A Qualitative Post-assessment Study on the Impact of a Parenting Programme linked to the [redacted] in Nepal

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TABLE OF CONTENTS

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EXECUTIVE SUMMARY

The purpose of this study was to follow up on the qualitative pre-assessment conducted in March 2018 of a parenting programme introduced by [redacted] for beneficaries of the [redacted] (for under 5s) in Nepal. The parenting initiative is based on the understanding that cash alone will be limited in terms of promoting development of children and that improving parenting skills can be a key approach to maximise outcomes for children of the Child Grant. The parenting programme introduced comprises 14 sessions and a majority of these (8 sessions) were geared towards building a better relationship between caregivers and their children by drawing on the International Child Development Programme (ICDP). Fundamental to the ICDP approach is to bring the child into the caregiver's zone of empathy, and enhance the caregiver's ability to attune with- and respond to the child's needs and initiatives. The ICDP works with 8 guidelines for good interaction, which connect to three dialogue forms; Emotional, Comprehension (meaning), and Regulative or Behavioural dialogue.

The focus of this report is on understanding the impact of the [redacted] on the positive parent-child interaction as encouraged in the [redacted] Four methods to collect qualitative data were selected: **Observation of parent-child activity using the PICCOLO observational tool for positive parenting; Three Minute Speech Sample (TMSS); In-Depth Interviews (IDIs) with caregivers, and Focus Group discussions (FGDs) with caregivers and facilitators.** The qualitative analysis was focused on extracting stories of change and observing differences in the practices of caregivers in relation to the children relatable to the ICDP.

The findings indicate, first, a paradigm shift in how caregivers perceive children; children are increasingly seen as human beings who deserve respect, love and need attention to grow up well. Similarly, the data shows that various positive parenting principles are increasingly practiced, for children are praised, hugged and kissed more, are encouraged in their learning opportunities, and less harshly punished (e.g. spanking or scolding is happening less). The observational data largely confirms the accounts of the caregivers and facilitators, with higher PICCOLO scores for the dimensions Appreciation, Responsiveness, Encouragement & Teaching. Also, with regards to the ICDP programme, it seems that parents enjoy the sessions a lot, and wish them to be implemented for more caregivers. It was found useful to share parenting challenges with other parents, which, in some cases, leads to better co-parenting between mothers and fathers as well.

To further improve the ICDP in the context of Nepal, it was suggested to expand the programme with one or two classes on positive limit setting for older children. Similarly, some of the material already used in the existing sessions could be adjusted to include examples for parents with older children. Even though this programme is focused on parents with young children, the data indicates that there is a need to understand how they can continue to keep the connection with the children into an older age, when peer influences become stronger. Stories are perceived as effective tools for learning, and could similarly be improved to better fit the context of Nepal. The FGD with facilitators of the parenting programme showed that facilitators were very able to critically assess their own work, which will help to further improve the implementation of the programme. It is important, finally, to consider the changes in parenting practices that have been demonstrated through this study, to continue to strenghten the impact of the ICDP in the project areas of Nepal.

INTRODUCTION

[redacted] has developed projects referred to as [redacted] in a range of countries. The [redacted] has been implemented in Nepal since 2010, to reduce poverty and vulnerability in children through improving access to social protection programmes and addressing the needs and rights of children through complementary interventions. The [redacted] is essentially an approach based on the notion that cash or social protection benefits flowing to households is not enough to enhance children's wellbeing. One of the key interventions of the project is therefore based around developing improved parenting skills with caregivers, including sessions on topics such as healthy nutrition, family budgeting, gender equality and the value of education.

In 2018, the International Child Development Programme (ICDP) was introduced as cornerstone of this parenting package, to support and enhance the positive child-raising capacities of caregivers. The ICDP is a universal programme focused on positive interaction between caregivers and children. It emphasizes an empowering approach to encouraging further development of caregivers' parenting skills, is in use in over forty countries worldwide and has been shown to be easily adapted to different cultural contexts. Research studies indicate many positive effects for caregivers who participate in ICDP interventions, including the development of more positive parenting strategies, improved self-confidence as parents, improved familial relationships, better psychosocial and general health and life quality.[1][2]

The ICDP approach is centred around the idea that the best way to help children is to support caregivers in their parenting practice. Fundamental to the approach is to bring the child into the caregiver's zone of empathy, and enhance the caregiver's ability to attune with- and respond to the child's needs and initiatives. The ICDP works with 8 guidelines for good interaction, connected to three dialogue forms; Emotional, Comprehension (meaning), and Regulative/ Behavioural dialogue (see table 1).

Table 1. ICDP dialogues and guidelines

ICDP dialogues	ICDP guidelines *
Emotional Dialogue	1. how do you express love to your child? 2. how do you follow and respond to your child's initiative? 3. how do you establish close communication with and without words? 4. how do you show appreciation and praise your child's efforts and achievements?
Comprehension Dialogue	5. how do you help your child focus on things/ situations in the environment? 6. how do you convey meaning and enthusiasm to your child's experiences? 7. how do you expand and enrich your children's experiences through explanations, comparisons and fantasy?

[1] Skar, A.-M. S., Sherr, L., Clucas, C., & von Tetzchner, S. (2014). *Evaluation of Follow-Up Effects of the International Child Development Programme on Caregivers in Mozambique.* Infants and Young Children, 27(2), 120-135.

[2] Skar, A.-M. S., von Tetzchner, S., Clucas, C., & Sherr, L. (2015). *The long-term effectiveness of the International Child Development Programme (ICDP) implemented as a community-wide parenting programme.* European Journal of Developmental Psychology, 12(1), 54-68.

Regulative/Behavioural Dialogue	8a. how do you help your child learn rules and values? Do you set limits in a positive way? 8b. how do you help your child plan and carry out activities and projects, step by step?

**ICDP guidelines are used as questions for caregivers to explore in everyday interactive situations.*

As the ICDP sessions are built around learning and practicing these skills, this study focuses on understanding how these lessons have been integrated into the parenting practices of caregivers in relation to their children. For the districts Kavre and Mahottari, 16 ICDP facilitators were trained. For the current parenting pilot program. Caregivers of children aged 0 to 5 years old who receive the government Child Grant [3]were recruited from the families living in hill lands and the Terai Lowlands[4]. A qualitative and quantitative baseline study was conducted in March 2018, before the parenting sessions started. Subsequently, about 100 caregivers were enrolled in groups of approximately 10 members, following a total of 14 weekly sessions over the period April to August. Only the last 8 sessions are based on ICDP content and hence form the main focus of this post-assessment.

Objective: the purpose of this qualitative study is to understand the impact of the ICDP on the parenting practices of caregivers, as well as the positive relationship between caregivers and children, in two [redacted] istricts of Nepal.

[3] The Child Grant is a Nepal government cash transfer programme (amounting to 400 NRS per child per month) aiming to improve nutritional outcomes for children under 5 years.

[4] Due to the relevant economic, cultural, political and social differences existing between Kavre and Mahottari, some variety is expected with reference to the impact of the ICDP in these respective areas.

METHODOLOGY

The [redacted] esearch team in Nepal consisted of local staff, two external, independent research consultants and six trained facilitators. As there was some familiarity with the tools already, the methods were discussed among the team members and adjusted to include questions focused on lessons learned from the ICDP. The six ICDP facilitators were involved in the data collection process to ensure enough rapport and trust while doing the home-visits. The interviews were conducted by the external researcher, and translated by the local consultants. The same number of caregivers as involved in the pre-assessment were followed up in the post-study. All participants were asked to give their consent to participating in this research after having been instructed about the process. All the research activities were recorded on video and audiotape, and also transcribed. The analysis of the data was done through a semi-open coding process, looking for relevant themes and categories to understand the changes that could be linked back to the ICDP principles.

Triangulation through the cross referencing of various data sources, as well as the use of different methodologies, helped to validate the data. The following research tools were used in the post-assessment; most of them the same as in the baseline study:

- 3-Minute Speech Sample (TMSS) with 9 caregivers (minus 3 who dropped out from the programme in Kavre).
- Parent-child activity with 9 caregivers.
- In-depth interviews (IDIs) with 3 caregivers in Kavre and 5 caregivers in Mahottari.
- 2 FGDs with approximately 5-7 caregivers in both Kavre and Mahottari.
- 1 FGD with facilitators in both Kavre and Mahottari.

3-Minute Speech Sample

The TMSS tool has been adapted from the original Five-Minute Speech Sample, which is a method used to assess caregivers' expressed emotion with respect to a member of the family with mental illness. Subsequently it evolved to investigate parent-child relationships and interactions in a broader sense. The tool is described by Sher-Censor (2016)[5] as holding strong potential as a brief and richly informative tool for indexing parent-child dynamics, and particularly affective dimensions of the parent-child relationships, in both research and clinical settings. The tool also helps to start the research with an open, inductive approach, allowing any sort of relevant data to come up without steering it towards any expected outcome parameters (such as those formulated by the ICDP). The TMSS was therefore chosen to, first, gain insights into the general perceptions of caregivers on the children, and their relationship, by inviting them to speak on this unreservedly.

Discussions prior to the pre-assessment led to a shortening of the speech to three minutes, as the caregivers in the areas in which the CSSP operates are not used to speaking spontaneously about their children.

[5] Sher-Censor, E., Khafi, T. Y., & Yates, T. M. (2016, September 5). Preschoolers' Self-Regulation Moderates Relations Between Mothers' Representations and Children's Adjustment to School. Developmental Psychology. Advance online publication. http://dx.doi.org/10.1037/dev0000178

In our study, the caregivers are asked to talk for three minutes about their focus child[6] and their relationship with him or her. In case the parent would stop talking, the interviewer would wait for approximately 30 seconds, before urging the caregiver to speak a bit more. In case the caregiver would stop entirely, the TMSS was followed-up with questions related to the emotional, learning and regulative dialogue patterns of the caregiver with the child. These questions were based on the three interaction dialogues of the IDCP; emotional, comprehensive and regulative dialogue.

In the current setting of this pilot study, the free-flowing speech part of the TMSS was used predominantly to understand the perspective and attitude of the caregiver towards (their) children. In the ICDP it is emphasized that caregivers should look at the child as a person, with his own needs, wishes, qualities, etc. This is often referred to as a humanistic approach. When comparing the pre-assessment with the post-assessment, a 5-point Likert Scale was used to measure to what extent the parents have adopted this Person-centred approach to the child (see Appendix, table 1).

Observation of parent-child activity

For the purpose of understanding how the ICDP programme worked through to the actual practices of caregivers and relationship dynamics between caregiver and child, a short activity in which both caregiver and child are involved, would be observed. The activities could be anything easily performed at home, ranging from e.g. story-telling, bathing and dressing the baby, playing a small game, putting he child to sleep, or feeding the baby.

The PICCOLO (Parenting Interactions with Children: Checklist of Observations Linked to Outcomes) scale was used to score the quality of the parent-child interactions, measuring 29 developmentally supportive parenting behaviours. The PICCOLO Scale is a comprehensive system, especially suitable for the systematic observation of parents and young children (under approximately 5 years of age). It provides a checklist of observations linked to outcomes that are organized under four key domains: Affection; Responsiveness; Encouragement and Teaching.[7] It was decided that this would provide useful, detailed information on parenting behaviour both pre- and post -participation in the program.

There are seven sub-components each under affection, responsiveness, and encouragement and eight sub-components in the teaching component. The frequency of each sub-component is rated as either "absent", "rarely" or "clearly". Overall scores for interactions in the four key components are categorized as **'high risk', 'moderate risk'** or **'strength/good'**. 'High risk' in the context of this study can be understood as 'low frequency'. Mother-child interactions scoring below 6 for one-year old children and below 7 for two to three-year old children are categorized as "high risk" interaction, whereas scores of 7-9 for one year olds and 8-10 for two to three year olds are categorized as "moderate risk". The cut off score is 10-14 for one year olds and 11-14 for two to three year olds for strength/good'

The local consultant trained the data collectors in the use of PICCOLO and supervised the final scoring. It was expected that the ICDP would have a positive impact on the parent-child interaction across all dimensions, lowering also potential risk involved for families and children.

[6] This is the child that the caregivers choose to focus on when the pre-assessment took place. During the post assessment, the inquiry was based on the same child, as that would enable more systematic comparison.

[7] Roggman, L.A., Cook, G.A., Innocenti, M.S., JumpNorman, V.K. and Christiansen, K. (2009) Logan, UT: Utah State University.)

In-Depth Interviews (IDIs) & FGDs for understanding Most Significant Change

Finally, to create space for caregivers and facilitators to share their experiences and perspectives on what changed through the ICDP, individual interviews and group discussions were held in the respective sites. The IDIs were generally conducted as follow-up to the TMSS or parent-child activity and focused on lessons learned, practical implementation, previous and current challenges, general experiences of the ICDP sessions, future dreams and suggestions for improvement (see Appendix 3 for the topic guideline). FGDs held with caregivers followed a similar structure, but were particularly focused on collectively gathering the lessons learned, and eliciting stories of Most Significant Change (MSC) [8] (see Appendix 4). Finally, the FGDs with facilitators was focused on evaluating the individual ICDP sessions and scoring them together on a 5-Point Likert Scale, after which the original objective, actual practice, and impact of the sessions on caregivers was discussed. Similarly, the facilitators were invited to share suggestions for improvement (Appendix 5).

RESULTS

The results will be presented in the following order. In the first part, the results from the 3-minute speech will be interpreted and described based on the Likert-scale average scores, as well as their responses to the follow-up questions. Similarly, and following the TMSS, the results of the parent-child activity will be presented based on the PICCOLO scores, and the overall interpretation of the changes observed in the parent-child interaction.

In the second part, the relevant themes that came up through the data analysis of the FGDs and IDIs will be explained with regards to the ICDP sessions. In this section, stories of significant change will also be presented to support the analysis.

It should be mentioned, finally, that although the caregivers involved in this study were asked to only talk about their focus child below 5 years old, some of their accounts include references to older children as well. However, the results as depicted here will largely reflect the experiences of caregivers in relation to their younger children below 5 years old.[9]

THREE MINUTE SPEECH SAMPLE (TMSS)

All together nine mothers participated in the three minutes free flow speech in th pre an post-assessments. There were all together 12 mothers in pre-assessment, among them three mothers from [redacted] district did not participate in the parenting sessions. So they were not included in the study. In this activity as in pre-assessment, mothers were asked to talk freely about the child as long as they could. Overall, mothers were rather enthusiastic to talk about their children. Although some differences were anticipated between [redacted] the latter being a more deprived and harder to reach area), the data does not show such disparity.

[8] Most Significant Change technique is a qualitative and participatory tool commonly used in monitoring and evaluation research. The idea is to emanate stories on what actually happened in a particular field. It is an often used tool to capture what has changed, for whom, and why.

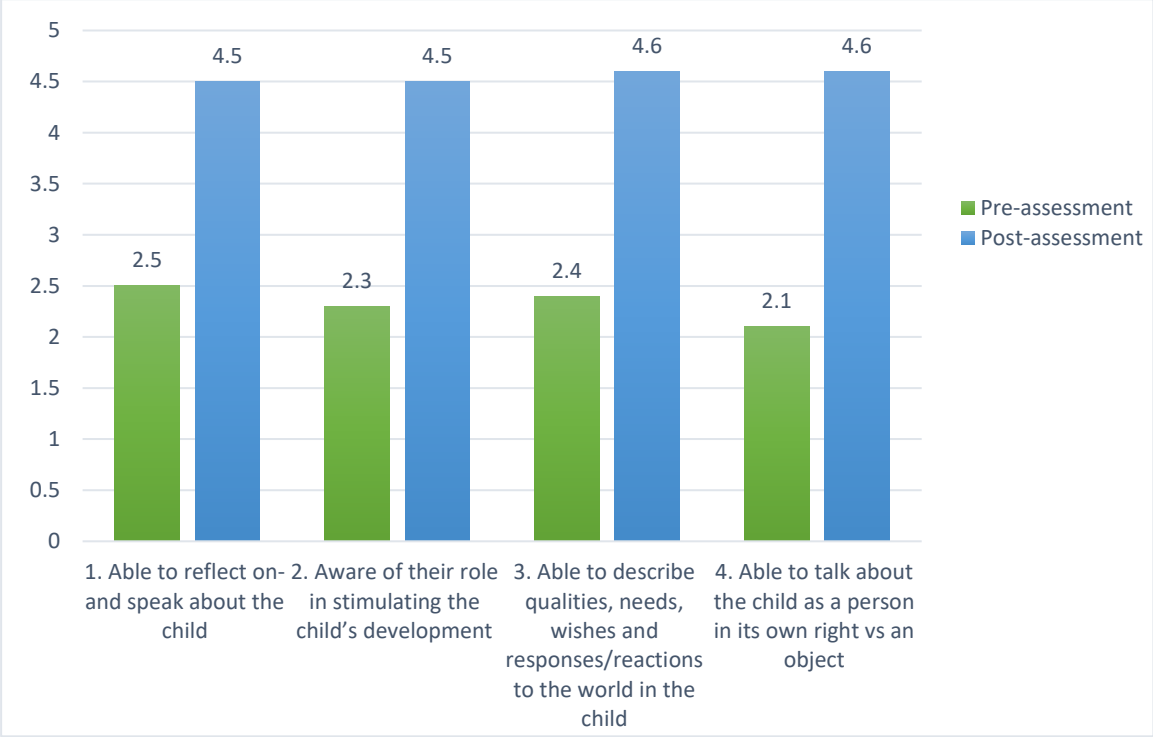
[9] Quotes in this report are a direct English translation of the respondent's account in the local language. It was decided to leave the quotes as much as possible unedited to represent the way respondents formulated their thoughts in this study

The TMSS scores show that, based on how and what the caregivers shared during just the free-flowing speech, some changes are witnessed between pre-and post-assessment. Although these parameters have not been used and validated in studies before, we treat these parameters as important indicators for the level of awareness on the caregiver's role in stimulating the child's development (as intended by the ICDP). The first parameter looks at the length of the speech itself, as well as the level of detail and variation in the sharing. The second parameter looks at how caregivers refer to their own role, e.g. whether the caregiver is aware of the fact that her attitude and approach affects the child's positive development. The caregiver, for instance, might make references to how her level of attention and presence to the child's needs/questions impacts them. The third parameter, more specifically, tests the level of interest and awareness of the caregiver in their child's unique character. The caregiver might, for instance, make references to the child's ways of responding to him or her, or what, at the moment he or she is learning about the world. The fourth parameter, finally, looks at the caregiver's perspective on the child. Caregivers might refer to their child as an object (e.g. talk about the child as needing to fulfil certain chores, objectives and generally obey the caregiver's wishes, in order to have value) or as a person (e.g. talk about the child as valuable as it is, deserving respect, and needing love and attention to grow). In Table 2., below, the individual scores of 9 caregivers are displayed, while the average before- and after scores of all caregivers is visualised in Graph 1.

Table 2: TMSS pre-& post- assessment scores for individual caregivers (pre-assessment scores indicated in red).

CAREGIVER nr.	**Scores based on the free-flowing speech (3-minute speech)**							
	***Pre*/post**		***Pre*/post**		***Pre*/post**		***Pre*/post**	
[redacted]	3	4	2	5	1	5	2	4
	1	4	4	4	3	5	3	5
	3	5	3	4	3	5	2	5
	4	5	2	5	2	5	3	5
	1	4	3	5	2	4	1	3
	2	4	2	5	2	4	1	5
	3	4	2	4	2	5	3	5
	2	5	2	5	3	5	1	5
	4	5	3	4,5	4	4	3	5
Mean average	**2,5**	**4,5**	**2,3**	**4,5**	**2,4**	**4,6**	**2,1**	**4,6**
Item	1. able to speak about the child		2. aware of their role to stimulate their child's development		3. able to describe the qualities, needs and wishes of the child		4. able to talk about the child as a person in its own right vs. an object	

The strong bonding between the caregivers and their children was quite clearly reflected in the free speeches. Regarding the ability of caregivers to speak about their children (**item 1)**, caregivers seemed to be much more proficient. This might be due to the fact that caregivers were slightly more acquainted with the method, or with speaking to strangers in general as a result of taking part in group sessions, but it also surely indicates an increased ability of caregivers to reflect at length on their relationship with the child. In the pre-assessment, the mothers were not able to talk spontaneously for as long as three minutes. The longest speech was fourteen sentences; the shortest was just one sentence. This was significantly increased, from 2 mins to 5 mins, in free flow speech across the 9 participants. The caregivers provided remarkably richer accounts of the bond they shared with the children. For example, *"I take him on my lap, offer him food"* mother K4 in pre-assessment, went on like this: *"I show love to him by hugging. Though he can't talk properly, I keep on talking with him when I am even feeding to him. I always maintain eye to eye contact with him when I talk to him"* (Participant K4; post-assessment).



Graph 1: TMSS: average pre- and post-assessment scores of caregivers.

To elucidate the level of 'progression' in this, we also refer to Box 1 with a pre- & post assessment excerpt that is fairly exemplary to the rest of the data. This item also increased in score by approx. two points difference (graph 1).

BOX 1. Participant M4, TMSS

Pre-assessment:

He does not like to eat other things. He usually eats biscuits and milk. He usually plays every time even forgetting food. Whenever he goes to shop with me, always demands for biscuits. When I keep him anywhere, he keeps playing. Whenever he founds mobile he enjoys watching pictures.

Post-assessment:

Earlier to training I used to beat my child a lot. But, from training I knew that I shouldn't beat him. Whenever I raise my hand to beat him, I remember the training. Now, I play with my child more. When he pulls my sari to go somewhere, I follow him. He laughs to me and I reply to him. Though I don't know how to write and read, I pretend as writing so that he could follow. Whatever he wants I feed him. When he obeys me, I laugh at him and give him smile. I explain the surrounding, which is danger and which is not for my child. I kiss him, touch his cheek when I am happy with him. When he does good things, I thank him. But he is just 14 months can't speak. I try to understand by looking at him. I teach him showing different things like these are sharp instrument, that may cause injuries. That is a hot thing that may burn you like that. From the training I learned that we need to show our love to make our child happy.

Compared to the pre-assessment, mothers in the post-assessment were also found to be more conscious of their role in stimulating the child for their holistic development (**item 2**). This item was scored 2.2 points higher in the post-assessment. Caregivers described their role in both active, direct form ('*As his mother, I learned we need to show our love to the children to make them happy'- participant M2* or *'if we caregivers treat them well, they will learn good things'- K2),* as well as in more indirect ways. One mother, for instance, shared during the post-assessment:

"When I am cooking he resides near to me. Sometimes I give him soybean, or potato whatever I am cooking. So that he engages on. And when he stars playing with these I also explain him what I am cooking, why we need to eat food and other things related to kitchen, which is helpful to learn new things about this world".

Various perspectives on the role of caregivers were reflected during the TMSS, including the role of a 'teacher/guide', and 'loving nurturer'. Compared to the pre-assessment, mothers started explaining more things to their children so that their children could understand the world well. For instance, one mother said:

"I explain the surrounding, which is danger and which is safe for him. I give answers of his queries politely, I kiss him, touch his cheek when I am happy with him" (Participant 12M).

What was finally quite revealed through half of the speeches, was the fact that caregivers learned to follow their child's lead in teaching them new things, or to make a connection to see what the child is understanding. For instance, one mother shared:

'When he pulls my sari to go somewhere, I follow him. He laughs at me and I reply to him. Though I don't know how to write and read, I pretend as writing so that he could follow. I try to look at him to see what he understands'. (Participant 6M).

Regarding the ability of parents to describe their children's wishes and needs (**item 3**), a similar improvement was witnessed. In fact, caregivers were already somewhat able to express some references to their child's needs or wishes (including some food habits, or their interest in playing), but these accounts certainly became more pronounced during the post-assessment. Parents seemed to be more aware of their children's unique developmental traits, even at a relatively young age.

Information mothers provided in the pre-assessment, for instance, were mostly functional descriptions like *"I give him food when he is hungry, take to hospital or traditional healer when he gets sick*" (Participant 5K), whereas the post-assessment finding shows more continuous attention to their

needs: *"Even when I am working I think of my child, whether he is hungry or had something, what food he wants to have. He loves eating banana, so I grew banana tree in back yard of garden. Now I take care of him. I am worried if he gets sick."* (Participant 5K).

Similarly, there were many caregivers who explained what the children like to do (e.g. play with clay, play with their sisters, jump on their backs during trips into the field, eat Dal, taking care of the younger children, etc.), and to some extent how their moods can change (e.g. when they smile, get frustrated, tired or weary) and how they respond to that.

Finally, the speeches also revealed a change in perspective on what sort of perspective caregivers held of the child (**item 4)**. In general, they seemed more conscious of the idea that children have a right to happiness, and should be respected as a whole being. This is reflected in the statements of e.g. the following mothers:

'He is an independent individual, I need to respect his feeling like I do with my husband and father in law (Participant, 5K) *.*

Child needs to be cared for and he need to be given value, like adults." (Participant 06K).

"He is a child, not an animal, he can understand if we explain properly, no need to hurt." (Participant 07M).

Similarly, more positive feelings were shown towards children in the post-assessment, as reflected in their ways of responding to certain behavioural trends. Parents were particularly more lenient and, in fact, encouraging towards their children's curiosity. Almost all mothers during pre-assessment said that they used to get irritated when a child asks them questions; they would hit, slap and scold the child when they commit some mistakes. For instance, one mother:

"If he disputes with his friends, I warn him not to behave like that, if he does not follow my instruction I beat him and scold him, to restrict and maintain his behaviour. (Participant 10 M, Pre-assessment).

In the post-assessment, mothers did not talk about punishment in the three minutes free flow speech. Most of the mothers realized providing an explanation of the situation was stronger than hitting and scolding the child. *"I kiss her and keep her on my lap. When she makes some mistakes, instead of scolding I explain her why she needs to follow the given instruction (Participant 10M, post assessment).* These statements reflect how mothers are perhaps more constructive in their attitude towards children. Furthermore, mothers started showing their love to children more affectionately compared to before they attended the parenting sessions: *"I learned that from our polite behaviour we also can change the behaviour of our children; when he follows me or obeys my things, I praise him thanking and kissing him. (Participant 4K, post-assessment).* It's interesting to note that some mothers shared that, when children did not listen to them earlier they got angry and would start hitting them, but now they distract them and control their anger by quietly staying away for 5-10 minutes or detaching themselves from the situation of conflict.

PARENT-CHILD ACTIVITY

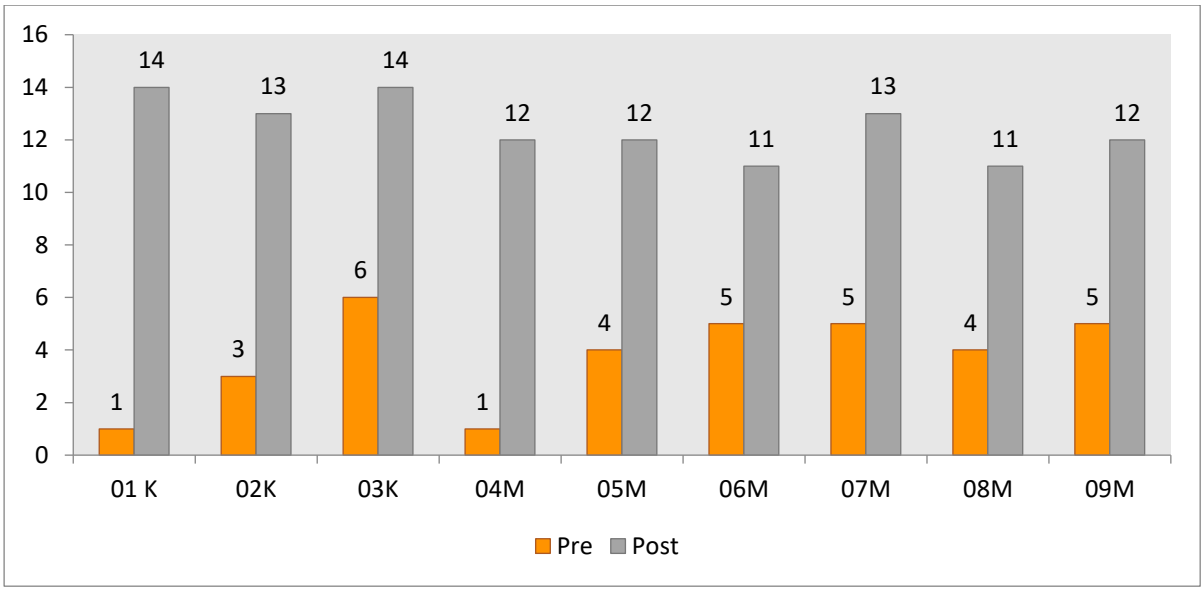
Altogether, 9 out of 12 caregivers or mothers included in the pre-assessment were invited for post – assessment, as the other 3 mothers did not attend enough number of parenting sessions to make a post assessment purposeful. Their interactions with the child were assessed using the PICCOLO tool by two ICDP facilitators. Most parents seemed at ease during the activities, which ranged from bathing the child to feeding the child and putting them to sleep. While the activity (which was video-recorded) formed the main focus of the scoring, the entire home-visit (from entering the house to leaving again) was observed closely to witness relevant interactions between the caregiver and the children.

1. Affection

The theme of affection includes items related to warmth, physical closeness, and positive expression towards the child. It comprises seven sub-components; speak in a warm tone of voice, smile at child, praise child, being physically close to child, use positive expressions with child, engaged in interacting with child, show emotional support.

In the pre-assessment, 10 out of 12 caretakers/mothers fell in the High- Risk group, while two performed as Medium Risk.[10] The mean score was 3.9. The main reason for the low scoring was the relative absence of warm tone of voice, praising or positive expressions. This improved quite remarkably, as in the post-assessment all caretakers belonged to strength (positive) group, with scores 11-14, out of a total 16. The mean score increased to 12.4 (see graph 2). The main differences were noticed in caregivers bringing themselves to eye-level with the children, soothing them, having more smiling or comforting expressions on their face, etc. Before, in some of the activities, we could see that because of the relative absence of affection there was also either more resistance witnessed in the child (e.g. during a massage the child would make efforts to get away) or the child would be a little placid in behaviour, without much connection with the parent. For instance, in case of one mother (K5), she was holding her baby without much eye-contact and affection, which changed towards praising her child and kissing him frequently during the post-assessment. Generally, there were more moments of shared laughter and warmth, as well as reassuring gestures coming from the caregivers.

[10] Cut off point for High Risk (6,7,7 for 1,2 and 3 yrs. old); Moderate risk (7-9 for 1 yr., 8-10 for 2 & 3 yr. olds) and Strength/Good 10-14 for 1 yr. old, 11-14 for 2 & 3 year olds)



Graph 2. PICCOLO: Affection

2. Responsiveness

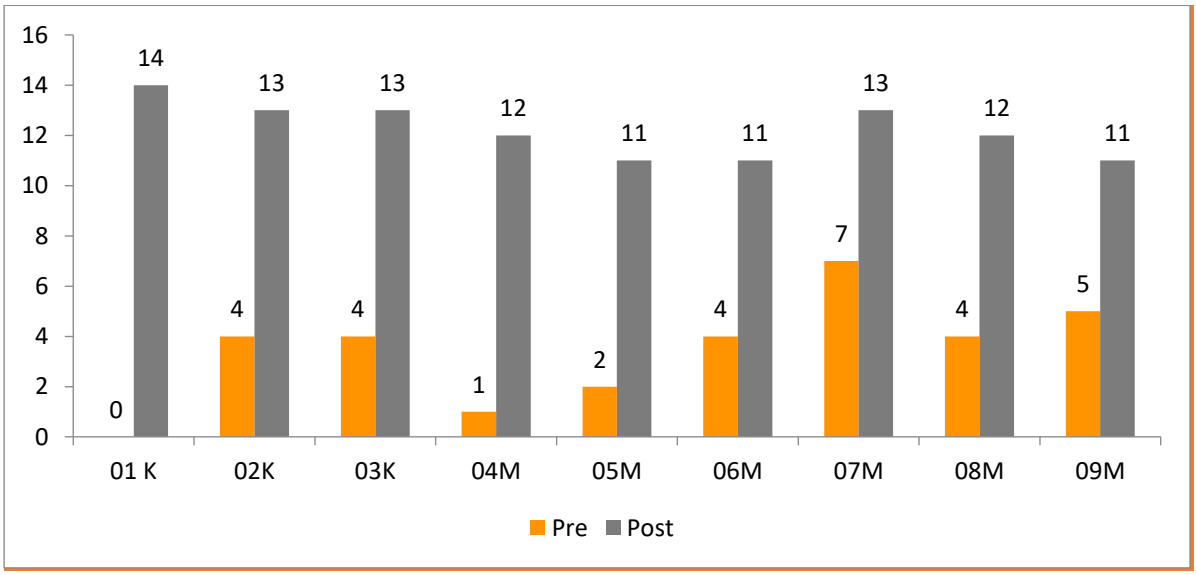
The Responsiveness component involves responding to the child's cues, emotions, words, interests, and behaviours. It comprises seven sub-components such as paying attention to what the child is doing, changing pace or activity to meet the child's interest or needs, being flexible about the child's change of activities or interests, following what the child is trying to do, responding to the child's emotions, looking at the child talk or making sounds, and replying to the child's words or sounds.

The pre- and post-assessment scores indicate that care givers' composite responsiveness score on the above said sub-components increased highly after they participated in the ICPD parenting sessions. Under responsiveness component seven sub-components were observed during mother- child interaction. The composite score of each caretaker in the pre- assessment ranged from 0 to 6 which increased to 10 to 14 in the post-assessment. The responsiveness mean score increased from 3.4 in the pre-assessment to 12.2 in the post assessment.

What was witnessed earlier was the tendency of caregivers to control and monitor the activity; making sure it would be completed well. An excerpt of one of the post-assessments conducted in Kavre displays the level of responsiveness in a mother, as representative to other caregivers as well (box 2).

Box 2. Mother washing and massaging her baby

This mother lives with her husband, baby and mother-in-law in the hills. During the pre-assessment her son was about 8 months old, and now he's about 1. She attended all the sessions with much interest. During the pre-assessment, where she undressed and put the child to bed, her actions were somewhat hurried and her expressions cold. The child was placid and did not show much emotion. The post-assessment shows a somewhat different picture. The mother is relaxed, and she begins the activity with picking up the child with outstretched arms, an open smile, and her body levelled to his position. As the child responds, she brings him to the water bucket outside. She continuously keeps eye-contact, while feeling the temperature of the water and effectively undresses the baby. During the bathing, she explains what a good boy he is and how clean he will be. She responds to his intentions to feel the water, and gives him a little bucket to clean himself too. He likes that, which she reflects back to him. When the water comes in his face, the child responds upset and tries to get away, but she focuses her attention effectively on his, by saying: *'ah, that must be a little cold and annoying, isn't it? But we are almost done'.* Later, during the massage, the baby wants to hold the oil bottle, and she allows him to play with it while she finishes the routine. The whole time the mother smiles and seems at ease with the situation.



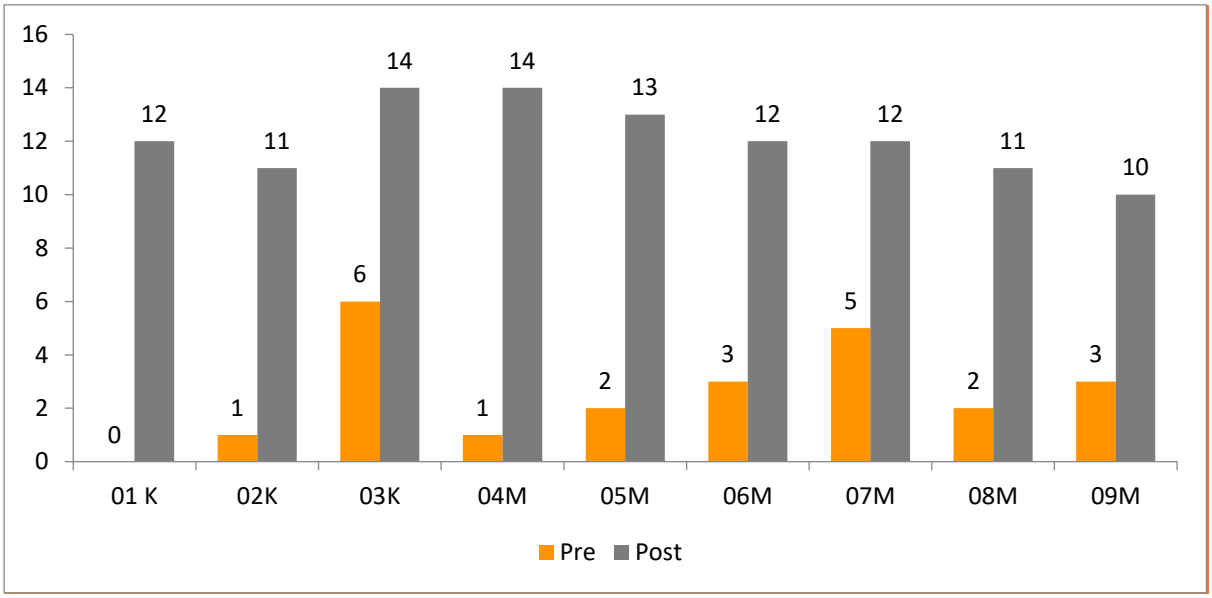
Graph 3. PICCOLO: Responsiveness

3. Encouragement

The encouragement component in the PICCOLO scale contains seven different sub-components such as waiting for the child's response after suggestion, encouraging the child to handle toys, support to the child's choices or activity changes, support the child to do activities on his/her own, verbally encourage the child's efforts, offering suggestions to help the child, and showing enthusiasm about what the child is doing. In the pre-assessment, none of the mothers clearly demonstrated behaviors that encouraged their children in any of the seven activities. In total, all mothers' interactions with their children fell under "high risk". In the post-assessment, all mothers' interactions with their child

were found strong/positive. The mean encouragement score increased from 2.5 in the pre-assessment to 12.1 in the post-assessment.

Mostly, this had to do with the caregivers being more enthusiastic and attentive to their children's initiatives or actions. For instance, one mother in Mahottari (12M), during the pre-assessment was working in the kitchen and peeling potatoes, while her child was sitting near and tried to copy her and failed. The mother ignores this activity, and does not explain. During the post-assessment, there was more contact, and at some point, the child tries to eat peanuts. The mother explains to him how to peel the nuts and eat them, and explains why eating peanuts is good for him.



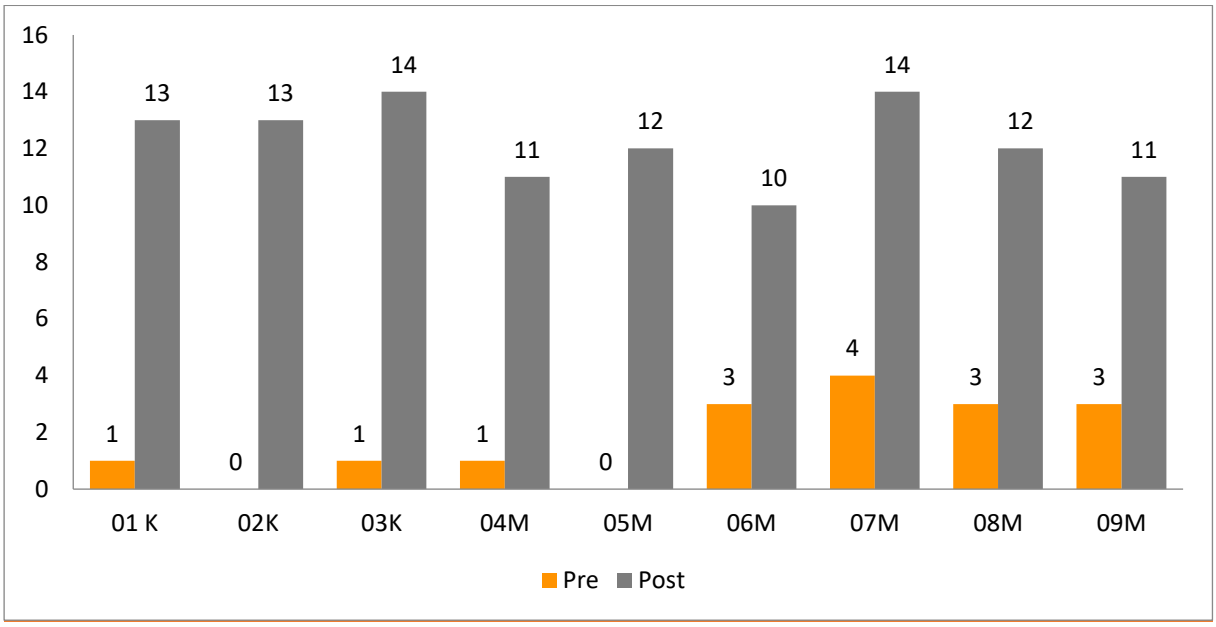
Graph 4. PICCOLO: Encouragement

4) Teaching

The teaching component has eight sub-components. It includes; explaining reasons for something to the child, suggesting activities to extend what the child is doing, repeating or expanding the child's words or sounds, labelling objects or actions for the child, engaging in pretend play with the child, doing activities in a sequence of steps, talking to the child about characteristics of objects and asking the child for information.

In the pre-assessment none of the mothers demonstrated any teaching activity "clearly". Half of the mothers "barely" explained reasons for something to their children and repeated or expanded their child's words or sounds. None of the mothers taught their children to do activities in a sequence of steps. The pre-assessment score ranged from 0 to 4 whereas the post-assessment scores varied from 10 to 14. The mean composite score increased from 2.5 in pre-assessment to 12.2 in the post-assessment. This has much to do with caregivers explaining and describing more. For example, in the pre-assessment, one mother K4 spends 30 minutes on a household chore without engaging the child or explaining anything. There was no communication between the two. During the post-assessment, she was found explaining every step to her child, all the while making eye-contact. Similarly, more

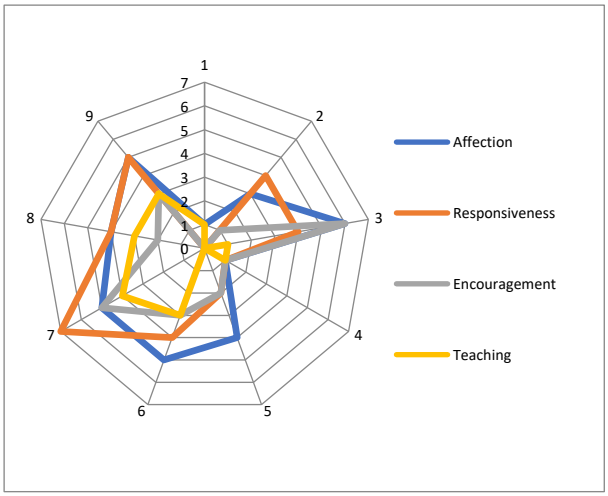
mothers explained certain characteristics of the objects around them, or in reference to the activity they were performing.



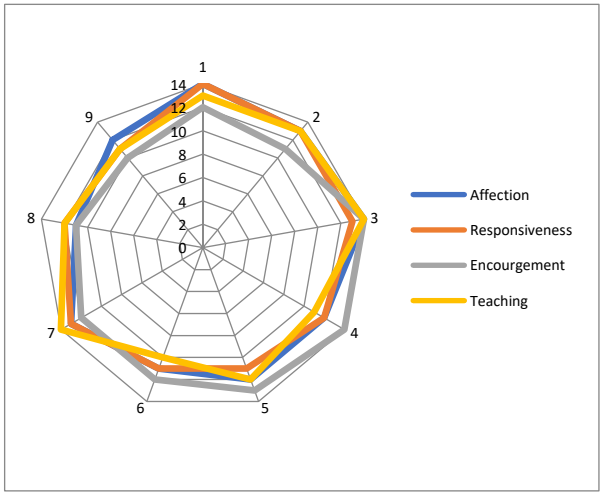
Graph 5. PICCOLO: Teaching

The pre-assessment findings on mother-child interactions on the four key components of PICCOLO; affection, responsiveness, encouragement and teaching, is illustrated by the 'spider's web' diagram (graph 6 and 7). It shows mothers' interactions with their children were at "high risk". The findings indicated a room for improvement after the ICDP intervention sessions. It was expected to change scores from 'high risk' to 'moderate risk' and 'strength/good' categories in each of the four key components after mothers' participation in the parenting sessions in the project communities. In line with the expectations, the post-assessment scores improved considerably in the post-assessment, as witnessed in the expanding spider webs.

a) Pre-assessment

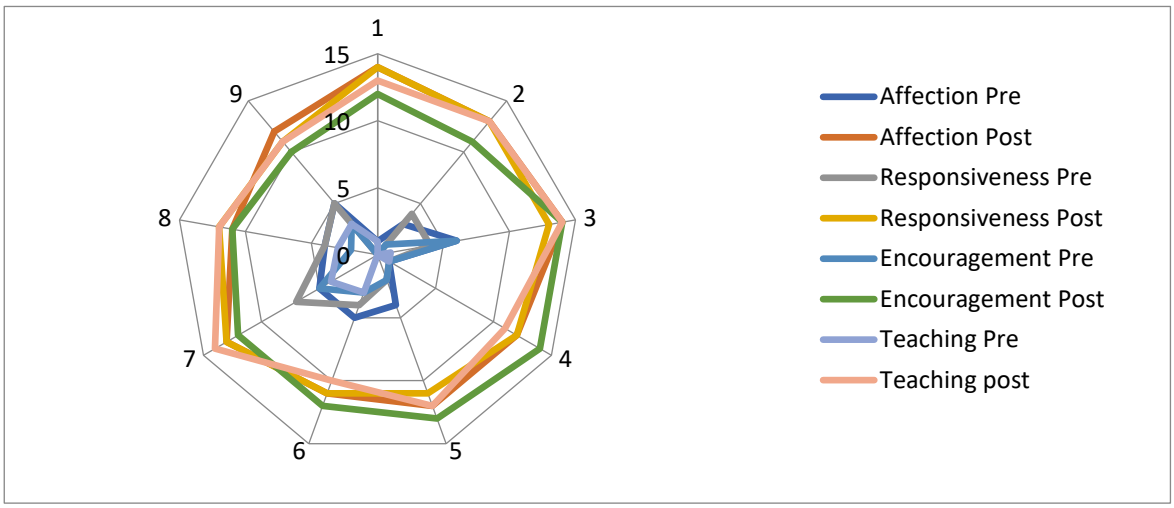


b) Post-assessment



Graph 6 & 7. PICCOLO Scores of caretakers on four key components

Alternatively, we display the pre- & post-assessment scores together to illustrate the progression in one figure (graph 8).



Graph 8. Final average score differences PICCOLO between pre- & post-assessment

FOCUS GROUP DISCUSSIONS & IN-DEPTH INTERVIEWS: LESSONS LEARNED

The data analysis of the FGDs with caregivers, and facilitators generated more in-depth information regarding the following:

- The overall experiences of caregivers as participants of the ICDP.
- Lessons learned, examples of practical implementation, and the family's response to the change.
- The practical implementation of the ICDP sessions in Kavre and Mahottari, and suggestions for improvement of programme in the current context.

Overall experience

From asking caregivers about their overall experience, there are some differences detected in how enthusiastically and easily participants respond, not only between the different districts [redacted] but also at times between communities within the districts. Generally, [redacted] caregivers express themselves more elaborately and enthusiastically about their experiences. This might be due to contextual differences as earlier explained, or some methodological/operational variances.

Nevertheless, caregivers share interesting insights with regards to how the programme itself was experienced. For some parents, the programme was initially regarded with some apprehension. Some parents felt that their children were too young still for them to learn something useful about parenting (because the baby just needs to be fed and cleaned), but after two sessions changed their mind. Others felt that the programme was perhaps some economic scheme, just for facilitators to make money, but similarly turned around after one or two sessions, finding the sessions to be very useful. Finally, there was also one mother who expressed to feel a little unworthy at first to learning something new. She expressed that coming from a Dalit community made her feel like this, but that she was very happy to

have continued the program. She realized it was very worthwhile for her to be part of the program. She also tries to share her lessons to other community members now.

During the FGDs it became clear that caregivers were very appreciative of the program, and shared that it was beneficial to them in many ways. It helped them to support their children in their development, and made them aware of the developmental stages of their children and how to respond to these. Some shared they didn't know how to really care for the children at first, and this programme thus helps them practically. During a FGD in [redacted] mother 1 shared:

'I'm so happy with the program. It is totally different now! Before the training we just didn't really know how to love the baby or take care of it. When to provide it food for instance, we just sort of did something. There was no fixed schedule or plan. Also, I wasn't aware that if I'm busy, I still need to make sure to be present to my child. To respond to her...'

Caregivers also explained that coming together with other parents was very valuable. One mother of two children in [redacted] xplained that she used to walk at least 30 minutes through the hills to get to the sessions, but she did so gladly, because she learned so much from the other parents. When asking her if this was otherwise practiced in her community, she said: '*no, we talk about the children sometimes, but we never share ideas about parenting. It was nice to reflect on how to respond to a child in different situations.'*

Finally, some few remarks made regarding the impact of the ICDP on the co-parenting practices between husbands and wives were noteworthy. It seems that the context in Nepal offers challenges for wives to participate, as some families are worried it might emancipate the women too much[11]. However, when these challenges are overcome, and in some cases, fathers actually participated in some of the sessions, parents became better at negotiating their ideas on parenting. One mother in Kavre, explained:

'*My husband came with me to all the sessions. We do the parenting together now and discuss the lessons from the classes together and how we want to implement it. We remind each other of the ICDP program. One outcome is that we don't want to fight in front of the children, when we are angry.'*

<u>Lessons learned and implemented</u>

When asking caregivers directly about the benefits they gained from the program, the following topics were most emphasized (and with these wordings):

- *Respect and importance of loving the child.*

When asking about lessons learned, and analysing the responses, it is interesting to pay attention to the level of 'originality' in the responses. When parents recite a lesson in their own words, with a sense of enthusiasm, it somehow indicates that this lesson was important to him or her. This is different from a response that reflects an often-repeated version of a lesson, using the exact words as mentioned in the ICDP itself. Taking note of this, the varied and rich data reveals that in both Kavre and Mahottari caregivers found considerable value in learning to change their mind-set towards children, and what they need from parents. This came up in various different ways, with some caregivers referring to

[11] This is explained in more depth in the discussion.

children as deserving the same respect as adults, whereas previously they were considered as less important. During a FGD in Kavre the following was mentioned by two mothers:

'*During one session there was a story on how we respond when an adult drops a glass versus the child. In fact, we should treat both with respect and some patience. The child deserves to be treated well and with love'.*

and,

'We realize that the chil is not just a thing, or an inferior human being, but just like adults we should treat them with respect.'

A mother in [redacted] xplained:

'I need to think that she is a complete single individual like others. So, I need to address her needs and her wishes. Providing nickname is also not good, they may feel humiliated; we need to treat them a bit more like adults.'

Other caregivers share that they now understand that the children do not just need food but also love to grow and develop to become good human beings (read: human beings that can learn, grow and be happy). Some caregivers relate this to the 'sunflower'-analogy; a child is like a flower that needs a seed, nourishment of the soil, enough sunlight and rain, all to grow well.

Similarly, this new awareness was expressed by another mother as leading to the realisation that she can already nurture her child when it doesn't have all the functions (e.g. of speaking) yet. She:

'*Earlier I just fed and cleaned my baby. But as the training continued I realized the changes in myself; I was talking to the baby more, perhaps because she was growing also, but I think it had something to do with the programme..i became aware that I should interact with her, even if she doesn't speak back yet.'*

Finally, some caregivers expressed their 'new mindset' in reference to their own role and behaviour. Both participants in [redacted] shared how they learned that the child should not work too much, but go to school. Also, many parents commented on the fact that now they felt it was necessary for them to share with the small children whenever they would go to the field to work, and when they would return. Earlier they would just leave the child in the baby court and go without engaging the child in their plan. This simply changed as they realized that the children are already affected by such expressions of love and care. When asking caregivers why they felt it was important to change their behaviour, many confirmed that it would help the children grow and develop into happy beings.

- Emotional dialogue, kissing, praising and following the child's lead.

During the pre-assessment it was shown that parents were already, to some degree, holding their babies close, and showing their love through kisses and hugs. Similarly, the age of the children in this particular pilot study quite naturally leads to such expressions. Nevertheless, caregivers showed in many ways to be more attentive to the needs of the children, or, as one mother explained: '*to not overrule them all the time'*. One Kavre mother shared:

'*I definitely kiss the child more often than before and give him more affection. I wish I had done this earlier with my oldest daughter as well; I was more harsh and inattentive then. Now I do help her with her homework.. earlier I felt I couldn't because I'm not educated, but I just sit with her now'.*

Another mother shared about being more attentive to her children's moods:

'*The other day my child was suddenly sad. Now when my child is sad about something, I ask: what makes you feel sad? She shared that she wanted me to play with her. Slowly, slowly, I see more of her interests and needs and try to respond.'*

- *Teaching and expanding the child's world.*

Caregivers also shared in-depth about how the ICDP has changed their perspective on teaching new things to the child. They suggested that children should be taught step by step, shown new things, and that it is important to start early with this. One mother explained that the mind of the child is so quick to learn new things, and that they could encourage this.

In a similar vein, many caregivers made remarks regarding the curiosity of their children. Ample examples were provided on children asking questions, to which the parents respond with more positive and patient attitudes. While earlier these questions would be ignored by parents or followed by negative remarks, caregivers now try to encourage their children's curiosity by responding. One mother: '*haha, even when I don't know the answer, or the question is seemingly so stupid (like, who is that man, or why does this woman do that?), I do try to give some reply.'*

When asking about 'how' caregivers like to expand their children's learning experiences, caregivers give detailed accounts on how they involve them in learning about cooking, washing themselves, or fetching water. As one mother in Kavre shared: *'After explaining all about the rice and how to cook it, my son expressed confidently: I can do it as well!*'. Some caregivers explain that they need to trust the children or follow their lead a bit more. For instance, a mother expressed that she knows that her daughter can't do the dishes properly yet, and it will take her time to repeat after her, yet still she allows her daughter to do it if she wants to learn. Another story (box 3) reflects how parents implement these lessons, and indeed experiment in small ways to give their children more learning opportunities.

Box 3: Child learns to fetch the water. Kavre, Nepal.

A mother with one child of 5 years old explains how she responds one day to her child's request of getting the water:

'Not long ago my little child kept saying: *'please can I fetch the water? I can do it, I'm big enough!'.* She's very small and so I doubted whether she could indeed take the water! Normally I would have been impatient after her nagging and ignored her. But this time I tried to listen and think, maybe she can do it. I gave her a smaller bucket and she went to fetch the water. Of course, it was very heavy for her still and the exercise made her very tired. She then became a little whiny and wanted food from me and a massage. I gave her some food and just laughed. Later, when we were doing the dishes, she kept saying so proudly*: 'I have fetched this water, it is my water!'* Also, she didn't want anyone to spill any of the water, and even was proud to tell my husband that she had brought the water herself. It made me feel nice that she was so happy about it, which before I would not have allowed.

- *Regulating behaviour: from spanking & scolding, to explaining and inclusive planning*

What came up repeatedly in each IDI and FGD was the fact that parents don't want to physically punish their children anymore. This was an important lesson for parents; to not beat, spank or scold their children. They make many references to this as for instance, in Mahottari, by one mother:

(laughing) It took some time to change my old habits, because I had a rule of scolding and hitting my child for long. But now, whenever I raise my hand to hit her, I remember the parenting class. When I get irritated, I try to leave my child to my husband and go out for a while, which helps to distract me and to resolve the conflict.'

Other caregivers confirmed to have spanked their children, as this is part of how they have been raised themselves. In fact, some parents deal with the fact that their parents-in-law judge them for not spanking their children, advising that this is what they need to learn for better behaviour. Interestingly, caregivers can refer to the lessons of the ICDP to better defend their child rearing ideas, as some express to have come to a joint understanding in the family on this topic.

When asking caregivers on what they alternatively use to correct their children's behaviour, most refer to two sets of skills: 1) Explaining and confirmation of good behaviour, and 2) Preparation and inclusive planning.

Caregivers, first, try to describe and explain to children why they expect certain behaviours from them (1). As one mother in Kavre shares:

'I try to explain things with calm voice now. One day my child came home early from school because he had heard the school bell ring (after lunch) and thought the day was over. When she arrived at home, I didn't get angry but stayed positive and explained how the bell works. Then I brought him back to school.'

Another parent expressed how she used to control her baby's behaviour during bathing:

'Earlier I used to bath my child but he would not like the water. In order to control him I would just hold him tight and sometimes use beating. If he was crying I would be quite harsh and forceful. Now I see that I praise him when he's doing well, like 'good boy', or explain that it is almost done or that he will be nicely clean after this. Earlier he would try to run away and I'd grab him, but now as I motivate him positively, he follows better.'

Preparing well and including children in the planning (2) was also considered an important parenting skill for many participants. For instance, engaging children in what will happen when they go to the market to buy food helps to prevent tantrums and undesired demands for snacks or money. Parents found it valuable to have learned about the ways in which children can be given some foresight on how much money they will be taking, what food they will need to buy, and what will then still be left for a small additional treat. Even young children are thus able to comprehend what they can expect when going to the market and are less likely to become upset.

Finally, some parents worried about how the behaviour of children might be regulated as they grow older and are influenced by other peers, and modern factors like Facebook and drinking. They felt it

was perhaps more challenging to raise older children. As a mother said: '*I don't want my child to start lying to me like other older children do'.*

Interestingly, a father remarked during an IDI that having a good connection and attachment with the child also helps to prevent negative behaviour. To show your love and support, so that the child also accepts difficult situations and limits better.

'For instance, we try to bring her to school now every day. This makes her very happy. But now when it so happens that we can't take her, she also does not rebel, because she sees that we try at least. The relationship improved.'

Practical implementation of the ICDP and suggestions for improvements

We asked ICDP facilitators in Kavre and Mahottari to score the sessions of the ICDP with regards to how well these topics were conveyed, understood and practiced by the caregivers. The sessions included topics as indicated in table 3. below. We invited facilitators to score each session on a scale from 1 (not at all successful) to 5 (very successful). Unfortunately, this process did not elicit much useful data in Mahottari, as the facilitators scored all sessions with the highest score only (thus not showing much variation). We therefore reflect on the Kavre data to begin with, and use the descriptive data of Mahottari to supplement the analysis.

As seen in table 4., particularly topics related to love, close communication, and focusing were rated high. Following the child's lead and praising were rated relatively low, as well as expanding and step by step scaffolding.

Table 3: sessions and ICDP topics

Session no.	Topics addressed
1	Redefinition of the child Empathy
2	Love Following the child's initiative
3	Close Communication Praise
4	Focusing Describing and giving meaning
5	Expanding
6	Setting positive limits
7	Step by step scaffolding

Table 4: overview of scores given to 7 ICDP sessions based on a scale from 1 to 5.

Facilitator no.	**1**	**2**	**3**	**4**	**5**	**Accumulated average score**
Session	Score	Score	Score	Score	score	
1	4	4	4	4	3	**19**
2	3	3	4	4	3	**17**
3	3	4	4	4	4	**19**
4	4	3	3	4	3	**17**
5	3	4	3	3	4	**17**
6	3	4	3	3	4	**17**
7	4	3	3	3	4	**17**

Subsequently we discussed with the facilitators *how* and *why* some topics were better received than others. Here also, there was not so much variation in end score, but the exercise did bring up lots of discussion. We highlight a few facilitating and hindering factors as derived from these sessions.

- *Facilitating factors: stories, home-visits and exercises.*

First, according to facilitators, the first session worked particularly well because there were stories and exercises involved that helped parents 'experience' and 'have an emotional response to' certain parenting situations. The session includes an exercise where parents think about their own childhood, which is quite emotional for some caregivers. Bringing up these memories helps parents connect with the idea of empathy, according to facilitators. Similarly, there was a role-play introduced around a story of an adult dropping a glass, versus a child dropping a glass (read: this story was also brought up during the IDI's by caregivers). The elderly man was easily accepted for making his mistake, while the child was punished. This story was very confronting for the parents which encouraged them to change their mind-set. The facilitators also said that, because empathy is not an easy word to translate to Nepalese, it is important to make parents 'feel' what it means.

Exercises were also mentioned as valuable tools to encourage caregivers to imbibe new lessons. It helps to make sure parents actually practice with a new concept. For instance, following the child's lead needs to be practiced because otherwise parents are too busy to notice the moods and behaviours of the child. One facilitator:

'The parents tell them that they never did this before because they were always focusing on their work. Now it made them to make eye contact and they wanted to spend more time with them.'

The third session was also rated high and involves praising and close communication. The session works well because it includes a story about a father who would work hard to get his child through medical school to be a doctor, but did never show empathy to this child. From this story, parents remember that '*love hunger is worse than hunger*'. This, in combination with more role-play and home-work exercises, worked to motivate parents to have closer communication their children and praise more. One facilitator:

'What really happened is that the parents have love in their heart for the child, but they never show it. Now they really show the love'.

A side-note to this is that facilitators seemed to bring this concept of praising forward as connected to '*doing good work'* (the exercise was phrased as: *how do you praise your child when they do good work*?). It might be helpful to clarify how the ICDP presents this concept.

Hindering factors: Issues of contextualization.

From the data it seems that most of the lessons are indeed transmitted and imbibed through stories, and practice in the local context. Caregivers clearly recall stories more than distinct sessions or even topics, and facilitators confirm that stories work effectively in the given contexts. As such, it is perhaps worth putting attention to the type of stories that are used and how relevant they are to the contexts of the [redacted] istricts in Nepal, as well as the developmental stage of the child the story seems to address (to see if this is in line with the age of the caregiver's children also). To this end, facilitators expressed to have encountered some difficulties in contextualizing the ICDP stories, and needing time to develop perhaps new stories that match the given parameters of culture and the children's age, better. Not just the stories, but any form of drama, role-play, and parenting examples used as material in the programme require this level of contextualisation, especially as these seem to be notably important modes of learning. According to the facilitators, some material lacks proper translation, is derived from other countries (e.g. Brazil), or fails to talk about a topic (e.g. setting positive limits) in a way that caregivers with children in a particular age can actually work with.

A second challenge addressed by respondents was the occasional resistance experienced from other family members with regards to the parenting program. In some three to five cases the husband or family-in -law would be opposed to the idea of the mother learning something new about parenting. This issue is not sufficiently explored as to why this resistance might have occurred, but it was suggested that the idea of emancipating the mother, or allowing her to learn something new, is not always welcomed. In some cases, the mother was forbidden by the family to participate entirely or asked to leave the class on occasion. In other cases, the mother would be allowed to participate, but resistance would be experienced at the level of actually adopting the lessons (such as the concept of 'not spanking' as earlier mentioned). In general, such situations can bring challenges for the facilitators, and it takes additional time to align the program's intentions with the family's norms and values. Facilitators also mention that some caregivers experience being teased and humoured at times for their participation by other community members, telling them: '*We have children and don't need to learn about parenting. Why do you need that?*' Although this is certainly an important issue, it is also rather exceptional and not experienced by many families.

SUMMARY AND DISCUSSION

This qualitative study was conducted to understand the impact of the ICDP on the positive parent-child relationship between caregivers and children in two different districts in Nepal. The analysis of the data was focused on finding differences in parental behaviour & interaction patterns in before-and after data, and as narrated through the stories of significant change. Four tools were used to conduct the data collection, including the TMSS, the parent-child activity, follow-up IDI's and FGDs with caregivers, and facilitators. The triangulation of data sources helped to validate the data.

Overall, the findings show a transformation with regards to how caregivers think about their children; from somewhat lower-ranked objects to complete persons with distinct human rights and needs. During the post-assessment, caregivers talked about their children as deserving of love, attention and respect (similar to an adult). Similarly, they shared about seeing the value of nurturing the child, not only with food, hygiene and schooling, but also with love (e.g. the sun-flower analogy).

What seems to have emerged from this paradigm shift and the additional ICDP lessons caregivers learned is an enhanced ability to 1) show love and positive feelings to the children, 2) expand the children's learning opportunities, and 3) positively regulate the behaviour of the child. Caregivers give accounts of their learning through uniquely formulated examples, which could indicate a process of 'second-order' learning[12]. This is witnessed, for instance, in the story about the child being allowed to fetch water (illustrating the adoption of guideline 2 and 6).

These accounts were reasonably confirmed by the observations made during the parent-child activity. The post-assessment data showed caregivers to be more relaxed, affectionate and responsive towards their children, with increased non-verbal expressions of care (e.g. smiling, nodding, eye-contact, and levelling with the child's height). Similarly, children's intentions were picked up on regular occasions, such as their desire to pick up- or hold something as a toy, their pointing at objects, etc. Parents recognized these actions, and integrated them as part of the activity (e.g. bathing and massaging). Finally, caregivers were also more able to encourage and expand their children's experience of the world, by 1) offering more opportunities for learning and scaffolding (e.g. helping the child understand their surrounding) and 2) using current scenario's for learning new principles, such as e.g. how to peel and eat peanuts.

What remains more challenging, perhaps, particularly as addressed by the caregivers themselves, is setting positive limits to older children. As children grow up, caregivers find it harder to keep the connection and hold control over their behaviour. Some parents were anxious about their children misbehaving more as they grow older, as they might become influenced by other teenagers or social media. They shared it would be helpful to have sessions on positive limit setting in relation to teenage and adolescent children. Therefore, although the programme is focused on caregivers with children under 5 years old, it might be helpful to include a session that helps to prepare caregivers for other development phases of the child as well, more specifically the adolescent phase. Otherwise, it was clear that caregivers enjoyed the programme and wish it to be continued and implemented for other parents as well.

[12] Second order learning happens when lessons are adopted in a way that the essential principle can be recognized, adapted and applied by the learner in various new contexts.

Finally, this report reflects on the factors that enable or hinder the success of the ICDP in Nepal. First, stories and contextualized role-plays facilitated the learning of ICDP principles well in both districts. The approach of the ICDP is to '*start with what they know, and build with what they have'*. The stories that work well embody this principle; they connect to what the parents recognize as 'true' in their own context, and then introduce a twist. An example is the story about the elderly man and the child, who both break a glass. In this situation, what happens is that the child is more likely to be punished than the adult. The emotional responses that get evoked in the caregivers through hearing this familiar scenario helps them to also welcome a different one; in which the child is not punished but, with respect, is encouraged to be more careful next time. The alternative scenario is acted out through a role-play by the caregivers themselves. The familiarity and relevance of the story is therefore very important, and, according to facilitators, could be improved in some ways.

The ICDP also does not work with ready-made formula's or materials, but aims to encourage self-exploration to empower and create confidence. To some family and community members in Kavre district, the idea of empowerment was perhaps perceived as a threat to the common family life-style, and hence some resistance was encountered. In such specific situations, it was found useful to continue an open dialogue with the community and the household involved, to ensure the woman could still participate in the parenting sessions.

What is encouraging, finally, is that facilitators are actively shaping and also questioning the material and mode of delivery in the ICDP. This shows that they are confident to co-create new ideas and initiatives, which is also intended by the programme. As there was quite some variation in the self-scoring of the parenting sessions (particularly in Kavre), the self-reflective mindset of the ICDP facilitators was equally demonstrated to be high. Nevertheless, any additional forms of further training, reflection on practice and/or booster sessions are still suggested to help sustain the positive effects of the ICDP in Nepal.

APPENDIX

1. TABLE 1: SCORING FOR THE TMSS.

Likert Scale scoring	**Scores based on the free-flowing speech (3-minute speech).**			
5 - to a very great extent				
4 - to a great extent				
3 – to a medium extent				
2 - to a small extent				
1 –to a very small extent				
	1. Able to reflect on- and speak about the child (*practically speaking, how long and 'rich' is the caregiver's account of the child and their relationship in the free-flowing speech?).*	2. Aware of their role in stimulating the child's development? (*practically speaking, does the caregiver mention his or her role in supporting the child's positive growth in the free-flowing speech?)*	3. Able to describe qualities, needs, wishes and responses/reactions to the world in the child during the free-flowing speech?	4. Able to talk about the child as a person in its own right vs an object (*e.g. an object that can be used for any household chores, labour, or future support to the family*).

2. TABLE 2. PARENT-CHILD ACTIVITY SCORING

Likert Scale scoring	**Scores on 8 dialogues (G1 – G8b) for all 12 caregivers, each performing 2 activities with their child.**								
5 - to a very great extent									
4 - to a great extent									
3 – to a medium extent									
2 - to a small extent									
1 –to a very small extent									
	G. 1	**G. 2**	**G. 3**	**G. 4**	**G. 5**	**G. 6**	**G. 7**	**G. 8a**	**G. 8b**
	How do you show positive feelings, that you love your child?	*How do you follow and respond to the initiatives of your child?*	*How do you hold an intimate dialogue with your child with and without words?*	*How do you praise and give approval for what the child does?*	*How do you share experiences and focus your child's attention with yours?*	*How do you describe and give meaning to your child's experiences and show enthusiasm for your child's experiences?*	*How do you expand and enrich your child's experiences by connecting through imagination and logic?*	*How do you support your child by setting limits in a positive way, by pointing out consequences & offering alternatives?*	*How do you offer gradual support to your child's activities and plan step by step to achieve the goal?*

3. IDI TOPIC LIST

Interview guide post-intervention with caregivers
BEFORE
Can you tell us a little bit about your child?
How was the relationship with your child before you participated in the program?
Were there certain challenges you faced in parenting your child? What were they?
How did you feel about participating in a parenting program? How many sessions did you follow?
ABOUT THE PROGRAM
What did you learn during these sessions?
Did you benefit from the program?
How is the bond with your child now?
How do you implement some of the lessons learned in your parenting? *Can you give some examples?*
(if parent doesn't share much, you can continue to ask if there were any eye=openers/ aha moments)
How does the child respond to you now? *Examples*
Did the programme have any other effects on you? *Positive or negative.*
- If possible, also more deductive questions derived from the ICDP principles: 1. How did the programme influence the quality time you spend with your child? 2. How do you show your love to your child? 3. How do you set limits or regulate the behaviour of your child? 4. How do you help your child learn new things about the world?
FUTURE
Are there any challenges you still experience now in your parenting? What would you like to learn more about?

Do you think this programme should be continued? Why and for whom?
What suggestions do you have for improving the content or structure of the program? *E.g. exercises, time, meeting place, facilitation, other parents, homevisits..*

4. FGD WITH CAREGIVERS: GENERAL STRUCTURE

1. Start with an introduction round in which participants mention their name, age, and focus child. Perhaps also how many sessions they participated in.

2. Invite caregivers to briefly share their first impressions/experiences with the ICDP (1-3 minutes per person).

3. Collecting lessons learned together. One moderator writes along on a chart paper or white board. The caregivers are asked to think of 1 to 3 lessons they remember learning mostly from the ICDP sessions. After all the lessons are collected, and the caregivers feel it is complete, the moderator can ask participants to explain why they chose this lesson and what it means.

4. Stories of Most Significant Change. Caregivers are asked to focus on one or perhaps two specific lessons and think of how their parenting practice has changed in this area. They receive 10 to 20 minutes to write or draw a story of **before** (how they were acting before the programme and how the child responded), what happened in **between** (lessons learned, which session, etc.) and how that improved the situation **now (**what do they do differently and how is the child responding). They are asked to be as specific as possible, including references to the time period, which child it involves, what specific things were said or thought, and how they themselves behaved differently.

** Sometimes a story of caregivers in another site was shared (as a vignette) to inspire or help parents understand the sort of stories would be valuable.*

5. FGD WITH FACILITATORS: GENERAL STRUCTURE

1. Start with an introduction round and/or icebreaker.

2. Find a way to display the ICDP sessions in the space (either on a table or written on a chart paper). Ask the facilitators to score each individual session on a scale from 1 (very low) to 5 (very high) based on 1. The way they themselves understood the session, 2. How well it was implemented in the pilot study and 3. How well caregivers were able to understand and implement the key messages.

3. After scoring and accumulating the scores, the moderator leads a discussion among the facilitators on 1. What went well? And 2. What could have gone better? The moderator aims to understand and create some sense of consensus as to why certain topics were better received than others in the current cultural context.

4. In the final part, facilitators are asked to think of stories of Most Significant Change. They are invited to focus on one particular family in which they have witnessed some sort of transformation. Again they are also invited to share in a rich and detailed manner.