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Pre-post Mixed Methods Study of a Parent and Teen Support Intervention to Prevent Violence Against Adolescents in the Philippines

Rosanne M. Jocson, Ph.D. [a,*], Liane Peña Alampay, Ph.D. [b], Jamie M. Lachman, D.Phil. [c,d,e], Denise Hazelyn A. Maramba, M.Psy. [b], Marika E. Melgar, M.A. [b], Catherine L. Ward, Ph.D. [f], Bernadette J. Madrid, M.D. [g], and Frances Gardner, D.Phil. [c]

[a] *National Institute of Education, Nanyang Technological University, Singapore, Singapore*
[b] *Department of Psychology, Ateneo de Manila University, Quezon City, Philippines*
[c] *Department of Social Policy and Intervention, University of Oxford, Oxford, United Kingdom*
[d] *MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, Glasgow, United Kingdom*
[e] *Centre for Social Science Research, University of Cape Town, Cape Town, South Africa*
[f] *Department of Psychology and Safety and Violence Initiative, University of Cape Town, Rondebosch, South Africa*
[g] *Child Protection Unit, Philippine General Hospital, University of the Philippines, Manila, Philippines*

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A B S T R A C T

Purpose: This study examines the feasibility of a culturally adapted parenting intervention (MaPa Teens) within the national cash transfer system to reduce violence against adolescents, the first such program in the Philippines.

Methods: Thirty caregiver-adolescent dyads who were beneficiaries of a government conditional cash transfer program participated in a pilot of a locally adapted version of the Parenting for Lifelong Health for Parents and Teens program. Primary outcomes of reducing child maltreatment and associated risk factors were evaluated using a single-group, pre-post design. Focus group discussions explored the perceptions of participants and facilitators regarding program acceptability and feasibility.

Results: Significant and moderate reductions were reported in overall child maltreatment and physical abuse (caregiver and adolescent reports) and in emotional abuse (adolescent report). There were significant reductions in neglect, attitudes supporting punishment, parenting stress, parental and adolescent depressive symptoms, parent-child relationship problems, and significant improvement in parental efficacy in managing child behavior. Adolescents reported reduced behavior problems, risk behavior, and witnessing of family violence. Participants valued learning skills using a collaborative approach, sustained their engagement between sessions through text messages and phone calls, and appreciated the close interaction with caring and skilled facilitators. Program areas of improvement included addressing barriers to attendance, increasing adolescent engagement, and revising the sexual health module.

IMPLICATIONS AND CONTRIBUTION

MaPa Teens is the first known locally adapted evidence-based parenting program to prevent violence against adolescents in the Philippines. The results of this pilot evaluation show promising indications of the program's effectiveness in reducing violence against adolescents and the feasibility of its integration within an existing cash transfer delivery system.

Conflicts of interest: JML is the CEO of Parenting for Lifelong Health (PLH), a charitable organization based in the United Kingdom that developed the Parenting for Lifelong Health for Parents and Teens program, which is licensed under a Creative Commons Attribution 4.0 International license. JML also receives occasional fees for providing training and supervision for PLH programs. LPA, RMJ, JML, CLW, and FG have participated (and are participating) in several research studies involving the program as investigators, and the Universities of Ateneo de Manila, Oxford, Glasgow, and Cape Town receive research funding for these. Conflict is avoided by declaring these potential conflicts of interest and by conducting and disseminating rigorous, transparent, and impartial evaluation research on both this and other similar parenting programs.

Trial registration: ClinicalTrials.gov (NCT03903445).

* Address correspondence to: Rosanne M. Jocson, Ph.D., National Institute of Education, Nanyang Technological University, 1 Nanyang Walk, Singapore 637616.
E-mail address: rosanne.jocson@nie.edu.sg (R.M. Jocson).

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Discussion: The study provides preliminary support for the effectiveness and feasibility of the program in reducing violence against Filipino adolescents. Findings suggest potential adaptations of the program, and that investment in more rigorous testing using a randomized controlled trial would be worthwhile.

Globally, almost one billion children and adolescents annually experience physical and psychological violence in the home [1]. Physical violence includes corporal punishment behaviors, whereas psychological or emotional violence includes verbal forms of abuse such as shouting at a child [2,3]. Prevalence rates of mild to severe forms of violence are higher in low- and middle-income countries (LMICs) than in higher-income countries [2], where the impact is compounded by higher levels of poverty and limited access to support services. In the Philippines, a national study on violence against children found that 66% of the respondents aged 13 to 24 reported experiencing physical violence prior to age 18, with 60% of these incidents occurring in the home and most commonly perpetrated by mothers, fathers, and siblings [4].

High rates of abuse and violence against adolescents are concerning given documented evidence of negative effects on developmental and health outcomes. Studies show that adolescents' exposure to violence prospectively predicts risk behaviors [5], substance use [6], chronic physical health conditions [7], internalizing and externalizing problems [8,9], and academic difficulties [9]. The negative effects of abuse and harsh parenting may be aggravated in conditions of socioeconomic disadvantage: several studies link pathways from economic stress to parent psychological distress, harsh and abusive parenting, and adolescent health risks and maladjustment [10–12].

There is strong empirical evidence for the effectiveness of parenting support interventions in reducing child maltreatment and associated parenting risk factors [13], including in LMICs [14]. Recognizing the important role of parents in reducing child maltreatment, international agencies identify parent and caregiver support as a key evidence-based strategy to end violence against children [15], in line with the 2030 sustainable development goals [16]. A systematic review and meta-analysis of parenting interventions conducted in LMICs in East and Southeast Asia found that evidence-based parenting programs may be effective in reducing harsh and abusive parenting and improving parent-child relationships in these contexts [17]. These programs strengthen parenting skills by enhancing parental knowledge and competence in parenting, teaching stress reduction strategies, and facilitating discussions on child development and behavior management [18–20]. Parenting interventions during the middle childhood years are as effective as those targeting the early childhood years, suggesting that it is never too late to invest in parenting programs for families with older children [21]. However, the existing evidence on parenting interventions to reduce violence is largely based on programs for caregivers of young children, rather than the adolescent period, when demands on parents change, parenting may be more difficult as children start to become more independent, and violence against children increases [22].

Parenting for Lifelong Health (PLH) is an initiative in collaboration with UNICEF and WHO to support evidence-based parenting programs to reduce violence against children and adolescents in low- and middle-income contexts. PLH Philippines has been developing and testing locally adapted parent support interventions, called *Masayang Pamilya* (Happy Family) or MaPa since 2016 [23,24]. A randomized controlled trial (RCT) of the program for families with children ages two to 6 (MaPa Kids) implemented with beneficiaries of the national conditional cash transfer program *Pantawid Pamilyang Pilipino Program* (4Ps) demonstrated effectiveness in reducing child maltreatment at posttest and one-year follow-up [25]. Given the needs of families with adolescents, PLH Philippines developed the MaPa Teens program in collaboration with government and community officials and stakeholders, to expand the suite of violence prevention parenting programs to families with adolescents ages 10 to 17. The program was adapted from the PLH for Teens program, originally developed and tested in South Africa [26]. Based on the theory of change, the program used the Hanf two-stage model by focusing on cultivating positive parent-adolescent relationships and providing parents with nonviolent tools to promote prosocial behavior [27,28].

The current mixed-methods study describes results from a pre-post pilot test of MaPa Teens conducted with families with adolescent children in Metro Manila. Following the success of the program for parents of younger children, MaPa Teens was also implemented with 4Ps beneficiaries to support the most vulnerable Filipino families. This study aims to (1) examine the effectiveness of MaPa in reducing adolescent maltreatment, improving positive parenting, and reducing other risk factors for child maltreatment and (2) examine the relevance, acceptability, and feasibility of the program in an urban Filipino context.

Methods

Participants

The sample ($N = 60$) included 30 primary caregivers ($M_{age} = 41.66$, $SD = 11.53$, 90% female) and a target adolescent child aged 10 to 17 ($M_{age} = 13.40$, $SD = 1.99$; 43% female) recruited from an urban community. All families were 4Ps beneficiaries and were referred by community social welfare officers. The 4Ps conditional cash transfer provides cash grants to eligible low-income families with children ages 0–18 if they comply with the following conditions: regular health checks and vaccination, enrollment of the child in school with at least 85% attendance rate per month, and attendance in monthly family development sessions (FDS). Participation in MaPa Teens counted as FDS attendance in fulfillment of the conditions of receiving cash grants. Inclusion criteria for caregivers included being 18 or older, being the primary caregiver of the target adolescent, spending at least four nights a week in the same household as the target adolescent in the previous month, and being a beneficiary

of the 4Ps program. Exclusion criteria included prior participation in parenting or family development programs for adult participants (i.e., belonged to the earlier cohorts of 4Ps beneficiaries), having severe mental health problems for adult and child participants, and previous referral of the adult or child to child protection services due to child abuse. 30 of 33 families (91%) who were recruited were eligible and provided consent to participate; the families who did not participate continued to attend FDS as part of the 4Ps program.

Procedure

All procedures were conducted in coordination with government and community officers and staff. Prior to study enrolment, the program was introduced at a community orientation for 4Ps beneficiaries. Eligible and consenting caregivers and adolescents completed standardized questionnaires in a community center prior to the start of the program in April 2019 and within a month after the program ended in July 2019. Bilingual researchers translated English questionnaires to Filipino, and translations were checked by back-translation to ensure linguistic and conceptual equivalence. Trained researchers orally administered the questionnaires in Filipino via structured one-on-one interviews using e-tablets. Computer-assisted self-interviewing methods were used for sections on child maltreatment and family violence to facilitate disclosure of experiences [29]. After the program, 17 caregivers, 13 adolescents, and three program facilitators participated in focus groups discussions (FGDs) to explore their experiences and perceptions regarding program acceptability. Five FGDs were conducted—two for caregivers, two for adolescents, and one for facilitators. Each FGD lasted one to two hours and was moderated by a trained researcher fluent in Filipino. The study received ethics approvals from Ateneo de Manila University (AdMUR-EC_18_092PA) and the University of Oxford (SPIC2_18_005).

MaPa Teens program

The community-based program was delivered by trained professional and graduate student facilitators over nine weekly group sessions with caregivers and a target adolescent child. Training was provided over five days (30 hours) by PLH trainers from Clowns Without Borders South Africa, an NGO that has supported the dissemination of PLH programs in 29 countries. 4Ps staff and community coordinators assisted with the implementation of the weekly sessions. The sessions, outlined in Table 1, focused on developing skills in engaging in positive interactions, forming guidelines and consequences for behaviors, family budgeting, problem solving, and keeping safe in the community. Sessions lasted 2–3 hours and were conducted face-to-face in a community center to which families could easily walk. Consistent with core principles of evidence-based parenting interventions, the sessions were delivered with an emphasis on collaborative discussion and problem-solving, modeling of positive behaviors, and practice of skills during group sessions and at home. Each session included the use of illustrated stories or comics and physical and mindfulness-based exercises to reduce stress. In between sessions, facilitators sent four standardized text messages and conducted one phone call to parents that lasted up to 15 minutes to reinforce skills learned in previous sessions. Participants were provided with refreshments during program sessions. Based on facilitator self-report checklists, 95% of the program session components were faithfully delivered. The manual is available at https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health.

Measures

Primary outcomes. Overall child maltreatment, physical abuse, and emotional abuse were assessed using the International Society for Prevention of Child Abuse and Neglect Child Abuse screening tool trial version (ICAST-T) [30], an adaptation of the ICAST parent version (ICAST-P) [31]. The parent version (ICAST-TP, 27 items) and the child version (ICAST-TC, 25 items) measures incidence of abuse perpetrated against the child in the past month using a frequency score of 0–8 or more times. Reliabilities in this study were $\alpha = 0.87$ for parents and $\alpha = 0.79$ for adolescents. The measure has subscales for physical abuse (ICAST-TP, 14

Table 1
MaPa Teens program sessions

Session	Format	Goals
1. Family goals and one-on-one time	Joint[a]	Identify specific, positive, and realistic goals; Understand the importance of one-on-one time.
2. Keeping it positive: praise and instructions	Joint	Learn how to praise and appreciate one another; Become more effective at giving specific, positive, and realistic instructions.
3. Keeping it cool: managing anger and stress	Joint and Separate[b]	Learn how to become more aware of their own emotions, how to respond effectively to other people's emotions, and how to communicate about their own emotions.
4. Establishing guidelines to keep healthy and safe	Joint	Learn how make guidelines together and how to create guidelines to keep them healthy and safe.
5. Family budgeting and ways to save	Joint	Learn ways to manage money, reduce stress about money, and establish plans on how to save together as a family.
6. Accepting responsibility for our actions	Joint and Separate	Learn how to share responsibilities and identify realistic, appropriate, and reasonable consequences for noncompliance.
7. Solving problems together as a family	Joint	Learn collaborative methods of problem solving.
8. Keeping safe in the community and responding to crisis	Joint	Learn how to effectively respond to conflicts when they arise.
9. Widening circles of support	Joint	Reflect on experience during the program and discuss how to continue supporting each other after the program.

[a] The session included activities in which caregivers and adolescents participated together.
[b] The session included activities in which caregivers and adolescents worked in separate groups.

items; ICAST TC, 10 items) and emotional abuse (10 items). Scores on each subscale and the overall scale were summed.

Secondary outcomes. Secondary outcomes include caregiver and adolescent report on neglect, positive parenting, attitudes toward corporal punishment, parental monitoring, parent and child depressive symptoms, and parent-child relationship problems; caregiver report on parenting efficacy, parent emotional self-regulation efficacy, parenting stress, and intimate partner violence and coercion; and adolescent report on behavior problems, prosocial behavior, risk behavior, and witnessing of family violence. Caregivers and adolescents reported on community violence exposure, family functioning, educational aspirations and expectations, and parental support for education (see Supplementary Material for a description of secondary outcome measures).

Implementation outcomes. Implementation outcomes included recruitment, enrollment, and participation rates. The focus group discussion guide contained a set of open-ended questions on participants' experiences during the program, relevance and acceptability of parenting topics, and program delivery issues.

Analyses

All statistical analyses were conducted using SPSS 26.0. Intervention effects were examined by conducting paired *t*-tests comparing pre-post scores and Wilcoxon signed-rank tests for comparisons of pre-post outcomes with skewed distributions (i.e., z skew scores larger than 1.96). Caregiver report and adolescent report analyses were conducted separately. An intention-to-treat approach was used in which all outcome data from participants with pretest data were included in the analyses regardless of extent of program attendance or completion. All participants with pretest data were interviewed at posttest, and there were no missing data.

Bilingual researchers transcribed the FGD recordings verbatim. The fourth author, fluent in Filipino and English, analyzed the transcripts using thematic analysis procedures [32]. To enhance trustworthiness in the analytic process, the transcripts were coded in the original language to preserve the meaning of the responses. Three other researchers who are skilled in qualitative methods and fluent in Filipino reviewed the codes and themes to corroborate or suggest alternative interpretations to the analyses. All analysis steps, consultation notes, and draft reports were documented to improve reliability of the process.

Results

Table 2 presents socio-demographic characteristics and child maltreatment risk factors among the sample at pretest. Most parent participants were the biological mother of the teen. Economic stress on the household is evident in that the majority was either unemployed or working in the informal sector, and nearly a quarter reported acute household hunger. More than two-thirds of caregivers had experienced corporal punishment or other forms of abuse as a child.

Table 2
Socio-demographic and child maltreatment risk characteristics of caregivers at pretest (N = 30)

Variable	*n* (%)
Female	27 (90%)
Mean age (*SD*)	43.83 (8.42)
Target adolescent child female	13 (43%)
Mean target adolescent child age (*SD*)	13.40 (1.99)
Target adolescent child enrolled in school	23 (43%)
Biological parents	27 (90%)
Marital status	
Married	16 (53%)
Living with a partner	5 (17%)
Single	3 (10%)
Separated	3 (10%)
Widowed	3 (10%)
Filipino spoken at home	30 (100%)
Education	
No high school education	5 (17%)
Some high school education	8 (27%)
Completed high school	17 (57%)
Employment	
Employed	6 (20%)
Unemployed	12 (40%)
Informally employed	12 (40%)
Other adult working in household	20 (67%)
Mean household size (*SD*)	6.63 (2.62)
Mean number of children (*SD*)	3.50 (1.57)
Presence of other caregiver	24 (80%)
Acute household hunger (more than five times in the previous 30 days)	7 (23%)
4 or more necessities not met	5 (17%)
Experienced corporal punishment as a child	20 (67%)
Experienced abuse as a child	23 (77%)

Means with *SDs* are presented when indicated.

Primary outcomes

Tables 3 and 4 present descriptive and comparative data for all outcome variables for caregivers and adolescents at pretest and posttest. *Overall child maltreatment* and *physical abuse* significantly decreased at posttest for caregivers and adolescents. The decrease in *emotional abuse* was statistically significant for adolescent reports only.

Secondary outcomes

Caregiver and adolescent reports of *neglect* decreased, with statistically significant decreases found for adolescents only (Tables 3 and 4). *Positive parenting* did not significantly change from pre to posttest. There was a significant improvement in *parental efficacy in managing child misbehavior,* and no significant change was seen in general *parental efficacy* and *emotional self-regulation efficacy*. *Parenting stress* and *parental depressive symptoms* significantly decreased at posttest. There was a significant decrease in *attitudes supporting punishment* and *parent-adolescent relationship problems* reported by caregivers and adolescents at posttest. *Parental monitoring (solicitation of information and rule-setting)* did not significantly change from pre to posttest.

For adolescent outcomes, *adolescent depressive symptoms* and *adolescent behavior problems (irritability and externalizing behavior)* significantly decreased based on caregiver and adolescent reports. Adolescents reported a significant decrease in *risk behavior* and a nonsignificant change in *prosocial behavior*.

Table 3
Caregiver-report outcomes at pre and posttest (N = 30)

Outcome[a]	Possible	Pretest	Posttest	Test Statistic[b]		*p*	*d*
	Range	*M (SD)*	*M (SD)*	*t*	*z*		
Primary							
Overall child maltreatment	**0–192**	**14.53 (15.27)**	**10.17 (12.79)**		**−2.29**	**.022**	**−0.46**
Physical abuse	**0–112**	**6.13 (7.75)**	**3.80 (6.82)**		**−2.43**	**.015**	**−0.39**
Emotional abuse	0–80	8.40 (9.98)	6.37 (7.11)		−1.91	.057	−0.36
Secondary							
Neglect	0–24	0.77 (1.36)	0.67 (1.63)		−0.42	.677	−0.11
Positive and involved parenting	0–42	36.60 (6.86)	37.90 (7.88)		−1.48	.138	0.20
Attitudes toward punishment MICS[c]	1–5	2.13 (1.04)	1.73 (0.91)		−1.61	.108	−0.32
Attitude toward punishment ICAST-I[d]	**4–20**	**9.40 (2.19)**	**8.57 (1.63)**	**2.12**		**.042**	**−0.35**
Parent solicitation of information	0–18	13.27 (3.62)	13.93 (3.29)		−1.10	.270	0.21
Parent rule-setting	0–21	14.73 (3.45)	14.53 (3.51)	0.34		.738	−0.06
Parental efficacy	8–40	34.53 (4.04)	34.50 (3.95)	0.04		.968	−0.01
Parental efficacy in managing child behavior	**0–16**	**7.57 (4.22)**	**5.13 (3.82)**	**2.87**		**.008**	**−0.50**
Parent emotional self-regulation efficacy	1–20	11.33 (2.25)	12.27 (2.69)	−1.61		.119	0.33
Parenting stress	**18–90**	**49.27 (5.74)**	**46.93 (6.37)**	**2.20**		**.036**	**−0.43**
Parent depressive symptoms	**0–26**	**8.60 (4.75)**	**6.57 (4.00)**	**3.55**		**.001**	**−0.62**
Parent-adolescent relationship problems	**1–10**	**6.48 (2.51)**	**3.34 (2.71)**		**−4.15**	**<.001**	**−1.15**
Adolescent depressive symptoms	**0–26**	**7.13 (4.04)**	**5.73 (3.94)**	**2.46**		**.020**	**−0.45**
Adolescent behavior problems	**0–28**	**9.47 (4.97)**	**7.10 (3.49)**	**3.80**		**<.001**	**−0.65**
Intimate partner violence[e]	0–64	1.55 (2.70)	1.72 (2.93)		−0.26	.798	0.12
Intimate partner coercion[e]	0–80	9.70 (12.31)	8.67 (13.38)		−1.30	.195	−0.17
Community violence exposure	0–96	6.20 (8.93)	4.83 (7.25)		−1.39	.165	−0.26
Family functioning	23–92	71.90 (9.42)	73.33 (12.40)	−1.05		.303	0.24
Educational aspirations	1–7	5.83 (0.70)	5.87 (0.68)		−1.66	.097	0.06
Educational expectations	1–7	4.93 (0.98)	5.23 (0.97)		−0.28	.783	0.31
Parental support for education[f]	6–30	24.79 (3.37)	25.21 (3.34)	−0.74		.465	0.15

[a] Statistically significant differences ($p < .05$) between pre and posttest are in bold.
[b] Paired t value for normally distributed outcomes and Wilcoxon signed-rank tests z score for skewed outcomes.
[c] MICS = Multiple Indicator Cluster Survey measures agreement that child needs to be physically punished.
[d] ICAST-I = ISPCAN Child Abuse Screening Tool-Intervention measures perceived effectiveness of physical punishment.
[e] Intimate partner violence and coercion scales answered only by participants living with a partner in the past month ($n = 18$).
[f] Parental support for education scale answered only by participants with school-enrolled child ($n = 23$).

For family violence and functioning, *adolescent witnessing of family violence* significantly decreased at posttest. There was no significant change in caregivers' reports of *intimate partner violence* and *intimate partner coercion* and in caregiver and adolescent reports of *community violence exposure* and *family functioning.*

For educational outcomes, there were no significant changes in caregiver and adolescent reports on *educational aspirations, educational expectations,* and *parental support for education.*

Implementation outcomes

All 30 caregiver-adolescent dyads attended at least one session of the program. The overall attendance rate was 73% for caregivers and 66% for adolescents. Twenty-five caregivers (83%) and 21 adolescents (70%) attended at least five sessions. Twenty-one caregivers (70%) and 17 adolescents (57%) attended at least seven sessions. All participants, including those who attended fewer sessions, completed post assessments within a month after the program ended.

Focus group discussions revealed themes on the relevance, acceptability, and challenges in implementing the program (Table 5). Caregivers, adolescents, and facilitators shared helpful learnings and changes in parent-adolescent relationships. Caregivers and adolescents mentioned that they learned better awareness and regulation of their own emotions, became more attuned to each other's feelings and behaviors, improved their communication with each other, became more effective and collaborative in problem-solving and in delegation of household tasks, engaged in joint efforts to enhance safety in the neighborhood, and learned strategies to budget and save money. Facilitators regarded one-on-one time, taking a pause, and praise as topics that were most appreciated by parent and adolescent participants. Adolescents liked being "thanked and praised" by their parents and shared that "it feels good."

Regarding delivery, caregivers appreciated the effective program facilitation. They valued the warm attitude and genuine concern displayed by facilitators about their lives and relationships with their children. One caregiver shared that she "felt safe sharing [our lives] with them" and that "a relationship was formed." Caregivers considered weekly text message reminders and phone calls from facilitators to be beneficial: "[Receiving messages and phone calls] feels good because we feel that we are important."

Caregivers, adolescents, and facilitators noted some barriers to participation. Some caregivers mentioned feeling anxious during their first individual meeting with the program facilitators because they did not know what to expect or how the program fit within the larger context of services. Facilitators encountered challenges in conducting phone consultations because of weak reception and parents' lack of access to working mobile phones. Caregivers noted barriers to attendance, such as sickness, family emergencies, and schedule conflicts with work and school. On the issue of sexual health, caregivers and facilitators noted the discomfort around the topic ("It is embarrassing to talk about," - parent said). One facilitator explained, "there are

Table 4
Adolescent report outcomes at pre and posttest (N = 30)

Outcome[a]	Possible range	Pretest *M (SD)*	Posttest *M (SD)*	Test Statistic[b]		*p*	*d*
				t	*z*		
Primary							
Overall child maltreatment	**0–160**	**12.40 (12.74)**	**6.07 (7.31)**		**−2.86**	**.004**	**−0.45**
Physical abuse	**0–80**	**5.17 (7.17)**	**2.03 (2.95)**		**−2.64**	**.008**	**−0.48**
Emotional abuse	**0–80**	**7.23 (7.53)**	**4.03 (5.30)**		**−2.44**	**.015**	**−0.38**
Secondary							
Neglect	**0–40**	**4.73 (6.14)**	**2.60 (4.97)**		**−2.35**	**.019**	**−0.28**
Positive and involved parenting	0–42	31.30 (9.15)	31.47 (9.42)	−0.10		.923	0.02
Attitudes toward punishment MICS[c]	**1–5**	**3.20 (1.32)**	**2.53 (1.28)**		**−2.29**	**.022**	**−0.41**
Attitude toward punishment ICAST-I[d]	4–20	10.10 (2.52)	10.50 (2.03)	−0.67		.512	0.11
Parent solicitation of information	0–18	10.83 (3.68)	11.07 (3.85)	−0.45		.657	0.09
Parent rule-setting	0–21	13.17 (4.15)	13.10 (4.27)	0.09		.931	−0.02
Parent-adolescent relationship problems	**1–10**	**4.77 (2.13)**	**3.07 (1.47)**	**4.34**		**<.001**	**−0.69**
Adolescent depressive symptoms	**0–26**	**10.37 (3.90)**	**7.33 (3.60)**	**3.87**		**.001**	**−0.68**
Adolescent behavior problems	**0–28**	**8.17 (3.55)**	**5.37 (3.36)**	**3.36**		**.002**	**−0.60**
Adolescent prosocial behavior	1–80	53.20 (10.04)	54.50 (10.07)	−0.69		.497	0.12
Adolescent risk behavior	**0–64**	**3.83 (6.29)**	**1.77 (2.42)**		**−2.38**	**.017**	**−0.32**
Adolescent witnessing of family violence	**0–16**	**5.27 (4.23)**	**2.90 (2.99)**		**−3.05**	**.002**	**−0.50**
Community violence exposure	0–96	5.83 (4.80)	4.77 (4.44)		−0.99	.325	−0.17
Family functioning	23–92	67.47 (6.96)	68.40 (6.99)		−0.80	.432	0.15
Educational aspirations	1–7	6.23 (0.90)	6.07 (0.94)		−0.74	.458	−0.15
Educational expectations	1–7	5.70 (0.99)	5.43 (1.14)		−1.20	.229	−0.22
Parental support for education[e]	6–30	23.04 (4.03)	23.22 (3.86)	−0.21		.834	0.04

[a] Statistically significant differences ($p < .05$) between pre and posttest are in bold.
[b] Paired t value for normally distributed outcomes and Wilcoxon signed-rank tests z score for skewed outcomes.
[c] MICS = Multiple Indicator Cluster Survey measures agreement that child needs to be physically punished.
[d] ICAST-I = ISPCAN Child Abuse Screening Tool-Intervention measures perceived effectiveness of physical punishment.
[e] Parental support for education scale answered only by school-enrolled child ($n = 23$).

older teens that may benefit from [discussing sexual health], and they are really open [to discussion], but they see their parents are not, so the teens do not talk about it either." Some caregivers believed that their child was "too young" to think about sexual topics, while adolescents made no mention of sexual health issues during focus groups. Lastly, facilitators observed the tendency of some adolescent participants to be disengaged and distracted during sessions and mentioned the need to find ways to increase their engagement.

Discussion

This study examined the feasibility of a parenting program delivered within the national cash transfer system and aimed at reducing violence against Filipino adolescents. The statistically significant decrease in pre-post scores on overall child maltreatment and physical abuse reported by caregivers and adolescents provides cross-reporter validation of the potential effectiveness of the program in reducing violence against adolescents. For the secondary outcomes, caregivers reported a greater sense of efficacy in managing child misbehavior and lower levels of parenting stress and depressive symptoms. Based on adolescent reports, there was a significant decrease in neglect, witnessing of family violence, and notable reduction in risk behavior. Overall, the changes were small to moderate in magnitude, with average pre-post decreases of two to three instances of physical abuse, and the largest positive effect was on parent-adolescent relationship problems. There were no negative effects on any of the outcomes.

There was no significant difference between pre and posttest in caregivers' reports of emotional abuse and neglect, positive parenting, and other secondary outcomes. It should be noted that caregivers reported an average decrease of two instances of emotional abuse at posttest, and this decrease was trending

Table 5
Key themes from focus group discussions with caregivers, adolescents, and program facilitators

Helpful learnings and changes in parent-adolescent relationship	Effective program facilitation	Barriers to participation
- Better awareness and regulation of emotions	- Good interactions with facilitators	- Anxiety at the start of the program
- Attunement to each other's feelings and behaviors	- Sustained engagement through weekly phone calls and text reminders	- Logistical challenges with receiving phone calls and text messages
- Improved parent-adolescent communication	- Helpful and effective program facilitators	- Program schedule conflicts with personal and family affairs
- More effective problem solving and delegation of tasks at home		- Discomfort with sexual health topics
- Joint efforts to promote safety		- Lack of teen engagement
- Learned strategies to budget and save money		

toward significance. The nonsignificant change in caregivers' reports of neglect at posttest could be because of very low reports of neglect at baseline. There was also no significant change in positive parenting, contrary to the results reported in previous trials of the PLH program for adolescents in South Africa [26,33], probably because of the high levels of positive parenting reported by both caregivers and adolescents at pre and posttest. Caregivers did not report a significant difference in intimate partner violence and coercion, although adolescents reported lower frequency of witnessing family violence, suggesting that other forms of violence may have been indirectly affected.

Results for reduction of child maltreatment are consistent with those from previous studies on the PLH program for adolescents [26,33], thereby adding to the evidence on the positive effects of the program on adolescent children in LMICs. Consistent with the theory of change [27,28], program components such as positive instruction-giving, setting realistic consequences, and group problem solving may equip caregivers with the necessary knowledge, skills, and resources that promote change in parent-child relationships; these changes, in turn, may contribute to the reduction of risk of child maltreatment [23,24,34]. Our findings imply that these processes of change that involve the strengthening of the caregiver-child relationship, such as decreasing parent-adolescent relationship problems, may remain crucial in preventing violence during adolescence. This is particularly relevant in the Philippines, where the family serves as an important source of instrumental and emotional support for adolescents despite their increasing needs for autonomy [35,36].

The findings suggest the relevance, acceptability, and feasibility of the program in an urban poor context in the Philippines. Apart from reporting reduced levels of violent parenting strategies, participants mentioned learning strategies to improve the caregiver-adolescent relationship, such as awareness and regulation of emotions, effective communication skills, collaborative problem-solving, efficient delegation of tasks at home, budgeting of finances, and promoting safety in the neighborhood. Caregivers and adolescents found the collaborative approach helpful and appreciated interacting with caring facilitators and receiving messages and calls from them in between sessions. These results imply that nurturing and collaborative strategies may be effective in the Filipino context, despite a reported cultural emphasis on authoritarian values [24]. The findings also highlight the important role of facilitators in building a collaborative and caring environment and in sustaining participants' engagement.

The study suggests potential adaptations to improve the program's implementation in future trials. First, participants mentioned family, work, and school schedule conflicts as the primary barriers to attendance. Facilitators also noted logistical difficulties in contacting caregivers by phone in between sessions. To address these concerns, facilitators may consider doing home visits for participants who missed sessions and who do not have access to working devices. Conducting regular home visits may be feasible if the facilitators are members of the community or if they are embedded within existing community services. Further, program implementation will require close coordination with local government units, school officials, and community staff such that the sessions do not conflict with participants' other commitments at home, work, and school. Second, to address caregivers' anxieties about participating in the program, future implementation may benefit from enhanced community orientation sessions before meeting with program facilitators. Although it was not yet feasible to engage 4Ps staff and community leaders as facilitators in this pilot, it would be helpful to train them as program facilitators in future programs as they already have a relationship with potential participants [25]. Third, modules on adolescent development, such as sexual health, can be revised. For instance, caregivers and adolescents can be allowed their own safe spaces to discuss the topic and access helpful resources prior to a joint session. Facilitators may discuss with caregivers their concerns that their children are too young and not yet ready to learn about adolescent sexual development. Considering the sensitivity of the topic in the local culture, facilitators can prepare parents and teens to discuss sexual health by modeling strategies and using relatable scenarios that can ease parents' and teens' discomfort. Fourth, redesigning program sessions to include strategies that promote active involvement, such as physical activities and games, may increase the engagement of teen participants.

The study's findings and recommendations should be interpreted in light of its limitations. The study used a pre-post design without a control group; therefore, causal attributions about program effects cannot be made. Study outcomes were assessed immediately after the program ended; thus, longer-term effects on reduction of violence and associated risk factors cannot be determined. The sample is small, limiting generalizability of the findings outside the study context of an urban poor community and delivery within the conditional cash transfer system. Although the program is designed for both universal and indicated prevention, we did not target families with specific risk factors for child maltreatment and tested the program with families characterized by more general risk, namely poverty. Future studies with larger samples should examine family risk level and other process factors (e.g., dosage) as moderators of program effects. Further, the primary caregivers who participated were mostly mothers, and future trials are needed to include more fathers and alternate caregivers. Integrating the program within existing networks and services that include fathers and considering having a father-only group for some sessions may increase the involvement of fathers in the program [37,38]. Lastly, the program was delivered by trained professionals and graduate students and needs to be further tested with government and community staff as facilitators to examine scalability and applicability in real-world conditions.

Despite these limitations, this study has several contributions. MaPa Teens is the first known locally adapted evidence-based parenting program to prevent violence against adolescents in the Philippines. The results of this study provide evidence for the feasibility and potential effectiveness of a parenting program to reduce violence against adolescents in an urban poor context and present an example of how a parent and adolescent support program can be integrated within existing government systems. The compatibility with the Philippines's conditional cash transfer system enhances the likelihood that this program can be taken to scale. The findings add to the increasing evidence base for parenting and child abuse prevention programs in LMICs [17,26,39]. These findings can be used to inform further adaptation of the program and more rigorous testing using an RCT or strong quasiexperimental design with follow-up assessments to determine sustainability of program effects.

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Supplementary Data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.jadohealth.2023.02.027.

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