CAREGIVERS' AND INTERVENTIONISTS' PERCEPTIONS OF A CHILD-CENTRED HOME VISITATION INTERVENTION

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Home visitation is an intervention approach for families at risk of poor child outcomes. Negative outcomes include malnutrition, the risk of unintentional injuries, and child maltreatment, to mention a few. The effectiveness, appropriateness, and feasibility of Home Visitation Programmes (HVPs) remain under-researched in middle- to low-income settings. This study constitutes one component of a formative evaluation of a child-centred home visitation intervention in a low-income South African community. The aim of the study was to explore caregivers' and interventionists' perceptions of the content and delivery of the intervention. To this end the study employed qualitative methods, which included seven focus groups with caregivers and interventionists. The data were thematically analysed upon which four themes emerged namely human agency, accessibility to the intervention, attributes of the intervention, and safety-health behaviour, and are presented according to the Process–Person–Context–Time model. This study contributes to the science and praxis on conducting evidence-based home visitation interventions in a resource-constrained setting.

Keywords: *Caregivers, child safety, community, home visitors, intervention*

1. Introduction

Home visitation programmes (HVPs) are family-based interventions in which trained professionals (interventionists or home visitors) visit caregivers in their homes and administer a standard programme that can range from one to multiple visits, over months or even years. HVPs are viewed as an important intervention approach for families at risk of poor child outcomes, especially those who may have limited access to resources. Programmes are diverse in nature and, in general, aim to provide information, referrals and parental support to promote and improve child and family safety, peace and health outcomes (see Peacock et al., 2013; Zercher & Spiker, 2004).

HVPs have increasingly been shown to yield improved outcomes in areas of family life related to childhood injury and, parenting skills, by reducing problem behaviour, and promoting healthy home environments (see Heaman et al., 2006; Koniak-Griffin et al., 2003; Michalopoulos et al., 2013). Evidence indicates that HVPs aid caregivers in fostering positive parenting actions, stimulate more responsive caregiver-child interactions (DuMont et al., 2011; Schmidt et al., 2015), and generate a more developmentally-engaged home environment for the child compared to other interventions which target children (Olds et al., 2004). Consequently, engaged parenting can act as a mitigating factor, by protecting children against the adverse effects of psycho-social, environmental and societal challenges (Duncan & Brooks-Gunn, 2000; Olds et al., 2004).

Home visitation interventions have proven to be particularly beneficial when the intervention recipients participate actively in their implementation (Katz et al., 2001; Peterson et al., 2007; Spieker et al., 2000). Active participation implies that households engage

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dynamically with the activities and knowledge provided during the visit, and collaborate with the interventionist(s) to plan, implement, and integrate activities into their everyday family life.

The efficacy of HVPs is dependent on a range of factors, including home visitors' perceptions of the programme goals, the fidelity of implementation, and the moderation of the programme's impact by family attributes (Sweet & Appelbaum, 2004). In their review of HVPs, Peacock et al. (2013) report that programme efficacy is optimal when interventionists are trained to meet the demands of the family systems in which they are intervening; regular visits are conducted over an extended period; and programmes assume a single rather than multiple intervention focus. The outcomes of HVPs may be impeded by the barriers facing participants, which include: 1) competing priorities which decrease receptivity to the programme (Ismail & Van Niekerk 2020); 2) an invasion of privacy with interventionists entering homes to conduct the intervention (Peacock et al., 2013); and 3) poor rapport between interventionists and households (Lovett et al., 2016). Failure to deliver the HVP content according to the prescribed model, as well as an inability to conduct the allocated visits for the intervention due to caregivers' commitment of time and energy, has been shown to have a negative impact on the programme outcomes (Peacock et al., 2013). Despite these challenges, the benefits of HVP outweigh the limitations thereof.

The effectiveness, appropriateness, feasibility and relevance of HVPs remain under-researched in middle- to low-income settings. Despite the growing interest in, and implementation of HVPs in resource-constrained contexts such as Africa (see Swart, Van Niekerk, Seedat, & Jordaan, 2008), much of the published literature on this type of intervention emanates from the Global North (Knerr et al., 2013; Mejia et al., 2012), thereby limiting the replication potential of programmes in settings that vary vastly in terms of their societal, community, familial and individual make-up and resources. Mikton (2012) asserts that the efficacy of programmes imported from high-income settings into marginalised, disadvantaged and under-resourced communities may be compromised by factors related to language, culture, literacy, poverty, health and access to services. Indeed, poverty and a lack of social services delivery are, by definition, pervasive in such communities.

Accordingly, we explored caregivers'[1] and interventionists' perceptions of the content and delivery of a child safety, peace and health home visitation intervention pilot in a low-income community in South Africa. The study is framed by Bronfenbrenner's Process-Person-Context-Time (PPCT) model. This model emphasises the two-way interplay between the *person*, and various interconnected systems in their environment (*context*) which, over *time* influence the activities and interactions in which they participate (*proximal processes)* (Tudge, 2016), thus allowing for a multifaceted understanding of child safety, peace and health. In the current study, the participants' perceptions of the HVP will be framed according to the *context,* which is denoted by the individual, interpersonal, community and societal levels, respectively. The study aims contributing to the identification and understanding of those factors that support receptivity to similar interventions in comparable communities.

2. Method

In the design of this study, the HVP represented a case study which was utilised to qualitatively explore and analyse caregivers' and home visitors' experiences of a child safety, peace and health promotion. A case study which can be understood as a focused analysis of a programme, intervention, or individual (Merriam, 1998) is well suited to this purpose (see

[1] An individual who takes primary responsibility for the child in the home, such as a parent, grandparent, sibling, other family member or guardian.

Creswell, 2007). Although the case study method limits the generalisation of findings to wider social settings, its merit is best observed in the richness and depth of information garnered through the detailed and contextually-located scrutiny of a particular case.

2.1 The intervention

This study (i.e., assessing the content and delivery of the intervention) constitutes one component of the formative evaluation of a larger multi-level, multi-site South African study on child safety, peace and health. The HVP component of this intervention initiative comprises four phases namely 1) a critical literature review of safety, peace and health among individuals in disadvantaged communities; 2) the design of a contextually relevant child safety, peace and health assessment tool; 3) the development and piloting of a basket of safety, peace and health interventions at the household level; and 4) the implementation of a full complement of child safety, peace and health interventions across several South African communities. The current research study, which is in phase 3, is intended to inform the final phase of the HVP component, and more broadly to supplement the existing literature on HVPs, while enhancing implementation and outcomes.

The HVP is located in a low-income community in the Western Cape province of South Africa. The community is predominantly 'coloured'[2] and Afrikaans-speaking[3]. Approximately 8000 people, of whom 2700 are children, reside in this community. With limited infrastructure, 16 per cent of the residents reside in informal homes, and nearly 30 per cent of the adult population is unemployed. The community records a high incidence of violence and injuries (Baillie, 2013).

The HVP intervention was piloted across 72 households. In total 11 home visits per household were conducted over a three-month period. The home visits, which occurred on a weekly basis were undertaken by interventionists (i.e., trained community members who assist researchers during the programme, in addition to administering the home visits; see figure 1). While the caregivers were considered to be the recipients and primary agents of change of the HVP, the children concerned, from zero to seven years of age were the primary target of the intervention. The home visitations, which were theme-based, focused on child development, traffic injuries, and the prevention of child maltreatment and promotion of family well-being, good nutrition and immunisation practices (see figure 2).

Nine community members were recruited as interventionists, and each was assigned to eight different households. The training of the interventionists occurred concurrently with the implementation of the home visits, such that training on each theme was delivered at the beginning of a week, and home visits were undertaken immediately thereafter. The training of the interventionists utilised interactive modalities (e.g., role-plays, group exercises and reflections on activities), and included a focus on their roles, the logic and aim of the intervention, information-sharing protocols, ethics, and topics related to child safety, peace and health.

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[2] The term 'coloured' constitutes one of the legally recognised population groupings used under the apartheid system to refer to people of mixed heritage and is currently still socially recognised and used in South Africa.
[3] Afrikaans, a Germanic language spoken in South Africa, is classified as one of the country's 11 official languages.

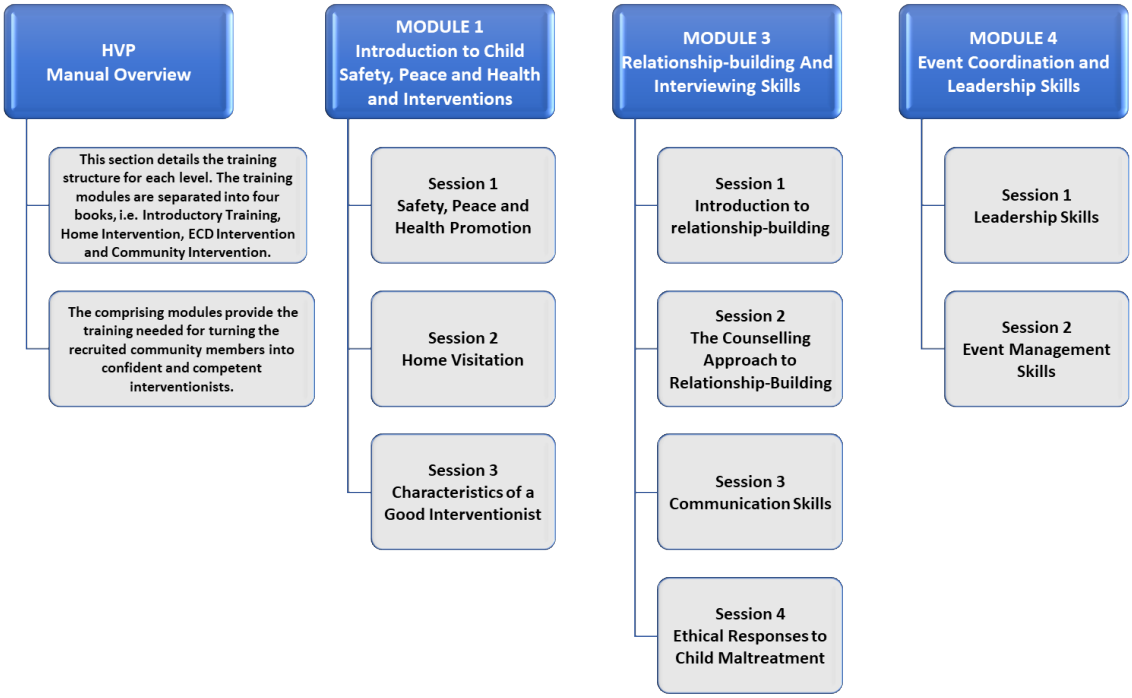

Figure 1. Interventionist Training Component

Week	Task/Visit	Visit Description	Home Level Training Objectives
One	Introduction	Introducing the HVP programme and process to the caregivers	• Have knowledge of the home intervention.
Two	Visit one	Solidarity Economy	• What solidarity economy is. • How solidarity economy can be used towards family development.
Three	Visit two	Solidarity Economy	• How solidarity economy promotes peace and safety. • The concepts of Co-ops, Stokvels, food gardens and recycling.
Four	Visit three	Solidarity Economy	• Creation of co-ops, stokvels, food gardens and recycling programmes.
Five	Visit four	Child Development and Safety	• Have knowledge of the relationship between child development and injury. • Have knowledge of the specific risks facing children at different ages. • Know how different caregiving skills can help to prevent injuries.
Six	Visit five	Child Development and Safety	• Have knowledge of the role of caregivers in the health and development of a child. • Know how parents/caregivers can actively bond with children. • Have knowledge of the home intervention.

Seven	Visit six	Traffic Injury Prevention	• Be knowledgeable on the key aspects on childhood pedestrian injuries, especially in relation to:
			  • Child pedestrians being at particular risk to road traffic injuries.
			  • Child pedestrian-related injuries being preventable.
			  • The main risk factors for child pedestrian-related injuries relating to inadequate caregiver supervision, inadequate child visibility, and unsafe road crossing behaviours.

Eight	Visit seven	Traffic Injury Prevention	• Be knowledgeable on the key aspects on childhood pedestrian injuries, especially in relation to: • Opportunities for reducing childhood pedestrian injuries. • Caregiver supervision, child visibility, and road crossing behaviours.
Nine	Visit eight	Child Maltreatment Prevention	• Know what effective discipline is • Know the difference between discipline and punishment • Know how to implement effective discipline strategies
Ten	Visit nine	Child Maltreatment Prevention	• Know what the alternative methods are to corporal/physical punishment • Understand the use of effective communication to solve problems
Eleven	Visit ten	Nutrition and Immunisation	• Have knowledge about the importance of good nutrition.

Figure 2. Caregiver Home Visit Programme

2.2 Study participants

The participants included 25 caregivers and nine interventionists. All the participants were female, aged between 20 and 55 years. They were predominantly Afrikaans speaking, either unemployed or precariously employed, and were long-standing residents of the community. Purposive sampling was employed to select participants for the focus group discussions. Participants were only eligible to partake in the study if they fulfilled the inclusion criteria, namely: a trainer or recipient of the HVP. Thus, this sampling method was utilised because these participants were deemed to be information-rich illustrations as a result of their exposure to the programme either as trainers or as recipients.

2.3 Procedure

Data were collected through a total of eight caregiver focus group discussions (FGDs), and one interventionist FGD which were guided by a semi-structured interview schedule. That included questions aimed at exploring the participants' perceptions of the home visit, the interventionist-caregiver interaction, and the training and intervention materials and resources provided. Caregivers were recruited by the interventionists, since they had direct contact with them through the home visits. The researchers then provided a more detailed description of the research aims and procedures, and of the ethical issues pertaining to participation in the study, including an assurance of anonymity, the right to withdraw from the study, and the provision of support services. Once informed consent had been obtained from participating caregivers, they were assigned to one of eight FGDs that served as the data source for caregiver responses.

Informed consent was also obtained from the nine interventionists prior to their participation in an independent FGD, to which they were all assigned. The FGDs for the caregivers occurred bi-weekly over a four-week period, and were held at a community church hall. The duration of the FGDs was contingent on the interactions and discussions, participants' readiness to engage in the discussion subject matter, and the number of participants in the group. On average, the FGDs lasted approximately 60 minutes. These were conducted by two external facilitators, and (with permission) were audio-recorded and then transcribed verbatim. Even though the caregivers and interventionists were predominantly Afrikaans speaking and were in separate FGDs, they preferred the sessions to be conducted in English for reasons of practicability and because they were bilingual, with English as their second language. Furthermore, many training opportunities and activities occurring in their community are often provided in English, and thus participants were accustomed to receiving information in this medium. Ethical clearance for the study was granted by the College of Human Sciences, at the University of South Africa.

2.4 Analysis

Thematic analysis was utilised to analyse the data. The analytic process, informed by the approach outlined by Braun and Clarke (2006) encompassed 1) reading and revisiting transcriptions; 2) reading and revising the researchers' noted observations; 3) cross-referencing FGD transcripts with the noted observations; 4) extrapolating and undertaking a preliminary indexing of emerging themes from the data; 5) clustering these themes according to patterns across all the data; and 6) refining and labelling themes. Three researchers analysed the transcripts independently. Their analyses were subsequently subjected to a two-phased verification process in which 1) the analyses undertaken by each researcher were compared for consistency and conformity, and 2) an external review panel further ensured that there was consistency in the identified thematic categories, and verification of the analyses. The feedback from these processes identified overlaps in thematic categories and allowed for the clarification

and refinement of common themes. The feedback served as a means of assessing the usefulness, fit, and resonance of the interpretations and categorisations developed, and was integrated accordingly to improve the rigour of the findings. The verification process further supported the data trustworthiness of the study.

3. Findings and discussion

Four thematic categories emerged from the analyses, and are presented according to the PPCT model which focuses on the developmental process, the person, the context of nested systems, and various types of time. The resulting thematic findings which describe the caregivers' and interventionists' perceptions of the home visitation intervention pertained to 1) process - accessibility to the intervention, 2) person - human agency, 3) context - attributes of the intervention, and 4) time - safety-health behaviour. The process, person and context themes also comprised several sub-themes, all of which were aligned to the four systems delineated within the PPCT model (see figure 3).

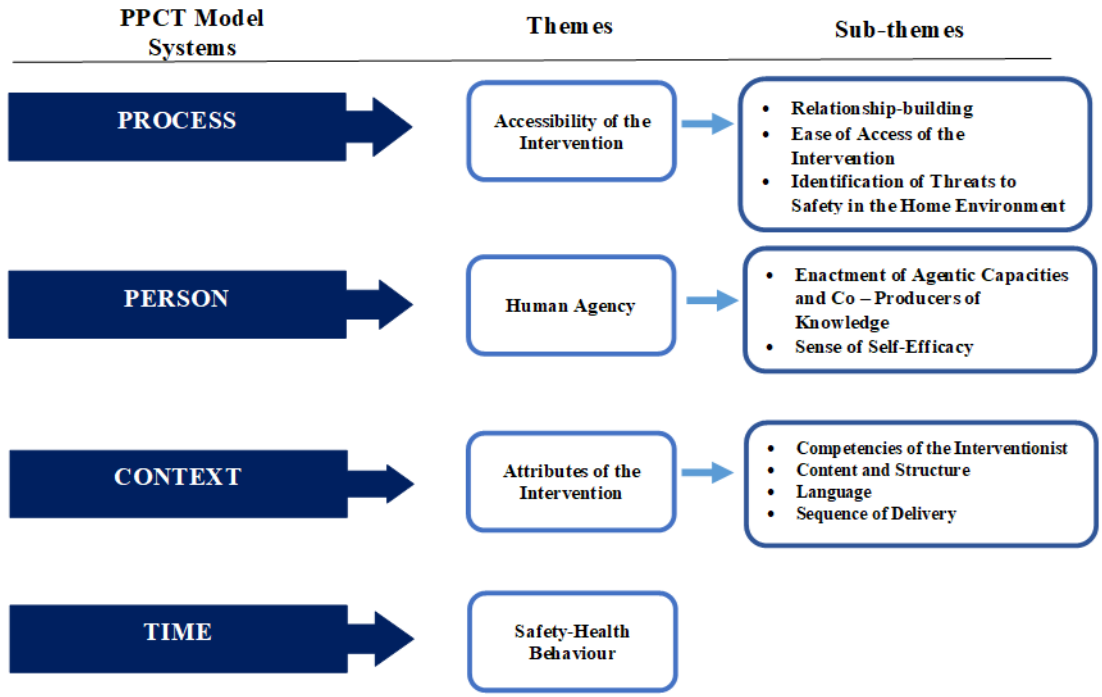

Figure 3. Data Structure of the Focus Group Discussions

3.1 Process - accessibility of the intervention

The HVP occurred in a progressive and complex reciprocal interaction between interventionists, caregivers, the community, objects and symbols in the person's immediate environment (Hapunda et al., 2017). Modes of interaction between the person and their environment are referred to as proximal processes. These processes "function over time and are posited as the primary mechanisms producing human development" (Bronfenbrenner & Morris, 1998, p. 994). Accessibility emerged as a process-related theme which encompassed relationship-building, ease of access to the intervention, and the identification of threats to

safety in the home environment. Process-related factors can potentially impede and/or promote behaviour change (Bronfenbrenner & Morris, 2006).

3.1.1 Relationship-building

Caregivers viewed the fostering of relationships between caregiver and interventionist as an important characteristic of their entry into and retention in, the intervention programme. Even though the process of developing relationships differs from one individual to the next, the caregivers all indicated that a reciprocal relationship of care, understanding and respect, fostered a facilitative learning environment. Familiarity and feeling comfortable with the interventionists enhanced the caregiver-interventionist relationship: "*... the fact that I know her and I see her every day, made me feel comfortable with her"* (Caregiver FGD 3). "*I also think if you know the person and that person knows you, it is easier to talk ... You can open up [more] easi[ly] ..., You know you can trust them*" (Caregiver FGD 8).

These positive feelings allowed caregivers to actively engage with the interventionists and the content, and created an atmosphere of informality, authenticity and ease: "*I really wanted to tell her* [the interventionist] *she is welcome ... We worked well together, we laughed, we discussed, and yes, I enjoyed it"* (Caregiver FGD 1). The caregivers indicated that they also felt comfortable with the interventionists, thereby providing an opportunity for the latter to access the former's homes: "*I felt at ease because I knew her ... because it's home visits I prefer that it was someone I knew"* (Caregiver FGD 5). These sentiments were echoed by the interventionists who experienced caregiver receptivity as follows:

> *... I didn't say anything to my caregiver, but they even gave me a glass of drinks ... Or they will tell me 'Let me make you a cup of coffee.' And if I tell her that if you are busy then I can always come later and then she says no, no, no. Come and sit ...* (Interventionist FGD).

Throughout the implementation of the programme, closer relationships seemed to be forged between home visitors and caregivers, despite initial trepidation being expressed in some instances: "*Obviously we [were] going to feel anxious, but it was nothing serious"* (Caregiver FGD 4). The relationship established through HVPs introduced a human and social element, which contrasted with passively receiving information via the newspaper, television or other media.

A positive relationship between caregivers and interventionists has been reported to enhance the outcomes of HVP (Klass, 2003; Lovett et al., 2016). The PPCT model resonates with the finding that the interventionist-caregiver relationship is an important consideration in supporting and strengthening caregivers' competencies, and thereby stimulating change in the home environment, and possibly also in other proximal environments (see Fowler et al., 2012; Kirkpatrick et al., 2007; Klass, 2003; Olds et al., 2007). As a caveat, however, intervention effectiveness could be compromised if the caregiver-interventionist relationship is prioritised over the fidelity of the intervention (i.e., adherence to the study protocol, and following the planned implemention of the intervention) (see Hebbeler & Gerlach-Downie, 2002; Roggman et al., 2001). For that reason, to improve the likelihood of achieving the desired outcomes, the fidelity of the intervention is critical.

Research indicates that the enrolment and engagement of caregivers is a major challenge in HVP (Heaman et al., 2006; Riley et al., 2008; Tandon et al., 2008), and that gaining access to caregivers' homes can be challenging (Jack et al., 2002). A negative relationship between caregiver and interventionist typically results in caregivers refusing to participate in the programme, or disengaging entirely (Barnes et al., 2006). This was, however, not the case in

our study, which found caregivers to be willing and excited to participate in the programme, with caregivers establishing a positive relationship with interventionists.

Research evidence suggests that the caregiver-interventionist relationship predicts the intensity of caregivers' engagement with the programme (Allen, 2007; Brooks-Gunn et al., 2000; McCurdy & Jones, 2000). All caregivers and interventionists remained committed to and engaged in the programme throughout the seven-week rollout, with no attrition reported. Caregivers valued the opinion of the interventionists, and the quality of their relationship appeared to positively influence their enrolment and sustained participation in the seven-week programme. Attrition and the low frequency rate of visits have been identified as critical components of programme implementation which, in turn, impacts the efficacy of an intervention (Gomby, 2007).

3.1.2 Ease of access of the intervention

The caregivers felt that the accessibility of the intervention would encourage future participation, given that "*this programme can be done in our community*" (Caregiver FGD 6). The caregivers further indicated that the HVP "*was something different to the usual because normally nothing like this happens in* [their] *community,* [namely] *people coming out to your homes to conduct research*" (Caregiver FGD 5). This was corroborated by the interventionists who reflected that by "*bringing the study to them* [caregivers]" (Interventionist FGD) some of the barriers to accessing the intervention could be overcome. A sense of meaning making was created by the interventionists and caregivers as a product of all their experiences with and during the HVP. Personal characteristics influence how specific or varying contextual experiences may be positively or negatively received by an individual. Thus, there is always an interplay and an interdependence between the personal characteristics of the interventionist and those of the caregiver, as well as the specific environment in which the intervention is administered (Bronfenbrenner & Morris, 2006).

In disadvantaged communities, adverse conditions with limited resources may restrict community members from engaging in local interventions (Ismail & Van Niekerk, 2020). In light of competing priorities, such as employment opportunities, the need to earn an income and having to meet their family's needs (Islam, 2005) caregivers may elect not to participate in interventions. Interventions that require participants to incur travel costs, impose an additional financial burden on them. HVPs are usually cost-efficient for caregivers, and practical in terms of childcare arrangements, since they only minimally disrupt the daily routine and activities of caregivers. The HVP's positive stimulus in this study was seen to disrupt feelings of hopelessness which are commonly encountered and experienced in disadvantaged communities (Garnham, 2015; McDaid, 2017). This is consistent with the findings of Sweet and Appelbaum (2004), who reported the relative advantage of home visits in eradicating the need for transportation, childcare, or time off work.

3.1.3 Identification of threats to safety in the home environment

An additional benefit of implementing the intervention in the home was the ability to identify potential risks to safety in the home. The presence of the interventionist in the home evoked a different perspective on the safety of the home environment. Interventionists provided caregivers with information that raised their own awareness and stimulated their own thinking with one of the interventionists admitting that she "*wasn't aware [and] must be careful of*" such risks in the home (Interventionist FGD). The caregivers conceded that, in their homes they "*cannot always see the* [dangers] *but someone from outside can, and give advice and then it is good advice*" (Caregiver FGD 8). Interventionists could then advise caregivers on "*what*

[they] *could have put away, to make it safe for* [their children]*"* (Caregiver FGD 8). It is envisaged that these home visits will provide a crucial service, and in-house support to parents or caregivers who may as a result enhance the safety, health and peace of their families (Howard & Brooks-Gunn, 2009). The home is the hub in which an individual develops. Thus, proximal processes that are experienced and occur on a regular basis (such as the identification of threats to safety in the home, to peace, and to health thanks to exposure and access to the resources of the HVP, and the interventionist), are mechanisms that promote human development (Bronfenbrenner & Morris, 2006). Participation in these proximal processes over the duration of the HVP and beyond, develops caregivers' confidence, competence, knowledge and skills, allowing them to engage in such activities with the interventionists, their children and their families (Bronfenbrenner & Morris, 2006).

3.2 Person - human agency

Human agency was an identifiable characteristic of both the caregivers and interventionists, whereby each individuals' unique characteristics have an impact on their interaction with the environment, and simultaneously on proximal processes over time (Tudge, 2016). This theme was exemplified by an enactment of agentic capacities and a sense of self-efficacy.

3.2.1 Enactment of agentic capacities and co-producers of knowledge

The HVP appeared to have facilitated both caregiver and interventionist agency by recognising their respective capacities for action and, in so doing, resisting the dominant narrative that constructs individuals from disadvantaged settings as victims of their circumstances.

The HVP granted caregivers and interventionists the agentic disposition to be reflexive in respect of their representations of child safety, peace and health in their community, through dialogue about, and discussions on the various modules in the programme. The caregivers engaged with the interventionists about the desire to be good carers and providers for their children: "*It is important to know more in this day and age because … my children always come first*" (Caregiver FGD 2).

The interventionists offered support to caregivers beyond the sessions in the home, and these interactions became additional opportunities for co-learning and the co-construction of knowledge: "*Even after the session we continued our discussions… Such things are very important… that's why I did not worry about time*" (Caregiver FGD 2).

The caregivers viewed the HVP as "*relevant for my community"* (Caregiver FGD 2), and as these learnings were internalised and applied in the home, so too was the realisation that, "*actually parents can implement it* [the HVP]" themselves*. The* caregivers became aware of the importance of this kind of programme, its benefits and the need to expand the programme beyond their homes, "*to include the other mommies in the community"* (Caregiver FGD 2).

The co-construction of knowledge, by caregivers as well as interventionists, evoked a sense of agency, which produced in the former a willingness and enthusiasm to engage with the content as well as the lessons learnt:

> *… for my people in my home I tell them that it doesn't matter that I go out and deliver the message but then I am unable to do it in my own house. Like now, I don't buy white bread, I just buy brown bread. And my white sugar I now too will change to brown sugar … We must be[gin] to live healthy [lives]... and nobody eats vegetables in the house, but we [are] going to start eating vegetables.* (Interventionist FGD)

... as I have learnt here now: you have to stop and listen and connect and you look at your child to discover what the problem is. And many a times you tell your child. 'Speak, I am listening', while I am busy because this needs to be done, as I still need to do this and that. And it was actually that section that was […] actually an eye opener for me. (Interventionist FGD)

Home visitors and caregivers alike reported that they became more actively engaged in safety- and health-promoting behaviours. This they attributed to their knowledge on issues such as the nutritional intake of their families; how they interacted with their children; and traffic safety and awareness guidelines which they acquired during the home visits. The interactive HVP sessions generated enthusiasm, and expanded ability, motivation, knowledge, and skill, amongst both caregivers and interventionists, in respect of engaging in safety- and health - promoting behaviours as individuals, with their families, communities and society (Bronfenbrenner & Morris, 2006).

For Hawley and Little (2002), the agentic capacity of humans consist of a multi-faceted, striated system of needs, motives, goals, beliefs, and behaviours. Riger (2001), describes humans as agentic, since, because of their very nature, they are adept at negotiating and shaping, as well as being influenced by the environment. Both the caregivers and interventionists displayed agentic engagement through their proactive stance, their intentionality and their constructive contribution to the intervention activities, thus enriching their learning.

3.2.2 Sense of self-efficacy

Closely linked to caregivers' agency, was their sense of self-efficacy. The caregivers felt confident in their ability to utilise and share the information they had gained from the home visitation content and activities, *"because I just took my friend one day and then told her, just listen here, what* [the interventionist] *had to say"* (Caregiver FGD 1). They recognised the relevance and appropriateness of the HVP and its materials for their own lives and their community and appeared to have assumed ownership of the knowledge they gained. The caregivers felt *"more in control of* [their] *children now ....* [and] *more empowered to inform others"* (Caregiver FGD 2).

As was the case with the caregivers, the interventionists also described having had informal meetings with the caregivers, or friends and neighbours who were not part of the study, to discuss what they had learnt and how it could benefit them in rearing their children, "*but maybe it is like this in this world that the closer you become with your neighbours in order to help them, to give them information, and to change their household*" (Interventionist FGD).

This renewed enthusiasm coupled with a heightened sense of self-efficacy provided caregivers and interventionists with a valuable opportunity to take charge of and manage their volatile circumstances (Hapunda et al., 2017). Self-efficacy is a focal mechanism in human agency that influences individuals' hopes, desires and strength of commitment (Bandura, 2008). The sense of self-efficacy which the caregivers experienced through the home visitation process, may be an indication of the positive outcomes or efficacy of the intervention. The caregivers reported having learnt best from this method of intervention, and said they would participate in another HVP if the opportunity arose. They also believed that this intervention delivery modality was key to their receptivity, for fostering a sense of self-efficacy in them.

It is interesting to read and you can go through the notes at your […] leisure. I learnt a lot through the programme. Especially the road signs. (Caregiver FGD 3)

I … feel more … how can I say … [from what I have learnt] *I can speak to others about these issues.* (Caregiver FGD 2).

From that day on, I am very cautious [about] how I am with my children, how I talk to them. I think that [the] abuse lesson actually stood out for me. That really made me realise I was on the wrong way now. (Caregiver FGD 1).

The caregivers' actions reflected their confidence, and confirmed their conviction that they had the necessary skills to improve the conditions of their children's lives, as well as their own parenting skills. They were prepared to modify their current parenting styles to incorporate learnings from the programme. This finding conforms to a key assumption of the home visitation intervention, that caregivers mediate changes for their children (Sweet & Appelbaum, 2004). The combination of a sense of self-efficacy and improved parenting skills was also evident in the caregivers' belief that they "*feel more in control of* [their] *children now, feel more knowledgeable to inform others"* (Caregiver FGD 2). Bandura (2008 p. 170) notes that "without a resilient sense of efficacy, people are easily overwhelmed by adversities in their efforts to improve their lives and th[ose] of others". Self-efficacy is regarded as an agency-related construct, and a predictor of behaviour and outcomes (see Feldman, 2016).

Gomby (2007) suggests that interventions need to reflect contextual relevance, if they are to have efficacious outcomes. The caregivers were emboldened by the intervention, and through informal community conversations, disseminated the information and skills they had acquired. The HVP was therefore understood to also be beneficial for the community at large, including caregivers who had not been exposed to the intervention.

The manifestation of personal characteristics (e.g., agentic capacities and self-efficacy) functioning in concert, had a collective and cumulative mediating impact that leads to positive adaptive outcomes in caregivers and interventionists alike, in promoting safety, peace and health in their homes and community (see Bronfenbrenner & Morris, 2006). Since proximal processes are relationships of reciprocal interaction that occur consistently over time (Bronfenbrenner & Morris, 2006), they arguably enabled the enactment of agentic capacities and a sense of self efficacy, encouraged by the HVP.

3.3 Context - attributes of the intervention

The context is a critical component of a transforming and dynamic bio-ecological model, and refers to various systems to which an individual is connected, and with which s/he engages. The context can also be considered fundamental in the conceptualisation and development of child-centred interventions (Hapunda et al., 2017). A key aspect of the PPCT model is the recognition of the symbiotic influence and connection between the person and the environment (see Tudge, 2016). Environmental characteristics may either foster or interfere with the development of proximal processes at the contextual level (Bronfenbrenner & Morris, 2006). This theme speaks to those attributes of the intervention that were found to encapsulate environmental characteristics which are evident in the competencies of the interventionist, content and structure, language, and logic of the delivery programme.

3.3.1 Competencies of the interventionist

The preparatory training phase with interventionists was experienced as informative and sufficient in terms of preparing for home visits. The varying approaches which the trainers used were, however, said to affect the interventionists' uptake of information among. Some trainers

supplemented their training with visual aids and prepared PowerPoint presentations, while others merely spoke to the interventionists. As one interventionist remarked:

> *…if you can communicate the information by means of visuals like PowerPoint like the other lessons did then it creates a better learning environment. And when I am by the caregiver then I can visualise what I saw and [it] helps me to communicate the message better. [When] people did the training with the PowerPoint, [it] helped a lot in our understanding…* (Interventionist FGD)

> *The trainers ensure that we understand before they drive off. They will never leave us or say that they will explain to us tomorrow again. They usually make sure that we understand everything …before they leave.* (Interventionist FGD)

One training modality uses role play to demonstrate how home visits should be conducted, and that was regarded as an important preparation for visits, as this statement confirms:

> *… with the role play,* [we] *were more confident. It prepares you in a way that when you reach the caregiver, then you know what to say and you remember everything. And it makes you aware of what to say.* (Interventionist FGD)

These proximal processes whereby interventionists are gradually exposed within their training environment to more intricate activities and preparation, allow them to progress as agents of this progress. The aforementioned training modalities and preparation were thus deemed the primary mechanisms of development (Bronfenbrenner & Morris, 2006). The effectiveness of an intervention programme is subject to what occurs when the interventionists are in the caregivers' homes (Gomby, 2007). An intervention is more likely to be effective when its content and activities are emphasised by interventionists during their interactions with the caregivers (Gomby, 2007). In other words, the intervention delivery by the interventionist, and reception by the caregiver, are linked to the quality of preparative training which the interventionist receives (Wessels et al., 2016). "Direct, systematic, concrete [training] with everything made explicit and reinforced through regular meetings", is deemed important when charging paraprofessionals with delivering interventions (Musick & Stott, 2000, p. 449). Similarly, Hiatt et al. (1997) advocate for training activities with lay persons to adopt a unique approach, and for on-going supervision to be provided. The supervision of interventionists is deemed essential for guaranteeing the efficacy and fidelity of a programme (Wessels et al., 2016).

3.3.2 Content and structure

While the caregivers expressed an interest in, and enthusiasm for, engaging with the content and activities, they raised concerns regarding the intensity of the information, the presentation style used to impart the information, as well as the length of the visits: *"The time should not be made so long … [keep it] short and sweet … [Only give] the important facts and so, but everything is very nice…The material had to be more visually stimulating, more graphics, more illustrations"* (Caregiver FGD1). The caregivers suggested that if sessions were kept short and succinct, they could still have the desired impact. Both the caregivers and interventionists believed that more illustrations in the modules would be useful. This may include additional materials which children could engage with, beyond the implementation of the intervention timeframe, as proposed here:

What I can say, what could perhaps be added, besides the material perhaps such visual material […] as magnets or a sticker or something that you can leave the person with……so that when we send the kids to the school, […] they can put it on their school bags […]. I'm just thinking now of things like that, of something or stories like that [which] can keep the message alive, so that the children can always be aware… Just so that it can promote and keep the message alive, so that people do not forget about it (Interventionists FGD)

By contrast, some caregivers felt that the information provided was necessary and appropriate, and that the hand-outs allowed them to revise the content if required: "*The information was not too much but […], how can I put it, it was intensive"* (Caregiver FGD 2); "*It is interesting to read, and you can go through the notes at your […] leisure"* (Caregiver FGD 6).

Even though the caregivers expressed mixed views on the content and information of the programme, the interventionists' believed that adequate information was conveyed to create awareness among the caregivers on each topic, as this statement confirms:

I think the information was enough. […] very important questions [were] raised, as well as important information w[as] carried across that was needed…Also, the questions created consciousness among the caregivers as to whether the children are eating enough. (Interventionist FGD)

It was nice and compact. The message was there, and it was realistic. (Interventionist FGD)

The interventionists also highlighted that the content of the intervention was contextually relevant and appropriate, and addressed the needs of the community. The information educated caregivers on nutrition, immunisation, and the potential for food gardens to meet nutritional needs. Information on nutrition was said to supplement the information obtained at clinics:

I don't think that the clinic explains to the people, because many of the caregivers were surprised because they did not receive that information before, and they received this information the first time [from] us. But even for myself and I think that the others will agree with me, that I did not receive that type of information at the clinic. (Interventionists FGD)

…previously the people only gave their children what there was to eat and now they received a very good idea of what nutrition is beneficial and the food pyramid gives a good indication of what the worth/value/importance of food is… They are now making an effort to go and purchase that food which has that nutritional value in order to help the children to grow. (Interventionist FGD)

These views on contextual relevance were also endorsed by the caregivers, who suggested that the HVP be implemented with other households, rather than being limited to only a few. They believed that the expansion of the programme would benefit and empower other community members: "*They must have more such programmes in our community then people might stand up"* (Caregiver FGD 7) *"We have to expand the programme to include the other mommies in our community"* (Caregiver 5).

The interventionists believed that the programme augmented present levels of awareness of child health and maltreatment in the community and amongst community members. One of the

three elements of the 'process' component of Bronfenbrenner's PPCT model, is the interaction that caregivers have with their children, service providers, family and friends. While larger contextual factors shape children's and parents' lives, the environment is similarly influenced by the behaviour and skills of the caregivers. It is at this juncture that HVP intervene to equip and capacitate them with skills (Olds et al., 1997). Understanding child maltreatment is therefore believed to modify parental/ caregiver behaviour, so that they can detect or, prevent it, and respond appropriately.

The caregivers also provided feedback on how to improve their understanding of the information imparted to them during home visits:

> *…to make people understand maybe we should also receive a role play because… [we] as parents working together, also may [use] a role-play, just to see if the people really understand because many people just say they 'understand but then they don't understand at all, you understand?* (Caregiver FGD 7)

When developing an intervention, consideration needs to be given to the community's capacity and resources, and to tailor the intervention accordingly, such that members are likely to be more receptive to the programme (Center for Substance Abuse Prevention, 2009).

3.3.3 Language

Even though the caregivers and interventionists preferred the sessions to be conducted in English, the latter expressed mixed views concerning the intervention being primarily delivered in English, since the community was predominantly Afrikaans speaking. The quality of the Afrikaans translated material was disconcerting, as noted by the interventionists:

> "*I am guessing that that could perhaps be English speaking people that had set up the questions for us and maybe they do not know the Afrikaans so for them it is that word but maybe not for you" (Interventionist FGD)*

> "*…some of the things are set up quite strangely…Perhaps they need to pass it on to a translator… but just remember that at the end we leave the hand-outs with the caregivers..." (Interventionist FGD).*

Other interventionists, however, found that caregivers favoured the use of English, and that they sought help from others within the household, to clarify the meaning of terms:

> *...they don't mind that the material is in English. […]this one old lady I go to, she tells me that she gave it to her sons and then the next week she tells me that her eldest son […] explained to her what she does not understand… Many of them understand it better, like my one caregiver tells me that she understands it better in English than […] she would […] in Afrikaans.* (Interventionist FGD)

It was also suggested that the language used in the training of interventionists be simplified:

> *…the language and some of the words were not clear … it confused us. And the trainer asked us to read it, there was no PowerPoint and it is not comprehensible. The information is not easy to understand, the way the trainer conveyed it, it stressed me out. And I communicated to the trainer that I did not think that the caregiver would understand what was being said, because I myself did not know what I should say to the*

caregiver. And only after the [child development] *milestones were delivered in training, […] then things started to make a bit more sense ... But at the beginning it was just very stressful, and I became panicked.* (Interventionist FGD)

Language barriers were also overcome through additional preparation on the part of the interventionists, to anticipate problematic terms, and their explanations. This was evident from the mode of delivery which the interventionists employed during their home visits, as well as their willingness to explain the material in simple and accessible terms to caregivers.

if there is a big word and if we did not understand it and then you would usually write down in the hand-out what the Afrikaans word is. And now when we explain to them in Afrikaans and then it is very easy for them when you leave the hand-out with them and they already heard what we said… (Interventionist FGD)

… the hand-outs must be in Afrikaans the next time please, so that the caregivers can understand it the next time. Cause we leave the hand-outs for them to read so most of the time they won't understand some of the things that are being said.
(Interventionist FGD)

She talked and explained, [saying] 'Ask if you did not understand anything, if there's something more to explain'. And when I did not understand then I would say, 'Now explain that more on that section'. (Caregiver FGD1)

Language and the use of people who are familiar to the research participants, aspects which are antecedents of culturally-sensitive research, can affect receptivity to an intervention (Resnicow et al., 1999). In this study, this suggests that the use of English may have hampered caregivers' acceptance of intervention messages but, it can also be argued that the use of interventionists from the community may have augmented their receptivity.

3.3.4 Sequence of delivery

The interventionists expressed their opinions with regard to their personal experiences of the sequencing of the intervention modules in which they were trained, in relation to child safety in the home. They reported that the sequencing of the intervention delivery was not logical. Admittedly, the coherent sequence in which modules are delivered to caregivers during home visits may affect the overall effectiveness of the programme. An interventionist suggested that it would be more practical to cluster together certain modules:

...if you look at the section o[n] nutrition, you can blend it with the child development [section] ... the nutrition and immunisation did not have many hand-outs, and it was manageable. So […] they could have brought some of the information from the child development, and placed it over here. The section on the bonding and the milestones itself almost speaks to the clinic card, so you can place it together with the clinic card. And even the rights can go with […] the child maltreatment and even the abuse. The themes speak to each other more appropriate[ly]. Because when I spoke to the caregivers, I had to refer them back to the child development module and then they remembered some of the information. And so, if felt weird that we did these two modules apart, because the milestones and the clinic card actually speak to each other.
(Interventionist FGD)

Notably, the sequence in which intervention modules are delivered to participants may affect the effectiveness of the intervention in its entirety (Stephenson, et al., 2013). However, even though the interventionists critiqued certain aspects of the intervention, they felt comfortable with the caregivers, the material and the resources, which they found to be relevant, appropriate and applicable to their community. According to Gomby (2007), this is indicative of the effectiveness of an intervention.

3.4 Time - safety-health behaviour

The concept time is the last element of the PPCT model, and it provides a longitudinal understanding of the various changes in the safety and health behaviours of caregivers, interventionists and communities. As time goes by, so caregivers' and interventionists' lives and experiences/actions change, and improve through their regular interactions (Rosa & Tudge, 2013), with the result that their safety and health behaviour cannot be fully understood and attributed to a single point in time, or to one HVP session. Interventionists' and caregivers' safety and health behaviour evolves as they contend with everyday safety and health situations that affect them and their families.

The caregivers' and interventionists' expectations have changed since they became more aware of how to intervene when faced with child and family-related safety and health issues. After the completion of the seven-week programme, the caregivers and interventionists effectively executed their training and learnings:

> *everything* [the interventionists] *gave me and the opportunities that you can develop for yourself, [to become] an owner of your own business … and how to plant a garden […]. We are busy planting our vegetable garden in the backyard … There are already mielies and beans planted, and they are sprouting.* (Caregiver FGD 6).

The caregivers began a stokvel[4] and over time it matured and was working for the caregivers and interventionists, as this statement confirms:

> *Yes, it is just to motivate yourself and to take a step, but sometimes the money is not always there …. But if you are a few … everyone puts in a hundred rand every month …. so if you are four or five together, then* [when it is your turn to get the money] *you can take that money and start a small business, that's how it works.* (Caregiver FGD 6).

Time had granted the caregivers and interventionists some level of mastery of the content of the HVP. Hapunda et al. (2017) concur that time affects ongoing, bi-directional proximal processes in multiple contexts, and also influences a person.

3.5 Summary: Lessons from implementing a HVP intervention

The home visitation model mitigated those barriers to participation which are characteristic of standard intervention programmes, such as the retention of all the caregivers and home visitors, and their engagement in, and participation for the duration of the programme. This can be attributed to positive caregiver-interventionist relationships, familiarity, and compatibility between caregiver and interventionist, which are essential elements for preventing attrition,

[4] A savings club where members contribute an equal share of money at agreed-upon intervals.

and contribute to intervention continuity and efficacy. It is important to note that whilst a positive caregiver-interventionist relationship might present complications.

Role-playing proved to be an important modality for ascertaining how well information was understood. Moreover, the interventionists spoke at length about how enjoyable and beneficial it was to act out home visits. However, when engaging in role-play considerations such as group size and group dynamics require skilful facilitation and management. Similarly, those training home visitors should highlight the importance of creating an interactive environment with the caregivers, during the delivery of an intervention. During the visits, interventionists should optimally use the visual aids and handouts provided, to ensure maximum participation and understanding. Interventionists should also be well versed in the home language of the caregiver or inhabitant of the home they are visiting.

It is important to note that whilst the researchers evaluated the suitability of the content of the intervention and the procedural component of implementation caregivers and interventionists embraced the lessons conducted during the visits. Thus, this method of implementation facilitated the adoption of the safety practices within the home by both the caregivers and the interventionist alike, and that further reinforced the safety of other members of the family inside the home.

4. Conclusion

In this study, we explored caregivers' and interventionists' perceptions of the content and delivery of a child safety, peace and health home visitation intervention pilot in a low-income community in South Africa. The findings revealed that human agency and capacity, structural accessibility, and the attributes of the intervention and the associated sub-themes encouraged receptivity and participation. This included environmental characteristics which were evident in the interventionist's competencies, the intervention program's content and structure, its language, and the logic of the programme. The analyses reflected an interdependence between the themes and sub-themes, that is congruent with the PPCT model, which postulates the dynamic interplay of the proximal process(es), person, context and time (Bronfenbrenner & Morris, 2006).

Although the researchers did not test the efficacy of the intervention, the findings/factors uncovered through this study are significant and relevant to consider when implementing an HVP intervention. The suggestion is that trainers follow a participatory, didactic, and interactive approach in preparing and training community members as paraprofessionals, using creative materials and methods/modalities to convey information via visual aids, role-plays, and slideshows.

Supplementary findings beyond the assessment of delivery and content of the programme indicate acculturation of practised safety behaviours in the home context through HVP training.

This study contributes to the science and evidence base of a child-centred HVP intervention in a resource-constrained and marginalised community, by highlighting best practices in a low-income setting. Further studies should consider evaluating the effectiveness and longitudinal impact of the HVP on safety and health promotion across various low-income settings in South Africa and the rest of the continent.

Conflict of interest

The authors of this article declare no conflict of interest.

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