Strengthening family resilience:
Evaluation of a community-based family programme in Doornkop, Soweto

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Abstract

There is a need for evidence-based programmes that support family functioning in South Africa. Therefore, the Centre for Social Development in Africa, research department of the University of Johannesburg, adapted an evidence-based family programme 'SAFE Children'. A preventive programme that was developed for low-income neighbourhoods in Chicago, by the University of Illinois. The South African version of the programme is called 'Sihleng'Imizi'. It consists of twelve group meetings, addressing topics ranging from child rearing and school involvement to financial skills. A pilot of the programme ran in Doornkop from September until December 2016. In this master thesis, the outcomes of the Sihleng'Imizi programme were investigated five months after the programme has ended. The focus of this evaluation were its outcomes for four determinants of family resilience: 1) parenting skills, 2) family warmth, 3) values and beliefs, and 4) the use of social and community resources. Interviews were held with the ten caregivers who attended the programme and the facilitator. Self-reported outcomes are that communication improved, and that the cohesion in nuclear families increased. The use of physical punishments decreased and the use of non-violent discipline methods increased. Furthermore, the majority of caregivers is still in contact with one or more group members. The caregivers perceive an increased access to emotional and practical support. The results of this exploratory study indicate that the Sihleng'Imizi programme strengthens the resilience of families in Doornkop, but several recommendations for improvements are given to increase its impact.

Introduction

According to Gould and Ward (2015), families fulfil a crucial role in society, by forming the groundwork for the attachment and cognitive development of the new generation. In South Africa, poverty poses a threat to family functioning. In 2014, approximately 63% of the children (11.7 million) were living under a poverty line of R923 per person per month (Hall and Budlender, 2016). Poverty can result in stress and depression among caregivers, a lack of warmth and supervision, and an increased use of harsh and inconsistent discipline (Gould and Ward, 2015). According to Mandisa (2007) these inadequate parenting styles can lead to the development of deviant behaviour. Inconsistency in rule-setting and harsh discipline result in poor self-regulation skills and aggression (Bandura, 1977). Next to that, a lack of warmth and secure attachment negatively shape children's reactions to their surroundings (Bowlby, 1973; Loeber and Stouthamer-Loeber, 1986).

In 1996, the Child Support Grant was introduced in South Africa to support families financially. Currently, the grant is provided to the families of 11,3 million children (Patel, 2015). Next to financial assistance, there is a need for welfare services that support families in their caring functions (Richer and Naicker, 2013; Gould and Ward, 2015). Holtzkamp (2010) argues that, in the past, healthy family functioning has not been supported sufficiently, because welfare services were too focused on malfunctioning, and their main activity was repairing what was already damaged. She sees this approach as unfavourable because it undermines the adaptations that South African families make. There are families who manage to function positively, despite poverty and other risk factors. What South African families need, according to Holtzkamp (2010), are intervention programmes that strengthen their reparative potential, in order to support them to cope better with the adversity they face. This reasoning fits well into the paradigm shift towards a preventive approach that has taken place in South Africa's social policy. Now, the priority is to enhance a family's ability to function positively, rather than intervening after problems have occurred (Roman, Isaacs, Davids and Sui, 2016; Department of Social Development, 2013).

The ability of a family to not only cope with adversity but even rise above it is called 'resilience' (Walsh, 2012). Research

has shown that family resilience depends on their use of internal family strengths and resources in their social network, schools and the community (Walsh, 2012; Raninga and Mthembu, 2016). However, a translation of resilience theory into practical intervention programmes is lacking (Holtzkamp, 2010).

Even in general, evidence-based preventive family programmes are not widely available in South Africa. Programmes have often been developed in high-income countries, and their effectiveness in the context of South Africa is uncertain (Richter and Naicker, 2013). According to Lachman, Sherr, Cluver, Ward, Hutchings and Gardner (2016), norms and values about parenting and family structures differ across cultures, and therefore, some components may be irrelevant. Furthermore, existing programmes are often too costly and training intensive for lower-resource settings (Lachman et al., 2016).

For these reasons, the Centre for Social Development in Africa (CSDA), research department of the University of Johannesburg, decided to adapt a preventive family intervention. They have chosen for the 'Schools and Families Educating Children' programme (SAFE Children), developed by the University of Illinois, a holistic approach to prevent problem behaviour in low-income neighbourhoods in Chicago (Tolan, Gorman-Smith and Henry, 2004). The South African version is called 'Sihleng'Imizi', aimed at families who receive the Child Support Grant. From September till December 2016 a trial of the intervention run in Doornkop, a low-income settlement in Soweto, Johannesburg.

Knerr, Gardner and Cluver (2013) stress the importance of evaluating family programmes in South Africa. Evaluation results are needed to advice policy makers in their decision to upscale effective programmes, and prevent that scarce resources are wasted. Additionally, an evaluation provides insights that can be used to improve the programme. Chiba (2017) conducted pre- and post-intervention interviews to investigate the short-term outcomes of the Sihleng'Imizi programme, but no results are available yet. A follow-up evaluation is needed to understand the sustainability of the program's outcomes. Strengthened family resilience is perceived as one of the most important potential outcomes of the Sihleng'Imizi programme, because it reveals to some extend a family's ability to achieve positive outcomes and to deal with future challenges (Walsh, 2012). Therefore, the aim of this study is to evaluate how the Sihleng'Imizi programme has

influenced the resilience of families in Doornkop, five months after the pilot programme ended.

Theoretical exploration

The background of family resilience

The concept ‘resilience’ builds on stress and coping theory, but goes beyond that, because it involves a process of embracing potential to grow and overcoming adversity (Walsh, 2012; Sixbey, 2005). In the 1970s, scientists started to investigate individual resilience. This was elaborated by Antonovsky (1987) who developed the salutogenic model to gain a better understanding of the relationship between stressors and coping, with a focus on why and how people stay healthy. He identified the sense of coherence as determinative for coping abilities. Having a high sense of coherence involves perceiving adversity as a challenge, and having confidence in one’s ability to overcome it. Around 2000, attention for resilience of the family as a system grew (Sixbey, 2005; Bhana and Bachoo, 2011). The concept of family resilience is related to the socio-ecological system approach. This approach suggests that children develop within systems of the family, school, community, and a broader societal context, and that there are interactions between these contexts (Bronfenbrenner, 1979). The influence of system thinking was that persistent adversity was no longer perceived as only influencing the individual, but also the family as a unit. How a family reacts to adversity was shown to mediate the adaptation of all family members (Bhana and Bachoo, 2011; Walsh, 2012). The family is crucial because it provides interactions that shape the development of adaptive skills, which includes self-regulation, social and emotional skills (Masten and Monn, 2015; Raninga and Mthembu, 2016; Walsh, 2012).

Defining family resilience

The definition and the application of family resilience are quite contested. According to Patterson (2002) a source of confusion is the lack of differentiation between resilience as an outcome and resilience as a process. Sixbey (2005), Walsh (2012) and Patterson (2002) argue that resilience can be seen as both a process and an outcome. However, seeing it as a process is favourable, because this emphasizes its dynamics (Patterson, 2002). Family resilience is an interplay of multiple risk factors and protective processes varying over time, influenced by individual, interpersonal, social, cultural and economic forces. It is not very useful to ‘capture’ this pattern of interactions at a single moment,

because they are constantly developing, depending on circumstances and changing priorities (Walsh, 2012). Perceiving resilience as a process helps to explain why families are resilient in certain situations but not in others, and why it changes over time (Patterson, 2002). Based on Patterson's (2002) conceptualization, the definition of family resilience used in this study is: '*The process by which families are able to not only restore balance after experiencing stressors, but also to function competently and positively'*. Competent and positive family functioning in itself are rather hard to define, because it is dynamic as well, depending on culture and context (Patterson, 2002).

In a review study, Kalil (2003) questions the usefulness of the concept resilience because of its ambiguity. What she concludes is that family resilience may only be observable in aspects of family functioning that are associated with positive adaptation, and that it may be best to conceive it as a latent quality. To make the concept family resilience concrete and measurable, in this study it is used as an umbrella term, and the focus are its determinants. A perceived advantage of focusing on the determinants is that this provides specific knowledge about the ways in which the Sihleng'Imizi programme has influenced resilience.

Determinants of family resilience

Overall, scientists broadly distinguish the same type of determinants of family resilience. Some researchers include economic security, while others do not mention this as being part of family resilience (Walsh, 2012; Bhana and Bachoo, 2011; Ranninga and Mthembu, 2016). According to Holtzkamp (2010), the determinants of family resilience within one culture do not necessarily apply in another culture. This research builds on a systematic literature review of Bhana and Bachoo (2011), in which they identify the determinants of family resilience specifically for low- and middle income countries, including South Africa. Their determinants are used as the basis for this research. For every determinant is described what is considered as competent functioning, and how a group intervention program could influence this.

1) Family warmth

Resilience increases when there is mutual support, trust, and commitment to the family, while at the same time respecting each other's boundaries, needs, and differences. Family relations are strengthened when

feelings and emotions are openly shared. Shared acknowledgment of adverse circumstances, and being able to express your feelings fosters positive coping (Bhana and Bachoo, 2011; Sixbey, 2005; Walsh, 2012).

Effective communication involves speaking for oneself, sending clear, consistent, specific, congruent, direct, and honest verbal and non-verbal messages. When family members are able to give each other clear information about a situation, this fosters meaning making and informed decision making. Problem solving can be considered as effective when families are able to recognize a problem, discuss options, and make decisions together. Afterwards, the family has to be able to monitor the chosen action and evaluate it (Sixbey, 2005; Walsh, 2012).

Family warmth can be enhanced by informing caregivers about the importance of actively listening to their children. Through active listening the child will feel valued and appreciated, and starts to behave more positively, which contributes to a more positive family environment (Zastrow and Kirst-Ashman, 2007). During an intervention programme caregivers can be taught about the importance of giving clear and consistent messages, and explaining their actions. To solve problems more effectively family members can be encouraged to listen to each other and come to a mutual decision. Additionally, families can be encouraged to make time for each other and express feelings in order to develop stronger relationships (Sixbey, 2005; Walsh, 2012).

2) Parenting skills

Children need a strong and reliable caregiver to protect, nurture, and guide them. Authoritative leadership is perceived as the best parenting style for family functioning. Caregivers have to be strict, but at the same time responsive and warm. Clear rules, roles and routines are needed to make the family a balanced system, that is able to restore after disturbances (Walsh, 2012; Masten and Monn, 2015).

According to Richter and Naicker (2013) and Zastrow and Kirshman (2007), most parenting intervention programmes are based on a transactional model of child-caregiver relations. It is assumed that knowledge and actions of the caregiver influence the child's behaviour, and reciprocally the child affects the caregiver. Interventions thus aim to change a problematic vicious cycle by providing caregivers with information about their children's developmental stage, temperament, and needs. They promote

positive parenting strategies and effective discipline. Caregiver's understandings, interpretations, and responses to child behaviour are expected to change through an intervention. Their new actions and beliefs are expected to evoke changes in child behaviour, which in turn can decrease stress, strengthen relationships, and have a beneficial influence on well-being. When the well-being of caregivers is increased this fosters their positive attention for the child. When the child and caregiver get a stronger relationship this increases the impact of what caregivers teach their children, and it thus enables them to give their child more guidance (Richter and Naicker, 2013).

3) Beliefs and values

The beliefs of a family are social constructs that provide them with a way of organizing experiences, and making meaning of the world around them. Belief systems are crucial for how family members deal with adverse circumstances, because it gives them guidance which can increase effective functioning and foster problem solving (Sixbey, 2005; Walsh, 2012).

Hope for a better future is an essential source of energy for dealing with adversity. When caregivers lack hope for their own future, having hopes and dreams for their children's future instead can function as a source of energy (Walsh, 2012). A positive view on life enables family members to encourage themselves and others, and stay focused on making the best of what they have (Sixbey, 2005). Dubow, Arnett, Smith and Ippolito (2001) found that positive expectations for the future led to lower levels of problem behaviour, and to higher levels of school involvement, social support, and less negative influence of peers. In general, faith, cultural heritage, and ideologies can provide families with the motivating idea that life is meaningful (Walsh, 2012; Bhana and Bachoo, 2011; Sixbey, 2005).

Another source of hope for achieving a better future is schooling. According to Henderson and Berla (1994) a caregiver's beliefs and values regarding school are highly important for their child's school achievements. Children of caregivers who are involved in school generally attain higher results in school. When caregivers tell their children about their hopes and expectations regarding school, and express concern about their education and experiences, this helps children to develop more self-esteem, and stimulates a more positive attitude towards school (Grolnick and Slawiacek, 1994).

During family intervention programmes, to a certain extent, optimism

can be learned and helplessness and pessimism can be unlearned. Affirming and encouraging family strengths can counter feelings of helplessness, and it builds self-confidence. Family members learn to believe that they are able to make a difference with their actions, for their own lives and for the lives of family members (Walsh, 2012; Zastrow and Kirst-Ashman, 2007).

4) Social and community support

Positive contributions to family resilience are also made by the extended family, friends, acquaintances and the community. A family's ability to seek, access and mobilize helpful people and resources in their environment is strongly related to their resilience (Bhana and Bachoo, 2011). Having a relational network provides families with emotional, instrumental, and informational support (Kesselring, 2016). When financial resources are scarce social capital is even more important for resilience, because it functions as a buffer system (Nkosi and Daniels, 2008).

Furthermore, being connected to the community, sharing values, and trusting each other enhances social control. Community members watch over each other's children and provide youth with norms about how they should behave. People need to feel accepted and included for the sake of their well-being. Receiving emotional support increases self-confidence and improves mental health. Additionally, it is beneficial if caregivers know on which services they can rely when they need help (Walsh, 2012; Sixbey, 2005; Richter and Naicker, 2013).

Social support is a widely used tool in family intervention programmes, because it gives families the opportunity to give and receive advice, make friends, access new resources, share troubles, and counters social isolation (Richter and Naicker, 2013; Walsh, 2012). The four-step model of Snel and Boonstra (2005) provides more insight into how group interventions achieve this. The first step is meeting other caregivers, this leads to *'public familiarity'*, which means that caregivers start to recognize and know each other. The second step are dialogues about child rearing. Having these conversations can stimulate caregivers to reflect on their own way of child rearing (Kesselring, 2016). Furthermore, it is beneficial on a collective level as it learns caregivers to give and receive help and advice (Lans, 2010). The third step is getting a more positive neighbourhood climate. Knowing more people in the neighbourhood can enhance the formation of social networks, and the uptake of collective

activities. The last step is the formation of self-sustaining social networks, families continue to meet each other regularly after the intervention (Kesselring, 2016; Snel and Boonstra, 2005).

The Sihleng'Imizi programme

The Sihleng'Imizi programme has four goals, namely: 1) Strengthening child-caregiver relations; 2) Promoting social and community connectedness; 3) Increasing caregiver involvement in the child's education; 4) Strengthening financial skills (CSDA, 2016). While strengthening family resilience is not an explicit aim of the programme, its activities can be expected to influence family resilience. *Family cohesion and warmth* are stimulated by stressing the importance of active listening. Families are advised to take a time-out during conflicts and to listen to each other's viewpoints. The programme tries to stimulate better communication between family members by encouraging a clear expression of ideas and feelings. Caregivers are given a home assignment to have 'special time', in which they undertake an activity with their child and give them undivided attention. The intervention was expected to improve *parenting skills* by providing caregivers with information about the importance of clear rule-setting, and having consistent consequences when rules are not kept. Caregivers receive information about different ways to reinforce behaviour, and about different types of discipline and their effects. *Family beliefs and values* are influenced by encouraging families to think about their strengths, discussing them, and by emphasising these as means for coping with hardship. Next to that, caregivers are encouraged to become actively involved in school and are asked to contact teachers. Families meet each other every week, discuss problems, and give each other advice. Every family has a 'buddy family', whom they are asked to visit weekly. The intervention is expected to broaden the social network of families, and thereby increase their *use of social and community resources* (CSDA, 2016). A model has been created of all mechanisms and outcomes of the Sihleng'Imizi programme that are expected to influence family resilience (Appendix 1).

Aim of the research

In order to provide policy makers and programme developers with information about the longer-term outcomes of the Sihleng'Imizi programme, the sustainability of the outcomes needed to be investigated. This can help them to decide whether or not

to upscale the programme, and prevents that scarce resources are wasted (Knerr et al., 2013). According to Walsh (2012), family resilience needs to be researched among different population groups, because it is culture- and context dependent which determinants are most salient. This study was expected to provide insight into how well the four determinants of resilience used in this study hold for families in Doornkop.

Furthermore, an evaluation of the Sihleng'Imizi programme was needed to further improve the adaptation of evidence-based family programmes in South Africa (Richter and Naicker, 2013). Therefore, the following question was answered: **'How has the Sihleng'Imizi programme influenced family resilience in Doornkop, Soweto?'**

Sub questions:

1) What are the perceived outcomes of Sihleng'Imizi programme for family warmth, parenting skills, beliefs and values?

2) How has Sihleng'Imizi programme influenced families' use of social and community resources?

Methodology

Implementation of the programme

The SAFE Children programme is a well-evaluated preventive intervention, applied in poor-resource neighbourhoods of large American cities. The programme improved parental involvement in school, social competences, decreased aggression and hyperactivity (Tolan et al., 2004). For its implementation in South Africa the main programme content was preserved, but some adaptations were made to be more culturally appropriate, and to meet the needs of the local community more. Material of a similar South African family intervention programme 'Sinovuyo' was used to complement the SAFE Children programme. Additionally, two sessions about financial literacy were added to make the programme more suitable for a context with high levels of poverty and unemployment. Similar to the SAFE Children programme, the whole family was invited for the meetings. This stimulates an optimal use of the resources of family members around the child, and is particularly suitable for the South African context where extended family members often live together in one household (Patel, 2015). The Sihleng'Imizi programme consisted of twelve weekly group sessions, starting with a

meal and after that a session of 1,5 hour. The programme was facilitated by a social worker of NGO Humana People to People in Doornkop, who used a structured script for each session, and the families received a workbook. The basic content of each session was: discussing the weekly topic, role-plays or activities, and discussing home assignments.

The Sihleng'Imizi programme was piloted between September and December 2016 in Doornkop, a settlement in Soweto with 24,225 official inhabitants in 2008. Almost 50% of the households is female-headed, and approximately the same percentage is receiving the Child Support Grant. Poverty and unemployment levels are high. Only 10% of the households can be classified as food secure, while over 50% of the households regularly experiences a severe lack of food. Furthermore, the prevalence of HIV/AIDS, drug abuse, food insecurity and sexual abuse are high (De Wet, Patel, Korth and Forester, 2008).

Local teachers of children in the age of 5-7 identified children struggling at school, and/or caregivers struggling with child rearing practices. Families selected by teachers were approached by the programme facilitator and intake home-visits were planned. Ten out of fifteen families agreed on participating in the intervention. However, after the first meetings, three families decided to quit. Three new families were approached and decided to participate. They missed the first two meetings, but were informed about the content by the programme facilitator. In total, ten families completed the programme, they were separated in one group of six families and one of four families. Only primary caregivers (eight mothers, and two grandmothers) attended the meetings. Despite being invited, fathers and extended family members did not attend the sessions, or not more than once (Chiba, 2017; CSDA, 2016).

Research design

Qualitative methods were perceived to be most suitable for gaining in-depth information about how the programme worked, and to unfold the subjective processes of meaning making by which family resilience is shaped (Patterson, 2002). Evaluative interviews were held with all ten caregivers who completed the programme, and the social worker who facilitated the programme in Doornkop. Their contact details were provided by Jenita Chiba, PhD student at the CSDA. The three caregivers who quitted the programme were not included in the interviews because there were

no contact details available. Only two out of ten caregivers were reached via phone, and therefore the decision was made to visit the caregivers at their houses. Interviews were held at the caregivers' houses in Doornkop, and on average lasted 45 minutes. The interview questions were translated by a local woman, who took care of the children during the Sihleng'Imizi programme, from English into Zulu, Xhosa, Setswana or Sesotho, depending on the caregiver's preference. The programme facilitator was interviewed at the University of Johannesburg, and this interview lasted one hour. All participants gave permission to have the interview recorded for the purpose of transcribing.

Demographics of research population

The caregivers who attended the meetings of the Sihleng'Imizi programme were eight mothers and two grandmothers. Their ages varied from 22 till 70, and on average they are taking care of five children in the age of 0 till 18. Four mothers shared the responsibility for caring with the father of the children. The other four mothers shared the responsibility for caring with their mother and/or a sister. The grandmothers who attended Sihleng'Imizi programme were responsible for caring alone, but one of them lived in a house with two adult children. Table 1 provides demographics per household. It is mentioned whether or not extended family (aunts, uncles, and or grandmothers) lived in the household, next to the caregiver who attended the meetings.

	Children in household	***Age of children***	***Caregivers***	***Age of attending caregiver***	***Extended family in household***
A	6	5-15	Mother and grandmother (Foster care)	62	Yes
B	4	6-12	Grandmother	70	No
C	5	0-15	Mother and father	32	No
D	10	0-18	Mother and sister	22	Yes
E	3	6-18	Mother and father	43	No
F	2	7, 7	Grandmother	66	Yes
G	4	1-12	Mother and father	35	No
H	5	1-18	Mother and grandmother	28	Yes
I	9	1-18	Mother, sister and grandmother	23	Yes
J	2	2, 8	Mother and father	36	No

Table 1: Demographics of families

* The underlined caregiver attended the meetings and was interviewed

Measures

An operationalization of the core concepts was made based on the theoretical exploration and the Family Resilience Assessment Scale (FRAS), a validated measurement tool developed by Sixbey in

2005 (Appendix 2). These concepts were processed into open-ended interview questions. The interview questions for the facilitator differed from the questions for the caregivers, but addressed the same topics (Appendix 3). The interviews were structured and theory-driven. The evaluator was steering the interviewee in the direction of theoretical concepts, but the interview questions were open-ended. The aim was to give caregivers the possibility to talk about what they perceived as the most important changes. After transcribing the interviews, data were organized by theme in software programme Nvivo11. The majority of themes were deductive, as they were drawn from the theoretical exploration. Next to that, inductive data collection was used, due to it not being possible to predict beforehand how interviewees would react to the questions.

Results

Family warmth

Communication

According to the programme facilitator, the families were having communication problems at the start of Sihleng'Imizi. It was difficult for them to talk about their experiences and feelings with each other, but she noticed improvements throughout the meetings. Five months after the programme ended, the most extensively mentioned change by caregivers was that communication within their nuclear family has changed in a positive way. They describe these changes as: 'communicating more', 'sitting down to talk', 'going to the child's level', 'listening to the child' and 'talking to them with a calm voice'. For example, caregiver A said: '*Because of Sihleng'Imizi, I know I must sit down and talk to them nicely. What I realize now is that children listen and that you do not have to scream'.* And caregiver I: '*I can always talk to my son with a really calm voice, so that he can listen to me better. Because when I am yelling, obviously he would do the same thing over and over again'.* This change in communication seems closely related to increased active listening and giving children more room for expressing their feelings and emotions, illustrated by a quote of caregiver B: '*For example, the younger one would always be the one who cried a lot, and told me like 'that one has done this to me'. And then I would just be like 'Ai ai ai, just go away, I don't want to listen to you', but now, after the Sihleng'Imizi, I listen to them to hear what they are crying about. I no longer chase them away. Yeah, so I am more comforting now. Also, before I was always*

pinching them if they were naughty, but now 'no no no', I stay with them and I try to understand their feelings.' And caregiver J: '*We do support each other even emotionally, and we do this by talking about what we feel, and we listen to each other. Everyone has the right to express him or herself and we tell each other: 'I am angry today because of these things' and we talk about the problems, and try to help each other with the troubles.'* One way of showing support to a family member who is expressing emotions is hugging, caregiver G said: *' We have to hug, that is the best to comfort the person who is emotional. And then after the stress is out we have to talk, people are allowed to cry, you know?*' An effect of increased room for emotions is that children start to share their feelings and experiences more often, participant I said: *'Now my son knows: 'Ah I can talk to my mom'. 'Everything he does, he always tells me'.*

Cohesion

During the Sihleng'Imizi programme, caregivers' awareness about the importance of a warm and supportive environment was raised. For example, the programme facilitator said: '*I remember there was a young boy who loved hugging, but the parent did not understand this. Until we spoke about the developmental needs of children. Since then, she had a different way of communicating with her child and gave him a hug when he wanted.'*

Caregivers told they experience emotional support between them and their children, and in their perception, attending the Sihleng'Imizi programme has increased this support. For example, caregiver D said: '*Before the Sihleng'Imizi programme nobody cared about anybody, if you were done with your thing then it is your thing, nobody cared. But Sihleng'Imizi has taught us that we need to communicate more, that we need to listen more to each other.'* Caregivers have the feeling that relations between them and their children became stronger. Some of them spoke about more *'love'*, *'trust'* and *'happiness'*, which also implies increased cohesion. The improved cohesion mainly seems the result of the changes in communication and increased emotional support. According to Zastrow and Kirst-Ashman (2007) changes in communication, active listening and room to express feelings do indeed increase family cohesion. Furthermore, spending more time together also strengthened cohesion, participant D said: '*This togetherness with the kids came after the Sihleng'Imizi because they told us to have good communication and relations with*

the kids, and they showed that we have to commit. So that is why we are playing and spending time together more than before.'

Some of the married caregivers perceive an improvement in the relationship with their husband, caregiver E said: *'I cannot just pick one thing that Sihleng'Imizi has done, because for me it has done a lot of things and especially even for the father. He is now able to sit with us and to talk and communicate with us, but before he could not do that.'* By sharing experiences and insights after the programme's sessions the communication between her and her husband became better. This was not the case for caregivers living in a household with extended family members, like a grandmother and/or a sister. Although the Sihleng'Imizi programme had positive effects on the relationship between the caregivers and their children, nothing changed in their relationships with extended family members.

Family cohesion was mentioned as a way to deal with hard circumstances and poverty, caregiver C said: '*I always tell my children we don't have to envy other people's things, because I don't have these things. So in order for you to be happy, or to be okay with what you don't have, just sit here and talk, and sometimes I borrow them my phone so that they can play a game and forget about what they want from outside and what other children are having'.*

Parenting skills

Rule-setting and consistency

Caregivers perceive their house rules as more explicit than before attending the Sihleng'Imizi programme, for example, caregiver B said: *'Now I can write the rules and before I did not know what to write. I am writing the rules and everybody knows the rules are there. So it has become much more easy.'* However, caregiver I experiences problems with setting rules, she told: '*I set rules and then my mother will come with her own rules. And then the kids start listening to my mother's rules and they do not follow my rules. So I am tired of trying to make rules'…'We always fight when we make rules. Because she thinks that my rules are too harsh for the kids'.* This implies that it can be hard to practice at home what was taught during the Sihleng'Imizi programme when the responsibility for caring is shared with an extended family member who is not open for changes.

Discipline

The consequences for when rules are not kept have changed through attending the Sihleng'Imizi programme. Caregivers who

used to beat or pinch their children as a punishment gained knowledge about the adverse effects of this. A result of this is that they are no longer using physical punishments, but instead, use the alternative ways of disciplining that were presented in the programme. The most popular method is the cool-down, which caregivers use as a consequence when children do not keep the rules, caregiver D said: '*Before, I used to beat the kids, or smack them, but now I tell them to go to the corner and sit there for five minutes. So I use this and they don't like that cool-down corner. So when I say: 'You are going there' they start to behave in the right way*.' A second method that was mentioned is withholding rewards, for example pocket money. Furthermore, caregivers use praising to reinforce positive behaviour, for example caregiver G: '*Not everything is about money, but I can always praise them and say: 'What you did is nice, keep it up, what you did will make you grow and be a bigger person, keep on doing what is right'. Because you know boys? How they grow up? When they see things they wish to be like that person, and I say if you want to reach that you have to behave like this.'*

A study of Lachman et al. (2016) reveals a high prevalence of physical punishments in South Africa, 75% of the caregivers reported to use harsh physical and psychological discipline. The authors state that the use of physical punishments is seen as normative. However, there were caregivers who were willing to stop using physical discipline, but they said to lack alternative ways to get their children to obey. In the Sihleng'Imizi programme caregivers were taught alternative methods, and in combination with a willingness to change, this explains the caregivers' shift to non-violent discipline methods. Through the Sihleng'Imizi programme caregivers became more aware of the adverse effects of shouting and its ineffectiveness as a discipline method. Shouting was mentioned as a habit that is hard to change in practice. However, some caregivers were applying the cool-down method to control their anger and perceived this as effective.

Beliefs and values

Awareness of family strengths

According to the programme facilitator, shifting attention to strengths was an important element of the Sihleng'Imizi programme, she said: '*The families are held in their problems and what is going wrong, more than what is going right. So through the Sihleng'Imizi programme I think they would start looking at things not as weaknesses, but*

actually as strengths', the Sihleng'Imizi programme helped caregivers to identify their family strengths and raised their awareness of it. During the interviews, caregivers named their family's strengths. These ranged from watching television together, playing games, and dancing, to shared Christianity. Praying together was a common way of dealing with different occurrences in life, for example caregiver E said: '*We pray together. So that is where we go to for everything, when we are happy, when we improved something, we go.'* A study of Greeff and Loubser (2008) showed the importance of spirituality for family resilience in South Africa. According to this study, praying is often done with the whole family and more frequently in times of crises. Reported outcomes of this were material needs being met, feelings of joy, and strength and guidance in dealing with hard circumstances.

Involvement in school and dreams for future

Caregivers perceive themselves as being actively involved in school. Ways of involvement are talking about their children's school experiences, attending meetings and helping with homework. The most important contribution of the Sihleng'Imizi programme concerning the stimulation of parental involvement seemed to be the 'homework' assignment to contact teachers, caregiver F told: '*The thing that made me so active is that even the school told me that we need to be involved. That the caregiver and the teacher should be like friends. I should know what is happening at school and the teacher should know what is happening with the child at home.'* Caregivers started to take more initiative in the contact with teachers, for instance, caregiver J: '*Now I am more involved than before. Sometimes I go without even being called and just check. I want to see my child progress to another grade and I do not want to blame teachers for the shortfalls of my child, that is why I am involved in school. I want to see what is going on with my child.'* The programme raised caregivers' awareness of the positive relationship between their involvement in school and their child's achievements. School achievements are perceived as very important by the caregivers. Their main dream for the future is that their children finish school to *'have a bright future'* and to *'become something better'*. Being actively involved in school is seen as a way to realize these dreams. Family members talk about their hopes and dreams for the future with each other and this can give motivation, for example, caregiver J told: *'I have one child who wants to be a*

doctor and I always tell him: 'Hey doctor wake up. If you want to be a doctor go to school.'' Younger caregivers also hope to finish their own education, and others are hoping to find a job. According to Walsh (2012) hopes for the future indicate a positive view on life, which provides families with energy and focus to achieve things.

Use of social and community resources

Need for social support

Increasing the access and use of social support seemed necessary for families in Doornkop. In a study of De Wet et al. (2008), 37% of the households in Doornkop reported that there was nobody in the community they could rely on for support when facing serious problems. The programme facilitator expressed her concerns about upcoming individualism in Doornkop, she said: *'Our grandparents used to make us aware of the little that we have. When I look back it does not mean that there was no poverty back then. But it is because of the resources that we had: the support system, having another family next to us that we could rely on. At this moment, people are no longer using the resources that they are having around them, because they are too busy concentrating on what they do not have.'*

Group contact during the programme

During the Sihleng'Imizi programme, relationships were built between group members. According to the facilitator, caregivers regularly visited their buddy during the programme, and they started picking each other up to come to the meetings together. The facilitator noticed that some relationships were formed easily, she said: '*The ones who live in the same block are the ones who clicked together so quickly, because they can visit each other. Through the Sihleng'Imizi they realized 'No, you stay in the same block?!' So they started being parents to each other's children even, but for the ones who were staying further from each other it was difficult to do the buddy system.'* There was progress in the openness of the caregivers, the programme facilitator said: '*In the beginning there was a lot of mistrust and people did not want to share personal issues, but as the sessions went on, I was actually surprised when we were talking about money, how honest they were. I don't think if you started talking about money in the third session they would have opened up about it.'* However, caregiver D mentioned she keeps finding it hard to open up, she said: *'I don't trust that people will keep my family problems safe as a secret. I do not want to go*

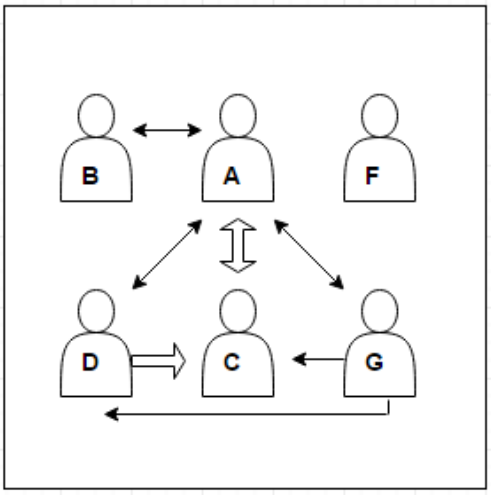
on the street and that people will talk about me: 'Look at her she has family problems.''

During the sessions, caregivers compared their parenting styles and started giving advice to each other. The programme facilitator sees this as an important element of the programme, she said: *'How we are communicating with our child, and hearing from other parents and caregivers how they react to their children. It gave them a chance to relate. It were either parents who said: 'I need to improve', or others who said: 'I am in a better position'. So it was a wake-up call for some of them.'*

Staying in contact after the programme

Five months after the intervention, eight out of ten caregivers were still in contact with one or more group members. Two visualizations of the networks have been made (Figure 1).

Group 1



Group 2

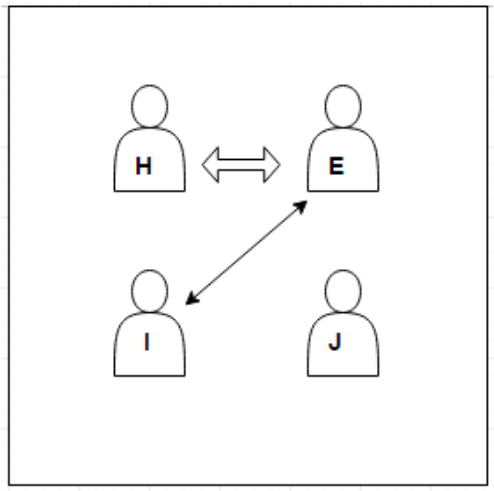


Figure 1: Social contacts between group members five months after the pilot programme

Bigger arrows represent more intensive contact. These caregivers visit each other often and are discussing their family problems. Thin arrows represent meeting each other occasionally. These caregivers are talking about everyday life, but some of them also about topics addressed in the programme, caregiver A said: *'We are in contact all the time. We always talk about how the children are doing at school, in life maybe, and how we are managing to keep constant behaviour, with the laws and the consequences, so yeah, we always talk about those things, if we are still doing what Sihleng'Imizi has taught us.'*... '*Most of the time, we just meet outside because we live close to each other. Sometimes we meet each other in the shops: 'Hey my buddy, how are*

you? How are things?" According to Hansen and Wänke (2009), living close to each other increases the chance to meet each other occasionally and makes staying in contact simply more convenient. Next to that, there is the mere exposure effect. Meaning that, in general, people start liking each other more when they see each other more.

Even caregivers with 'thin' connections feel that they can rely on those contacts for borrowing money, water, or babysitting. Not all relations are reciprocally, this has been visualized by the direction of the arrow. The most mentioned reasons for loosing contact with group members were a lack of time and being unable to contact them because their phone numbers had changed.

Contact with other community members

For some caregivers, the Sihleng'Imizi programme influenced their social contact with other community members. For example, for caregiver C, learning to talk about conflicts and being less stubborn helped her to improve the relationship with her neighbours. For caregiver A this change seemed even bigger, she said*: 'It was very difficult for me to make friends. But now I am able to go to someone's house, and if you offer me a drink I will have it. Before I could not do that, I was very shy. So because of the buddy thing the Sihleng'Imizi has helped me a lot to maybe learn more how to socialize'… 'Now I can trust. I do not look at people like they are going to harm me. I learned how to speak about life and make friends, yeah.'* For her, having positive interactions with group members increased her trust in general. This confirms that group meetings can lead to changes in the way people interact with other community members (Kesselring, 2016).

Use of resources in the community

Most caregivers were already familiar with the existing services in Doornkop, including a clinic, a police station, social workers from NGO's, and also pastors were providing social support. In case caregivers did not know where to go for help, they were not helped by the Sihleng'Imizi programme because no information was provided about supportive services in Doornkop.

Feeling left behind?

A recurrent theme was that the Sihleng'Imizi programme ended too quickly. Caregivers bringing up this topic felt in need of more sessions. For example, caregiver C said*: 'During the programme I have raised a problem. Now I want my problems to be solved, but I cannot speak to anybody because there is no Sihleng'Imizi anymore. I feel more comfortable speaking to the people*

with whom I was involved in the Sihleng'Imizi. Then I can solve the problems I have. I feel uncomfortable talking about it with other people. That is why I want it to be reachable'. Others seem to feel abundant by not hearing anything after the programme ended, caregiver G said: *'I say those people they are forgetting us'… 'They helped us and then 'okay, no'. This is life. We have to live with it'.* A topic about which also the programme facilitator expressed her concerns, she said: *'We are making them aware that they are not alone and that they have resources. And then we leave them, with that thinking, you know. So there is a cut, saying the community is your resource: use it, and then they cannot use it.'*

Caregivers seem motivated to continue with the group meetings, for example, A said: *'It has to form a support group for mommas where we can talk about problems. Maybe once a month we can go to the park and talk about problems, and solve those problems outside the centre that we were using for the Sihleng'Imizi'.* Despite having the wish to continue, the caregivers have not formed a self-sustaining network. Caregivers who were willing to organize these meetings mentioned to need coordination and practical support in the beginning.

Involving fathers and extended family

Caregivers and the programme facilitator mentioned that the involvement of fathers and extended family members would increase the impact of the Sihleng'Imizi programme. According to the programme facilitator, this could be done by renewing the way of recruitment, she said: '*Maybe it should be done in a more celebratory way, to say: 'Bring your family, we are having a family day' … 'If an uncle sees that there are other uncles that were invited and it is actually a family gathering, they would understand why they need to come'.*

Conclusion

In this study, the outcomes of a pilot of the Sihleng'Imizi programme in Doornkop were investigated for four determinants of family resilience. The Sihleng'Imizi programme has the potential to strengthen the resilience of South African families in multiple ways. Five months after the programme ended, caregivers reported improvements in the communication and cohesion between them and their children. The Sihleng'Imizi programme raised awareness of their family strengths and parenting skills. The programme stimulated caregivers to become more consistent in rule-setting and to use non-violent discipline methods.

Additionally, they became more aware of the positive relationship between their active involvement in school and children's achievements. Next to the use of inner family resources, also the use of external resources increased. Eight caregivers are still in contact with at least one group member, and this increased their perceived access to emotional and instrumental support.

Discussion

Theoretical reflections

According to the programme facilitator, the main strength of the Sihleng'Imizi programme is its holistic approach. Having a variety of issues enables every family to focus on the topics that are important to them. That interventions with a holistic approach are most effective to strengthen family resilience was also concluded by Infante (2001) in a review study. In the words of the facilitator, the Sihleng'Imizi programme functioned as a *'wake-up call'*. Or, as caregiver A said: *'it opened my mind'*. It was not that all information was entirely new for the caregivers, but merely that they were stimulated to think about topics, and discuss them. That discussions are an important working mechanism of family programmes confirms theory (Kesselring, 2016).

The choice to evaluate Sihleng'Imizi from a resilience approach provided focus, which was needed because of time constraints. Overall, the resilience approach was perceived to be suitable for investigating the outcomes of the Sihleng'Imizi programme. By evaluating it from a different angle some new light was shed on what the outcomes of the programme can be for families in Doornkop. It furthered the understanding of the interrelatedness of different outcomes and what their bigger and longer-term effects can be. For example, it became clear how an outcome like 'better communication' not only improves relationships within the family, but also fosters more effective coping styles. By using family resilience as an umbrella term and not testing it directly, there remains some uncertainty about whether these determinants hold for the resilience of families in Doornkop. However, based on the study of Bhana and Bachoo (2011) it is likely that these determinants are valid indicators of family resilience in South Africa, and nothing indicated that these determinants do not hold for families in Doornkop. Conversely, some affirmation was found for these determinants, because family warmth, beliefs and social contacts were stressed by caregivers and the

facilitator as being helpful for dealing with adversity.

Reflection on the implementation

The results of this study suggest that the South African version of the SAFE children programme fits well into the context of Doornkop. Knerrr et al. (2013) and Reid, Webster-Stratton and Beachaine (2001) argue that evidence-based parenting intervention programmes may be quite flexible in cross-cultural implementation. They are found to have positive effects despite cultural differences in parenting norms. This would mean that deeper structures keep their validity, and that adaptation of the surface (e.g. material) is sufficient (Knerr et al., 2013).

However, this study does show that family structures in South Africa can form a barrier to the effectiveness of family programmes. For caregivers living in a household with extended family it can be hard to bring the things they have learned in the programme into practice, when extended family member(s) do not support these changes. Lachman et al. (2016) stressed that the involvement of multiple caregivers in intervention programmes, including fathers, is needed to increase the consistency of care and discipline delivered to children in South Africa.

Furthermore, to improve the programme's impact there needs to be contact with the families after the programme. It is beneficial for resilience when caregivers know there is always a place where they can receive support and encouragement (Walsh, 2012). Therefore, it is recommended to continue with the meetings regularly, or to support caregivers in organizing the meetings themselves, in order to form a self-sustaining network.

Quality of the data

There are several limitations to the results of this study. First of all, the sample group is small, and this increases the chance that findings are coincidence and that saturation has not been reached. The caregivers that were interviewed kept bringing up new information. Nevertheless, recurrent themes were found in the data. Therefore, the data are perceived as sufficient for drawing some tentative conclusions about the outcomes of the Sihleng'Imizi programme. When it comes to the internal validity, there was no control group, so it is not entirely certain whether changes were caused by the Sihleng'Imizi programme or by external factors. The changes were self-reported and

thus only inform about what the caregivers perceive as the influence of the Sihleng'Imizi programme. Another possible threat to the internal validity is social desirability of answers. Even though before every interview the independency of the study was explained, it is possible that caregivers felt the need to be more positive about the programme than they are in reality.

A limitation for the external validity is that five families that were invited for the programme have chosen not to attend, and three families quitted after the first sessions. This may have resulted a selection bias in programme attendance. The families that completed the programme may have been more willing to work on family issues than the families who did not complete the programme. The result of this could be that the outcomes of the Sihleng'Imizi programme are more positive for families in the pilot group than they would have been for the general population of Doornkop. However, programme attendance is voluntary, so when implementing the programme on a bigger scale it is likely that again the more motivated families choose to attend. In that case, similar outcomes can be expected.

Further research

The limitations of this study show that the results need to be interpreted with caution. It is recommended to further investigate the effectiveness of the Sihleng'Imizi programme, among a bigger population in Doornkop and caregivers in other communities in South Africa. One of the options is to conduct a randomized controlled trial, because this is expected to provide more certainty about the causality of the programme's outcomes (Knerr et al., 2013). Next to that, methodological triangulation, including observation, could be used to reduce the social desirability bias of results.

Furthermore, it is recommended to investigate the implementation and effectiveness of other evidence-based family programmes in South African communities. More knowledge about this is needed to advice policy makers in selecting the programmes that are most well suited and beneficial for South African families, or to combine elements of the best programmes.

The potential of programmes that strengthen family resilience

Interventions to strengthen family resilience fit well into the current family policy focus of South Africa. Namely, to support families in

their ability to increasingly meet the needs of their members (Department of Social Development, 2013). However, a danger of this is mentioned by Walsh (2012). She warns for a misuse of the concept family resilience. She argues it should never be used to blame families for not being able to overcome adversity, because a positive mind-set is not sufficient for overcoming problems if life conditions are persistently harsh. Sometimes families simply have to few opportunities to overcome adverse circumstances, because they are out of their control. For example, this can be the case with poverty. First and foremost, families need supportive structures, systems and policies that enable them to be resilient. To have optimal outcomes preventive family intervention programmes need to be combined with an improvement in living conditions and services in the community. Success experiences are needed to reinforce the optimism that families were taught during the intervention programme (Walsh, 2012).

Despite this remark, the core message of this exploratory study is hopeful. The evaluation of this pilot programme showed that a relatively simple and low-cost programme fits well into the context of Doornkop, and the outcomes are promising. In just twelve weeks, caregivers were able to strengthen the relationships with their children and bond with each other. This leads to concrete and sustainable changes, such as a decrease in the use of physical punishments, increased active listening to the child and the formation of new friendships. All these 'little' changes can support families in managing the challenges they are facing.

However, it is recommended to further develop the Sihleng'Imizi programme to increase its impact. Efforts need to be made to involve fathers and extended family members. Next to that, caregivers should be supported to organize follow-up meetings. When this is done, and optimally, in combination with structural improvements in the community, implementing the Sihleng'Imizi programme on a larger scale is expected to improve the functioning and well-being of families in South Africa.

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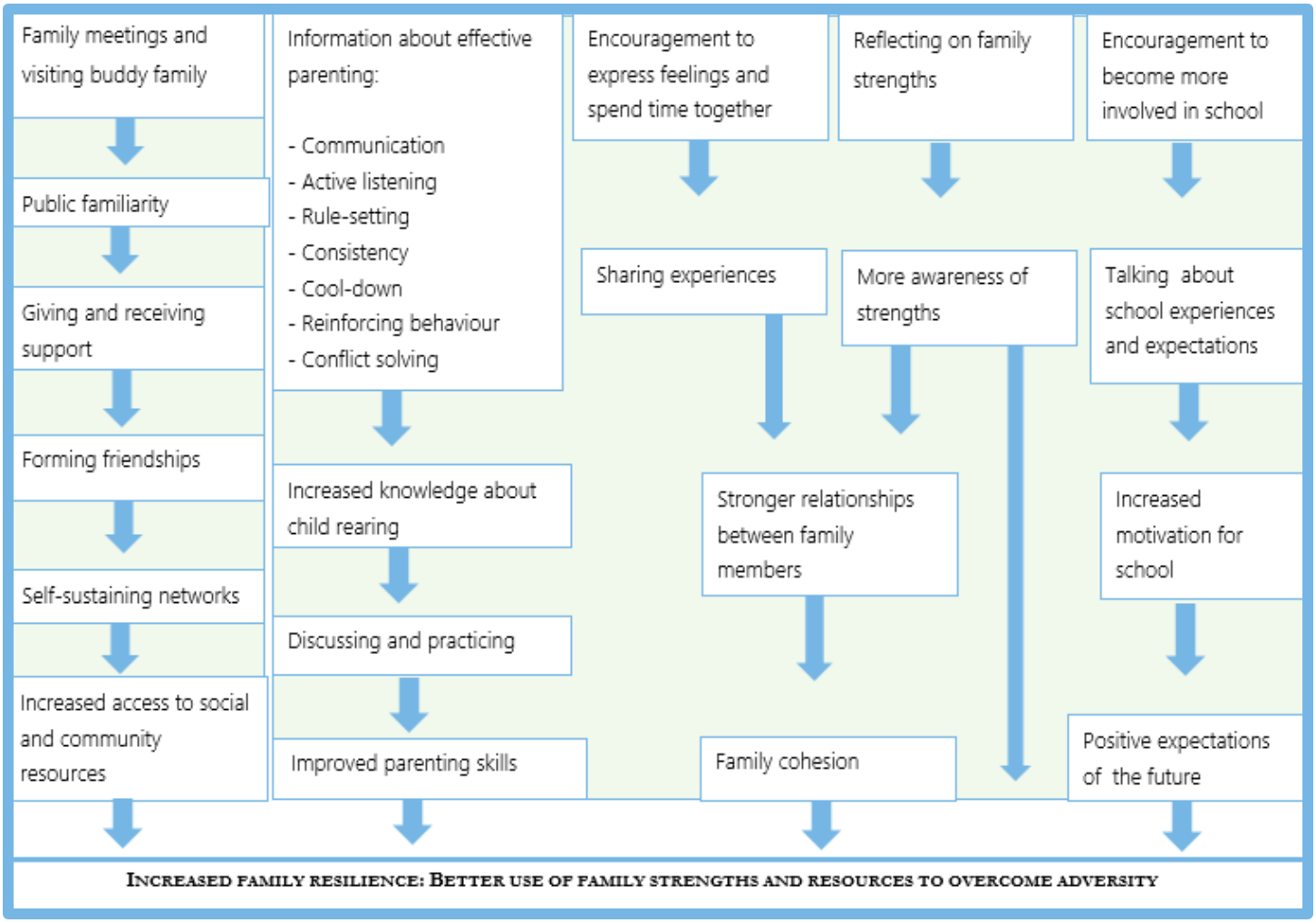
Appendix 1: Influence of the Sihleng'Imizi programme on family resilience



Appendix 2: Operationalisations

DIMENSION	CONCEPTS	OPERATIONALISATION
Parenting skills	Rule-setting	Clear rules about what family members can and cannot do and their consequences
	Consistency	Rules and consequences are the same in every situation
	Cool down	Taking a time-out when you feeling angry
	Communication	Giving clear and consistent messages, and explaining actions
Family cohesion and warmth	Family cohesion	Forming a unit - Putting energy in satisfying the needs of all family members
	Mutual support	Displaying affection and emotional support
	Expressing feelings	Showing feelings and talking about feelings - Sharing concerns and problems - Daring to express different opinions
	Spending time together	Making time for 'fun' activities with child
	Strength of relationships	Perception of intensity of relationships– Feeling close
Beliefs and values	Family strengths	Aware of family capacities to handle/ solve problems
	Expectations for future	Having goals and aims – Thoughts about future

	Involvement of caregiver in school	Showing care and concern about child's education – Talking about experiences at school, hopes and expectations for school achievement
Use of social and community resources	Contact outside the programme	Frequency of meeting each other - Type of activities - Contact with the buddy family - Formation of friendships
	Emotional support	Verbally or non-verbally expressing what you feel or what bothers you to friends or community members, receiving empathy, love, trust and encouragement of other people
	Practical support	Receiving physical help of other people - Receiving gifts. Receiving helpful information of other people
	Awareness of resources and services in community	Knowing to which organisations you can go for social, psychological and financial help
	Self-sustaining social networks	Meeting families who participated regularly

Appendix 3: Interview tools

Interview questions for the programme facilitator

Section A: General

1. How long have you worked as a social worker?
2. Have you facilitated other family programmes?

   What do you see as the biggest difference between those programmes and Sihleng'Imizi?
3. Are you still in contact with the families who participated in Sihleng'Imizi?

   In what way and how frequent?

Section B: Programme outcomes

4. What are the strengths and weaknesses of this programme?
5. Which activities in this programme do you think helped families the most? And which least?

   Why?

   What would you say, was it the new information or the process of discussing it?

   If the information, how new do you think this information was for the people?
6. Do you think Sihleng'Imizi was beneficial for every family?

   If the intervention was more or less effective for certain families - Why? How do these families differ from each other?

   Differences for more or less financially struggling families?

   Differences for younger and older caregivers?
7. Four families quitted after two meetings, what do you think were their reasons to quit?
8. How well does this programme fit in the context of Doornkop, and why?
9. Can you think of any unexpected outcomes?

Section C: Parenting skills

10. Have you noticed changes in the communication between family members during the meetings?

    What, and what do you think was the main cause?- Active listening?
11. Have you seen changes in the child rearing skills of caregivers during the meetings?

    What skills, and what influenced this?

Section D: Family warmth and cohesion

12. Have you experienced people becoming more open in expressing their feelings during the meetings? *Can you tell me more about this? Or - What could be obstacles?*
13. Do you have the impression that the programme made relations between family members stronger?
    What gave you this impression? Or - why not?

Section E: Beliefs and values

14. How would you describe the self-confidence of caregivers and children in the intervention?
    Has Sihleng'Imizi strengthened this and how? – If low - What else do you think is needed?
15. Could you describe which family strengths help families to deal with adverse circumstances?
    Do you think Sihleng'Imizi made families more aware of this?
16. Do you know which hopes and dreams families have for the future?
    Do you think Sihleng'Imizi changed anything in this and how?

Section F: Use of social and community resources

17. How would you describe the group bonding during the programme?
    (E.g. sharing feelings, problems, giving and receiving advice, friendships)
18. What could be done to stimulate contact after the programme?
19. What can be done for parents who keep having difficulties with sharing their problems in a group? *Have you noticed this in the group?*
20. Have you informed people about services and organizations in the community?
    Would the families use these? What would be barriers?
21. Do you expect the intervention had influence on the broader community?
    How? (E.g. interactions, trust, organizing activities, forming a unit)
22. Do parents still come to you with problems? Examples? If not, is it important to arrange this for a future intervention?

Section G: Potential of the programme

23. To what extend do you think the programme reached its goals? *Strengthen family relations, the caregivers involvement in school, increasing the social network*
24. Would you recommend this programme to policy makers?
    For what reasons (not)?

25. How well does this programme respond to the needs of families?

    What else should be included to increase family's strengths to overcome adversity?

    What do children need to grow positively in this environment?

26. How do you think caregivers can be encouraged to continue practicing what they have learned?

27. Is there anything relevant that we have not discussed yet?

Interview questions for the caregivers

Section A: Demographics

1. Who are living in your household? *Age?*
2. Who is responsible for caring in the household?

    If multiple –> what is the relationship?

Section B: Family cohesion and warmth

3. How would you describe the support between your family members?

    (E.g. feeling understood – receiving instrumental, emotional, informational help)

4. How open do you think you and your family members are in sharing and showing emotions?

    Can you give me some examples?

    Has the Sihleng'Imizi intervention influenced this?

5. What activities do you undertake with your children for fun and how often?

    Is this any different than before the intervention?

6. *If enough time:* Have relations between people in your family become stronger through Sihleng'Imizi? *How do you see this?*

Section C: Beliefs and values

7. What do you think a child in Doornkop needs to grow up well?
8. How often do you talk with your children about their experiences at school?

    What things do they tell you?

9. Are you involved in school?

    In what ways? (E.g. homework, attending meetings, contact with the teacher)

    What is your goal with doing this?

    How were you involved before Sihleng'Imizi?

10. Can you tell me about your family's strengths?

    Do you think the programme made your family stronger?- In what ways?

    Did the programme make you more aware of your family's strengths?

11. Can you tell me something about the way your family deals with problems?

    What kind of things are helping to make hard circumstances more manageable?

Section D: Parenting skills

12. Has the Sihleng'Imizi programme changed your parenting skills?

    In what ways?

    Are there things you still want to change?

13. Could you tell me something about your way of setting rules?

    And what happens when the rules are broken?

    Did Sihleng'Imizi influence your ways of making rules and consequences?

14. How do you generally solve fights between family members?

    Did anything change in this?

Section E: social and community connectedness

15. Have you stayed in touch with your buddy family?

    How does this contact look like? Activities, discussing problems, helping each other

    - And with other group members?

16. If you have a problem/challenge, would you turn to group members for help?

    For which kind of things would you ask help?

17. *If enough time:* Do you feel your relationship with other community members has changed since the programme? (*E.g. interaction, trust, feeling part of the community)*

18. Do you know to which organizations and services you can go social, psychological and financial help?

    When would you go to these organizations?

    How did you first hear about these organizations?

Section F: Participant satisfaction

19. What do you see as the most important change for your family after the programme?

    If nothing changed, what do you think is the reason?

20. Would you recommend the programme to other families?

    To what kind of families?

21. What can make the programme better?

22. What are your hopes and dreams for the future?

23. This were my questions, is there anything else I have to know?