the programme intervention

Family Matters - Bauman et al., 2002	A master's level public health professional administered phone calls to adolescents and parents
CHAMP - McKay et al., 2004	The programme leaders are comprised of one or two mental health interns (BA or MA level), and one or two community consultant/parent co-facilitators
ImPact - Wu & Stanton, 2003	Programme was facilitated by a group leader with an assistant group leader (both of whom are older than the youths in the intervention); gender and race of the group leaders were not necessarily the same a those of the youths.
SAAF - Brody & Murray, 2004	The facilitators were community liaisons who were African American community members selected on the basis of their social contacts and standing in the community.
HOPE - Beharie & Kalogerogiannis, 2011	The HOPE Family staff members engaged parents and youths in activities during the family discussion to facilitate communication and identify and develop strategies to reduce risk behavior among th youths.
PAS - Koning et al., 2009	A short presentation was given by an expert on alcohol abuse, mentors conduct meetings with parents, and trained teachers conducted intervention and booster classes.

Father & Sons - Caldwell et al., 2011	programme facilitator and observer were present during intervention sessions. The observer completed field notes on group dynamics, ke discussion points. Facilitators co-lead in a male/female pair often.
EcoFit - Stormshak et al., 2011	Facilitators were health educators, specialists and practitioners. The programme also included a part-time parent consultant who provide services to families within the school context.
SFP/MSFP - Coatsworth et al., 2009	All facilitators were required to have a minimum of a bachelor's degree and experience working with youth or parents. MSFP facilitators were required to have training and personal experience with a contemplative practice. Prior to conducting sessions, facilitators of both interventions completed a three-day certified training programme. Part of MSFP training was dedicated to review and practice of the added mindfulness activities.
SFP 10-14 –Kumpfer et al., 2012	50 professionals from a range of disciplines in the South of Ireland was trained in the SFP programme, including programme managers and programme funders, and at a practitioner level, addiction counselors, social workers, probation officers, youth workers and community police.

3.2.2.7 Programme Results

Programme efficacy draws its conclusion about interventions using closely controlled scientific conditions (Sam, 2013). All studies reported some significant findings at 00.5 or 0.01 alpha levels. Most studies reported an increase in parental protection factors and where direct outcomes such as substance use and sexual risk behaviour were measured, significant reductions in the growth of this behaviour was also reported in comparison to control groups. Results showed that youth increased talking to parents about sex, an increase in parent decision-making and communication, and decreased youth sexual involvement and unsafe sex, smoking and risky behaviours (Caldwell et al., 2011; Lederman et al., 2008; McKay et al., 2004; Wu & Stanton, 2003). Significant differences were reported in regulated, communicative parenting behavior, and positive impact on youth antisocial behavior and substance use, as well as youth protective factors (Brody & Murray, 2004; Stormshak et al., 2011). Four studies reported statistically significant programme effects that suggested the programmes bolstered family functioning, parent practices and communication regarding sex, alcohol and drug use, as well as long term reduction in decreased smoking and drinking prevalence (Beharie & Kalogerogiannis, 2011; Bauman et al., 2002; Coatsworth et al., 2009; Koning et al., 2009).

The SFP 10-14 programme (Kumpfer et al., 2012) results showed positive outcomes. Positive results were reported for increased parental involvement, parental efficacy, parental supervision, and parenting skills. Statistically significant differences were reported for family variables including family cohesion, family organization, family resilience and family conflict. Significant reductions or delays were reported for engagement in health risk behaviours including criminal behaviour, aggressive behaviour, alcohol use and substance use. Interaction effects were reported where parent skills, family skills and child skills training were combined and the whole

family attended together producing the most efficacious results. **Table 3.8** illustrates the programme results addressed by the included studies.

Table 3.8

Programme Results

Intervention Programme	**Programme Efficacy/Results**
PARE - Lederman et al., 2008	Efficacy was small although results showed that youth increased frequency of talking with their parents about sex and protection against pregnancy and STDs, even though there was a decrease in parental involvement
Family Matters - Bauman et al., 2002	There were statistically significant programme effects that suggested the programme decreased both smoking and drinking prevalence.
CHAMP - McKay et al., 2004	Preliminary analyses of the pre-adolescent data suggest that the programme is associated with strengthening parental decision making, increasing comfort in family communication regarding sensitive topics, and increasing parental HIV/AIDS knowledge. Unfortunately, long-term data on HIV risk behavior effects was not yet available.

ImPact - Wu & Stanton, 2003	Participants reported lower rates of sexual intercourse, sex without a condom, alcohol use, cig use, "risky sexual behaviors" for participants in the family intervention. Although intervention impact was sustained through 12 months, the effect was not as pronounced on sexual risk behavior. Although it is possible that events such as condom use may be less amenable to parental interventions.
SAAF - Brody & Murray, 2004	A medium effect size emerged for regulated, communicative parenting behavior and a small to medium effect size emerged for youth protective factors.
HOPE - Beharie & Kalogerogiannis, 2011	Preliminary data results revealed youths involved in the family-based programme evidenced significant changes in suicidal ideation comparative to basic provision of HIV education, and bolstered communication between parents and youth regarding hard-to-talk-about subjects such as alcohol and other drug use, and sex and sexuality.
PAS - Koning et al., 2009	Programme showed long term reduction in youth heavy weekly drinking, and frequency. It also delayed effectively the onset of weekly drinking in the short term as well as the long term.

Father & Sons - Caldwell et al., 2011	The programme showed to increase father - son communication and emotional understanding, as well as sons' violence avoidance, however no objective findings were gathered in relation to youth risky behaviors and substance use patterns.
EcoFit - Stormshak et al., 2011	Results showed positive impact on antisocial behavior and substance use. In particular, youth whose families engaged in the intervention showed less growth in antisocial behavior and substance use during the middle school years.
SFP/MSFP - Coatsworth et al., 2009	Results of this study provide empirical support for the efficacy of both SFP 10-14 and MSFP to improve parenting practices and family functioning factors that serve as important mediators of youth risk behaviors.
SFP 10-14 –Kumpfer et al., 2012	This programme shows significant results of outcomes in parent communication, monitoring, reduction in youth alcohol and drug use reduced risky sexual behaviors, decreased susceptibility to peer pressure, and increased in parent child relationships and general child management post programme intervention

3.2.3 Discussion

There were eleven (11) programmes identified from good quality literature with a family focus. All programmes reported significant outcomes, which supports the strength and potential of family -based interventions. Two iterations of the SFP was included in the final summation. The SFP 10-14 programmes were combined with mindfulness training with reported success which support the adaptability of the programme. Results indicated that, in general, MSFP was as effective as SFP 10-14 in improving multiple dimensions of parenting, including interpersonal mindfulness in parenting, parent-youth relationship quality, youth behavior management. It was curious that mothers in SFP 10-14 reported better self-regulation in parenting and emotional awareness of youth at both post-intervention and follow-up than mothers in the Mindfulness/SFP programme. The SFP addressed delaying and/or preventing the onset of high risk behaviours in pre-in addition to reduction of engagement. This suggests that the SFP programme is appropriately focused for preventative intervention with at risk pre-and early adolescents.

The SFP included more outcome variables than other programmes which speaks to the comprehensiveness of the intervention. The SFP reported the most robust effect sizes with effects across programme outcomes. SFP 10-14's impact on long-term youth substance use and delinquency outcomes are mediated through its more immediate or proximal influence on targeted risk and protective factors (Spoth et al., 2011). Immediate gains in skills, attitudes, knowledge, and beliefs serve to strengthen the family unit and promote positive family dynamics that buffer youth against initiation and lifetime use of drugs, alcohol, and tobacco and delinquent behaviors, such as aggression (Spoth et al., 2011). Unlike many prevention programmes that show a decline in achieved outcomes shortly after the intervention, SFP 10-14 demonstrates positive and significant impacts up to 10 years following programme participation (Spoth et al.,

2002; 2005; 2011). The data revealed SFP 10-14 to be unique in its objective to put parents back in control and it introduces protective factors against most of the risky behaviours displayed by pre-and early adolescents, ideally between the ages 10-14.

The programme preferably has 2-hour sessions for 7 weeks, of which the parents and children meet separately during the first hour and together for the next hour. SFP 10-14 can be conducted with multi ethnic groups across socio-economic backgrounds by facilitators at practitioner level from a wide range of disciplines.

3.2.4 Conclusion

In South Africa, research shows pre- and early adolescents are at particular risk of substance abuse and becoming involved in sexual risk and other risky behaviours (Reddy et al., 2013; Windle et al. 2008). Health risk behavior has been clearly defined as a developmental characteristic, coupled with a preference of influence shifting from family to peer relations, as a primary source of influence. Current evidence suggests that certain family-based prevention programmes can be effective and could be considered as adaptation and implementation options for the South African context. The findings of the systematic review indicate that, through a filtering process, the SFP 10-14 emerged as the most robust programme which was empirically supported, and which had the most improved efficacy or impact of reducing, delaying and preventing the onset of health risk behaviours in pre- and early adolescence. Since this programme was successfully adapted and implemented in different contexts, it provides the scope to adapt the SFP 10-14 programme to the South African context with the primary focus on culture and language.

3.2.5 Limitations of the Review study

Publication bias may be a limitation in that the systematic review drew on mainly published studies which is not necessarily an accurate representation of the larger body of research that has been conducted. Reference mining was included in the reviews to try and alleviate publication bias.

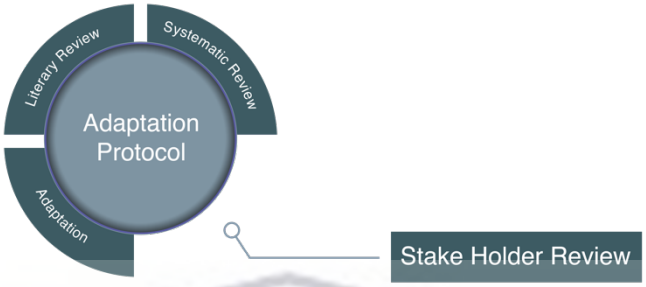
Language bias was also present as the inclusion criteria specified that only articles in English were considered for the reviews. Thus, the results must be interpreted in relation to the linguistic limitation.

3.2.6 Recommendations

- The selection of the SFP 10-14 for adaptation is supported by the empirical evidence for the programme from the systematic review
- The programme details or intervention description included criteria along which adaptations should be considered such as
    - Target group,
    - Language,
    - content or programme outcomes,
    - facilitation
    - Participation, and
    - Resources
- It is the recommendation that stakeholders should be consulted on the elements for adaptation. Incorporating all stakeholders plays a pivotal role in attempting to effect change and increase buy-in (Pharaoh et al., 2018).

- The systematic review methodology was useful for filtering information about effective programmes and can aid selection of programmes for adaptation in a meaningful manner.

CHAPTER FOUR: PHASE TWO – STAKEHOLDER REVIEW



4.1 INTRODUCTION

Chapter Four reports on the second phase. This phase addresses the second objective of the study. The objective was to understand the views of stakeholders of the elements that should be considered in adapting the SFP-10-14 programme designed to prevent, reduce or delay the onset of high-risk behaviours in pre-and early adolescents. The chapter is divided into two sections, Section A describes the specific methodology that was followed to collect and analyse the data gathered, and section B reports the results of the analysis followed by discussions about the results.

4.2 SECTION A - METHODOLOGY

4.2.1 Study Aims

The aim of this stage was to collect stakeholders' perceptions about cultural elements that should be considered in an adaptation of SFP 10-14, a family-based programme, to delay engagement in HRBs in pre-and early adolescents in the South African context.

4.2.2 Research Question

What elements needs to be considered in an adaptation of the SFP:10-14 programme for implementation in the South African context (Cape Flats and Metropole)?

4.2.3 Research setting

Cape Flats, Cape Town South Africa

The setting of this study is amongst the youth of the Cape Flats, in the Western Cape Province of South Africa, who are a part of a predominantly fractured community that has or is experiencing various levels of poverty and injustice germinating from the oppressive apartheid system. Bray and colleagues (2012) reported that the youth population of the Cape Flats are predominantly Coloured Africans and Black Africans and only represents 3/5ths of the total Cape Town population. The youth population of Cape Town reportedly is mainly Black African at 46%, Coloured African, (40%) White African (13%) and Indian/Asian African (1%). The most dominant spoken language is IsiXhosa at 41%, Afrikaans at 30%, and English at 26% (Bray et al., 2012; Statistics of South Africa 2016). Bray and colleagues (2012) also indicated that 42% of the youth live in income-poor households and 14% live in overcrowded homes. Numerous research report on the challenging lived realities of the Cape Flats youth, from witnessing, perpetrating and being affected by the most violent of crimes, substance abuse, risky sexual activities (Kahn, 2005); gangsterism (Bowers Du Toit 2014); broken and dysfunctional family settings (Dames 2014); poverty (Bray et al. 2012); and substantial levels of fear and anxiety (Dickie, 2020).

This researcher's interest resides in the community from the Cape Flats, because it has a personal resonance with him, as he was born and spent most of his childhood and youth years in the Cape Flats. This current study is conducted in this setting with youth attending a privately funded school in the Metro South Education District of the Cape Flats.

Christel House South Africa (CHSA)

Established in 1998, Christel House SA (CHSA) is an international charity school with a single mission: to break the cycle of poverty (Christel House SA, 2021, About us section, para.1). The school had given verbal permission for this study to be conducted as well as for the disclosure of the school name in future publications (N. Sheridan, verbal permission, November 26, 2014).

Poverty touches every aspect of a child's life, determines their future and almost always leave them trapped in a spiral of unemployment and continued poverty (Bowers DuToit, 2014). Christel House SA, set in the Metro South education district in the Cape Flats, offers no-fee scholarships to students from some of Cape Town's most impoverished communities and provides them with "quality education, health care, daily meals, guidance counselling, college and careers support, and daily transportation to the school" (Christel House SA, 2021, About us section, para 1). Every child attending Christel House SA comes from an extremely poor community situated in one of the 20 peri-urban, townships and high-density living areas it serves in Cape Town where crime, poverty and violence are extensive.

In 2021 CHSA served the 20 poorest townships and informal settlements in Cape Flats area, with 700 student enrollments (Christel House SA, 2021, Annual Report). The CHSA

Annual Report (2021) reported the percentage composition of students around language and race, and found that Coloured students, who spoke primarily Afrikaans and English, represented 62% (434) of the students, where Black African students, who spoke isiXhosa and English represented 38% (266) of the students. The statistics also suggested that forty-one percent (290) of the student body represented the ages 10-14, i.e. from grades 5-9 (Christel House SA, 2021, Annual Report**).**

4.2.4 Study Design – Concept Mapping

As mentioned before, modified concept mapping was the methodology used in this stage. Concept mapping is a stakeholder-driven, research approach that is particularly well suited to the evaluation of health issues within the local community context (Vaughn et al., 2013). Concept Mapping applies an action research approach, in which the research participants are actively engaged throughout the research process (Rebich & Gautier, 2005). Concept mapping is particularly appropriate for community-based participatory research (CBPR), because it is designed to integrate input from individuals with differing content expertise, interests, and experience, and generates repeated opportunities for input in the processes of sharing opinions, interpreting results, and prioritizing next steps (Allen et al., 2015).

A singular strength of concept mapping is that it moves beyond the mere identification of priority health conditions by offering stakeholders the opportunity to become directly involved in discussing strategies to address those health conditions. Benefits of concept mapping include its visual end-products that can facilitate decision making (Kane & Trochim, 2007), its use of stakeholder language (Trochim, 1989), and the flexibility in how it is conducted (Anderson et al., 2011). Participatory approaches can engage local youth and families in research to address

problems of interest to the stakeholders involved. Benefits of participatory research include increased relevance of the research to both the various stakeholders and the academic partners, and development of interventions that are informed by the lived experience of the stakeholders involved (Israel et al., 1998).

Concept mapping is flexible and allow users to decide on the format and content of maps, steps and outputs that are most important and feasible to answer a particular research question (Daley, 2004). Concept mapping has been used effectively with a range of stakeholder groups. For example, concept mapping has been widely used with adults and, to a more limited extent, with youth in conducting health research (Burke et al., 2005; Vaughn et al., 2013). Children and adolescents are uniquely situated to benefit from participatory research approaches that emphasize multifactorial elements affecting health and illness (Vaughn et al.; 2013). Israel et al. (2005) postulate that youth health research that includes adolescents and families increases the contextual relevance of findings. Although children and adolescents are especially impacted by health conditions with social and environmental aetiologies, youth engagement in health research using participatory approaches remains less frequent than among adults (Vaughn et al., 2013). Langhout and Thomas (2010) underscored the benefits of participatory research methods with children or youth as a stakeholder group and referenced a dedicated issue of the American Journal of Community Psychology that addressed participatory research. Participatory research is also particularly important among marginalized populations (Israel et al., 2005), including minorities and populations of low socio-economic status (Vaughn et al., 2013). Similarly, an issue of Family & Community Health identified participatory methods as useful with immigrant youth as a stakeholder group (Allen et al., 2015).

Concept mapping has been used successfully on a number of topics in youth research. For example, to examine coping strategies among high-risk youth (Estrada-Martinez et al., 2011), as well as youth perceptions of physical activity (Ries et al., 2008) and bullying (Vaughn et al, 2013). Participatory methods such as, concept mapping, was applied to topics like examination of school recess (Ren & Langhout, 2010) and work on youth mental health issues (Liegghio et al., 2010). Participatory research work has also been applied to topics ranging from substance abuse prevention (Kulbok, et al., 2015) to immigrant issues (Allan, et al., 2015).

Englebrecht et al. (2005) outlined concept mapping as a descriptive approach that involves five distinct phases: (1) Preparation, (2) Generation, (3) Structuring of statements, (4) Analysis, and (5) Interpretation and Utilization of maps.

4.2.5 Steps in Concept Mapping

Step 1: Preparation.

The preparation step consists of three key operational activities namely, identifying stakeholders, developing stimulus prompts, and determining time frame/schedule (Novak & Canas, 2006).

a) Operational activity 1: Identifying stakeholders

The current study incorporated two qualitative methods of data collection based on Babbie's (2013) argument that focus *groups* and *individual interviews* were the most used methods of data collection with qualitative research. Trochim and Linton (1986) advocated for concept mapping to include a wide variety of relevant stakeholders, and for stakeholder groups to be clearly

defined. Burke and colleagues (2005) identified that it was challenging to balance the need for multiple perspectives with the ideal group size when making decisions about the adaptation elements. These authors further recommended that stakeholder groups should be balanced carefully. Researchers need to recognize that the selection of stakeholder groups is a methodological decision that must be empirically supported (Kane & Trochim, 2007). Four stakeholder groups were identified namely, youth, parents/ caregiver, educators, and experts in community development and youth work, in order to represent their collective perceptions and experiences.

Focus groups were the primary method of data collection and interviews were used where participants, specifically experts in the community, were unable to fit into scheduled group sessions. Three focus groups and three individual semi-structured interviews were conducted in total. Below is a brief description of the targeted stakeholder groups with a motivation for inclusion.

1. Youth.

Youth were an important demographic to consider as a stakeholder group. Relatively little information exists about what adolescents prioritise or need for health and development (Pharaoh et al., 2018). This directly impacts whether and how they engage in intervention, as well as whether interventions are appropriately targeted and relevant (Evans et al., 2013; Pharaoh et al., 2018). Reich et al. (2015) highlighted the concern that youth are rarely involved in the process of identifying or addressing their own needs. Yet, search suggests that by involving youth from the onset, interventions have the potential to be more successful (Lowe et al., 2004,

Horne et al., 2009; Pharaoh, et al, 2018; Vaughn et al., 2011). Thus, involving the young people in the generation of research and its use, enhances the opportunity for optimal health outcomes (Thompson et al., 2009). For the purposes of this study, learners enrolled in the Metro South Education district in grades 5-9 were identified as the target group. These learners included primary and high school learners aged between 10-14 years.

2. Parents/ caregivers

Growing evidence suggests that helping learners adopt, change, and maintain healthy behaviours require a multi-faceted approach that would include family context (Cummings et al., 2003; Hawkins et al., 2002; Pharaoh et al, 2018). Weis and colleagues (2014) postulated that parents wield significant authority as the most important decision-makers in the children's lives. These authors further claimed parents to be contributors towards understanding youth, family, social and cultural backgrounds, suggesting that effective communication and trust between home and school is impossible (Weis et al., 2014). The term "parent" here refers to 'those who act in a primary caregiver or parent role, whether they are the biological parent, a relative, adoptive parents, foster parent, or non-related caregiver (Smith et al., 2019).

For the purposes of this study, parents and caregivers of adolescents enrolled in the Metro South Education district were targeted. Participants in this subgroup had to have adolescent learners who were also willing to participate in the study. Thus, parents and youth were recruited into the study as dyads or pairs, but they would participate in their respective stakeholder groups. This provided an opportunity to obtain information from different vantage points on the same issue in the same context.

3. Educators

Given that school-based programmes, and the interventions within, rely on a range of stakeholders, the extent to which educators are engage in any intervention can impact on the overall direction and outcome of the programme (Della Torre et al., 2010). Osowski and colleagues (2013) underscores the need for educators to be collaborators in community-based research because of their influence over the children's activities, choices, lifestyles and productivity at an early age (Osowski et al., 2013). In particular, their role and experience in teaching this target group of adolescents is critical for underpinning any intervention feasibility, acceptability and overall performance (Bruss et al., 2010, Downs et al., 2012).

For the purpose of this study educators who had experience in teaching grades 5-9 in the Metro South Education district were targeted. These grades correspond to the identified age group for the adaptation of the programme. Participants for this sub-group were chosen based on their years of experience (least two to twenty years) in teaching adolescent learners between the ages 10-14. Thus, their qualifications and years of experience was critical, as it would inform the intensity and ferocity in which pre- and early adolescent risky behaviour increased within the school context post-apartheid.

4. Experts in community development and youth work

Burke and colleagues (2005) recommended that subject matter experts are included as an important stakeholder group. Experts are considered as outside stakeholders who bring academic and contextual relevance to concept mapping processes (De Weger et al, 2018). De Weger and colleagues further suggested that subject matter experts have knowledge of systems

and processes that are useful to locate or situate the subjective lived experiences of insider stakeholder groups into the process. Cluley and colleagues (2022) added that experts' relative areas of expertise must be defined clearly as a motivation for inclusion and subsequent recruitment of participants.

For the purposes of this study, individuals, with expertise in developmental knowledge of adolescents, programming and intervention for adolescents, community-based youth work, and research into interventions including life skills and transferable skills training, were included. Professionals working in the field of childhood and youth development were targeted, e.g. psychologists, youth workers, and youth researchers. Eligible participants had to work in the Metro South Education district as this was representative of the research setting. The primary focus of their expertise must include youth risk reduction and skill development. Thus, their qualifications, the nature of their experience and years of experience would be used to determine their status as experts in the identified field.

5. Recruitment of participants

The recruitment strategy for participants from identified target groups must follow normal sampling strategies. The number of participants per group can vary. Seminal references stated that it is possible to engage a large number of participants however, typically 10 to 40 over all are needed to achieve saturation in the brainstorming phase (Trochim & Linton, 1986). These authors further recommend 10 participants be recruited per stakeholder group for a project that will compare groups with each other in terms of differences in their statement ratings. For the purposes of the present study, the target number of participants was set at 10 participants for

each of the following stakeholder groups: educators, youth and parents/ caregivers. This number was in keeping with the recommendation of Trochim and Linton (1986). Participants for this study were chosen based on their knowledge or experience on the topic and stimulus prompts (questions and probes) were planned in advance to focus attention on the topic. For experts, a minimum of one participant per area of expertise was set as the threshold. Further recruitment would be dependent on the nature and comprehensiveness of the contribution of the expert. Thus, a minimum of three as per the identified areas of expertise.

6. Sampling strategy

Typically Grade 7 is offered at primary school and grade 8-9 are offered at high school. To facilitate ease of access, comprehensive schools in the Metro South Education District were targeted, because they offer education from Grade R to grade 12. This would enable recruitment of learners, educators and caregivers across the identified grades within a single context of school. A comprehensive school was identified that houses three separate academic programmes, pre-primary, primary, and high school, which meets the criteria for youth aged 10-14 years for this present study. The school educates children from impoverished neighborhoods with the goal of creating sustainable social and educational impact. Thus, this school included learners from the communities where there were known risks and vulnerabilities for engagement in a range of health risk behaviours amongst adolescents. The enrolment profile at the school provided a range that was representative of communities in the Cape Metropole and Cape Flats.

The learners, parents and educators in grades 5-9 formed the sampling frame from which recruitment took place. All eligible stakeholders were invited to participate in the study.

Therefore, the sampling strategy was a simple random sample as all eligible participants had an equal opportunity to form part of the study. The responses to the invitations are discussed in Section B with the profile of the final sample.

Experts were purposively sampled. They were identified through networks based on the stated criteria. A list of 12 potential participants (4 per area of expertise) was compiled and they were invited to participate. The response to invitation is discussed in Section B.

b) Operational activity 2: Developing the stimulus prompt

This activity requires a stimulus prompt to be developed. The aim of the prompt is to present it to the participants from the respective stakeholder groups and to elicit their view and opinions (perceptions) of the material presented to them (Chacón, 2006). These prompts, often presented as questions, serve to encourage (or constrain) the breadth of ideas generated during brainstorming. Therefore, careful attention must be given to this step (Chacón, 2006). A logical analysis of possible responses must be conducted which serves to anticipate how the prompt would function and whether it would produce the desired information (Novak & Canas, 2006). The prompts must be aligned to the objectives of the study in order to maximise relevance of the data and reduce the burden of participation (Given, 2008). The stimulus prompts would become the schedule for subsequent data collection.

For the purposes of this study, the principal researcher and his supervisor brainstormed possible focus prompts. This process considered the study objectives that aimed to identify which adaptations would be recommended by stakeholders or required by stakeholders to increase relevance of the programme and promote buy-in. The narrative review, theoretical framework and the body of knowledge about adaptation, programming, intervention, and

evaluation matrices were considered. Drawing on this fund of knowledge and experiences in the field, six core elements were identified that were important in the field of programme development, evaluation and adaptation.

1. ***The target group***

From the literature it was identified that first time engagement with a range of health risk behavior is at younger ages within the pre-teen phase (Lester and Cross, 2015; Pharaoh et al, 2018). The need for intervention with pre-and early adolescence was established (Reddy et al., 2013). Programming already exist for intervention with this age group with a focus on reducing engagement or delaying engagement in HRBs.

The role of parents, family and caregivers in developing healthy resistance skills in youth was also developed (Weis et al., 2014). Systems theory expounded many benefits of including networks such as family in the intervention (Weaver et al., 2013). The SFP-10-14 was identified based on a number of considerations mentioned before. This programme identified family-based target groups including the adolescent aged 10-14 and at least one family member (Spoth et al., 2014)). The stakeholder input and views on this conceptualization of the target group would be important. A number of questions were formulated to stimulate discussion for example,

- Who should be included in programme?
- Is it feasible and desirable to include parent/guardian-child dyads in such programmes?
- Is the 10-14 age group appropriate? Should it be amended in any way?

2. *Language*

Adaptation entails moving content from one context to another ensuring that the adapted content is suitable to the targeted context with specific reference to culture and cultural considerations (International Test Commissions; ITC, 2017). Language is an important cultural artefact that must be considered in adaptation (Wegner et al., 2007). South Africa is a multilingual country with 11 official languages (StatsSA, 2011: Census 2011). In the Western Cape there are three official languages including Afrikaans, spoken by 49.7% of the residents, isiXhosa, spoken by 24.7% of the residents, and English, which is spoken by 20.3% of the residents (StatsSA, 2011: Census 2011).

Public schools and most private schools, teach according to the South African curriculum, which means the students get taught in two languages, usually English and Afrikaans, one being a home language and the other a first additional language (Department of Education, South Africa, 2002).

Thus, stakeholders must be consulted about language considerations in the programme. The following questions were formulated to stimulate discussion:

- What languages should be considered when implementing the programme? Are there preferences?
- What elements regarding language should be considered e.g. level of difficulty, fluency of participants, existence of equivalent concepts in target languages,
- Linguistic abilities of participants and presenters or facilitators
- Are reading materials in western version of English accessibility of

- Is translation of materials required? Is it feasible?

3. *The degree and nature of participation*

The SFP 10-14 programme includes both adolescents and family members. Stakeholder groups were requested to consider any elements regarding participation that may require adaptation. The evidence provided in the narrative review and the systematic review reported moderate to strong effect sizes for the intervention. This included a specified nature of participation. Programme evaluation makes a distinction between the degree and the nature of participation (Wegner et al., 2007; Wood et al., 2013). The degree of participation may relate to more technical aspects such as frequency of meetings, attendance, completion of homework etc. (Wegner et al, 2007). Conversely, the nature of participation related to the quality of the contribution or participation. Stakeholders were requested to consider whether any elements of participation required adaptation. Questions included

- What kind of involvement should there be from participants?
- What should everyone be doing in these sessions?
- How many sessions should be appropriate?
- What kind of engagement should be required?
- How should participation be defined and measured?

4. *Content*

The narrative review and systematic review identified a range of HRBs that required intervention. The programmes identified in the systematic review reported

success with targeted HRBs. The SFP 10-14 was identified to include the widest range of content including skills training and psychoeducation, and applicability to HRBs in general as the focus is on risk behaviour. Thus, stakeholders were required to provide their views on the content that should be covered and which adaptations may be required for the SFP programme. Questions may include

- What should be covered as high-risk behaviours in such a programme?
- What skills training is required?
- Are there any specific things in your context that must be targeted?

5. ***Facilitation***

Programme evaluation and programme design literature identified facilitation and decisions about facilitation as important issues to address explicitly (Kumpfer et al., 2012). The systematic review identified a range of facilitation approaches in successful programming. The SFP 10-14 incorporates specific facilitation styles and activities. Stakeholders were requested to consider whether there were elements of facilitation that should receive attention or required adaptation. Questions included

- What style of facilitation works best in your context?
- How many facilitators should be involved?
- What qualifications or experience must facilitators have?
- How should programme activities be facilitated?

6. ***Resources***

Programmes include resources for implementation including material resources (consumables), infrastructural or physical resources (rooms etc.), instructional or teaching resources (videos, games, guides) financial resources, human resources and other categories of resources. Stakeholders were asked what elements of resources would need to be considered for successful implementation?

c) Operational activity 3: Determination of the time frame/ schedule

This activity refers to planning the timeframe for executing the fieldwork that will inform the concept mapping exercise. The fieldwork for this phase was conducted between October 2015 and February 2016. A twelve-day period for data collection, i.e. focus group discussions and interviews and was decided upon by the time and the number of days the stakeholders were available. A total of six days was allocated for data collection i.e. one day per focus group (3 days total) and one day per interviews (3 days total). Another six days was allocated for transcription of recorded information and consolidation of data collected (1 day per group/interview) in order to prepare the information for content analysis.

The scheduling of activities followed the sequence of steps in the concept map. A full schedule including all steps and activities is reflected in **Appendix L and M.**

Step 2: Generate ideas

The purpose of this phase is to yield a set of ideas that represents the diversity of thought regardless of who specifically is generating those ideas. The generation phase begins with a brainstorming process and results in a final statement set which is the basis for the structuring

phase. According to the standard concept mapping methodology, demographic data are not collected during the generation phase, but rather during the structuring phase, which enables subgroup analyses (Kane & Trochim, 2007; Trochim, 1989). At this stage, participants/stakeholders brainstorm responses anonymously to the focus prompt, participating either in individually or in groups. Participation can be in person or via the Internet (Engelbreght, et al., 2005). Barki and Pinsonneault (2001) suggests placing emphasis on the volume of ideas while deferring judgment on their quality maximizes creative idea generation during brainstorming.

The generation of ideas is often facilitated through qualitative methods (Lincoln et al., 2011). Focus groups and interviews are the primary methods of qualitative data collection (Babbie, 2013). Similarly, focus groups and interviews were also more commonly used in concept mapping (Daley, 2004). For the present study, focus groups were selected as the method of data collection with youth, educators and parents/caregivers. Interviews were used to collect data from experts. The focus groups and interviews were semi-structured in that the six domains of the stimulus prompts were used to ensure that insights were explored within each of these areas. As mentioned before, these domains were distilled from literature and methodology as important domains to cover. Thus, the semi structured format for both focus groups and interviews was important and the structure was informed by the six domains in the stimulus prompt. Then, in another deviation from the normal process, participants rated the domains (dimensions) in terms of importance or relevance to the cultural adaptation process on a 5-point likert scale. Below is a brief discussion of how each method was applied.

1. Focus Groups

The focus group discussion was used to get more in- depth information on the perceptions, insights and beliefs of learners, teachers and youth experts on the cultural elements to be included in family-based intervention programmes aimed at reducing or delaying the onset of high risk behaviours in pre-and early adolescents. A focus group is an informal discussion among a group of selected individuals about a particular topic (Wilkinson, 2004). Kamberelis & Dimitriadis (2008) further explains it to be 'collective conversations', which can be small or large. The purpose of the focus group discussion is to promote self-disclosure among participants and to obtain in-depth information on concepts, perceptions and ideas of a group. According to Liamputtong (2009) the primary aim of a focus group is to describe and understand meanings and interpretations of a select group of people to gain an understanding of a specific issue from the perspective of the participants of the group.

The characteristics of a focus group discussion include (i) having 5-10 participants; (ii) composed of participants who are similar to each other; (iii) Provide qualitative data; (iv) involves a topic of interest that has been carefully planned and (v) session length is under two hours (Krueger & Casey, 2000). The discussion was planned to promote spontaneous dynamic interaction between participants so that ideas could be explored.

The general consensus on what the core components of a focus group should be include the ideas that a) the group is constructed with a research focus and data collection in mind, b) the researcher needs to collect specific data and determines the research agenda c) the data are enhanced through group interaction (Barbour, 2007; Puchta & Potter, 2004). Thus, the focus

group was structured specifically along the stated aims of the study. It was deemed appropriate to make use of focus group discussions to facilitate the generation phase with three stakeholder groups. The focus group was semi-structured. The stimulus prompts developed in step 1 was used to ensure that the required content was covered.

The focus groups were facilitated as a once off encounter with a specific stakeholder group. The primary researcher facilitated the focus group. The stimulus prompts were presented to each group and their responses elicited. Sessions were facilitated at the school as this represented a familiar setting and promoted safety. This was also convenient in terms of access to the participants and therefore no additional transportation was required by participants. This was an important consideration given the socio-economic realities of the target group. Sessions were facilitated after school and was approximately 90 minutes long. Sign up/attendance register (**Appendix N-P**) and completion of consent forms were done before the focus group session commenced. The generation or brainstorming phase started with a review of the research aims and an explanation of the process. The duration of the brainstorming was between 60 and 80 minutes long. After each brainstorming session, there was a reflexive session of 20 minutes in which participants were asked about their experience and they were given an opportunity to raise any suggestions not covered by the six dimensions of the stimulus prompt. This session also included an opportunity to raise concerns and debrief. No participants required containment or referral to professionals as a result of adverse reactions to the content. Focus groups were audio recorded and transcribed.

The focused groups were structured into two parts. In the first part, the researcher presented the prompt questions and participants had to write down their immediate reaction to

the prompt. These reaction (in written form) were collected and collated into an electronic format. The purpose of this exercise was to gain the unprocessed reactions to the stimulus prompts. Collecting and collating these responses into an electronic form provided the opportunity to create a greater level of anonymity in relation to the content of the response. The responses were collected and collated by a research assistant which assisted with time management.

The second part of the focus groups entailed presenting the stimulus prompts and the initial reactions. The group then discussed these reactions and formulated ideas around it. For example, what does it mean? Why is it important? This facilitated a safe discussion in response to stimulus prompts and responses that were a little separated from individual contributors. This method was useful in filtering and processing the views and reactions of the participants. As the participants were only available for a single session, this format and style of facilitation allowed for secondary processing and reflexivity. An added benefit was that participants were able to clarify and explain their initial responses. Clarifications were captured and the recorded statements edited to ensure that it was clear and a more accurate reflection of the participant's thoughts. Reflections and clarifications helped participants to open up, disclose their views more freely, and openly discuss their experiences on a more personal level. This resulted in a richness of the data collected during all focus groups and interviews. Both the original and edited versions were kept as evidence of the process.

2. Interviews

Interviews involve a one-to-one, qualitative and in-depth discussion where the researcher adopts the role of an "investigator" (Hohenthal et al., 2015). It implies the researcher asks questions, controls the dynamics of the discussion, or engages in dialogue with a specific individual at a time. The researcher thereby takes a center-stage role, unlike in a focus group discussion, where the researcher is more peripheral (Bloor et al., 2001). Interviews were adopted as feasible alternatives to focus groups for participants from the subject matter expert group. Focus group discussion have been seen as "group interviews" and sometimes as synonymous with interviews, especially the semi-structured "one-to-one" (Parker & Tritter, 2006). The role of the researcher and the relationship with the participants points to a fundamental difference between the two techniques (Smithson, 2000). The interviews were selected for stakeholders who would be difficult to convene as a group. Thus, in the present study interviews were seen as a viable alternative to focus groups rather than an equivalent. The stimulus prompts were used as the interview schedule.

The interviews were conducted by the primary researcher at a location that was mutually agreed upon by the interviewer and interviewees. Interviews lasted about 90 minutes. The same structure was applied to interview as the focus groups. Interviews were audio recorded and transcribed.

Step 3: Structuring and sorting statements

This step includes two operational activities namely structuring and sorting. Structuring entails the creation of statements taken from the idea generation phase. Statements should be

easily understandable, clear and unambiguous. Above all the statements must relate to and be relevant to the focus prompt(s). Statements can also be clarified with the following actions: correcting grammar, synthesizing ideas, and deleting duplicates. The ideal number of statements for use in the sorting phase is between 50 and 100 (50 < 100) (Kane & Trochim, 2007). This number is generally accepted as sufficiently representative of the diversity of ideas.

To increase contextual relevance, the primary researcher and the research assistant who co-facilitated the focus groups, conducted the process of creating statements. Care was taken to remain as close as possible to the participant's original wording. Statements were created in each of the six domains. The decision to keep the domains separate was a strategic consideration as these domains were considered important in adaptation as motivated earlier. This generation phase produced 387 responses or statements. These statements, generated through the brainstorming process, were reviewed and distilled as recommended by Trochim (1989). This included condensing duplicate ideas, enhanced wording to improve clarity and representativeness as mentioned before. The aim was to reduce the statements to a final 100 distinct ideas. Because of the anonymous submission of ideas, an exact response rate and average number of responses submitted per respondent were not calculated.

The next operational activity entailed sorting and rating of statements (Trochim & Kane, 2005). Tullis and Wood (2008) stated that sorting can be conducted either in person or on-line (virtually). Barki and Pinsonneault (2001) indicated that sorting can be done by an individual or by groups or pairs. As mentioned before, the researcher and research assistance continued to work as a pair on the sorting. Sorting of statements was done within the domains for consistency. The retention of the domains meant that they formed natural clusters into which statements could

be sorted. Sorting did not preclude moving statement from one domain (cluster) to another. Sorting was an iterative process and continued until the team was satisfied that all statements were accounted for, duplications were removed and no content was lost.

The statement and clusters are usually rated by the participants. Due to limited access, this operation was not possible in the present study and constituted a deviation from the activities in the third step of concept mapping. This omission was offset by the aforementioned ranking of the domains (dimensions during the brainstorming phase).

Step 4: Content Analysis

This step entails organizing the statements into themes. Generally thematic analysis or content analysis as qualitative methods of data analysis is recommended (Trochim & Kane, 2005). For the purpose of this study, content analysis was employed. Braune and Clark (2006) defined it as "a method for identifying, analysing and reporting patterns within data" (p.79). The transcripts from the interviews and focus groups, as well as the summaries used in the focus groups formed the source documents of the analysis.

Content Analysis was applied to the source documents. Bengtsson (2016) explained content analysis as a process of identifying and grouping text taken from the verbatim transcripts to develop an understanding. This technique enables researchers to make valid inferences from texts (Krippendorff, 2004). Content analysis attempts to create a picture of a specific phenomenon a particular context rather than an objective account of reality (White & Marsh, 2006).

The three-phased process proposed by Vaismoradi et al. (2013) was followed namely, preparation, organisation and reporting. *Preparation* entailed reading and re-reading transcripts to become familiar with the content. Repeated reading of the statements already started in the previous step and contributed to fostering increased familiarity that in turn helped me to identify salient concepts and patterns as described by White and Marsh (2006). Organisation is a process in which data was placed into content groupings. I assigned codes to assist with the grouping and *organisation of t*he data set. The groupings adhered to the following guidelines: (1) at least two statements were required in a grouping, and (2) each idea statement can be placed into only one grouping. During *reporting the content clusters were examined to identify* illustrative quotes. This phase focused on answering the research questions and to demonstrate conceptual understanding in the arrangement of data observations. Out of the six domains presented, eighteen sub-themes/categories emerged.

1. Reflexivity

Reflexive research requires an awareness of the researcher's contribution to the construction of meaning and the improbability of remaining neutral, impartial, and unconnected to one's subject (McKay et al., 2003; Nightingale & Cromby, 1999). Within constructivist accounts of knowledge, meaning is assumed to be highly subjective and best understood through social interaction and personal histories and experiences (Creswell & Plano Clark, 2007). As a result, knowledge is inherently localized, and the notion of generalizability is seen as overly mythologized. Within qualitative research precision is prized (Winter, 2000), and credibility and transferability provide a means of evaluating research findings (Golafshani, 2003). Cognizant that the approach chosen by the researcher will shape any interaction between the phenomena

studied and the data collected, researchers cannot assign value to one meaning without acknowledging the role that they personally play within this construction (Morrow, 2005). Qualitative research has usefully attempted to acknowledge this limitation through reflexivity (MacBeth, 2001; Willig, 2001).

Reflexivity was considered throughout the research process as an interpretive approach was used. Critical self-awareness was needed on the researcher's behalf. Therefore, the researcher needed to be continuously aware of how he might project his own subjective views onto the research; how he was experienced by participants; as well as ensuring that the meaning and content of the information was not changed. Throughout the research process, the principal researcher reflected on himself as a researcher with a cultural and socio -political identity, family therapist and a father and considered the potential impact he had on the research process.

Lastly, the researcher maintained an awareness of his almost automatic inclination to provide support and comfort to participants, especially in hearing about their personal challenges as mothers, teachers and professionals. The researcher focused his mind on the fact that he was in a researcher role and that his main aim was to elicit responses and collect data. This stance assisted in conducting research that was meaningful and that would eventually contribute to support the notion of a better future for children. As such the researcher's own preconceptions, judgements, views and biases were considered when collecting, analyzing and interpreting the data. Self-awareness and reflexivity of all the aspects of his subject position were essential to maintain the rigour and integrity of the data and research process. To facilitate continuous self-awareness and reflexivity, the researcher wrote reflections after each of the groups and also discussed this in supervision sessions during all phases of the research.

2. Trustworthiness of the data

Trustworthiness of data for quantitative studies, is referred to as validity and reliability. However, in qualitative studies, this concept is more obscure because it is put in different terms. Since qualitative researchers do not use instruments with established metrics about validity and reliability, it is pertinent to address how qualitative researchers establish that the research study's findings are credible, transferable, confirmable, and dependable (Golafshani, 2003). Cutcliffe and McKenna (2001) suggested that the purpose of establishing trustworthiness was to increase the rigour of the methodology and to enhance the credibility of the study by ensuring that the findings, interpretations and conclusions were supported by the data. Trustworthiness is all about establishing these four things, which are described in more detail below.

3. Credibility

Credibility refers to how confident the qualitative researcher is in the truth of the research study's findings. This boils down to the question of "How do you know that your findings are true, accurate and credible" (Golafshani, 2003). According to Merriam (1998), the qualitative investigator's equivalent concept, i.e. credibility, deals with the question, "How congruent are the findings with reality?" Lincoln and Guba (1985) argue that ensuring credibility is one of most important factors in establishing trustworthiness. The following provisions were made by the researcher to promote confidence that he accurately recorded the data:

a) the researcher adopted research methods well established both in qualitative investigation in general and in information science in particular. Interviewing and focus groups are the most common methods of data collection in social science

research, and being a family therapist for nearly 25 years, the researcher was well-versed with these methods.

b) the researcher established trust with participants based on early familiarity with the culture of participants as the researcher was raised in the same neighborhoods of participants.

c) the researcher eliminated possible researcher bias in the selection of participants by random sampling of individuals to serve as informants.

d) the researcher's use of the most common methods of data collection in social science research, i.e. focus groups and individual interviews, allowed for individual viewpoints and experiences to be verified against others and, ultimately, a rich picture of the attitudes and risk behaviours of the target group was constructed based on the contributions of a range of people.

e) the researcher summarized and paraphrased throughout the process to improve the trustworthiness of the data as advocated by Cresswell (2007). In addition, the researcher used clinical skills to reflect on content and process. In doing so, participants could verify the correctness of impressions relative to their contributions as suggested by Krueger and Casey (2000).

4. Transferability

Transferability refers to how the qualitative researcher demonstrates that the research study's findings are applicable to other contexts and situations (Silverman, 2001). In this case,

"other contexts" can mean similar situations, similar populations, and similar phenomena (Aguinaldo, 2004). Qualitative researchers can use sufficient thick description to show that the research study's findings can be applicable to other contexts, circumstances, and situations. To this end, a clear description of the research setting and participants was provided in this study to allow readers to have a proper understanding of it, thereby enabling them to compare the instances of risk behaviours (phenomenon) reported with those that they have seen emerge in their own situations. Furthermore, the multiple environments (learners and parents are from 20 townships in the Cape Flats area) in which the phenomenon of the researcher's interest takes place provide a baseline understanding with which the results of subsequent work could be compared.

5. Dependability

Finally, dependability is the extent that the study could be repeated by other researchers and that the findings would be consistent. In other words, if a person wanted to replicate your study, they should have enough information from your research report to do so and obtain similar findings as your study did. A qualitative researcher can use inquiry audit in order to establish dependability, which relates to the reliability of the study and requires an outside person to review and examine the research process and the data analysis in order to ensure that the findings are consistent and could be repeated (Cohen & Crabtree, 2008). Thus, to promote trustworthiness of data, all interviews and focus group data was transcribed by the principle researcher. The researcher and research supervisor further reviewed the themes and clusters identified and resolved differences through discussion and reflection until consensus was reached consistent with recommendations by Cresswell (2004). In order to address the dependability

issue more directly, the processes within the study is reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results.

Step 5: Interpretation of maps

The final step entails the creation and interpretation of concept maps. This step depends on the interpretation of the results from the data analysis including the comments on reflexivity, trustworthiness of data, and how subjective experiences may have influenced data collection and analysis. The concept mapping procedure results in a visual representation. The cost of using proprietary concept mapping software or the services of a statistician may be a barrier for some researchers (Buchanan et al., 2005). Clusters and statements are used to structure ideas, producing what could be called a conceptual framework (map). Final decisions about the use of the maps and other data would be driven by the initial reasons for the process and its desired outcomes (Gregory et al., 2009). Finally, the concept map is used for evaluation and planning (Brownson et al., 2006).

For the purposes of the study, a visual representation of the elements identified by participants was created. This was the result of collective thinking about specific questions related to the elements that ought to be considered in the adaptation process of the SFP:10-14 programme to the South African context. In a fully participatory process, interpreting the maps usually takes place within the group (Trochim et. al., 2006). In other words, the concept map is presented to participants for feedback. Unfortunately access to participants for this purpose was not possible due to the commencement of the examination period. Researchers were not permitted to engage the learners, educators and parents during this period. The experts were not available for follow up due to difficulty in scheduling. Subsequently, other events such as the

student protests (2016 – 2017), and the pandemic (2019-2021) limited contact with research participants. However, in the present study, the researcher presented the concept map to the supervisor and the research assistant during this phase to approximate the process of validation.

4.3 SECTION B - RESULTS AND DISCUSSION

The results are presented in three sections namely: 1) description of the sample, 2) ranking of domains and 3) themes from content analysis. Lastly, each section is concluded with a discussion of the results.

1. Description of the sample

The overall sample consisted of 39 participants across four stakeholder groups, namely youth, parents/caregivers, educators, and youth experts. Pharaoh et al. (2018) propose that interventions cannot only be implemented for those at risk, but should also incorporate every stakeholder within the community that interacts within the changing environment. Furthermore, they claim that incorporating all stakeholders plays a pivotal role in attempting to effect change and increase buy-in (Pharaoh et al., 2018). Interventions therefore cannot only be implemented for those at risk and should also incorporate every stakeholder within the community that interacts within the changing environment. Below is a description of the participants per group.

a) Youth ages 10-14

All learners from grades 5-9 were invited to participate in the study with an expectation that 10 learners from this subgroup be randomly selected. However, the actual learner subgroup that participated consisted of 14 learners from grade 6 and 7 since access to Grades 8 and 9

learners was revoked due to examination preparation. Thus, four additional learners were allowed in the selection to increase input from different perspectives. Learner demographics of participants includes: race (4 black/African and 10 Coloured), religion (5 Muslim and 9 Christian), and gender (10 females and 4 male learners). The communities represented included Mitchell's Plain, Manenberg, Bridgetown, Hanover park and Langa. De Lannoy (2018) posits that social problems and vulnerabilities in these areas in the Cape Flats are complex ranging from poverty, the breakdown of family control and a loss of ties to extended families, the increasing divorce rate, producing more single parent households. Youth from such disrupted households, full of anger and humiliation, engage in high risk behaviours including drugs and alcohol, sexual risk behaviour and join gangs or form gangs to demonstrate a degree of defiance and pride in their desolate communities (Pillay, 2016). All of the learners from the above-mentioned areas met the criteria for youth between the ages 10-14, being vulnerable to, or who are engaged in high risk behaviours. **Table 4.1** reflects the distribution of learners in terms of gender, age and grade.

Table 4.1

Demographic Profile of the Learners.

	YOUTH (n=14)				
Gender	**Ages**			**Grade**	
	11yr	**12yr**	**13yr**	**6**	**7**
Boys (n= 5)	**0**	**3**	**2**	**3**	**2**
Girls (n= 9)	**2**	**4**	**3**	**4**	**5**

b) Parents/guardians

This subgroup included parents and caregivers of children who agreed to participate. Fourteen parents/guardians were invited and participated since fourteen learners were selected to participate in the study. The sample included two fathers and twelve mothers of the learners who participated in the study. This subgroup is typical representation of Cape Flats population in terms of marital status, level of education and employment status. **Table 4.2** reflects the demographic profile of the parents/caregivers who participated in the study.

Table 4.2

Demographic Profile of the Parents/Caregivers

PARENT/CAREGIVER (n=14)								
Ages			**Level of Education**		**Marital Status**		**Employment status**	
(24-30)	**(31-50)**	**(51-75)**	**(Gr 5-7)**	**(Gr 8-12)**	**Married**	**Single**	**Employed**	**Unemployed**
2	8	4	6	8	6	8	6	8

c) Educators

Ten educators who teach grade 5-9 were invited, but only eight educators agreed to participate in the study, an 80% response rate. The two remaining educators were high school educators (grade 8 and 9) who withdrew from participation due to examination preparation with high school learners. Six females and two male teachers were represented. The educators come

from similar backgrounds to the learners and their combined years of teaching experience totaled one hundred and six years, which allowed for well-informed input and participation. The years of teaching experience, thus offset the number of participants being below 10.

The educators' level of training was an additional advantage. One educator had additional training in Accelerated Christian Education (ACE) apart from their Higher Diploma in Education (HDE) training, which allowed the educator to focus on producing learners with a higher sense of moral compass. Two educators had additional training in Educational Management (EDU MGT). Teacher leadership (middle managers or Heads of Department) is a post-apartheid phenomenon that has political and professional implications and was influenced by past struggles of teachers in the previous education dispensation during the apartheid era (Kruger, 2003; Bambi, 2012). A solid leadership with a positive attitude and the ability to create a school environment that encourages cooperation and communication among staff members, education stakeholders, learners and parents, is the most essential key to school success (Bambi 2012).

Table 4.3 reflects the profile of the educators that participated in the study.

Table 4.3

Demographic profile of educators

EDUCATORS (n=8)			
Qualification	**N=**	**Years of teaching**	**School System**

ACE	1	19 years	Governmental/Independent
HDE	5	19-26 years	Governmental/Independent
EDU MGT	2	2-15 years	Independent Schools

d) Subject matter experts

Twelve subject matter experts were invited to participate in the study, but only three were recruited into the study, a response rate of 25%. Once again, the number of years of expertise offset the number being below twelve. Participants worked in the Metro South Education district, representative of the research setting, and as indicated before, the primary focus of their expertise included youth risk reduction and skill development. The first participant had expertise after school skill development programmes, faith-based youth development programmes and community youth projects, which included prevention and reduction of risk behaviours. The second participant was a practicing physiotherapist with expertise in Life skills, youth risk behaviours and community and school-based rehabilitation and prevention programmes. The third and final participant was experienced in youth related research, including community-based youth research, as well research in school settings with the focus on risk reduction and prevention.

Table 4.4 below reflects the profile of the experts that participated in the study.

Table 4.4

Demographic Profile of the Youth Experts

YOUTH EXPERTS (n=3)				
Profession	**Qualification**	**n**	**Years of service**	**Sector of work**
Youth Worker	B. Science	1	18 years	Churches, schools, Community Centers
Physiotherapist	PhD	1	12 years	Life skills, youth risk behaviours and community and school-based rehabilitation and prevention
Youth Researcher	MS. Science	1	15 years	Community based projects, Schools

The participants met the inclusion criteria for their respective groups. The demographic profiles of the youth and parents/ caregivers were consistent with the composition of the targeted Cape Flats research setting. The educators had extensive experience teaching in at-risk communities. Similarly, the experts had grassroots experiences in addition to advanced skills and expertise in research and practice related to youth, health risk behaviours and intervention.

2. Sorting and structuring

The sorting process produced 100 statement across the 6 domains adopted as clusters. Domain 1 included 16 statements relating to the target group. Domain 2 included 15 statements related to linguistic considerations for programmes. Domain 3 included 20 statements related to participation. Domain 4 included 25 statements related to the content of the programme. Domain 5 included 14 statements related to facilitation, and domain 6 included 10 statements related to resources. **Table 4.5** below present illustrative statements and the number of statements for each domain.

Table 4.5

Statement Analysis with Examples of Statement Ideas

Table 4.5 Results of statement analysis with examples of idea statements

.

Domains	**Examples of idea statements**
Target Group	Engagement in HRBs is prevalent at age 10-14 years
(16 Statements)	Prevention and risk reduction should start at age 7-12 years
	Younger children at age 6-9 years are already engaged in HRBs at alarming rates
Language	The SFP programme should be offered in the mother tongue of participants
(15 Statements)	The language used in the SFP programme depends on which area the SFP is offered
	The SFP programme should also be translated into Afrikaans and Xhosa languages

	Parents and youth should be consulted regarding the language of the programme
Participation	Frequency of participation must be more than once per week
(20 statements)	Participants must include one child and one parent/guardian
	Engagement should be interactive not passive participation
	Feedback session is necessary in between programme sessions
Content	Younger children are using alcohol, dagga, tik, and sniffing glue
(25 Statements)	Gangs are recruiting children to do drug runs and dealing
	Young children are engaging in bullying, gang fights and robbery
	Children are influenced by peers rather than parents/guardians
Facilitation	Most parents and children need to be instructed to do what is right
(14 Statements)	Participants should be able to do groupwork and individual writing exercises
	Facilitator must be aware of the culture and understand the audience
	Number of facilitators will depend on the group size. Ratio of 1:10 is preferred
Resources	Use social media and technology during and after sessions
(10 Statements)	Need finances for excursions and other activities both parents and children can attend
	Needs finances for transport cost and food for participants

a. Rating of domains

The participants rated the clusters and prioritized them in order of importance for adaptation. **Table 4.6** presents the six domain titles and depicts the ranking order. The table presents the overall ranking based on aggregated scores on the Likert scale. The ranking of domains per subgroup is also presented.

Table 4.6

Mean Importance Rating for Each Domain

Rank	Domain	Mean Totals (N=38)	Youth (N=14)	Parents (N=14)	Teachers (N=8)	Youth Experts (N=2)
1.	**Target Group**	**4.23**	1 (3.89)	1 (4.53)	2 (4.00)	2 (4.50)
2.	**Language**	**4.05**	2 (3.82)	2 (3.89)	1 (4.25)	3 (4.25)

3.	**Participation**	**3.74**	4 (3.50)	4 (3.07)	3 (3.62)	1 (4.75)
4.	**Facilitation**	**3.58**	4 (3.50)	3 (3.21)	5 (3.37)	3 (4.25)
5.	**Resources**	**3.46**	4 (3.50)	5 (2.21)	5 (3.37)	1 (4.75)
6.	**Content**	**3.45**	3 (3.57)	5 (2.21)	4 (3.50)	2 (4.50)

The average (mean) importance ratings per domain ranged from a low 3.45 to a high of 4.23. As indicated, target group was ranked first and language was ranked second in the aggregated perceived importance of the domains for adaptation. On the hand, content was ranked the lowest. The rankings suggest that the *who, when* and *how* was more important to participants than the *what* that needs to be addressed in the adaptation process.

The average (mean) importance ratings per participant group is also presented. The rank is presented and the mean values are in parentheses. The youth's ranking was truncated with only 4 ranks. Target group and language ranked the highest in importance, whereas resources, participation and facilitation were joined at the lowest rank.

For parents, resources and content were joint at the lowest rank, and also ranked target group and language their highest in importance. The next two group have mixed perspectives regarding the importance ratings.

Teachers interestingly considered content to be at the third rank since they have high familiarity with content based on the school curriculum (life orientation) and programming (Gurr & Drysdale, 2013). Also, the school where they teach have a social justice and intervention stance, so they deal with related content as a matter of course. There is also a high level of engagement with social services due to the profile of learners and the fact that the school has a social services department to service the needs of the learners and their families. Thus, they have insight into the additional variables that may be important and have been overlooked in current practice. Facilitation and resources were considered the lowest since the school does not lack in resources or capacity in facilitation being a charity school, and have established appropriate partnerships and funding sources for their curricula and other school related projects needs.

The overall mean rankings for the experts were consistently higher. Language was ranked lowest, possibly linked to their experience and insight into the challenges of service delivery in a multi-lingual setting.

Overall, target group has been rated the highest of the clusters, indicating that participants viewed this element to be the most important factor to consider in the adaptation process. Language was rated the second most important factor to be considered in the adaptation process. This stresses the importance of language being considered in the context of implementing a family-based intervention programme.

3. Content analysis

The results of the content analysis within domains/ clusters are presented below.

a. Target group

The analysis identified to two themes. The first related to the age band for intervention as a primary content category in the discussions of adaptations related to the target group. The second theme related to the combination of family representatives and children as the target group for the programme.

For the first theme, the discussion around age groups generated robust discussion in the brainstorming process. Within this category, three sub-categories emerged. Each sub-category represented a different age group. **Table 4.7** outlines the sub-categories of statements related to the target group per stakeholder group.

Table 4.7a

Adaptation Related to Target Group- Age Bands for Interventions

Domain: Target group - Age bands for intervention				
Number of statements (16)	**YOUTH**	**PARENTS**	**EDUCATORS**	**EXPERTS**

Sub-Categories	(4)	(5)	(3)	(4)
1. 10-14 yrs	2 statements	3 statements	1 statement	2 statements
(8)	Pre-high school is good time to address drugs	This is when they start getting their own ideas	Ideally ages 10-14 is good to focus on	I think 10-14 age group is right but it can extend to 16yrs
2. 7-12 yrs	2 statements	1 statement	1 statement	1 statement
(5)	Kids in lower grades also use drugs	Where I live it starts from age 7 onwards	We need to intervene at an earlier age	Age 7 and above in certain communities
3. 6-9 yrs	0 statements	1 statement	1 statement	1 statement
(3)		I would say start with the age 6-9 group	At this age they are they playing "rape-rape" with others	Children are using drugs at an earlier intervention age

The first sub-category identified the age band for intervention as 10-14 years old. This sub-category corresponded to the target group as defined in the SFP:10-14. There were 8 statements

that supported retaining this age band across the four stakeholder groups. The youth and expert groups had two statements each supporting the 10-14 age band. Support for this age band comes from grade 6 and 7 learners, aged 11-13 and their parents. These learners are reportedly experiencing peer pressure for risk behaviours at this age already. Their parents share the same concerns. The experts concur with this age as the intervention age based on their own research of trends observed and their work in the communities. A clear recommendation for the age 10-14 emerged therefore as preferred target group. The quote below illustrates the sentiment expressed.

> "At 10-14 years old because it starts at a very young age. Children are behaving like that because of the community, no one is stopping it" (Youth, P3).

The parent group had 3 statements and the teachers had one statement supporting the retention of the 10-14 age band. The quote below illustrates their conveyed reaction.

> "This is the age when they start getting their own ideas and follow their peers" (Parent, P2).

The second sub-category identified that the age band had to be adapted from 10-14 to 7-12 years old. Five statements were recorded across the stakeholder groups. The youth included two statements and the others groups had one statement each. The motivation here was that engagement with HRBs was noted at younger ages. Therefore, the focus was on the lowering of the band from 10 to 7 years old. The upper band of the age group was reflected as 12 which was more pragmatic.

Primary schools generally have 12/13 as the upper age in the final grade 7. This band corresponds to the intermediate and senior phases of primary school in South Africa (DoE, 2000). The thinking was that primary school aged children in these phases formed a natural cohort. The quote below illustrate the motivation for this adaptation.

"Where I live, it starts from age 7 years onwards already" (Parent, P6).

The third sub-category suggested a more radical amendment to the age band of the target group to ages 6-9. The core argument was that intervention should begin even earlier. The entire age band is lower than the lower age limit of the SFP 10-14 and would correspond to the SFP 6-11 version. The age band would target learners in the foundation phase of primary school. The motivation provided centered around observations that children in this age group were exposed to trauma and HRBs. They reportedly re-enact through play, various risk behaviours. For example, the parent and teachers reported that children at this age were re-enacting observed sexual violence or personal child sexual abuse. If the play or behavior was reactive, then it constituted a health risk (Whitebread et al., 2017). The quote below illustrate the motivation for this adaptation.

"At this age they are playing "rape-rape" with others" (Teacher, T3).

Another reflection from parents and experts were that children at this age were enlisted to do drug runs in their communities. Thus, engagement, vulnerability and exposure to health risk behaviours such as substance use/abuse and aggressive behavior including gender-based violence was a reality.

"I would say at the younger age group from 6-9 years old

because the drug lords already use kids this age as their runners" (Expert, E1).

Discussion: Overall, there was support for the retention of the age band as 10-14. The suggested adaptations reflected an awareness of vulnerability to and engagement in HRBs in children younger than 10 years old. The suggested adaptation underscores the belief that intervention is required for younger children in addition to the target group of 10-14 years. Thus, the suggested adaptations did not provide sufficient grounds for adapting the age band. An important consideration in the development of the SFP programming is that the different versions of SFP target developmental cohorts. The lower age bands would include younger cohorts with implications for implementation, facilitation and resources. It would also dilute the benefits of peer group learning. The results here point to the importance of exploring interventions for younger age groups. For example, SFP 6-11 (Kumpfer & DeMarsh, 1985; 1986).

The second theme that emerged related to the focus of combining child and family representative in the target group. **Table 4.8** reflects the content for the second theme.

Table 4.7b

Adaptation Related to Target Group- Child and Family Focus

Domain: Target group - Child and family focus				
Number of statements (4)	**YOUTH**	**PARENTS**	**EDUCATORS**	**EXPERTS**
Sub-Category	**(1)**	**(1)**	**(1)**	**(1)**
1. Combination of child and	1 statement	1 statement	1 statement	1 statement

family members	My dad must also come for programmes	Training must be on Saturdays when dads can come	Father must be encouraging to participate	Programmes must target fathers

The second category contained thematic content related to the intended target group for the SFP10-14 programme. There was a clear indication from the stakeholders that a combined strategy was needed. That participants felt that the intervention cannot be conducted with only the child and it cannot be conducted with the parents only. It was recommended that intervention must include both child and at least one parent/guardian.

"All parents and kids must be there together, including fathers" (Parent, P6).

The participants did not recommend any adaptation to the stated target group or participants of the SFP 10-14 programme. Parents and experts specifically identified the need for greater involvement from fathers. Some participants in these two stakeholder groups even suggested that the programme should be organized in such a way to promote father involvement.

"A number of interventions include mothers in parent and child

programmes, but very few target fathers and they should" (Experts, E3).

Discussion: The views of participants were consistent with the SFP programme that requires a parent or guardian to participate in the intervention (Kumpfer et al., 1996; 2008;

2015; Kumpfer, 2014). There is clear evidence that parental practices of monitoring and communication are protective measures against alcohol and drug use amongst middle- and high school aged adolescents (e.g. Brody et al., 2013). Greef et al., (2006) underscored the benefits of family involvement in a local study. The programme makes provision for fathers to be involved, and the concern from stakeholders about the tendency of fathers to be less involved was noted. Literature clearly identified that father absence in their children's lives contribute to adverse outcome such as engagement in HRBs and criminal activity, and poor health outcomes (Sylvester and Reich, 2002). Similarly, there is evidence that fathers (biological or otherwise) make a valuable contribution to treatment, intervention and rehabilitation (Avellar et al., 2011). There is evidence of successful outcomes in programmes offered to father-son dyads (Caldwell et al., 2011). Coatsworth and Colleagues (2009) reported on an adaptation to SFP programming to specifically offer a mindfulness-based programme to mother-daughter dyads. Thus, there is an acknowledgement of the need for and possibility for gender-based parent-child dyads as an adaptation of the target group (Lanvers, 2004).

b. Language

The analysis identified the language of implementation as a thematic category related to language adaptations. Participants identified that the language of implementation must be considered as an adaptation given that the local context was a multi-lingual context. The data suggests that the choice of language in programme implementation is informed by the local context and programme considerations.

Four sub-categories emerged for adaptations related to language. A total of 15 statements were selected from the brainstorming phase that spoke to adaptations in terms language across the stakeholder groups. **Table 4.8** below summarises the sub-categories for adaptations related to language.

Table 4.8

Adaptation Related to Language per Stakeholder Group

Domain: Language of Implementation				
Number of statements (15)	**YOUTH**	**PARENTS**	**EDUCATORS**	**EXPERTS**
Sub-Categories	**(2)**	**(3)**	**(3)**	**(7)**
1. Mother tongue (5)	1 statement We speak two languages in my home.	1 statement Home language will make us more comfortable.	1 statement The language spoken in the home.	2 statements Home language preferred for ease in comprehension and transferability.
2. Predominant language in area (4)	0 statements	1 statement Area has two languages, but	1 statement	2 statement Different regions have different

		Afrikaans is preferred.	Different areas have dominant languages.	languages and is to be considered.
3. School Language (3)	1 statement English is preferred as learners take English as 1st or 2nd language	1 statement Our kids speak English in school, we speak English at work	0 statements	1 statement English as general language, but group work is done in preferred language.
4. consultative process (3)	0 statements	0 statement	1 statement Parent and child must decide for themselves, ask them.	2 statement Families need to be engaged in this matter to make it their choice

The first sub-category suggested that the programme must be adapted so that it can be implemented in the home language of the participants or target group. There was one statement recorded for each of the youth, parents and teachers in support of home language implementation, whereas experts had two statements supporting it. The idea of using the home

language was raised as parents and children reported that they would feel more comfortable when using the home language.

Educators and Experts reflected that parents and children often have different levels of fluency, especially where the home language of the child is different from the instructional language at school. Similarly, where the children and parents have different first languages or mother tongues, there would be different levels of fluency. Participants also identified that the fluency differs between the spoken and written language.

Experts thought that using the home language would provide a baseline fluency in comprehension which may not as easily be achieved with written word and textual material. Thus, it contributes to a greater level of engagement and comprehension. It would also facilitate a higher level of participation and completion of the programme activities. Participants acknowledged that this adaptation would be important and necessary, but complex to implement in the South African multilingual setting. The quote below illustrate the motivation for this adaptation.

> "It is best that the family's home language is considered for such programming to ensure ease in comprehension and transferability" (Expert, E2)

The second sub-category suggested that the programme should be adapted and implemented in the predominant language of a particular region or geographical setting. Parents, educators and experts had statements supporting this adaptation. Participants reflected that regions or communities are multilingual, but there usually is a predominant language that most people are conversant in. The participants reflected that if the SFP programme is implemented at

a community level using community structures and organisations (e.g. schools, churches, not-for profit organisations), then there would be merit in using the language that is already predominant in that setting. This is based on the understanding that organisations and services in a given community would likely be offered in a predominant language.

> "In our area we speak two languages mainly, but Afrikaans is more popular" (Parent, P5)

Experts reflected that they often facilitate meetings and programmes in the predominant language. They make use of additional facilitators who can translate content and instructions into other languages (not predominant) spoken by the participants. This increases the reach of the programme and prevents exclusion based on language.

The third sub-category suggested that the programme should be adapted and presented in English. Their thinking was that all learners are required to take English as a subject (first or second language) and most schools use English as the language of instruction at local schools. Participants reflected core content could be presented in English and that small group activities and homework assignments could incorporate other languages. English becomes the delivery and pull through language, but participants can engage in their own language in small groups.

> "We teach in English at this school, but group activities use the language they are comfortable in, programmes must do the same." (Teacher, T1)

One language is therefore proposed to be the general learning language, while the use of other languages is utilized in group discussions to increase the level of understanding. For instance, in the Western cape, English is the language medium used in most of the school systems, but two other languages, namely Afrikaans and isiXhosa could also be used in group

discussions to increase participation and level of understanding, depending on the language preference of the participants and fluency of the facilitators. Experts reflected that participants in the programme can also translate in discussion forums which qualitatively increases the nature of participation and provides an additional opportunity for learning.

The fourth and final sub-category suggested that the decisions about language-based adaptations must be taken in a consultative process. Educators and Experts contributed to this thematic sub-category. They suggested that targeted participants should be engaged and become part of the decision -making process.

> "Ask the family, they need to be engaged in these decisions "
>
> (Teacher, T3)

The focus was less on the language that was finally selected and more on creating the feeling that participants were part of decision-making. This increases buy-in and promotes a higher level of identification with the programme that in turn could impact participation, retention and outcomes positively.

This thematic category underscored that language is an important factor to be considered in adaptation of programming. South Africa implemented one of the most inclusive language policies on the African continent when the apartheid era ended in 1996, and with that the new language policy rendered official status to 11 languages (Kamwangamalu, 2004). The constitution acknowledges 11 languages and make provision for variation in how these languages are applied to operations, services etc. within provinces. In the province of the Western Cape, English, Afrikaans and isiXhosa are the official languages (StatsSA, 2011:

Census 2011). As mentioned before, all schools include English as a second or first language subject. Thus, most residents have some level of fluency in English.

Discussion: These sub-categories essentially identified that there is power or political dynamics involved in language and decisions about language. The decisions about language-based adaptations therefore must consider the socio-cultural and socio-political context. Tano (2007) emphasized that there are sociocultural factors significantly associated with learning achievement, and the need to connect learning to students' daily lives so that learners can construct meanings of their world as they organize, restructure and represent what they already know. Haworth *et al*. (2006) concur that socio-cultural factors are an inevitable part of achieving competence. These authors support a more nuanced understanding of language and point to the need for fundamental changes in the global discourse of English, one that denaturalizes the colonial, privileged and superior status it has been imbued with (Flores and Rosa, 2015). The decolonial movement also highlights the need to decenter colonialist assumptions that English is a universal language and that English should be adopted as the primary language of implementation without acknowledgement or due consideration for the politics of language in the context of service delivery (Kumaravadivelu, 2016).

The findings suggest that there are different approaches to decisions about language adaptation and programme implementation. For example, participants suggested that the predominant language should be identified in the target community and that adaptations should be aligned with that. This approach assumes that programme or implementation language is a function of the geographical area that the participants come from. This relativist approach has implications for staffing both in terms of the number of facilitators and the linguistic capabilities

of facilitators. It promotes the notion of training facilitators who will be able to provide training in different languages. Participants expressed this as an ideal, but did not engage with the resource implications or practical realities for implementation.

The second suggestion was that English be adopted as the primary language and that other languages can and should be used in small group discussions, materials and homework. This would acknowledge and accommodate contributions in other languages (Grin, 2010). The assumption would be that the programme should be offered in a non-standard English version that is more colloquial or conversational. This would demonstrate contextual sensitivity and decenter English as an ideological and colonial artefact (Motha, 2014). This approach by definition makes the use of translators or bilingual facilitators a given. There are guidelines that have emerged for the use of translation in transferable skills training and programme implementation (Grin, 2010). Similarly, there is evidence from programme evaluations that translation and language inclusivity have a positive impact on participation, retention and outcomes (Grin et al., 2014).

The third suggestion was that programme implementation should be prefaced with a consultative process in which decisions about the language of delivery are negotiated with participants. This is a potentially empowering process that increases buy and ownership. The participator nature of decision-making emphasizes consultation and engagement (Ginsburg and Weber, 2011). Community engagement scholars identify that negotiating entry into communities is responsible and respectful, and programme delivery should use this step as a basis. The participants live in a multilingual reality which they navigate daily (Gazolla & Grin, 2013). Thus, they can give input into how decisions about language can be negotiated in their setting

and for the reciprocal benefit of programme developers, implementors and recipients (Ginsburgh and Weber, 2011).

c. Participation

The analysis identified three thematic categories from the brainstorming on adaptations related to participation. Each category deals with different aspects of participation. The categories and the number of statements per stakeholder group are presented in **Table 4.9** below

Table 4.9

Adaptation Related to Participation

Domain: Programme Participation				
Number of statements (16)	**YOUTH**	**PARENTS**	**EDUCATORS**	**EXPERTS**
Sub-Categories	**(2)**	**(4)**	**(4)**	**(6)**
1. Schedule (4)	0 statement	1 statement Once a week for 7 weeks at the right time is appropriate.	1 statement 2-hour sessions is enough time for families to focus.	2 statements 2- hour sessions for mixed participation and engagements.

2. Engagement (8)	2 statements Roles plays to make sessions fun and exciting.	2 statements Ice breakers and fun activities to build trust with our children.	2 statements Involve police and health officials to speak to families.	2 statements Accountability group is necessary after completion of programme.
3. Ground Rules (4)	0 statements	1 statement Regular attendance allows for growth.	1 statement 100% attendance and punctuality are necessary.	2 statement Arrange for weekend sessions for those who work including fathers.

Thematic Category One related to the schedule of the programme which included the frequency, the intensity and duration of sessions. The youth did not generate statements about the frequency of the programme that could be sorted into the structure and subsequent content analysis. One statement retained from the brainstorming phase was taken from the parents and educators. Two statements were retained from the experts. Participants reflected that the proposed weekly frequency of sessions was acceptable. It allowed for processing and reflection on content covered. It also provided enough time for homework and fostered continuity of the programme. Parents and educators thought that more frequent sessions would become too intensive. Experts thought that less frequent sessions may impact the cohesion of the programme

and retention negatively. Overall, the primary view amongst participants was that the proposed frequency and intensity of sessions was acceptable and no adaptations were suggested.

> "Weekly meetings are appropriate but remind and motivate them." (Teacher, T5)

> "Weekly sessions, but know the needs of the community first." (Expert, E1)

Duration addressed both the duration (time) of sessions and the duration (weeks) of the programme. The participants expressed agreement with the 7-week duration of the SFP 10-14. Experts and educators thought that the 7-weeks coincided with the duration of school terms and could therefor make for easy integration into the structure of the school year. Parents identified that anything longer than 7 weeks would be difficult to commit to. Thus, there were concerns about the impact of life events if the programme exceeded 7 weeks. Thus, no adaptations were recommended to the 7-weeks duration of the programme.

The participants identified that two-hour slots were appropriate as it would allow sufficient time for the programme implementation and coverage of content. Anything longer than two hours would become problematic.

> "Two-hour sessions are enough time for families to focus on programme content." (Teacher, T1)

> "A two-hour session, and it must be structured well to ensure engagement and participation." (Expert, E3)

Educators identified that 2 hours would be the maximum duration for sessions and Experts advised that the 2 hours should be structured to allow for maximum concentration and participation. Thus, no adaptations were recommended for the duration of sessions.

Discussion: The findings did not suggest any adaptation to the frequency, duration and intensity of the programme (sessions). The initial SFP programme was 14 weeks (ISFP) and the SFP 10-14 is a shortened version implemented over 7 weeks with once weekly sessions. The primary consideration for the duration of the SFP programme and the duration of individual sessions was well-documented (e.g. Kumpfer, 2008; Kumpfer et al., 2004). The shortened version has also been evaluated with evidence of its success (e.g. Kumpfer, 2002; Kumpfer et al., 2010). Adaptations to other contexts within the US and in other countries largely used the SFP shortened version (e.g.Allan et al., 2006; Kumpfer and Alvarado,1995; Skärstrand et al., 2008). Thus, there is a theoretical and empirical basis for the duration of the programme. The results suggest that several practical considerations in the target context support a shorter programme of 7 weeks.

The International Classification of Functioning (ICF) identified frequency, duration and intensity as important process variables in rehabilitation or programme development (Üstün et al. 2009). The literature on programme development underscores that there is a relationship between frequency and intensity. Low frequency of sessions refers to the spacing of sessions over a longer duration e.g. once a month or every two months. Low frequency corresponds to what would constitute a low intensity. Conversely, a truncated or short duration would be considered to be intensive (Kongstvedt, 2001). More than once a week dosage of participation would also constitute high intensity (McCauley and Fey, 2006).

Research regarding programme intensity indicates that student characteristics are factors that are considered the most when making recommendations on programme intensity. For instance, Brandel & Loeb (2011) reported that high-risk or low-functioning students participated in intervention 2–3 times a week. Students with the least severe cases should receive intervention 1 time a week. The SFP 10-14 is intended as a prevention programme and thus, there is no indication of more than once weekly contact (Spoth et al., 2012).

The duration of a session can also be considered in terms of intensity. A longer session, like a whole day programme, would constitute intensity. Once a week frequency would for sessions shorter than two hours constitutes a more medium, or intermediate intensity. Using this formulation, the proposed 2-hour weekly sessions of the SFP 10-14 over a shorter 7-week term constitutes an intermediate intensity, and high frequency programme. There is evidence that intermediate intensity and high frequency programming is suitable for contexts in which many practical, logistic and resource constrains apply (McCauley and Fey, 2006). Thus, the truncated, once a week intensive intervention preferred by stakeholders was consistent with the SFP10-14 programme and literature.

d. Engagement

The sorting of the statements generated during brainstorming identified engagement as the second thematic category. Three ideas concerning engagement became evident from the statements. First, the participants stated that activities needed to be interactive and stimulating. Educators reflected that age appropriate facilitation and learning activities must be used to facilitate a high level of engagement. For example, “having fun, playing games, etc. The stakeholders supported the use of role plays, fun games, ice-breakers, and speeches as they

have element of excitement and fun. Similarly, they recommended that a high level of activity was preferred above a more passive (lecturing) mode of participation.

> "I'd like to do roleplays to make the discussions more fun and keep it exciting." (Youth, Y4)

> "Icebreakers and physical activities that is fun and allow for experiential learning." (Expert, E1)

The participants reflected that engagement must happen in both plenary and subgroup level. The need for separate sharing times promoted sharing within subgroups and takes pressure off the need to negotiate expectation and feelings of children and family members. It also is a space in which to practice engaging with the other groups. In other words, stakeholders supported the notion of engagement in separate and conjoint parent-child groups per session. Another point strongly surfacing, was that the engagement with members and between members must engender or promote *trust* between parents and children.

> "We should include breakout groups time for sharing and talking about home life and personal relationships with our kids." (Parent, P6)

> "Having parent and child group time is important for trust building." (Expert, E3)

Overall, stakeholder endorsed the confirms list of activities within the SFP programme and its contribution to active engagement. The participants suggested four programme amendments related to engagement. The first amendment was that the two-hour, weekly session allocates more time to general feedback. It was envisaged that both parents and children can use the additional time to report on progress or struggles. The group and facilitator will provide

support and encouragement, as well as feedback on how to manage or praise for success. The participants did not engage with what would be removed or reduced in the sessions if more time is allocated for feedback and reflection. The participants also did not indicate that the duration of sessions could be increased to accommodate the feedback slot.

The participants recommended that the programme be amended to include outside speakers such as, youth mentors, policemen, etc. The intention was that these speakers would address the participants on combatting risk behaviours. They also identified health advocates who could share their own stories as a motivation.

> "Invite the police and health department to speak to families to talk about risk behaviours and to motivate them." (Teacher, T8)

The experts and educators advocated for the addition of groups sessions after the programme is terminated or completed. During these sessions, participants can meet as a means of family support.

> "we need ongoing accountability groups/support groups that meets after the programme to deal with challenges as part of the programme." Expert, E1)

The stakeholders did not qualify whether the sessions should be conjoint or subgroup focused. They also did not specify the frequency, duration and for how long after the programme these sessions should continue. The proposed amendment was that the programme participants took responsibility for the sessions. Thus, the programme must prepare them to take on facilitation of the ongoing sessions. In addition, it required leadership to emerge from the participant group. The experts referred to the proposed sessions as accountability groups. Their

thinking was that such group sessions would consolidate and extend the effect of short-term intensive programmes. Continued support from the group was a means to establish a mutual aid group that provides follow through with youth and families.

Participants also suggested that the programme be amended to include ongoing support after the programme has concluded. There is a general sense that in the South African context, progress cannot be expected to be maintained without giving support to the families between sessions as well as, an ongoing process after the completion of the intervention programme. The expectation was that the programme facilitators took responsibility for the follow-up sessions and input.

Discussion: The findings endorsed the SFP programme activities and ways in which participants are endorsed. The SFP uses active learning methods, and age-appropriate activities to foster learning and a high level of participatory engagement (Kumpfer et al, 2010). The findings suggest that the engagement must engender effective communication and build trust between children and parents/ caregivers. Spoth et al. (2004) identified that successful parent-child communication was correlated with lower levels of adolescent risk behaviours. Similarly, Greeff et al. (2006) reported that effective parent-child communication was a protective measure against high risk behaviours.

The proposed amendments fell into two categories. The first category of amendments included changes to the programme. For example, a different allocation of time within sessions to make provision for a more substantial feedback session. This amendment would be difficult to implement as the session is highly structured. It would be difficult to affect this amendment without extending the duration of the session. However, a longer session was not supported by

participants. This amendment would also impact the fidelity to the programme that in turn would impact efficacy (Reid et al., 2005). In essence, it seems that what the participants were advocating for was time and a forum in which to share and support each other during the programme.

The other amendment was the inclusion of external speakers. The motivation provided was very similar to how other programmes are offered. It may be that participants were exposed to this kind of programming (e.g. Wegner et al., 2008). The SFP programme did not make provision for this. The programme uses trained facilitators and highly curated material including videos to deliver the skills training (Kumpfer et al., 2010). Thus, the inclusion of external speakers would constitute a significant change and reduce the fidelity to the programme. Permission to adapt SFP programmes does not allow for this kind of amendment as it would change the programme integrity (Jonson-Reid et al., 2005).

The second category included additions to the programme once it has been completed. The first was additional input sessions facilitated by staff as ongoing support. This was akin to booster sessions. The SFP programme makes provision for booster sessions on a predetermined schedule (Spoth et al, 2012). The amendment thus, was aligned with the programme. An important point was that participants did not specify or engage with the duration (over time) of booster sessions or the frequency thereof.

The findings indicated that the addition of a supportive forum after completion of the programme was desired in order to consolidate gains and provide support. These sessions were to be facilitated by participating members and approximated a mutual aid or support group as described by Kelly and Yeterian (2011). The participants essentially envisaged that termination

of the programme would constitute a loss and expressed a desire for a mechanism to continue the memberships (community) and benefits gained from participating in the SFP programme. Thus, people who complete the programme become a support network for each other and the need for a formalized space was expressed. Smith et al., (2013) identified that termination of programmes constituted a loss of resource and reported efforts by participants to continue the group membership established in the programme and receiving the perceived benefits. In other words, the framework of the intervention is extended.

Ground rules

The third category that emerged regarding participation was the idea of setting *ground rules*. The participants reflected that the programme must have ground rules that are agreed upon and form a contract for accountability, and make expectations and roles clear. Ground rules must be covered and negotiated with participants as part of the orientation to the programme. No statements were pulled through to the content analysis from Youth. This was the result of 1) statements being more relevant to other categories and domains and 2) low productivity of statements in response to this domain.

Four statements were pulled through to this category. Educators and Parents produced one each and experts had two statements included. Regular attendance, punctuality and commitment were offered as important rules for participation in the programme. Parents reflected that regular attendance allow for continuity of the programme and more importantly, allows the participants to grow and develop as intended by such an intensive programme.

> "Parents must tend regularly and not be allowed to skip so that we can follow through and grow." (Parent, P7)

The parents acknowledged the programme requirement that a minimum of four out of the seven sessions be attended. They opted to talk about regular attendance without specifying a minimum number of sessions to be attended. They felt that specifying a minimum would create the opportunity for non-attendance. Educators felt that attendance should be compulsory and that challenges with attendance could be addressed on a case-by-case basis. They too felt that it was important to create an expectation of full attendance in the programme.

> "Select suitable day and time to ensure 100% attendance and punctuality." (Teacher, T8)

Experts identified punctuality as an important ground rule. The experts felt that punctuality was the responsibility of the participants. They also reflected that punctuality could be framed as a behavioural change target and tracked through the programme as an indicator of behavioural change. The experts did not offer any suggestions as to how punctuality should be managed. There was also a strong sentiment expressed about commitment in some of the statements about ground rules. Regular attendance and punctuality, as well as active participation were all considered to be indicator of commitment to the programme. The participants identified that flexibility on the programme part can also be considered as an indication of commitment. For example, facilitating sessions on weekends may enable fathers and other family members who may work during the week to attend.

> "weekend session will allow for shift workers and especially fathers to also participate." (Expert, E2)

Discussion: The SFP programming already has a set of ground rules built into the programme (Spoth et al., 2012). The ground rules raised by participants are addressed in the identified programme rules. The programme has a more clearly articulated set of rules with accompanying minimum requirements. For example, a minimum of four sessions need to be attended. Similarly, the programme leaves decisions about when sessions are facilitated up to the implementer and the target group or participants (Kumpfer et al. 2010). Thus, the amendments suggested around facilitation on the weekend and attendance are already covered in the programme and do not constitute amendments. In essence, participants indirectly were asking for programme implementors to be sensitive to the realities of the target recipients of the programme. The programme requires a consultative process in the orientation phase for finalizing ground rules (Kumpfer et al. 2010). Thus, the concern of the participants is already part of the standard process of implementation for SFP 10-14.

e. Facilitation

The Fourth thematic category that emerged related to adaptation to facilitation. A total of 14 statements filtered into this category across stakeholder groups. Three sub-categories emerged namely, Formal input, experiential learning and the number and profile of facilitators. **Table 4.10** below present the categories related to amendments to facilitation.

The first subcategory related to the formal input provided by facilitators. Participants identified that instructional input could take on the form of lectures and other electronic formats such as, video clips and voice over power point lectures. The participants endorsed the range and variety of instructional formats proposed by the programme.

Table 4.10

Thematic content related to facilitation

Domain: Adaptation to programme Facilitation				
Number of statements (15)	**YOUTH**	**PARENTS**	**EDUCATORS**	**EXPERTS**
Sub-Categories	**(1)**	**(2)**	**(5)**	**(6)**
1. Formal Input (3)	0 statement	0 statements	1 statement They need instruction verbally or videos for part of the sessions	2 statements Include short lectures and check for understanding
2. Experiential Learning (5)	0 statements	1 statement Put us in teams and have fun activities to learn and grow.	2 statements Experiential learnings through role plays, and ice breakers, excursions, etc.	2 statements Make sessions interactive and use reflexive writing
3. Facilitator profile/ratio	1 statement	1 statement	2 statements	2 statement

(6)	One Facilitator per group of 10, like in school classroom.	Must have good and positive attitude, non-judgmental and be funny	Facilitator must be well-trained and informed about the community	Facilitator must be knowledgeable and understand culture, 1:10 ratio as in education system.

Educators underscored that short intermittent lecture-type sessions led by one facilitator were useful and appropriate for the conjoint sessions.

> "Include lecture style sessions and check for understanding and transferability." (Expert, E2)

Formal inputs were seen as an important way to facilitate an increase in the knowledge base of participants. The transferable skills training would readily be facilitated through instruction and the use of instructional materials and resources. The availability of instructional material (e.g. video clips) that have been carefully curated was seen as a mean of standardizing content and increasing fidelity to the programme.

The second sub-category identified *experiential learning* as an important form of facilitation in the proposed programme. Group work, team processes, individual one-on-one, sessions, and reflexive writing were identified as activities that promote experiential learning.

> "Put us into teams and have fun activities to learn and grow." (Parent, P4)

> "Make sessions interactive and use reflexive writing to ensure understanding." (Expert, E1)

The participants supported the use of such activities as proposed in the SFP programme outline. Participants recommended that excursions could be considered as an amendment to the activities identified for experiential learning. The participants did not engage with the type of excursions and how those linked with the specific programme content. The experts identified excursions as a means to promote leisure and educational aspects, and indicated that it offered alternatives to engaging in HRB and reduces idleness.

The participants suggested that the programme be amended to include mentoring. Participants did not engage with practical considerations such as who would mentor, how would mentors be recruited and how long would mentoring relationships continue. Mentoring was identified as an important method of facilitation that could provide powerful learning and modelling experiences. It was not clarified whether the child-parent dyad would be mentored or whether the mentor would work with either the child or parent.

The third sub-category dealt with two aspects namely 1) *the profile of the facilitators* themselves, and 2) the *number of facilitators*.

One of the issues around the profile of the facilitator according to the stakeholders, is that he or she should be knowledgeable. They also thought that facilitators must have the ability to transfer that knowledge to a diverse group of people.

> "Facilitator must be knowledgeable and understand culture." (Expert, E2)

The other important aspect discussed was the attributes of facilitators. Participants identified the following attributes: non-judgmental, positive, caring, patient, and the ability to build trust.

> "Must have good and positive attitude, be non-judgmental and funny." (Parent, P11)

There were two views about the number of facilitators required in the intervention sessions. On the one hand, participants felt it was important to identify the ideal *number* of facilitators. For the stakeholders the *ideal* was that there would be a primary and constant facilitator. This facilitator will be present throughout the seven weeks and create a sense of continuity and cohesion. The number of facilitators can be increased to include translators if the participating group included individuals who spoke a language/s that the facilitator was not fluent in. For example, should isiXhosa participants be present, a co-facilitator or interpreter who was fluent in isiXhosa should be included. What emerged was that the ideal number of facilitators tended towards smaller rather than larger numbers. On the other hand, participants felt that a *ratio* of facilitators to size of group was meaningful. The participants did not propose a ratio or a formula. The experts referred to the guideline ratios proposed by the National Qualifications Framework to determine the number of facilitators.

> "Use the standard 1:10 ratio as promoted in education system." (Expert, E3)

Discussion: The findings endorsed the SFP guidelines for the format of facilitation and the learning activities proposed. The findings also underscored that facilitators must be knowledgeable about the content and possess good facilitation or teaching skills in addition to certain personality

characteristics. The SFP programming makes use of trained facilitator (Kumpfer et al., 2012). Trainees are carefully selected and the criteria for trainees include personality characteristics and knowledge of systems and the SFP programming (Kumpfer et al., 2012). Training further hones both content knowledge, facilitation skills and professional traits to achieve what the stakeholders described. Thus, the stakeholders did not propose any tangible amendments in terms of the profile of facilitators and the instructional methods used by facilitators.

The findings identified at least one facilitator per group or a ratio. The *ratio* is proposed by the National Qualification Framework's directive for facilitation in training and development in South Africa is one facilitator for every 10 participants (1:10) (Department of Education, 2000). The ratio assumes that facilitation is managed by a single facilitator. The views of stakeholder reflect assumptions about facilitation characteristic of general practice. It suggests that stakeholders did not always track that the programme required child and parent subgroups to work together and separately. The SFP proposes two facilitators who manage subgroups separately and manage conjoint plenary sessions together (Kumpfer et al., 2012). Theories on group facilitation generally recommend a pair of facilitators. This does not preclude translators who may add to this configuration (Rycroft-Malone et al., 2010). Thus, their recommendation of one facilitator was not appropriate.

f. Resources

Participants identified four types of resources for programme implementation. This included *implementation resources, financial resources, infrastructural resources and partners as resources. Implementation resources* describes consumables such as, eg. hall charts, poster

boards, flip charts, visual boards, note books, etc. *Infrastructural resources*, on the other hand, are suggested to be included items such as venue, and audio-visual equipment. *Financial resources refer to funding for operations. Partner resources refer to other* organizations that contribute to the programme from their own resources. The statements generated by stakeholders largely identified resources that are considered standard for implementation of programmes and were included in the SFP programme. The stakeholders stressed the importance of securing enough resources to sustain the programme needs.

Stakeholders revisited the earlier suggestion of excursions and external speakers. In this discussion, they identified that partnership resources and financial resources were crucial for excursions to be realized as a learning activity. External speakers were expected to be given stipends or honoraria for their contribution which then increased the need for financial or partner resources. Stakeholders also identified wi-fi capability as an example of infrastructural resources, but did not engage with how Wi-Fi was related to programme implementation. Lastly, stakeholders identified partner and financial resources were required for catering. Catering at programmes was often provided and it has been linked as an important incentive for attendance and basic need.

Discussion: Overall, the stakeholders endorsed the resources already identified for implementation for the SFP programme. The amendments they suggested related to learning activities that did not form part of the SFP programme. Thus, the statements generated by stakeholders in relation to resources did not support any realistic amendments to the programme from a resource point of view.

The stakeholders emphasized the need to ensure that there were sufficient resources for programme implementation. The South African context reportedly is resource constrained, and programme implementation is often impacted by the lack of funds or other resources (Rule et al., 2019). The reliance on the not-for -profit sector to deliver social service interventions is a reality of the South African landscape (M'kumbuzi & Myezwa, 2016). Globally, funding has been reduced following events such as the pandemic that in turn impacts the availability of funds for service delivery in developing countries and within the not-for-profit sector (Booyens et al., 2015). Thus, the strong sentiment expressed by stakeholders about resources were informed by their experiences in the resource constraint environment in South Africa.

g. Content

The sorting of statements relating to adaptations of the content in the SFP- 10-14 produced two thematic categories namely, Health risk behaviours in the local context and skills required to promote pro-social behavior and resist engagement in HRBs.

In Category One, four sub-categories of HRBs were identified including substance abuse, sexual risk behaviours, violence and gangsterism, and peer pressure. **Table 4.11** below presents the recommended adaptations to programme content. Each sub-category is presented below.

Table 4.11

Adaptation related to Programme Content

Domain: Programme Content - Health-risk behaviours				
Number of statements (15)	**YOUTH**	**PARENTS**	**EDUCATORS**	**EXPERTS**
Sub-Categories	**(3)**	**(6)**	**(8)**	**(8)**
1. Substance Abuse (6)	0 statement	2 statement Must address the dangers of drug use, alcohol use and sex.	2 statement Tik, marijuana and alcohol use are mostly what the learners are struggling with.	2 statements Risky behaviours including substance use is increasing with teens.
2. Sexual Risk behaviours (6)	1 statement Friends are raping friends because they get drunk and behave stupid.	1 statement Children are getting pressured to be sexually active an at younger age.	2 statements Children are engaging in aggressive sexual behaviours at school.	2 statement Programme should cover sex and teenage pregnancy
3. Violence & Gangsterism (8)	2 statements Children join gangs to belong somewhere.	2 statement Gangs recruit young children as their runners for drugs.	2 statements Children are selling drugs as the family's only income.	2 statements Children are getting into gang fights and robbing people.

4. Peer Pressure **(5)**	0 statements	1 statement Children don't listen to parents anymore but are pressured by their friends to do bad things.	2 statements Children are forced to drink and bully others by their peers.	2 statement Parents are no longer children's social power, peers are.

Substance use and abuse: The stakeholders identified that there was an increase in risk behaviour involving substance use and abuse amongst pre- and early adolescents. The participants identified the following substances as being of concern in their context: alcohol, dagga (marijuana), methylated spirits, cigarette (nicotine). Tik (Methamphetamines) and sniffing glue. Alcohol use was identified as widespread and a full range of alcoholic beverages are used. Beer and spirits were the most widely used. In poorer communities, home-brewed alcohol and spirits were consumed.

Stakeholders identified that nicotine (cigarettes) is common place and was not particularly considered as a drug and a health risk behavior. More concern was expressed towards the smoking of marijuana in social groups using the Hookah pipe. This posed several risks including addiction, exposure to tuberculosis and upper respiratory issues. In addition, it was noted that teens create their own blends to use in hookah pipes which means that there is no clear way of tracking which substances have been combined and ingested.

> "Children reportedly are mixing marijuana with other drugs and smoking it in a hookah pipe" (Teacher, T5)

Amongst poorer communities, methylated spirits and glue are often substituted for more expensive substances. This is mostly sniffed and inhaled with serious addictive and adverse health consequences. Tik, is a locally produced version of crystal meth that includes ingredients such as rat poison. Tik was described as the most concerning and widely used substance as cheaper versions and more expensive versions were available. The impacts were described as ravaging and very serious. Experts identified that the widespread use of TIK has reached epidemic proportions. Stakeholders reflected that the age of first-time use is becoming lower or younger.

AOD were reported to be related to engagement in other HRBs such as unprotected sexual encounters, unplanned pregnancy, interpersonal violence and delinquent behaviour. Alcohol related injuries were often reported over weekends that place a burden on the hospital and health system. Stakeholder reported academic, behavioural and relationships problems, as well as the development of an unhealthy life style and long-term health problems as outcomes. Stakeholders expressed that the programme content should be directed to specific health substances and noted that TIK and glue sniffing were particularly important for the local context.

The second sub-category is related to sexual risk behaviours. Stakeholders identified that children are becoming sexually active at a younger age. They also identified that there is a high incidence of child sexual abuse and gender-based violence. Sexual predation was also described by the experts. Educators reflected that younger children were re-enacting sexual play i.e. *"rape rape"* at school and engaging in aggressive sexual behavior (Teacher, T3). The stakeholders

identified that unplanned teenage pregnancy was a major concern with far-reaching implications. They also identified that sexually transmitted diseases were increasing or often go undetected and untreated with serious health implications. HIV, and Hepatitis were identified as major concerns over and above the general STDs. The number of sexual partners is increasing and tracking for infection control is very complicated. Stakeholders reported that sexual activity and risky sexual behavior was also linked to substance use, and needed to be targeted as a HRB in the programme.

The third sub-category related to violence and gangsterism. Stakeholders reported that there was a rise of violence and gangsterism in our neighborhoods. Stakeholders reflected that gangs in local areas were recruiting younger children to do the dealing, and selling of substances. In certain poor communities, this has become the primary income and the behaviour is supported by the family. Children are also using illegal substances at a younger age. Thus, stakeholder identify that children are exposed and engaging in illegal activity from an early age.

> "Children are used as *runners* by gang lords in our neighbourhood." (Parent. P2)

Children between 6 and 10 years of age are reportedly carrying weapons, including knives and guns, that are used in mobbing, robbery, bullying, and gang fights.

> "Children are bunking school and stand on the street corners robbing people at knife or gunpoint and getting into gang fights." (Expert, E1)

The fourth sub-category related to peer pressure and the need to conform. Asserting undue pressure on peers to engage in HRBs was noted as a concern. This was often accompanied with bullying, use of social media to spread rumours and shame peers, as well as victimization.

Understanding this type of behavior as a health risk for all involved was an important recommendation from the stakeholders. They also identified that those youth who give into peer pressure and bullying often has poor self-esteem, identity issues and poorly defined values that could have served as protective factors.

> "Children's social influence is peers and not parents and they are pressured into all kinds of behaviours including bullying and other risk behaviours." (Expert, E1)

Thematic category 2: Prosocial behaviour and Life skills training.

The youth and experts highlighted that skills to manage emotions were lacking in youth. They reflected that engagement is often linked to emotional experiences and engagement provided a means to escape their difficult life circumstances and challenging peer relationships. The experts more formally referred to emotion regulation skills and linked this to the "*emotional roller coasters"* often experienced as part of normal adolescence (Expert, E2). Educators reflected that youth often deal with intense negative emotions including *"shame and guilt"* (Teacher, T8). This often produces fear of negative emotions resulting from challenging situations. Thus, stakeholders supported the inclusion of skills to manage emotions.

The stakeholders expressed the general sense that young people lack "*self-identity"* and a strong value system or *"moral compass" (Teacher, T2)*. This makes them more vulnerable to peer pressure and bullying. Stakeholders identified that poverty, homelessness, violence, and crime have become common place in the local context. The socio-economic challenges experienced in communities contribute to a lack of positive identity, confidence and strong values in children and families. Stakeholders felt that these contextual challenges have a

detrimental effect on the well-being and healthy development of children. Parents cited *"murder by handguns"* as *one of the major causes of childhood death in our neighborhoods over and above general health outcomes"* (Parent, P3). Therefore, stakeholders underscored that there was a need for young people to develop important human qualities such as, justice, diligence, perseverance, compassion, respect, courage, etc., and to indicate understand why it is important to live by them. The stakeholders did not engage with the exact skills that children and families needed to develop, but expressed an overall view that programme content matter should include skills training that contribute to the formation of internal resources, healthy self-image and transactional skills to navigate relationships in the family and community.

Discussion: The findings identified that programme content should address health risk behaviours and life skills training. Stakeholder identified a number of health risks behaviours and highlighted specific HRBs that may be more prominent in the local context. The identification of alcohol and other drugs by stakeholders was supported by research around lifetime prevalence of engagement in AOD (Burton and Leoschut, 2013a; Reddy et al, 2013). Similarly, the stakeholders identified that the age of first-time use is decreasing. Research supported this observation and expressed concerns about it (Meader et al., 2016; Pettifor et al, 2015). Stakeholders identified the engagement with AOD a having a number of health and functional outcomes such as unplanned pregnancy and criminal activity. Local research supported this observation (Ebersohn and Eloff, 2002; Pharaoh et al., 2018; Willemse et al., 2011).

The stakeholders identified that it was important to impart skills that will enable youth to resist the lure of engaging in HRBs. Life skills were identified as protective factors against

engagement in HRBs (Botvin and Griffin, 2004; Pharaoh, 2015; Tiendrebeogo et al., 2003, Wegner et al., 2008). Similarly, stakeholders identified that strengthening the ability of families to provide effective parenting were identified as protective (Greeff et al., 2006; , Shin, & Azevedo, 2004; Spoth, Redmond). The stakeholder view that programming to preventing, delaying and treating engagement in HRBs was supported in literature consistently supported in the literature over the last two decades.

The SFP programme is predicated on the assumption that strengthening families and children can contribute to the delay or prevention of engagement in HRBs (e.g. Kumpfer et al., 2015). The programme addresses HRBs by unpacking what health risk behaviour is and how it impacts health outcomes and functioning (Kumpfer et al., 2015). Through the programme, the HRBs that are engaged in by the participating group are addressed (Kumpfer, 2008, Kumpfer et al., 2015). Thus, the programme is designed to have a process understanding of HRB and what drives engagement and then applies that to particular programme groups. Thus, the programme does not require an amendment to focus on specific HRBs, as the general process of facilitation and implementation makes provision for the range of HRBs reported by programme participants. Prior knowledge of the particular HRBs and the drivers of engagement is useful and would prepare facilitators. Thus, this does not constitute a programme amendment, but it provides context that will be considered in the preparation of facilitators who will work in the local context.

The underlying assumptions of the SFP programme includes skills training for individuals and family systems that enhance communication and a list of prosocial outcomes (Kumpfer et al., 2010; 2015). The programme includes life skills that specifically address

resistance to engagement and peer pressure for the youth. Thus, the view of stakeholder that life skills and prosocial skills training must be incorporated is already covered in the programme as part of the theory of change for the programme. The findings related to amendments of content thus supported the current structure and theoretical understanding with in the programme (including the theory of change). As such, there were no actual amendments proposed that required further consideration. An important observation was that the stakeholder contribution underscored the importance of knowing the context and expressed for a consultative and engaging process to ensure that the needs of programme participants were catered for. These two issues were already key principles underpinning the SFP programmes.

4.4 CHAPTER SUMMARY

This study (phase) sought to elicit the views of stakeholder groups about the adaptations they thought were necessary to the SFP-10-14 programme. The study used a modified concept mapping design to explore stakeholder views and to generate a process guideline for adaptation. Stakeholders were presented with a stimulus document to generate statements during the brainstorming phase. The stimulus document was structured along six domains. These domains were identified through theory, literature and experiences on adaptation, programme development and intervention. The six domains included target group, language, content, resources, facilitation and participation. These domains acted as an overall process structure to guide participants through their thinking about which adaptations were required.

Four stakeholder groups were included as key agents in the process. These included youth, parents, educators and experts. Each of these groups were drawn from the setting where

the programme was earmarked for implementation which increased contextual relevance. The stakeholder groups provided different vantage points to ensure that a comprehensive and robust input was generated. The benefits of including stakeholder are an increased relevance of the research to the stakeholders (relevance and buy-in) and the potential to lead to greater adoption of the programme that in turn produces improved health outcomes (Vaughn et al., 2011). In particular, youth are rarely involved in priority setting regarding health research (Reich, et al., 2015). Thus, the present study did well to include programme recipients (children and family members) as well as educators and experts who specifically work in the context of child development and know the impact on functioning and service delivery.

The study also used child-family dyads as stakeholders. These dyads were important as it mimicked the programme recipients. It was beneficial to see how the different subgroups in the family viewed the domains and thought about adaptations. Their different vantage points were important as a big challenge is often getting both sub-groups to see a particular behaviours as a risk or as less beneficial while promoting other behaviours as pro-social. This was an added advantage that increased the contextual relevance of the information gathered. The different vantage points of stakeholder groups became evident in their statements and contributions. For example, youth was less productive on issues related to facilitation and resources whereas parents were very productive on issues related to language and content. Experts offered different views on language, content, target group, resources and facilitation that illustrated their experience in good practice service delivery and programme delivery for interventions at community level.

The statements produced during brainstorming were subjected to a content analysis within the domains. There was opportunity for statements and thematic categories that emerged to be moved between the domains. So, the domains were not seen as static and mutually exclusive, but rather as focal point in adaptation. The thematic categories that emerged identified several issues or considerations that stakeholders' thought might impact adaptation.

In this phase, stakeholders' views about elements that may require adaptation of the SFP:10-14 was specifically sought. During the brainstorming phase some recommendations for adaptation demonstrated that there was not a sufficient knowledge of the programme specifics and issues of fidelity. Alternatively, stakeholder focused on issues that may have contributed to unsuccessful implementation in their prior experience. Thus, suggested adaptations were discussed relative to the current programme specification and the underlying theoretical tenets of the programme including the theory of change as outlined in Chapter Two.

There are a few really important ideas that emerged at a process level. First, there is a distinct recommendation from the stakeholders that, in the South African context, intervention was required throughout childhood and adolescence as engagement in and exposure to HRBs has been reported at younger ages than early adolescence (10-14). This was consistent with global and local studies (e.g. MacPherson et al., 2010; Peake et al., 2013; Reddy, 2010; Pluddemann et al., 2008, Pluddemann & Dada, 2010) that youth initiate high risk behaviours during pre-and early adolescence.

Secondly, South Africa is a multilingual society. Adaptations often are from one uni-lingual country to another. Thus, an understanding of language complexities in the local context

was important. Participatory processes should be included in the planning, adaptation and implementation phases of intervention programmes. Language impacts how children learn and improve a child's motivation (Laitin et al., 2015). Therefore, considering language is crucial to developing a contextually relevant pedagogy and research base for implementation e.g. Diarra, 2003; Harris, 2011; Motala, 2013). Trudell and Piper (2014) underscored the benefits of using a child's own language as medium of instruction and not to default on the medium of instruction at school that might not be clearly understood by the youth. This could significantly impede learning. Stakeholders were not able to engage with the complexities and implications of their recommendations, but they demonstrated a nuanced understanding of the importance of language in programme adaptation and implementation.

Thirdly, the stakeholders understood that effective programme must employ a range of teaching and learning strategies and must engage programme participants actively. Learning and facilitation must be based on exciting, fun, and pro-social alternatives. The programme is a resource in and of itself and a positive relationship or association with the programme must be developed to increase, recruitment, retention and positive outcomes.

The stakeholders recommended adaptations to the programme content and resources such as the inclusion of guest speakers, health advocates and excursions that reflect current practices in programming and intervention. They also identified catering as an important issue. These amendments underscore the resource constraints in the local context and drew on resources external to the programmes for implementation. This was very different from how SFP was conceptualized. These amendments would pose a threat to fidelity of the programme. However,

failure to consider it may impact attendance, participation and engagement especially around the provision of basic resources such as food and transportation.

The stakeholders also identified that programming must consider how their footprint can be extended post implementation of the programme. The SFP provides booster sessions, but participants expressed a need to a clear commitment to ongoing support. There were some suggestions about the format of said support, but this remains open to negotiation. What becomes clear is that programme participants and other agents may have certain expectations of the programme that extend beyond the remit of the programme. Thus, the process of negotiating and clarifying ground rules and expectations must become a consistent feature of community engagement and negotiation with programme participants. The SFP has a standard protocol covering orientation and ground rules that makes provision for engagement and consultative processes. However, this context may require a more intentional and dedicated process during the planning and adaptation phases, and must constantly be revisited during implementation.

The six domains emerged as very useful in the process of considering adaptations.

Conclusion

The concept mapping process, as presented here, appears to be a viable method of engaging stakeholders. Stakeholders were able to provide insight into the reality of the local context. Proposed adaptations were not necessarily substantiated, and therefor may not be adopted. However, these proposed amendments contributed to an enriched understanding of the politics and dynamics of programme delivery in the local context. Important process lessons

were learnt that will support adaptation initiatives. From this process, insights emerged that can be used as a guide to adaptation.

4.5. LIMITATION OF STUDY

Among the limitations observed, the most significant, during the brainstorming stage of the concept mapping was participants' frustration at being restricted to completing sentences in a brief and summary fashion, without being able to express themselves further regarding its content or meaning. Indeed, several participants wished to develop or illustrate their ideas, while others expected an opportunity to confront other opinions and debate certain statements. The advantage of placing distance between personal contributions for a more objective discussion was weighed against stakeholders' wish to explore. As mentioned before, the process provided opportunities for discussion and clarification, but participants had to bind their anxiety and manage any negative feelings experienced during the brainstorming phase. This may have impacted the youth more as they were less productive during the clarification stage.

Stakeholders initially wanted to have an unstructured brainstorming session. They expressed this as a preference and expressed their frustration during the initial brainstorming. The stakeholders wanted information about how the domains were decided upon. This was explained as part of the process, and stakeholders were encouraged to continue. They were reassured after learning that there was provision for any other suggestions to be raised at the end. However, they did not raise any additional information as their concerns were adequately covered in the domains. At times, stakeholders made contributions that were not relevant to domains. These contributions were still coded and placed where they had the most relevance.

The limitation was that the structure of the brainstorming was not optimally described before data collection started. In subsequent stakeholder groups, this was addressed and less concern were expressed. It would have been ideal to anticipate this and implement it from the start. The benefit was that instrumentation processes were flexible and could be adapted to promote high participation without deviating from the integrity of the overall research process and methodology.

The modification to the design was the omission of step 5 that entailed the creation of a concept map. The overall study aimed to integrate the findings of all phases and develop from those insights a guide for adaptation that would operationalise the conceptual framework proposed by Castro et al (2010). The decision not to illustrate the findings of the second phase can be seen as a limitation. However, in the broader conceptualization of the doctoral study, the construction in Phase 3 can address this limitation. In addition, the triangulation of methods for the whole study strengthens the quality of data and the inferences made and offsets the potential losses due to the decision not to develop a concept map based on stakeholders' views only.

4.6 RECOMMENDATIONS

- A recommendation is that more time was be dedicated to discussing the steps in concept mapping with participants and ensuring that there is buy-in to the proposed process to be followed. This participatory adaptation would enhance buy-in and potentially positively impact data collection and the quality data. It may require a greater participant time commitment to achieve a more active participant involvement in the planning steps of the process.

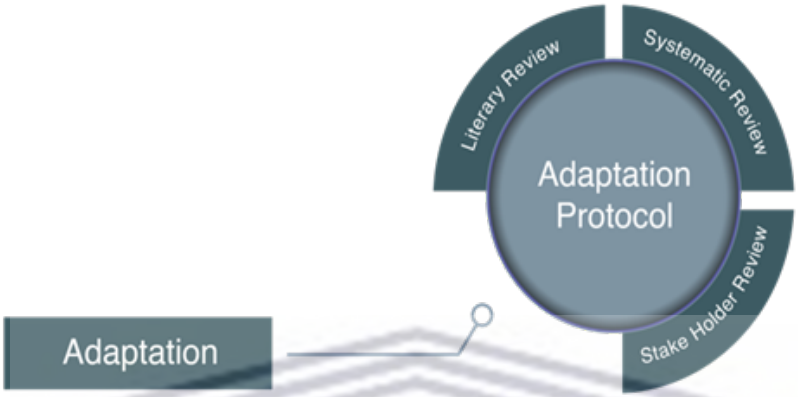
- The clear need expressed by stakeholders was for responsible community engagement. The participatory spirit of the methodology, must become a key feature of the planning, adaptation and implementation phases of the SFP 10-14.

- Programme adaptation must engage with the potential loss of a resource once the programme is completed and explore how to create meaningful and mutually beneficial processes to expand the footprint of the programme as an intervention. Thus, these require longer term commitments and multiple stakeholder collaboration for successful and sustainable implementation, productive community relationships and enhanced impact.

- The guide to adaptation must be distilled from an integration of all aspects of the study (Phases 0-3). The resultant guide must function as a process guide to adaptation rather than a guide to adaptation of content of the programme, and other programme specifications. Thus, it is recommended that the insights gained from stakeholder engagements be integrated into the construction phase.

- An important outcome of the study was the identification of domains in the stimulus prompt. The lessons learnt from this process should also be integrated in the development of the guide in the construction phase.

CHAPTER FIVE: PHASE THREE ADAPTATION



5.1 INTRODUCTION

Chapter Five reports on the third and final objective of the study. As mentioned before, several studies addressed the development of guidelines for the adaptation of existing interventions to context (e.g. Kumpfer et al., 2008; Mckelroy et al., 2006; Wingood & Diclemente, 2008). Most guidelines available to adapt interventions to a specific context spell out processes, but lacked the important aspect of concrete, practical, scientifically-based actionable steps (Harrison et al., 2010). Thus, the guidelines, however useful conceptually, lacked an operationalisation. Phase Three set out to develop such concrete and actionable steps to operationalize the adaptation process of programming in general, and the SFP 10-14 specifically, for use in the South African context, specifically in the Cape Flats context in Cape Town, South Africa. In this phase, the recommendations from previous phases were synthesized with the conceptual framework to distill the actionable steps that will make up the guide.

5.2 AIM

To develop a guideline of actionable steps to follow in the adaptation of the SFP-programme that will still maintain the integrity of the SFP 10-14 programme protocols and the international dissemination process.

5.3 DESIGN

This phase entailed construction of the adaptation guideline. The design continues the principles of concept mapping methodology from the previous phase and draws on the findings of all previous phases (Phases 0-2) to develop the proposed guide. The resultant guide will represent a modified form of a concept map. This chapter reports on the construction process that approximates step 5 of the concept mapping process. This step draws on the outcomes of all previous phases to inform the resultant guide.

The construction followed five operational steps, recommended in the ITC (2016) guidelines for test construction and adaptation, namely,

1. Step One entailed finalising the theoretical structure for the guideline

2. Step Two entailed deciding on the format and structure of the guideline as well as, numeration in the event that a scoring scale is developed.

3. Step Three entailed generating a pool of items and finalising the draft instrument.

4. Step Four entailed reviewing and refining the draft scale.

5. Step Five entailed developing any accompanying templates and instruction guide.

To achieve a logical flow for this chapter, the theoretical steps are presented in sequence with their outcomes or results. This helps to create a coherent argument and report on the construction of the guideline in process.

Step 1: Theoretical structure

The first step entailed building a theoretical structure for the proposed guideline. The ITC guidelines for test construction and adaptation recommend that the theoretical structure that underpins the proposed measure or target measurer must be developed clearly (ITC, 2016). The aim is to make the theoretical tenets explicit and to ensure that the resultant instrumentation is aligned with the underlying theoretical structure.

For the purposes of this study, four key strands were triangulated to develop a theoretical structure for the resultant guide. The motivation for a triangulated theoretical structure becomes evident when examining the nature of adaptation studies. For example, the operationalization of adaptation processes is at the discretion of individual practitioners and researchers who adopt a strong interpretive stance on the broad guidelines offered. In addition, adaptation studies often focus on the outcomes and efficacy of adaptations without consistent and systematic reporting on the process of adaptation (Cooper et al., 2016). Such process information and the ability to evaluate the processes followed during adaptation, impact the findings presented subsequently and become a spurious factor in any subsequent measurements and findings. Thus, the need to develop actionable steps that could operationalize broad conceptual frameworks for adaptation

(e.g. Castro et al., 2010; Kumpfer et al., 2008) become imperative. The theoretical structure was developed out of the following conceptual strands:

First, the conceptual framework of the study, The Cultural Adaptation Process (CAP) (Castro et al., 2010) was very clear in how it conceptualized an understanding of adaptation processes. Castro derived his nine-step framework from a comparison of three different stage models for adaptation namely Kumpfer et al (2008); Mckleroy et al. (2006) and Wingood and DiClemente (2008). As mentioned in the theoretical framework, the nine steps include the following:

1. Initial assessment of the target population's risk factors and etiological precursor to such factors.

2. Selection of an evidence-based intervention which has a proven evidence of effectiveness, and which best fits the needs and requirements of the target population.

3. Establishment of an advisory group which can review the original intervention materials in order to determine the appropriateness of the selected intervention programme, and to determine the types of cultural adaptations that are needed.

4. Identification of experts to assist in the cultural adaptation of programme components

5. Staff selection and training/supervision to ensure quality implementation.

6. The production of a draft version of the programme which includes initial cultural adaptation changes (maintaining high fidelity to core elements).

7. The production of a final culturally adapted programme which integrates feedback from previous stages.

8. Implementation of the culturally adapted programme and conscientious monitoring of programme fidelity

9. Research and dissemination of study outcomes and the effectiveness of the culturally adapted version of the programme

(Castro et al., 2010).

This stage framework is generic and not targeted to specific programmes. This framework specifically underscores the importance of training staff who will implement the programme. The emphasis contributed to addressing issues related to fidelity which has been overlooked in adaptation processes (Zetterlund et al., 2022). This framework also underscores the importance of selecting an intervention that has demonstrated evidence of efficacy and effectiveness. Bell et al. (2008) point out that adaptation of an intervention programme must be culturally sensitive, contain issues of relevance to the culture, and be generic enough to be efficacious and effective with diverse cultures. Efficacy refers to the beneficial effects of a programme under optimal conditions of delivery, whereas effectiveness refers to effects of a programme under more real-world conditions (Greenberg, 2004; Kellam & Langevin, 2003). Not all programmes of proven effectiveness are ready for widespread dissemination. It is important that programmes are chosen that are ready for dissemination so that they can be

adapted and implemented effectively, that is, in a manner that achieves the expected effects (Flay et al., 2005).

The framework also emphasized the use of advisory boards that enhances buy-in once adapted and informs cultural considerations. Steps 3 and 4 in the framework specifically addressed the need for community engagement in the cultural adaptation process. The inclusion of these two steps in the adaptation process correspond to the Burlew et al. (2013) recommendation to use research experts or other professionals, community representatives including stakeholders and other members of the target group as broad strategies in the cultural adaptation of evidence-based interventions. Similarly, Mouw et al. (2016) recommended that the involvement of community stakeholders as partners on the research team as essential to adapting an intervention for a new setting or target group.

The second strand was taken from Kumpfer et al. (2008). These authors proposed a nine-step framework specifically aimed at cultural adaptation of the SFP programmes. This framework was referred to as the Cultural Adaptation Process for International Dissemination of the Strengthening Families Programme (CAPID). The framework conceptualizes adaptation as a dissemination process which centralizes the need for empirical, methodologically rigorous and coherent strategies to operationalize the steps. Dissemination presupposes that the processes and methods followed in adaptation would be as important as the outcomes of the intervention once implemented. The steps are as follows:

1. Gather needs assessment data on etiological precursors

2. Careful selection of the best EBT to culturally adapt and transport: review literature for evidence of effectiveness; conduct focus groups of parents and staff to review intervention materials.

3. Pilot original EBT with just minor changes to the surface structure

4. Staff selection and training

5. Programme implementation with fidelity and quality

6. Cultural adaptations made continuously with pilot groups

7. Revisions of programme materials to improve engagement

8. Empowerment evaluation to improve outcomes and implementation

9. Disseminate results of the effectiveness of the culturally adapted version

(Kumpfer et al., 2008)

The framework proposed by Kumpfer et al. (2008) makes a unique distinction in the implementation of the programmes. The framework requires two pilot implementations of which the first (Step 3) is implemented with minor adjustments only. The second (step 5) entails implementation with a focus on fidelity. Moreover, the framework conceptualizes adaptation as an ongoing process with continuous pilot groups (step 6) that will move towards a final revision. This iterative process also includes evaluation of implementation processes and outcomes.

A major criticism of this framework is that the suggestion to have an initial pilot with minor changes is often taken out of context and used as a justification for implementation

without due consideration for the appropriateness of the programme specifics and the identification of processes to address fidelity. As a result, the programme implementation often falls flat and produces null or mixed results. An unfortunate response to this is then to discard the programme as an option for intervention in the context (Gottfredson et al., 2015). This criticism arises out of a clinical approach which is adopted at the expense of research rigour (Fixsen et al., 2005). For example, in response to dire clinical needs, the SFP 10-14 was implemented in Cape Town, South Africa as is with very poor outcomes due to exclusion of researchers in the implementation process (N. Burnhams, personal communication, 2014). In many minority communities, such as is in South Africa, there is a history of mistrust of outsiders, government agencies, or researchers in particular (Brown et al., 2014). This influences the degree to which implementation is successful without researchers being involved in decision making (McKay, et al., 2007). Steps 2 and 3 in this framework assume that there is a working knowledge of the theory of change of the selected programme that informs the selection (step 2) and capacity to implement or pilot the programme as intended i.e. fidelity (step 3). It appears that the steps in this formulation are too broad and assumes too much on the part of clinical, research and policy staff. Failure to consider these distinctions more carefully and explicitly result in poor outcomes that in turn contribute to premature abandoning of adaptation (Gottfredson et al., 2015).

In order to take the notion of fidelity further, the third strand was taken from the theory of change or logic model of the SFP programmes. Stefanek et al. (2022) stated that the SFP programme assumes that parenting behaviours mediate between family strength and child behaviour. The two main theoretical tenets of the programme were 1) the family systems theory by Bowen (1991) and 2) the social learning theory by Bandura (2001). The pathway of family bonding, parental supervision, and communication of positive values and expectations are

considered to be most predictive of a reduced risk for ICD diagnoses. Essentially, poor family communication and ineffective parenting strategies are key risks for engagement in health risk behaviours. Thus, young people's behavioural problems and substance misuse is linked to risk and protective factors within the family system.

The theory of change for SFP programming holds that strengthening family bonding, parenting and parental supervision, as well as family communication in the form of communication of positive values and expectations results in the prevention, delay, or reduction of engagement in HRBs. Essentially the theory of change suggests that improved family problem-solving skills and strengthened family bonds become key protective processes. Strategies for identifying and reducing the risks within their family system and increasing the protective factors are transferable skills that parents and young people are taught in the progamme. These strategies include more effective parenting practices (including limit setting) and communication. The capacity to acquire and generalize these skills to everyday functioning results on prosocial and good health outcomes. Kumpfer et al. (2003) successfully applied structural equation modelling to illustrate this underlying assumption. The theory of change predicts short- and longer-term outcomes. In the short term, parenting practices, family communication and young people's attitudes improve (Coatsworth et al., 2010; Coatsworth et al., 2015). In the longer term, young people are less likely to be involved in substance misuse or antisocial behaviour and are more likely to do better in school (Spoth et al., 2004).

The theoretical structure for the adaptation of SFP programmes must draw on the theory of change as formulated above. This contributes to a higher probability of attaining fidelity in the adaptation. In addition, there must be an exploration of the core constructs in the theory of

change to determine whether these are transferable in the target culture or if there are differences in how these core constructs of family bonding, family communication, parenting and the notion of family itself are understood in the target culture (Tabak et al., 2012).

The fourth strand was taken from a seminal paper by Castro et al. (2010) who identified critical issues and challenges in adaptation of EBI. The first critical issue involves the understanding of culture when designing an adapted EBI that is tailored to the needs of a particular cultural group. According to Munoz and Mendelson (2005), culture is a complex construct that can be construed in three conceptual levels: 1) universal characteristics that tend to apply to all people, 2) group-focused characteristics and norms that apply to special cultural groups (or subcultural groups), and 3) individualized characteristics that are unique to the individual person. Dickerson (2018) argued that a distinct group of people is described as "having a culture," in that its members share a collective set of values, beliefs, expectations, and norms, that include traditions and customs, as well as sharing established social networks and standards of conduct that define them as a cultural group. Although culture is a complex concept, it can nonetheless be applied in the design and cultural adaptation of an original EBI (Castro et al., 2010).

A major challenge in this application involves problems that emerge when equating culture with ethnicity and/or when using ethnicity or nationality as alternative variables for culture. Culture and ethnicity are not synonymous (Castro et al., 2004), and developing a cultural adaptation does not necessarily involve the development of an ethnic adaptation. Erez and Efrat (2004) proposed a multilevel model of culture that features both structural and dynamic elements. Structurally, these levels of culture range from the most macro (global culture) to the

most micro (the individual person). Bronfenbrenner's (1986) earlier version of this systemic model, eco-developmental model describes how events at each of these levels can influence an adolescent's identity development and behaviors. From a dynamic perspective, temporal influences on individual behavior and development can also be examined systemically, e.g., how parents influence a child's development over time. This multilevel model is similar to another more recent systemic eco-developmental model that have been proposed (Castro et al. 2009). Another principle to consider regarding culturally relevant and effective EBI is the development of a deep structure understanding of a subcultural group's culture (Resnicow et al. 2000). Castro et al. (2004) indicates that an EBI that lacks relevance to the needs and preferences of a subcultural group, even if the intervention could be administered with complete fidelity, would exhibit low levels of effectiveness. Falicov (2009) described cultural adaptations to EBIs as a process to add certain cultural content to the intervention relevant to the needs of the sub-cultural group, while maintaining fidelity to the core elements of EBIs.

The second critical issue affecting cultural adaptations involves the selection of and the distinction regarding the types of EBI. Kazdin (2008) describe two approaches to intervention adaptation, one is evidence-based treatment (EBT), which indicates the specific intervention or technique that have produced therapeutic change as tested within clinical trials, and the other is evidence-practice (EBP), which refers to "clinical practice" that is informed by evidence about interventions, clinical expertise, patient needs and values and preferences in decisions regarding individual care (Kazdin, 2008). In other words, in addition to empirical research evidence, clinical expertise is also regarded as a viable source of evidence that can guide the development of interventions. However, a major concern is to what extent clinicians actually utilize the results of clinical research to guide their clinical interventions.

The third critical issue affecting adaptations of evidence-based interventions according to Castro et al. (2010) is the fidelity-adaptation dilemma. There are two major arguments concerning this. One favours fidelity in the delivery of an EBI as designed versus the other that favours the need for adaptations to reconcile intervention-consumer mismatches in accordance to the needs of and preferences of a particular sub-cultural group (Castro et al., 2004; Elliott & Mihalic, 2004; Movsisyan et al., 2021). The former argument suggests that efficacy is best attained under strict adherence to the intervention's procedures as tested and validated with no compromises (Elliott & Mihalic 2004). This produces high levels of internal validity. The latter argument considers certain adaptations usually necessary if an intervention lacks relevance and fit with the needs and preferences of a specific subcultural group (an intervention-consumer mismatch) or within diverse ecological conditions, including group characteristics, programme delivery staff and administrative/community factors (Castro et al., 2004). This produces higher levels of ecological validity or external validity. Tredoux and Smith (2006) cautioned that there is an inverse relationship between internal and external validity. Cultural adaptation of EBIs essentially require an intentional engagement with his tension between internal and external validity.

The fourth critical issue involves determining whether cultural adaptations of EBI is justifiable (Castro et al., 2010). Lau (2006) advocated for a theory-driven selective and directive approach to determine whether an EBI should be culturally adapted and which treatment elements must be altered. Barrera and Castro (2006) proposed that cultural adaptations of an original EBI is justified under the following four conditions namely, 1) ineffective clinical engagement, 2) unique risk or resilient factors, 3) unique symptoms of a common disorder, and 4) non-significant intervention efficacy for a particular sub-cultural group.

A fifth critical issue affecting adaptations of evidence-based interventions is identifying and selecting procedures to follow in the adaptation. As mentioned before, Castro et al. (2010) compared three stage models (Kumpfer et al., 2008; Mckleroy et al., 2006; Wingood & DiClemente, 2008) and described how they converge and diverge in content, comprehensiveness and scope. According to them these models utilize steps that guides the determination of the need for cultural adaptation, the elements that needs changing, and estimates of the effects of intervention alterations (Castro et al, 2010). Barrera and Castro (2006) simplified their own framework that contains some essential elements from these comprehensive stage models. Their model presents four stages, namely, information gathering, preliminary adaptation design, preliminary adaptation tests, and adaptation refinement. These and other models (e.g. Bernal et al., 1995; Domenech et al., 2004; Rogers, 2000) are conceptual frameworks that describe the processes to follow in designing, implementing and evaluating a culturally adapted EBI (Castro et al., 2010). There are other frameworks that provides guidance in identifying the intervention content that might be adapted (e.g. Hwang, 2006). It is clear that significant advancements have been made in establishing systematic processes for determining if EBIs should be adapted, how they should be adapted, and what the results of those adaptations are on engagement and intervention outcomes. A valid criticism is that these processes are broad and leaves room for varied interpretation of how to actualize these processes. There remains a need for actionable steps that guides and operationalize the cultural adaptation of interventions.

The sixth critical issue affecting adaptations is assessing the evidence that cultural adaptations are effective. Several journal special issues (Bernal, 2006, Bernal et al., 2009; Griner & Smith, 2006) and other noteworthy studies have been published to add support to the conclusion that culturally adapted interventions are effective. Griner and Smith (2006) in

particular produced several important findings to suggests that culturally adapted interventions are effective. In their review, they identified that 1) half of the studies accommodated adaptation elements, such as cultural values, concepts, language, and diverse cultural backgrounds; 2) that interventions were moderately effective; 3) that interventions were more effective when conducted with groups of the same race; 4) that interventions conducted in the same language as the target group were more effective; 5) that low acculturation participants are in greater need of cultural adaptations and stand to benefit more, and 6) that adapted intervention with older participants produced larger effect sizes than interventions with younger participants. These findings show the pervasiveness of cultural adaptations developed from original EBIs and that they are typically more effective than the original EBI in general and usually exhibit greater relevance to the needs of the targeted sub-cultural group. (Castro et al., 2010).

A seventh and final critical issue that affects adaptation is the accommodation of wide within-group cultural variations in cultural adaptations (Castro et al., 2010). They argue that within large populations, a particular ethnic minority group consists of many individuals who differ from each other very broadly from dimensions of acculturation and other cultural factors and that cultural adaptation should be carefully considered for such diverse populations. One solution in the design of culturally adapted EBIs is to utilize population segmentation to identify a more narrowly defined subcultural group, thus reducing the within-group variability that exists within a large ethnic population (Chong & Matchar, 2017; Lynn et al., 2007). A second strategy is to develop adaptive intervention protocols that are tailored to the individual's or subcultural group's unique needs and preferences (Collins et al., 2004).

This fourth strand introduces critical thinking about cultural adaptation that goes beyond clinical and epidemiological patterns, programme fidelity and cultural criterion referencing. Castro et al. (2010) firmly cemented critical thinking as an additional consideration that can be parallel to or embedded within adaptation processes.

The abovementioned frameworks and heuristic models that informed the four strands all contain deliberate steps, albeit not prescribed in operations, that are intended to guide intervention developers. From these frameworks, there is a guide to decision-making that is intended to help determine the following:

1. Need for cultural adaptation
2. The elements of the intervention that might need to be changed
3. Estimates of the effects of alterations to the intervention.

Table 5.1 outlines how the four conceptual strands were triangulated to inform the theoretical structure for the development of the process guide for adapting SFP 10-14 to the South African context. The theoretical tenets drawn from these guides to form the theoretical structure for the adaptation are presented below. The resulting theoretical structure consists of 14 points. It is thus expanded from the nine steps in the international dissemination process guide (Kumpfer et al., 2008) and the Cultural Adaptation Process (Castro et al., 2010) respectively. The expanded theoretical structure provides an implicit logic model for adaptation.

Table 5.1

The 14-Point Theoretical Structure

Theoretical structure	Key Strands
1. Assess the target behaviour in the target population	CAP - Step 1 - Conduct an initial assessment of the target population's risk factors and etiological precursor to such factors.
	SFP- CAPID - Step 1 - Gather needs assessment data on etiological precursors.
2. Develop a formulatory understanding of the problem behaviour	TOC - Young people's behavioural problems and substance misuse is linked to risk and protective factors within the family system. key risks include poor family communication and ineffective parenting strategies
3. Evaluate the theory of change	TOC - Parents and young people primarily learn strategies for identifying and reducing the risks within their family system, while at the same time increasing the protective factors
4. Define the culture	CCI - Define the culture and sub-cultures - Provide justification for cultural adaptation - Identify the range of within cultural variation for cultural adaptations.
5. Select the Evidence-based Intervention	CAP – step 2 - The careful selection of an evidence-based intervention which has a proven evidence of effectiveness, and which best fits the needs and requirements of the target population.
	SFP-CAPID – Step 2 - Careful selection of the best EBP to Culturally Adapt and Transport.
	CCI - Select the type of EBI

6. Develop an initial position to resolve fidelity and adaptation	CCI - Identify the fidelity-adaptation dilemma
7. Review programme materials and specifications	SFP-CAPID - Step 7 - Revisions of the programme materials to improve engagement of families.
8. Stakeholder consultation to identify recommended cultural adaptation	CAP – Step 3 & 4 - The establishment of an advisory group which can review the original intervention materials in order to determine the appropriateness of the selected intervention programme, and to determine the types of cultural adaptations that are needed. - Identification of experts to assist in the cultural adaptation of programme components
9. Produce a draft version of recommended cultural adaptation	CAP – Step 6 - The production of a draft version of the programme which includes initial cultural adaptation changes (maintaining high fidelity to core elements).
	SFP-CAPID - Steps 3, 5, 6 and 7 - Pilot original EBT with just minor changes to the surface structure - Programme implementation with fidelity and quality - Cultural adaptations made continuously with pilot groups - Revisions of the programme materials to improve engagement of families.
10. Define staffing needs including training, supervision and quality assurance	CAP – Step 5 - Staff selection and training/supervision to ensure quality implementation.
	SFP – CAPID - Step 4 - Staff selection and training/supervision to assure quality implementation.
11. Piloting	CAP - Step 8 - Implementation of the culturally adapted programme

12. Production of a final culturally adapted programme	SFP - CAPID - Step 7 - Revisions of the programme materials to improve engagement of families.
	CAP- Step 7 - The production of a final culturally adapted programme which integrates feedback from previous stages
13. Programme evaluation and refinement	CAP - Step 8 - Conscientious monitoring of programme fidelity.
	SFP – CAPID - Step 8 - Empowerment evaluation to improve outcomes.
14. Dissemination	CAP – Step 9 - Research and dissemination of study outcomes and the effectiveness of the culturally adapted version of the programme
	SFP – CAPID - Step 9 - Disseminate the results of the effectiveness of the culturally adapted version.

Abbreviation key:

CAP –The Cultural Adaptation Process

SFP – CAPID – Strengthening Families Programme - Cultural Adaptation Process for International Dissemination

ToC – Theory of Change

CCI – Castro et al- Critical Issues

EBI – Evidence-based Intervention

EBT– Evidence-based Treatment

EBP– Evidence-based Practice

1. Assess the target behaviour in the target population: This first point underscores the importance of understanding the target behaviour in the target population and goes beyond description and epidemiological data to theorise about aetiological factors that predispose, precipitate and maintain problem behaviours (Berrera et. al, 2011). Developing a comprehensive understanding of the problem behaviour in the target population is crucial. A thorough analysis of the problem lays the foundation for behavior change initiatives for the target population (Bartholomew Eldredge et al., 2016). Behavior change approaches tend to operate on the assumption that interventions affect behavior by modifying social, environmental, and/or cognitive predictors of the target behavior (Yardley et al., 2015).

2. Develop a formulatory understanding of the problem behaviour: This emphasizes a careful description of the problem that will enable intervention planning. The adaptation team conducts an analysis of health and quality of life, behaviours, and environmental conditions that contribute to the health problem directly or to the risk behaviours. The team also identifies factors (determinants) that influence the risk behaviors and problematic environmental conditions contributing to the health problem. Next, the adaptation team then specifies performance objectives (or sub-behaviors) for the at-risk group. The team sets performance objectives breaking down each behaviour and environmental condition into subcomponents by answering certain questions like, "What does the person need to do to accomplish the behaviour?" and "What does the person need to do to create the environmental change?" They then identify determinants of health-promoting behaviours and environmental conditions by asking: "Why would someone do this behaviour?" and "Why would someone make this environmental change?"

3. Evaluate the theory of change: The theory of change (TOC) provides hypotheses of change, i.e. the rationale and assumptions about mechanisms that link processes and inputs to both intended and unintended outcomes, as well as conditions and context (De Silva et al., 2014), and a formalized understanding of the problem behaviour that goes beyond identifying risk factors. These hypotheses are validated according to the extent to which the theory, highlighting the causal pathway, corresponds to what is observed in the context (Moore et al., 2015). Systematic adaptation requires that planners make adaptation decisions by comparing the logic of change in the EBI with the needs of the new community or intervention context (Fernandez et al., 2019). Theory has a central role to play by synthesizing evidence of causes and predictors of the target behaviours (Bartholomew Eldredge et al., 2016). Where multiple behaviors are targeted, a process of testing multiple theories across multiple behaviors can be used to identify the most consistently predictive constructs within their theories across behaviors, then theorize and test how such theories and their constructs can be applied (Presseau et al., 2014). Thus, a formulatory understanding of the problem behaviour elevates the use of theory. It makes the theoretical tenets explicit and assists in the subsequent selection of EBIs. Traditionally, this has been overlooked as the focus was a statistical or clinically.

4. Define the culture: An understanding of the target culture is integral to selecting EBIs. Culture may be viewed as the totality of a subcultural group's knowledge, transmitted from elders to children, which includes observable entities (patterned behaviors, symbols, and artifacts) and cognitive entities (shared beliefs, schemas, and norms) (Cohen, 2009). Accordingly, the cultural adaptation of an original intervention should incorporate observable aspects of a local culture into treatment media and activities, and infuse cognitive aspects of that culture into intervention content (Falicov, 2009). The goal of the cultural adaptation of

preventive programmes is the achievement of activities, procedures, and materials that are perceived as appealing, motivational, clear, understandable, suitable, and relevant for the new context (Castro et al., 2010).

5. Select the Evidence-based Intervention: The adaptation team apply the logic model and assessment findings in a process of thinking critically and systematically about the conceptual fit with the community's logic model, practical fit with the community's needs, resources and readiness to act, and the evidence of effectiveness (Castro et al., 2010). Thus, this identifies both the evidence of effectiveness and the match to the needs of the intended target population. It underscores the importance of the selection as an intentional step. Castro et al. (2010) makes a further distinction between types of EBI which makes the decision or selection more refined. This point is crucial and the considerations must be more explicit. In the theoretical structure this is placed later in order to promote more informed and intentional decision-making.

6. Develop an initial position to resolve fidelity and adaptation: This denotes a theoretical exercise which draws on the previous points in order to find a resolution to the dialectic between resolving fidelity and adaptation to a new context. Castro et al (2010) makes this point explicit and recommends that it be engaged with intentionally so as not to become a spurious factor in subsequent evaluations. Adaptations have been suggested to be appropriate as long as the core components of an intervention are implemented with high fidelity and the adaptations are aligned with the intervention's goals (Moore and Cooper, 2013). The responsibility for handling the fidelity–adaptation dilemma and making important and

complicated fidelity and adaptation decisions when delivering EBIs often lies with the professionals using the EBI in the natural context (Spoth et al., 2011).

7. Review programme materials and specifications: The programme's core components can be cast as theory-driven, empirically derived principles and then further operationalized as the contextual factors, structural elements, and intervention practices that are aligned with these principles (Webster-Stratton & Herman, 2009). Review and revision of programme materials and core components were not dealt with explicitly in the SFP protocol for international dissemination and were only highlighted in later steps after initial piloting. The justification for cultural adaptation already provides direction to possible revisions and therefore reviewing progamme materials and specifications can be conducted prior to piloting with specific reference to the dialectic between fidelity and adaptation in point six. This is a theoretical exercise which the adaptation team conducts to identify possible adaptations to the materials and implementation strategies. This can be used as stimulus for the stakeholder consultation to achieve a more focused response.

8. Stakeholder consultation to identify recommended cultural adaptation: Research recommends following the community-based participatory research (CBPR) approach to engage with and seek input from community partners and representatives of the target population (Bernal & Sáez-Santiago, 2006; Card et al., 2011; Chen et al., 2013; Domenech-Rodriguez and Wieling, 2005; Hwang, 2009; Kumpfer et al, 2008; Kumpfer et al., 2017). CBPR can enhance the implementation process by contextualizing EBTs to the cultural and social realities of communities, integrating ethno-cultural values, perspectives and preferences into the content and form of EBTs to enhance their relevance, acceptability and feasibility, and by strengthening the

capacity of community stakeholders to support implementation efforts and community-based research (Minkler & Salvatore, 2012). Castro et al. (2010) addresses stakeholder consultation at level two. The advisory group holds a more formal position and may have decision-making power or only make recommendations. The identification of experts relates to the established understanding of the problem behaviour, target population and target cultural context where implementation takes place. Stakeholders are broadly conceptualized in an inclusive manner. At an operational level, the kind of consultation and the range of stakeholders should be identified. This does not preclude an advisory group and allows for flexibility relative to the programme and the target context, as well as funder requirements.

9. Produce a draft version of recommended cultural adaptation: The contextual adaptation process (CAP) recommends the production of a draft version next which includes the initial cultural changes, maintaining high fidelity to core elements (Castro et al, 2010). The draft asks for a theoretical engagement prior to implementation. The SFP International dissemination protocol addresses this as an iterative process over several steps involving piloting. They suggest piloting the original EBT first with minor changes to the surface structure, programme implementation with fidelity and quality and cultural adaptations made continuously with pilot groups (Kumpfer et al, 2008). The emphasis on drafting is important as it enables further consultation with panels through methods such as Delphi processes to obtain feedback from experts about the appropriateness of the adapted intervention compared to other culturally-tailored interventions (Burlew et al., 2020).

10. Define staffing needs including training, supervision and quality assurance: Organizational level factors can impact programme implementation (Colditz, 2012). Programme

fit refers to how well a programme meshes with, for example, an organization's structure, the demands placed on staff, and/or staff skills (Mowbray et al., 2003). Even with high-quality training and quality assurance, if there is poor fit, programmes may not be implemented with fidelity. Fit challenges may emerge during training, early on in programme implementation (e.g., pilot runs), or during full implementation (Dolcini et al., 2010). Ongoing quality assurance serves as a mechanism for addressing fit problems, and may lead to modifications. This is an important consideration as it impacts implementation. Decisions and or recommendations about staffing, training and supervision contribute to higher levels of fidelity and must be made explicit in adaptation processes.

11. Piloting: Piloting is a preliminary examination of the adapted intervention to determine feasibility and to assess whether it is likely to achieve the desired impact (Porta, 2008). This includes creating an implementation plan for the adapted intervention and a successful pilot test of the adapted intervention or components of the intervention. The implementation plan serves as a useful tool to guide and monitor milestones, adhere to tasks, and track performance (Leon and Davis, 2009). Pilot tests are exploratory in nature, and are used to refine adaptation in regards to recruitment, intervention and assessment procedures (Castro et al., 2010). If the pilot uncovers problems, it is essential to determine what is not working, make modifications, and repeat the pre-test and pilot test activities (Kraemer et al., 2006).

12. Production of a final culturally adapted programme: This step integrates feedback and lessons learned from the preceding steps into a revised intervention that could be used and studied more broadly. SFP International dissemination recommends revisions of the programme materials to improve engagement of families (Kumpfer et al., 2008). Castro et al. (2010) refer to

this as adaptation refinement, a modification of the intervention based on pilot results and subjecting the intervention to a full evaluation with quantitative and qualitative data to evaluate the efficacy of the adapted intervention. These strategies include both bottom-up and top-down approaches, thus, striking a balance between community needs and scientific integrity (Castro and Yasui, 2017; Domenech et al., 2004).

13. Programme evaluation and refinement: The purpose of evaluating an adapted EBI is to determine whether the intervention achieves outcomes in the new setting comparable with outcomes in the original evaluation ("effect evaluation") and whether the new setting can successfully implement the adapted EBI e.g., by measuring reach and fidelity (Escoffery et al., 2019). Evaluation questions for adapted EBIs can be borrowed from the original EBI evaluation. If the target behavior or environmental condition has been adapted, the indicators and measures must match the new logic model (Stirman et al., 2013). This approach also suggests effective methods should be pilot tested and revised, as needed, to be culturally appropriate including surveys, data collection methods, and reporting methods (Castro et al., 2004).

14. Dissemination: The last point involves activities to disseminate the adapted intervention and sustain it through training systems and ongoing re-assessments. To improve the field's knowledge on the effectiveness of culturally adapted or modified versions of EBIs, it is recommended that the process and outcome research results and lessons learned in implementation of the adapted EBI model is published (Kumpfer et al., 2008). Aarons et al. (2017) make a conceptual argument for the possibility to "borrow strength" from evidence in the original effectiveness study to allow for a more limited evaluation when scaling-out interventions to new populations and/or using new delivery systems. This would include, for instance, using

implementation evaluation rather than a new effectiveness study to promote the dissemination of effective EBI programmes (Kumpfer et al., 2008).

These fourteen points form the theoretical structure for the proposed guideline. The theoretical structure can further be organized into four distinct conceptual sections that corresponds to the taxonomy proposed by Movsisyan et al. (2021). As mentioned before, the taxonomy includes 1) exploration, 2) preparation, 3) implementation and 4) sustainment.

Section 1, Exploration, relates to considering and assessing the behaviour needs of the target population. The first four points of the theoretical structure form part of the exploration in the process of adaptation. Point One deals with the needs assessment which is crucial as it provides an understanding of the challenges experienced in the local or target context. Needs assessment can follow specific research methods dedicated for this purpose. For the purposes of this section, the focus is on determining whether and how needs assessment was conducted.

Point Two deals with developing a formalised understanding of the problem behaviour. A formalised understanding of the problem behaviour helps planners distinguish between behaviours, environmental conditions, and their determinants, helping them better articulate and document needed changes and desired outcomes.

Point Three deals with evaluating the theory of change. This involves examining the elements of the context in which the intervention is delivered separately from the parts of an intervention. This must precede the selection of the EBI, as alignment or compatibility of the EBI and the TOC is imperative if good results are to be expected. Point Four deals with defining the target culture. This requires the adaptation professional to engage with the levels of cultural

representation that need to be considered in selection and adaptation. It prefaces the contextual issues and promotes the specification of limits and parameters (Barrera et al., 2011; Castro et al., 2010).

Section 2, Preparation, entails identifying potential barriers and facilitators of implementation, further assess needs for adaptation, and to develop a detailed implementation plan to capitalize on implementation facilitators and address potential barriers. Points 5-10 are categorized under preparation for adaptation. Point Five deals with the selection of the programme. The focus here is to assess the decision-making process followed in the selection of specific programmes, practices, and strategies that are: appropriate for the community's population, cultural context, and feasible, given local circumstances, including resources, organizational resources, and readiness to act, and that demonstrate sufficient evidence or support for documented effectiveness (Castro et al, 2010; Kumpfer et al., 2008).

Point Six deals with developing an initial position to resolve fidelity and adaptation. It includes the requirements of the programme for full implementation and fidelity. Point Seven deals with the review of specifications for the selected programme. Specifications can include target group, programme language, training and selection of facilitators, content and teaching methods. An overarching consideration in this section is clarifying the theory of change for the selected programme. Point Eight deals with stakeholder consultation to identify recommended cultural adaptation and corresponds to step eight of the theoretical structure. The focus of this section is how the stakeholders were selected and the nature of the engagement processes employed. Point Nine deals with producing a draft version of recommended cultural adaptation

which includes the initial cultural changes, maintaining high fidelity to core elements. Point Ten deals with defining staffing needs which include training, supervision and quality assurance.

Section 3, Implementation, relates to initiating and instantiating the use of the adapted evidence-based programme. This section includes two points, 11 and 12, from the theoretical structure. Point 11 deals with piloting the initial adapted programme. This is exploratory in nature, and is used to refine recruitment, intervention and assessment procedures elements of the adaptation. Point 12 deals with producing the final culturally adapted programme, which integrates feedback and lessons learned from the preceding steps.

Section 4, Sustainment, relates to the application and evaluation of insights from the need assessment, review of literature, stakeholder consultation, initial piloting and includes considerations for implementation and research. Two points are included in this proposed section, namely point 13 and 14. Point 13 deals with programme evaluation and refinement. Exit interviews may be used with participants and staff to determine ways of improving the adaptation. The focus here is to determine how the adaptation team has considered implementation and research in relation to the adapted programme.

Point 14 deals with dissemination. Outcome research results and lessons learned in transportation of the EB interventions should be published to improve the field's knowledge on the effectiveness of culturally adapted or modified versions of EB intervention programmes. Additionally, research on factors affecting selection and adoption of EB intervention programmes is also needed to promote the wider dissemination of effective interventions capable of reducing the problem behaviour.

Step 2: Format of the guideline

The second step entailed deciding on the format of the proposed measure, as well as the quantification for scoring purposes. The ITC guidelines recommend that scalar decisions be taken in order to ensure that the selected form and intended function of the instrument or measure are aligned (ITC, 2016).

The decisions taken about the format of the guideline constitute scalar decisions that dictate the use, format and structure of the guideline. The following eight aspects were considered in the process of deciding on the format of the guideline.

a. Target group of the guideline.

The intended target users of the guidelines are three-fold: First, researchers and practitioners interested in adapting programmes can use the guidelines to make methodological decisions that are rigorous and coherent.

Second, practitioners who want to implement adapted programmes can use guidelines to evaluate the process of adaptation followed. This helps to formulate the clinical or practice considerations when selecting a programme for implementation.

Third, the guidelines can also be used by funders and stakeholders who want to evaluate whether the processes followed in the adaption of a particular programme (or proposed adaptation) were rigorous, replicable and accountable.

b. Respondent group.

Respondents refer to those individuals who would physically apply the guidelines. The intended respondent group will be researchers, practitioners, stakeholders and any staff involved with evaluation of processes. It will be advantageous for respondents to have training in research including programme adaptation and evaluation. This is not a prerequisite, but a benefit.

c. Use of the guideline.

The guidelines are intended to be used to assess the quality of adaptation processes or proposed adaptation processes. Thus, the guideline can be used formatively and summatively. In a summative sense, the guideline should provide an overall indication of the quality of the adaptation process. At a formative level, the guidelines can identify areas in which the adaptation process was not optimal or require a closer look. Thus, the guideline can direct the intended users to corrective actions.

d. Format of the guideline.

The proposed measure would be called, the Contextual Adaptation Model and Process Checklist. It will be abbreviated as the CAMP-C. The checklist format was deemed appropriate as it would guide the process of adaptation of an EBI with operational steps and activities that support design, decisions, capacity building and implementation in relation to programme adaptation.

e. Structure of the guideline.

The guideline will be structured into four sections to reflect the conceptual organization of the theoretical structure described in the second step. Each section will include items relating to the core content covered by the points included in the relevant sections. The four sections include 1) Exploration, 2) Preparation, 3) Implementation and 4) Sustainment.

These sections are conceptualized as both independent and complimentary of one another. Thus, users may choose to use a specific section to guide or inform an aspect of the adaptation process. Alternatively, users may choose all or some sections of the guide to inform an entire process.

f. Items.

The generation of items is a key aspect of the construction process. There are decisions that need to be taken about the format of items and how they will function (Foxcroft, 2004). For each point in the theoretical structure items were generated. A pool of 178 items was generated. The pool of initial items was then reduced to a final set as per the recommendation of De Villes (2016).

g. Scoring:

This checklist uses a dichotomous scale with no quantification. Instead, the checklist generates qualitative lists of questions. Participants can motivate decisions that differ from the operational activity reflected in the question or item.

h. Interpretation:

There was no quantification used, and therefore no scoring was provided in the checklist. Data generated creates a qualitative descriptive, which describes the "who, what, and where" of experiences from a subjective perspective (Kim, et al., 2017, p. 23). Interpretation then is made simple: the more affirmative answers there are, the better the quality or rigour of the adaptation or proposed adaptation.

Step 3: Generating a pool of items.

The third step entailed generating a pool of items to assess the various domains or components of the intended measure. The format of the items must be aligned with the intended use of the measure and the items must cover the content outlined in the theoretical structure. It is generally recommended that more items are generated from which a final list can be distilled.

For the purposes of developing the guide, the 14 points in the theoretical structure were too complex to formulate simple, statement-based items for each point. Therefore, each point was decomposed into operational activities.

For Section One operational activities were generated on the first four points. Points One to Four were broken down into 36 operational activities as illustrated below in **Table 5.2**.

Table 5.2

Section 1 – Operational Activity

Point		Operational activity
1	Needs Assessment	- Determine the selection of the target population before all other adaptation questions can be formulated. - Describe the target population in terms of demographics, recent trends and social norms. - Clearly define target group - Clearly define target behaviours - Conduct a thorough literature review - Obtain epidemiological data - Review statistics of HRBs in target population
2	Formulatory understanding	- Conduct an analysis of health problems - Conduct an analysis of quality of life, - Identify behaviours that contribute to the health problem or risk behaviours directly - Identify environmental conditions that contribute to the health problem or risk behaviours directly - Specify performance objectives (or sub-behaviours) for the at-risk group - Break down performance objectives into subcomponents - Break down environmental condition into subcomponents ▪ "What does the person need to do to accomplish the behaviour?" ▪ "What does the person need to do to create the environmental change?" ▪ "Why would someone do this behaviour?" ▪ Why would someone make this environmental change?" - Identify determinants of health-promoting behaviours and environmental conditions - Identify formal (behavioural) theories that aid in understanding the predictors of the target health behaviour - Rate determinants or influencing factors (psychological, social, predictors/mechanisms) for changeability and relevance

3	Theory of Change	- Identify hypotheses of change in the programme - Make the hypothesized causal assumptions explicit - Make the rationale about mechanisms that link processes and inputs explicit to ▪ intended outcomes ▪ unintended outcomes ▪ conditions and context - Develop a formalized understanding of the problem behaviour that goes beyond identifying risk factors. - Ensure that multiple theories are tested for multiple target behaviours - Identify the most consistently predictive constructs within the theories across behaviours - Theorize and test how such theories and their constructs can be applied - Compare the logic of change in the EBI with the needs of the new community or intervention context - Assess the extent to which the theory (causal pathway) corresponds to what is observed in the context - Identify specific issues that create barriers to intervention success
4	Target Culture	- Identify if there is a total culture or subculture - Describe dynamic issues and cultural complexities - Describe cultural beliefs - Describe cultural differences in expression and communication - Describe cultural issues of salience (e.g., shame and stigma, acculturative stress). - Specify the language of the target group - Identify cultural expressions and sayings that might be used in treatment - Identify cognitive aspects of the local culture that might be used in treatment - Identify aspects of the local culture that can be incorporated into treatment media and activities - Identify any activities, procedures, and materials that can be perceived as appealing, motivational, clear, understandable, suitable, and relevant for the new context

Section Two, preparation, addressed points 5 – 10. **Table 5.3** below summarises the 57 operational activities per point in this section.

Table 5.3

Section 2 – Operational Activity

Point		Operational activity
5	Selection of the programme Selection of the programme cont.	- Develop review questions to identify EBIs - Select a review methodology to identify EBIs - Develop a comprehensive search strategy including ▪ key words ▪ databases ▪ time frame - Develop guidelines to extract information about ▪ the public health problem of interest ▪ target behaviours ▪ theoretical underpinnings ▪ duration ▪ methods of implementation ▪ the level of effectiveness ▪ appropriateness of evidence ▪ resources required - Clearly define the quality of selected programmes - Evaluate basic fit of the EBIs - Determine if the EBI matches problem behaviours, environmental conditions, organizational resources, and characteristics of the target population. - Indicate how programmes have been replicated in other cultures/contexts - Select the best matching intervention
6	Fidelity and adaptation	- Evaluate how well the selected EBI fits the desired behavioural and environmental conditions of the logic model of change within the community - Evaluate whether the determinants of behaviour and environmental conditions and the change methods used to influence them in the original EBI are adequate in the new setting

	Fidelity and adaptation	- Evaluate how well original delivery, design features, and cultural elements fit the new setting and population - Evaluate the fit of implementation strategies to the new setting - Assess fidelity/adaptation concerns for the particular implementation site - Develop a position for resolving the fidelity/ adaptation
7	Programme specifications	- Determine alignment with programme specifications - if target group includes combination of youth age 10-14 and family members - Determine if programme language considers the socio-cultural and socio-political context - Determine if content addresses HRBs including, sexual risks, substance abuse, violence and gangsterism - Determine if content addresses pro-social skills including managing peer pressure and emotions - Determine if content addresses family values including communication, respect, courage, diligence, justice, etc. - Determine if facilitator profile includes having content knowledge, facilitation skills and good characteristics - Determine if facilitation methods includes both formal and experiential learning - Determine if frequency in participation is at least once a week session - Determine if duration in participation is for at least 7 weeks - Determine if intensity in participation is at least 1hour separate and 1hour conjoint sessions - Determine if full attendance in participation is expected and challenges are addressed appropriate - Determine if required resources are attained to sustain programme needs - Determine if expected resources are secured for infrastructure, incentives and stipends - Determine if termination and sustainability considers booster follow up and accountability sessions

	Programme specifications cont.	- Determine if community engagement is considered for planning, adaptation and implementation of the programme
8	Stakeholder consultation	- Select a community-based participatory research (CBPR) - Conceptualize stakeholders in an inclusive manner - Identify the range of stakeholders to be consulted - Identify the kind of consultation required with each stakeholder group - Follow a fair and inclusive selection process of stakeholders - Consult with stakeholders to identify cultural elements to be considered for programme adaptation - Identify potential experts - Assess whether experts have an established understanding of ▪ the problem behaviour ▪ target population ▪ target cultural context where implementation takes place ▪ assess stakeholder input and potential collaborations and secure their meaningful involvement - Assess whether the capacity of community stakeholders to support implementation efforts was strengthened - Develop an implementation plan for a particular setting incorporating input from ▪ community stakeholders ▪ organisational stakeholders ▪ experts ▪ intervention/ programme developers - Decide whether an advisory group will be required. - Decide the role of the advisory group ▪ a formal position ▪ decision-making power ▪ an informal position

		▪ can only make recommendations. ▪ Identify and recruit potential implementers, if possible, with the same ethnic background as the target population

9	Draft version Draft version cont.	- Integrate the input of relevant stakeholders into a draft treatment adaptation. - Assess whether core elements of original intervention were preserved - Identify any core elements that should be dropped - Document the evidence that revisions will not constitute modifiable risk factors for fidelity - Assess barriers and facilitators of fidelity and quality in the proposed cultural adaptations - Adopt a rigorous process for the translation of materials from original language into language appropriate for subcultural group. - Develop a consultation plan with panels based on rigorous research methods - Asses the quality and extent of theoretical engagement prior to implementation - Integrate feedback from stakeholders about the appropriateness of the proposed adaptations - For technology-mediated interventions, conduct usability tests to determine how well participants can navigate equipment and procedures - Identifying training needs based on the proposed adaptations.
10	Staffing needs	- Identify staffing requirements ▪ staffing skills ▪ implementation requirements ▪ training ▪ supervision - Assess programme fit with ▪ organizational structure ▪ demands placed on staff ▪ staff skills - Identify any potential fit challenges - Plan quality assurance mechanisms to address fit problems - Develop a strategy to identify modifications

For section Three, Points 11 and 12 related to implementation and formed the basis of the operational activities. **Table 5.4** below summarises the 12 operational activities and points in this section of the guide.

Table 5.4

Section 3 – Operational Activity

Point		Operational activity
11	Piloting	- Develop an implementation plan - Identify milestones for the programme that would guide monitoring and evaluation - Conduct an evaluation of the programme to assess ▪ feasibility ▪ desired effects on engagement ▪ desired effects on putative mediators ▪ desired effects on health outcomes. ▪ process, summative and formative evaluations ▪ outcome ▪ fidelity - Determine what is not working - Formulate refinements and adaptations - Determine whether further piloting is required
12	Final cultural adaptation	- Collate feedback and lessons learnt from the pilots - Integrate feedback and steps into a refined adaptation - Finalise the implementation plan - Implement the adapted intervention - Conduct a full programme evaluation with outcome and process data to evaluate the efficacy of the adapted intervention. - Develop a mechanism for ongoing support, feedback and refinement

For Section Four, operational activities were developed from points 13 and 14 that comprised sustainability. **Table 5.5** below summarises the 9 operational activities per point.

Table 5.5

Section 4 – Operational Activity

Point		Operational activity
13	Evaluation and refinement	- Select evaluation questions from the original EBI evaluation - Plan an "effect evaluation" including ▪ Intervention outcomes in the new setting ▪ Comparison of intervention outcomes between settings ▪ Success of implementation ▪ Reach ▪ Fidelity ▪ Match between the logic model, indicators and measures - Pilot methods for cultural appropriateness - Assess adaptations for effectiveness - Adopt effective adaptations formally - Drop or revise ineffective adaptations - Identify further adaptations - Revise the intervention
14	Dissemination	- Develop a dissemination plan including ▪ factors affecting selection and adoption of EBI Implementation analysis ▪ process results ▪ outcome results (efficacy) ▪ lessons learned in transportation of the EBI ▪ training of facilitators and staff

The 14 points were decomposed into 114 operational activities. The operational activities provide a comprehensive coverage of the points in the theoretical structure. It provides a good alignment between the points and operational activities that can be seen as an adequate operationalization of the adaptation process as recommended by Harrison et al. (2010). It also drew on the results of the preceding phases and the methodological processes followed. The operational activities were used as the basis for item writing. Items were generated to address the 114 operational activities. Some operational activities were articulated into several draft items while other operational activities were merged. In some instances, operational activities were used at the item level because they had a more granular nature whilst others were retained as broad operational activities. The items developed for the assessment of points and operational activities are presented in tabular form per section. **Table 5.6** below presents the items developed for Section One.

Table 5.6

Items for Section One

Section 1: Exploration		
Points	Operational Activities	Guiding questions/ items
1. Needs assessment	- Determine the selection of the target population before all other adaptation questions can be formulated.	- Was the target population selected prior to the formulation of (other) adaptation questions ?
	- Identify the target population in terms of demographics, recent trends and social norms.	- Was a demographic profile established for the target population ? - Were social norms in the target population identified? - Were recent trends identified in the target population?

Point 1 cont.	- Clearly define target group	- Was the target group clearly defined?
	- Clearly define target behaviours	- Were the target behaviours defined clearly in terms of ▪ health risk behaviours ▪ pro-social behaviour ▪ Anticipated outcomes
	- Conduct thorough literature review	- Was a comprehensive search strategy developed with relevant keywords and Boolean strings? - Was a thorough literature review conducted on ▪ health risk behaviours ▪ Pros-social behaviours ▪ Anticipated outcomes
	- Review statistics of HRBs in target population	- Was good quality epidemiological data on health risk behaviours obtained?
	- Overarching questions	- Was a thorough needs assessment conducted? - Were empirical research method used to conduct the needs assessment?
2.Formulatory understanding	- Conducts an analysis of health risk behaviour	- Has an analysis of quality of life (indicators) been conducted? - Has an analysis of health risk behaviour been conducted?
	- Identify behaviours that contribute to the health problem or risk behaviours directly	- Have behaviours been identified that predispose or precipitate engagement in HRBs?
	- Identify environmental conditions that contribute to the health problem or risk behaviours directly	- Have environmental conditioned been identified that precipitate or predispose to engagement in HRBs?
	- Specify performance objectives (or sub-behaviours) for the at-risk group	- Have performance objectives been identified? - Are there sub-behaviours that should be considered as possible outcomes? - Are the performance objectives specific and relevant to the at-risk group?

	- Break down performance objectives into subcomponents	- Can performance objectives be grouped into sub-components - How many sub-components were identified?
	- Break down environmental condition into subcomponents	- What does the person need to do to accomplish the behaviour? - What does the person need to do to create the environmental change? - Why would someone do this behaviour? - Why would someone make this environmental change?
	- Identify determinants of health-promoting behaviours and environmental conditions	- Have determinants of health promoting behaviours been identified? - Have determinants of environmental conditions been identified?
	- Identify formal (behavioural) theories that aid in understanding the predictors of the target health behaviour	- Have theories been identified that can assist in developing a formulatory understanding of the predictors of the target health behaviour?
	- Rate determinants or influencing factors of Health behaviours	- Have you rated psychological factors? - Have you rated social factors? - Have you rated predictors (mechanisms) for changeability? - Have you rated the relevance influencing factors?
3. Theory of change	- Hypotheses of change in the programme	- Have causal hypotheses of change been identified for the programme? - Have the hypothesized causal assumptions been made explicit?
	- Make the rationale about mechanisms that link processes and inputs explicit	- Are there explicit links between the mechanisms of change? - Are there explicit links between the mechanisms of change and intended outcomes? - Are there explicit links between the mechanisms of change and unintended outcomes? - Are there explicit links between the mechanisms of change and conditions or context ?

Theory of change cont.	- Develop a formalized understanding of the problem behaviour	- Has a formalised understanding of the problem behaviour been developed? - Does that understanding go beyond identifying risk factors?
	- Ensure that multiple theories are tested for multiple target behaviours	- Have multiple theories been considered? - Was there a systematic process for deciding about theories?
	- Identify the most consistently predictive constructs within the theories	- Have predictive constructs been identified within the theories? - Were predictive constructs been identified that are consistent across theories?
	- Theorize and test how such theories and their constructs can be applied	- Have the theories been tested for its applicability to the target behaviour? - Have the theories been tested for its applicability to the target group?
	- Compare the logic of change in the EBI with the needs of the new community or intervention context	- Has the logic model in the EBIs under consideration been compared to the identified community needs? - Has the logic model in the EBIs under consideration been compared to the intervention context?
	- Assess the extent to which the theory (causal pathway) corresponds to what is observed in the context	- Were indicators of fit identified? - Has the causal pathway (theory) been assessed for fit with the context?
	- Identify specific issues that create barriers to intervention success	- Have potential barriers to intervention success been identified?
4. Target culture	- Identify if there is a total culture or subcultures	- Has there been an assessment of the target culture? - Were any sub-cultures identified?
	- Describe dynamic issues and	- Were any dynamic issues identified? - Were any cultural complexities identified? - Were specific cultural beliefs identified?

Point 4 cont.	- Describe cultural differences in expression and communication	- Has the language of target group been specified? - Were any cultural expressions and sayings that are unique to the target culture identified? - Have the cultural expressions been assessed for potential incorporation in the treatment
	- Describe cultural issues of salience in the target culture	- Were any issues of salience to intervention identified? - Was the cultural expression of emotions assessed? - Was the culture assessed for stigma around ▪ Disclosure of health risk behaviours ▪ Expression of feelings ▪ Engagement in treatment ▪ Acculturative stress
	- Identify cognitive aspects of the local culture that might be used in treatment	- Were any culture-specific thought patterns identified? - Were thought patterns evaluated for relevance to the intervention success? - Were any thought patterns identified for potential inclusion in the adaptation?
	- Identify aspects of the local culture that can be incorporated into treatment media and activities	- Were any aspects of the local culture incorporated into the treatment activities, including demographic, geographic and associative aspects? - Were any cultural expressions and saying been identified and incorporated into the treatment activities?
	- Identify any activities, procedures, and materials that can be perceived as appealing, motivational, clear, understandable, suitable, and relevant for the new context	- Were there any activities identified as relevant for the new context? - Were any procedures been considered as appropriate for the new context? - Were any materials identified to be suitable for the new context?

For Section One, a total of 68 items were drafted across the first four points on the theoretical structure, which form part of exploration in the adaptation process. Point One deals with how needs assessment was conducted to conceptualize the challenges experienced in the target context. Learnings pulled through from Phase 0-2 was specifically utilized for item production here. For example, the systematic review had specific steps to develop a comprehensive search strategy. This inspired the operational activities and items here. It was found to be a robust method that produced clear evidence for the SFP programme. Thus, drawing on the process steps of the SR, the operational steps were informed.

Point Two deals with developing a formalised understanding of the problem behaviours, behaviour objectives, environmental conditions, influencing factors, needed changes, and desired outcomes. Learnings pulled through from the literature review was utilized for item production here. The literature review identified concrete evidence that the youth in South Africa is predisposed or precipitating engagement in HRBs from an early onset (e.g. Reddy et al., 2013, Pharaoh et al., 2018, Khuzwayo, et al., 2020), and that a range of behaviours place them youth at risk, including practicing unsafe sex, binge drinking and using illicit drugs, and being involved in violence (Shuro and Waggie, 2021, Daniels and Pharaoh (2021). This provided an understanding of the problem behaviours and influencing factors in the local context.

Furthermore, the stakeholder review engaged stakeholders in discussions regarding target group, pre- and early adolescents HRBs, language specific to culture and context, degree and nature of participation, programme content to fit context, facilitation requirements, and resources needed for adaptation and implementation. This provided an understanding of the challenges experienced in the target group (pre-and early adolescents) in general, and more specifically in the

local or target context (target population). These learnings contributed towards the items here. Thus, drawing on the process steps of the stakeholder review, the operational steps were informed.

Point Three in section one deals with evaluating and comparing the theory of change (logic of change) in the EBI against the needs of the new community or intervention context. Learnings pulled through from Phase 0-2 was utilized here for item production. The description of the SFP programme introduced in Phase 0, offered that the strengthening of family bonding, parenting and parental supervision, as well as communication of positive values and expectations results in the prevention, delay, or reduction of engagement in HRBs. The SFP's theory of change, therefore, suggests that improved family problem-solving skills and strengthened family bonds become key protective processes. Furthermore, the narrative review rendered specific results and evidence relating to the theoretical justification for family interventions and the theory of change of the SFP 10-14 programme. Thus, the items for point three were produced by drawing on the process steps of the narrative review.

Point Four deals with defining the target culture and identifying aspects of the local culture that can be incorporated into treatment strategies. Learnings pulled through from Phase 0-2 was utilized here for item production. For example, Phase 0, which consisted of the introduction chapter of the study as well as the narrative review, identified specific evidence relating to the research setting, local cultural elements, nuances and conditions of the local (South African) context, pre- and post-conceptualization period of 2013. Thus, drawing on the process followed and the evidence revealed in phase 0, the operational steps and resulting items the items for point three were informed.

Next, **Table 5.7** below presents the items for Section Two.

Table 5.7

Items for Section Two

Section 2: Preparation		
Point	Operational Activities	Items
5. Selection of programme Selection of programme cont.	- Develop review questions to identify EBIs	- Have review questions been identified
	- Select a review methodology to identify EBIs	- Have review methodologies been assessed for appropriateness? - Has a review methodology been selected?
	- Develop a comprehensive search strategy	- Have appropriate key words been developed? - Have a set of relevant databases been selected? - Has a time period been set for the search? - Have guidelines been developed to extract information about ▪ the public health problem of interest ▪ target behaviours ▪ theoretical underpinnings ▪ duration ▪ methods of implementation ▪ the level of effectiveness ▪ appropriateness of evidence ▪ resources required
	- Clearly define the quality of selected programmes	- Have indicators of quality been stipulated explicitly

	- Evaluate basic fit of the EBIs	- Have indicators of fit been articulated? - Have EBIs been evaluated for fit to the target culture?
	- Determine EBI match to target population	- Do the EBIs address the identified problem behaviours? - Do the EBIs address the identified environmental conditions? - Are the EBIs suitable for the characteristics of the target group? - Are the EBIs a match to organizational resources available in the target group.
	- Indicate how programmes have been replicated in other cultures/contexts	- Have the potential EBIs been replicated to other contexts? - Have the replication of potential EBIs to other contexts been evaluated? - Has the evidence for replicability been assessed? - Have indicators been developed for successful replicability? - Have criteria for the best match been articulated? - Has a recommendation been made for the best matching intervention?
6. Fidelity and Adaptation Fidelity and Adaptation cont.	- Evaluate how well the selected EBI fits the desired behavioural and environmental conditions from the community's logic model of change	- Does the selected EBI fit the desired behavioural conditions of the community's logic model of change? - Does the selected EBI fit the desired environmental conditions of the community's logic model of change?
	- Evaluate whether the determinants of behaviour and environmental conditions and the	- Have the determinants of behaviour in the original EBI been evaluated as adequate for the new setting? - Have the determinants of environmental conditions in the original EBI been evaluated as adequate for the new setting?

	change methods used to influence them in the original EBI are adequate in the new setting	- Have the change methods in the original EBI been evaluated as adequate for the new setting?
	- Evaluate how well original delivery, design features, and cultural elements fit the new setting and population	- Does the original delivery fit the new setting and population? - Does the original design features fit the new setting and population? - Does the original cultural elements fit the new setting and population?
	- Evaluate the fit of implementation strategies to the new setting	- Do the implementation strategies fit the new setting?
	- Assess fidelity/adaptation concerns for the particular implementation site	- Have the fidelity concerns been evaluated for the particular implementation site? - Have the adaptation concerns been evaluated for the particular implementation site?
	- Develop a position for resolving the fidelity/ adaptation	- Has he position been developed for fidelity/ adaptation?

7. Programme Specifications	-identify the programme inclusion and exclusion criteria -Identify any programme specifications for implementation	- Has it been determined if target group includes combination of youth age 10-14 and family member? - Has it been determined if programme language considers the socio-cultural and socio-political context? - Has it been determined if content addresses HRBs including, sexual risks, substance abuse, violence and gangsterism? - Has it been determined if content addresses pro-social skills including managing peer pressure and emotions? - Has it been determined if content addresses family values including communication, respect, courage, diligence, justice, etc.? - Has it been determined if facilitator profile includes having content knowledge, facilitation skills and good characteristics? - Has it been determined if facilitation methods includes both formal and experiential learning? - Has it been determined if frequency in participation is at least once a week session? - Has it been determined if duration in participation is for at least 7 weeks? - Has it been determined if intensity in participation is at least 1hour separate and 1hour conjoint sessions? - Has it been determined if full attendance in participation is expected and challenges are addressed appropriate? - Has it been determined if required resources are attained to sustain programme needs?

		- Has it been determined if expected resources are secured for infrastructure, incentives and stipends? - Has it been determine if termination and sustainability considers booster follow up and accountability sessions? - Has it been determined if community engagement is considered for planning, adaptation and implementation of the programme?
8. Stakeholder consultation	-Identify stakeholders	- Has a community-based participatory research (CBPR) been selected? - Has stakeholders been conceptualized in an inclusive manner? - Has the range of stakeholders to be consulted been identified? - Has the kind of consultation required with each stakeholder group been identified? - Has a fair and inclusive selection process of stakeholders been followed?
	-Identify the nature of consultation	- Have stakeholders been consulted with to identify cultural elements to be considered for programme adaptation? - Have potential experts been identified? - Have experts been assessed to have an established understanding of ▪ the problem behaviour ▪ target population ▪ target cultural context where implementation takes place

Stakeholder consultation cont.		▪ stakeholder input and potential collaborations and securing their meaningful involvement
	- Obtain stakeholder input on the adaptation	- Has the capacity of community stakeholders been assessed to support whether implementation efforts was strengthened?
	- Integrate stakeholder feedback into an implementation plan	- Has an implementation plan been developed for a particular setting incorporating input from ▪ community stakeholders ▪ organisational stakeholders ▪ experts ▪ intervention/ programme developers
	- Consider advisory roles for stakeholder	- Has it been decided whether an advisory group will be required? - Has it been decided the role of the advisory group to be ▪ a formal position ▪ decision-making power ▪ an informal position ▪ can only make recommendations.
	- Identify potential implementers from the stakeholder pool	- Have potential implementers, if possible, with the same ethnic background as the target population been identified and recruited?

9. Draft version	- Develop a draft treatment adaptation	- Has the input of relevant stakeholders been integrated into draft treatment adaptation? - Have the core elements of original intervention been preserved? - Have any core elements that should be dropped been identified? - Has the evidence that revisions will not constitute modifiable risk factors been documented? - Have barriers and facilitators of fidelity and quality in the proposed cultural adaptations been established? - Has a rigorous process for the translation of materials from original language into language appropriate for subcultural group been adopted? - Has a consultation plan with panels based on rigorous research methods been developed? - Has the quality and extent of theoretical engagement prior to implementation been established? - Has the feedback from stakeholders about the appropriateness of the proposed adaptations been integrated?
	- Assess feasibility	- Have usability tests been conducted to determine how well participants can navigate equipment and procedures in technology-mediated interventions? - Have training needs based on the proposed adaptations been identified?
10. Staffing needs	- Identify staffing requirements	- Have staffing requirements been identified including: ▪ staffing skills ▪ implementation requirements ▪ training ▪ supervision

	- Assess programme fit	- Has programme fit been assessed to include ▪ organizational structure ▪ demands placed on staff ▪ staff skills - Have any potential fit challenges been identified?
	- Address quality assurance	- Have quality assurance mechanisms been planned to address fit problems? - Has a strategy to identify modifications been developed?

For Section Two, preparation in the theoretical structure, a total of 75 items were drafted. Items in this section were produced to address the six operational points by pulling through learnings from the systematic review.

Point Five deals with the decision-making process followed in the selection of the programme. This point drew on the systematic review which offered tangible steps in its process that made the steps in decision-making explicit. The operational steps that were followed in the systematic review were reported in greater detail than is generally the case, which helps to understand the methodological aspects that will be of benefit when selecting EBIs.

Point Six deals with developing an initial position to resolve fidelity and adaptation. This point drew on the systematic review which utilized the Preferred Reporting Items for Systematic reviews and Meta-Analyses and its four levels of review to ensure that the selected EBI design features fits the new setting and population and desired behavioural conditions of the community's logic model of change.

Point Seven deals with reviewing programme materials and specifications. This point drew on the learnings from the stakeholder review, which adopted a modified version of a concept mapping as a descriptive approach to explore stakeholders' perceptions about cultural elements that should be considered in an adaptation. Thus, drawing on the design and results of the stakeholder review, the operational activities in point seven were informed.

Point Eight deals with conducting stakeholder consultation to identify recommended cultural adaptations. This point drew on the learnings from the stakeholder review. For example, stakeholders were consulted regarding the establishment of an advisory group to determine the appropriateness of the selected intervention programme, the types of cultural adaptations that are needed, and deals with the identification of experts to assist in the cultural adaptation of programme components. Thus, drawing on the learnings from the stakeholder review, the operational activities in point eight were informed.

Point Nine deals with producing a draft version of recommended cultural adaptation. Learnings for this point were drawn from two main sources. First, point nine drew from Phase 0, the narrative review which includes chapter 1 and chapter 2. The narrative review outlined other models of adaptation including the SFP programme adaptation protocol for international dissemination and cultural adaptation process. Second, point nine additionally drew from the stakeholder review. The stakeholder review's consultative process and results ensured stakeholders' perceptions regarding, for instance, barriers, fidelity, quality, adaptation appropriateness, etc. Thus, drawing on both the narrative review and the stakeholder review, the operational activities in point nine were informed.

Point Ten deals with defining staffing needs, including training, supervision and quality assurance. This point drew on learnings from the SFP 10-14 programming as defined in the introduction chapter (Phase 0) of this study. The SFP 10-14 programme details what is required for staff to deliver the programme. This point additionally drew on learnings from the stakeholder consultation regarding staffing needs and requirements For example, the experts' specific input on what would be required for staff to be prepared to implement the EBI programme, which included formal, lecture-style input in addition to acute awareness and knowledge of the audience comprehension and transferability. Thus, drawing on both the SFP programming as well as the stakeholder consultation process and results, the operational activities in point ten were informed.

Next, **Table 5.8** presents the items for Section Three.

Table 5.8

Items for Section Three.

Section 3: Implementation		
Point	Operational Activities	Items
11. Piloting	- Develop an implementation plan	- Has an implementation plan been developed?
	- Identify milestones for the programme that would guide monitoring and evaluation	- Have milestones been identified for the programme that would guide monitoring and evaluation?
	- Conduct an evaluation of the programme to assess	- Has an evaluation of the programme been conducted to assess feasibility? - Has an evaluation of the programme been conducted to assess desired effects on engagement?

		- Has an evaluation of the programme been conducted to assess desired effects on putative mediators? - Has an evaluation of the programme been conducted to assess desired effects on health outcomes? - Has an evaluation of the programme been conducted to assess process, summative and formative evaluations? - Has an evaluation of the programme been conducted to assess outcomes? - Has an evaluation of the programme been conducted to assess fidelity? - Has an evaluation of the programme been conducted to determine what is not working?
	- Formulate refinements and adaptations	-Has it been determined whether further piloting is required?
12. Final cultural adaptation	- Collate feedback from pilot	- Has feedback and lessons learnt from the pilots been collated? - Has feedback and steps into a refined adaptation been integrated?
	- Finalise implementation plan	-Has the implementation plan been finalised?
	- Implement adaptation	-Has the adapted intervention been implemented?
	- Evaluate the adapted programme	-Has a full programme evaluation been conducted with outcome and process data to evaluate the efficacy of the adapted intervention? - Has a mechanism for ongoing support, feedback and refinement been developed?

For Section Three, implementation, a total of 17 items were drafted. This section deals with piloting the adapted version and producing the final cultural adaptation intervention after programme evaluation/ pilot feedback respectively. This section has two operational points namely, 11 and 12. First, point 11 and 12 drew on knowledge of programme evaluation and programme implementation to develop items.

Next, **Table 5.9 b**elow presents the items for Section Four.

Table 5.9

Items for Section Four.

Section 4: Sustainment		
Points	Operational Activities	Items
13. Evaluation and refinement	- Select evaluation questions from the original EBI evaluation	- Have evaluation questions been selected from the original EBI evaluation?
	- Plan an "effect evaluation"	- Has an "effect evaluation" been planned to include intervention outcomes in the new setting? - Has an "effect evaluation" been planned to include comparison of intervention outcomes between settings? - Has an "effect evaluation" been planned to include success of implementation? - Has an "effect evaluation" been planned to include reach? - Has an "effect evaluation" been planned to include fidelity? - Has an "effect evaluation" been planned to include the match between the new logic model, the indicators and measures?
	- Pilot methods for cultural appropriateness	- Have methods for cultural appropriateness been piloted?

	- Assess adaptations for effectiveness	- Has effective adaptations formally been adopted? - Has ineffective adaptations been dropped or revised? - Have further adaptations been identified?
	- Revise the intervention	- Has the intervention been revised?
14.Dissemination	- Develop a dissemination plan including	- Has a dissemination plan been developed to include factors affecting selection and adoption of EBI? - Has a dissemination plan been developed to include implementation analysis? - Has a dissemination plan been developed to include process results? - Has a dissemination plan been developed to include outcome results (efficacy)? - Has a dissemination plan been developed to include lessons learned in transportation of the EBI - Has a dissemination plan been developed to include training of facilitators and staff

For Section Four, sustainment, a total of 18 items were drafted across the two points and related operational activities. In this section, the operational activities were very detailed and included details at two distinct levels. These were divided and the concrete activities were adopted as items. The more abstract or complex activities were retained as operational activities. This created a better flow and articulation between operational activities and items.

The draft checklist consisted of 178 items distributed across the sections as follows: 68 in Section One. Section Two included 75 items. Section Three included 17 items, and section Four included 18 items.

Step 4: Reviewing and refining the draft scale.

The fourth step entailed reviewing and refining the draft scale. During this step it is recommended that independent reviewers are recruited with expertise in research and test construction, as well as the topical focus of the measure (Charif et al., 2018). The draft measure must be presented to the reviewers who in turn will offer constructive feedback. The reviewers must be blind to the processes followed in the development in order to maintain independence and must also conduct their work independently of one another.

The draft checklist was reviewed by the research team and three independent reviewers who were registered research psychologists (n=3). The reviewers had expertise in research methodology, psychometric test construction and psychological assessment as evidenced by their qualifications, work experience and publications in the areas mentioned. **Table 5.10** below summarises the demographic profile of the reviewers.

Table 5.10

Demographics of CAMP-C reviewers

Reviewer	Profession	Field of expertise	Programme adaptation		Programme development	
			Experience	Years	Experience	Years
R1	Research Psychologist	Statistical techniques, psychometric test construction	Yes	10	Yes	18

R2	Research Psychologist	Capacity development, transferable skills training in research methodology	No	0	Yes	7
R3	Research Psychologist	Psychometric test construction, programme development and evaluation	Yes	6	Yes	10

The reviewers identified that the items were logically aligned with the operational activities as a coherent whole. The reviewers expressed concern about the number of items. The resultant guide would be very long and it might discourage adoption and use. The reviewers could not identify any items that were superfluous or could be omitted. They found the items too granular, but felt that this was what made it more useful. Reviewer 2 suggested that the guideline take on an electronic format where the items could be embedded into hyperlinks on the operational activities. This would create an interactive feel that would also promote formative applications. The reviewers' recommendation was adopted. This recommendation significantly impacted the construction of the guide in an electronic format.

Step 5: Developing accompanying templates and instruction guide.

The fifth step requires that any accompanying templates and/ or instruction guides must be developed for the intended users. The aim is to ensure that the resultant measure (guide) is used as was intended. The need for an accompanying document(s) was deemed unnecessary since instructions and the guide could be integrated into a single document on the electronic platform.

The following instructions were developed to be integrated into the checklist to facilitate ease of use. **Table 5.10** below contains the instructions.

Table 5.10

Instructions for the Contextual Adaptation Model and Process Checklist (CAMP-C)

The Contextual Adaptation Model and Process Checklist (CAMP-C)	
Aim and Purpose	The CAMP-C is an operational guide for the process of adaptation of an Evidence-Based Intervention (EBI). The operational activities support design, decisions, capacity building and implementation in relation to programme adaptation. The guidelines are intended to be used to assess the quality of adaptation processes or proposed adaptation processes
Target group	1. Researchers and practitioners interested in adapting programmes can use the guidelines to make methodological decisions that are rigorous and coherent. 2. Practitioners who want to implement adapted programmes can use the guidelines to evaluate the process of adaptation followed. This helps to formulate the clinical or practice considerations when selecting a programme for implementation. 3. Funders and stakeholders who want to evaluate the processes followed in the adaption of a particular programme (or proposed adaptation) are rigorous, replicable and accountable.
Use of the guideline	The guideline can be used formatively and summatively. Summative application: The guideline can provide an overall indication of the quality of the adaptation process.

	Formative application: The guidelines can identify areas in which the adaptation process was not optimal or require a closer look. The guideline can direct the intended users to corrective actions.
Structure of the guideline.	There are four sections that represent distinct phases of a rigorous adaptation process. Section 1: Exploration deals with considering and assessing the behaviour needs of the target population. Section 2: Preparation deals with identifying potential barriers and facilitators of implementation, and developing a detailed implementation plan Section 3: Implementation deals with initiating and instantiating the use of the adapted evidence-based programme. Section 4: Sustainability deals with the application and evaluation of insights and considerations for implementation and research. The sections are conceptualized as both independent and complimentary of one another. Users may choose to use a specific section to guide an aspect of the adaptation process. Alternatively, users may use all the sections to inform an entire process.

In addition, a respondent template was imagined based on the structure of the guide. This would simply be a template to allow respondents to record their process or proposed process of adaptation. The completed respondent template would have ensured that information was recorded in an accessible manner that enabled the users to apply the guidelines. The use of the template was not envisaged to be compulsory, but it would have ensured that information is recorded in a manner that is aligned with the evaluation process. The decision to adopt the recommendation of a guide that could be electronic, opened possibilities for designing the guide

to incorporate space on the guide to capture information for review. The resultant guide can be accessed via the following link: https://sites.google.com/uwc.ac.za/camp-c

5.4 REFLECTIONS

Phase Three set out to develop an empirically-based guideline of actionable steps that would operationalize the guideline for adapting EBIs in general and the SFP 10-14 programme specifically. This is particularly necessary when implementing an existing EBI in another area, country, or culture. According to Schloemer and Schröder-Bäck (2018), the transferability of existing interventions is complex, and a good fit between an intervention and the context is greatly affected by similarities and differences in the original and new contexts. Transfer of interventions to other contexts has often been ineffective because such contextual aspects were ignored (Moore et al., 2021). The guide was developed in a rigorous way by following a five steps process for the construction, recommended in the ITC (2016) guideline for test construction and adaptation. The use of such a structured process for the construction of the checklist allowed for scale decisions and the construction process to be explicit. The focus of this phase was on comprehensiveness, seeing each part of this study as a function of constructing the resultant guide and checklist.

Compared to similar guidelines, such as the ADAPT guideline (Moore et al., 2021), the report of Graig and colleagues (2018) and the Cultural Adaptation Process for International Dissemination of the Strengthening Families Programme (Kumpfer et al., 2008) etc., the CAMP-C guideline is a valuable addition to guidelines for the contextual and cultural adaptation of interventions. The CAMP-C guideline offers a framework and checklist to help researchers,

policy and practice stakeholders, and funders in undertaking and assessing the adaptation of interventions for a new context, and reporting these transparently.

Findings from phases 0-2 were incorporated to help generate items for the resultant guide. Phase 0 entailed a narrative review to gain understanding of the target group, risk factors, and cultural issues. The findings for this phase are integrated in the exploration section of the guide. Phase 1 consolidated evidence for effective intervention programmes via a systematic review. The findings from this phase are incorporated in the preparation section of the guide. Phase 2 engaged stakeholders to identify contextual specifications and requirements for implementation. Findings for this phase was incorporated into the preparation section of the guide.

The theoretical structure frames and enables the operationalization of the adaptation process in a systematic and consistent manner. This theoretical structure triangulated four key strands. The key strands considered other stage models for adaptations, some not targeted to specific programmes and one specifically aimed at cultural adaptation and dissemination of the SFP programme. The theoretical structure further drew on core constructs in the theory of change to ensure higher fidelity in adaptation, as well as critical issues and challenges regarding the understanding of culture in adaptation of EBI programmes. The theoretical tenets drawn from the four conceptual strands resulted in the fourteen-point guide for adaptation. Hemingway & Brereton (2009) emphasizes data triangulation as a meticulous research strategy that enhances the validity and credibility of outcomes. This means that a higher level of evidence can be upheld (McGowan & Sampson, 2005). For this purpose, the current researcher applied the concept of data triangulation by a varied the data collection process by using multiple data sources across a

twenty-year time frame that included the study period (2002-2012) and a post-conceptualization period (2013-2022).

To further operationalize the guide, each point was defined, expanded on and filtered into four sections, namely exploration, preparation, implementation and sustainment. The four sections were informed by Movsisyan et al (2021). Operational activities were articulated for each of the 14 points to complete the guide. These operational activities formed the basis for item development. A pool of 114 items was generated to develop the resultant checklist for adaptation of EBIs in general and specifically for adapting the SFP 10-14 to the South African context. This process followed the ITC guidelines to generate a pool of items that was further refined into a final guide. The resultant guide is a modification and an expansion on the SFP adaptation process.

In summary, this phase set out to consolidate findings from each of the previous phases to develop a guideline of actionable steps to adapt the SFP 10-14 programme for use in the South African context. The process followed produced a conceptual framework and model for contextual adaptation of EBIs. The construction of the resultant guide and checklist was aligned with this underlying theoretical structure. The CAMP-C guideline can be used formatively and summatively. In a summative sense, the checklist provides an overall indication of the quality of the adaptation process. At a formative level, the checklist identifies areas in which the adaptation process was not optimal or require a closer look. Using the checklist can be carried out periodically to check if changes are needed due to changing the context and/or culture. This makes it a concrete and practical tool for the improvement as well as development of an intervention.

The guide culminates from a multi-phase study that triangulated different research methodologies and the methodological steps and decision-making was made explicit throughout the process which makes for a more robust guide for systematic adaptation of interventions. The methodological principles and operations contributed equally to the resultant guide as the findings of the various stages did. The permission granted for this study was limited to a theoretical adaptation. The process of the PhD revealed that the gaps in the operationalization of the guide was more pressing than the theoretical adaptation of the programme content. Thus, the study prioritized the development of the actionable steps and the guide above an adaptation of content.

This study contributes toward enhancing the discussion around the importance and need to adapt interventions to diverse populations in a methodologically rigorous and coherent manner. The resultant guide succeeds in operationalizing the original guide for international dissemination and broadened it to present a more robust basis with clear actionable steps. The CAMP-C in its electronic format increases dissemination and accessibility for the target group. In this way, it helps the field to move forward with providing greater structure and direction to practitioners without being prescriptive. It builds reflexivity about the intentional use of research methodology.

5.5 CONCLUSION

The aim for this study was to develop a guideline of actionable steps to follow in cultural adaptation of the SFP 10-14 programme for use in the South African context. For this task, the study utilized a four-phased approach (protocol) which informed the following outcomes:

- The SFP 10-14 programme was identified as the most robust programme for intervention with the target group.

- The SFP 10-14 programme is appropriate for adaptation for use in the local context.

- The study produced a guideline entitled the CAMP-C, a guideline of actionable steps in the form of a checklist for adaptation of EBIs in general and specifically for adapting the SFP 10-14 to the South African context.

- The CAMP-C is a robust guideline as evidenced by:
    - An expanded theoretical structure that is more comprehensive than that contained in the guide for international dissemination developed by Kumpfer et al (2008) and triangulated from four strands;
    - Clearly articulated operational activities for each point in the theoretical structure;
    - An empirical and explicit process followed in the construction process.

- The electronic format of the CAMP-C enables flexible use and applications within summative and formative assessments.

5.6 Limitations

The following are the limitations of each of the contributing phases of the study.

- The narrative review in Phase Zero focused on the need for adaptation at the expense of a history of adaptation. This potential limitation was offset by the engagement with seminal literature in the theoretical structure.

- Phase One, the systematic review was limited in terms of potential publication and language bias resulting from the inclusion criteria. The review set out to identify EBIs that address the target behaviour in the target population. Evidence in this instance was generally accepted to be presented in the form of published manuscripts. Thus, the potential limitation is within the acceptable practices of the discipline.

- Phase Two, the stakeholder review had two limitations. First, the stakeholders were not involved in all the stages of the concept mapping process due to restriction on their time. Second, the study followed a modified concept mapping process that drew on stakeholder contributions and findings form the narrative and systematic reviews.

- Phase Three, the study aimed to focus on the development of the guide and had a qualitative focus. This prioritized conceptual clarity above quantification in techniques like item analysis and data reduction.

- The theoretical adaptation of the SFP 10-14 was limited to the operationalization of the guide and its strengthening or expansion. The adaptation of the actual content and implementation guidelines in addition to the substantive work on the expansion of the theoretical structure and the

guideline would have been beyond the scope of a doctoral study. This remains a focus of further research that can be addressed or attempted with greater certainty using the resultant guide created as an outcome of this study.

5.7 Recommendations for further study

Recommendations that emerged from this for study are as follows:

- First, the SFP 10-14 programme emerged as the most robust programme which was empirically supported, and which had the most improved efficacy or impact of reducing, delaying, and preventing the onset of health risk behaviours in pre- and early adolescence. It is recommended to implement the programme in the context of the Cape Flats of the Western Cape in South Africa. A further recommendation is to pilot the CAMP-C checklist against this particular context in order to refine it further and reduce the number of items if appropriate for wider adoption and use.
- Second, the study focused on high-risk behaviours of pre-and early adolescents and the interventions that reduces, delays or prevent the risk behaviours. However, both the narrative review and the stakeholder review indicated earlier onset of high-risk behaviour, it is recommended that interventions aimed at youth risk behaviour should start at primary school level, specifically ages 6 - 9 years.

- Third, the adaptation phase focused on item writing and conceptual clarity. Further research could explore the development of a scoring system including quality descriptors and an interpretation matrix to assist with the interpretation of the scores. Each section of the guide could be assigned a quality description to guide the interpretation of the sub-section and composite scores. Each quality description or category could have corresponding actions that can assist researchers or practitioners to apply corrective actions. An advantage of this is that scores can be expressed as a percentage to guide the quality descriptions with indication of poor and good compliance.

- Fourth, the adaptation of the content and implementation guide of the SFP 10-14 for the identified context should be attempted using the resultant guide as a framework.

Next, ideas are offered for the contribution of the study to both research and practice related to cultural adaptation.

5.7 Contribution of the study

The SFP's international dissemination protocol is too broad and leads to individual interpretation of how to apply the protocol. The guide developed in the study provides a comprehensive 14-points theoretical structure that articulated into actionable steps for each of the points. The CAMP-C constitutes a robust and more systematic approach to adaptation of the SFP 10-14 to other contexts. The CAMP-C constitutes a unique contribution to the body of

knowledge in that it proposes and follows a rigorous, multi-phased research approach to conduct quality adaptations.

At a theoretical level, the study developed a theoretical structure for the guideline that was expanded and more comprehensive than the leading theoretical formulations. The triangulation of theories and contextual information adds to the robustness of the theoretical structure. The study prioritized conceptual construct clarity above the traditional item analysis and data reduction methods. In this way, the study produced a theoretical structure that is comprehensive and directive without being prescriptive. The directive lies in the articulation of actionable steps or operational activities that delineates important considerations for adaptation researchers.

At a methodological level, the study was conceptualized as a multi-phase study. This was not a mixed methodology, but was an exercise in triangulation at a methodological level. The study makes an important contribution by clarifying the distinction between mixed methodology and triangulated multiphase methodologies. The tendency to label all studies that use multiple methods (especially the combination of qualitative and quantitative methods) as mixed methodologies is a gross over-simplification that does not pay attention to the philosophical underpinnings of mixed methodology in particular and the philosophy of science in general. Thus, the study demonstrated the importance of intentionality in methodological decision-making.

At a practical level, the study produced the Contextual Adaptation Model and Process Checklist (CAMP-C). The CAMP-C is a guide of actionable steps that operationalize the guide for international dissemination of the SFP programmes. The guide is a tangible outcome that can

be used by researchers, funders and clinicians in their decision-making, planning or execution of adaptation studies. This electronic guide is a practical aid to conceptualizing, executing, or evaluating adaptation studies. Below are some implications for practice from the contribution of the study.

- First, service delivery agencies that work with diverse populations may refer to the checklist, reflect on what they are currently doing, and consider what other adaptations may be helpful.
- Second, researchers and practitioners could use the checklist to build awareness in terms of the quality of interventions that have been culturally adapted thus far.
- Third, the checklist may be used to support practitioners in the community to gain a deeper understanding of culture and what careful considerations, beyond linguistic translation, are warranted when attempting to use EBI with diverse families.
- Fourth, the guideline is a practical and concrete guideline that can be assessed by different levels of involved people, e.g., intervention developers, implementers, observers, and/or trainers.
- Sixth, the guideline provides insight into the need for change in the already existing interventions. Using the checklists can be carried out periodically to check if changes are needed due to changing the context and/or culture.

As described before, extant research has limited identified quality indicators and clear guidance despite the benefits of cultural adaptation of an intervention. The checklist, which was developed in an iterative process, may help address this gap to guide research and practice with the hope that services and interventions provided to marginalized and minoritized families have contextual fit and lead to the intended outcomes.

Finally, it is anticipated that this adaptation guidance will lead to more systematic and accountable decision making and reporting of adaptation processes, as well as stimulate new thinking and innovation in adaptation research. Over time, an accumulation of adaptation studies based on this guidance and other approaches will help determine what conditions work best in adapting interventions for new contexts, with recommendations refined and firmly grounded in empirical evidence.

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APPENDICES

APPENDIX A
SENATE APPROVAL OF RESEARCH PROJECT

UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

04 July 2013
To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Mr W Jacobs (Psychology)

Research Project: Strengthening Families Programmes (SFP): 10-14. A cultural adaptation to a family- focused risk prevention programme Registration no: 13/4/25

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer University of the Western Cape

Private Bag X17, Bellville 7535, South Africa T: +27 21 959 2988/2948 . F: +27 21 959 3170 E: pjosias@uwc.ac.za
www.uwc.ac.za

Dear Learner,

UNIVERSITY OF THE WESTERN CAPE

Department of Psychology

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2283, Fax: 27 21-959 3515

APPENDIX B

INFORMATION SHEET - LEARNER VERSION

Project Title: Strengthening Families Program (SFP): 10 -14. A Cultural Adaptation to a Family-focused Risk Prevention Programme.

What is this study about?

This is a research project being conducted by Warren R. Jacobs and Dr. M. R. Smith at the University of the Western Cape. We are inviting you to participate in this research project designed to prevent teen substance abuse and other behaviour problems, strengthen parenting skills and build family strengths. The study is delivered with seven sessions for parents, youth and families with the purpose to:

- Enhance and promote effective parenting skills, such as setting limits, using appropriate consequences, communicating expectations, and protecting against substance abuse and problem behaviors;
- Build life skills in youth, including goal setting, stress management, conflict resolution, empathy and appreciation, and peer pressure resistance;
- Strengthen family bonds by creating a shared understanding of family values, building family communication, promoting joint problem-solving skills, and enabling families to recognize individual and family strengths and spend special time together.

What will I be asked to do if I agree to participate?

The project has one activity in particular that will require your participation:

1) A focus group discussion will be conducted for the purpose of exploring contextual ideas around six areas, including: content, participation, facilitation, language, resources and target group, that should be included in a family-based programme to delay engagement in high risk behaviours in pre and early adolescents.

Would my participation in this study be kept confidential?

This research project involves making an audiotape of your participation in the focus group discussion. This information will be accessed by myself and my supervisor. We will do our best to keep your personal information confidential. To help protect your confidentiality, your name will not be mentioned in my research project and the tape recording will be destroyed at the

end of this study. This information will be kept locked in a secure safe at all times. ***All participants will be asked to undertake to keep the content of the discussion confidential.*** If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

Participants will not be subjected to any danger or harm during the research process.

What are the benefits of this research?

This project will generate knowledge that can help strengthen families in our communities. We must emphasize that because this is a research study and we will have to demonstrate the benefit through the evaluation. This is why we are requesting assistance from you.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

Appropriate referrals will be made if unforeseen negative impacts arise.

What if I have questions?

This research is being conducted by Warren R. Jacobs at the Department of Psychology at the University of the Western Cape. If you have any questions about the research study itself, you can contact

Warren R. Jacobs
Dept of Psychology, UWC 021-9592283/ 0767231250 warrenj@cornerstone.ac.za

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Supervisor: Dr. Mario Smith
Dept of Psychology, UWC

021-9592283/ 0823309284

mrsmith@uwc.ac.za

Head of Department: Dr. Michelle Andipatin Dept of Psychology, UWC

021-9592283/ mandipatin@uwc.ac.za

Dean of the Faculty of Community and Health Sciences: Prof. J. Frantz University of the Western Cape

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021-959 2631/ jfrantz@uwc.ac.za

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Dear Learner,

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Department of Psychology

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APPENDIX B

INFORMATION SHEET - LEARNER VERSION

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Appropriate referrals will be made if unforeseen negative impacts arise.

What if I have questions?

This research is being conducted by Warren R. Jacobs at the Department of Psychology at the University of the Western Cape. If you have any questions about the research study itself, you can contact

Warren R. Jacobs
Dept of Psychology, UWC 021-9592283/ 0767231250 warrenj@cornerstone.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Supervisor: Dr. Mario Smith
Dept of Psychology, UWC

021-9592283/ 0823309284

mrsmith@uwc.ac.za

Head of Department: Dr. Michelle Andipatin Dept of Psychology, UWC

021-9592283/ mandipatin@uwc.ac.za

Dean of the Faculty of Community and Health Sciences: Prof. J. Frantz University of the Western Cape

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UNIVERSITY OF THE WESTERN CAPE

Department of Psychology

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APPENDIX D

INFORMATION SHEET - TEACHER VERSION

Project Title: Strengthening Families Program (SFP): 10 -14. A Cultural Adaptation to a Family-focused Risk Prevention Programme.

What is this study about?

This is a research project being conducted by Warren R. Jacobs and Dr. M. R. Smith at the University of the Western Cape. We are inviting you to participate in this research project designed to prevent teen substance abuse and other behaviour problems, strengthen parenting skills and build family strengths. The study is delivered with seven sessions for parents, youth and families with the purpose to:

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- Strengthen family bonds by creating a shared understanding of family values, building family communication, promoting joint problem-solving skills, and enabling families to recognize individual and family strengths and spend special time together.

What will I be asked to do if I agree to participate?

The project has one activity in particular that will require your participation:

3) A focus group discussion will be conducted for the purpose of exploring contextual ideas around six areas, including: content, participation, facilitation, language, resources and target group, that should be included in a family-based programme to delay engagement in high risk behaviours in pre and early adolescents.

Would my participation in this study be kept confidential?

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APPENDIX E

INFORMATION SHEET - COMMUNITY EXPERT VERSION

Project Title: Strengthening Families Program (SFP): 10 -14. A Cultural Adaptation to a Family-focused Risk Prevention Programme.

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What will I be asked to do if I agree to participate?

The project has one activity in particular that will require your participation:

4) A focus group discussion will be conducted for the purpose of exploring contextual ideas around six areas, including: content, participation, facilitation, language, resources and target group, that should be included in a family-based programme to delay engagement in high risk behaviours in pre and early adolescents.

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APPENDIX F
ASSENT FORM - LEARNER

I, the undersigned, fully understand the research aims, my rights and my role as participant in the study, as well as issues related to confidentiality, as outlined in the information leaflet.

I also undertake to keep the content of the discussion confidential so as to protect the rights of every participant in the study.

☐ **I agree** to participate in the focus group sessions that will assist with the programme adaptation process.

☐ **I agree to be audiotaped during my participation in this study.**

I also grant permission to the researcher to disseminate the information obtained in the following formats:

- Unpublished thesis
- Conference presentation
- Published manuscript or article

I take cognisance that all documents and recordings will be destroyed at the end of the research process.

---------- ---------- ----------
Learner's Signature **Print Name** **Date**

This section is to be cut off and retained by the participant for future reference.

Researcher's Contact Details

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Student: Warren R. Jacobs
Dept of Psychology, UWC
021-9592283/ 0767231250
warreni@cornerstone.ac.za

Supervisor: Dr. Mario Smith
Dept of Psychology, UWC
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mrsmith@uwc.ac.za

Thank you for your cooperation and you are welcome to contact me for any queries at the address given above.

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Department of Psychology
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APPENDIX G
CONSENT FORM- PARENT/GUARDIAN

I, the undersigned, fully understand the research aims, my rights and my role as participant in the study, as well as issues related to confidentiality, as outlined in the information leaflet.

I also undertake to keep the content of the discussion confidential so as to protect the rights of every participant in the study.

☐ **I agree** to participate in the focus group sessions that will assist with the programme adaptation process.

☐ **I agree** to be audiotaped during my participation in this study.

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- Unpublished thesis
- Conference presentation
- Published manuscript or article

I take cognisance that all documents and recordings will be destroyed at the end of the research process.

---------- ---------- ----------
Parent/Guardian's Signature **Print Name** **Date**

This section is to be cut off and retained by the participant for future reference.

Researcher's Contact Details

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Student: Warren R. Jacobs
Dept of Psychology, UWC
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Supervisor: Dr. Mario Smith
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APPENDIX H
CONSENT FORM- TEACHER VERSION

I, the undersigned, fully understand the research aims, my rights and my role as participant in the study, as well as issues related to confidentiality, as outlined in the information leaflet.

I also undertake to keep the content of the discussion confidential so as to protect the rights of every participant in the study.

☐ **I agree** to participate in the focus group sessions that will assist with the programme adaptation process.

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I also grant permission to the researcher to disseminate the information obtained in the following formats:

- Unpublished thesis
- Conference presentation
- Published manuscript or article

I take cognisance that all documents and recordings will be destroyed at the end of the research process.

---------- ---------- ----------

Teacher's Signature **Print Name** **Date**

This section is to be cut off and retained by the participant for future reference.

Researcher's Contact Details

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APPENDIX I

CONSENT FORM- COMMUNITY LEADER VERSION

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Signature **Print Name** **Date**

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APPENDIX J - STAKEHOLDER SIGN-UP/IN SHEET - PARENTS

Name & Surname	Marital status	Age	Occupation	Contact details	Level of Education	Race	Area Live you in	# of Children between 10-14

UNIVERSITY OF THE WESTERN CAPE
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APPENDIX K - STAKEHOLDER SIGN-UP/IN SHEET – YOUTH

Name & Surname	Race	Age	School Name	Grade	Area Live you in	Caregiver

UNIVERSITY OF THE WESTERN CAPE
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APPENDIX L - STAKEHOLDER SIGN-UP/IN SHEET – TEACHERS

Name & Surname	Marital Status	Current School	Grade/s you teach	Years teaching	Qualifications	When achieved	Area you Live in

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STAKEHOLDER SIGN-UP/IN SHEET – COMMUNITY EXPERTS

Name & Surname	Occupation	Involvement with Youth age 10-14 (how)	# of years	Community / Area (where)	Qualifications	Race	Area you Live in

APPENDIX M - IOWA STATE EXTENTION PROGRAMME PERMISSION LETTER

IOWA STATE UNIVERSITY
Extension and Outreach

Cathy Hockaday, Ph.D.
Program Manager
Strengthening Families Program for Parents & Youth 10-14
68 LeBaron Hall, 626 Morrill Rd
Ames, IA 50011
515-294-7601
hockaday@iastate.edu
www.extension.iastate.edu/spf10-14

September 28, 2022

To Whom It May Concern,

I am writing this letter to acknowledge and give my permission for Warren Jacobs to use the Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) for his dissertation. I first had contact with Warren in 2013. Shortly after he started talking to me about his dissertation topic. As he was not adapting the content or implementing SFP 10-14, I gave him permission to use it for his dissertation topic without a written legal contract. I commend Warren on his persistence to finish his dissertation.

.

Sincerely,

Cathy Hockaday

Cathy Hockaday, Ph.D.
Adjunct Assistant Professor, Iowa State University
Strengthening Families Program: For Parents and Youth 10-14 Program Manager

APPENDIX N – SFP 10-14 TRAINING CERTIFICATE

UNIVERSITY OF THE WESTERN CAPE

Department of Psychology

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2283, Fax: 27 21-959 3515

APPENDIX O

FOCUS GROUP/INTERVIEW SCHEDULE

FOCUS GROUPS	DATE	START TIME	HOURS
Day 1 – Learners	14/10/2015	10:30am-12:00pm	1.5 hrs
Day 2 – Teachers	21/10/2015	12:00pm-13:30pm	1.5 hrs
Day 3 – Parents/Guardians	04/11/2015	15:00pm-16:30pm	1.5 hrs

INTERVIEW SCHEDULE

EXPERT GROUP	DATE	START TIME	HOURS
1. Royston Bennet	01/18/2016	14:00pm-15:30pm	1.5 hrs
2. Hamilton Pharaoh	01/25/2016	14:00pm-15:30pm	1.5 hrs
3. Reese	02/08/2016	14:00pm-15:30pm	1.5 hrs

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APPENDIX P

STEPS AND ACTIVITIES FOR FOCUS GROUP DISCUSSIONS

Introduction:

1. Welcome
   Introduce yourself and the notetaker, and send the Sign-In Sheet with a few quick demographic questions (age, gender, cadre, yrs at this facility) around to the group while you are introducing the focus group.
   Review the following:
   - Who we are and what we're trying to do
   - What will be done with this information
   - Why we asked you to participate

2. Explanation of the process
   Ask the group if anyone has participated in a focus group before. Explain that focus groups are being used more and more often in health and human services research.

   About focus groups
   - We learn from you (positive and negative)
   - Not trying to achieve consensus, we're gathering information
   - In this project, we are focus group discussions. The reason for using this tool is that we can get more in-depth information from a smaller group of people in focus groups. This allows us to us explore topics in more detail than we can do in a written survey.

   Logistics
   - Focus group will last about one hour
   - Feel free to move around
   - Where is the bathroom? Exit?
   - Help yourself to refreshments

3. Ground Rules
   Ask the group to suggest some ground rules. After they brainstorm some, make sure the following are on the list.
   - Everyone should participate.
   - Information provided in the focus group must be kept confidential
   - Stay with the group and please don't have side conversations
   - Turn off cell phones if possible

- Have fun

4. Turn on Tape Recorder

5. Ask the group if there are any questions before we get started, and address those questions.

6. Introductions
   - Go around table: job here, where you were born

Discussion begins, make sure to give people time to think before answering the questions and don't move too quickly. Use the probes to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

Materials and supplies for focus groups

- Sign-in sheet
- Consent forms (one copy for participants, one copy for the team)
- Evaluation sheets, one for each participant
- Name tents
- Pads & Pencils for each participant
- Focus Group Discussion Guide for Facilitator
- 1 recording device
- Batteries for recording device
- Extra tapes for recording device
- Permanent marker for marking tapes with FGD name, facility, and date
- Notebook for note-taking
- Refreshments

Focus Group Discussion Information sheet

Thank you for agreeing to participate. We are very interested to hear your valuable opinion on what elements you would include in a family- focused programme designed to prevent, reduce or delay the onset of high-risk behaviours in pre-and early adolescents.

- The purpose of this study is to learn what elements are relevant to include in a family-focused programme that would help prevent, reduce or delay the onset of high-risk behaviours n pre- and early adolescents.

- The information you give us is completely confidential, and we will not associate your name with anything you say in the focus group.

- We would like to tape the focus groups so that we can make sure to capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed.

- You may refuse to answer any question or withdraw from the study at anytime.
- We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other's confidentiality.
- If you have any questions now or after you have completed the questionnaire, you can always contact a study team member like me, or you can call the Supervisor whose names and phone numbers are on this form.
- Please complete the consent forms and sign to show you agree to participate in this focus group.

QUESTIONS:

Let's start the discussions by thinking about if we were to develop or adapt a family focused prevention programme, what elements would we include in such a programme that would help prevent, reduce or delay the onset of high-risk behaviours in pre-and early adolescents? Make suggestions regarding the following 6 areas:

1. What elements regarding Target group should be considered? Is 10-14 appropriate? Who should be included in programme?
2. What elements regarding Language should be considered?
3. What elements regarding participation should be considered? What kind of involvement should there be? What should everyone be doing in these sessions? How many sessions should be appropriate, etc.?
4. What elements should be included regarding content? What should be covered as high-risk behaviours in such a programme?
5. What elements should be considered regarding facilitation? Style, how many facilitators, activities, etc.
6. What elements should be considered regarding resources? Videos, games, guides, etc.

That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us. We have a short evaluation form that we would like you to fill out if you have time. If you have additional information that you did not get to say in the focus group, please feel free to write it on this evaluation form.

Strengthening Families Programme
Focus Group Evaluation Form

Name:_____

Please give us feedback on your impressions and observations of the focus group experience. Use the back of the page if necessary.

	Not helpful			Very helpful
1. How useful were the questions?	1	2	3	4
	5			
2. How useful were the discussions?	1	2	3	4
	5			
3. Please rate the following items about your facilitator.	Low			High
• Easy to get along with	1	2	3	4
	5			
• Knowledgeable	1	2	3	4
	5			
• Led good discussions	1	2	3	4
	5			
• Good at keeping on time	1	2	3	4
	5			

4. Which Discussion Question seems to be most useful?

____1. Target group
____2. Language
____3. Participation
____4. Content
____5. Facilitation
____6. Resources

5. One thing I learned from this process is:

_____

_____

_____

Participant's Signature: _____

Date: _____

APPENDIX Q

SFS (VERSION C) - CRITICAL APPRAISAL CHECKLIST FOR A SYSTEMATIC REVIEW

Bibliographic Details	Author	Title	Source

Description of Intervention Study/programme		Year

Purpose	Yes (1)	No (0)
1. Is there evidence that literature has been consulted in providing context or background?	☐	☐
2. Is a clear problem statement?	☐	☐
3. Is a clear rationale provided for the study?	☐	☐
4. Are the aims of the study clearly stated?	☐	☐
5. Are the aims explicitly related to the problem statement?	☐	☐
Total points for this section		

Study	Yes (1)	No (0)
1. Is this an intervention study?	☐	☐
2. Is the theoretical orientation of the interventions reported and described?	☐	☐
3. Was the theoretical orientation described in detail?	☐	☐
4. Did the authors report on the development of the intervention?	☐	☐
5. Were the elements of the programme reported on?	☐	☐
6. Did the authors report on the implementation of the programme?	☐	☐
7. Is there a description of fidelity to the implementation of the programme?	☐	☐
8. What is the relationship of the study to the area of the topic reviewed?		
a. Minimal to no relevance (0) ☐		
b. moderate relevance (1) ☐		
c. Highly relevant (2) ☐		
Total points for this section		

Sample	Yes (1)	No (0)
1. Was the source population clearly identified?	☐	☐
2. Were the inclusion/ exclusion criteria specified?	☐	☐
3. Did the authors make a distinction between probability and non-probability in sampling? Did every eligible person have an equal chance of being included in the study?	☐	☐
4. Was the sampling choice motivated?	☐	☐
5. Was the sampling frame identified?	☐	☐
6. Was the sampling method appropriate?	☐	☐
7. How were subjects allocated to the groups?	☐	☐
a. Pre-existing (1) ☐		
b. Random assignment (2) ☐		
8. How was the size of the study sample determined?		
a. Not reported (0) ☐		
b. Using threshold numbers (1) ☐		
c. Formulas (2) ☐		
d. Statistical requirements (3) ☐		
9. What techniques were used to ensure optimal sample size?		
a. None (0) ☐		
b. Mortality follow up (1) ☐		
c. Incentivization (2) ☐		
d. Oversampling (3) ☐		
Total points for this section		
Ethics	Yes (1)	No (0)

1. Was ethics approval obtained from an identifiable committee?	☐	☐
2. Was informed consent obtained from the participants of the study?	☐	☐
3. Have ethical issues been reported on:		
a. Confidentiality?	☐	☐
b. Anonymity?	☐	☐
c. Withdrawal	☐	☐
d. Informed consent?	☐	☐
Total points for this section		

Instruments	Yes (1)	No (0)
1. Were instruments clearly identified with full references?	☐	☐
2. Were specific outcomes identified?	☐	☐
3. Were instruments appropriate for the outcomes identified?	☐	☐
4. Which of the following psychometric properties were reported on:		
a. Did they report on the psychometric properties?	☐	☐
b. Did they report on psychometric properties of the scale for this sample?	☐	☐
c. Did the authors report on the type of data produced by the instruments?	☐	☐
d. Did the instruments produce data that supported the proposed analysis?	☐	☐
Total points for this section		

Data Analysis	Yes (1)	No (0)
1. Was the method of analysis made explicit?	☐	☐
2. Was the method of analysis motivated?	☐	☐
3. Was the method of analysis appropriate relative to the research question?	☐	☐
4. Were the conclusions drawn appropriate and supported by the data?	☐	☐
5. Were the inferences drawn supported by the type of sampling?	☐	☐
Total points for this section		

Results	Yes (1)	No (0)
1. Were alpha levels reported?	☐	☐
2. Were results correctly interpreted?	☐	☐
3. Were the results clearly linked to the research questions?	☐	☐
4. Were the results presented in a tabular form?	☐	☐
Total points for this section		

Conclusion	Yes (1)	No (0)
1. Was a clear conclusion drawn?	☐	☐
2. Was the conclusion supported by the findings?	☐	☐
3. Were relevant recommendations made based on the findings?	☐	☐
4. Were limitations identified?	☐	☐
Total points for this section		
Total score/Score (%):	**Score (55)**	**Score (%)**
Weak ☐ **(<40%)** ☐ **Moderate (41-** ☐ **60%)** ☐ **Strong(61-80%)** Excellent (>80)		
(Studies will be excluded from the systematic review if the quality of evidence was rated as weak (<50%) and if the combatting of health risk behaviour was not used as an outcome of the intervention.)		
Overall Appraisal: **Include** ☐ **Exclude** ☐ **Seek further info** ☐		